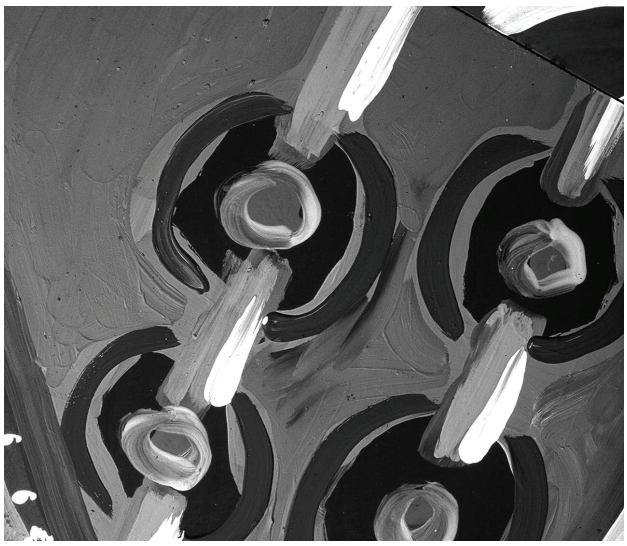

Promising Practices

Stuart Ablon, Ph.D.

Julie Brown, LICSW

Beth Caldwell, MS

Janina Fisher, Ph.D.

Ross Greene, Ph.D.

Julie Heuberger, LICSW

Lareina LaFlair, MPH

> “Do not follow where the path may lead, go instead where there is no path and leave a trail.”
>
> Ralph Waldo Emerson

Promising Practices

Many programs that have significantly reduced or eliminated the use of coercive interventions, including S/R, have embraced specific models of care that are trauma-focused, strength-based, and have an emphasis on building skills and competencies. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Child Traumatic Stress Network (NCTSN) have categorized treatment approaches based on rigorous standards of research and evaluation. There are also numerous treatment approaches that are being used successfully around the country and showing positive results that are not listed with SAMHSA or NCTSN. For the purpose of this *Resource Guide*, the term "promising practices" refers to treatment practices where at least some components of the practice have been shown to be effective, either through research involving control groups, or through less stringent evaluation protocols. Most of the practices listed in this chapter of the *Resource Guide* are being used by residential and hospital programs in Massachusetts, New York, and other areas.

SAMHSA model programs

SAMHSA defines model programs as well-implemented and well-evaluated programs that have been reviewed from National Registry of Evidenced-based Programs and Practices (NREPP) according to rigorous standards of research. SAMHSA also recognizes Promising Programs, which are those programs that have been implemented and evaluated sufficiently and are considered scientifically feasible and have produced some positive outcomes. Below are two examples of model programs.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Cognitive-behavioral therapy emphasizes the idea that our thinking causes us to feel and to behave the way we do (NACBT, 2006). According to the model, if we are experiencing unwanted feelings and behaviors, then we need to change our way of thinking. CBT involves several essential features: identifying and correcting inaccurate thoughts associated with the problem (cognitive restructuring), helping children engage more often in enjoyable activities (behavioral activation), and enhancing their problem-solving skills.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a short-term individual treatment for children ages 4 to 18, and combines trauma sensitive interventions with CBT (NCTSN, 2008). Children and parents are provided with knowledge and

skills related to processing trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.

TF-CBT has been proven to be effective in improving PTSD, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust.

The specific approaches considered to be model and effective programs by SAMHSA are TF-CBT and CBT for Child Sexual Abuse (CBT-CSA).

Multisystemic Therapy (MST)

MST is an evidenced-based practice for children ages 12 to 17 who have a history of violence or substance abuse (SAMHSA, 2008). At the core of MST is the belief that family strengthening is key in promoting positive social behavior and helping children make better connections to other environmental supports (e.g., peers, neighborhoods, schools). MST aims to address risk factors in an individualized, comprehensive, and integrated manner. Its primary goals are to reduce antisocial behavior, to improve functioning, to decrease the number of out-of-home placements, and to empower families. It has been proven to have positive results on serious, violent, and chronic juvenile offenders (MST Services, 1998).

