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# Meeting Biopsychosocial Needs of Individuals with Histories of Multiple Adverse Childhood Experiences

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# MEETING BIOPSYCHOSOCIAL NEEDS OF INDIVIDUALS WITH HISTORIES OF MULTIPLE ADVERSE CHILDHOOD EXPERIENCES

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I dedicate this work to Michael, my four children, my four parents, and the victims of the Holocaust.

Thank you Michael, my husband, for all of your love and encouragement throughout our 30 years of marriage. You are my secure base and safe haven. I have loved every minute with you and look forward to many more years together. Thank you for believing that I was experiencing normal reactions to abnormal events. Your persistence has "clipped my chains" and your encouragement has helped me to "find my wings." Come fly with me.

Thank you to my four children. I have thoroughly enjoyed watching each of you become the unique and beautiful adult you are today. Each of you adds so much sweetness to my life. Memories of our family time are so precious to me. I look forward to more memories as our family continues to grow. I am honored to be your mother.

I extend my gratitude posthumously to my four parents. I am eternally grateful to my foster parents for giving me nurturance, guidance, support, and predictability. Their daily acts of care helped define parenting for me. I knew how to be present for my children because my parents were present for me. I am also eternally grateful to my biological parents for giving me life and providing me with two-and-a-half years of love and care. I am comforted by music, nature, art, and reading because my biological parents shared these things with me.

The Judenplatz Memorial (Figure 1) in Vienna, Austria is dedicated to the Austrian victims of the Holocaust. The memorial portrays a collection of books with their spines turned inward; a tribute to the many stories that will never be known because of the annihilation of an entire race. The stories of my maternal ancestors are included in these stone volumes; stories that are too painful to tell. I dedicate my work to all of the Holocaust victims in order to honor the untold stories. May future generations find the strength and ability to author and share their own stories with their children and grandchildren. May there be no more stone volumes.

Figure 1. Author's personal photograph of Judenplatz Memorial in Vienna, Austria

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**ABSTRACT**

According to Felitti and colleagues (1998), a significant portion of the general population has been exposed to adverse childhood experiences (ACEs) with subsequent and persistent, dose-related, negative consequences to physical and mental health. Debilitating disturbances to biopsychosocial well-being are significant and frequently lead to fatality in adulthood. After reviewing the prevalence and severity of ACEs, this thesis presents an overview of the literature outlining the biological, social, and psychological factors contributing to the development and progression of disease in the brain and body. Additionally, current trauma-informed interventions are summarized. Three experienced clinicians share practical advice for implementing evidence-based, trauma-informed mental health services. Suggestions for integrating components of empirical literature with practical advice are provided to meet the biopsychosocial needs of those with histories of multiple adverse childhood experiences. A sample integrated curriculum for middle school students who have been exposed to multiple adverse experiences is included.

The strengths-based curriculum proposed in this thesis combines trauma-focused cognitive behavioral therapy (TF-CBT), the *gold standard* for trauma-informed care, with principles from schema-focused cognitive behavioral therapy (SFCBT; Young, Klosko, & Weishaar, 2003); neurobiological and mindfulness research; motivational interviewing; existential psychology; and, attachment theory. Consistent with new recommendations for children with complex trauma histories (Cohen, Mannarino, Kliethermes, & Murray, 2012), the proposed *Building Healthy Core Beliefs* curriculum is the skill-building, phase one of a three-phase program. The skills learned in this curriculum include: (a) recognizing, normalizing, and managing the "fight-flight-freeze" response (b) recognizing, identifying, and managing emotions; (c) differentiating inaccurate thoughts from accurate, helpful thoughts; (d) using positive self-talk; (e) practicing mindfulness and meditative exercises; (f) completing a program with sequenced steps and specific tasks; (g) recognizing and celebrating accomplishments; and, (h) building healthy core beliefs. The four healthy core beliefs promoted are: (a) I am loved; (b) I am lovable; (c) I am worthy; and, (d) I am capable of achieving my goals. This curriculum prepares clients for the second-phase of integrated trauma-informed care, i.e., life-scripting. Sample letters to parents or guardian are provided to maintain communication between therapist and caregiver. Homework is designed to encourage positive parent-child interactions.

## PART I. BASIS FOR THE BIOPSYCHOSOCIAL TREATMENT OF COMPLEX TRAUMA

According to Felitti and colleagues (1998) and the Centers for Disease Control (U.S. Department of Health and Human Services, 2010), more than 50% of the population has experienced childhood adversity severe enough to affect both physical and mental health. The negative consequences of childhood adversity are extensive and extend into adulthood. Due to the impact on development of early-onset, chronic, multiple, and/or ongoing adversity, this type of trauma presentation is also known as *complex trauma*. Without effective intervention targeting root sources of dysfunction in complex trauma, i.e., an injured stress response system, attachment disruptions, and maladaptive core beliefs, the effects of experiencing adversity become manifested in adulthood as obesity, diabetes, cardiac diseases, gastrointestinal difficulties, debilitating depression, and anxiety. Additionally, prolonged stress results in progressive damage to brain structures, metabolism, and immune systems.

The prevalence of children, adolescents, and adults affected by adverse childhood experiences, the severity and persistence of the subsequent negative health consequences, and the progressive nature of the damage are indicative of the need for empirical research to expand the effectiveness and efficiency of population-specific, trauma-focused psychotherapies. The purposes of this thesis are to examine the prevalence and negative effects of adverse childhood experiences (ACEs); to review the disruptions to biological, social, and psychological development in children and adolescents with histories of ACEs; to examine the components and scope of effectiveness of current trauma-focused interventions; to relay practical suggestions given by experienced mental health clinicians to implement evidence-based, trauma-informed principles into direct practice; and, to propose an original and integrated, trauma-informed, psychotherapeutic curriculum for children and adolescents with histories of multiple, early onset, or ongoing exposure to adverse experiences, *Building Healthy Core Beliefs*.

The proposed integrative trauma-informed psychotherapy curriculum for children and adolescents who have been exposed to adversity includes enhancing current best practice, i.e., trauma-focused cognitive behavioral therapy (TF-CBT; Cohen, Mannarino, Deblinger, 2006) with principles from neurobiological research, attachment theory (Bowlby, 1969/1982, 1973, 1980), mindfulness (Germer, 2009; Kabat-Zinn, 2003; Neff, 2003; Neff & Germer, 2013) motivational interviewing (Miller, 1983), existential psychology (May & Yalom, n.d.), strength-based perspective (Saleebey, 1996), and schema therapy (SF-CBT; Young, 1990; Young, Klosko, & Weishaar, 2003). The overall objectives of the proposed, integrated, biopsychosocial treatment model are to help the

participant: (a) to become the author or agent of his or her own life; (b) to accept and grieve losses; (c) to resolve unfinished business; (d) to recognize that problems caused by adversity are external to identity; (e) to recognize that the traumatic experiences of one's life are merely part of a larger life story; and, (f) to integrate psychological, emotional, physical, and social aspects of self.

*Building Healthy Core Beliefs* is phase one of the integrated curriculum, developed by this author, for treating children and adolescents with complex trauma histories. The goals of Building Healthy Core Beliefs are: (a) to understand the physiological and psychological consequences of trauma or adversity; (b) to recognize personal strengths; (c) to expand understanding and utilization of social support systems, especially by increasing positive interactions between child and caregiver; (d) to enhance self-understanding and build self-compassion; (e) to be able to recognize, express, and manage emotions; (f) to increase one's ability to empathize with others; (g) to replace inaccurate and unhelpful thoughts with accurate and helpful thoughts; (h) to recognize the impact of adverse experiences on core beliefs about the future, the world, other people, and the self; and, (i) to replace maladaptive core beliefs with healthy core beliefs. The expected outcomes of Building Healthy Core Beliefs are increased self-understanding, improved emotional and behavioral regulation, improved connections with parent or guardian, and increased motivation for participating in phase two of the intervention, i.e., the life-scripting phase. Specifically, completion of the Building Healthy Core Beliefs curriculum is believed to positively influence the student's self-reported ratings on the Healthy Core Beliefs Scale and to a lesser extent influence the Child Behavior Checklist scores (CBCL; Achenbach, 1991; Achenbach & Rescorla, 2001) and other measurements of psychosocial functioning, such as the Telesage Outcome Measurement System (TOMS; Telesage, Inc., 2012/2015).

As a second-generation Holocaust survivor and an alumna of foster care, this author has been on a quest searching for emotional healing and resolution of grief- and trauma- related symptoms. As a masters of social work student, this author has focused on literature pertaining to the treatment of children and adults with histories of multiple adverse childhood experiences. During this quest, it has become apparent that this author is not alone in wanting an effective and comprehensive treatment program. The Building Healthy Core Beliefs curriculum is this author's synthesis over the past year of the relevant and useful information involving trauma and healing. The sources for the components of this curriculum are identified in this thesis and found both in the evidence-based literature as well as in the practice-based evidence.

## Chapter 1. Adverse Childhood Experiences

### Prevalence of Childhood Adversity

Recognizing that many adult patients being treated for obesity also had a history of sexual abuse in their childhood or adolescence (Stevens, 2012), Felitti and colleagues (1998) completed the Adverse Childhood Experiences (ACE) Study between 1995 and 1997, surveying over 17,000 adult patients in the general population of a large health maintenance organization in California. The purpose of the ACE study was to ascertain the correlation between adverse childhood experiences and health in adulthood.

**The ACE Study.** Felitti and colleagues (1998) computed Adverse Childhood Experience (ACE) scores by summing the total number of categories pertaining to each participant. Scores ranged from 0 to 10. Felitti and associates included ten categories of adversity in the ACE Study:

1. Psychological abuse
2. Physical abuse
3. Sexual abuse
4. Violence against mother
5. Living with household members who were substance abusers
6. Living with household members who were mentally ill or suicidal
7. Living with household members who had been incarcerated
8. Emotional neglect
9. Physical neglect
10. Parental separation or divorce

The ACE Study revealed that 50% of the sample reported at least one category of adverse childhood experience and 25% of the participants had at least two adverse childhood experiences. The occurrence of each of the categories in the ACE sample were as follows: (a) psychological abuse 11%; (b) physical abuse 28%; (c) sexual abuse 21%; (d) violence against mother 13%; (e) living with household members who were substance abusers 27%; (f) living with household members who were mentally ill or suicidal 17%; (g) living with household members who had been incarcerated 6%; (h) emotional neglect 15%; (i) physical neglect 10%; and, (j) parental separation or divorce 23%. It is important to note that the ACE sample was from a general population and not from a group of people presenting for mental health services. Felitti and colleagues concluded that experiencing adversity in childhood was common.

The Centers for Disease Control and Prevention replicated the ACE study across five states: Arkansas, Louisiana, New Mexico, Tennessee, and Washington. CDC results were consistent with the findings of Dr. Felitti and colleagues (U.S. Department of Health and Human Services, 2010). CDC noted that there was very little variation across the five states in the number of categories reported. There was a correlation between numbers of categories and high school education. Those with at least a high school education compared to those without a high school education were less likely to have experienced physical abuse, separation / divorce, familial incarceration, or familial substance abuse. CDC also reported that those in the younger age group, 18 to 24 years old, reported more categories of adversity than the older age group, i.e., those greater than 54 years old. The CDC survey estimated that 59% of adults in the general population had experienced at least one and 37% have experienced two or more categories of adverse childhood experience. In other words, the CDC agreed with Felitti and colleagues that adverse childhood experiences are a common problem for a major portion of the population.

Considering that the ACE questionnaire only included ten types of childhood adversities and that multiple occurrences in one category are not included, the ACE and CDC studies are most probably conservative estimates of the prevalence of adverse experiences and the ensuing negative consequences of elevated ACE scores (Felitti et al., 1998). Research indicates that the effects of trauma are cumulative, i.e., a single event does not have the same effects as chronic trauma (Cook et al., 2005; Hodges et al., 2013; Lawson & Quinn, 2013). Additionally, a more complete ACE survey could include separation from primary caregivers, foster care, kinship care, bullying, community violence, domestic violence to persons other than mother, war, historical trauma, internalized oppression, discrimination, generational transmission of trauma, parental discord, physical injury, disease, physical disability, intellectual disability, learning challenges, homelessness, poverty, and parental unemployment.

**Current statistics of childhood adversity.** The U.S. Department of Health and Human Services (2015) noted that in 2013 there were 678,932 confirmed reports of child abuse and neglect and 1,520 childhood deaths due to maltreatment. According to Stevens (2013), a recent National Survey of Children's Health estimated that approximately 35 million children or adolescents have been exposed to at least one category of adverse childhood experience. Additionally, Staumbaugh et al. (2013) noted that more than 50% of the children in child welfare services had an ACE score of four or more. In concordance with Felitti and associates (1998), those receiving child welfare services are twelve times more likely to have negative physical and mental health consequences. Stevens

suggested that without effective trauma-informed care, the incidence of chronic physical and mental illness would continue to rise.

**Biological Factors and ACEs**

According to Felitti and colleagues (1998), ACE study results indicated that physical and mental health risks were significantly and positively correlated with the ACE score. For example, the incidence of substance abuse, depression, and suicidal behavior increases by a factor of 4 to 12 when comparing adults with an ACE score of 4 to those with an ACE score of zero (Felitti et al., 1998). The negative physical health consequences that are positively correlated with increased ACE scores include: heart, lung, and liver diseases; cancer; obesity; sexually transmitted diseases; and, skeletal fractures. The negative mental health consequences of ACEs include alcoholism, substance use disorder, depression, and attempted suicide (Felitti et al., 1998).

Felitti and associates stressed that attempted strategies to cope with the emotional pain associated with ACEs, e.g., alcohol or drug use, overeating, multiple sexual partners, and early age of first sexual activity, further aggravate physical and mental health symptoms. That is, the attempts to cope with the traumatic experience may include behaviors that cause significant damage to the individual.

Subsequent research indicated that increasing the number of categories of adverse childhood experiences, experiences of adversity at earlier ages, and ongoing adversity tended to compound the severity and persistence of subsequent problems (Child Welfare Committee, 2008; DeBellis et al., 1999). Considering the pervasiveness and the severity of physical and mental health consequences, it is prudent to closely examine biological, social, and psychological needs in order to design and implement effective psychotherapy for treating those affected by ACEs.

**Defining stress and trauma.** Bowlby (1980) defined *distress* as existing when environmental conditions are outside of normal limits required for proper functioning of homeostasis. Bowlby labeled the environmental conditions themselves as *stressors*. Similar to Bowlby's definition of stressor, Briere and Scott (2015) defined a traumatic event as that which "at least temporarily overwhelms the individual's internal resources and produces lasting psychological symptoms" (p. 10).

Consistent with the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5; American Psychiatric Association [APA], 2013), Levine and Kline (2007) specified that "trauma is not in the event itself;

rather, trauma resides in the nervous system" (p. 4). As Bowlby, Levine, Kline, Briere, Scott, and other traumatologists have emphasized, reactions to adverse experiences is in the biological system. Comprehending the link between adverse childhood experiences and health begins with understanding the biological aspects of stress.

**The stress response.** The following is a description from Cohen, Perel, DeBellis, Friedman, and Putnam (2002) of biological responses to stress. The vast array of incoming sensory information travels through two different pathways to the brain: one pathway is quick and the other is slow. If the amygdala senses danger, there are *quick* connections from the amygdala to: (a) the locus coeruleus which releases norepinephrine; (b) the HPA axis, i.e., the hypothalamus which secretes corticotropin releasing hormone (CRH) that stimulates the pituitary to release corticotropin (ACTH) which stimulates the adrenal cortex on the kidneys to release cortisol; (c) the vagus nerve to elevate heart rate and blood pressure; (d) the parabrachial plexus to elevate respiratory rate; (e) the central grey matter to register the event as frightening; (f) the nucleus reticularis pontis caudalis activating the startle reflex; and, (g) the medial prefrontal cortex which applies a *brake* to the amygdala and stops the actions of the norepinephrine, dopamine, and serotonin systems. The fast activation of this quick stress response, also called the *fight-or-flight* response, prepares the individual to fight or run away from danger by directing freshly oxygenated blood to the muscles and away from bodily functions that are not related to survival, such as digestion, attention to non-survival behaviors, and social engagement. The fast pathway saves milliseconds that may be essential for survival in situations of actual danger. Van der Kolk (2014) recommended that clients need education about the bodily sensations that are associated with this *automatic quick stress response* in order to calm the response.

