CHAPTER 3

Best Practices in Psychotherapy for Children and Adolescents

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Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder (PTSD) were first developed by an expert panel convened a decade ago by the American Academy of Child and Adolescent Psychiatry (AACAP; 1998). Since the release of that seminal set of practice guidelines, substantial additional validation has been provided in scientific studies of the most robustly evidence-based treatment model, trauma-focused cognitive-behavioral therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006). Other cognitive-behavioral therapy (CBT) interventions that were either developed originally for adults (e.g., eye movement desensitization and reprocessing [EMDR]) (Jabergharderi, Greewald, Rubin, Dolatabadim, & Zand, 2004) or modified for child-specific settings and clinical populations (e.g., cognitive-behavioral intervention for traumatized students [CBITS]) (Kataoka et al., 2003; Stein et al., 2003) have been adapted and tested in children with PTSD. Members of the National Child Traumatic Stress Network's (NCTSN) Complex Trauma Work Group (Cook et al., 2005) have developed and conducted randomized clinical trials (Van Horn & Lieberman, 2008) or scientifically rigorous but preliminary (Blaustein & Kinniburgh, 2007; Cloitre, Cohen, & Koenen, 2006; DeRosa & Pelcovitz, 2008; Ford & Russo, 2006; Kagan, 2008) tests of interventions for children and adolescents with complex traumatic stress disorders.

No new practice guidelines have been published for the treatment of children with PTSD in the past decade. Studies of the best-validated treatments

for children with PTSD have not systematically assessed symptoms of complex traumatic stress disorders, such as dissociation, emotion dysregulation, and somatization, and toxic self-perceptions have not been systematically assessed (Saxe, MacDonald, & Ellis, 2007; Vickerman & Margolin, 2007). Thus, the utility of PTSD psychotherapies for children with complex traumatic stress disorders is uncertain. This chapter, therefore, provides an overview of preliminary practice guidelines for the treatment of children with complex traumatic stress disorders, building on the work of the NCTSN Complex Trauma Work Group (Cook et al., 2005; Spinazzola, Blaustein, & van der Kolk, 2005) and Systems Work Group (Ko et al., in press), as well as guidelines for the treatment of adults with complex traumatic stress disorders (Ford, Courtois, van der Hart, Nijenhuis, & Steele, 2005; Courtois, Ford, & Cloitre, Chapter 4, this volume).

Although empirically supported therapies are essential as a basis for effective treatment of children with psychological disorders, the American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) also identified the experience of skilled clinicians and of ethnoculturally diverse children and families as being necessary to establish a psychotherapy as "evidence based." Therefore, in addition to describing empirically supported and empirically based psychotherapy models, we describe clinicians' observations and key features of children and families that may be relevant to the assessment and psychotherapy of toddlers, children, adolescents, and families with complex traumatic stress disorders.

GOALS OF PSYCHOTHERAPY FOR CHILDREN WITH COMPLEX TRAUMATIC STRESS DISORDERS

The proposed new diagnosis of developmental trauma disorder (DTD; van der Kolk, 2005) and empirically based conceptualizations of the core features of childhood complex traumatic stress disorders (Cloitre et al., 2006; Cook et al., 2005; Ford, 2005; Van Horn & Lieberman, 2008) provide frameworks for delineating the goals of psychotherapy for children with complex traumatic stress disorders. DTD requires a history of exposure to early life, developmentally adverse interpersonal trauma (Ford, 2005), such as sexual or physical abuse, violence, traumatic losses, or other significant disruption or betrayal (Freyd, 1994) of the child's relationships with primary caregivers (Schore, 2001), which has been postulated as an etiological basis for complex traumatic stress disorders (Herman, 1992; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Serious and lasting alterations in the neurobiological substrates of emotion, information processing, bodily self-regulation, consciousness and motivation, and attachment often occur following complex trauma in early childhood (Browne & Winkelman, 2007; Dumont, Widom, & Czaja, 2007; Finkelhor, Ormrod, & Turner, 2007).