National Child Traumatic Stress Network (NCTSN) promising practices

The NCTSN incorporates trauma-informed approaches in their treatment programs to reduce the impact of exposure to traumatic events on children and adolescents. NCTSN assigns a level of evidence for each service approach that ranges from "novel and experimental" to "supported and acceptable," but these levels are subject to change as the approaches are further refined and implemented. Below are NCTSN examples of promising practices.

Attachment, Self Regulation, and Competency (ARC)

The goal of ARC is to provide a guiding clinical framework to address symptoms of complex trauma in children and adolescents (please refer to the *Trauma-Informed Care* section of the *Resource Guide* for more information on complex trauma). The ARC approach is built around three core domains affected by trauma: attachment, self-regulation, and competency (Kinniburgh & Blaustein, 2005; NCTSN, undated). Treatment goals are identified for each of these domains and the framework includes a menu of suggested interventions. The ARC framework also recognizes that each child brings unique attributes, exposure history, context, and presentation to their treatment, and it encourages clinicians to modify the suggested interventions as necessary to meet the needs of their clients.

Sanctuary Model

Sandra Bloom, M.D., created the Sanctuary Model. It was originally developed for adult treatment programs, but has been adapted for use with children. It is a trauma-informed method, where the goal of the treatment is to restore hope, meaning, and purpose in the lives of people who have experienced trauma (Bloom, 2005). It reaches the treatment goal by focusing on creating a democratic, non-violent community environment for the client with an emphasis on affect management, safety, positive social connections, and skill building.

Trauma Systems Therapy (TST)

Glenn Saxe, M.D., and his team at Boston Medical Center developed TST based on the child development concepts of attachment, identity, and emotional and cognitive development. TST is a community-based program that includes the child's family, school, and neighborhood to help children and adolescents who have difficulty regulating their emotions (NCTSN, 2008).

The program has up to five phases, including surviving, stabilizing, enduring, understanding, and transcending (Saxe, Ellis & Kaplow, 2006). The child's treatment phase depends on the degree to which he/she can regulate his/her emotional responses and the stability of his/her social

environment. There are prescribed treatment modules within each phase, many of which have their own demonstrated efficacy, such as Dialectical Behavioral Therapy (DBT).

For a complete list of SAMHSA and NCTSN of model programs/promising practices, please go to:

www.nrepp.samhsa.gov

and

http://www.nctsn.org/resources/audiences/parents-caregivers/treatments-that-work

Other promising treatment approaches

Applied Behavioral Analysis (ABA)

Behavioral analysis techniques used by the famous psychologist B.F. Skinner were expanded upon to create ABA. The goal of ABA is to create a structured environment where children and adolescents with developmental disorders acquire the same skills that other children learn naturally (Saffran, 2006). Ivor Lovaas, Ph.D. developed discrete trial training (DT), which is an intervention based on a series of table-top drills focusing on a particular skill-set that is repeated until the child masters it and can apply it in a variety of settings (Loovas,

1987). In this technique, the child is given a stimulus as well as hints at what the responses should be.

The following is a child's interaction with a teacher who is being as helpful as possible **without** ABA training:

Teacher:	Are you excited about Thanksgiving?
Sam:	[no response]
Teacher:	Are you going to eat turkey?
Sam:	Yes.
Teacher:	What else are you going to eat?
Sam:	I don't know.
Teacher:	Will you eat pumpkin pie?
Sam:	Yes.
Teacher:	Thanks, Sam!

Here is how an **ABA-trained person** might make this an opportunity for practicing conversation skills:

Teacher*:*	Hi, Sam, are you excited about Thanksgiving?
Sam:	[no response]
Teacher*:*	Are you excited about Thanksgiving? Say, "Yeah, I can't wait to eat…"
Sam:	Yeah, I can't wait to eat turkey!
Teacher:	What else will you do on that day?
Sam:	I don't know.
Teacher:	What else will you do on that day? Say, "On Thanksgiving I'm going to watch…"
Sam:	I'm going to watch the parade. On Thanksgiving.

