Real Life Heroes: Application of a Developmental, Resilience-Centered Treatment Model for Children in Residential Treatment

Richard Kagan, Ph.D.

Principal Investigator and Co-Director

HEROES Project

Parsons Child and Family Center

60 Academy Rd.

Albany, New York 12208

Citation: Kagan, R. (In Press). *Real Life Heroes*: Application of a Developmental, Resilience-Centered Treatment Model for Children in Residential Treatment. *Journal of Family Violence.*

Abstract

Real Life Heroes has been successfully implemented in residential treatment programs to engage children and caregivers to rebuild (or build) emotionally supportive relationships, develop affect regulation and co-regulation skills, reduce traumatic stress reactions, and integrate a positive self-image. The model has been integrated into a systems approach and includes psychoeducation, a life storybook, multi-modal creative arts, and a toolkit to help practitioners implement recommended components of treatment for Complex PTSD as part of an integrated trauma-informed child welfare program. A case study and pilot study results are presented to outline how the model can help practitioners facing common challenges in residential treatment by empowering youths and caregivers to overcome nightmares of the past and realize heroic qualities within themselves.

Real Life Heroes: Application of a Developmental, Resilience-Centered Treatment Model for Children in Residential Treatment

*Real Life Heroes (*Kagan, 2004, 2007a, 2007b, 2009*)* combines attachment-enhancing interventions, creative arts, cognitive behavioral therapy, and the metaphor of the hero's journey (Campbell, 1968) to provide a structured system of trauma therapy that focuses on restoring hope and building resilience for children, families, residential counselors, and practitioners. Emphasis on multi-modal and nonverbal activities helps practitioners to engage troubled children, caregivers, and residential staff to work together to promote affect regulation and co-regulation skills, to rebuild (or build) trust with caregivers, and to implement recommended components of treatment for Complex PTSD (Cook et al, 2003, Ford & Cloitre, 2009). The model was especially designed to help practitioners and caregivers counter the hopelessness and acute and longstanding distress often seen with children placed into residential treatment facilities. A chapter by chapter workbook and session structure helps engage and children and caregivers in phase-based trauma therapy sessions and to maintain participation as they build the safety, support and skills needed to reduce high risk behaviors. The model also includes a psychoeducational framework and tools to engage children, parents, guardians, and staff to implement trauma-informed services from referral to discharge from group care.

Real Life Heroes has demonstrated efficacy with children in child welfare programs in a pilot outcome evaluation (Kagan, Douglas, Hornik, & Kratz, 2008) and over 12 years of use by practitioners in child welfare programs. The model has been expanded been expanded to include organizational development of integrated trauma and resiliency-centered services (teambuilding, psychoeducation on trauma and resilience for youths, caregivers, practitioners and administrators, workshops, group consultation, and individualized consultation for practitioners, peer program-based coaches, and on-going evaluation systems with feedback to practitioners). The current article delineates application of the model in residential treatment programs, a vignette of a high risk youth, and clinical outcomes.

Challenges in Residential Treatment

Referral to residential treatment programs typically follows dangerous behaviors by a child to self or others including significant and repeated harm to others, self-abuse, or suicide attempts. Very often, these children have had a long history of home and clinic-based services and prior placements in psychiatric, juvenile justice, foster family care, or short-term psychiatric centers coupled with multiple traumatic events in their lives. In a large national study of comparing youths in residential treatment with youths in other treatment programs, Briggs, Greeson, Layne, Fairbank, Knoverek and Pynoos (In Press) found higher rates of trauma exposure and higher rates of impairments for the youths placed into residential treatment. Youths in residential treatment were reported to be more likely to have behavior problems (80% vs. 69%), attachment problems (70% vs. 43%), runaway behaviors (30% vs. 5%), substance use problems (42% vs. 8%), suicidal ideation (30% vs. 13%), self-injurious behavior (28% vs. 12%), and involvement in criminal activity (30% vs. 6%). 92% of the youths in residential treatment had

experienced multiple traumatic events and as the number of traumas experienced increased, the percent of youths reported as showing functional impairments also increased.

For children in residential placement, primary traumas often include years of living with severe neglect, drug abuse by caregivers, domestic violence, multiple moves, losses of primary caregivers, emotional abuse, physical abuse, and sexual abuse. Children in child welfare programs also have been found to show a high rate of developmental impairment including delays in receptive language, expressive language, fine motor skills, sequential processing, visual processing, inattention, and memory abilities and significant levels of aggression, breaking rules, social difficulties, and total behavior problems {Henry et al, 2008).

Referrals to residential treatment may include partial information about suspected or alleged traumatic events in the child's life; however, referrals often focus on justification for the cost and necessity of placement based on the high risk presented by children's' behaviors and DSM-IV diagnoses. The focus on the risk of severe behavior problems often obscures the reality for these of children of living with on-going crises over many years, lack of safety in their homes and communities, and chaotic, disorganized and disrupted attachments. A high proportion of children referred to child welfare programs demonstrate behaviors typical of complex trauma (Cook et al, 2003) including affective dysregulation, dissociation, impulsive behaviors, decreased cognitive abilities, and poor social skills.

Children in placement very often lack validation, or at times, even awareness, by their primary caregivers of what the child experienced (perceived, felt, thought, and did) in often multiple traumatic events. In many referrals, children's partial disclosures of family violence have not been validated by caregivers and lack the substantiation necessary for court orders of protection or requirements for reunification. This can contribute to assessments that focus on disorders within the youth and neglect the breakdown of a child's primary attachments, lack of safety or protection and the impact of multiple traumatic events over many years on a youth's development. Children may learn to recite diagnoses given to them with little understanding of what disorders listed in the DSM-IV actually mean. Many youths have also experienced threats of being placed prior to referral. These children may perceive placement as a punishment, time to be served for bad behavior, or confirmation of how terrible or damaged the child really is. Each day in placement in this context may increase feelings of anxiety over losing relationships, distrust in all adults (family members as well as substitute caregivers, practitioners, and authorities), and shame over what the child did that the child believes led to family hardships and separations.