**Context of traumatic event: The details about what happened.** Van der Kolk (2014) also described a slower pathway for incoming stimuli allowing for detailed analysis and interpretation of the context of a situation. The *slow* pathway moves information from the thalamus to amygdala to hippocampus to anterior cingulate to cortex. Saxe, Ellis, and Kaplow (2007) emphasized that the details of a traumatic stimulus are not the focus during an initial experience of a traumatic event, i.e., while the *fast pathway* is activated; however, contextual details of an event are stored in the cortex and can be accessed during calm, regulated states. To reiterate, the lack of processing of the contextual material during a potentially threatening situation serves to expedite the survival response. Additionally, Saxe and colleagues hypothesized that flashbacks are the activation of the emotional memories and bodily

sensations without the contextual details. Saxe and associates suggested that helping clients to pair emotion-laden memories with contextual information during regulated emotional states could reduce clients' traumatic responses.

**Homeostasis.** There is feedback system between the amygdala and the medial prefrontal cortex so that the stress response is deactivated once the threat has passed. The well-regulated mammal lives in a state of homeostasis where natural fluctuations of stress and relaxation are experienced. Adverse experiences can disrupt the homeostasis and are manifested as prolonged stress responses and enduring trauma symptoms. Watts-English, Fortson, Gibler, Hooper, and DeBellis (2006) noted, "Traumatic reminders (i.e., conditioned stimuli and *perceived* threats) cause continuous reactivation of the neurobiological stress systems and alter responsivity of the catecholamine (epinephrine, norepinephrine, dopamine) system, which mediates stress" (p. 720). In other words, the disequilibrated individual frequently remains in an involuntary and prolonged *Fight-Flight- Freeze* mode.

**Biological sequelae of prolonged stress.** Cohen and associates (2002) posited that an individual with PTSD experiences both a hypersensitive amygdala and an underactive medial prefrontal cortex. Thus, the hypersensitive amygdala responds more readily to minor perceived threats; and, the underactive medial prefrontal cortex displays a reduced ability to deactivate the stress response. In other words, there is a malfunction in the components of the stress response system as well as the feedback system itself.

**The effects of prolonged stress on biochemicals.** As stated earlier, there are links between the stress response and catecholamines, i.e., epinephrine, norepinephrine, and dopamine. Specifically, Cohen and colleagues (2002) noted that excessive dopamine is associated with the traumatized individual's underactive prefrontal cortex. The excess of norepinephrine is associated with the hypersensitive amygdala. Additionally, excessive norepinephrine is toxic to the immune system.

The stress response is also associated with disequilibrated levels of serotonin, endorphins, and cortisol. Cohen and colleagues (2002) reported that PTSD symptoms were positively correlated with low serotonin levels and abnormally high endorphin levels, possibly resulting in mood disturbances. Watts-English and colleagues (2006) reported that although cortisol is elevated during and after a traumatic event, there is a paradoxical decrease in the production and management of cortisol in certain cases of clients with histories of early adversity. In other words, excessive, prolonged cortisol production results in adrenal fatigue, i.e., a decreased ability to properly produce and utilize cortisol. Kempke and colleagues (2015) have specifically linked adrenal fatigue to early adversity.

Additionally, Briere and Scott (2015) posited that the presence of cortisol in the bloodstream is part of the negative feedback system to turn off the HPA-axis. Briere and Scott explained the effects of adrenal fatigue when an individual is overwhelmed, i.e., the decreased cortisol in the presence of the elevated ACTH and CRF results in an inflammatory process. Inflammation has been identified as the precursor to disease and source of physical pain.

**The effects of prolonged stress to brain structures.** Cohen et al. stressed that excess cortisol might be "toxic to many brain areas" and "the longer the maltreatment, the smaller the brain and corpus callosum and the lower the child's IQ" (pp. 99-100). Additionally, DeBellis and colleagues (1999) discovered that intracranial volume was negatively correlated both with earlier onset of adversity and with the amount of traumatic experience. DeBellis and associates reported that several researchers attributed the reduced intracranial volume to a smaller hippocampus in traumatized individuals; however, DeBellis and colleagues postulated that the reduced size of the hippocampus may be due to alcoholism rather than the trauma itself. Thus, the negative effects of trauma are exacerbated by a prolonged stress response as well as by the maladaptive coping strategies. For example, individuals with higher ACE scores have an increased risk of alcoholism which results in damage to the hippocampus.

**Neuroplasticity: The good news.** Blakemore and Choudhury (2006) described the advances in the understanding of neuroanatomy and neurophysiology as a result of the use of neuroimaging, such as functional magnetic resonance imaging (fMRI). Blakemore and Choudhury explained that neurogenesis, myelination, and neurosynaptogenesis occurs across the lifespan. Neurogenesis is the growth of new nerve cells, i.e., neurons. Myelination is the growth of the protective cover around the axon of the neuron, i.e., the myelin sheath. Neurosynaptogenesis is the development of new connections between neurons, i.e., synapses. This is good news for the treatment of individuals with high ACE scores in that the structure of our brains can be rewired; thus, people can grow and learn throughout the life cycle. Davidson and colleagues (2003) demonstrated that mindfulness meditation exercises have positive effects on brain structure and function. Additionally, Davidson and associates provided evidence that mindfulness meditation boosted immune system function.

**The adolescent brain: Hope and caution.** Blakemore and Choudhury also discussed sensitive periods where growth and development appear to be accelerated. It is beneficial for parents of teenagers to learn that the teen's erratic behavior means that his or her brain is growing. Specifically, neurogenesis and neurosynaptogenesis peak at approximately 10-12 years of age. The good news about having extra pathways is that the adolescent has the

potential to learn new hobbies and skills. The teenager requires the parent's wisdom and guidance to stay safe, to see the bigger picture, and to help him or her navigate through this difficult process. Physiologically, maturation of the pathways to and from the frontal lobe, i.e., the area of the brain responsible for executive thinking, is not complete until approximately 25 years of age.

**Environmental influences on biological structures and function: For better and for worse.** Although in its infancy, research in the field of epigenetics is providing evidence for the influence of the environment at the genetic level. Specifically, genes are expressed or not expressed, i.e., turned on or off, based on epigenetic factors, such as methylation. For example, Liu et al. (1997) have demonstrated that maternal care in rats changed the way that the animal and the animal's descendants responded to stress. Liu and colleagues concluded from this study that the caregiving environments have significant and measurable effects on the individual, specifically on his or her behavior and biology.

The following is Siegel's (2001) description of the basic biology of the development of the mind. Siegel stated that each neuron connects to approximately 10,000 other neurons to form pathways. He specified that *messages* travel inside neurons as electrical impulses and between neurons as chemical impulses. The neural connections, like forest paths, become consolidated with frequent usage. Memory also becomes more consolidated with multiple repetitions of information.

Siegel separated the formation of pathways in the brain as being either *experience-expectant* or *experience-dependent*. Experience-expectant pathways seem to be genetically hard-wired. These pathways begin functioning fairly soon after birth, for example, seeing, hearing, tasting, touching, smelling, and attachment. Maintenance of experience-expectant pathways is minimal.

On the other hand, the development of experience-dependent pathways is based upon experience, i.e., experience can generate the formation of new connections in the brain. Siegel also explained that brain structures are altered by the "strength of the synaptic connections…. [which] can be strengthened, weakened, or eliminated" (p. 73). Neural messages travel more efficiently, i.e., are strengthened, when the neuron is myelinated. Genetic coding, lack of stimulation, the presence of toxic substances, or stressful experiences can result in the elimination of some connections. The elimination of some pathways may be desirable and part of normal development; whereas, the elimination of other pathways may be deleterious to health.

Experiences that are capable of shaping the individual's behavior in future situations are considered to have been *stored* in memory. Siegel described two different types of memory, i.e., implicit and explicit. Implicit information is stored outside an individual's conscious awareness, such as pre-verbally or when a person has not consciously processed the information. Implicit memories influence an individual's behavior, tone of voice, and mood. Individuals do not have a sense of recall during the activation of implicit memories; therefore, the individual may not realize the relationship of a mood to its origin in his or her past experience. This is significant for the mental health professional in that what the client experienced with early caregivers will influence the client and not be recalled. Conversely, explicit memories, i.e., autobiographical and factual memories, are recalled.

Siegel specified that brain development depends more upon "collaborative interpersonal interaction" (p.72) than on "excessive sensory stimulation." Siegel defined development specifically as the "creation of specific circuits…responsible for emotional and social functioning… such as emotion regulation, empathy, and autobiographical memory" (p. 73). Thus, Siegel advocated for strong attachment relationships between child and caregiver as a means to help the child develop a strong mind. A biopsychosocial intervention must also include improving the attachment bonds between child and caregivers.

**Polyvagal theory.** The sympathetic branch of the autonomic nervous system regulates the neural elevation of heart rate. To maintain homeostasis, the vagus nerve, part of the parasympathetic branch of the autonomic nervous system, regulates the neural decline of heart rate. Porges (1995) posited the polyvagal theory to elucidate the additional role of the vagus nerve in coordinating the sympathetic versus parasympathetic innervation, emotions, and environmental stimuli. According to the polyvagal theory, sensory and motor nerve cells of the vagus nerve connect the brain and the internal organs. Porges specified that emotional responses elicited by external events travel from the midbrain to the internal organs and the organs transmit the visceral sensation elicited by the emotion back to the brain. Porges stated that this sensorimotor feedback loop is the reason that emotions are felt viscerally. Additionally, Porges (2003) explained that this environment-to-organ-to-emotional brain loop in the vagal nerve complex is responsible for the sense of *neuroception*, i.e., the visceral sense of the safety of one's environment.

Additionally, Porges (2003) stated that there is a hierarchy of three different responses to stress. An unmyelinated, dorsal branch of the vagus nerve is responsible for the *freeze and dissociation* response. This response to stress from the dorsal branch of the vagus nerve is lowest on the hierarchy and is phylogenetically the

oldest of the three stress response pathways. Second on the hierarchy of stress responses is the sympathetic *fight-or-flight* response. Porges postulated that if a person is in freeze or dissociation, he or she might engage in self-destructive or aggressive behaviors as a means of seeking to move up the hierarchy. Thus, Porges explained that behavioral difficulties are part of the *fight-flight-or-freeze* response.

Appearing the most recently in human evolution, Porges considered the ventral vagal response to stress to be the most effective means of calming the stress response in that the dangerous side effects of the *fight-or-flight* response are avoided, specifically excess adrenaline, norepinephrine, and cortisol. The myelinated ventral branch of the vagus nerve is also known as part of the system for social engagement due to its proximity to and connections with nerves innervating facial expressions, the ear, and the voice.

Additionally, Geller and Porges (2014) defined the ventral vagal connection as the essential element in the therapeutic relationship and might be achieved when the therapist has resolved his or her own issues, can be fully present to the client, and the client feels heard and understood. The client and therapist achieve this ventral vagal connection implicitly through tone and quality of voice (Geller & Porges, 2014). These findings are also consistent with attachment-based and other neurological research, i.e., the key to healing is high quality social connections. Schore (2011) also emphasized the importance of the implicit, nonverbal communication between the therapist and the client.

Porges reported that, according to neural imagery, activation of the sympathetic branch of the nervous system is predominantly in the right hemisphere while activation of the parasympathetic branch of the nervous system is predominantly in the left hemisphere. Teicher et al. (1997) found that maltreated children tended to have less development of the corpus callosum, the brain structure connecting the right and left hemispheres. Therefore, persons with histories of early childhood adversity may benefit from neurobiological integration of right and left hemispheres. In simple terms, the traumatized client will benefit from large motor activities that cross the midline.

## Social Factors and ACEs

**The physiological ability to connect to other people.** Humans possess biological equipment for being social, i.e., mirror neurons, biochemicals such as oxytocin, and innate behavioral systems. Mirror neurons biologically facilitate imitation behavior of the parent or guardian's expressions of emotions, as well as the imitation

of how to interact with and respond to others (Rizzolatti, & Arbib, 1998). This premotor, imitational representation allows individuals to develop empathy for another person. Significant to working with individuals having anxiety- and trauma- related symptoms, Bretherton and Munholland (2008) interpreted the actions of the mirror neurons as "allowing individuals to *experience* past and *preexperience* future episodes" (p.110). Bretherton and Munholland provide this explanation for the client's re-experiencing and future-oriented anxiety. Thus, a thorough understanding of mirror neurons can help the therapist to validate the client's experiences.

As stated earlier, prolonged stress negatively affects biochemicals with a cumulative negative effect on health. Fortunately, healthy social interactions have a positive effect on neurotransmitters and hormones in the body and brain. For example, Saxe, Ellis, and Kaplow (2007) stated that there is a *sense of calmness* as the dopamine is slightly elevated in anticipation of positive social interactions; and, oxytocin is released when comforting or being comforted by a human being. Additionally, positive interpersonal interactions stimulate the release of long-allele 5-HHT, a form of serotonin, has been associated with decreased activation of the amygdala and a corresponding decreased fear response (Kemph & Voeller, 2007). Natural endorphins, also known as opiates, are also released with positive interpersonal interactions.

Conversely, social rejection is registered in the same cortical region as physical pain, i.e., anterior cingulate and the insula (Kross, Berman, Mischel, Smith, & Wager, 2011). Lack of positive interpersonal connection causes distress similar to opioid withdrawal, low levels of MAO-A and short-allele 5-HHT (Kemph & Voeller, 2007). Short-allele 5-HHT, a mutated form of serotonin, has been associated with increased activation of the amygdala, increased fear, and depression. Additionally, Kemph and Voeller emphasized that dysfunctions in dopamine pathways can result in addictive, compulsive, and impulsive behaviors; furthermore, low levels of MAO-A combined with early maltreatment may result in antisocial behavior. In other words, the overwhelmed child with a history of maltreatment and without positive social interactions is at a greater risk on a biochemical level.

**Attachment behavior defined.** Bowlby (1969/1982) discussed the significance of the innate attachment and social behavioral systems in evolutionary terms. Bowlby observed that a child's discrete attachment behavior is directed towards a specific or principal attachment-figure when a child is "tired, hungry, ill, or alarmed…[or] uncertain of that [specific] figure's whereabouts" (p. 307). Bowlby specified that attachment behavior of the infant is necessary for survival. Additionally, Bowlby added that securely attached children tended to be more cooperative,

displayed more sympathy towards others in pain or distress, and exhibited more curiosity about others. Furthermore, Bowlby said that the most socially confident children were those who had "secure relationships with both parents" (p. 365). Conversely, insecurely attached children displayed inhibited behaviors with others. Therefore, attachment behavior is an intrinsic biological mechanism for survival and for being social.

**Subsidiary figures.** Bowlby (1969/1982) also noted a social behavioral system distinct from the attachment system that is activated when the child is not in distress, i.e., he or she is looking for a playmate-figure. According to Bowlby, a primary caregiver may serve as both an attachment-figure and a playmate-figure at different times in the child's life. Bowlby added that a limited number of "subsidiary figures" (p. 305) might also serve as attachment figures, affectional figures, or both. Ainsworth (1964) reported that the infant securely attached to his or her primary caregiver was more likely to develop strong discriminatory behaviors towards other subsidiary figures.