Increasing Affect Regulation and Impulse Control

To manage distress, think clearly, and make and act on choices that optimize the social and academic consequences, children need to be able to recognize, label, and modulate the behavioral expression of emotions and impulses. A primary goal of psychotherapy with children with complex trauma is to enable them (and their caregivers) to experience emotions and motivational states as tolerable, helpful, and practically manageable. Acquiring the capacities for emotion regulation requires safe, facilitated opportunities for playing, exploring, learning, and developing relationships with adults and peers in which other persons model mindful ways to recognize and verbalize emotions and goals (wishes, hopes, intentions). In psychotherapy, traumatized children can acquire the capacities necessary for recognizing, expressing, and modulating (i.e., restoring a tolerable and balanced level of affective and physiological arousal) a range of emotions. Helping children (and caregivers) enhance their abilities to regulate emotions and impulses may increase the child's (and the caregiver's) self-control, thereby reducing the risk or severity of the myriad dilemmas that occur when emotions and impulses are dysregulated.

Altered Information Processing (Attention, Memory, and Executive Functions)

Children who have been maltreated or exposed to pervasive domestic violence or profound traumatic loss often present clinically with problems in sustaining and focusing attention, in remembering both immediate and remote experiences and events, in thinking clearly when making decisions and planning courses of action, and in following through in pursuit of their plans and goals. Although these difficulties in information processing may be due, at least in part, to purely physiological causes (e.g., traumatic brain injury, neurological disease) or genetically based conditions (e.g., attention-deficit/hyperactivity disorder [ADHD], learning disabilities), the impact of prolonged severe stressors on the developing nervous system includes alterations in brain chemistry, structure, and function that may impair attentional focusing, memory, and executive decision making and goal-directed behavior (De Bellis, 2001).

Dissociation (Dysregulation of Motivation and Consciousness)

If emotions and impulses are poorly regulated and information processing is compromised by stress reactivity, then the child is likely to have difficulty in accessing and sustaining a clear and consistent motivation other than avoidance and hypervigilant self-protection. Avoidance and hypervigilance require a great deal of cognitive capacity and neurobiological resources, except when done automatically (i.e., without conscious awareness or control). As they become automatic, avoidance and hypervigilance shift from conscious avoid-

ance and self-protection to dissociative detachment and fragmentation of consciousness into compartmentalized, disconnected parts of the self, each of which is defined by a distinct dominant motivation or set of motivations (Steele & van der Hart, Chapter 7, this volume). What begins as an attempt to survive and to cope with traumatic stress may devolve into dissociation: detached and fragmented emotions, thoughts, perceptions, and self-awareness outside of conscious awareness or control. The optimal alternative to dissociative fragmentation is a mindful, self-aware, emotionally attuned, and cognitively planful approach to each step in ordinary day-to-day activities.

Somatization (Dysregulation of Bodily Functioning)

Traumatized children, particularly if the psychological traumas involved pervasive violence, neglect, or abuse by persons whom the child otherwise would have reason to trust—and most especially when those persons are the children's primary caregivers and role models—often report persistent chronic or episodic physical discomfort, distress, and illness symptoms (Cook et al., 2005; van der Kolk, 2005). Posttraumatic somatic complaints may be the product of several, often interrelated etiological factors, including (1) medically diagnosed illnesses, conditions, or injuries that are exacerbated by traumatic stress reactions (e.g., orthopedic conditions, asthma, congenital cardiovascular or neurological syndromes) or for which persistent stress reactions (e.g., irritable bowel syndrome) or health risk behaviors associated with traumatic stress reactions (e.g., obesity secondary to overeating, bronchitis secondary to cigarette smoking) may play a partial causal role; and (2) medically unexplained physical symptoms that are associated with emotion dysregulation (e.g., gastrointestinal or sexual organ pain, or conversion disorders related to alexithymia) or severe dissociation (e.g., tics, pseudoseizures, paralysis, or pain related to somatoform dissociation). The common therapeutic goal for all of the many complex forms of somatic dysregulation is to enable the children (and caregivers) to be able to recognize, label (in terms of discrete ordinary bodily sensations and physical/affective feelings), and utilize input from their bodies as a guide to managing their emotions, drawing on their cognitive competencies, and making purposeful consequence-sensitive behavioral choices that help their bodies to feel and be healthy.