At the same time, putting severely troubled and troubling youths together makes it likely that youths will experience reminders of past traumatic events displayed by peers who feel stressed, lack hope, and re-enact the physical, emotional, or sexual abuse in their own lives. These 'triggers,' in turn, can easily set off cycles of escalating behavioral problems that may appear on the surface to reinforce the perspective of the individual child as the carrier of a behavior disorder outside of the context of how those behaviors may have developed and helped the child cope with very real threats to the child or other family members. Meanwhile, a focus on behaviors and disorders within the child by systems of care may put off dealing with the impact of what happened in the family. This

may serve to freeze time and change within the family until the child nears the expected dates of return to family. At that time, conflicts and crises often increase in intensity (Kagan & Schlosberg, 1989) as the family faces the risks involved in reunification.

Kianna was placed at age 15 into residential treatment following her screaming fights with her foster mother, staying out late without permission, and threats to kill herself. Pre-adoptive placement followed five temporary foster placements beginning at age 13 and a psychiatric hospitalization due to her cutting herself,, running away, and threatening herself after her fourth foster family. In the psychiatric hospital, Kianna alleged that she was physically abused in her foster family at that time,, an allegation that could not be proven. She was diagnosed with Bipolar Disorder, Dissociative Disorder, and Mild Mental Retardation. Based on this diagnosis, her county department of social services recommended to the pre-adoptive family that Kianna be placed into long-term residential treatment when she began having conflicts and started running away from her pre-adoptive family A few months after placement into residential treatment, her adoptive family stopped visiting and backed away from their commitment to adopt.

Kianna, for her part, maintained that she wanted to return to Marilyn, her birth mother, and refused to work on placement in another foster family. Kianna recalled her mother's repeated message that she had been forced by county authorities to give up parental rights in order to maintain contact with Kianna, that she loved Kianna, and that Kianna could return to her mother as soon as she turned 18. Kianna also wished she could live again with her father and identified with his mixed African-American and Latino heritage which she preferred over her mother's mixed European heritage. However, his address was unknown and he had not cared for Kianna since age 5. She identified no other relatives or anyone else she wanted to live with and focused exclusively on return to her mother during her first year in placement, a wish that was reinforced by her mother telling her that she had completed a drug/alcohol/mental health in-patient treatment program, was no longer living with her previous boyfriend, and that she wanted Kianna back. By age 16, with no viable family options for kinship care and Kianna's refusal to consider living in another foster family, the county authorized a long term goal of return to live with Kianna's mother at age 18.

For practitioners in residential treatment, the greatest challenge is often to help children who do not have a stable, non-offending parent or substitute parent who is able and willing to participate in therapy and committed to providing nurture, care, and safety for the child into the future. Caregivers of children in placement are often grappling with their own life experiences of neglect, abuse, family violence, lack of secure attachments, poverty, and subsequent development of significant mental health, alcohol or drug abuse, and physical health problems.

Marilyn continued her on and off-again relationship with Kianna's father, a man she adored despite his repeated abandonments and chronic drug abuse. She also had an on and off relationship with another man who had been alcoholic and at times violent. Marilyn struggled with multiple addictions, severe diabetes, hospitalizations for depression and diabetes, and periods of homelessness. She also grappled with the suicidal behavior, incarceration and addictions of Kianna's older two brothers, the youngest of whom Marilyn kept in her home due to his chronic unemployment and homelessness. Marilyn helped this son care for his youngest child, Kianna's nephew.

Marilyn came into the residential treatment center for only a few treatment sessions during Kianna's first two years in residential treatment citing personal health, financial, and transportation problems and very often did not respond to calls from staff; however, she maintained periodic phone contact with Kianna and the bimonthly 3 hour visits allowed by the county department of social services. During the first year in the residential treatment program, Kianna was described as running away from the program, frequently hurting herself with repeated cutting of her legs, arms, and body, picking at sores on her body, poor hygiene, yelling and cursing staff over following rules, and telling staff she saw 'dead people' and demons, and that she often wanted to die. She was absorbed in the occult, and believed that she and her mother shared secret powers, a belief reinforced by her mother as passed down by both Kianna's mother and father through his ancestry.

Resiliency and the Challenge of Restoring Hope

Group care programs begin with the challenge of utilizing a placement away from family members to create safety and healing for severely troubled children who often demonstrate primary relationship traumas and have been unable to live safely within their homes and communities. Placement marks a point of tremendous stress for the child, family, and community, along with often unspoken fears obscured by high risk behaviors. Reenactments of traumatic stress and the high risk behaviors of these youths can all too easily lead treatment centers to develop parallel patterns of fragmented, chaotic, and abusive interactions that increase secondary traumatic stress in residential staff and break down the effectiveness of the organizations 'operating system' (Bloom, In Press).

From a resiliency perspective, residential treatment marks the start of a new opportunity that can include both high risk and growth. One of the gifts presented by youths in placement is how long they give new service providers, very often, after repeated previous placements, to demonstrate that something good could come out of this placement when so many previous group care and hospital placements have not led to improvement in their lives. However, this gift is limited. Without renewed hope, youths in placement can quickly, often within a few weeks, return to the high risk behaviors that led to placement.