**Attachment and responsiveness of caregiver.** Although many have supposed that attachment is based on the fulfillment of physical needs, Bowlby (1969/1982) observed that attachment bonds are based on social interaction and responsiveness. As evidence, Bowlby cited that children frequently display strong attachments to their fathers despite the fact that the fathers had not primarily fulfilled the child's physical needs. Additionally, Bowlby noted that Israeli Kibbutz children have strong attachments to their biological parents even though non-parental caregivers met the majority of the Israeli Kibbutz children's nutritional needs. Bowlby added that Kibbutz parents had minimal interactions with their children, i.e., one hour per night six nights a week and all day on the Sabbath. Therefore, Bowlby concluded that attachment behavior is based on social interaction and responsiveness.

**The function of attachment: Developing the skills and beliefs needed to survive and thrive.** The attachment relationship of the child to the primary caregiver provides more than protection and comfort for the child; attachment is essential for the development of the beliefs and skills needed to survive and thrive. From the consistent and sensitive caregiver, the child develops positive beliefs about the self, other people, the world and the future (Bowlby, 1969/1982). Additionally, Bowlby stated that the purpose of attachment behavior beyond nutritional sustenance was protection and the development of skills "necessary for survival" (p. 224).

The survival skills gained from attachment include: communication skills; emotional and behavioral regulation; the ability to explore and learn about the world; and, the ability to interact, be comforted by, and resolve conflicts with others. Bowlby (1969/1982) also observed that the secure attachment relationship is "a favourable

model on which to build future relationships" (p. 378) and a model for identification, modulation, and expression of emotions and regulation of behavior. Conversely, Bowlby noted that the child with less-than-secure attachment may have difficulties with core beliefs, skill development, building future relationships, and/or emotional and behavioral regulation.

**Need fulfillment and core beliefs.** Garbarino and Stout (1989) posited that children need nurturance, predictability, responsiveness, guidance, and support. Bowlby (1969/1982) and Young, Klosko, and Weishaar (2003) postulated that when the primary caregiver consistently meets the child's basic needs, the child believes: *I am worthy of care, therefore, I am worthy; Others are reliable and I can expect that my needs will continue to be met in the future; The world is a safe place; I am loved; and, I am lovable*. Conversely, the child who does not have his or her needs met in a reliable and predictable manner believes: *I am not worthy of receiving care; others are unreliable; and, the world is a dangerous place*. Without consistency and predictability, the child also has no experience of a sense of agency, i.e., being able to influence his or her world.

**Attachment security and skill development.** Bowlby (1969/1982) stated that when needs are met and the infant can sense the reliability of his or her caregiver, he or she is more likely to explore his or her environment. Bowlby noted that the increased exploratory behavior of the securely attached infant is foundational to the development of cognitive skills and a sense of competence.

**Attachment and communication.** Social learning theory (Baer & Bandura, 1963) posits that learning occurs during social interactions, especially in the family. As stated earlier, Siegel (2001) identified "collaborative interpersonal interaction" (p.72) as essential for brain development. One important aspect of social interactions with a primary caregiver is the development of expressive and receptive communication abilities.

Acquired before the child is capable of uttering a single word, the sense of agency is gained when the child's communicative attempts result in goal attainment. Blaustein and Kinniburgh (2010) noted that if the child's attempts to communicate are ignored or misread, he or she may either cease to communicate needs or may develop maladaptive expressive behaviors. Blaustein and Kinniburgh emphasized that the uncommunicative child tends to shut down and avoids emotions, people, or situations. Without communication, the isolated child lacks a sense of power or control over his or her own life. Lack of successful communication is a perpetually regenerating cycle in which the child's core beliefs are progressively damaged.

**Attachment and emotional regulation.** Social interactions with responsive caregivers result in the acquisition of skills necessary to identify, modulate, and express one's emotions. When the caregiving experience lacks responsiveness, as evidenced by cases of early child maltreatment, the child does not gain the skills necessary for appropriate identification, modulation, and expression of emotions (Briere & Scott, 2015). Van Horn (2011) noted that the caregiver's inability to relay skills necessary for the management of the adversity results in the fearfulness and helplessness induced by traumatic reminders. Van Horn emphasized that for the child who has not learned primary regulation skills, the reactions to traumatic reminders are automatic and are not "conditioned responses" (p.15). Considering that systematic desensitization involves the deconditioning of conditioned responses, systematic desensitization is not the treatment of choice to reduce the trauma-related symptoms themselves. Rather than retraumatizing an individual by requiring disclosure of detailed accounts of traumatic events, an individual can be taught the skills necessary to identify, modulate, and express his or her emotions. Of course, any concomitant phobias may be reduced with systematic desensitization after the child has a mastery of emotional regulation skills, including emotion management, grounding, orientation, compartmentalization and titration, resourcing, pendulating, and pacing (see chapter 2 of this thesis).

Furthermore, Saxe, Ellis, and Kaplow (2007) emphasized that emotional regulation is a prerequisite for behavioral regulation explaining that the emotional response and behavioral/ motivational/ reward systems are connected in the amygdala. Saxe and associates stressed, "Survival-related emotion [rage, helplessness, terror] can clearly cause survival-related behavior [tantrums, etc.]" (p. 35). Clearly, the mastery of emotion management skills is necessary before one can hope to regulate a child's behavior.

**Attachment and belief in conflict resolution.** Gusella, Muir, and Tronick (1988) demonstrated that infants become extremely distressed when the primary caregiver displays a *still face* or becomes temporarily nonresponsive. Gusella and colleagues noted the ability of the infant to return to a regulated state upon the mother's return to responsiveness and emphasized the infant's lesson that repair of a relationship is possible after a rupture. However, the converse of Gusella and associates' statement is also true and not specifically stated, i.e., children with complex trauma histories typically have unresolved ruptures in relationships. It is logical that the experience of multiple unresolved ruptures creates a belief that resolution after rupture is impossible. Therefore, the child with a complex trauma history lacks the rudimentary skill necessary for conflict resolution, i.e., the belief in resolution.

**Attachment and the ability to be comforted.** Inherent in the attachment behavior is the ability to be soothed by the caregiver. When the child experiences that the caregiver is not available for soothing, "the world is seen as comfortless and unpredictable; and they respond either by shrinking from it or by doing battle with it" (Bowlby, 1973, p. 208). The child with a history of complex trauma may not believe that other individuals can comfort him or her; he or she may only seek comfort via nonhuman means, e.g., nature, music, art, substance use, materialism, or perfectionism. Assessing the child's ability to be comforted by a human being is essential when evaluating children and adolescents with histories of complex trauma. Experiences where the child can be comforted by another human being and exercises to increase comfort-seeking behaviors are essential elements of care for individuals with complex trauma histories.

**Stable internal working models and changes in attachment behavior.** Bowlby (1969/1982) postulated that attachment is a lifelong behavioral system and specified that internal working models of relationships with primary caregivers provide a blueprint for interactions throughout one's life. By three years of age, a child will tolerate his or her primary caregiver's absence for short periods due to his or her ability to hold a mental representation of his or her mother and an internal working model (IWM) of the relationship with the mother (Bowlby, 1969/1982). In addition to allowing the child to have some separation from the caregiver, this internal parent image and IWM become the basis of an individual's framework for self-care and well being into adulthood (Young, Klosko, & Weishaar, 2003).

**Attachment, anxiety, and anger.** Bowlby (1973) postulated that separation from one's primary caregiver is a major origin of anxiety due to the young child's inability to meet his or her own needs. Additionally, Bowlby stated that the child relies on the attachment figure to determine the danger of a stranger or a situation. When there is a physical or psychological separation from the caregiver, the child becomes anxious. Also, Bowlby (1969/1982, 1973, 1980) discussed that the distraught or bereaved child displays protest and anger in an instinctive attempt to regain proximity to the primary caregiver, i.e., a behavior to increase the probability of survival.

**Attachment and maltreatment.** In situations where separations from caregivers are associated with maltreatment, a child's anger is frequently self-directed in that he or she is "unable to accommodate with[in] a single image the parent's kindly treatment of him [or her] as well as any less favourable treatment he [or she] may receive [such as abandonment, abuse, or neglect]" (Bowlby, 1980, p. 71). Persons who have experienced trauma at the

hands of the primary caregiver have frightening mental representations of the offending parent. Bowlby (1980) noted that the child who has been traumatized by a caregiver may carry an idealized split-off version of that parent in addition to the image created by the child's experience. Bowlby explained:

> On threat of not being loved or even of being abandoned a child is led to understand that he is not supposed to notice his parents' adverse treatment of him [or her] or, if he [or she] does, that he [or she] regard it as being no more than the justifiable reaction of a wronged parent to [the child's] bad behavior (p.71).

**Attachment and grief.** Bowlby (1980) noted, "Loss of a loved person is one of the most intensely painful experiences any human being can suffer" (p. 7). Bowlby observed despair and grief in children as young as 12 months old whenever hope of reunion with the caregiver had faded. Interestingly, Bowlby (1980) specified that loss is physiological and "what appears as restoration of function can often hide an increased sensitivity to further trauma" (p. 43). Bowlby discussed that enduring defense processes and beliefs function as "scar tissue" (p. 22) responsible for much "psychopathology and neurosis." Bowlby proposed working with the defensive beliefs and processes as a means to enable the child or adult to mourn losses from early childhood. Evident in Bowlby's observations is the sense that each relationship is unique; i.e., one relationship cannot replace another relationship.

**Secondary attachments.** Seibert and Kerns (2009) emphasized that children do have the capacity to form secondary attachments to others such as foster parents, teachers, and peers. Seibert and Kerns acknowledged that the formation of these new attachments will include difficulties. Care of the individual removed from his or her home home-of-origin must include acknowledgment of the grief regarding lost expectations and the lost relationship. Additionally, these individuals benefit when help is provided in redefining the new relationships.

**Attachment in middle childhood and beyond.** Kobak and Madsen (2008) explained that by middle childhood the goal of attachment behavior becomes availability of, i.e., accessibility and responsiveness, rather than proximity to, the caregiver. This tendency to desire an attachment's figure's accessibility and responsiveness remains active through adolescence and, for some, into adulthood. Kobak and Madsen (2008) described the source of problems in adolescence as frequently associated with the parent's lack of availability to the child. Kobak and Madsen defined lack of availability as the physical or psychological absence due to the disruptions of the parent's communicative and emotional responsiveness. Kobak and Madsen discussed that parental sensitivity may be affected by divorce, marital conflict, domestic violence, parental injury, mental illness, or substance abuse. The

parent or guardian benefits from learning of the importance of meeting his or her own emotional needs in order to be sensitive and responsive to his or her child or adolescent.

Allen (2008) discussed the difficulty that insecurely attached teens have with negotiating adolescent developmental milestones. Conversely, Allen said that the securely attached adolescent is able to engage in problem-solving communication with parents to effectively maneuver the transition to autonomy without destroying the attachment relationship. Additionally, Allen stressed that the securely attached teen has the requisite skills for secure peer relationships. In other words, fostering better parent to teen relationships may result in better peer relationships.

**Polyvagal theory revisited and social interactions of traumatized individuals.** As stated earlier in this document, the key to healing is high quality social connections. Unfortunately, as Geller and Porges (2014) emphasized, the person with a history of early childhood adversity tends to disengage socially. The traumatized individual is further traumatized by the negative feedback received when other people avoid him or her due to his or her heightened stress response or dissociation from emotional expression. Geller and Porges advocated for encouraging any positive attunement and connection in current relationships in order to strengthen the ventral vagal pathways. The therapist and caregivers will help the traumatized client by validating that the client's tendencies toward social disengagement and emotional avoidance are survival-related (Linehan, 1993).

**Parent or caregiver's attachment history.** Slade, Cohen, Sadler, and Miller (2009) explained the evolution of becoming a parent as beginning before or during pregnancy. Specifically, Slade and associates explained that identity as a parent is dependent upon one's own attachment experiences. Stover, Hahn, Im, and Berkowitz (2010) discussed the importance of helping the parent or guardian to understand the effects of his or her own adversity on his or her child or adolescent. Fraiberg, Adelson, and Shapiro (1975) used the metaphor of *ghosts in the nursery* to describe the interference to the parent's ability to be emotionally available for his or her child. Lieberman, Padrón, Van Horn, and Harris (2005) stressed that *angels in the nursery* can also affect the parent's availability in that unresolved grief issues may surface when loss reminders of the *happy times* are triggered. In summary, the therapist attends to the caregiver's early childhood history in order to help the caregiver to be fully available and sensitive to the child.

**Psychological Factors and ACEs**

Information that is seen, heard, smelled, tasted, or touched during a perceived threatening situation is bundled with the memories of one's bodily sensations, emotions, and thoughts of the event. This *memory package* is utilized as a guide to accelerate activation of the stress response in similar future circumstances. Activation of one part of the memory package frequently unleashes other *memories.* Formed with or without the stress response, a memory package may combine with other similar memory packages to form a schema.

**Schema defined.** In approximately the 3rd century B. C., Greek philosophers, such as Chrysippus, presented the concept of schema to indicate a framework or abstract thematic representation guiding interpretation and organization (Young, Klosko, & Weishaar, 2003). Beck (1967) clarified that, in psychological terms, a schema serves as a framework for analyzing, interpreting, and selectively attending to the vast array of information in the environment. In other words, schemas are used as filters to allow the individual to selectively attend to that information which he or she appraises as relevant. McBride, Farvolden, and Swallow (2007) noted that individuals attend to information consistent with their schemas about self, others, and the world. Morrison (2007) stated that one's thoughts are biased by his or her schemas resulting in avoidance of information contradictory to the schema and in magnification of partial truths that are consistent with the schema.

**Assimilation and accommodation.** Piaget described the concepts of assimilation and accommodation to explain the formation of schemata. According to Piaget, when incoming stimuli matches an existing schema, the new information is assimilated into that schema; however, when incoming information does not match the existing schema, the schema is changed to accommodate the new information. As stated previously in this paper, Bowlby (1980) posited that the maltreated child will not assimilate the parent's abusive or neglectful behavior into his or her existing representation of a loving parent. Rather than change or accommodate that loving parental image, said Bowlby, he or she develops two competing internal working models of the parent-child relationship. One of those internal working models, typically the model of the abusive relationship, is repressed and the child's anger is directed to him- or her- self rather than the offending parent.

**Early maladaptive schemas.** Young (1990) claimed that a child develops early maladaptive schemas (EMS) when he or she does not form a sense of connectedness, autonomy, worthiness, reasonable expectations, and realistic limits from the early caregiving experience. Conversely, being securely attached to a primary caregiver,

autonomous functioning, and a positive sense of personal worth allows an individual to develop adaptive or healthy schemas. Although schemas may be adaptive or maladaptive, Young included only maladaptive schemas in his evaluation of clients reasoning that persons seek mental health counseling for resolution of maladaptive, not adaptive, schemas.

**Core beliefs.** Aaron T. Beck (1967) specified that core beliefs are one of the cognitive aspects of a schema; other cognitive aspects of schemas are intermediate or conditional beliefs and automatic thoughts. Judith Beck (2011), Aaron Beck's daughter, defined core beliefs as unconditional, stable, and enduring appraisals about oneself, others, and the world. J. Beck specified that core beliefs form in childhood, become reinforced through life experiences, and are stated in absolute terms, e.g., "I am worthless" or "Others are unreliable." Although unarticulated and out of conscious awareness, J. Beck emphasized that core beliefs impact the development of assumptions, rules, expectations, attitudes, and the development of conscious, articulated, and situation-specific automatic thoughts. Young specified that core beliefs arising from early maladaptive schemas (EMS) tend to be negative, maladaptive, and not easily amendable. Furthermore, Young added that attempts to maintain an intact self-concept and reduce emotional pain when an EMS is activated may result in addictive, compulsive, or impulsive behaviors, i.e., maladaptive coping behaviors. Although successful in the short term, these maladaptive coping behaviors do not promote healthy functioning and long-term satisfaction.