Disorganized Attachment (Relational Dysregulation)

Children with complex traumatic stress disorders commonly present with disorganized patterns of engagement and withdrawal in relationships (Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006). Disorganized attachment involves a constellation of forms of relational dysregulation, including generalized expectancies ("working models"; Bowlby, 1969) based on profound distrust, alienation, and devaluation (van der Kolk, 2005), and patterns of interpersonal interaction characterized by all of the hallmarks of complex traumatic

stress disorders: emotion dysregulation, fragmented information processing, impulsive/avoidant behavioral self-management, dissociation, and somatization (Ford, 2005).

Summary

The goals of psychotherapy for children with complex trauma involve all domains of biopsychosocial functioning. The challenge to the clinician is to observe recursively, conceptualize, and intervene, with a simultaneous focus on all of these domains, while maintaining an awareness of the child as a whole person (not simply as a collection of emotions, bodily reactions, thought processes, and behavior). In practice, this involves ongoing reflective questioning by the clinician: What is this child aware of feeling and thinking, and of which bodily and emotional feelings and thoughts is the child unaware? What are the disconnects between what this child (or caregiver) wants and feels able to tolerate versus what he or she is actually experiencing? How can I communicate an understanding of this child's (or caregiver's) state of mind and body that will be meaningful and validating, while also moving him or her gradually toward greater integration, self-awareness, and self-control across all aspects of experiencing? Although these questions may seem obvious to experienced clinicians, they have therapeutic utility as a guide for the clinician's actual ongoing, moment-to-moment therapeutic interaction with children and caregivers. By asking these questions of him- or herself repeatedly in the course of therapeutic interactions, the clinician is engaging in the precise internal self-regulatory activities that are being taught to the client(s), and he or she is not just teaching but serving as a role model and coregulator (Schore, 2001) for the client(s).

EVIDENCE-BASED AND EMPIRICALLY INFORMED ASSESSMENT TOOLS AND PSYCHOTHERAPY MODELS

The observation and conceptualization components of psychotherapy with traumatized children and caregivers begin with the clinical assessment process. Assessment includes both semistructured interaction (e.g., psychosocial interview, observing spontaneous caregiver–child interactions) and the administration of formal psychometric measures (Pelcovitz et al., 1997). Assessment continues throughout all phases of treatment to monitor the therapy process and outcomes (and, as necessary, to revise the plan, goals, or interventions). The optimal sequencing and combination of assessment modalities differ for each individual child and caregiver, with a goal of maximizing engagement and therapeutic alliance, as well as giving the clinician an accurate and complete understanding of the clients' history, problems, strengths, resources, and goals. With children and adolescents, it is particularly crucial to obtain input and records (with appropriate consent from the guardian and assent from the child) from all accessible sources (e.g., current and past health care provid-

sufficient instability in the predictability or continuity of meaningful caregiver involvement and residential placement to contraindicate more direct traumatic memory work, but the child may benefit from learning about traumatic stress reactions and skills for increasing his or her sense of personal control despite the future uncertainties.

Option *c*, direct reconstruction of traumatic memories, is typically undertaken with a young child and caregiver(s) conjointly, in spontaneous nonverbal activities (Van Horn & Lieberman, 2008). With older children (Cohen et al., 2006) and adolescents (Cloitre et al., 2006), traumatic memory reconstruction more often is done separately with the youth, as a project in which the therapist assists the youth in repeatedly confronting a troubling memory (i.e., *exposure therapy*), with the goal of enabling the youth to think of the memory as a past experience that is over and done, and that can be recalled as fully (i.e., including self-validating as well as upsetting aspects) as other memories and placed within the youth's larger personal story of her or his life (i.e., *narrative reconstruction*). With older children and adolescents, if possible, separate sessions are conducted to prepare caregivers for their child's disclosures, and to help them address their own traumatic memories or stress reactions, followed by a conjoint closure session(s) in which the child shares the reconstructed memory with the caregiver.