Real Life Heroes provides a means of helping children and caring adults overcome the multiple and acute stressors that led to placement. Components include: Rebuilding Attachments (Safety and Attunement, Increasing *Personal Power* (Affect regulation by the child, Co-regulation with Caregivers, Mindfulness—Centering, Storytelling-Meaning-making, and Re-integration of the Child's Identity with their Family, Community, and Cultural heritage, and Reducing Traumatic Stress Reactions (Cognitive Behavior Therapy skills for the Child and Caregiver), Exposure—Desensitization, and Moving Through Traumatic Memories with Stories, Movies, and Creative Arts. These components emphasize recommended components for child welfare (Child Welfare Collaborative Group, 2008) including empowerment of youths in residential treatment and their caregivers with attachment-centered interventions (Bloom, In Press).

The framework for this work is a quest, a quest in which caring adults are encouraged to become the heroes children need to help learn new skills and overcome

their fears. The workbook provides a structured means of engaging children and caregivers to build coping skills and resources and become stronger, chapter by chapter:

- *The Pledge—beginning work on* safety and 'doing with' activities
- *A Little About Me*—identification of feelings, affect regulation, testing safety
- *Heroes and Heroines—uncovering* openings for hope, models of overcoming, strengthening ethnic heritage
- *People in My Life—highlighting memories* of people who cared
- *Good Times—Accentuating fun times,* connections, resources, and allies
- *Making Things Better*—pulling together new perspectives, resources, and allies to make a difference, restitution, using what has been learned
- *The ABC's of Trauma and The Hero's Quest*—understanding the impact of trauma on our bodies and beliefs, accepting and recognizing bodily reactions, changing from Catastrophic beliefs to Coping Strategies, rewriting our scripts, and practicing using new strategies with a low level stressful situations.
- *Looking Back*—making sense out of past transitions and challenging misunderstandings of the child's responsibility for what happened
- *Through the Tough Times*; desensitization to progressively more difficult traumatic memories utilizing CBT approaches and creative arts
- *Into the Future*—opening up possibilities, goals, utilizing connections

The *Real Life Heroes Practitioner's Manual* (Kagan, 2007b) provides a toolkit for engaging children and caregivers, safety steps, psycho-education materials[1], adaptations for special populations, and for each chapter: objectives, step by step guides, checkpoints, pitfalls, and troubleshooting tips. Sessions are structured to allow practitioners to match children's level of resilience (attachments, support, and coping skills) with emphasis in the session on what is most important at that time for the child and family. Each session follows a planned format to promote safety and security with the structure outlined as a bookmark and a combined progress note/fidelity checklist. Sessions include:

- *Self-Check Thermometers* using 0-10 scales for *Knots* (stress), *Personal Power* (self-control), and four feeling scales: *Mad, Sad*, *Glad* and *Feeling Safe.* Thermometers are designed to both help children share feelings to practitioners and caregivers and to also provide in-session measures to help practitioners adapt session material and focus to help children and caregivers stay with their 'window of tolerance.'
- *'Safety First'*: safety plans in place; before/during/after reminders for predictable crises; child's signal and action plan if *Knots* begin to rise or *Personal Power* falls; plans for practitioners and caring adults self-care.
- *A Magical Moment*. e.g. herbal tea, cookie, magic trick, to separate the session from other activities and inspire hope for change.
- *Centering* exercises to develop affect regulation and co-regulation skills including mindfulness, movement and fun activities with safe caregivers e.g. blowing bubbles, juggling, balancing a peacock feather (Macy, Barry, & Gil, 2003).

---

[1] *Real Life Heroes* also provides caregivers and residential counselors with psycho-education handouts from the NCTSN Resource Parent Curriculum (Grillo et al, 2010).

- 1-4 pages from the workbook beginning with nonverbal work. The child typically selects a special marker, sketches an image, taps a rhythm on a drum, tries out tones on a xylophone or keyboard to match the rhythm, develops this into a 2-3 note song and enacts a simple movement matched to the drawing. For more important pictures, including images of being cared for, a safe place or time, and later for traumatic events, the child is asked to make up a story with a beginning, middle and end. Use of a digital camera for taking photographs to express feelings and for making simple movies. Creative arts can be matched to a youth's age, interests, and talents. Older youths who are not interested in using the workbook can be given creative arts and storytelling activities that target key pages of the workbook. For work on desensitization, techniques from other models, e.g. TF-CBT (Cohen, Deblinger, & Mannarino, 2006), EMDR (Shapiro, 2001) or the Progressive Counting (Greenwald, 2005) are incorporated into sessions linked to the workbook's stress on developing three chapter stories that reinforce a youth's moving through a story of traumatic events with a beginning (before the event), a middle, and an end at a safer time. Each part of the story is enhanced to help children integrate feelings and experiences with the help of creative arts.
- Caring adults who meet safety criteria are invited into sessions as much as possible to work on repairing or building attachments with consideration for what is practical in residential treatment and what best helps youths feel safe enough to share their experiences. In sessions, caregivers are asked to work on their own stories and then to repeat and attune to each part of their child's expression of their story by copying the child's rhythm, tonality, and movement. These steps are then repeated with children asked to copy the adult's rhythm, tonality, and movement. Practitioners encourage attunement by adults and validation of losses, hardships, adult ownership of responsibilities for what happened, and co-regulation to broaden the child's tolerance for stressors.
- Practitioners work as coaches in this process, highlighting strengths, coping skills, and challenging dysfunctional beliefs with more constructive perceptions and problem-solving.
- Thermometers are repeated at the end of initial sessions and as needed.
- Focusing/Centering exercises are repeated if necessary to calm the child and caregivers.
- Reassurance is provided to the child for: thoughts or feelings to be expected as normal, how your mind is healing and becoming stronger and stronger, how to utilize bodily sensations as messages or reminders, ways to calm and self-soothe using understanding of trauma and positive self-statements; choices; caring adults to call if distressed (on safety cards); plans with caring adults and children to manage reminders of traumas.
- Sessions are ended on a positive note reinforcing strengths, lessons learned, helping others, etc.
- Activities for the coming week to enhance: fun, skill, and relationship-building with modulation practice related to chapter work