Abuse, neglect, deprivation, abandonment, or insensitive parenting typically leave these messages: *My feelings don't matter; I deserve to be abused, neglected, or abandoned; I am unlovable; I will always be alone; No one will ever meet my need. I must always do what other people want me to do; I do not deserve to be alive; other people are not reliable and trustworthy; the world is a dangerous place; I have no control over what happens to me; I am powerless; and, there is no hope for a bright future*. These statements are expressions of unhealthy core beliefs emanating from maladaptive schemas. Maladaptive core beliefs negatively influence emotions, moods, thoughts, attitudes, and behavior. The individual is typically unaware of the origin of negative core beliefs or of the existence of the early maladaptive schemas. Bowlby (1973) proposed that more than one *working model* for beliefs about self and relationships with other people coexist for the individual with a history of maltreatment.

**Differential Diagnosis: Behavioral Dysregulation, Inattention and Trauma**

The term Posttraumatic Stress Disorder (PTSD) was introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (Friedman, 2015). Friedman noted that the criteria for diagnosing PTSD have changed somewhat with each revision of the DSM. Rather than reserving PTSD diagnosis for anxiety-related symptoms after catastrophic events, Friedman reported that the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5; American Psychiatric Association [APA], 2013) categorized PTSD as a trauma- and stressor- related condition to include mood and behavioral disruptions that commonly are present after exposure to adversity. DSM-5 (pp. 271-274) defines the criteria necessary for PTSD diagnosis.

DSM-5: PTSD Criterion A - at least one for children age 6 and older:

Exposure to actual or threatened death, serious injury, or sexual violence in one or more of following ways:

1. Directly experiencing
2. Witnessing traumatic event of others
3. Learning about traumatic event of loved one, especially to caregiver in child < age 6
4. Experiencing repeated or extreme exposure to aversive details of traumatic event = Vicarious trauma

DSM-5: PTSD Criterion B - at least one of intrusive symptoms:

1. Memories
2. Flashbacks
3. Recurrent Dreams- content or affect
4. Intense or prolonged psychological distress to cues
5. Marked physiological reactions to cues

DSM-5: PTSD Criterion C* - at least one avoidance symptom

1. Avoidance or efforts to avoid memories, thoughts, feelings
2. Avoidance of external reminders that arouse distressing memories, thoughts, or feelings

DSM-5: PTSD Criterion D* - at least two cognitive and mood alterations:

1. Inability to remember aspects of traumatic event
2. Negative beliefs/ expectations about world, others, & self
3. Distortions about cause and consequences of traumatic event, i.e., inappropriate blame
4. Persistent negative affective state
5. Diminished interest in activities & anhedonia
6. Feelings of detachment and estrangement from others

DSM-5: PTSD Criterion E - at least two arousal & reactivity symptoms:

1. Irritable behavior and angry outbursts with little to no provocation typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance

*Note: Only one symptom from new combined category of criteria C and D is required for diagnosis in children < 6 years of age.

Grasso and colleagues (2009) labeled PTSD as the *missed diagnosis* in child welfare. However, Briere and Scott (2015) emphasized that posttraumatic stress disorder (PTSD) diagnostic criteria may not adequately represent

all significant presentations of posttraumatic stress responses (PTSR). Briere and Scott (2015) highlight the damage to the personal sense of self and difficulties with interpersonal relationships of those having experienced early, ongoing, and multiple adversity. Beyond trauma symptoms and the impact of prolonged stress, significant enough in themselves, Briere and Scott emphasized that the most detrimental trauma-related injury is damage to one's sense of self. Briere and Scott recommended that in addition to symptom assessment, clinicians should assess for the events that trigger avoidance, activation of stress responses, affect dysregulation, and relational disturbances.

The American Academy of Child and Adolescent Psychiatry concurs with Briere and Scott, "it is important for the child welfare community to understand that the PTSD diagnosis does not adequately capture the full picture of childhood trauma" (Griffin et al., 2011, p. 71). Children between infancy and age 5 are particularly vulnerable to the detrimental impact of trauma with developmental difficulties evident in "communication, relationships, empathy, self-awareness, self-regulation, and a basic sense of initiative and self-efficacy" (Lawson and Quinn, 2013, p. 499).

**Diagnostic caution for those with history of trauma.** According to the Child Welfare Committee of the National Child Traumatic Stress Network (2008), when there is a history of a traumatic event, mental health professionals should not diagnose a mental illness without first assessing trauma symptoms and using evidence-based, trauma-informed treatments. After resolution of the trauma symptoms, diagnosis of an additional mental illness may or may not be warranted. Diagnoses that do not address the stress response itself may do more harm than good. Calming the hypersensitive stress response and considering the impact of adversity on core beliefs will allow individuals with elevated ACE scores to reverse the disease processes and maladaptive coping behaviors. Although DSM-III may have only defined catastrophic events as traumatic, Briere and Scott would allow trauma to be defined as any adverse experience that overwhelms a person's coping abilities over the course of time. As such, criteria for justification of using an integrative biopsychosocial trauma intervention should be the presence of at least one adverse experience listed in the DSM-5/ ICD-10 codes (See Appendices A & B).

**PTSD, ODD, CD, ADHD: Symptoms manifested in behavior.** The diagnoses PTSD, Oppositional Defiant Disorder (ODD; APA, 2013, pp. 462-466), Conduct Disorder (CD; APA, 2013, pp. 469-475), and Attention-Deficit / Hyperactivity Disorder (ADHD; APA, 2013, pp. 59-66) are highly correlated, specifically in those with a history of traumatic victimization, such as "witnessing family violence or being exposed to assault, kidnapping, or community violence" (Ford, et al., 2000, p. 206). Crenshaw and Garbarino (2007) also recognized that a childhood

history of adverse life experiences, such as parental substance use disorder or exposure to violence, is frequently a significant factor in the etiology of behavioral and attentional difficulties. Lipschitz, Morgan, and Southwick (2002) described the difficulties of differentiating between PTSD and behavioral disorders. Lipschitz and colleagues explained that hyperarousal symptoms of PTSD in children can manifest as "bouts of irritability, aggression, rage… temper tantrums or constant arguing with adults" (p. 152). These symptoms are also the behavioral features of ODD. "Recurrent physical fights… [or] … bullying or threatening" (p. 152) are behavioral characteristics in Conduct Disorder. Lipschitz and associates also linked the "sense of numbness or foreshortened future" to "living for today and behaving impulsively with no thought of consequences" (p. 152); impulsivity and lack of regard for consequences or rules are criteria for conduct disorder. PTSD hyperarousal symptoms may also manifest as "poor attention span and concentration" (p. 152) which are also symptoms of ADHD.

**RAD.** Reactive attachment disorder (RAD; APA, 2013, pp. 265 – 268) is a failure to consistently seek comfort from a caregiver or to lack the ability to be comforted when a caregiver provides comfort. RAD typically appears in the last quarter of a child's first year of life in cases of severe neglect or when there have been frequent changes in primary caregivers. Children with RAD display disruptive and disorganized regulation of affect with "irritability, sadness, or fearfulness" (p. 265) and have low tolerance for distress. Individuals with RAD may also exhibit inattention, impulsivity, and hyperactivity. The etiology of RAD is attributed to: Severe deprivation which causes delays in physical growth and cognitive development; and, the disruption of brain development prenatally or at birth by exposure to drugs or other toxins, mother's illness, prematurity, hypoxia, or malnutrition. Another possible mechanism of injury to the attachment bond is via a prolonged stress response.

Kemph and Voeller (2007) stated, "A diagnosis of RAD may be made in older children or adolescents retrospectively from history" (p. 174). RAD in adolescence will usually have comorbidities such as ADHD, PTSD, ODD, CD, or a mood disorder. Exposure to violence increases the risk for concurrent behavioral disorders and RAD (Lehmann, Havik, Havik, & Heiervang, 2013).

Although the DSM-5 states that RAD occurs in less than ten percent of children who have experienced neglect prior to placement outside the home of origin (APA, 2013), Boris et al. (2004) emphasized that 35% to 45% of maltreated children in foster care demonstrate significant RAD symptoms. Although a separate DSM

classification is not available, disruptions to attachment, also associated with aggression and disruptive behavior, may warrant further research (Lyons-Ruth & Jacobvitz, 2008).

**DMDD and PBPD.** Eme and Mouritson (2013) stated that disruptive mood dysregulation disorder (DMDD) was added to DSM-5 (APA, 2013; See pp. 156-160) to reduce diagnosis of pediatric bipolar disorder (PBPD). The DSM-5 specifies that the presence of PTSD, separation anxiety disorder (APA, 2013; pp. 190-195), autism spectrum disorder (APA, 2013, pp. 50-59), or severe persistent depressive disorder (PDD; APA, 2013; pp. 168-171) would clearly rule out DMDD. After resolution of trauma symptoms, the assessment for DMDD may be prudent. Major depressive disorder (MDD; APA, 2013, pp. 160 -168), ADHD (APA, 2013, pp. 59-66), conduct disorder, and substance use disorder are frequently comorbid with DMDD. If child has both DMDD and ODD, the DSM-5 recommends using only the DMDD diagnostic code.

Mania, a major criterion for Pediatric Bipolar Disorder (PBPD; APA, 2013, pp. 123-154), was originally operationally defined in children as severe, non-episodic irritability; however, Marguiles, Weintraub, Basile, Grover, and Carlson (2012) stated that the decreased need for sleep is a more reliable symptom than elation, grandiosity, or irritability for diagnosing mania in children. If mania would be apparent, PBPD may be diagnosed and the child would be treated with antipsychotic medication and mood stabilizers. On the other hand, the child with DMDD would not get treated with antipsychotic medication and mood stabilizers. Therefore, it is vital that differential diagnosis is established between Pediatric Bipolar Disorder and Disruptive Mood Dysregulation Disorder. Marguiles and colleagues noted that mania also occurs in other disorders.

**Depression and grief may have similar clinical presentations.** Traumatic experiences frequently involve loss and grief. The following is an explanation of the differentiation between grief and depression as presented in the DSM-5 (APA, 2013). In grief, there is a sense of emptiness and loss accompanied by a preoccupation with missing the deceased. The grieving person can recall happy memories with the deceased. Suicidal urges or death wishes of the grieving individual are aimed at reunion with the deceased. Conversely, a major depressive episode (MDE) consists of a persistent decreased mood with an inability to experience pleasure. Additionally, the person with MDE will display evidence of cognitive distortions, such as self-critical remarks, ruminations, a sense of worthlessness, and self-loathing. Rather than wishing to reunite with the deceased, suicidal urges of the individual with MDE will

relate to perceptions involving a low sense of self-worth and the inability to cope with feelings (Dillen, Fontaine, & Verhofstadt-Deneve, 2009; Edgar-Bailey & Kress, 2010).

## Developmental Perspective on Grief

**Defining grief.** Cohen, Mannarino and Deblinger (2006) explained that grief components are frequently an inseparable element of trauma. "Grief is the normal and natural reaction to loss…grief is neither a pathological condition nor a personality disorder" (James, Friedman, & Matthews, 2001, p. 14).

James, Friedman, and Matthews (2001) defined grief as the mental suffering arising from the transformation or termination of familiar behavioral patterns or relationships. James and colleagues differentiate obvious losses, such as death, moving, or divorce, from the intangible losses, such as loss of trust, safety, health, aspirations, and control. James and associates warned that there is no comparing the grief of one person to that of another; loss is a 100% phenomenon. James and colleagues also emphasized that relationships are not interchangeable, i.e., "unresolved grief from old relationships interfere with new relationships" (James, Friedman, & Matthews, 2001, p. 32).

**Perspectives from the east and the West about grief.** There is a vast difference between eastern and western traditional mourning practices. Although traditional western models encourage detachment from the deceased and rapid grieving (Bowlby, 1980), eastern practices encourage the perpetual honoring of the dead (Goss & Klass, 1997; Wada & Park, 2009). Current wisdom encourages an integrative model of grief and recognizes normal variations in grief responses (Cohen & Mannarino, 2004; Tyson-Rawson, 1996). Detachment from the deceased is no longer recommended (Cait, 2008). Expanding the grief period, maintaining a connection to the deceased, and negotiating new roles in social situations are themes in the grief narratives of teens (Cait, 2008).

**Grief takes time.** Grief is a developmental process gradually unfolding over time (Cait, 2008). Internal defense mechanisms, such as temporary avoidance, allow the bereaved individual to process painful emotions in manageable portions (Walsh, 2011). Various unresolved issues may become evident over a period of many years as small reminders trigger unresolved memories of the deceased (Balk, Zaengle, & Corr, 2011). When the relationship with the deceased involved conflict, grief may be complicated (Herberman Mash, Fullerton, & Ursano, 2013). The attempts to avoid or suppress thoughts and feelings further complicate the grieving process (Eisma et al., 2013).

Resolution of the unfinished business, resentments, regrets, and unexpressed feelings are necessary for one to complete the grieving process. Furthermore, a history of prior uncompleted losses can have a cumulative effect on the current loss (Cohen, Mannarino, & Deblinger, 2006).

**Additional complications in the grieving process.** Circumstances of the person's death can impact the individual's grieving process. Sudden, unexpected death tends to be a shock and tends to be difficult to process. There may be a traumatic stress response when death is caused by suicide or homicide. Lack of predictability and order to one's universe may result in fear or mistrust of the universe. Alternatively, death from prolonged illness may involve confusing feelings of relief.

Ambiguous or disenfranchised loss is experienced when the importance of the lost relationship may not be recognized or may be minimized by traditional social support systems (Cohen & Mannarino, 2004; Dillen, Fontaine, Verhofstadt-Deneve, 2009; Malone, 2007). Some grief, such as the loss of a peer may be disenfranchised and not understood by a teen's support system. For example, the death of a significant other of a LGBTQ youth may be dismissed as inconsequential. Additionally, it is likely that a death involving any element of shame, such as the murder of a parent, would also be disenfranchised (Balk, Zaengle, & Corr, 2011).

Somatic symptoms may be evident in some cultures that do not condone the emotional expression of grief, e.g. males may not openly express their grief. Somatic symptoms could include sleeping and eating problems, gastrointestinal disorders, headaches, and fatigue (Balk, Zaengle, & Corr, 2011).

**Grief in children and adolescents.** Losing a loved one during the formative years of late childhood and early adolescence may alter the formation of identity. Additionally, the grief process may become complicated by normal adolescent characteristics (Balk, Zaengle, & Corr, 2011; Cait, 2008). Teenagers may not understand ambiguous feelings of missing the deceased while simultaneously feeling angry with the deceased for dying (Balk, Zaengle, & Corr, 2011). Additionally, adolescents want to have an image of being in control and may have difficulty talking about feelings that are out of control (Slyter, 2012). The adolescent is usually seeking for autonomy at the same time as he or she is yearning to be near the deceased (Malone, 2007; Slyter, 2012). This normative process of adolescent individuation must happen posthumously for the child who has lost a parent (Cait, 2008).

Adolescents have a more difficult time than younger children because they engage in abstract thinking; in contrast, younger children can accept death more easily than teenagers due to concrete operational cognition (Piaget,

1962), i.e., younger children accept the *rules* of life. The grieving adolescent may seek explanations for the causes and injustice of the death. The teen will also question the nature of an afterlife (Slyter, 2012; I.C. Noppe & Noppe, 2004). It is common for the bereaved teenager to have difficulty concentrating on academic assignments due to these abstract thoughts (Balk, Zaengle, & Corr, 2011).

