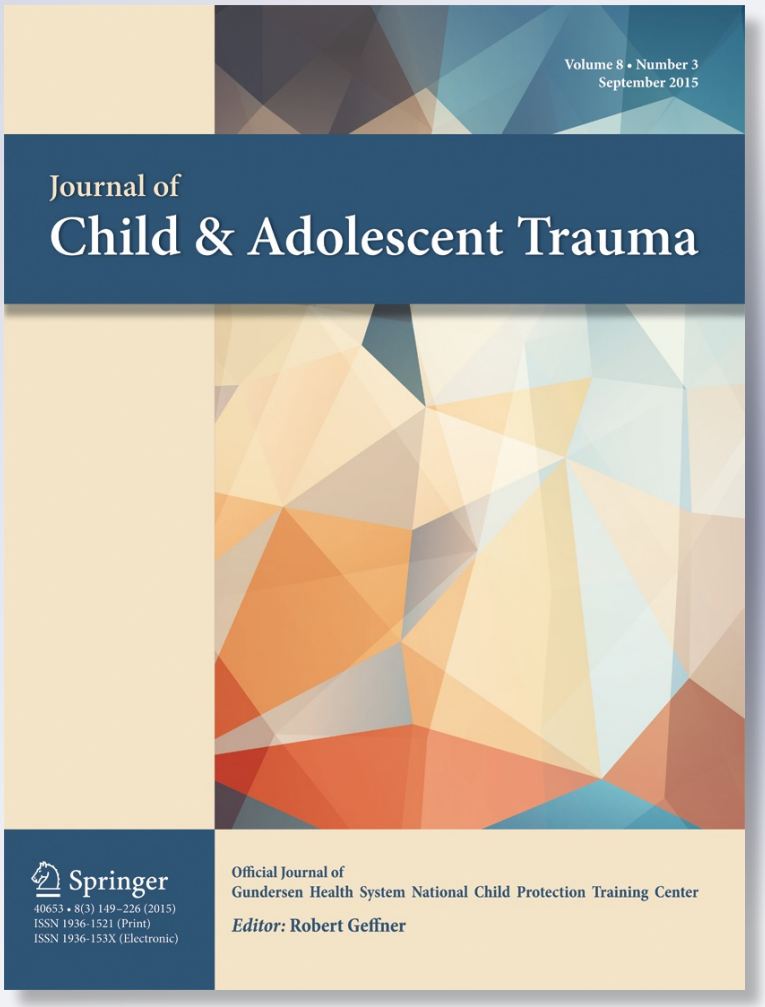
Treating Complex Trauma: An Evidence-Based Case Example of Severe Childhood Abuse

David M. Lawson & Stevie Malnar Hight

Journal of Child & Adolescent Trauma

ISSN 1936-1521
Volume 8
Number 3

Journ Child Adol Trauma (2015)
8:211-225
DOI 10.1007/s40653-015-0054-z



Springer

Journ Child Adol Trauma (2015) 8:211–225
DOI 10.1007/s40653-015-0054-z

CASE STUDY

Treating Complex Trauma: An Evidence-Based Case Example of Severe Childhood Abuse

David M. Lawson[1] · **Stevie Malnar Hight**[2]

Published online: 4 August 2015

Abstract Complex trauma (CT) results from exposure to severe stressors that occur within the caregiver system, are chronic, and largely begin in childhood or adolescence. This article describes the evidence-informed treatment of a 9-year-old female with chronic CT symptoms, resulting from long-term sexual, physical, and psychological abuse within her family. Treatment lasted 17 months and followed an assessment-driven, phase-based process. This process was flexibly implemented based on the unique circumstances of the case, while remaining consistent with the intent of the treatment models. Pre- to post-treatment data indicated significant reductions in trauma-related symptoms. Verbatim clinical vignettes illustrate specific interactions between family members and therapists, as well as interventions related to the treatment.

Keywords Interpersonal trauma · Complex trauma · Child maltreatment · Trauma Focused Cognitive Behavioral therapy · Attachment · Self-regulation, and competency · Integrated treatment of complex trauma

The experience of interpersonal trauma during childhood is widespread in our society. The Fourth National Study of Child Abuse and Neglect (NIS-4) reported the following incidence rates: neglect – 61%, physical abuse – 58%, sexual abuse – 24%, and emotional abuse – 27% (Sedlak et al. 2010). Also, estimates suggest that 15.5 million children are exposed to interparental violence, including 7,000,000 who were exposed to severe violence (McDonald, Jouriles, Ramisetty-Mikler, Caetano, and Green 2006). Many children experience multiple types of abuse (i.e., polyvictimization). The National Survey of Children's Exposure to Violence found that 66% had experienced multiple types of abuse, 30% experienced five or more types, and 10% experienced 11 or more types across their lifetimes (Turner, Finkelhor, and Ormrod 2010). Caregivers were the primary perpetrators. Children who experience multiple and chronic abuse by caregivers have significantly more symptoms, more severe and longer standing symptoms, and fewer family strengths than children with single incident, non-caregiver related trauma (Kisiel, Fehrenbach, Small, and Lyons 2009). The term complex trauma (CT) is associated with multiple and chronic abuse by caregivers (Cook et al. 2003).

Complex Trauma

CT denotes two related though different referents (Cook et al. 2003). One refers to traumatic events that are chronic, multiple, and interpersonal, while the second denotes the resulting *condition* that is characterized by a wide range of chronic symptoms (Briere and Scott 2013). With respect to the former, CT involves cumulative, polyvictimization perpetrated within the caregiving system during childhood by adults who are expected to provide security, protection, and stability. For these children, CT is an ongoing and stable condition rather than a time-limited event. Exposure to CT often results in lifelong difficulties related to self-regulation, attachment, relationships, addiction, dissociation, memory and attention, self-injury, self-identity, and cognitive distortions (Cloitre et al. 2009; Cook et al. 2005). The condition of CT is more

✉ David M. Lawson
dml3466@aol.com

[1] Department of Counseling, Sam Houston State University, Huntsville, TX 77340-2119, USA

[2] Athens Independent School District, Jacksonville, TX, USA

prevalent with chronic polyvictimization compared to intermittent and single type trauma (Cloitre et al.; Kisiel et al. 2009).

CT compromises a child's core perception of self and others, often manifested in mistrust of self and others. These children may be warned or threatened by a caregiver to keep the abuse secret, causing conflict, guilt, and a sense of betrayal. Moreover, they may make an outcry to non-abusive caregivers and either be ignored or threatened to conceal the abuse. Regular or intermittent CT exposure creates a near continual state of anxiety, hypervigilance, and the expectation of an unsafe world. Victims are at an increased risk for revictimization and cumulative impairment, with the highest risk associated with childhood sexual abuse (CSA; Maker, Kemmelmeir, and Peterson 2001).

Early, chronic exposure to CT disrupts normal neurological development, often leading to a shift from a *learning brain* to a *survival brain*, resulting in greater activation of the primitive brain rather than structures that are dedicated to making complex adjustments to the environment (Ford 2009). The survival brain leads to extreme responses to perceived threat such as dissociation, with an orientation of harm avoidance rather than openness to experience. CT compromises the ability to integrate sensory, emotional, and cognitive data into an organized whole (Cook et al. 2005).

In addition, caregivers with histories of child abuse can adversely affect treatment. Mothers with CSA histories have high rates of mental illness, substance abuse, partner violence, impaired caregiving skills, and insecure attachments, resulting in dysfunctional parent–child relationships such as parent–child role reversals, diffuse boundaries, confusing and frightening communication, and severe punishment (Newman and Stevenson 2008). A caregiver's ability to manage distress and to provide physical and emotional support are among the strongest predictors of a child's recovery from trauma (Cohen, Mannarino, and Deblinger 2006). Parents with unresolved trauma are less likely to provide such care. Mothers' history of CSA is the strongest predictor of CSA in the next generation, with their daughters having 3.6 times greater the risk for CSA (McCloskey and Bailey 2000).

Though accurate estimates on rates of incest are difficult to obtain, a few studies suggest possible percentages. A random sample of 940 women in San Francisco indicated a 4.5% incidence of father-daughter incest (Russell 1986). This translates to 1 in 20 families having experienced father-daughter incest and 1 in 7 stepfather-daughter incest. In an anonymous computer-based survey of 1,521 women, 15.8% reported CSA with 7.9% reporting father-daughter incest (Stroebel et al. 2012). Chronic CSA by a caregiver has the greatest negative impact on a child and is associated with severe CT symptoms (Kluft 2011). It creates an atmosphere of concealment, betrayal, helplessness, conflicted loyalty, fear of retaliation, self-blame, and shame (Collins, Griffiths, and Kumalo 2005). Only 30% of such cases are reported by victims. Children must adapt to horrific conditions resulting in symptoms such as extreme emotional numbing, affective dysregulation, and dissociation.

