Treating Trauma

Relationship-Based Psychotherapy with Children, Adolescents, and Young Adults

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This book is dedicated to the clinicians who volunteer their time
out of a conviction that healthy relationships can and do
make the world a better place.

Contents

Acknowledgments

A group of clinicians in San Francisco, CA, created A Home Within thirteen years ago to address a gap in effective mental health treatment for children and youth in foster care. By 2006, organized groups of clinicians providing treatment within the "One child, one therapist, for as long as it takes" model were working in eight states across the country and some of them came together and produced a book, *Building A Home Within: Meeting the Emotional Needs of Children and Youth in Foster Care*, about this model of care (Heineman & Ehrensaft, 2006). Now, seven years later, clinicians in fifty-four communities in twenty-four states are delivering open-ended, relationship-based therapy to current and former foster youth.

This book presents the rationale for this approach to treatment, provides several case illustrations written by A Home Within clinicians across the country, and outlines the eight essential elements that form the framework underlying effective intervention with these vulnerable children and youth. We have been honored to work with the contributors to this volume, whose care in honestly portraying the joys and challenges has been astounding. They have each taken extraordinary care to use pseudonyms, change all identifying information, and paraphrase conversations. In addition, they have elected to present this as a group effort, rather than take individual credit for their chapters, as a further protection for their clients' privacy.

This book, though organized and edited by the executive director, research director, and training drector of A Home Within, with chapter contributions from twelve A Home Within clinicians, is the work of many in the organization. We are particularly grateful to staff members Rene Fay, Jade Hoffman, and Edith Del Pezo Vargas for their support. Wendy Von Weiderhold and Molly Saeger, co-directors of our local chapters provided thoughtful clinical insights and Dr. Diane Ehrensaft, founding and continuing board

member, gave valuable feedback on both content and format. Rosana Aguilar, Ashley Plushnik, and Corie Schwabenland from the Foster Care Research Group at the University of San Francisco provided essential support in reviewing literature and organizing references; their work and that of many other research assistants who have participated in the research is essential to the evaluation of the work of A Home Within, the results of which are presented in this book. The work of the clinicians of A Home Within, together with the experiences of the patients served over the last thirteen years, provides the insight and rich information necessary to understand what works for foster youth, what doesn't work, and how to best survive, as a clinician or a patient, in a child welfare system.

We would like to express our gratitude to the many board members who have provided guidance over the years. They have helped us move from a grass roots group to a vibrant and growing organization. In particular, Linda Fitzpatrick, Kira Stiefman, and Michael Hansen have been steadfast in their commitment and leadership.

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We would also like to thank those who have taught us so much: caseworkers, judges, attorneys, foster parents, and other organizations serving the foster care community have broadened our perspective. The therapists who bring their skills, knowledge, and questions to A Home Within expand our clinical horizon. The consultation group leaders offer professional development to those in their group, but also help extend organizational knowledge. Of course, our most important teachers are the children, teens, and young adults who have shared their stories of life in foster care. They have allowed us to know their minds and hearts and for this we are profoundly grateful.

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Introduction

The Need for a Relationships Framework in Effective Trauma Treatment for Children and Youth

Children who experience abuse and neglect suffer consequences of trauma far beyond the initial physical and psychological injuries (Peckins, 2011; Rosenkranz, Muller, & Henderson, 2012; Trickett, Negriff, Ji, & Wilson, Hansen, & Li, 2011; Zielinsks, 2009). For many maltreated children and youth, the negative impact of abuse is exacerbated by their subsequent removal from home, school, and community and placement into foster care (Baugerud & Melinder, 2012; Wechsler-Zimring, Kearney, Kaur, & Day, 2012). And, for many who are moved to out-of-home placements, the instability, ambiguity, and unpredictability of the foster care system results in an even further worsening of the psychological consequences of the original trauma (Havlicek, 2011; Stott, 2012). These children, who have been ignored, abandoned, assaulted, exploited, and/or tormented by their parents or primary caregivers must now live in a world in which everything is unfamiliar and tenuous, in which they have little to no contact with their families of origin, and in which abrupt change recreates itself at a moment's notice, with no warning.