**Grief and identity formation.** Identity is formed via human interactions; the grieving adolescent continues to be influenced by the life of the deceased loved one throughout his or her lifetime. Adolescents' developing sense of empathy coincides with his or her increasing ability to comprehend the perspective of another person (McCarter, 2011). The adolescent can choose to incorporate or reject aspects of the loved one's personality and behavior into his or her own identity. This ability to identify strengths and challenges of a loved one matures as the adolescent develops. According to the life course perspective, the loss of a loved one is re-experienced with each significant life event, e.g. at graduation, a wedding, and the birth of children. This growing individual who has lost a primary caregiver is able to better comprehend the deceased parent's perspectives at each turning point of his or her life. He or she may imagine the advice that would be given at each significant life event (Kandt, 1994). For example, one cannot understand challenges of parenthood until one becomes a parent. When one becomes a parent, he or she will relate to memories of his or her own parent in a different way. As one matures, the individual is able to construct a more complete picture of the loved one. This dynamic memory of the loved one must be maintained past the initial grieving period in order to evolve with the individual's cognitive development. Only an adult can understand the complexities of life; one cannot fully connect to what one cannot know (Josselson, 1987; Cait, 2008).

According to Schultz (2007), maintaining a relationship with one's deceased mother was an important resource for value clarification and decision-making. Cait (2008) described the love of the deceased parent as being an inner force for sustenance. Additionally, having a balanced perspective of both the strengths and the challenges of the deceased is necessary. If one only remembers the strengths, the individual will have difficulty connecting with the life experiences of this glorified version. Glorification of the deceased is evident in the parents who immortalize a deceased child as a heroic image; any surviving children may feel inadequate and isolated from these parents (Herberman Mash, Fullerton & Ursano, 2013). Alternatively, if one only remembers the challenges, such as only remembering the dying image of the loved one, the individual will have difficulty drawing strength from the positive

influence of the deceased person. Attempting to avoid grief for the deceased or to obliterate the person's memory is analogous to saying that the person was not important in one's life.

**Spiritual maturation in grieving adolescents.** Maturation of morality and/or spirituality may be expedited as existential questions commonly arise when an adolescent experiences the death of a loved one (Fleming & Balmer, 1992; Balk, Zaengle, & Corr, 2011). Typically, death is not considered a normal event in the life of a teenager; experiencing the death of a loved one shatters the adolescent's belief in his/her own infallibility (Balk, Zaengle, & Corr, 2011). Yet, the inevitability of death has become a reality for the grieving adolescent. The bereaved teen may question his or her personal existence. *To be or not to be* has a new meaning to the adolescent who has lost a loved one (I.C. Noppe & Noppe, 2004; Slyter, 2012).

**Changes in behavioral roles and responsibilities for grieving adolescents.** With the death of significant person, the adolescent has a change in roles and responsibilities before he or she has actually recognized his or her own roles in life (Erikson, 1963). In the case of a loss of a parent, the adolescent may assume some or all of the responsibilities of the deceased (Cait, 2008; Klass, 1987; Fleming & Balmer, 1996). This role may be *off-time* and the teen may have a sense of being thrust into an adult role too soon (Schultz, 2007).

Although adolescence is a time of experimenting with risky behaviors, the intensity of feelings of grief may exacerbate the adolescent's desire to escape from those feelings with activities such as illicit substance use or early promiscuity. Teaching adaptive coping strategies to replace maladaptive behaviors is crucial during this time period (Balk, Zaengle, & Corr, 2011).

**Changes in interpersonal relationships for the grieving adolescent.** After the death of a parent, the relationship with the surviving parent may become either stronger or more confrontational. With the loss of an attachment figure, the teen may seek new attachments with individuals outside the immediate family (Schultz, 2007). The therapist must remember, as stated earlier, that relationships are not interchangeable; "unresolved grief from old relationships interfere with new relationships" (James, Friedman, & Matthews, 2001, p. 32).

Bereaved teens can become *out-of-sync* with peers who do not understand the grief response. Other people may not know what to say or may not feel comfortable discussing grief. The teen may recognize the other person's difficulty with the grief process. The adolescent may camouflage grief in order to spare his or her peers from the

intensity of his or her emotional pain. Youth may also feel a sense of embarrassment, shame, or guilt. Thus, the grieving child's actions may result in feelings of isolation (Balk, Zaengle, & Corr, 2011; Slyter, 2012).

**Implications for Mental Health Professionals**

A large proportion of the population has experienced childhood adversity. Screening instruments may not adequately assess the intra- and inter- personal difficulties arising from trauma exposure. Considering that prolonged stress results in progressive damage to the structures and physiology of the brain and body, there is an urgent need for standardized, efficient, and effective screening tools that could be easily administered in schools and physician offices. The goal of the mental health profession is to further the development of effective and efficient psychosocial assessment and intervention that reduces the negative biological, psychological, and social consequences of adverse childhood experiences for adults and for children.

Expanded diagnostic criteria for PTSD or adding additional trauma- and stress- related diagnostic dimensions to future editions of the DSM could help identify persons with elevated ACE scores, i.e., those in need of integrated biopsychosocial trauma interventions. Alternately, clients could receive services based on their exposure to adverse experience as coded in ICD-10 (see Appendices A & B). Mental health professionals could advocate for the recoding of individual trauma symptoms so that traumatized individuals could receive appropriate care prior to the onset of fatal disease processes.

Mental health clinicians could increase their own understanding of the potential client's needs by understanding the biological, psychological, and social effects of experiencing childhood adversity. Informed mental health professionals can plan treatment based on these biopsychosocial needs for clients with histories of complex trauma. Psychoeducation normalizes the reactions. The client is taught methods to reduce the progression of the deleterious effects of prolonged stress. When applicable, the causes of death and the wide range of grief reactions are also included in the client's education. The therapist allows the client to express a variety of feelings and displays nonjudgmental acceptance of the client. When the client has a sense or experience of connection and attunement with the therapist, there is a ventral vagal connection between the therapist and the client allowing for the relaxation of the stress response (Geller & Porges, 2014). Additionally, the therapist models a healthy relationship so that the client implicitly learns how to reverse previously negative relationship patterns. The client

also learns to reduce his or her frequency of disengaging from non-toxic social interactions. The clinician emphasizes the importance of remembering and tolerating both the pleasant and unpleasant times in life. The trauma-informed therapist strengthens personal coping skills, such as the client's relationship to nature, music, journaling, and creativity (Balk, Zaengle, & Corr, 2011).

As positive social interactions are vital for healing, the trauma-informed therapist helps the youth to recognize and strengthen current supportive relationships, especially with his or her primary caregiver. The therapist seeks to increase beliefs in the importance of seeking comfort from others and helps the client to identify supportive and comforting individuals. Specifically, the trauma-informed therapist will promote positive social interactions between the child and the caregiver. Trauma-informed counselors will also help the parent or guardian to increase his or her sensitivity and responsiveness to the child or adolescent by helping the caregiver to explore his or her own attachment history and by increasing reflective functioning. The clinician will also encourage the development of new supportive relationships for both the client and the caregiver as resources for future relief. The therapist helps the client and caregiver take the lead in helping others to feel more comfortable through the use of reflective listening.

The trauma-informed counselor assists the child or adolescent in integrating his or her past experiences with his or her new relationships, roles and responsibilities. The mental health professional helps the client to work through unresolved grief and trauma, then he or she encourages the teen to develop a sense of meaning and personal growth (Tedeschi & Calhoun, 1996; Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2012). The mental health professional also helps the client to explore personal beliefs about self, others, the world, and the future. The trauma-informed clinician educates the client about resources to promote adaptive self-care behaviors, such as a healthy diet, adequate sleep, and physical exercise (Cohen, Mannarino, & Deblinger, 2006).

An individual who has experienced prolonged stress and/or injury to schemas of self and other may avoid seeking mental health counseling because of the stigma associated with receiving mental health services. The social worker can reduce the stigmatizing effects by communicating that everyone could use support (Balk, Zaengle, & Corr, 2011). The therapeutic relationship may be the client's only chance to talk through: (a) the changes in his or her relationships; (b) his or her role changes; (c) the healthy management of his or her grief- and trauma- related symptoms; and (d) the integration of the past and the present into a coherent sense of self (Schultz, 2007).

## Chapter 2. Trauma-Focused Interventions

According to stringent reviews of meta-analytic studies of the American Psychiatric Association (APA), the American Academy of Child and Adolescent Psychiatry (AACAP), the International Society for Traumatic Stress Studies for Children and Adolescents (ISTSS), the British National Institute of Clinical Excellence (NICE), and the Australian National Health and Medical Research Council (NHMRC), TF-CBT is recommended as the first-level, best clinical practice for the psychological treatment of PTSD in children and adolescents (Forbes et al., 2010). Forbes et al. (2010) specified that clinical practice guidelines were based on well designed and conducted random controlled trials (RCTs) with large sample sizes plus replicated clinical effectiveness trials. Studies with small sample sizes, large attrition rates, or lack of double-blind status were excluded from analyses.

### Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT: Cohen, Mannarino, Deblinger, 2006) was designed for children ages 3 to 17 years. Cohen, Deblinger, and Mannarino (2006) used the acronym *P.R.A.C.T.I.C.E.* to describe the components of Trauma-Focused Cognitive Behavioral Therapy, i.e., psychoeducation, relaxation, affect modulation skills, cognitive coping skills, trauma narrative work, in-vivo mastery of trauma triggers, conjoint and individual sessions with parents, and ensuring safety. Clients are proficient with psychoeducation, relaxation, affect modulation skills, cognitive coping skills before the trauma narrative is told. Cohen and colleagues advised that skills are practiced throughout the program.

Psychoeducation, to normalize the client's experience, should include information about trauma, stress, trauma symptoms, and physiological responses to stress and trauma. Psychoeducation also includes basic information about emotions and thoughts. Relaxation, affect modulation, and cognitive coping skills, taught early in program, provide client with internal resources important for managing and constructing his or her trauma narrative. Rescripting or *working through* the narrative is a method of finding new meanings and redefining the self and one's role in life. Conjoint parent sessions are informed by knowledge from object relations theory, attachment theories, and family systems theory. Sessions with the parent or guardian are held after the child has processed the story. The parent has worked separately to learn the same skills as the child. The parent has confronted his or her own *ghosts in the nursery* and increased reflective functioning. The parent is ready to respond in an effective way with the child.

Ensuring safety is an important conjoint process where the caregiver and child make a plan to maintain skills acquired during therapy.

TF-CBT also recommends grief components when indicated. According to Cohen, the client grieves for his idealized representations of his *good parent* images and for the lost of his childhood innocence. He or she may also be grieving for the loss of his or her own sense of worth.

TF-CBT has been criticized for excluding clients with complex trauma in the RCTs. Cohen, Mannarino, Kliethermes, and Murray (2012) responded to this criticism with specific essential elements for trauma-focused cognitive behavioral therapy for complex trauma (TF-CBTCT; Cohen et al., 2012). TF-CBTCT recommends that ensuring safety is first and last. Due to the nature of posttraumatic responses and the negative impact on development from early and frequent adversity, the standard number of treatments (8 to 12 sessions) is extended to between 30 and 50 sessions. Additionally, treatment is divided into three distinct phases. Phase one is a skill-building phase encompassing psychoeducation about trauma and grief, relaxation, emotion regulation, and cognitive coping. Phase two is for creating and processing the trauma narrative. During phase two, the therapist meets individually with the parent or guardian to share the child's progress and validate the caregiver's feelings regarding his or her child's experiences. Phase three is a consolidation phase where the therapist meets with the parent or guardian and the child allowing the child a chance to tell his or her own story. During phase three, the parent or guardian gains new insight into how adversity has affected his or her child. Towards the end of phase three, the child and caregiver devise a specific and detailed plan for safety with in-session practice of that plan.

### ***Promising Practices*** **for Helping Those with a History of Complex Trauma**

Forbes et al. stressed that RCTs do not always coincide with clinical practice. Amaya-Jackson and DeRosa (2007) recognized as the *most promising practices* the following interventions: Attachment, Regulation, and Competence (ARC: Blaustein & Kinniburgh, 2010); Trauma Systems Therapy (TST; Saxe, Ellis, & Kaplow, 2007); Child Parent Psychotherapy (CPP; Lieberman & Van Horn, 2008); Intergenerational Trauma Treatment Model (ITTM; Copping, Warling, Benner, & Woodside, 2001); Integrated Treatment of Complex Trauma for Children (ITCT-C; Lanktree and Briere, 2012); Real Life Heroes (RLH; Kagan, Douglas, Hornik, & Kratz, 2008); and, Seeking Safety (Najavits, Weiss, & Liese, 1996).

**Attachment, Regulation, and Competence (ARC).** Kinniburgh, Blaustein, and Spinazzola (2005) developed Attachment, Regulation, and Competence (ARC) with the help of the National Child Traumatic Stress Network (NCTSN), a division of SAMSHA, specifically for children who have histories of complex trauma. ARC is an attachment-based intervention and requires approximately 50 sessions. Rather than a manualized treatment model, ARC is a component-based framework (Lawson & Quinn, 2013). The nine blocks of ARC arranged in three domains include focal points involving caregiving behaviors, the child's self-regulation skills, the child's competency skills, and integration of the child's traumatic experiences. ARC may be delivered to groups of parents, in family therapy, in individual therapy, or in home-based services. Arvidson and colleagues (2011) demonstrated the effectiveness of ARC for significantly improving Child Behavior Checklist scores (CBCL; Achenbach, 1991; Achenbach & Rescorla, 2001).

**Trauma Systems Treatment (TST).** Saxe, Ellis, and Kaplow (2007) developed Trauma Systems Therapy (TST) in conjunction with the National Child Traumatic Stress Network (NCTSN) with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). With a collaborative, team approach and an ecological framework, TST engages entire systems in the care of the child or adolescent who has been traumatized. First priority in TST is to establish safety for the child. The team uses the TST Assessment Grid (Table 1) assessing both social-environmental stability and emotional/ behavioral dysregulation to determine the phase of treatment to implement. The phases of treatment are listed below.

Table 1. TST Assessment Grid of Social-Environmental Stability and Emotional-Behavioral Regulation

| | Stable | Distressed | Threatening |
|---|---|---|---|
| Regulated | Phase 5: Transcending | Phase 4: Understanding | Phase 3: Enduring |
| Emotional Dysregulation | Phase 4: Understanding | Phase 3: Enduring | Phase 2: Stabilizing |
| Behavioral Dysregulation | Phase 3: Enduring | Phase 2: Stabilizing | Phase 1: Surviving |

TST phases are determined by social-environmental conditions and emotional and behavioral regulation. The purposes of the first phase, surviving, are to "protect the child from threatening [social] environment and dangerous impulses and to set the stage for other phases" (Saxe, Ellis, & Kaplow, 2007, p.126). Hospitalization may

be warranted for suicidal or impulsive impulses. Affect modulation skills can be taught during the first phase. Psychopharmacological intervention is typical. Treatment during phase one may be home-based or community-based. Advocacy for additional services is necessary, such as "special education, mental health, social services, housing, or immigration" (p. 128). If begun, the surviving phase may last three months.

During the second phase, stabilizing, home-based interventions help to create a safe home environment and to diminish stress and trauma triggers in the home. "In-the-moment" skills are used to help the client and family to manage the difficult environment. Frequently, psychopharmacological intervention is used in the second phase. If begun, the stabilizing phase may last three months.

The third phase, enduring, is an office-based program to help minimize extreme behaviors. The beginning of the third phase may overlap with the second phase, i.e., home- or community- based treatment are typically reaching completion during the first part of the third phase. The enduring phase should last at least three months.

Cognitive- behavioral therapy (CBT) is begun and affect modulation skills are completed during the fourth phase. Communication skills are enhanced and therapeutic processing of the trauma has begun during this phase as the child can talk about the traumatic event without becoming emotionally overwhelmed. Saxe and associates specified that pharmacological intervention should no longer be necessary in the fourth phase.