Additional traumatic experiences such as physical and emotional abuse and exposure to parental violence exacerbate the symptoms associated with parent–child sexual abuse (Cloitre et al. 2009) and increase the probability of high risk behaviors (e.g., self-injury, aggression, substance use), life functioning difficulties (e.g., school, peers, family), and being a danger to others (Kisiel et al. 2009). As a result, the development of self-regulation and interpersonal skills are central in most treatments, as well as collaboration with adults in a child's home, school, neighborhood, and community to develop protective resources in the child's environment (Grasso, Greene, and Ford 2013).

Treatment Related Issues

Though CT has received much attention in the literature, few studies have been conducted on treatment effectiveness compared to the number of studies examining PTSD. Most focus on single incident trauma rather than multiple, cumulative trauma (Silverman et al. 2008). A difficulty in conducting Randomized Controlled Trials (RCTs) with this population is the need to tailor treatments to each client's unique response to CT. Further, recent protocols indicate that multiple approaches and modalities often are necessary (Arvidson et al. 2011; Ford and Cloitre 2009). Yet, group designs with a specified sequence of interventions are standard. Also, large *N* group designs may obscure finer-grain elements of treatment unique to each case that may be critical to successful treatment. Some suggest the need to examine treatment for single cases based on evidence-informed interventions as a means of identifying important treatment dynamics, examining theoretical constructs, and to inform large *n* studies (Lawson and Quinn 2013). The case study below is an effort to contribute to this end.

Treatment Models

Because of the complicated and systemic nature of CT, the disruptions in normal child development, and the unique needs for each child and family, treatment likewise should be complex, comprehensive, and tailored to the needs of each client (Lanktree et al. 2012). Although treatment components vary across CT approaches, some treatment components appear common across most models (e.g., self-regulation skills). Also, several theoretical and best practices models for CT have been offered (e.g., Amaya-Jackson and DeRosa 2007; Cook et al. 2005). Trauma-Focused Cognitive Behavioral

Therapy (TF-CBT; Cohen et al. 2006) has been recognized for its effectiveness in treating PTSD. Though TF-CBT was not originally developed for working with CT, several proponents have suggested modifications to enhance its application with these cases (Cohen, Mannarino, Kliethermes, and Murray 2012; Kliethermes et al. 2013). Other approaches, such as the Attachment, Self-Regulation, and Competency framework (ARC; Arvidson et al. 2011) and Integrated Treatment of Complex Trauma for Children (ITCT-C; Lanktree et al. 2012), were developed expressly for treating children and adolescents exposed to CT. These models recommend flexible implementation of core treatment components based on individual needs. ARC and ITCT-C authors note that their approaches are informed by evidence-based practices such as TF-CBT.

Attachment, Self-Regulation, and Competency framework (ARC) The ARC model (Arvidson et al. 2011) is a component-based framework for children and adolescents with CT. The order and application of these components is modified according to the unique characteristics of the child and family. ARC draws from attachment theory, child development theory, traumatic stress theory, and resilience factors. The number of sessions ranges from 12 to 52, depending on symptom severity. Treatment focuses on three primary core areas, with each area targeting several "building blocks:" *Caregiver Attachment*: caregiver affect management, attunement to child, consistency, and routines; *Child's Self-Regulation*: affect identification, modulation, and affect expression; and *Child's Competency*: executive functions, self-development, and identity (Blaustein and Kinniburgh 2010). A final component, *Trauma Experience Integration*, integrates skills and concepts from the three core areas to target trauma memories, triggered arousal states, and trauma-based cognitions. Strategies are aligned with each building block and target the individual, caregiver-child, and system levels.

Several single group, pre- to post-treatment pilot studies have been conducted with children exposed to CT. In one study, pre- to post-treatment measures on the *Child Behavior Checklist* (CBCL; Achenbach 1991) noted significant improvements for 21 children who had completed treatment (Arvidson et al. 2011). A second employed a naturalistic, pre- to post-treatment study with 126 female youth exposed to CT and found significant reductions in PTSD symptoms and significant improvements on 10 of 11 CBCL scales (Hodgdon, Kinniburgh, Gabowitz, Blaustein, and Spinazzola 2013).

Integrated Treatment of Complex Trauma for Children (ITCT-C) ITCT-C (Lanktree et al. 2012) was developed for children ages 8–12 who have been exposed to CT. It is multimodal, component-based, assessment-driven, and is flexibly implemented, dependent on the needs of the child. ITCT-C is informed by the concepts of CT theory, attachment theory, Cognitive Behavioral Therapy (CBT), and the Self Trauma Model. The authors emphasize the importance of a strong therapeutic alliance with the child and caregivers, especially when processing traumatic experiences (Lanktree and Briere 2008). The number of sessions varies according to individual needs, with the average number ranging from 16 to 36.

ITCT-C is comprised of the following components: relationship building, safety, affect regulation training, psychoeducation, cognitive processing, trigger identification, titrated exposure, relationship processing, interventions to change internal state, interventions with caretakers, and family therapy. Attachment themes pervade the treatment process. Child-therapist individual sessions comprise a major portion of therapy, but work with caregivers, parent–child sessions, family sessions, and group therapy also may be included. Lanktree et al. (2012) reported on 151 multi-traumatized children who received ITCT-C. Based on a one-group, naturalistic study design, results indicated significant reductions in anxiety, depression, posttraumatic stress, anger, dissociation, and sexual concerns. Longer time in treatment was associated with greater improvement.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) TF-CBT (Cohen et al. 2006) was designed for children and adolescents who had experienced a traumatic event. It is the only such treatment that is considered well established with children and adolescents. Therapists work individually and conjointly with parent and child. Treatment is phase oriented and typically follows the order of core components based on the acronym PRACTICE (Cohen et al. 2006): *P*sychoeducation for parent and child, and parenting skills; *R*elaxation skills; *A*ffective modulation; *C*ognitive coping and processing (Phase I - Coping Skills); *T*rauma narrative; In vivo master of trauma reminders (Phase II - Trauma Narration Processing); *C*onjoint child–parent sessions; and *E*nhancing safety and development (Phase III - Consolidation/Closure). Treatment ranges from 12 to 16 sessions.

Although not originally developed for children exposed to CT, recent publications by Cohen and colleagues (Cohen et al. 2012; Kliethermes et al. 2013) suggest several modifications for applying TF-CBT to CT cases. First, extend the number of sessions from 8–16 to 25–30. Second, place a greater emphasis on the therapeutic alliance, due to repeated interpersonal trauma. Next, address safety in the initial phase of treatment as opposed to the final phase. Also, because exposure to CT often compromises self-regulation, increase the number of sessions devoted to coping skills from one-third to one-half. Further, therapy should focus more on processing trauma themes than a specific traumatic event due to the greater number of incidents. Finally, because of the complicated nature of CT, a life narrative is preferable to a trauma narrative alone. The life

narrative should begin as early as a child can remember and continue sequentially to the present including trauma and non-trauma themes and events, resources and strengths, and related thoughts, feelings, situations, and behaviors.

Cohen et al. (2012) identified three studies based on the use of TF-CBT with CT (TF-CBT-CT). In a published study, Weiner, Schneider, and Lyons (2009) compared TF-CBT-CT to Child–parent Psychotherapy, Structured Psychotherapy for Adolescents Responding to Chronic Stress, and Systems of Care (SOC) treatment. All three significantly reduced symptoms compared to SOC. Compared to SOC, TF-CBT-CT resulted in significantly greater reduction in emotional and behavioral problems and PTSD symptoms and was more effective in preventing placement disruption and running away.

Though differences exist between the three models (e.g., TF-CBT-CT tends to promote a circumscribed number of sessions and a specific order of treatment components; TF-CBT-CT and ITCT-C emphasize titrated trauma exposure to counter-condition and extinguish PTSD symptoms), all three models include the major treatment components identified by Cook et al. (2005): safety, psychoeducation, self-regulation skills, self-reflective information processing, trauma and cognitive processing, positive affect enhancement, and relational engagement. Further, all three models are assessment driven, informed by multiple theories, employ multiple modalities, and are culturally sensitive. As CT is associated with disruptions in attachment relationships, attachment theory and relationship enhancement influence choice of interventions, especially for ARC and ITCT-C.