Given these parameters, criteria for undertaking trauma memory exposure/reconstruction work should include a stable, physically and psychologically available, permanent primary caregiver who is willing and able to help the child work through traumatic memories; a child with adequate core self-regulation capacities and environmental supports (in daily life settings and via a therapeutic safety net) to be able to manage episodically intense distress and stress reactions, without becoming sufficiently affectively, dissociatively, or behaviorally destabilized to pose an immediate or chronic threat to the child's psychological health or safety (e.g., suicidality; psychotic or dissociative identity decompensation; severe self-injury, substance dependence, or reactive aggression); and a therapist with expertise in conducting traumatic memory reconstruction intervention with children of this age and developmental epoch who have significant complex traumatic stress disorder impairments, and who has access to sufficient psychiatric and crisis backup (e.g., pharmacotherapy, acute crisis evaluation and hospitalization, case management wraparound resources, pediatric care) to be able to identify, prevent, or rapidly resolve treatment-related or -unrelated crises.

The overall approach involves an initial linear progression from option *a* to option *c*, with each successive approach utilized only if traumatic stress or potentially traumatic stress-related symptoms and impairments are present and not sufficiently resolved or managed, and the necessary resources and competencies are in place to move to the next level. In practice, the progression from trauma-informed psychotherapy (option *a*) to traumatic memory re-construction (option *c*) might occur as rapidly as within a single intake evaluation or initial treatment session (e.g., a child referred following or dur-

ing a course of psychotherapy and pharmacotherapy in which the child and caregiver were stably and productively involved, but the child nevertheless was persistently troubled or impaired by PTSD or complex traumatic stress symptoms associated with well-documented traumatic experience(s) and the therapist did not feel qualified to conduct trauma memory reconstruction interventions). Alternatively, therapy might progress from the trauma-informed to the trauma-focused (option *b*) approach following a few, or several, sessions of initial assessment and therapeutic engagement, then continue at that level while completing a self-regulation–based intervention for PTSD and complex traumatic stress disorders, such as the life skills portion of Life Skills/Life Story (Cloitre et al., 2006), Real Life Heroes (Kagan, 2008), SPARCS (DeRosa & Pelcovitz, 2008), or TARGET (Ford & Russo, 2006). During or after trauma-focused treatment, the approach might be shifted back to trauma-informed treatment (e.g., if addressing traumatic past experiences as a source of current stress reactions or dysregulation is poorly tolerated by the child or caregiver or, in positive contrast, is sufficient to achieve full or substantial remission and to warrant either maintenance therapy or a focus on closure) or moved to trauma memory reconstruction (if sufficient remission has not been accomplished).

7. *Preventing and managing relational discontinuities and psychosocial crises.* Children with complex traumatic stress disorders typically have had to cope with chronic and often unpredictable discontinuities in their primary relationships and social support systems: losses due to deaths, out-of-home placements, institutionalization, family abandonment, and serial treatment providers (Faust & Katchen, 2004); neglect and abuse due to parental and familial psychopathology, substance use disorders, violent or antisocial lifestyles, or severe socioeconomic adversities. They often have come to view caring and facilitative adults or prosocial and accepting peers or peer-group activities (e.g., school, recreational, or social) as transient and likely to lead to disappointment or rejection; thus, even apparently positive events (e.g., birthday, holidays, field trips, family visits, recognition for accomplishments in school, sports, or arts, graduation ceremonies, new residence or school) may elicit stress-related dysregulation. This may be misinterpreted in pathologizing terms as self-sabotage; oppositional defiance or incorrigibility; an inability to tolerate delay of gratification or any deviation from the familiar; dependency; immaturity; or relational "splitting" consistent with borderline personality disorder. The corollary result is increased restrictiveness and intensity of supervision, and treatment emphasizing crisis deescalation or, alternatively, a determination that the child cannot tolerate (or even benefit from) therapeutic placement or services.