The purpose of the last phase, transcending, is to create "lasting meaning and perspective out of the traumatic experience" (p. 127). The therapist helps the client to define life more by the future than by the past. The transcending phase can last up to two months.

Saxe, Ellis, and Kaplow (2007) posited that the traumatized individual can only learn new skills when he or she is in an emotionally regulated state. The other three emotional states are revving, re-experiencing, and reconstituting. When a traumatized client encounters trauma- and/or loss- reminders, he or she will enter a revving state during which time only well-practiced skills will be useful. During the re-experiencing state, the therapist will attempt to keep the client safe. Once the client moves out of re-experiencing, he or she will be in the reconstituting state, i.e., a vulnerable state. The therapist can encourage the client to show compassion toward him- or her- self during the reconstituting state; the client may want to avoid any known triggers during this vulnerable time.

**Child Parent Psychotherapy.** Child Parent Psychotherapy (CPP; Liebermann & Van Horn, 2005) was originally developed for children from birth to age 6 years. CPP is an attachment-based intervention and includes

approximately 50 conjoint sessions focusing on the caregiver's relationship with his or her child. The therapist works to increase the caregiver's ability to read his or her child's cues, especially regarding traumatic material. The caregiver learns to decrease hostile attributions of the child's behavior. Lieberman and Van Horn stressed that the goal of CPP is to enhance the caregivers' abilities rather than to rescue the child. The CPP therapist uses specific ports of entry to cultivate the relationship between the caregiver and child. Dowell and Ogles (2010) explained that a meta-analytic review of forty-eight studies demonstrated that interventions focusing on caregivers compared to child-only interventions had improved outcomes ($d = 0.27$). Additionally, Ghosh-Ippen, Harris, Van Horn, and Lieberman (2011) tested the effectiveness of CPP with 75 children aged 3 to 5 who had been exposed to physical abuse, sexual abuse, domestic violence, or separation from his or her primary caregiver. There were significantly greater reductions in traumatic stress symptoms and depressive symptoms in children with four or more stressors compared to the control group.

**Intergenerational Trauma Treatment Model.** Copping, Warling, Benner, and Woodside (2001) developed Intergenerational Trauma Treatment Model (ITTM) for caregivers of children aged 3 to 18 years old. Copping et al. recognized that many caregivers of children with complex trauma have experienced multiple adversities themselves. In order for the caregiver to become a secure base and safe haven, ITTM focuses much attention on helping caregivers to resolve their own traumatic experiences. Caregivers learn emotional regulation skills and empathic reflective listening.

ITTM usually meets for 21 sessions. The first six sessions are 90-minute multifamily group sessions. This first phase teaches caregivers about trauma, attachment, emotional regulation, empathy, and therapeutic response to child's dysregulated behaviors. Additionally, participants learn CBT skills to connect trauma themes arising from adverse experiences and current behavior. The second phase includes eight individual sessions with caregivers to discuss caregiver's beliefs about the adversity itself and talking about adversity with his or her child. The third phase includes 3 to 8 sessions of conjoint sessions of child, caregiver, and therapist.

**Integrated Treatment of Complex Trauma for Children (ITCT-C).** Lanktree and colleagues (2012) designed the Integrated Treatment of Complex Trauma for Children (ITCT-C) for individuals aged 8 to 12 years old. ITCT-C usually consists of 16-36 sessions and is component-based. In addition to TF-CBT, ITCT-C incorporates titrated exposure, structural family therapy, and a focus on increasing self-esteem and agency. Effectiveness studies

suggested a correlation between significant reduction in traumatic stress symptoms and length of involvement in ITCT-C (Lanktree et al., 2012).

**Real Life Heroes.** Kagan, Douglas, Hornik, and Kratz (2008) developed Real Life Heroes (RLH) as a manualized curriculum requiring weekly meetings for 6 to 18 months. Nonverbal activities are interwoven with biographies of ethnically matched heroes who have survived and thrived beyond difficult life circumstances. The child learns to write a life story that honors his or her experiences and losses while restructuring cognitions to make sense of traumatic experiences. Like ITCT-C, effectiveness studies suggested a correlation between significant reduction in traumatic stress symptoms and length of involvement in RLH.

**Seeking Safety.** Najavits, Weiss, and Liese (1996) developed Seeking Safety as a structured, group-based, cognitive-behavioral treatment program for women having both PTSD and substance use disorder (SUD). Twenty-four 90-minute sessions are to occur twice weekly for three months. Each session is present-focused and consists of: (1) approximately five-minutes per person check-in; (2) a group tally of abstinence, attendance, and completion of homework; (3) daily quotation chosen by group members; (4) agenda of lesson for the session; (5) experiential exercises involving the daily lesson; (6) homework review of last session's homework; and, (7) closure for summations and homework assignment. After two initial, individual sessions for contracting and HIV counseling, participants complete two introductory group sessions, seven group sessions regarding behavioral skills, six group sessions for cognitive skills, six group sessions for relationship skills, and three group sessions focusing on termination.

Najavits, Weiss, Shaw, and Muenz (1998) demonstrated that Seeking Safety is promising in that women who completed at least six sessions displayed improved psychosocial functioning. This study was limited in that it did not include a control group. However, Najavits et al. reported a 63% retention rate which they considered "higher than most other studies of substance abuse populations with comparable lengths of treatment" (p. 451). Additionally, Najavits et al. noted that the study's completers were those who were more significantly impaired compared to those who did not complete the program.

Najavits, Gallop, and Weiss (2006) provided preliminary evidence of possible effectiveness of using Seeking Safety in a small sample of adolescent girls (n=33). Najavits and associates suggested that early intervention can facilitate change for co-occurring PTSD and SUD.

**Structured Sensory Intervention for Traumatized Children, Adolescents, and Parents**. Steele and Raider (2001) designed Structured Sensory Intervention for Traumatized Children, Adolescents, and Parents (SITCAP) based on neuroscience research that traumatic symptoms are sensory rather than cognitive experiences. Levine and Kline (2008) and Van der Kolk (2014) concurred that the focus of intervention must initially be sensory-centered. Perry (2009) described the sequential nature of neurological development and suggested to allow therapy to follow the same pattern, i.e., begin with repetitive, rhythmic activities, such as dancing or drumming; proceed to increasing awareness of body sensations, then encourage an awareness of emotions; and, the last therapeutic task would be cognitive work, such as working with core beliefs.

**Schema-Focused Cognitive Behavioral Therapy**

The foci of schema-focused cognitive behavioral therapy (SFCBT; Young, 1990; Young, Klosko, & Weishaar, 2003) are the establishment of healthy core beliefs and the reduction of maladaptive core beliefs. SFCBT was originally developed to help the clients for whom traditional cognitive-behavioral therapy had not been effective. Young and colleagues (2003) stated that the overall objective of schema therapy is to reduce maladaptive schemas and promote healthy schemas. SFCBT has been proven effective with adults demonstrating personality disorders (Bamelis, Evers, Spinhoven, & Arntz, 2014; Sempértegui, Karreman, Arntz, & Bekker, 2013) and substance use disorder (Daneshjoo, Navabinejad, & Shfia-Abadi, 2015). SF-CBT has shown promise with adults having symptoms of depression (Malogiannis et al., 2014; McBride, Farvolden, and Swallow, 2007; Riso, Maddux, and Santorelli, 2007; Swallow, 2000), obsessive-compulsive disorder (OCD; Sookman and Pinard, 2007; Waller, Kennerly, & Ohanian, 2007), and eating disorders (Waller, Kennerly, & Ohanian, 2007). There is theoretical justification suggesting that SFCBT would be helpful to reduce the anxiety of psychosis (Morrison, 2007), and the depression and anxiety associated with posttraumatic stress disorder (PTSD; Gray, Maguen, & Litz, 2007).

Aaron T. Beck (1967) originally included core belief work as part of cognitive behavioral therapy (CBT). MacArthur (2013) noted that as CBT became more manualized, in order to be more easily replicated and studied, attention was placed on conscious, automatic thoughts with increasingly less emphasis on core beliefs. Manualization allowed CBT to be tested in large clinical trials. Random control trials (RCTs) have empirically-proven the effectiveness of CBT with specific populations; however, RCTs typically do not include those with early-

onset, severe, ongoing, multiple, and/or chronic exposure to adverse experiences, i.e., those with histories of complex trauma (CT). These CBT-resistant clients are frequently labeled as difficult or uncooperative and tend to prematurely terminate CBT. Many clients in clinical caseloads are these CBT-resistant individuals who also frequently have histories of exposure to multiple adverse experiences of early onset and/or ongoing nature.

Considering the pervasive and powerful influence of core beliefs on behavior, Young (1990) developed Schema Therapy, or Schema-Focused CBT (SFCBT), to shift the focus of psychotherapy back to core beliefs. According to Young, Klosko, and Weishaar (2003), schema therapy is an integration of CBT, psychoanalytical, object relations or attachment, Gestalt and constructivist perspectives. Young and colleagues identified 18 possible maladaptive schemas, three coping styles, and four main modes for each person. The following is a list of the three domains and 18 maladaptive schemas identified by Young et al. In the Disconnection and Rejection Domain are: (a) Abandonment/ instability; (b) Mistrust/abuse; (c) Emotional Deprivation; (d) Defectiveness/ shame; and, (e) Social Isolation/ alienation. In the Impaired Autonomy and Performance Domain are: (f) Dependent/ incompetent; (g) Vulnerability to Harm or illness; (h) Enmeshment/ undeveloped self; and (i) Failure. In the Domain of Impaired Limits are: (j) Entitlement/ grandiosity; (k) Insufficient self-control/ self-discipline; (l) Subjugation; (m) Self-Sacrifice; (n) Approval-seeking/ recognition-seeking; (o) Negativity/Pessimism; (p) Emotional Inhibition; (q) Unrelenting Standards/ Hypercriticalness; and, (r) Punitiveness.

Any of the 18 maladaptive schemas may be manifested in one of three coping behavior styles: surrender, avoidance, and compensation. Surrender behaviors are indicative of acceptance of the maladaptive schema as truth. Avoidance behaviors may include substance abuse and self-harm behaviors. When individuals are utilizing avoidance behaviors, he or she avoids thinking about the maladaptive schema. When the person recognizes the existence and attempts to disprove the maladaptive schema, he or she may exhibit compensatory behaviors. An individual may use different behavioral styles for each active maladaptive schema. Young noted that the *difficult* clients often display behavioral manifestations of multiple maladaptive schemas. Young added that persons with early abuse and abandonment histories often present with nearly all of the 18 maladaptive schemas.

According to Young, Klosko, and Weishaar (2003), each person, clinical or non-clinical, operates in one of four modes: the vulnerable child mode, the detached protector mode, the dysfunctional parent mode, and the healthy adult mode. Young and associates described that the non-clinical person is capable of integrating these modes and

typically reacts to activation of a maladaptive schema with mild mood swings. Those persons presenting in clinical situations will exhibit distinct mode activations. The detached protector mode is an immature defense mechanism shielding the vulnerable child from feeling pain or expressing unpleasant emotions. The dysfunctional parent mode is also an immature defense mechanism driving the vulnerable child to surrender, avoid, or overcompensate for any maladaptive schema. Conversely, the inner healthy adult: negotiates with the detached protector and the dysfunctional parent in order to gain access to the vulnerable child; allows for the recognition and expression of all emotions; and, is nurturing and supportive. The aim of schema-focused, mode work is to help the client to empower his or her inner healthy adult to allow his or her inner, vulnerable child to be heard and validated.

Kinniburgh, Blaustein, and Spinazzola (2005) perceived aggression as a coping behavior formed as a result of insensitive, abusive, or neglectful parenting. Young and associates (2003) concurred that the individual with a history of adverse childhood experiences frequently holds anger, a concept congruent with Bowlby's proposition. According to schema therapy principles, the vulnerable child vents anger in order to validate his or her own rights as human beings. Clients learn that all human beings deserve to be treated with respect, affection, attention, understanding, protection, and that each human has the right to the honorable expression of feelings and needs. In expressing anger, the client asserts that he or she *deserved better than what happened as a child* and gains emotional distance from the dysfunctional parent image. The client renders maladaptive schemas as distinct and separate from his or her identity, finds emotional strength to dispute the maladaptive schema, and formulates a healthy and functional internal script separate from the script created by the adversity.

Young (1990) developed the schema classification system based on the most common early maladaptive schemas. The client's active maladaptive schemas are converted gradually to new, more functional schema by using traditional CBT techniques, such as continuum methods, scaling or rating, historical review for evidence of previously ignored healthy schema, positive data logs, and Socratic questioning (McBride, Farvolden, & Swallow, 2007). Riso, Maddux, and Santorelli (2007) emphasized that, unlike traditional CBT, SF-CBT incorporates attachment history and early childhood experiences into the problem formulation and treatment. Young, Klosko, and Weishaar (2003) recommended specific cognitive, behavioral, and experiential goals for each of the 18 maladaptive schemas.

Young (2005) integrates attachment theory with schema therapy via the therapeutic relationship, i.e., the therapist temporarily acts as a secure base or substitute parent for the client whose own parents had been insensitive, inconsistent, non-nurturing, or unavailable perhaps due to substance abuse, mental illness, incarceration, or their own unresolved traumatic histories. Young, Klosko, and Weishaar have provided specific guidelines for the therapist to follow for each of the 18 maladaptive schemas.

Many schemata are organized before an individual has learned language; therefore, early schemata are stored in the unconscious mind, i.e., implicitly. Without conscious involvement, reminders of part of a schema, such as an old song or smell, may activate other aspects of the schema, such as bodily sensations, emotions, or the stress response itself. A person may experience significantly intense reactions without any knowledge about the source of his or her distress.

Research is needed to extend the usefulness of schema therapy to children and adolescents who have experienced adversity. The effectiveness studies of Deactivation Mode Therapy (DMT; Bass, van Nevel, & Swart, 2014; Swart, & Apsche, 2014), a variation of SFCBT, have suggested effectiveness; however, DMT focused on negative beliefs and required parental attendance at every session. In contrast, the proposed program in this thesis focuses on strengthening positive, healthy core beliefs and attempts to support and include parents or guardians through written correspondences.

**Components of the Building Healthy Core Beliefs Curriculum**

Integrative trauma-informed psychotherapy for children and adolescents who have experienced early-onset, chronic, ongoing, and/or multiple adversities includes enhancing trauma-focused cognitive behavioral therapy with empirically-proven aspects of attachment-based interventions, schema therapy, neurobiological research, narrative therapy, and existential principles. The approach proposed here, based on a synthesis by this author of the existing treatment literature, will help children and adolescents between 8 years and 14 years of age to understand the physiological and psychological consequences of trauma, recognize personal strengths, expand understanding and utilization of social support, enhance self-understanding, and build self-compassion. The overall objectives of the integrated treatment model are to help the participant to become the author or agent of his or her own life; to accept and grieve losses; to resolve unfinished business; to view problems caused by adversity as ego-dystonic, i.e.,

external to one's own identity; to recognize that traumatic experiences are only one part of a much larger picture; and, to integrate psychological, emotional, physical, and spiritual aspects of self.

The purpose of the *Building Healthy Core Beliefs* curriculum, phase one of the integrated model, is to provide the skills necessary for an individual to begin phase two of the program. The aims of *Building Healthy Core Beliefs* are to be able to recognize, express, and manage emotions in self and empathize with others; to replace inaccurate and unhelpful thoughts with accurate and helpful thoughts; to recognize the impact of adverse experiences on core beliefs about the future, the world, other people, and the self; and, to replace maladaptive core beliefs with healthy core beliefs. The expected outcomes of *Building Healthy Core Beliefs* are increased self-compassion, improved emotional and behavioral regulation, and improved connections with parent or guardian.