How We Employed ARC, ITCT-C, and TF-CBT

Largely, we followed the three phase model associated with TF-CBT-CT and other CT literature (Cook et al. 2005): stabilization phase, trauma processing phase, and integration phase. Also, we employed many of the phase specific components and skills, such as controlled breathing, to manage anxiety and trauma processing. ARC and ITCT-C also employ these components in a phase-based manner, but flexibly tailor them to each case. Likewise, we found it necessary to overlap phase components as well as repeat earlier phase components in later phases as new trauma material emerges. Further, as recommended by all three approaches, we began treatment with stabilization components such as safety and the therapeutic alliance. All three models agree that the stabilization phase may last weeks to months, dependent on case severity. We found this to be the case as well.

Attachment and the therapeutic alliance are important in all three models, but are particularly integral with ARC and ITCT-C. In particular, ITCT-C focuses on relational processing. This refers to the therapeutic alliance as a healing agent, a prerequisite for trauma processing, and a trigger that activates implicit memories, emotions, and cognitions associated with the relationship to the abuser. A traumatized child may expect a response that is similar to that of the abuser. The therapist can provide an accepting, safe, and warm environment that is *incongruent* with the child's anticipated response. With time, the child's fear and abuse-related responses are reduced as a result of extinction and cognitive reconsideration (Lanktree and Briere 2008). This process strongly informed our individual sessions between both the therapist and child client and with the mother-daughter relationship.

As does ITCT-C, we used family therapy to stabilize the family and build family cohesion. Lastly, TF-CBT-CT suggests treatment duration of 25 to 30 sessions. ARC and ITCT-C are less delineated, with severe cases lasting a year or more. For our case, treatment continued for over a year.

The mother and children in the following case provided informed consent/assent to participate in the project. Identifying information was changed or removed to protect client confidentiality. Names used in the case are pseudonyms, and details of the case not pertinent to treatment were altered.

Case Background Information

"Carol," a 9-year-old female, was referred to a university training clinic from a family crisis agency. She lived with her mother and brother, "Jake" (age 7). She had been repeatedly and severely sexually, physically, and psychologically abused over 7 years by both her biological father and step-father. The abuse began around age 3 during visitations with the biological father. At age 7 she made an outcry to her step-father who then began to abuse her repeatedly in the home. She was abused by both fathers for 18 months. The mother eventually suspected CSA by the step-father. She asked Carol, who acknowledged the abuse. The step-father was arrested the next day.

Instruments

Carol's assessment included data obtained by self-report, the mother's report, and the clinicians' observations and interviews. The mother reported on her own symptom distress level, PTSD symptoms, the therapeutic alliance, and on her children's behavior. Instruments were chosen based on our interest in complex trauma. We also included alliance measures. All instruments were administered either prior to or after therapy sessions.

The Outcome Questionnaire-45 (OQ-45; Lambert et al. 1996) assessed the mother's distress on four scales: Symptom Distress (SD; anxiety and depression); Interpersonal Relations (IR); Social Role (SR; life satisfaction); and Total. Clinical cutoff scores and reliable change

index (RCI) are: Total score=63 (RCI=14), SD=36 (RCI =10), IR=15 (RCI=8), and SR=12 (RCI=7). Items are scored on a 5-point Likert scale and scores range from 0 to 180. Higher scores indicate more distress. Alphas ranged from .71 to .92. The OQ-45 has acceptable concurrent validity (Lambert et al.).

The Individual Therapy Alliance Scale (ITAS; Pinsof 2005) assessed the therapeutic alliance between the therapist and the mother and produces scores (1–7) for Goals, Tasks, Bonds, and a Total score. Higher scores indicate a stronger therapy alliance. Alpha coefficients ranged from .68 to .73. The ITAS has acceptable construct validity based on confirmatory factor analysis (Pinsof).

The Detailed Assessment of Posttraumatic Stress (DAPS; Briere 2001) assessed the mother's trauma symptoms on several scales: Relative Trauma Exposure; Peritraumatic Distress; Peritraumatic Dissociation; Posttraumatic Stress symptoms; Posttraumatic Impairment; Trauma-specific Dissociation; Substance Abuse; and Suicidality. Clinical scores are T-scores of 65 and higher. Alphas ranged from .67 to .98. It has acceptable convergent and divergent validity (Briere 2001).

The Eyberg Child Behavior Inventory (ECBI; Eyberg and Pincus 1999) is a caregiver report of a child's behavior. An Intensity score (Cronbach's alpha=.94) assesses how often a child exhibits each of 36 problem behaviors. The Problem score (*KR20*=.93) notes if a caregiver perceives a behavior as "a problem." Clinical scores are T-scores greater than 60 for the Intensity and the Problem scores. The ECBI possesses acceptable convergent and discriminant validity (Eyberg & Pincus).

The Youth Outcome Questionnaire-Self Report (YOQ-SR; Wells et al. 1999) assesses symptoms in several areas: Interpersonal Distress (ID); Somatic (SOM); Interpersonal Relations (IR); Social Problems (SP); Behavioral Dysfunction (BD); and Critical Items (CI). Clinical cutoff scores and RCIs, respectively, are: Total score=47 (18), ID= 17 (9), SOM=6 (6), IR=3 (6), SP=3 (5), BD=11 (12), and CI=6 (6). Items are scored on a 5-point Likert scale with total scores ranging from −6 to 240 (negative scores represent items tapping healthy behaviors that positively impact mental health). Alphas range from .70 to .94. The YOQ has good concurrent validity (Wells et al.).

The Trauma Symptom Checklist for Children (TSCC; Briere 1996) assessed Carol's self-reported trauma symptoms: Anxiety (ANX); Depression (DEP); Anger (ANG); Posttraumatic Stress (PTS); Sexual Concerns (SC); and Dissociation (DIS). Alphas range from .78 to .89. It possesses good convergent, discriminant, and construct validity (Briere 1996). The author holds that because it examines both trauma symptoms and common comorbidities (e.g., dissociation), the TSCC can evaluate complex traumatic effects. Clinical scores are T-scores of 65 or higher.

The Therapy Process Observational Coding System for Child Psychotherapy Alliance Scale (TPOCS–A; McLeod 2001) assessed the therapist-child alliance. A session observation coding system was used to assess the alliance along two dimensions: bond (6 items) and tasks (3 items). Scores range from 1 to 7. It has good internal consistency (.95) for the total scale (McLeod). Higher scores indicate a more positive alliance.

The Child and Adolescent Needs and Strengths (CANS; Kisiel et al. 2010) is a clinician reported tool that compiles information from various sources, resulting in an inclusive assessment of a child and caregiver's mental health needs and strengths, including dimensions associated with CT exposure. It includes the following domains: trauma experiences; trauma symptoms; child strengths; life domain functioning; acculturation; child behavioral/emotional needs; child risk behaviors; and caregiver needs and strengths. We used only the trauma experiences domain to assess for exposure to CT. Exposure is based on the presence of two or more of the following caregiver initiated trauma experiences at an actionable level (2 or 3): sexual abuse, physical abuse, emotional abuse, neglect, or family violence. Ratings include: 0=*no evidence of trauma* (no plan needed); 1=*single incident or suspected incident* (plan for watchful waiting); 2=*multiple incidents or moderate degree of trauma* (plan for action needed); and 3=*repeated and severe incidents of trauma* (immediate action needed).

The UCLA PTSD Reaction Index for *DSM-IV (*PTSD-RI; Steinberg et al. 2004) is used to assess for PTSD symptoms in school-age children and adolescents during the past month (0=*none of the time* to 4=*most of the time*). Items correspond directly to Criterion A1, A2, B, C, and D in the *DSM-IV* and provide a PTSD-RI total score and B, C, and D category subscale scores, with results based on minimum scores for a diagnosis of PTSD (Total=38; B=1 out of 5 symptoms; C=3 out of 7 symptoms; D=2 out of 5 symptoms). Cronbach's alphas ranged from .88 to .90 with test-retest reliability coefficients in the .80s. The PTSD-RI has demonstrated convergent validity with other trauma measures (Steinberg et al.). It was administered verbally to the child.

Clinicians who are less focused on identifying and assessing for CT might use a reduced set of instruments such as the TSCC, OQ-45, and YOQ-SR.