Collaborative Problem-Solving (CPS) and Collaborative Practice Solutions (CPS)

Ross Greene, Ph.D., and Stuart Ablon, Ph.D., Boston-based child psychologists, developed specific collaborative approaches, both called CPS, to teach problem-solving skills to children and adolescents (Greene & Ablon, 2005). It emphasizes the need for a comprehensive assessment and understanding of the specific factors underlying each child's oppositional behavior. CPS articulates common pathways to oppositional behaviors including:

- executive skill deficits,
- emotion regulation difficulties,
- language processing deficits,
- social skill deficits,
- cognitive rigidity,
- and sensory and motor difficulties.

Using the pathways as a guide, in the CPS model, families and staff members learn to view oppositional behavior as the byproduct of difficulties in the areas of frustration tolerance, problem solving, and flexibility. This helps staff respond to oppositional behavior in a more empathic manner, and recognize the necessity for a specialized approach to intervention.

Many parents and treatment programs have adapted components of Dr. Greene's CPS. A popular adaptation guides

parents and staff in how to respond to behaviors before the incidents occur and suggests that they categorize the behavior into one of three plans before responding:

Plan A: A safety situation that requires imposing adult will

Plan B: An opportunity to use a CPS approach

Plan C: A situation where it is best to ignore the behavior, because it is not worth getting into a power struggle

Plan B is the preferred response approach in many situations, because it allows a parent or staff member to gain an understanding of what is driving a particular child's oppositional behavior, and work with that child to solve the problem at hand. By repeating these interactions over time, children develop their own tolerance for difficult situations and enhance their ability to solve problems by themselves. Parents and programs have found that when adults use this collaborative and respectful approach, they are often able to diffuse potential power struggles and help children practice thinking skills.

Dialectical Behavioral Therapy (DBT)

DBT is a cognitive-behavioral therapy that was developed by Marsha Linehan, Ph.D. (1993) to treat individuals with Borderline Personality Disorder. DBT is based on the proposition that the core problem for the individuals with "borderline personality patterns" is that they lack coping skills to manage feelings, thoughts, and behaviors effectively.

Without such emotional regulation skills, these individuals are particularly vulnerable to what are described as “invalidating environment.” Invalidating environment are those that:

- do not value the individual’s behavior;
- inconsistently punish and ignore emotional expression;
- oversimplify how difficult it is for the person to cope and change; and
- treat the person as a threat to the system and teach the individual not to disclose his/her needs.

Families and residential support environments may be unintentionally invalidating and further perpetuating the individual’s problems, thus making it very difficult for the individual to learn new skills using a DBT framework. It is important for programs to assess how their practices may be invalidating and strive to make necessary changes.

Some DBT concepts that are particularly important for support providers to integrate into a program include:

- Individuals accept themselves as they are to move towards changing.
- DBT is based on the idea that individuals are doing the best they can, given their experiences and skill deficits in each situation. This mindset is critical, because it creates a non-judgmental and accepting environment for the individual.
- Teams need to continually improve their abilities and increase motivation to effectively support individuals.

Grotberg Resiliency Model

Edith Grotberg, Ph.D., a national leader in the field of developmental psychology and child resilience, examined the factors that enable children to overcome adversities. In her publication, A *Guide to Promoting Resilience in Children: Strengthening the Human Spirit***,** resilience is a basic human capacity present in all children, but adults must teach them how to communicate with others, solve problems, and successfully handle negative thoughts, feelings, and behaviors (Grotberg, 1995). Dr. Grotberg grouped the factors into a paradigm of resilience consisting of three components:

1. **I have**: Names the source of support around each child. For example "I have people around me I trust and who love me, no matter what."
2. **I am**: Encourages self esteem and responsibility. For example, "I am respectful of myself and others."
3. **I can**: Fosters the acquisition of interpersonal and problem-solving skills. For example, " I can control myself when I feel like doing something not right or dangerous."

By encouraging children to think of and act on their competencies, parents and staff members create an environment where the children can build on their natural strengths and promote resilience through their words and actions.