The *Practitioner's Manual* also includes a brief Developmental, Attachment and Resilience-Centered Assessment guide including: (1) the child's social and emotional developmental age; (2) traumas the child experienced; (3) strengths, including individual talents and the family's cultural and spiritual heritage; and (4) risk factors including triggers to traumatic stress reactions and high risk behaviors along with what has helped reduce stress reactions. This framework focuses practitioners from the time of referral on identifying caring adults who have been and continue to be committed to nurture, care for, guide, and protect the child, and who could feasibly and effectively serve as caregivers, mentors, and role models for the child now and in the future. The assessment leads directly into a trauma and attachment-focused service plan that targets: Safety plans for known risks and triggers to trauma reactions Building/rebuilding committed caring relationships and attachments; Child skill building; Parent/Guardian skill-building; Traumatic Stress Re-integration, Life Story work to develop a new future and strengthen hero qualities; and Community re-integration including helping others.

Application: Responding to 'Real Life' Challenges in Residential Treatment

Work on complex trauma in residential treatment often seems to flow in spirals with improvements in resilience and trauma desensitization followed by reminders of other traumatic events, disclosures of previously unknown severe traumatic events, and often, discovery or sharing of these events through re-enactments as children have expanded home visits or get closer to returning to living full time with their families. Reminders of previous traumas are often hard to prevent when youths are exposed to other youths acting out at times their personal distress by repeating primary triggers, e.g. cursing, threats, loud voices, and lack of quiet space or freedom to get away. Managing severe behaviors has to be part of any safety plan.

Real Life Heroes provides practitioners with resilience-based worksheets to develop both *Youth and Caregiver Personal Power Plans* which can be used in place of more typical, problem-focused safety plans. The *Youth Power Plan* begins by identifying special qualities about the youth, important people for the youth, and some of the best things that happened for the youth and their family using both open-ended questions and checklists. After reinforcing strengths, the Power Plan addresses stressors for the youth, behaviors when stressed (warning signs), behaviors that led to problems for the youth or others, actions that help the youth calm down and feel safe, actions that make the youth feel more stressed (and don't help), and a *Power Plan* including: what the youth can do to keep calm, 24-7, involving all of their senses, body, and mind; what warning signals the child will watch for; what warning signals the child would like caregivers to watch for; who the child can go to for help through-out the day and night; what the youth would like caregivers and staff to do to help keep them safe; and how they will practice the plan. The *Power Plan* includes how the child will help others, bringing out the hero in the child, and how the child will develop their special skills and talents. *Power Plans* are typically presented from the beginning of placement and as part of work on Chapters One and Two in the life storybook. This includes using the child and family's heroes as a means of restoring hope and inspiring learning how to develop the skills of their heroes.

The *Caregiver Power Plan* is similar but also includes sections on decoding children's behaviors, identifying reminders and matching Personal Power Plans for each reminder with steps that can be taken by caregivers, the child, family, friends, community

resources, and professional staff. The *Caregiver Plan* includes a section on identifying the caring adult's own reminders and developing and practicing plans to increase their own resilience and get the support they need to cope and help manage the child.

Kianna's Power Plans initially included identification of strengths including: her artwork, caring for others, loving insects and small animals, friendliness, writing skills. Identified traumas included neglect, abandonments, domestic violence, physical abuse, and sex abuse at an early age reported by her mother. Triggers included visits, missing her mother, her mother not responding to calls, perceptions by Kianna that her mother was at risk of hurting herself, resuming drug use, or killing herself, as well as flashbacks of physical abuse, domestic violence, her mother's cutting and attempted suicide attempt as perceived by Kianna, and males acting aggressively or in a sexualized way. Warning signs included: pacing, isolating herself, provoking others to hate her; running away or dissociating with fantasies; screaming, dressing in dark clothes, putting on dark make-up, and talking about blood and monsters. If stress increased, high risk behaviors included cutting herself, feeling like killing herself, and seeking out "bad" boys.

Interventions and safety plans for Kianna were targeted to her developmental age with a grade equivalent identified as 2nd to 3rd grade level skills in most areas in contrast to her chronological age of 16. Interventions initially targeted multiple steps staff could take including close, safe, female staff asking if Kianna wanted a hug, giving her space but keeping her in eyesight, responding to threats by staying calm and recognizing Kianna's traumatic stress reactions to reminders of her past violence, and encouraging Kianna to use calming activities she enjoyed including balancing a peacock feather with deep breathing (after Macy,2003), use of puppets, use of techniques from Cool Cats (Williams, 2005), writing stories or poetry, and sharing with others how she felt through writing. Use of her fingers and hands for calming activities, and later, application of scented lotions, was encouraged to help her replace cutting with self-soothing, and to replace self-shaming thoughts with self-validation and seeking support from trusted staff.

These steps were replaced over time with a more advanced Power Plan as Kianna progressed developmentally and expanded her network of resources including being able to call her mother and additional staff. Moreover, her mother was helped to identify triggers in her home including noise, jealousy of Kianna's nephew, yelling by her older brothers, flirtations by boys she knew in the neighborhood when she was younger, and fears of her mother becoming hospitalized , going back on drugs, or becoming involved in another violent relationship.