Baseline Assessment

Beyond the abuse, the mother reported that Carol was having problems at school academically and behaviorally. Also, Carol and Jake began to physically fight after the step-father's arrest. Jake had a close relationship with the step-father and blamed Carol for his removal. Historically, the mother had limited involvement in disciplining the children and described

the current home environment as chaotic, crazy, and out of control. She reported being overwhelmed with the abuse and the children's aggression. A parental executive subsystem largely was absent.

Family members were cooperative in discussing personal problems and the home atmosphere. They described ongoing experiences of depression, anxiety, anger, and being "afraid" the biological father (not yet arrested) would attempt to hurt the family. Additionally, Carol reported difficulty sleeping, feeling uneasy around men, and problems with short and long-term memory.

The mother's pretreatment scores on the OQ-45 were clinically elevated, indicating a distressed emotional state, high anxiety and depression, elevated relationship problems, and life dissatisfaction (see Table 1). She reported intense guilt for being unaware of the abuse. Also, the revelation of the abuse triggered flashbacks of her own physical/sexual abuse during her first marriage, making it difficult for her to hear about Carol's abuse. Surprisingly, her DAPS scores largely were within normal range. There was a clinical elevation on the Peritraumatic Distress scale (T-score=65) and a non-clinical elevation on the Peritraumatic Dissociation scale (T-score= 62), indicating moderate levels of distress and dissociation during the index Traumatic. DAPS scores did *not* support a diagnosis of PTSD.

Carol's pretreatment ECBI score on the Intensity Scale was in the clinical range, indicating high levels of acting out behaviors such as arguing with parents, temper tantrums, verbally and physically fighting, being easily distracted, short attention span, difficulty concentrating, and over activity. These behaviors were problems for the mother, resulting in clinical elevations on the Problem Scale. Jake's ECBI score on the Intensity Scale was in the clinical range with high levels of problem behaviors resembling Carol's, resulting in clinical elevations on the Problem Scale.

Carol's YOQ Total score of 163 was well beyond the cutoff score (47), as were all subscales except Social Problems. Elevated Critical Items scores suggested a need for close monitoring for self-harm. Thus, we implemented a plan involving the mother, grandparents, and the school counselor to ensure Carol's close supervision. All TSCC scores were in the clinical range. The Anxiety and Sexual Concerns scores were elevated to the highest points on their respective scales, with Sexual Concerns denoting preoccupation, fears, and conflict associated with sexual issues. The Anxiety, Post Trauma Symptoms, and Dissociation score elevations suggested clinical levels of PTSD that disrupted daily functioning. Scores exceeded the clinical cutoff for the four scales on the UCLA PTSD-RI, meeting criteria for PTSD. Carol exceeded the requirements for a diagnosis of PTSD (*DSM-5*; American Psychiatric Association 2013) based on criteria A (exposure), B (intrusion symptoms), C (avoidance), D (alterations in cognitions and mood), E (arousal), F (duration more than 1 month), G (distress or impairment), and H (not attributable to substance use/medical condition). She reported persistent depersonalization and derealization.

Carol reported elevated symptoms associated with CT such as emotional/behavioral dysregulation (YOQ; BD), dissociation (TSCC), interpersonal conflict (YOQ; IR), intrusive memories (TSCC; PTS), and distorted views of self ("I blame myself for things that go wrong"; YOQ; ID) and others ("I have a hard time trusting friends, family members, or adults"; YOQ; IR). Based on the CANS, Carol experienced four of the five types of trauma (sexual, physical, and emotional abuse, family violence) at an actionable level (2 or 3), supporting the presence of CT exposure. Both the therapist-mother alliance and the therapist-Carol alliance were moderately high. Given (a) the severity of the abuse; (b) the assessment results; (c) that Carol was abused by fathers; (d) the abuse was long-term and inescapable; and (e) the actionable level of abuse (CANS), we viewed her symptoms as indication of CT stress. Further, her symptoms were ingrained in daily living and her coping skills focused on avoidance-oriented survival skills.

Case Conceptualization and Treatment Phases

With the family's instability, sibling violence, and fused parent–child boundaries, we employed family therapy to help the mother assume an authoritative parent role in order to establish stability and safety, enhance family cohesion, and support the individual work with Carol. Further, family therapy addressed the importance of providing nurture and structure by a parent. This largely had been absent up until this time due to the mother's lack of involvement in discipline.

We conducted periodic mother-daughter and brother-sister sessions to repair these relationships. Though many mother-daughter sessions were planned, many were unplanned and occurred as a result of mother-related issues emerging during individual sessions with Carol, often related to trust. When these events occurred, the therapist would invite the mother into the session from the waiting room and process the event. We pointed out their willingness to engage in these interactions as signs of strength. Individual sessions with the mother focused on her trauma background and parenting skills.

Treatment spanned 17 months for a total of 43 sessions plus follow-up. The first 12 months involved weekly and biweekly sessions. The last 5 months involved 1–2 sessions per month. Follow-up assessment occurred at 12 months post-treatment. Sessions lasted 1.5 to 2 h.

Overview of Individual Treatment for Carol

Carol's individual work co-occurred with family therapy and followed a flexible phase-based treatment model consistent

Table 1 Assessment data

Reporter	Measures/Subscales	Pre-treatment	Intermediate			Post-treatment	12-Month Follow-up
Mother	OQ-45 (self-report)						
	Total	90*		93*		60	53
	SD	49*		54*		35	29
	IR	24*		27		14	14
	SR	17*		12*		11	06
	ITAS (self-report; 1–7)						
	Tasks		4	5	5		
	Goals		5	6	6		
	Bond		5	6	6		
	Total		4.7	5.6	5.6		
	ECBI (on Carol)[1]						
	Intensity	62*		44		47	43
	Problem	68*		50		52	00
	ECBI (on Jake)[1]						
	Intensity	66*		48		44	43
	Problem	69*		52		50	00
Carol	YOQ-Self Report						
	Total	163*		51*		22	17
	ID	55*		10		04	04
	Somatic	27*		15*		03	−03
	IR	21*		03*		01	−01
	SP	03*		00		−02	−01
	BD	29*		14*		13*	07
	CI	28*		09*		03	01
	TSCC[1] (self-report)						
	ANX	91*		57		55	35
	DEP	91*		60		41	36
	ANG	82*		48		38	28
	PTS	80*		53		45	40
	DIS	69*		49		40	37
	SC	103*		45		41	41
Researchers	TOPCS-C (Carol's alliance with therapist; 1–5)						
	Bond		3	5	5		
	Task		3	5	5		
	UCLA PTSD Index Criterion Severity Score						
	Reexperiencing	16[2]				4	
	Avoidance	19[2]				7	
	Arousal	18[2]				3	
	Total	53*				14	

OQ-45 Outcome Questionnaire-45, *ITAS* Integrated Therapy Alliance Scales, *ECBI* Eyberg Child Behavior Inventory, *YOQ-S* Youth Outcome Questionnaire-Self, *TSCC* Trauma Symptom Checklist for Children, *TPOCS* Therapy Process Observational Coding System-Child

*Score in clinical range; [1] T-Scores reported; [2] Meets or exceeds criterion for subscale; [3] Exceeds clinical cutoff score for PTSD diagnosis

with all three models. Phase 1 addressed safety and stabilization, psychoeducation, attachment, self-regulation skills, strengths, and resources. For Carol, coping strategies revolved around non-reflective, survival-based avoidance responses like dissociation; thus, self-regulation skills were necessary to replace avoidance responses (Ford and Cloitre 2009).

Carol was uncomfortable in relationships and trusted few people, for to be attached often meant to be abused. Thus, attention to the therapeutic alliance was critical. Further, she had an anxious-ambivalent attachment to her mother. She cared for and desired to be close to her mother yet did not trust that her mother could protect her. Further, she was concerned that her mother might not love her because of the step-father's abuse. Thus, attachment development and repair were major tasks.

Phase 2 emphasized increasing Carol's self-reflective abilities, processing trauma memories and emotions, continued development and expansion of conscious-based coping skills, and attachment repair. We addressed maladaptive meanings about self and others through cognitive processing (Lanktree et al. 2012). These strategies enhanced awareness and choice of when and how to reflect on one's abuse history, not simply the absence of intrusive memories and reduction of fear.