**Manualized and school-based.** Rolfsnes and Idsoe (2011) emphasized that manualized studies can be replicated; therefore, *Building Healthy Core Beliefs* is a manualized program. *Building Healthy Core Beliefs* may be used in a school or office setting. The concluding chapter of this thesis, Chapter 5, presents the entire Building Healthy Core Beliefs manual.

**Therapeutic relationship.** The therapeutic relationship becomes the secure base and safe haven for the child and the caregivers. The therapist treats the client and family with positive regard, accurate empathy, and authenticity (Rogers, 1951). As Linehan (1993) recommended, the therapist expresses unconditional acceptance of the client including an understanding of the functional benefits the client obtains from maladaptive behaviors and beliefs, i.e., the clinician has an attitude of empathy for the client's avoidance behaviors and attempts to reduce or eliminate emotional and physical pain.

Using polyvagal theory and neuroception, Geller and Porges (2014) explained the biological justification that the therapeutic relationship is an effective and essential component of treatment. Polyvagal theory is explained in chapter one of this thesis. Using the fact that sensory and motor neurons run between the organs of the body and the emotion center, Geller and Porges explained neuroception as each person's vagal-visceral connection to his or her surroundings such that safety in the environment is *felt viscerally*. In other words, people have *gut feelings* about whether another person is safe. Geller and Porges defined ventral vagal connection as occurring when the nondefensive, consistent, open, and well-grounded therapist connects to the client's physiology calming the stress

response and instilling a sense of safety. Geller and Porges declared that within this therapeutic space the client may be willing to engage in the deeper work of therapy, i.e., confronting emotional pain and psychological struggles.

**Intervention should be developmentally appropriate.** Perry (2009) emphasized that interventions must be informed by the knowledge of the bottom-to-top, back-to-front, and inside-to-out development of neural pathways and by the knowledge of the effects of trauma. Perry explained that damage or dysregulation at the level of the brainstem or diencephalon needs to be repaired before proceeding to interventions requiring limbic involvement. Activities involving cortical functioning must be reserved for later treatment. As a first step, Perry recommended that neural pathways become organized with frequent, patterned, rhythmic stimulation. Sensory information is allowed to travel to the limbic and cortical systems along these organized pathways. Examples of useful patterned and rhythmic activities include dancing, yoga, deep breathing, or drumming. Perry stressed that once the child has some sense of self-regulation, then the therapist can incorporate play and art activities to improve interpersonal interactions and self-esteem. Perry asserted that the use of verbal and insight-oriented approaches, such as cognitive-behavioral techniques, would be most beneficial after the child has acquired some sense of self-regulation and secure attachment to a primary caregiver.

**TFCBTCT components.** As stated earlier, the components of Trauma-Focused cognitive behavioral therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006) with the additional recommendations for those with complex trauma (TF-CBTCT; Cohen et al, 2012) include ensuring safety; psychoeducation about trauma, stress, and grief; skill training and practice to increase relaxation, affect modulation, and cognitive coping; parallel individual sessions for children or adolescents and caregivers; narrative component to include trauma themes; in-vivo mastery of triggers; and, conjoint sessions of caregivers and children together. The integrated, biopsychosocial trauma intervention proposed here also incorporates these TF-CBTCT components. Additionally, the following suggestions may enhance TF-CBTCT components.

**Ensuring safety.** Saxe, Ellis, and Kaplow (2007) proposed a system for assessing safety. See Table 1 (p. 34 this document) and the subsequent explanation in the *Promising Practices* section of chapter two of this thesis for the chart regarding TST assessment of social-environmental stability and emotional- behavioral regulation. This TST assessment protocol introduces an ecological framework to the TFCBTCT program.

**Psychoeducation.** Siegel (2012) suggested teaching clients about the two stress response pathways, i.e., quick versus slow pathways, via use of the hand as a model for the brain. The thumb folded into the palm represents the amygdala and the arm represents the brainstem. The forefingers folded over the thumb represent the cortex. Siegel represented the concept *flipping your lid* (Codrington, 2010) as part of the quick response to stress by raising the forefingers away from the thumb and palm. Siegel advocated for telling clients that psychotherapy is about getting the *thinking brain* or cortex into the action, represented in the hand model by folding the four fingers back down. In order to incorporate the contextual details of a traumatic event into one's traumatic narrative, the therapist must first assist the client in calming the automatic stress response. This *contextualization* is necessary for differentiating current reminders of the traumatic event from the traumatic event itself.

**Skill training**: **Do not overwhelm the child.** Blaustein and Kinniburgh (2005) defined survival as the first priority for those with an activated stress response. In this light, Cook and colleagues (2007) emphasized that the client is not capable of higher order thinking when overwhelmed. Therefore, the Building Healthy Core Beliefs clinician is careful not to overwhelm the client. Saxe, Ellis, and Kaplow (2007) stressed that the mental health professional chooses to teach new skills while the client is in a regulated state; therefore, the therapist remains mindful of the client's state of emotional regulation. Alternatively, the clinician reminds the client to use well-practiced skills during the revving state, i.e., when traumatic reminders are threatening to induce a state of re-experiencing. Clinicians must ensure the safety of the client during the re-experiencing state of emotional regulation. Saxe and colleagues suggested that clinicians remain aware and inform the clients of their increased vulnerability to being re-triggered during the reconstituting state, i.e., when the client is exiting the re-experiencing state and attempting to re-integrate into the here-and-now.

**Relaxation.** Mindfulness-based stress reduction (MBSR; Kabat-Zinn et al., 1992; Kabat-Zinn, 2003) encourages mindful awareness of one's breath and body with nonjudgmental acceptance of emotions and wandering thoughts. In an attempt to not overwhelm the client, Building Healthy Core Beliefs teaches active, direct forms of mindfulness, emotion regulation, and cognitive coping skills before attempting open-ended meditations. The therapist is cautioned that individuals who have been traumatized may have difficulty with open-point meditation, i.e., non-directed and passive meditation. The mindfulness skills taught in the Building Healthy Core Beliefs are: (a) here and now awareness; (b) grounding; (c) orientation to the present through attention to the five senses; (d)

acceptance of self, emotions, others, and the environment; (e) a nonjudgmental attitude; (f) a tolerance for distress; (g) loving-kindness meditation; (h) compassion; and, (i) self-compassion.

Neff (2003) defined self-compassion as having three components: (1) being kind and nonjudgmental to oneself in times of difficulty; (2) recognizing that human limitations are shared by all of humanity; and (3) mindfully accepting all thoughts and emotions as passing events. Neff advocated for teaching self-compassion to adolescents to decrease their belief that they are the focus of other people's attention. Neff added, "Those who approach their own experiences with compassion are more likely to have compassion for others" (p. 92). According to Neff, self-compassion shifts the individual's intrinsic motivation away from the building of one's status and towards a genuine caring attitude for all. Germer (2009) defined self-compassion in terms of self-acceptance and emphasized the importance of self-acceptance in doing *heart work,* i.e., experiential work. Building Healthy Core Beliefs emphasizes self-understanding and self-compassion.

**Trauma narration**. Building Healthy Core Beliefs is an initial, skill-building phase of an integrative intervention to help individuals who have experienced multiple, ongoing, and/or early-onset adversity; therefore, trauma narration is reserved for the second phase of the program. Unlike TF-CBT, the proposed integrated biopsychosocial intervention specifies that the trauma narration is merely one part of a much larger life script. Although Cohen, Deblinger, and Mannarino (2006) advocated including other components of one's life in the trauma narrative; however, the proposed intervention recommends clearly stating that the purpose of the second phase is life-scripting and not trauma narration. Additionally, in order to differentiate the past from the present and the future, the life narrative is completed in three separate chapters: (1) Who I was; (2) Who I am; and (3) Who I want to be. Individual sessions with parents or guardians to help them accept the child's narrative are included in phase two. As recommended in TF-CBTCT, conjoint sessions with caregivers and children are included in phase three.

Saxe, Ellis, and Kaplow (2007) suggested the use of an outline that is conducive to whole-life scripting (see pp. 269-275). Saxe and associates also designed emotional regulation worksheets (see pp. 318-324) to help the traumatized child or adolescent to regulate his or her emotions and behaviors. These emotional regulation worksheets may be particularly useful during phases two and three of this biopsychosocial intervention.

**Trauma processing.** Consistent with Cohen and associates (2006), trauma processing includes several reviews of the client's narrative adding *moment-to-moment* details about the client's sensory memories, i.e., contextual details of the traumatic event. Similar to Cohen and colleagues' (2012) recommendations for the treatment of individuals with complex trauma histories, the proposed intervention looks for themes about the trauma rather than recall about specific traumatic events. Considering that individuals with complex trauma histories may have had chronic and/or ongoing exposure to adversity, specific traumatic events may be too numerous to recall. Additionally, events may have happened prior to the child's acquisition of language and would have been implicitly stored. As stated earlier, implicit events do affect one's beliefs, mood, and tone of voice even though they are not recalled.

Unique to the proposed intervention, Building Healthy Core Beliefs (BHCB) focuses on processing the core beliefs inherent to the client's script. TF-CBTCT does give some attention to beliefs about trauma itself; however, TF-CBTCT does not focus on core beliefs about self, other, the world, and the future. Although Mode Deactivation Therapy (MDT; Swart & Apsche, 2014) focuses on maladaptive schemas, BHCB is a strength-based approach emphasizing the development of positive, healthy core beliefs. Note that although the emphasis with the client is on building healthy core beliefs, the maladaptive schemas are not to be ignored.

Questionnaires inquiring about maladaptive schemas would be overwhelming for the child or adolescent who has experienced multiple, ongoing, and/or early exposure to adversity. Therefore, the *Building Healthy Core Beliefs* therapist completes an informal assessment of the client's maladaptive schemas using the child's narrative discourse and the descriptions of the behavioral manifestations of each maladaptive schema as provided by Young, Klosko, and Weishaar (2003).

Young, Klosko, and Weishaar (2003) suggested therapeutic goals for each maladaptive schema. The therapist is cautioned to proceed slowly and work with only one maladaptive schema at a time. In Building Healthy Core Beliefs, working through the maladaptive schemas begins with third person stories of characters with difficult circumstances. The characters in the client's stories will be representations of the four modes proposed by Young, Klosko, and Weishaar (2003), i.e., the vulnerable child, the dysfunctional or critical parent image, the detached protector, and the healthy adult image. Consistent with narrative therapy principles (White, & Epston, 1990), third

person narration distances the client from his or her problems inducing less emotional pain while the client discovers possible resolutions.

Freeman, Epston, and Lobovits (1997) cautioned that the seriousness of adults is obstructive to the creative, playful, and hopeful exuberance of youth. Freeman and colleagues explained how children naturally use play to work through their internal conflicts. According to Freeman and associates, as children discover their own solutions, they develop a sense of agency. Additionally, Freeman and colleagues explained that children personify problems in order to depersonalize the problems; this externalization relieves self-blame, a common issue for children who have experienced interpersonal trauma by an attachment figure.

**Motivational interviewing.** The decision-matrix from motivational interviewing (Miller, 1983) is utilized to increase the client's capacity to make informed decisions which also increases the client's probability of success in therapy. Using stages of change (Prochaska, DiClemente, & Norcross, 1992) would be helpful for parents, therapist, and some children. Stages of change include precontemplation (*no interest in changing*), contemplation (*thinking about changing*), preparation (*making plans for how to change*), action (*doing the steps necessary for making a change*), and maintenance (*learning strategies to help when old habits come back*). Children and parents learn that minor setbacks do not equate with starting at the beginning again.

**Existentialism.** In *Building Healthy Core Beliefs*, the clinician gives attention to the client's experience of existential anxiety. May and Yalom (n.d.) described existential themes that typically induce anxiety in all individuals, including: finding meaning in one's life; accepting the inevitability of death; isolation versus connection; and, freedom or agency in one's life. For the previously traumatized individual, trauma- and loss-anxiety exacerbates existential anxiety.

May and Yalom described that in order to resolve the anxiety due to isolation or lack of connection, an individual must develop the ability to be comfortable with him- or her-self before attempting to connect with trustworthy and reliable others. For the previously traumatized individual, beliefs that others are not reliable interfere with this ability to connect.

According to May and Yalom, freedom or agency in life is directly affected by one's ability to know what he or she wants and wishes. May and Yalom explained that an emotionally-restricted individual does not know what he or she wants or wishes. May and Yalom also explained that freedom or agency is dependent upon accepting

responsibility for one's own actions. May and Yalom described impulsivity, compulsivity, and passivity as: (1) a lack of freedom in life; and, (2) an individual's refusal to accept responsibility for his or her own actions, thoughts, beliefs, and emotions. Therefore, building a sense of agency involves helping the client: to understand and express his emotions; to discover his or her wishes and wants; and, to empower him or her to accept responsibility for his or her actions, thoughts, beliefs, and emotions.

Frankl (1959/2006) provided meaningful answers for a traumatized individual's heightened existential anxiety. Having been exposed to the horrific conditions of a concentration camp during World War II, Frankl identified that it is in within each person to choose what response he or she will have to life's events. Frankl explained that both kindness and cruelty were observed in both prisoners and guards during his internment. Frankl advised individuals that rather than asking the question "Why should I be alive?*",* the more useful questions are "What do I want to do with my life today?*"* and "How do I want to respond today?*"*

**Group Work.** RLH and ITCT-CT have been criticized as lacking any focus on peer groups. As interpersonal skill-building is the focus of phase three of the proposed intervention, group work is included with other families and/ or children who have also experienced adversity. Group work is not included earlier in the program as "some individuals may be retraumatized or additionally distressed by hearing the experiences of others before they have processed and integrated their own reactions" (Briere & Scott, 2015, p.234). With restored security in the attachment relationship, acquisition of intrapersonal skills, and the resolution of trauma and grief, the client will be ready to establish relationships with peers. As beliefs about being able to rely on others frequently do not exist for the individual who has experienced early, chronic, or ongoing adversity, the major goals of this component of the intervention would be to correct maladaptive beliefs about others and foster positive connections with other people. As the therapeutic relationship and the improved caregiver and child dyad have been models for the child, the child or adolescent will be more capable of interacting with his or her peers.

## Chapter 3. Implementing Trauma-Informed Interventions

In an effort to understand how evidence-based, trauma-informed principles are implemented in mental health services, this investigator interviewed three experienced mental health clinicians to obtain their practical advice for implementing evidence-based, trauma-informed mental health services. These interviews were an adjunct

to the investigator's conceptual thesis. Inclusion criteria included that clinicians have extensive knowledge and experience using trauma-informed interventions to treat individuals with histories of exposure to multiple, ongoing, and/or early adverse childhood experiences. Clinicians were identified by the National Child Traumatic Stress Network and/or by local reputation. No compensation was provided to clinicians. No exclusion criterion existed other than clinicians meeting the above conditions who did not wish to participate.

**Method**

Interviews were conducted face-to-face or via the telephone depending on the clinician's availability and preferences. Investigator procured approval for this qualitative study from the Louisiana State University Institutional Review Board (see Appendix E). This investigator reviewed the informed consent document (see Appendix F) with each clinician before the interview. Clinicians were informed that interviewer would benefit from gathering this information to compare the state of knowledge and the state of practice. Although no harmful consequences were anticipated or revealed, the investigator confirmed with each clinician that psychological resources would be available in the event that discussions led to psychological discomfort. Clinicians were reassured that participation was voluntary and that withdrawal from the study was acceptable at any time before or during the interview without penalty or ill-will.

Clinicians were given the choice about whether or not their comments would be confidential. Of the three people interviewed, one clinician chose to remain anonymous. Two other participants gave permission to use their names and the contents of their interviews; however, in order to maintain anonymity for all, participants are identified as "A" or "B" or "C" and are cited as personal communication and the date of the interview is included.