Real Life Heroes also includes guides to help practitioners adapt interventions to changes in the family including external threats or reminders of past traumas that can easily de-rail progress in treatment or lead to discharge to higher levels of care.

Kianna demonstrated significant improvements in her behavior and was legally allowed to start overnight home visits when she became 18, following a long series of visits at and then near the residential center. Overnight home visits, however, ended abruptly after Kianna became engaged in an altercation with her older brother who was living in Marilyn's home with his son. Unknown to staff or Kianna, Marilyn also took her former boyfriend back into her home during Kianna's second visit. Kianna heard his voice in the middle of the night and found him sleeping in the apartment's living room. Marilyn assisted in setting up safety measures after this visit to assure that her boyfriend out of the home. However, Kianna experienced multiple other stressors on the

next three visits including Kianna's perception that her mother and older brother consistently gave in to Kianna's nephew, unfair treatment from Kianna's perspective and reminders of her being sent away and neglected. Kianna also had nowhere to go during weekend visits as the small apartment had no space for her to find a quiet spot. Also, unknown to staff, Kianna's uncle brought his older three children into the home on subsequent weekend visits. As a result, visits home involved a high level of commotion, noise, and yelling, all triggers for Kianna. And, magnifying the stress level in the family, Marilyn was told by her landlord that she was being evicted from her apartment because of the behavior of her grandson and his older sisters during their weekly visits.

During Kianna's fifth visit, she found her mother sleeping late in the morning, a reminder of past drug abuse. Kianna took money from her mother's purse for her and her nephew to spend at a store down the block. Later that day, she felt shamed, became agitated, and flew into a rage when she perceived her nephew receiving no consequences or sharing blame for the theft. Kianna yelled and screamed, cursing her mother and older brother. Her mother tried to call the agency for support and Kianna tried to pull the telephone away from. Kianna later said she believed her mother was sending her away again, a primary trigger, and realized she had used 'no words.' Instead, she hit her mother. Her uncle then tried to restrain Kianna who surprised him by fighting back and breaking free. He pulled out a kitchen knife and threatened Kianna who wrestled him for the knife. She, then proceeded to cut herself, essentially repeating what her mother had done so many years ago. Kianna then left her mother's home, coming back only after the police found her a few blocks away. Marilyn was terrified about how Kianna could have hurt herself severely or have been hurt wandering around an urban neighborhood at night.

Kianna's experiences reflect the challenges of work with severely stressed families including multiple stressors. The objective through-out this work was to enlarge the 'window of tolerance' by building safety and resilience. Work did not stop despite the loss of the dream of reunification held so dearly by Kianna and Marilyn over the five years of her placements.

Marilyn recognized after this visit that she was too scared of another outburst to take Kianna home as they had both wished for and worked for over the previous two years. By that time, Marilyn was homeless herself again. Kianna initially became severely depressed, blaming herself entirely for losing the chance to live with her mother. She, cut herself on her leg one more time and begged her mother to take her home.

Marilyn's car broke down, and it would be five months before she got another apartment and another vehicle. In that time, she also was hospitalized again for severe diabetes. However, unlike previous years, Marilyn kept coming to treatment sessions. Marilyn shared with Kianna how her former boyfriend validated her continued fears, even though he was now sober and Marilyn no longer feared his anger. He also apologized to Kianna over the phone. Marilyn and Kianna began to accept that her mother would not take her back. Kianna could move to a community residence near her mother, see her mother weekly, and call her daily providing more support than Kianna had had in the past. Nevertheless, she and her mother both needed to grieve the loss of their shared dream of reunification and the fervent wish Kianna had clung to over six years of placements. Kianna also needed to overcome renewed feelings of shame over

her fighting and she began making amends in her family including apologies to her uncle and nephew for her role in the fighting.

Real Life Heroes promotes desensitization of children within relationships with caring adults committed to protecting and guiding children and making it safe for children (and caregivers) to share what they heard, saw, felt, and did during multiple trauma events and together to work to reduce the power of traumatic memories and reminders while increasing resilience. This is a particularly difficult challenge in residential treatment due to children's frequent lack of stability and history of chaotic, disorganized attachments. *Real Life Heroes* helps practitioners manage the level of stress and prioritize work to maintain progress and keep the child, caregivers, and practitioners within the 'window of tolerance.' Tools are provided for repeated assessments and prioritizing service plans from the time of referral through review conferences. Core components include a brief assessment checklist and service plan prioritization table:

ASSESSMENT CHECKLIST		SERVICE PRIORITIES	
ASSESSMENT DOMAINS	COMPLETED	GOALS	PRIORITY
Developmental Age		Safety	1 2 3 4
Strengths		Attachments & Permanency	1 2 3 4
Cultural Heritage		Child Skills	1 2 3 4
Attachments		Adult Skills	1 2 3 4
Traumatic Events		Community Support	1 2 3 4
Triggers & Reactions; Risks		Trauma Integration	1 2 3 4

The model also provides practitioners with a guide for which parts of the session or chapter, e.g. centering, telling the story, to emphasize, using a two-dimensional chart:

Priority Guide[2] for Sessions and Chapters				
	STRENGTH OF EMOTIONALLY SUPPORTIVE ENDURING RELATIONSHIPS			
		High	Medium	Low
	High	Trauma Integration Overcoming 'Tough Times; Desensitizat	Attachments & Skills Strengthen Supportive Relationships & Memories	Attachments & Community Support Search for and Strengthen Caregivers

[2] Adapted from Saxe, G.N., Ellis, B. H. & Kaplow, J.B. (2007) Collaborative treatment of traumatized children and teens. New York: Guilford.