Phase 3 focused on integration and generalization of self-regulation skills, positive affect, relationship involvement, and cognitive work. As CT often limits one's perception of choices in dealing with stressors, expanding choice as a state of mind was a major theme. Such nascent experiences need time, repetition, and support to become the rule rather than the exception of living.

Given the severity of Carol's symptoms, phase implementation involved overlapping phases, often revisiting earlier phases and combining phases (such as acquiring new self-regulation skills in Phase 2 and emotional processing in Phase 3) due to the emergence of new phobic reactions and trauma memories (Lanktree and Briere 2008). Both authors were involved in the treatment process, with the second author largely providing therapy for Carol, while the first author worked with the mother and in early conjoint family sessions. The first author is a licensed psychologist with over 25 years of clinical experience with interpersonal and combat-related trauma employing integrated trauma models. The second author was a senior-level doctoral student with 3 years of supervised clinical experience working with interpersonal trauma. The first author supervised the second author.

Assessment and Stabilization with Mother (Phase I): Sessions 1–2

The first two sessions involved only the mother who presented as highly distressed, indicated by statements such as "I don't know what to do about this," "I should have known [about the abuse]," and "I'm overwhelmed." She provided an overview of Carol's abuse by both the biological and step-father from age 3 to 9. She related that the biological father told Carol that "…if she told anyone (about the abuse) he would make her (Carol) watch him kill your mother and Jake." Also, she related her son's anger upon the step-father's removal from the home: "He hates his sister and blames everything on her." Also, the mother was unemployed, adding financial stressors to the abuse issues. We pointed out strengths that she exhibited since the abuse occurred: quick removal of the father from the home; validating Carol's abuse; acting to increase safety for the children; and commitment to treatment.

She was provided information about trauma, adaptive responses, and the treatment process (Cohen et al. 2012). She also learned focused breathing in the second session and how to shift her thinking to non-abuse issues. A safety plan was implemented involving neighbors who watched the house and checked on the family. Finally, parent management was introduced, emphasizing a predictable and consistent routine for the family, as well as consequences of behavior, ignoring small disruptions, differential reinforcement, and consistency (Blaustein and Kinniburgh 2010).

Phase I: Conjoint Family Therapy and Individual (Sessions 3–9)

The family met conjointly for the 45–60 min followed by individual sessions with mom, Carol, and Jake for 30–60 min. The information below is based on case notes and recorded sessions. The immediate goal was to establish a stable unit of three without the step-father.

Family members shared their perspective on the family, concerns, and goals for treatment. We also focused on establishing an alliance with the family, validating their experiences, and adjusting to the style of each member. All family members expressed a willingness to "try to make things better around the house," although they were unsure how achieve this. In session 3, the family determined the following goals: (a) being and feeling safe; (b) finding alternative means to deal with the anger and fighting; (c) having fun; and (d) establishing a few basic house rules, such as designated household responsibilities. The mother was supported in providing structure and direction in establishing family rules, especially pertaining to the aggression between the siblings. A portion of each family session included playing games and activities to reinforce cooperation. We used family enactments to practice more effective problem-solving skills and to address recurrent problems. In session 4, the family practiced focused breathing together and committed to practice it at home daily.

In session 6, the children talked about a disagreement they were able to resolve without violence by taking a break and talking to mom. In session 7, Jake brought up being angry and sad about his step-father being in jail. The mother and Carol showed empathy for his sadness and loss. This led to a discussion about how the father hurt Carol physically, leading to his removal from the home.

Initial sessions with Carol focused on stabilization and building the alliance. Psychoeducation addressed the benefits

of therapy, treatment overview, and how the abuse affected her ability to manage emotions and behavior (Cohen et al. 2012). She continued to develop coping skills, such as focused breathing, grounding, shifting to non-stressful thoughts, and cognitive restructuring (e.g., some people can be trusted), and learned how to implement these skills at school, church, and in other settings where she felt anxious. Dissociation, emotional numbing, and poor memory were common coping skills, thus, sessions focused on remaining in the present and self-awareness (Lanktree and Briere 2008). She viewed dissociation positively as it helped her survive many abuse incidents. The therapist validated this ability to protect herself as a strength by "not feeling and not remembering."

In session 7, with only the children present, they stated they felt happiest and safest "being with mom. She can make the bad things better." This contrasted with earlier sessions in which Carol stated a lack of confidence in the mother's ability to protect her, which provided evidence of a growing family bond.

Carol reported frequent thoughts of self-harm due to the negative attention she received at school. The therapist encouraged her to talk about this with her mother:

> **Carol**: I feel like hurting myself a lot because people make fun of me a lot. I feel like I'm trapped here. They just keep talking about it. If I go to heaven, people won't talk about it.
> **Mother**: I know it's been real hard for you, but those kids haven't been in your situation. They don't understand. But they'll eventually stop.
> (Dialogue between mom and daughter continues)
> **Therapist**: How was that talking to your mother?
> **Carol**: Yeah. It felt good. I don't always listen to them [peers]. It's just sometimes. Talking helps.
> **Therapist**: (to Carol) Maybe you can say, "Mom can we talk a little bit about my feelings."
> **Mother to Carol**: I'm here. You can talk to me about this. You don't need to think about hurting yourself. I'm here for you. You're important to me! You can talk to your school counselor too.
> **Carol**: (soft smile) Ok – yeah. (long pause) But another thing. What if he [step-father] tries to hurt us?
> **Mother**: I won't let them hurt you.
> **Carol**: I know but that's why I can't sleep at night. I'm afraid he'll come in while we're sleeping.
> **Mother**: The judge won't let him out [of jail]. Think about girl stuff like what you're going to wear to school. That's why I call that number they gave me every day to check and make sure he's not out.

In this interchange, Carol moved to the couch facing her mother. Her mother was calm, resolute, and persistent in reassuring Carol that she would make sure that neither father would hurt her. Carol was fixated on her mother's explanation. It had a noticeable calming effect on Carol, supporting attachment repair and safety. We also processed the mom's statement of "You're important to me!" This challenged Carol's belief that she was *not* important. We processed and tracked Carol's self-harm thoughts, which peaked during this session and decreased thereafter. Processing the relationship is consistent with ITCT-C's relational processing component. Such experiences challenge and reconfigure both emotions and beliefs associated with trauma experiences in vivo within the significant relationship.

In session 9, the mother stated that the children's aggressive behavior had decreased, though there was still occasional arguing. The home was calmer and everyone was less anxious. She attributed this change to clearer, more consistent structure and spending daily time with each child.

Phase II: Individual Trauma Processing with Ancillary Family Therapy (Sessions 10–33)

Our decision to begin processing trauma memories with Carol was based on several changes: (a) family members reported feeling safer and exhibited a significant increase in stability and cohesion as noted by more amicable sibling interactions, no violence, and appropriate parental authority; (b) Carol was able to identify and express a range of positive and negative emotions, express anger toward her brother and he to her without aggression, and employ focused breathing to calm herself when distressed, in and outside of session; (c) Carol and her mother reported and exhibited in session interacting in a warmer (hugging, touching) and more secure manner (e.g., spending more time together); and (d) many of Carol's symptoms had significantly decreased (see Table 1).

Therapy shifted emphasis to Carol's trauma memories and continued development of coping skills (Cohen et al. 2012; Lanktree and Briere 2008), individual sessions with Jake (school problems), and individual sessions with the mother focusing on her past abuse. Family therapy became secondary, emphasizing family collaboration, reinforcing mother's leadership role, and practicing learned skills.

This phase began with an explanation to Carol about the importance of a timeline/life narrative and writing a trauma narrative (Cohen et al. 2012). These activities often seem counterintuitive to survivors. Carol asked, "Why do I need to talk about it. I'm always thinking about it. I want it to stop." It was explained that by talking and writing about the "bad experiences," Carol would have more control over whether or not she would think about the memories and that she would feel less "scared."

Early sessions (10–13) focused on helping Carol write and discuss the impact abuse had on her life (e.g., fear of men), the duration of abuse (e.g., "as long as I can remember"), a life

narrative including abuse and non-abuse memories, and her survival and resilience skills (Cohen et al. 2012). The timeline began the process of memory reconstruction and the integration of abuse incidents into a coherent, historical autobiography, as well as enhanced tolerance for the emotional arousal and desensitization of the trauma memories. It included both perpetrators. Emotional regulation skills were practiced in each session including assessing subjective units of distress (SUD; 0 - *no distress* to 10 - *overwhelming*) to gauge her level of awareness and distress (Lanktree and Briere 2008).