Any therapist who provides mental health treatment for a child in foster care must address the psychological consequences of the neglect and/or abuse the child experienced, as well as the loss of the family of origin. Clinicians working with foster youth must also attend to the trauma of unanticipated and often poorly executed changes in the care provided by the child welfare system, all within the context of the uncertainty and ambiguity of the child's life in out-of-home care. The child in foster care needs support in the process of grieving uncertain loss, a far more difficult task than the grieving

of loss that is certain and unchanging. When a caregiver dies, children must eventually come to terms with the impossibility of a reunion; in contrast, children in foster care are often left with terrible uncertainties. They may have weeks or months—or sometimes even years—of visits with their biological parents with the presumed intention of the reunification of the biological family. Because of their uncertainty, these ambiguous losses are nearly impossible to mourn. While processing the impact of chronic and uncertain loss, the therapist must also address the mental health symptoms expressed by foster children as a consequence of their history and current context of ambiguity and insecurity.

Professional journals, newsletters, and conferences abound with reports of evidence-based treatments (EBTs) with demonstrated efficacy in treating a variety of mental health symptoms in children and youth (Chorpita, Daleiden, Ebesutani, Young, Becker, Nakamura, & Starace, 2011; Southam-Gerow, Rodríguez, Chorpita, & Daleiden, 2012); however, these interventions have only recently begun to be evaluated with children in foster care or with children who have experienced multiple traumas and present with a complex array of mental health symptoms. And, with the exception of information about oversight of psychotropic prescription guidelines for foster youth (Mackie, Hyde, Rodday, Dawson, Lakshmikanthan, Bellonci, Schoonover, & Leslie, 2011) and recommendations for relationship-focused approaches to policy and work with emancipated foster youth (Smith, 2011), few guidelines exist to assist therapists in navigating the unique challenges of providing treatment to a child or adolescent living in foster care who, by definition, does not have a reliable and continuous parent figure available.

The goal of this book is to begin to address the failure of the clinical and research literature to provide a theoretically sound and empirically supported framework for mental health treatment of traumatized children and youth in foster care. In the paragraphs that follow, we briefly summarize the EBTs that have been developed to date for use with children and adolescents, each of which has been found to improve mental health functioning in research samples. We discuss the limitations of these treatments with children in foster care and advocate for inclusion of EBTs, when indicated, within a relationship-focused therapeutic framework that is sensitive to the unique needs and context of children and youth in foster care. We present findings from an initial evaluation of Relationship-Based Therapy (RBT) with foster youth and describe the nature and mission of A Home Within, a non-profit organization that delivers this RBT approach to foster children throughout the United States.

EBTs such as Parent-Child Interaction Therapy (PCIT), Multi-Systemic Therapy (MST), Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT), and Interpersonal Psychotherapy for Adolescents (ITP-A) have

demonstrated efficacy in reducing disruptive behavior, externalizing behavior problems, the negative impact of sexual abuse, the consequences of exposure to domestic violence, juvenile delinquency, substance abuse, and depression in non-foster children (Cohen, Deblinger, Mannarino, & Steer, 2004; Henggeler et al., 2011; Liddle, Dakof, Henderson, & Rowe, 2011; Lyon & Budd, 2010; Mufson, Dorta, Wickramaratne, Nomura, Olfson, & Weissman, 2004; Waldron & Turner, 2008). These treatments have only very recently begun to be implemented and evaluated with clients who are in foster care (Dorsey, Kerns, Trupin, Conover, & Berliner, 2012; Farmer, Burns, Wagner, Murray, & Southerland, 2010; Timmer, Urquiza, & Zebell, 2006; Weiner, Schneider, & Lyons, 2009). EBTs should be employed in treatment of foster youth whenever appropriate, for example, when the foster child's diagnosis or presenting symptom(s) is comparable to the presenting symptoms of the youth who participated in the research studies and when the foster parents' ability and willingness to engage in treatment is comparable to that of the families of origin who participated in the research studies. However, as noted recently by child welfare researchers (Briggs & McBeath, 2010; Maher et al., 2009; Naccarato & DeLorenzo, 2008; Storer, Barkan, Sherman, Haggerty, & Mattos, 2012), therapy with foster youth must go beyond EBTs in order to effectively assist these children, who are not living with their parents, to process their traumatic past and survive the uncertainly and ambiguity of their present. In order to maximize the effectiveness of EBTs with the foster child client, the therapist must employ these tools within a sound clinical framework that is sensitive and responsive to the unique challenges of the child welfare system and the needs of a child in out-of-home placement.