		ion (7-8); Identity and Future (9)	of Caring (3-4); also Caregiver's Capacity to Manage Stress & Triggers with Caregiver Power Plan (5-6). Start Trauma Integration (7-8)	and Supportive Relationships. Recover Memories of Caring for Child (Chapters 3-4)
CHILD'S SELF-REGU-LATION	Medium	Cognitive Processing Skills Increase Stress Management Skills for Child with Caregivers for Triggers (5-6; begin 7-8)	Attachments & Cognitive Processing Skills Strengthen Supportive Relationships & Memories of Caring (3-4) also Caregiver's Capacity to Manage Stress & Triggers, Caregiver Power Plan; Cognitive Processing (5-6)	Attachments, Cognitive Processing Skills & Community Support Engage Caregivers & Supportive Relationships, Recover Memories of Caring (3-4)
	Low	Affect Management & Safety Affect Regulation , Personal Power Plans (1-2), Memories of Caring	Attachments, Affect Management & Safety Child and Caregivers' Affect Regulation & Personal Power Plans (1-2);	Safety 'SOS[3]' Restoring Safety & Hope for Relationships. Affect Regulation (1-2). Community Support and

[3] *Real Life Heroes* utilizes an adapted version of 'SOS' (Ford & Russo, 2006) stressing: S: *Slow down, Scan your body,& use Six-step breathing*; O: *Orient yourself to protective people and things available*; and S: Seek support & Support others

(3-4) Memories of Attachments Caring (3-4)

Clinical Outcomes

In a pilot study (Kagan, Douglas, Hornik, & Kratz, 2008), seventeen clinicians from the Parsons Prevention (High Risk Home-based Family Counseling), Therapeutic Foster Care, Residential Services (Group Care) and Outpatient Treatment (Child Guidance) were selected and trained in the *Real Life Heroes* trauma treatment approach including use of the *Real Life Heroes Practitioner Manual,* structured session outlines, and fidelity checklists. These clinicians screened children between the developmental age of 8-12 for study inclusion based primarily on the appropriateness of the treatment intervention and anticipated length of treatment by their program. Forty-one children were enrolled in the study. The mean age at the start of the study was 10.5; 41% were female, 53% were members of an ethnic minority group, and 36% were living out-of-home.

Data was collected from children, their primary caregivers, and clinicians. Children and their caregivers participated in interviews on four separate occasions: study enrollment, a four-month follow-up, at eight months, and again at twelve months. Clinicians submitted enrollment paper work, a baseline trauma screen, ratings of therapeutic alliance with the enrolled child and on-going process data regarding treatment fidelity and skill assessment of weekly *Real Life Heroes* sessions.

Over the first four months, children demonstrated ($p<.05$) reduced trauma symptoms on child self-reports (TSCC) and caregivers reported fewer problem behaviors ($p<.05$) on the Conners Parent Behavior Rating Scale-Long version (Conners, 1997). Twelve month results included reduced trauma symptoms reported by the adult caregiver on the PROPS (Greenwald & Rubin, 1999) in relation to the number of life storybook chapters completed ($p<.001$) and increased security/attachment (adapted Security Scale, Kerns et al, 1996) over time reported by the child ($p<.05$).

The pilot study did not include a comparison group; however, results appear to be very reflective of the everyday world of child and family services. Families did not self select, respond to ads for services, or in most cases, seek mental health services without pressure or mandates from an authority such as child protective services. Families moved away during the project. The state delayed approval 4 months beyond the projected start date creating an artificial waiting period which may have neutralized any expected recovery from beginning therapy and services. In addition, three staff left the agency before finishing work with children.

Practitioners in this study and during 10 years of informal testing have consistently reported positive regard for the value of the *Real Life Heroes* workbook and *Manual*. Children and parents have noted how the curriculum has fostered self-control and increased feelings of attachment. For instance, one boy reported, “I have so many more people in my life that can help me now, I am not alone anymore.” A girl listed her life storybook as the most important thing she would want to take out of her house if there was a fire.

For Kianna, developmental growth during her last two years of residential treatment was promoted by her relationships with several very caring staff and introduction of Real Life Heroes. Kianna's favorite pastimes changed from playing with puppets, and drawing and writing fantasies to a more age-appropriate focus on dating, adolescent-level books, and writing her own 'graphic novel.' Her dress changed from a preference for Goth-like make-up and clothing to more typical high school clothes and she graduated from a special education high school. Changes also included her mother coming to biweekly family sessions when she had only been going to a few therapy sessions in previous years. Progress on reducing the toxicity of relationship traumas included her mother validating Kianna's experiencing her mother's drug use, how her mother's boyfriend had terrified Kianna by hitting Marilyn in the face and body with a liquor bottle, how Kianna had perceived her mother's cutting herself as a suicide attempt, how Kianna worried about her mother dying from her lack of self-care for diabetes, how terrible Kianna felt, her worst trauma, when her mother left her in foster care, and how reminders of stressors led Kianna to feel alone and then progressively dissociate into a fantasy world.

Marilyn also validated Kianna's disclosure of how terrified Kianna had been as a four-year old when her father kept her in a bathroom 'all day' while her mother was working, how Kianna's father had physically abused Kianna, and how relieved Kianna felt when Marilyn took Kianna and fled that relationship, taking a train from California back to upstate New York. Kianna shared that when she was locked in the bathroom (age 4-5), her father and his friends were using drugs, she began dissociating while staring at the bathroom door, seeing images and things that weren't there. She also disclosed to her mother how she felt shamed by going off with an older cousin and having sexual relations with him when he stayed at her mother's home just a few months before her mother placed her into foster care, how she had been previously sexually abused during visits in this cousin's home, and how she felt shamed that she had killed pet mice as a 6-year-old when her mother was asleep all day and Kianna had tried to play with the mice. Marilyn and Kianna also both developed more effective Power Plans to help prevent or reduce future reactions to reminders of traumas including how Marilyn could help her daughter get to a quiet space for 1:1 time before stressors escalated.