After the construction of the life narrative, Carol wondered why her biological father was abusing her initially but not the step-father. She wondered if abuse was "OK" for a child and a father. So at age 7, she told her step-father that her biological father was "doing things to her:"

Carol: I told [step-father] that my dad had been doing things [sexual] to me and he said it's not against the law and that he could do it to me too.
Therapist: That really surprised you; kinda confusing?
Carol: Yeah, at first I was confused but then I thought if both said it was OK and it wasn't against the law, it must be OK, even though it hurt. But I couldn't understand why they *weren't* doing it to Jake. That freaked me out. Then I thought maybe it only happens to girls. But as I got older and saw abuse on TV I figured out, oh my gosh, they're doing that to me. But I still didn't have enough strength to tell mamma or anybody. 'Cause if I told somebody, they might start doing it to me too.
Therapist: Pretty bad stuff was happening to you but you figured out that it wasn't the things they should be doing to you. You wanted to tell someone but you thought they might sexually abuse you like your step-father. How'd you figure that out?
Carol: I was scared; but after a long time I figured it was wrong by things I heard. I was just hoping mamma would come in and catch him, but she didn't. I was afraid to tell her. Something bad could happen. Later she caught him when he thought she was asleep. I told her what he did the next day. He said I was dreaming. I trusted him but then I found out it [abuse] was bad. That made me mad.

Carol was trying to determine if the abuse was right or wrong. The therapist helped her reflect on this issue (utilizing Socratic questioning) and how she came to conclude the abuse was wrong (Cohen et al. 2012). A clear strength was her intelligence, which likely gave rise to her inclination to question the rightness of the abuse. This was pointed out to her. Carol was thoughtful in how she compared her experience with her brother's. She could not understand why they were not abusing Jake. She was aware of the differences in treatment, which generated more questions about the abuse (e.g., "Can it be alright if it hurts?"). An issue weighing on whether or not to report the abuse was the fear that if she told someone, even her mother, they too might abuse her, as her step-father did when she made an out-cry to him. Betrayal by an initially trusted adult is the ultimate relationship violation for a child (betrayal trauma), creating a bind that seems to have no escape (Ford and Courtois 2009).

As with many CSA survivors, Carol had problems with memory (e.g., on the TSCC, she self-reported a score of *almost all of the time* for item "Forgetting things, can't remember things"). Her dissociation score on the TSCC at pretreatment was in the clinical range (T=69). Her most frequent symptoms were emotional numbing, memory, and derealization. Initially, her memories about a wide range of experiences were sketchy with gaps. More detail and new material emerged as we focused on specific abuse incidents or themes (Lanktree and Briere 2008). Carol was eager to talk about the abuse, so much so that the therapist limited the discussion of detail until the life narrative was completed. The details of her narratives were consistent over time and matched her mother's recollection of times and locations that Carol reported.

Later, she talked about the time when the biological father stopped abusing her:

Carol: For a long time [about 18 months] they both abused me. It happened everywhere. I couldn't get away. But daddy [biological] finally stopped.
Therapist: What was it like for you when he stopped?
Carol: I felt better because it happened everywhere, but now I could go somewhere where it wasn't happening. But it still happened at home a lot.
Therapist: How does it feel now talking about it with me?
Carol: Kinda weird. But I'm starting to feel more comfortable – don't think about it as much.

Asking Carol to reflect on her feelings was a frequent intervention. It countered her tendency to dissociate or avoid uncomfortable feelings through maladaptive means (Briere and Scott 2013).

Sessions 14–27 largely focused on trauma memories related to abuse by the biological father, though she included the step-father in comparing the two men. In session 17, the therapist discussed improvements in scores on the second administration of the TSCC; from all scores in the clinical range to no scores in the clinical range (see Table 1). These results coincided with a significant reduction in the YOQ total score (141 to 51), though 51 was still in the low clinical range (cutoff=47). With reduced symptoms, she was better able to distinguish between emotional states and to tolerate trauma memories. With enhanced memory came more trauma memories and processing.

During this time, the mother attended seven individual sessions. She disclosed a history of physical abuse in her first marriage by Carol's biological father. Hearing about Carol's abuse triggered flashbacks of her own abuse and increased her anxiety level. She was hesitant to address her own abuse as a means to relieve distress but she was willing to address it if it enhanced her ability to help Carol. Focused breathing and cognitive restructuring were effective in reducing the intrusive thoughts and enhancing her tolerance level, though she could have benefitted from additional sessions. Later, she was able to talk with Carol in depth about her abuse as well as listen to Carol read her trauma narrative. Yet, scores for the mother on the OQ-45 remained clinically elevated until the last few months and the follow-up. Beyond Carol's abuse revelation, the mother's distress was attributed to her abuse history, seeking employment, adjusting to single parenthood, and the trial of the step-father. Further, the biological father was not incarcerated until mid-way through treatment.

A typical session with Carol included checking on homework, practicing self-regulation skills, cognitive restructuring, processing new trauma material, and utilizing problem-solving skills. Attachment issues often emerged that were addressed in-session between Carol and her mother:

Carol: But do you think mamma's mad at me because she loved him [step-father]?
Therapist: That's a good question. Maybe you think so?
Carol: Well, yeah. And I think she's mad because I never did tell her [about the abuse].
Therapist: What do you think kept you from telling her?
Carol: I didn't have enough strength. And I heard on the news that women that are abused might abuse people, and I didn't want her to abuse me. Also, [biological father] said he'd break mamma like a tooth pick if I told anybody and he'd kill me too.
Therapist: Maybe you were scared *of* her (pause) and scared *for* her.
Carol: Uh huh. I think so. I just didn't do nothing. I didn't know what she might do?
Therapist: Makes sense. You didn't want her to abuse you too. Want to bring mom in and ask her?
Carol: Yeah. (Therapist invites mother into session with Carol.)
Carol: Mom, do you still love ____ [step-father]?
Mother: No. I don't even like him.
Carol: Do you still love me because I never told you about daddy?
Mother: Of course I still love you. I'm mad that you got hurt but not at you.
Carol: I love you too.
Therapist: How was it to hear your mamma say that?
Carol: Good (soft smile looking at mother and physical relaxation response). I know she loves me.

Such interchanges were critical to repair the breach in the mother-daughter attachment, as they challenged and replaced inaccurate beliefs perpetuated during the years of abuse with more accurate ones ("Of course I still love you"), as well as created positive emotional engagement between them (Lanktree and Briere 2008). The importance of a supportive caregiver is obvious. Later, Carol talked with Jake regarding the step-father's removal. He told her that he missed him but he was not mad at her anymore. These relationship repairs diminished Carol's self-blame as she often blamed herself for the mother and brother's distress. Self-blame is a common response for children in an attempt to make sense out of an abusive situation and the frequent blame by the perpetrator (Cohen et al. 2006).

While processing trauma memories, Carol would scale her level of anxiety. If it exceeded 8, she would disengage from the narrative, take several slow breaths until she returned to a 3–4 range, and then return to the narrative. Initially, she reached 8–9 frequently and would begin to emotionally numb. Ratings during memory processing decreased to 4–5 in subsequent sessions along with a reduction in emotional numbing. Remaining engaged within the therapeutic window of emotional activation (i.e., between under- or overwhelming activation) increased tolerance for stressful memories and allowed processing and integration of the memories (Briere and Lanktree 2012).

For example, after she related a particular abuse incident, Carol processed it with the therapist:

Therapist: How were you feeling when he did that to you?
Carol: I was really scared, 'cause I knew he's gonna hurt me like before. But he was drunk and I thought he might hurt me even more. He might hit me like before too so I just got still and stiff.
Therapist: How does it feel now telling me about it?
Carol: It makes me scared. My stomach is all upset.
Therapist: I know you're scared. It's not easy. Can you rate feeling "scared" on the 1 to 10 scale?
Carol: A 6 or 7. I'm OK right now. I feel it, but it's not too strong. (Takes several slow breaths)

Following several trauma processing sessions, we returned to selected items on the second administration of the TSCC. Based on the question about fear of men, Carol stated "I am not as afraid of some men now. I used to not feel OK sitting around my grandpaw, but now I can fall asleep in his lap." Through Socratic questioning we explored how this belief change occurred. She concluded that her grandpaw had never hurt her before and would not hurt her now (Lanktree and Briere 2008).