Nearly all of the EBTs currently available substantially involve parents in the treatment; for foster youth, their parents are not available due to either incarceration, abandonment, or court restrictions on parent-child contact. Moreover, the future involvement of the biological parent in the foster child's life is uncertain and unknown. The availability and willingness of foster parents to participate in treatment varies. Even when foster parents are willing to engage in their foster child's mental health treatment, the utility of family-based treatment with the foster child and his or her foster parents may be limited. This is particularly true if the foster child's difficulties do not lie with problems in the foster family context or the foster parents' caregiving. Furthermore, the fact that most foster youth experience multiple and often-unplanned placement changes while in foster care (O'Neill, Risley-Curtiss, Ayón, & Williams, 2012; Unrau, Chambers, Seita, & Putney, 2010) often makes the involvement of foster parents in treatment untenable.

Children and youth in foster care, while often demonstrating symptoms which include the treatment targets of EBTs, rarely suffer from *only* those well-defined target symptoms. Research that supports EBTs typically ex-

cludes from study samples children and adolescents who also suffer from psychiatric, social, or developmental issues beyond the identified target symptom(s). The prototypical foster youth may present with depression, substance abuse, and disruptive behavior problems, each of which has been shown to decrease with the application of one or more EBTs when the parents are engaged in treatment or when administered in a school-based setting (Lyon & Budd, 2010; Mufson et al., 2004; Waldron & Turner, 2008); however, the foster child is typically also suffering from the consequences of attachment failures, chronic neglect and/or abuse, abandonment and loss, and the instability and uncertainty of foster care placement. EBTs, to date, do not include guidelines and techniques for intervention with these additional complexities. Thus, while EBTs should be utilized when indicated in the treatment of foster youth, effective intervention with these vulnerable children and adolescents must derive from a framework and structure designed to address their unique presentation of psychiatric symptoms, traumatic history, and current contextual uncertainty. EBTs with foster youth, the therapist's "tools" must be employed within the context of a theoretically sound and foster-care sensitive framework, the "toolbox" in order to be effective.

RBT is an evidence-supported approach to therapy with current and former foster youth that is based on the centrality of relationships as the key to psychological health (Bachelor & Horvath, 1999; Smith, 2011). A relationship with an experienced therapist provides the safety, stability, and containment required by these troubled children, youth, and young adults to work through their traumatic history and address their current physical health, mental health, educational, and adaptive problems. RBT pays close attention to childhood experiences and the ways in which these early experiences influence psychological development. In particular, the therapist focuses on the impact of traumatic experiences in childhood and their lasting influence on the individual. Relationships beget relationships; the stories of past relationships are played out in subsequent relationships. Reviewing and revisiting, in and through relationships, the remnants of the past, embedded in the psyche, can provide opportunities for finding new ways of understanding feelings, thoughts, and actions. Learning how to be in a healthy relationship with a therapist allows the foster child to develop and maintain healthy relationships with other adults and with peers.

Though the efficacy of RBT with specific populations of children and youth who suffer from clearly defined psychiatric symptoms has not been thoroughly evaluated, the effectiveness of this approach with foster youth is supported by preliminary practice-based evidence (Clausen, Ruff, Von Wiederhold, & Heineman, 2012). Data collected from A Home Within clinicians by the Foster Care Research Group at the University of San Francisco over the last ten years demonstrates significant reductions in depression, anxiety, dissociative symptoms, school problems, sleep problems, eating problems,

unsafe sexual behavior, self-injurious behavior, aggression and violence, risk taking, peer relationship problems, and foster family relationship problems. The average duration of treatments studied to date is three years and includes current and former foster children, youth, and young adults. Though the findings are preliminary, as the methodology is limited by sample size, potential bias of clinician reports, and the lack of a comparison group, results are encouraging and suggest that the RBT approach is supported by the data.