From a complex traumatic stress disorder or developmental trauma perspective, distress and dysregulation are predictable when traumatic memories are elicited by and reenacted in response to repetitions of relational discontinuities. Most such instances occur outside of the child's conscious awareness rather than as explicit declarative narrative memories, both due to developmental (Ford & Courtois, Chapter 1, this volume) and dissociative (Steele &

van der Hart, Chapter 7, this volume) factors. Therefore, the best approach to preventing or managing relational discontinuity–related crises or deterioration is to assist the child and caregiver (including health care, educational, judicial/legal, and mental health professionals and social/human service program staff) in anticipating and addressing the predictable dysregulation. This involves understanding the adaptive components (e.g., the child's attempt to protect against additional distress and demoralization, and to communicate to responsible adults the importance of relational continuity) and collaboratively (i.e., both the adults and the child) using self-regulation skills to increase or restore relational continuity. For example, rather than relying on medication, psychotherapy, and psychoeducation primarily to decrease symptom severity in preparation for the transition from an intensive residential treatment program to a group or foster home, treatment for a child with complex traumatic stress impairments would focus on helping the child to use affect regulation and relational skills to strengthen the internalized "working model" of important adults and peers as still caring, supportive, and accessible, despite a greater degree of physical separation.

When crises cannot be prevented, a similar approach that focuses on restoring a sense of relational continuity and self-regulation provides a framework for helping to deescalate distress and stabilize the traumatized child or adolescent. This is an adaptation or special case of generic models of crisis intervention, which prescribe activating two palliative factors: (a) social support to reduce extreme spikes in the intensity of anxiety, dysphoria, anger, confusion, or detachment; and (b) active problem solving to increase the sense of control, efficacy, and optimism. The primary threat to both objective and subjective social support for children with complex traumatic stress disorders is the loss of core relational (attachment) security, which the child experiences as a breakdown not only in relationships but also in self-regulation of the body, emotions, impulse control, memory and thinking, and consciousness (dissociation). Thus, beyond the generic approaches to providing reassurance, immediate safety, structure and limits (e.g., verbal deescalation tactics, timeout), crisis deescalation with traumatized children requires the use of several focal interventions: "grounding" strategies to counteract detachment, dissociation, and impulsivity (e.g., Cloitre et al., 2006; DeRosa & Pelcovitz, 2008; Ford & Russo, 2006); affective engagement strategies to reestablish an immediate sense of emotional connection with self and others (Fosha et al., Chapter 14, this volume); and sensorimotor strategies to increase bodily awareness and arousal modulation (Fisher & Ogden, Chapter 15, this volume). In the aftermath of crises, if therapeutic processing includes discussion of how these self-regulation skills were used by the child to restabilize, the result may be more than a generic review of the "lessons learned" and reaffirmation of the child's commitment to responsible behavior and self-care. Every crisis is an opportunity to highlight and enhance the traumatized child's competence and sense of efficacy in her or his self-regulation skills and trust in relational continuity.

CONCLUSION

Important innovations have been developed for the psychosocial treatment for children and adolescents with complex traumatic stress disorders (see also Resick, Monson, & Gutner, 2007; Welch & Rothbaum, 2007). Approaches to assessment and treatment of pediatric PTSD provide a strong foundation for this work. Two overarching conceptual models have been developed to guide clinicians in treating pediatric PTSD (trauma systems therapy [TST]; Saxe, Ellis, & Kaplow, 2007) and complex traumatic stress disorders (attachment, self-regulation, and competency [ARC]; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005). Each of these models has developed detailed, manualized guidelines for clinicians, extensive worksheets and exercises for children and families, and fidelity monitoring protocols. Clinical application of these models and the other interventions described in this chapter requires a focus on child and caregiver developmental attainments and limitations for self-regulation and relational involvement (Amaya-Jackson & DeRosa, 2007). The clinician also has a responsibility to serve as a role model, coregulator, and guide by using self-regulation skills not only to "talk the talk" but also to "walk the walk" with the child and caregivers. Until definitive guidelines are developed, the provisional principles and suggested strategies provided in this chapter are intended as a starting point for clinicians and clinical researchers.

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