Measureable improvement included changes in Trauma Symptom Checklist for Children (Briere, 1996) scores from admission to residential treatment at age 15 to a repeated administration at age 18 (using 17-year-old norms based on Kianna's developmental age) showed decreases in T Scale Scores on the Hyperresponse scale from 82 to 58, on the Anxiety Scale from 81 to 58, on the Depression scale from 78 to 52, on the Anger scale from 77 to 40, on the Post Traumatic Stress scale from 69 to 57, on the Dissociation scale from 78 to 56, on the Overt Dissociation scale from 78 to 52, on the Dissociation-Fantasy scale from 69 to 63, and Sex Concerns from 64 to 50. Kianna's Full Scale IQ went up during her three years of residential treatment from 64 on the WISC III prior to admission (Verbal IQ: 69, Performance IQ: 63) to a full scale IQ of 72 (Verbal Comprehension: 76 and Perceptual Reasoning: 82) on the WAIS-IV at age 17-8.

Lessons learned during the pilot study and informal testing included the need to develop a stronger systems model to counter fragmented child welfare services, the need to engage active support of supervisors and directors, and the importance of applying a

resilience model to residential counselors and practitioners as well as with youths and caregivers including birth, kinship and adoptive parents. This led to development of the *HEROES Project,* which included an integrated series of trauma-informed and resiliency-focused training, consultation and evaluation services for child welfare programs. The primary goal of this resiliency-focused initiative was to foster enduring, emotionally supportive relationships which protect children from abuse and neglect and help children resume healthy growth and skill development after experiencing traumatic stress. Organizational objectives included incorporation of trauma-informed and resiliency-focused tools into assessments, service planning, and team work including integrated resiliency-informed training for practitioners, residential counselors, parents, guardians, and other caregivers. Training programs included the NCTSN Resource Parent Curriculum, *Caring for Children Who Have Experienced Trauma (*Grillo, Lott, et al, 2010), and the NCTSN *Child Welfare Toolkit* (Child Welfare Collaborative Group, 2008) with all practitioners and resource parents introduced to the HEROES trauma and resiliency framework and the NCTSN 'Essential Elements for Child Welfare.'

Over 110 children ages 6-19 have been enrolled in the HEROES Project in eight child welfare programs (two residential campus-based programs, a community residential program, foster family care, day treatment, home-based family counseling, and two out patient clinics) with 45 practitioners and 98% staff participation. Results from initial baseline and three-month follow-up surveys with 36 children and caregivers (Richardson, Kagan, Henry, Trinkle, DeLorenzo, Brophy, 2011) include reducing high risk behaviors and trauma symptoms associated with placements and increasing children's well-being measured by children's ratings of social support, competence, and reactivity. Significant changes from caregiver evaluations included decreased behavioral problems on the Child Behavior Checklist (CBCL) scales for Anxious/Depressed ($p=.019$), Aggression ($p=.035$), Rule Breaking ($p=.033$), Internalizing ($p=.047$), and Total CBCL ($p= .026$). Significant changes from child evaluations included decreased traumatic stress on the Traumatic Symptom Checklist for Children (TSCC) subscales for Depression ($p=.022$), Anger ($p=.004$), Post Traumatic Stress ($p=.027$), Dissociation ($p=.006$) and Dissociation-Overt ($p=.021$) along with significant increased resiliency on the *Resiliency Scales* subscales for increased Relatedness ($p=.030$), decreased Reactivity ($p=.011$), increased Personal Resources ($p=.028$) and decreased Vulnerability ($p=.003$).

Discussion

Residential treatment presents a paradox for trauma-informed practitioners. Youths in placement have a critical need to re-integrate after multiple and complex traumas and have typically experienced disrupted attachments (Bloom, In Press; Briggs et al, In Press); and yet, by definition, placement in a residential treatment center with time-limited caring by staff means that these youths will be living without the close, safe, sustained relationships with caring, committed adults that children like Kianna crave and would best support them to share and reduce the toxicity of the traumas they have experienced. Recommended component-based guides to treatment for Complex PTSD (e.g. Ford & Cloitre, 2009) suggest that re-integration components of trauma therapy, e.g. desensitization, require re-establishment of primary relationships. With pressures by funding sources for reducing the length of time youths spend in out-of-home placements, much of this work needs to take place after return home and with provision of intensive

therapeutic supportive services including home-based family services, day treatment programs, and continued trauma and resilience-centered therapy. Briggs et al (In Press) recommended development of integrated trauma-informed services that emphasize work with families, providing support during transitions of youths, and offering aftercare services, when needed. Within an integrated model of services, trauma and resiliency services can continue from placement to home and community-based services in order to maximize the probability of sustaining treatment improvement in residential treatment.

A resilience-centered model such as *Real Life Heroes* and the *HEROES Project* keeps the focus of services on helping children and caregivers *move through* traumatic events and reminders or reenactments. Step by step activities increase resources and promote building, or rebuilding child-caregiver attunement and trust for a child that whatever happens, the youth and caregivers can come back together. For Kianna, this included her mother continuing family sessions and visits, even after a fight with her mother and her brother, her mother's repeated homelessness, and resumption of her mother's relationship to a previously abusive man. Maintaining a resilience-building framework with the ups and downs of events that are often out of the control of service providers takes a team of staff. Residential treatment staff can persevere and help children and families disclose, validate, and overcome experience of multiple traumatic events by utilizing a shared understanding of the impact of trauma on development and by developing the confidence and organizational support, training, and teamwork to implement components recommended for treatment of Complex PTSD (Cook et al, 2003; Ford & Cloitre, 2009).