Research has shown that children in foster care demonstrate high rates of mental health symptoms (Clausen, Landsverk, Chadwick, Ganger, & Litrownik, 1998; Landsverk et al., 2009; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009), yet most foster children do not receive appropriate mental health services (Levitt, 2009; Marx, Benoit, & Kamradt, 2003; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009; Unrau & Wells, 2005), particularly those who have experienced neglect or who are ethnic minorities (Blumberg, Landsverk, Ellis-MacLeod, Ganger, & Culver, 1996; dosRios et al., 2001; Garland & Besinger, 1997). The failure to deliver needed mental health services to these vulnerable children in our care is due primarily to limited and fluctuating state and federal support, together with high turnover among inexperienced mental health interns and providers working for community mental health and social services departments. When funding is available for mental health treatment, foster youth are typically seen in community mental health clinics or community-based non-profit agencies, which employ mental health interns who are assigned to the agency or clinic for only six to twelve months. Thus, the foster child suffering from a complex array of psychiatric issues with background replete with trauma and loss, located in an uncertain and ever-changing familial environment, is seen for a series of short treatments by a rotating series of clinical interns, during their first year or two of practice.

The material in this volume draws on the work of clinicians who volunteer their professional time and expertise through A Home Within to support the emotional growth and healthy development of current and former foster youth. This award winning organization is based on a very simple model: "One Child. One Therapist. For As Long as it Takes." Intentionally, the commitment is not time limited; by working with just one child, teen, or young adult, each therapist is in a position to truly focus his or her time and psychic energy on understanding and meeting the needs of that one client. The work of each therapist is supported by regular meetings with a consultation group. Senior clinicians volunteer their time to lead these groups usually composed of four to six therapists. These groups offer therapists the opportunity to think and learn together about the work they are doing; they also provide support when the work is stressful and a place to share triumphs when the work is going well. Each local chapter is coordinated by a volunteer clinical director who devotes approximately four hours of pro bono time each

week to establishing and maintaining the local chapter. This includes recruiting and vetting therapists and consultation group leaders, developing relationships with referral agencies, and matching therapists and clients. Clinical directors participate in a Three Year Fellowship in the Treatment of Foster Youth, which includes an annual conference for training, professional development, and networking. A Home Within is open to clinicians from diverse backgrounds bound together by their belief in the essential healing power of relationships and their willingness to make an open-ended volunteer commitment. A Home Within is built on the premise that everyone has something important to offer, from the newly minted therapist to the most seasoned clinician. Everyone is paid exactly the same—absolutely nothing. However, those who give their time through A Home Within extract value beyond monetary gain. They enjoy and benefit from their colleagues and they have the satisfaction of knowing that their efforts have made things better for someone sometimes a little and sometimes a lot. Clinicians who volunteer through A Home Within repeatedly say that their lives have been immeasurably enriched by the people they have come to know through their experience, both colleagues and clients.

Nine case studies exemplifying RBT with a diverse group of foster youth are examined in the chapters that follow. In addition, three clinicians describe their experiences of working therapeutically in the context of a consultation group, made up of like-minded peers and a senior clinician who facilitates discussion. At the end of the book, in the concluding chapter, we summarize the work presented in the chapters by articulating the eight essential elements of RBT with current and former foster youth. These eight elements—Engagement, Empathy, Environment, Egocentrism, Enthusiasm, Evidence, Endurance, and Extending—are the keys to successful RBT. As we share these experiences through the chapters of this book, it is our deepest hope that our readers take this framework home as a part the clinical toolbox in which they keep their therapeutic tools, equipping all of us to intervene most effectively and most humanely with the traumatized youth residing in the foster care system who come into our care.

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I

Holding the Hope

When children who have experienced foster care are referred for treatment it is often with enormous hope on the part of their caregivers and the other professionals involved in their lives. Sometimes, it is also with a profound, unspoken, expectation that the child is beyond hope and that the psychotherapy, like so many other things that have been tried, will fail. In these situations the child is often perceived as bad, willfully disobedient, unloving, and or unappreciative.

The therapist, then, is given the unarticulated and impossible task of both making the child "better" and demonstrating that any hope of that happening is misplaced. In these cases the parents, whether foster, adoptive, or relative caregivers, have often found themselves in unanticipated and difficult situations. A grandfather is called upon to raise a grandchild who has been mistreated by his own child; the difficulties the child brings to his life are a daily reminder of the ways he feels he has failed his child and his fears of repeating the story. A couple dreams of parenthood and the satisfaction of rescuing a child who would otherwise be parentless only to find themselves trying to maintain the safety of a child who is physically and emotionally out of control. A woman hears through her church that there is a shortage of foster parents and decides that she can help; the children placed in her care complain constantly about her and her cooking and her house, angrily protesting that they want to return to the parents she knows abused them.