Positive Behavioral Support (PBS)

PBS, sometimes called Positive Behavioral Interventions and Support (PBIS), is an empirically validated, function-based approach to decrease challenging behaviors in children and adolescents and replace them with prosocial skills (Cohn, 2001). It is often used in school settings, and it was developed because traditional methods for addressing serious behavior problems were often focused on consequences and were ineffective in helping children change their behavior. It is an approach that blends values about the rights of children with disabilities with a practical science about how learning and behavior change occur (PBIS, 2009).

The most important part of devising PBS plans is conducting a Functional Behavioral Assessment (FBA), which gives information about the antecedents, consequences, and frequency of problematic behavior. PBS plans are individualized and data-based, and they include procedures for monitoring, evaluating, and reassessing the process. A PBS strategy may be as simple as changing where a child is sitting in a classroom to help him/her pay attention in class and complete more written work. PBS is most effective when it is a collaborative effort among parents, school psychologists, teachers, counselors, administrators, and peers.

Risking Connections

Risking Connections is a training curriculum along with specific interventions for working with survivors of childhood abuse, which was created as a joint venture from the Sidran Traumatic Stress Institute, the Trauma, Research, Education and Training Institute (TREATI), and the Departments of Mental Health in Maine and New York (Saakvitne, Gamble, Pearlman and Lev, 2000). It is designed for staff members of all disciplines, and it may be used in a variety of treatment settings.

The curriculum helps staff members understand that most survivors of abuse need the support of interpersonal connections to resume meaning and wholeness to their lives. It recognizes that taking steps to form these connections can be very challenging for survivors who have been betrayed in relationships.

The curriculum consists of five parts, including:

- Understanding Trauma
- Learning to use connections to develop treatment goals with clients
- Learning to keep a trauma framework when responding to crises and life-threatening behaviors
- Learning to help clients with dissociation and flashbacks
- Learning to understand and manage symptoms of vicarious traumatization

Seeking Safety

Seeking Safety is a present-focused therapy developed by Lisa Najavits, Ph.D. (Seeking Safety, undated). It is a treatment approach for adults and adolescents with co-occurring substance abuse disorders and trauma. The treatment is designed for flexible use in a variety of inpatient and outpatient settings. Seeking Safety encourages the development of coping skills focused on behavior, thinking, and relationships and encompasses twenty five skill areas including: compassion, asking for help, boundary-setting in relationships, grounding, and self care.

Sensorimotor Psychotherapy

*S*ensorimotor Psychotherapy is a psychotherapy method specifically developed for the treatment of trauma and attachment-related issues and symptoms. Developed by Pat Ogden, Ph.D. (Ogden, Minton & Pain, 2006) and informed by the neuroscience and attachment research, Sensorimotor Psychotherapy focuses on the psychophysiological effects of trauma, including dysregulated autonomic nervous system arousal, sensitivity to trauma-related stimuli, inappropriate defensive responses, and alternations between hyperactive and hypo-activation, often mistaken for bipolar disorder. In Sensorimotor treatment, children and parents are taught to increase awareness of the signs of nervous system activation (anger, anxiety, agitation, shutdown) or defensive responses (fighting, fleeing, hypervigilance, mistrust) and to practice

alternatives to those automatic actions and reactions. Because Sensorimotor Psychotherapy includes attention to somatic responses, it is particularly useful and appropriate for young people who find it difficult to put their feelings and thoughts into words. By integrating talking therapy techniques with action, movement, sensory integration techniques, and mindfulness-based approaches, it gets below the level of words to the feelings and instinctual responses connected to the trauma.

Teaching Family

The Teaching Family approach was one of the first researched models in the country for use in residential programs that promoted a positive focus and attention to skill building (Bedlington et al., 1988). It has also been successfully adapted to hospital programs (Furst et al., 1994). It ensures that every aspect of the organization is focused on supporting the child for who he/she is as a whole and individual person and not focused primarily or solely on his/her problem areas. Any focus on problem or areas of need within a strength-based approach is based on helping the child and family build new skills and learn new approaches to experience more success, based on the individual histories and physiological make-up of each child.

Please see the *Strength-Based Treatment* chapter of the *Resource Guide* for more information on strength-based treatment approaches.