Real Life Heroes promotes strengths and resiliency by searching for, engaging, and rebuilding emotionally supportive relationships that are often lost after families experience multiple traumas (Bloom, In Press). The model provides structured activities to increase safety while promoting flexibility by practitioners to titrate work to the child and family's growing strengths and the likelihood of changing levels of stress. Activities in each session promote attunement with caring adults as a primary means of fostering self- and co-regulation for children who have experienced relationship traumas. Creative arts and life story work is used engage children and caregivers who all too often see little value in therapy, to rebuild fun, 'doing with' activities that foster trust, and provide a natural segue to desensitization with exposure-based interventions. Building on individual, family, and cultural strengths helps en-courage caring adults to become heroes for children increasing the security needed to overcome the nightmares of the past, and to create the safety children needed for desensitization and reintegration of both nurturing and painful memories. In this process, caregivers can help youths move from nightmares to stories of healing, from identities as victims to heroes helping others.

REFERENCES

Bloom,S.L. (In Press). Creating Sanctuary: A Trauma-Informed Approach to Human Service Delivery for Individuals Impacted by Family Violence, Neglect and Life Adversity. *Journal of Family Violence.*

Briggs, E.C., Greeson, J.K.P., Layne, C.M.,. Fairbank, J.A., Knoverek, A.M., & Pynoos, R.S. (In Press). Trauma Exposure, Psychosocial Functioning, and Treatment Needs of Youth in Residential Care: Preliminary Findings from the NCTSN Core Data Set. *Journal of Child & Adolescent Trauma.*

Briere, J. (1996). Trauma Symptom Checklist for Children (TSCC). Lutz, FL: Psychological Assessment Resources, Inc.

Briere, J. & Scott, C. (2006). Principles of trauma therapy: A guide to symptoms, evaluation, and treatment. Thousand Oaks, CA: Sage.

Campbell, J. (1968). *The Hero with a thousand faces.* Princeton, NJ: Princeton University Press.

Child Welfare Collaborative Group, National Child Traumatic Stress Network & The California Social Work Education Center. (2008). *Child welfare trauma training toolkit: Trainer's guide* (1st ed.).Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Cohen, J.A., Deblinger, E., Mannarino, A.P. 2006. *Treating Trauma and Traumatic Grief in Children and Adolescents*. New York: Guilford.

Conners, C.K. (1997). Conners' Parent Rating Scale-Revised: Long Version (CPRS-R:L). North Tonawanda, NY: Multi-health Systems Inc.

Cook, A., Blaustein, M., Spinazzola, J., van der Kook, B., & et al. (2003). *Complex trauma in children and adolescents; White paper from the national traumatic stress network complex trauma task force.* Durham, NC: National Child Traumatic Stress Network.

Ford, J. & Cloitre, M. (2009). Best practices in psychotherapy for children and adolescents. In Courtois, C.A. & Ford, J.D. Treating complex traumatic stress disorders; An evidence-based guide. New York, NY: The Guilford Press.

Greenwald, R. (2008). Progressive Counting: A new trauma resolution method. Journal of Child & Adolescent Trauma, 1, 249-262.

Greenwald R. and Rubin, A. (1999b). Child report of post-traumatic symptoms/Parent report of post-traumatic symptoms (CROPS/PROPS). Baltimore, MD: Sidran Institute.

Grillo, C.A., Lott, D.A., Foster care subcommittee of the Child Welfare Committee, National Child Traumatic Stress Network. (2010). Caring for children who have experienced trauma: A workshop for resource parents—Participant Handbook. Lost Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Kagan, R. (2007a). *Real life heroes; a life storybook for children.* 2nd edition New York, NY: Routledge.

Kagan, R. (2007b). *Real life heroes practitioner's manual.* New York, NY: Routledge.

Kagan, R. (2004). Rebuilding attachments with traumatized children; Healing from losses, violence, abuse and neglect . New York, NY: Routledge.

Kagan, R., Douglas, A., Hornik, J., & Kratz, S. (2008). *Real Life Heroes* Pilot Study: Evaluation of a Treatment Model for Children with Traumatic Stress. *Journal of Child and Adolescent Trauma.*

Kagan, R. & Schlosberg, S. (1989). *Families in perpetual crisis.* New York: Norton.

Kerns, K., Klepac, L., and Cole, A. (1996). Peer relationships and preadolescents' perceptions of security in the child-mother relationship. *Developmental Psychology,* 32, 457-466.

Macy, R. D., Barry, S., & Gil, N.G. (2003). *Youth facing threat and terror; Supporting preparedness and resilience.* San Francisco: Jossey-Bass.

Richardson, M., Henry, J., Black-Pond, C. & Sloane, M. (2008). Multiple types of maltreatment: Behavioral and Developmental Impact on Children in the Child Welfare System. Journal of Child & Adolescent Trauma, 1:317-330

Richardson, M., Kagan, R., Henry, J., Trinkle, J., DeLorenzo, E., & Brophy, M. (2011) Three month evaluation. Unpublished report. Albany, NY: Parsons Child and Family Center.

Shapiro F. (2001). *Eye movement desensitization and reprocessing; Basic principles, protocols, and procedures* (Second edition). New York: Guilford Press.

Williams, M.L. (2005). Cool cats; calm kids; Relaxation and stress management for young people. Atascadero, CA: Impact Publishers.