A distinction between CT and non-complicated trauma is a pervasive mistrust of others. Carol's fathers were associated with pain, secrets, and threats on one hand and disingenuous caring on the other. Messages were contradictory and confusing: "Then he [sexually abused] me but said he hated me. It's confusing."; "It made me feel dirty, nasty, nervous. But, I didn't know it was against the law because both did it to me. I trusted them."; "They were rough, mean, but sometimes they were nice." She struggled reconciling these associations with learning to identify and trust other safe people.

Continued processing of the abuse by her biological father led to greater ease in talking about the abuse and thus greater integration into her autobiographical memory (Cohen et al. 2012):

Therapist: How is it talking about the abuse with me now?
Carol: It feels better. It's about a 5. I'm not keeping any secrets and I'm getting it all out. It's hard to say all the things he did to me, but when I say it out loud it feels better. It's hard to talk to mamma because she tears up but you don't, so that makes it easier to talk about.
Therapist: I'm glad you feel comfortable talking about it with me. You can say anything in any way you want to or not say anything. It's up to you.
Carol: But whenever I tell mamma this stuff, she breaks down in tears. I don't want to make her cry.
Therapist: I know. You don't want to hurt her feelings. It hurts for you too.

Note the importance of the mother's ability to tolerate Carol's abuse story. Much of treatment alternated between trauma processing and the mother-daughter's evolving relationship.

Carol's progress was not a steady, linear path toward improvement, but one of fits and starts. For example, focused breathing helped to reduce anxiety with some abuse episodes but triggered dissociation in another abuse episode when one abuser said "take a breath and relax" as he abused her. In this situation, external grounding was a more effective initial intervention. Yet, identifying the new trigger memory ("take a breath and relax") was not readily apparent and took more time and exploration to identify and then to derive an effective intervention.

Between sessions 21 and 25, Carol prepared to talk with her mother about abuse incidents. She had several questions to ask her mother about sex such as, "What is rape? Am I a virgin?"

In session 26, Carol discussed several questions for her mother and read her trauma narrative. Largely, the session went well. Although the mother was noticeably upset, the therapist helped her clarify that her distress was due to hearing how Carol was abused, not that she was mad at Carol. While hugging Carol, the mother stated, "It's not your fault. I'm not mad at you. I love you and I don't want you to feel bad for telling me what he [biological father] did to you. He's the bad guy, not you."

This was another positive turning point for their relationship. Carol no longer felt compelled to keep abuse secrets from her mother, though she also felt less need to talk about it with her mother due to increased trust. It also reinforced Carol's growing belief that the abuse was not her fault. Following this session, the therapist had an individual session with the mother to process her feelings about the trauma narrative. She expressed feeling hurt and betrayed by both husbands, the pain and deep regret she felt for Carol, and her feelings of guilt over not discovering the abuse sooner.

Sessions 28 through 33 focused on developing a second trauma narrative about the step-father and identifying and examining triggers in their home associated with the abuse, such as the sofa, bedding, and bed. The therapist and Carol problem-solved on the later issue, deciding to replace old bed covering and rearranging some furniture to break up old patterns associated with abuse.

Carol stated that the second narrative was easier for her to write and process because of completion of the first narrative. She now possessed better coping skills. Further, the step-father's name calling and abuse, while anxiety provoking, was less severe than the biological father's threats and physical abuse, likely creating less distress. For example, compared to the biological father's threats, the step-father more often would try to bribe Carol to "keep quiet."

Carol finished the narrative and processed it in sessions 30–32 and read it to her mother in session 33. She reported less anxiety than the previous reading to her mother. Due to many abuse incidents, we focused on abuse themes (e.g., location or abuser's mood) rather than just an individual incident. Though this phase of treatment largely focused on processing trauma experiences, segments of many sessions included reviewing and processing additional assessment data, skill building, relationship issues with mom and Jake, and problem-solving sessions (e.g., problems with peers).

Phase III: Integrating and Consolidating New Learnings (Sessions 34–43)

This phase emphasized generalizing new coping skills, integrating new ways of thinking about the trauma history, self, and others, and viewing life from a more balanced perspective along a continuum rather than in a dichotomous fashion. All three models employ similar elements for this phase. As Carol's abuse began at age 3, her coping skills largely developed within an abusive context; thus, her new coping skills were a departure from dealing with stressors through avoidance, secrecy, and isolation. She focused on responding to demands in a manner consistent with the present context

rather than just her trauma history. Much discussion revolved around peer relationships.

At this time, we began spacing out sessions to every 2–3 weeks in sessions 36–39 and 4 weeks to 2.5 months for sessions 40–43. She reported sleeping better at night and seldom thinking about the abuse, and when she did, her anxiety was in the 4–5 range. She reported that she "felt stronger now," "thinks better" about herself, and said, "I know it's not my fault and my mamma loves me anyway."

Also, she enjoyed involvement in organized athletics at school and in her youth group at church. Her grades improved as well. She reported enjoying school and making new friends, though there were occasional unkind remarks about her abuse history. The therapist and Carol discussed and role-played different ways to handle these situations, such as walking away while telling herself, "It's better just to walk away. Some people just won't understanding my situation."

The mother attended the last half of sessions 41 and 42. She reported that Carol's life was now "happy and normal." Also, Carol and Jake were getting along with only an occasional "spat."

In sessions 42–43 we addressed maintenance, continued progress, and signs of relapse, such as feeling down for two or more days, extended dwelling on abuse events, or dissociative phenomenon. We reviewed coping strategies, such as daily mood ratings, journaling, and talking with others.

Evaluating Outcome

The OQ-45, YOQ, ECBI, TSCC, and UCLA PTSD-RI provided cutoff scores to distinguish clinical and nonclinical levels (see Table 1). Clinical level scores based on these cutoffs are noted by an asterisk (or a superscript in the case of the UCLA PTSD). The mother's OQ-45 scores remained in the clinical range until the last 2 months of treatment. Apart from Carol's BD score (YOQ), all scores evidenced change from clinical to nonclinical ranges pre- to post-treatment and were reduced or maintained at the 12-month follow-up. The alliance measures suggest improvement in the client-therapist relationship from early to mid-stage treatment for the mother and Carol.

Discussion

This case study described an evidence-informed treatment of a 9-year-old female with CT symptoms, due to chronic and severe polyvictimization by her biological father and step-father. Pre- to post-treatment scores indicated significant reductions in symptoms for Carol and her family, which compares favorably with similar larger *N* studies (e.g., Hodgdon et al. 2013; Lanktree et al. 2012). In addition to PTSD symptoms, we focused on symptoms associated with CT such as insecure attachment, dissociation, relationship conflicts, emotional dysregulation, and cognitive distortions.

Based on feedback from Carol, her mother, and our observations, we found several elements of treatment noted in the CT literature (Arvidson et al. 2011) to be especially critical: (a) attachment repair between Carol and her mother; (b) correcting Carol's distorted views of herself and the relationship with her mother; (c) attention to the alliance; (d) individual work with the mother; (e) conjoint family sessions to stabilize the family; and (f) flexibility in implementing treatment components. Further, it was important to apply CT treatment principles (e.g., self-regulation skills) but to match the intervention to the client needs (e.g., grounding versus focused breathing). Finally, therapist countertransference and self-care were addressed in supervision (Briere and Scott 2013).

Several factors beyond specific interventions may have contributed to Carol's improvement that may not be present with all CT clients: (a) the mother protected Carol by having the perpetrator removed from the home; (b) Carol was highly motivated to improve; (c) the mother supported Carol's involvement in treatment; (d) Carol exhibited high levels of reflective functioning ability and intelligence; (e) a strong therapist-child therapeutic alliance; and (f) the mother was directly involved in the treatment process. Absence or a lesser degree of these factors may have reduced improvement.

Although two therapists were involved in much of the treatment, a single therapist could conduct essentially the same treatment regimen, although session lengths might run 30–45 min longer. Further, cost-effectiveness may raise concerns by many therapists. It is likely that treatment length could have been reduced by 1–2 sessions per phase without adversely affecting outcome.

Though this case indicated improvement over the course of treatment, several limitations and suggestions warrant noting. First, case studies have notable limitations for drawing conclusions about treatment effectiveness. Factors beyond the interventions employed here likely influenced treatment outcome (e.g., imprisonment of both perpetrators, support by school personnel). Second, our goal was to examine the therapeutic processes of working with a complicated child trauma case, employing evidence informed treatments, rather than to demonstrate treatment effectiveness. Third, including additional cases with similar outcomes would enhance the credibility of the treatment. Fourth, the recursive and intricate interactional process of treatment may appear more linear and less complex than in reality. Relapses and stagnation were common and often took weeks from which to recover.