Caseworkers who are charged with creating safety and permanency for foster children often fail to explain fully the extent of children's difficulties out of a fear that they will be unable to find a suitable home for them. Or they

may downplay the problems in the hope and belief that if the child just finds a loving home the problems will disappear. Those hopes are often transferred to the therapist—not only the wish that the child will find relief from suffering, but the hope that the therapist will improve the child's behavior so that questions about whether the child will remain in the placement will dissipate.

Of course, foster and adopted children also begin therapy with unspoken and unarticulated hopes. Unsurprisingly, they hope that they will be reunited with their biological parents; even if they were abused and neglected while in their care, there is little to stop them from hoping that things could be different in the future. Whether consciously or not, it is often this hope that motivates children's defiance and misbehavior—they act badly in the hope that they will be returned to their parents. They also misbehave because they are afraid to hope—afraid to hope that someone actually does love and want them.

Therapists entering these worlds of swirling, ill-defined, unconscious, and contradictory hopes have difficult and complex tasks—not the least of which is finding and holding realistic hope for all. It is not realistic to hope that a traumatized child's behavior or demeanor will change merely by being placed with a loving adult. It is not realistic to hope that weekly psychotherapy will work magic in a few weeks or months. It is not realistic to hope that caregivers will not despair and when faced with children who continuously dash their hopes of feeling competent and confident.

It is realistic to hope that if all of the important adults in the child's life can find a way of working together to support each other, over time, the child's relationships and behavior will improve. It is realistic to hope—though difficult to maintain—that the adults will resist the impulse to blame each other (publically) and themselves (privately) for the misery and chaos in the child's life. It is realistic to hope that the self-perpetuating cycle of despair and defeat can gradually be transformed into a cycle of optimism and success.

The chapters in this section describe the painful outcomes of cases when therapists were unable to keep hope alive, despite their best efforts. They each had the hope of connecting with the child, a realistic hope for a therapeutic relationship. However, that was not enough to offset the unrealistic hopes that the child's behavior arising from past trauma could quickly change as a result of therapy, or that all questions about whether a child would follow in his wayward parents' footsteps could be erased, or that the fact of adoption would magically transform a child's sadness and selfishness into happiness and generosity.

Molly's parents want the therapist to make her better, but they don't want to form the relationship that would promote that end. Juan's aunt approaches his therapy with the unspoken and disavowed hope that she could have her needs met, leaving her to experience the therapist's overtures as demands,

rather than offers of help. All of Lilly's caseworkers' hopes for keeping her in her foster home are placed squarely on the shoulders of the therapist who is doomed to fail in meeting the unrealistic expectations set for the therapy without any input.

Despite the premature endings of these three therapies, in a most basic way they were not treatment failures. Each of these young people formed a relationship with the therapist and began to be more comfortable "in their own skin"; in other words, they were off to a good start when forces beyond their control brought the interpersonal relationship to an early end. However, in this context, it is important to remember that relationships are something created not only between people, but also within people. Both therapist and child will carry the other with them. Ending the treatment will not necessarily destroy the work that they did together, but it most likely will introduce a note of caution into the next relationship.

Ironically, by bringing an early end to the treatment the caregivers were also able to demonstrate what they had unconsciously hoped to show—that the child was beyond help. These children did not show enough improvement according to the external measures that had been established by the caregivers. However, all three did demonstrate progress not only in the context of therapy, but also in their relationships at home and at school. This raises the possibility that it was precisely because the success of the work was beginning to show, that it had to be brought to an end. Reaching the stated therapeutic goals would have undermined the unspoken belief that these children could not be helped—by the therapist, but more importantly, by the caregivers.

The final chapter in this section tells a therapist's story of fearing unknown relationships. Initially, rather than hope that the consultation group might be helpful, the therapist attempts to avoid the possibility of disappointment by avoiding the relationships offered by the group. Eventually, in the company of like-minded professionals who could see and know aspects of the treatment before the therapist could, the support and comfort provided by the group become evident.