Future vision

For any model to be successful, it is important that key administrative supports accompany the implementation process through training, supervision, and evaluation. These supports should continue beyond implementation to ensure model fidelity.

The treatment models and approaches described in this chapter all focus on resilience, strengths, and increasing competencies, but are not intended to be a comprehensive review. The *Resource Guide* will be updated in the future to include additional and evolving promising practices.

It is important to remember that specific treatment models may work very well for some children and not at all for others. When programs embrace specific models of care, they may have to make exceptions and modifications for children whose needs are different.

Promising Practices

Bedlington, M.M., Braukman, C.J., Ramp, K.A., & Wolf, M.M. (1988). A comparison of treatment environments in community-based group homes for adolescent offenders. *Criminal Justice and Behavior, 15*(3), 349-363.

Bloom, S.L. (2005). Introduction to special section-creating sanctuary for kids: Helping children to heal from violence. [Electronic Version]. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, 26*(1), 57-63. http://www.sanctuaryweb.com/PDFs_new/Bloom%20Intro%20Creating%20Sanctuary%20for%20Children%20TC.pdf

Cohn, A.M. (2001). *Positive behavioral supports: Information for educators.* National Association of School Psychologists (NASP). www.naspcenter.org/factsheets/pbs_fs.html

Greene, R.W., & Ablon, J.S. (2005). *Treating explosive kids: The collaborative problem solving approach.* New York: Guilford Press.

Grotberg, E.H. (1995). A guide to promoting resilience in children: Strengthening the human spirit. [Electronic Version]. *Early Childhood Development: Practice and Reflections* series. https://bibalex.org/baifa/Attachment/Documents/115519.pdf

Kinniburgh, K.M., & Blaustein, M.E. (2005). *Attachment, self-regulation, & competency (ARC): A comprehensive intervention with complexly traumatized youth*. Boston, MA: The Trauma Center.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M. (1993). *Skills training manual for treating borderline bersonality disorder*. New York: Guilford Press.

References

Loovas, O.I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting & Clinical Psychology, 55*, 3-9.

Multisystemic Therapy. (1998). *Treatment model*. http://www.mstservices.com

National Association of Cognitive-Behavioral Therapists (NACBT). (2006). *What is cognitive-behavioral therapy?* http://www.nacbt.org/whatiscbt.htm

National Child Traumatic Stress Network (NCTSN). (undated). *Attachment, self-regulation and competence: A common-sense framework for intervention with complexly traumatized youth.* http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/ARC_2-11-05.pdf

National Child Traumatic Stress Network (NCTSN). (2008). *Trauma-focused cognitive behavioral therapy (TF-CBT)*. http://www.nctsnet.org/sites/default/files/assets/pdfs/tfcbt_general.pdf

National Child Traumatic Stress Network (NCTSN). (2008). *Trauma systems therapy.* Retrieved March 24, 2012 from http://www.nctsnet.org/sites/default/files/assets/pdfs/tst_general.pdf

Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. *Traumatology, 6(3).* http://sensorimotorpsychotherapy.org/articles.html

Positive Behavioral Interventions and Supports (PBIS). (2009). *What is school-wide positive behavioral interventions and supports.* http://www.pattan.net/category/Educational%20Initiatives/Behavior/page/what_is_school_wide_positive_behavior_interventions_and_supports.html

Saakvitne, K.W., Gamble, S., Pearlman, L.A., and Lev, B.T. (2000). *Risking connection: A training curriculum for working with survivors of childhood abuse*. Lutherville, MD: The Sidran Press.

References

Saffran, R. (2006). *What is applied behavior analysis?* http://rsaffran.tripod.com/whatisaba.html

Saxe, G.N., Ellis, B.H., Kaplow, J. (2006). *Collaborative treatment of traumatized children and teens: The Trauma Systems Therapy approach*. New York: Guilford Press.

Seeking Safety. (undated). *About Seeking Safety*. www.seekingsafety.org

Substance Abuse and Mental Health Services Administration (SAMHSA), National Registry of Evidence Based Programs and Practices (NREPP). (2008). *Multisystemic therapy.* https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=17