Conclusions

The development of empirically supported CT treatment models for children is in its infancy, yet CT clinicians and

researchers have provided guidelines with respect to treatment phases, treatment targets, and specific interventions. While considering treatment parameters, clinicians must closely monitor client responses to treatment and make necessary adjustments (Amaya-Jackson and DeRosa 2007). Even within these parameters, a measure of trial and error is inevitable. As such, a strong therapeutic alliance is essential to provide flexibility for therapist decision-making and adjustments. In closing, evidence-informed case studies provide a fine-grain perspective that is necessary to identify change processes with CT cases, to confirm or disconfirm existing CT treatment principles, and to inform large *N* research designs.

References

Achenbach, T. M. (1991). *Manual for the child behavior checklist and revised child behavior profile*. Burlington: University of Vermont.

Amaya-Jackson, L., & DeRosa, R. (2007). Treatment considerations for clinicians in applying evidence based practice to complex presentations of child trauma. *Journal of Traumatic Stress, 20*, 379–390.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington: American Psychiatric Association.

Arvidson, J., Kinniburgh, K. M., Howard, K., Spinazzola, J., Strothers, H., Evans, M., … Blaustein, M. E. (2011). Treatment of complex trauma in young children: Developmental and cultural considerations in application of the ARC intervention model. *Journal of Child & Adolescent Trauma, 4*, 34–51.

Blaustein, M. E., & Kinniburgh, K. M. (2010). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency*. New York: Guilford.

Briere, J. (1996). *Trauma symptom checklist for children*. Odessa: Psychological Assessment Resources.

Briere, J. (2001). *Detailed assessment of posttraumatic stress*. Odessa: Psychological Assessment Resources.

Briere, J., & Lanktree, C. B. (2012). *Treating complex trauma in adolescents and young adults*. Thousand Oaks: Sage.

Briere, J., & Scott, C. (2013). *Principles of trauma therapy* (2nd ed.). Los Angeles: Sage.

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress, 22*, 399–408.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford.

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma focused CBT for youth with complex trauma. *Child Abuse & Neglect, 36*, 528–541.

Collins, S., Griffiths, S., & Kumalo, M. (2005). Patterns of disclosure in child sexual abuse. *South Africa Journal Psychology, 35*, 270–285.

Cook, A., Blaustein, M., Soinazzola, J., & van der Kolk, B. A. (Eds.). (2003). Complex trauma in children and adolescents. Retrieved from www.nctsn.org.

Cook, A., Spinazzola, J., Ford, J. D., Lanktree, C., Blaustein, M., Cloitre, M., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*, 390–398.

Eyberg, S. M., & Pincus, D. (1999). *Eyberg child behavior inventory Sutter student behavior inventory revised professional manual*. Odessa: Psychological Assessment Resources.

Ford, J. D. (2009). Neurobiological and developmental research: clinical implications. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: an evidence-based guide* (pp. 31–58). New York: Guilford.

Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy for children and adolescents. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: an evidence-based guide* (pp. 59–81). New York: Guilford.

Ford, J. D., & Courtois, C. A. (2009). Defining and understanding complex trauma and complex trauma disorders. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: an evidence- based guide* (pp. 13–30). New York: Guilford.

Grasso, D., Greene, C., & Ford, J. D. (2013). Cumulative trauma in childhood. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents* (pp. 79–99). New York: Guilford.

Hodgdon, H. B., Kinniburgh, K., Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and implementation of trauma-informed programming in youth residential treatment centers using the ARC framework. *Journal of Family Violence, 28*, 679–692.

Kisiel, C., Fehrenbach, T., Small, L., & Lyons, J. S. (2009). Assessment of complex trauma exposure, responses, and service needs among children and adolescents in child welfare. *Journal of Child & Adolescent Trauma, 2*, 143–160.

Kisiel, C., Lyons, J. S., Blaustein, M., Fehrenbach, T., Griffin, G., Germain, J., Saxe, G., Ellis, H., & Praed Foundation & National Child Traumatic Stress Network. (2010). *Child and adolescent needs and strengths (CANS) manual: The NCTSN CANS Comprehensive Trauma Version: A comprehensive information integration tool for children and adolescents exposed to traumatic events*. Chicago: Praed Foundation/Los Angeles, CA & Durham, NC: NCTSN.

Kliethermes, M., Nanney, R. W., Cohen, J. A., & Mannarino, A. P. (2013). Trauma-focused cognitive-behavioral therapy. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents: scientific foundations and therapeutic models* (pp. 184–202). New York: Guilford.

Kluft, R. P. (2011). Ramifications of incest. *Psychiatric Times, 27* (12).

Lambert, M. J., Lunnen, K., Umphress, V., Hansen, N., & Burlingame, G. M. (1996). *Administration and scoring manual for the outcome questionnaire (OQ-45.1)*. Salt Lake City: IHC Center for Behavioral Healthcare Efficacy.

Lanktree, C.B., & Briere, J. (2008). *Integrative Treatment of Complex Trauma for Children (ITCT- C): A Guide for the Treatment of Multiply-Traumatized Youth*. Unpublished treatment manual. Long Beach, CA: MCAVIC-USC, NCTSN (http://www.johnbriere.com)

Lanktree, C., Briere, J., Godbout, N., Hodges, M., Chen, K., Trimm, L., & Freed, W. (2012). Treating multi-traumatized, socially-marginalized children: results of a naturalistic treatment outcome study. *Journal of Aggression, Maltreatment & Trauma, 21*, 813–828.

Lawson, D. M., & Quinn, J. (2013). Complex trauma in children and adolescents: evidence based practice in clinical settings. *Clinical Journal of Psychology: In session, 69*(5), 497–509.

Maker, A. H., Kemmelmeir, M., & Peterson, C. (2001). Child sexual abuse, peer sexual abuse, and sexual assault in adulthood: a multi-risk model of revictimization. *Journal of Traumatic Stress, 14*, 351–368.

McCloskey, L., & Bailey, J. (2000). The intergenerational transmission risk for child sexual abuse. *Journal of Interpersonal Violence, 15*, 1019–1035.

McDonald, R., Jouriles, E. N., Ramisetty-Mikler, S., Caetano, R., & Green, C. E. (2006). Estimating the number of American children living in partner-violent families. *Journal of Family Psychology, 20*, 137–142.

McLeod, B. D. (2001). *The therapy process observational coding system for child psychotherapy.* Los Angeles: University of California, Los Angeles.

Newman, L., & Stevenson, C. (2008). Issues in infant-parent psychotherapy for mothers with borderline personality disorder. *Clinical Child Psychology and Psychiatry, 13*, 505–514.

Pinsof, W. M. (2005). *Integrative psychotherapy alliance scales revised-short form: individual*. Evanston: The Family Institute at Northwestern University.

Russell, D. E. H. (1986). *The secret trauma: incest in the lives of girls and women*. New York: Basic.

Sedlak, A. J., Mettenberg, J., Basena, M., Petta, I., McPherson, K., Greene, A., et al. (2010). *Fourth national incidence study of child abuse and neglect (NIS-4): report to congress, executive summary.* Washington: U.S. Department of Health & Human Services.

Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Lisa Amaya-Jackson, L. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology, 37*, 156–183.

Steinberg, A. M., Brymer, M., Decker, K., & Pynoos, R. S. (2004). University of California Los Angeles posttraumatic stress disorder reaction index: DSM-IV. *Psychiatric Assessment, 6*, 96–100.

Stroebel, S. S., O'Keefe, S. L., Beard, K. W., Kuo, S. Y., Swindell, S. V., & Kommor, M. J. (2012). Father–daughter incest: data from an anonymous computerized survey. *Journal of Child Sexual Abuse, 21*(2), 176–199.

Turner, H. A., Finkelhor, D., & Ormrod, R. (2010). Poly-victimization in a national sample of children and youth. *American Journal of Preventive Medicine, 38*, 323–330.

Weiner, D., Schneider, A., & Lyons, J. A. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: treatment retention and outcomes. *Child and Youth Services Review, 31*, 1199–12.

Wells, M. G., Burlingame, G. M., & Rose, P. M. (1999). *Administration and Scoring Manual for the Youth Outcome Questionnaire-Self-Report, 2.0.*Orem, UT: American Professional Credentialling.