This investigator used a protocol of questions as a guideline (see Appendix G); however, this investigator encouraged the clinicians to share actual experiences and practical information rather than strictly adhering to the protocol of questions. General concepts explored the clinicians' own reflections about: guiding theories and principles; the gap between evidence-based interventions (EBP) and direct practice; current screening instruments; diagnostic codes; statewide initiatives for disseminating and implementing EBP; training of trauma-informed mental health personnel; self-care for the mental health clinician working with traumatized clients; and/or, specific components of interventions.

**Participants**

Participant A, LCSW, BACS has worked as a child and family therapist for 27 years. Currently, Participant A is the executive director of the local Child Advocacy Center where youth and families can receive trauma-focused care to heal from experiences with violent crime. Participant A is a co-founder and provider at one Mind-Body Center in this state. Participant A has served as a first responder after several disasters including hurricanes Katrina and Rita, the Horizon oil spill, the earthquake in Haiti, and in the war-torn Gaza strip.

Participant B, PhD, LCSW has worked as a clinical social worker for 14 years. Participant B completed a clinical fellowship training from a renowned infant mental health center in 2003 and earned her PhD from Louisiana State University in 2007. Participant B also completed post-doctoral clinical supervision and training with Patricia Van Horn, one of the authors of *Don't Hit my Mommy: A Manual for Child-Parent Psychotherapy with Young Witnesses of Family Violence*. Participant B is currently an adjunct faculty member in the local university and has also been serving as the director of a local infant mental health team.

Participant C, PhD, is a clinical psychologist, consultant, and researcher. Participant C has worked for more than three decades as a mental health professional caring for persons who have experienced adverse childhood experiences.

**Advice from the Trauma-Informed Experts**

**Guiding principles.** Participant A (personal communication, March 21, 2016) emphasized that "Having a trauma lens means that one has an overall approach for how a child is seen." Participant A explained the trauma lens as being able to "recognize behavioral issues as trauma-related." Theories of trauma-focused cognitive-behavioral therapy (TF-CBT), attachment theory, and mind-body medicine inform Participant A's guiding principles. "Prevention and resiliency-building are key to helping the person who has been exposed to trauma; [thus] do not wait for people to develop symptoms," said Participant A.

Guiding principles for Participant B (personal communication, March 11, 2016) include aspects of the psychodynamic, cognitive, and behavioral perspectives, especially attachment theory. Participant B summarized her philosophy as "Understanding what has happened to clients and treating the resulting symptoms, while always keeping in mind influencing, contextual factors." Additionally, Participant B explained the historical perspective of

therapy with young children changing from being focused on merely creating safety and control in play therapy to a relationship-based process.

Participant C (personal communication, March 15, 2016) reported that many guiding principles are important including, but not limited to, psychodynamic, object relations, attachment, cognitive theory, and social learning theory.

**Treatment preferences.** Participant B endorsed the use of several relationship-based therapies including Child-Parent Psychotherapy (CPP; Lieberman & Van Horn, 2005), Attachment and Biobehavioral Catch-up (ABC; Dozier, Dozier, & Manni, 2002), Minding the Baby (Slade et al., 2005), Parent-Child Interaction Therapy (PCIT; Hembree-Kigin, & McNeil, 1995), and Circle of Security (CoS; Marvin, Cooper, Hoffman, & Powell, 2002). Participant B emphasized that each parent-child dyad will have unique needs that justify the choice of treatment model to fulfill those needs. Participant B explained, for example, that CoS uses a strengths-based approach, which helps parents see what they are doing well with their children now, as well as how to improve on areas of weaknesses. This is accomplished by helping parents to become aware of how much children want and need their parents, which is sometimes difficult when young children are in foster care.

Participant B also talked about the importance of considering all contexts that may affect a young child: "Systems frequently contribute to the problem so [mental health professionals] need to help address systems involved with the child, [including family, school, neighborhood, legal, etc.]." This is usually accomplished by providing assessments and treatment in the home and school, participating in educational and legal meetings, and advocating for the child in all contexts.

Additionally, Participant B uses elements of TF-CBT, mindfulness, systematic desensitization, Dialectical Behavior Therapy (DBT; Linehan, 1993), and behavioral modification. Participant B explained that systematic desensitization is used to help children who are having traumatic reminders that are interfering with their lives. For example, their clinic recently used systematic desensitization with a 3-year-old child who was intentionally burned in a bathtub and refused to bathe. Elements of DBT are occasionally used in individual therapy with parents who have tendencies of borderline personality disorder. Participant B discussed the importance of learning behavioral techniques to teach the client relaxation when his or her heart rate is elevated, which is often the case with

traumatized children. Participant B described many other situations in which behavior modification is helpful; one example of this may be when correcting sleep disturbances.

Participant B also reported that she uses family therapy with all clients, since her clients are so young and the family is the most important context in which a child should be considered. Additionally, Participant B stated that the parent-child relationship continues to be important in adolescence. Participant A also emphasized the importance of including all caregivers and siblings in psychotherapy in that "trauma affects the entire family." Participant B specified that many clients have four generations in one household and each generation is included in the treatment program. Participant B also stressed that even when grandparents do not live with the child, they frequently may be caring for the child and should also be included in treatment. Participant C also includes multiple generations in the treatment plan.

In addition to mindfulness and TF-CBT, Participant A reported that Filial Therapy (Guerney, 1964) is utilized with traumatized children and their families. Similar to Parent-Child Interaction Therapy (PCIT), Filial therapy works with the caregiver-child dyads in the therapy room while the therapist is outside the room. Instead of using a "PCIT-bug" in the parent's ear, Filial Therapy uses video recordings of the parent and child interactions. Similar to Circle of Security, the filial therapist reviews the videos with the caregiver. Additionally, Participant A stated that *Seeking Safety* is the treatment used with traumatized teens who may also have substance use issues.

Narrative therapy is also a very important part of Participant B and Participant A's toolbox; Participant B explained that trauma narrative work with young children may be completed through drawing, play, or more structured tasks such as narrative story stem batteries. Participant B also explained the usefulness of story stems for verbal children, up to approximately 9 years old. Participant A noted the effectiveness of using puppets, sand tray therapy, art, and other play therapy techniques to help the child tell his or her story.

Employed at a large clinic, Participant C revealed fidelity to Child-Parent Psychotherapy, Circle of Security, and Attachment Biobehavioral Catch-up (ABC). Participant C explained that other psychotherapists in the clinic are able to specialize in various other methods or programs.

**Criteria for receiving trauma-informed services.** Participant B's clients are typically referred due to involvement with the Department of Child and Family Services (DCFS). As such, clients have almost always been involved in at least one traumatic event. These clients are frequently involuntary and may prematurely terminate

when parental rights are terminated or if there is a reunion. The criterion for appropriate termination from relationship-based practice is very unique to each dyad; however, generally, Participant B defined therapy as being successful when "the parent and child are able to sustain the interactive and protective behaviors that were developed in therapy in all contexts." Participant B explained that many families return for "more services and support as different behaviors emerge, a phenomenon very common as children are constantly growing and changing."

Participant C stated, "Stress and suffering on part of child or adult- are enough for some level of treatment." Participant C added that the treatment program should be commensurate with the level of symptomatology. Participant C warned that the psychotherapist should be careful not to pathologize. Participant C explained that some people should not receive treatment because there are no symptoms; for example, some children in foster care have no symptoms. As stated earlier, since Participant A endorsed prevention and resiliency-building, she does not wait for symptoms to develop. This apparent discrepancy points to the need for varying levels of care, e.g., primary, secondary, and tertiary, such that those without symptoms would receive preventive care.

**Initiatives to disseminate and implement evidence-based, trauma-informed principles.** Participant A is involved in two statewide initiatives to disseminate evidence-based, trauma-informed practices: Educating child welfare workers on the use of the screening tools created by Tulane behavioral health (TBH; see www.kidcatch.org for public access to free downloads of trauma resources); and, the Adverse Childhood Experiences (ACE) initiative in Louisiana. Participant A explained that Louisiana is the 8$^{th}$ state to join the initiative. As of this writing, Participant A is a member of the ACE multidisciplinary team.

Participant C credited Michael Scheeringa of Tulane University for his efforts with the Department of Children and Family Services (DCFS). Participant C noted that there has been much progress in the last five years with this statewide initiative to train DCFS workers and clinicians to understand young child symptomatology.

**Assessment measures in trauma-informed care.** Participant B also referenced the statewide initiative using the Tulane behavioral health assessment measures for trauma. Participant B does employ Tulane's behavioral health assessments; however, Participant B expressed concern that many individuals do not report exposure to trauma on a brief screen, for many different reasons. Participant B specified that parents or caregivers usually reveal their own trauma while talking about something else. For example, Participant B often discovers traumatic events

that the parent and child have experienced while administering other assessments, such as the Working Model of the Child Interview (WMCI; Zeanah et al., 1997) or simply while talking to clients.

For the assessment of children, Participant B discussed the importance of measuring attachment parameters using the Strange Situation Procedure (Ainsworth, Blehar, Waters, & Wall, 1978) and the Crowell Procedure (Crowell, Feldman, & Ginsberg, 1988). Participant C also included the Strange Situation and Crowell Procedures as part of the trauma assessment battery.

**Behavioral dysregulation and diagnosis.** Many of Participant B's clients initially present to the clinic with complaints of significant behavioral and emotional disturbances which often mimic signs of ADHD, Oppositional-Defiant Disorder, and even Autism Spectrum Disorders. "Most times," Participant B explained, "when therapists dig deeper, instead of automatically looking for a pill, they'll find that these behaviors are symptoms of trauma or other caregiver-relationship disturbances."

When asked about possible connections between behavioral dysregulation and trauma, Participant A stated that clients quickly see results with proper implementation of trauma-informed care. Participant A provided the example that clients are typically sleeping better within three weeks of initiation of treatment. Participant A also referenced a study from Tulane regarding the misdiagnosis of ADHD and other behavioral disorders. According to Participant A, the study revealed that the subset of children having PTSD also were labeled as having ADHD. Participant A added that ADHD medication would be contraindicated in these children who have history of exposure to a traumatic event.

Participant C also identified the symptoms of PTSD as frequently consistent with symptoms of behavioral disorders. Participant C stressed the need to look at underlying causes of behavior. Participant C added that clinicians should "look at collaterals using a multimodal approach."

**Regarding gaps between evidence-based literature and clinical practice.** As both a researcher and a clinician, Participant C stated, "Clinical work informs research and research informs clinical practice." Participant C noted that people are more interested in becoming trauma-informed, including non-clinicians; however, Participant C expressed concern about some people asking for specific trauma interventions by name, e.g., a judge. Participant C emphasized that the mental health professional must be the person to decide which intervention is appropriate.

Participant C stressed that "education is needed at every level" and that "clinicians, scholars, and academicians need to be talking to each other."

In order to implement evidence-based practices in mental health services, Participant A recommended that everyone needs to be trained, including social workers, teachers, law enforcement, and front-office staff. Additionally, Participant A discussed problems associated with random controlled trials (RCTs). First, there may be difficulties including children who are representative of the children in the clinical population. That is, sample conditions may not match the cultural and symptom conditions of the clinical population. Participant A emphasized that "many good techniques are promising but hidden." Participant A recommended closer collaboration between researchers and practitioners. Participant A cited the example of a program used after Hurricane Katrina that was very cerebral and not focused on skill-building. She explained that this type of program, that had been validated with a RCT, "would only be capable of helping a small subsample of a clinical population." In other words, Participant A is calling for practice-based evidence (PBE; Brendto & Mitchell, 2014).

Participant B listed habit, financial climate, mental health message, and training cost, including time, as the reasons for the gap between research and practice. First, about habit, Participant B stated, "Some clinicians continue to operate on the old model, i.e., the medication and behavioral modification model. A newer model needs to consider that the caregiver-child relationship continues to be most important relationship into adolescence." Participant B continued, "Due to practitioners' concerns about reimbursement, [mental health professionals need to] educate insurance companies and policy makers." Participant B related her experience by serving on committees that provided education to one mental health management company about the definition of face-to-face counseling in infant mental health (IMH), as well as the importance of IMH work, in general. She has also participated in meetings with lawmakers during which she has shared "videos of parents learning to read the child's cues, and [the policy-makers] were stunned with the transformation in children's behaviors in a short period of time."

Secondly, the "financial climate favors the old model." For example, Participant B explained, "Walk-ins are preferred to no-shows; [however,] walk-in appointments tend to be more focused on short-term remedies rather than long-term solutions." Participant B recommended that agency administration and policy-makers "think of the money saved down the road, in terms of long term hospitalizations and legal involvement."

Third, the general mental health message is that something is wrong with the child. Participant B stated, "Mental health professionals should consider that systems cause problems and [systems] can work together to solve [these] problems." The fourth consideration listed by Participant B for the gap is that training for evidence-based treatments is frequently cost- and time- restrictive. Additionally, Participant B noted that there is a need for more trainers who can be available for agencies.

**Training to work with individuals who have been traumatized.** For persons wanting to become trained to work with traumatized individuals, Participant A recommended completing the trauma-focused cognitive behavioral therapy training (see online training available at https://tfcbt.musc.edu) and the mind-body medicine training. Participant A emphasized the importance of the focus on the provider as well as the client that is present in mind-body practice. The book recommended by Participant A is *Windows to Our Children*, by Violet Oaklander. Websites recommended by Participant A include: National Child Traumatic Stress Network (<www.NCTSN.org>); www.acestoohigh.com; Louisiana Children's Coalition; Louisiana Play Therapy Associates; National Children's Alliance; and, National Children's Advocacy Centers.

Participant B recommended that clinicians participate in training programs or workshops in order to meet the needs of the individual with a history of multiple adverse childhood experiences. Participant B also suggested that the clinician engage in intensive one-on-one supervision with experts. Participant B explained the importance of reflecting and reviewing videos of sessions where one case takes one hour to discuss. Participant B also recommended reading books and articles by Charlie Zeanah, Alicia Lieberman, Patricia Van Horn, and Bruce Perry.

Participant C suggested that clinicians become trained to work with traumatized individuals by learning from someone who knows trauma-informed care, knows about the types of presenting symptoms, and works with children in all important relationships in the day, e.g., at school, in the family, in other relationships. In other words, said Participant C, "learn from a clinician who is committed to this multimodal method." Participant C listed favorite authors as Alicia Lieberman, Patricia Van Horn, and Sandra Ghosh-Ippen. One book recommended by Participant C is *Don't Hit My Mommy* by Lieberman and Van Horn. Participant C stressed that all infant mental health material is devoted to trauma. Participant C referenced the website of the National Child Traumatic Stress Network (NCTSN) stating that there are excellent sections on the NCTSN website devoted to young children and specific types of trauma. Participant C liked that the website is updated in real time and changes regularly.

**Reducing vicarious traumatization.** Regarding self-care and reducing vicarious traumatization, Participant B recommended "keeping up-to date." Participant B added, "Keeping up with research every month [is] empowering [in that you] can feel good about what you're doing if you feel you know what you're doing." Of course, Participant B added, "take time off and time away from the clinic." Participant B also endorsed the typical recommendations such as having a good social support network and creating time for rest, relaxation, and reading.

Participant C also suggested to "keep up with developments, [the psychotherapist should be] always learning." Participant C also recommended that the psychotherapist should be aware of what he or she is "getting into." Participant C stressed that the clinician needs to "take care of self" noting that "burn out will not help anyone." Participant C added that clinicians need to also educate front staff in ways to prevent burnout.

In order to reduce vicarious traumatization, Participant A recommended that the clinician learn about him- or her- self through experiential exercises. Participant A emphasized the importance of using mind-body techniques. Participant A shared that she uses mind-body techniques at the start of every staff meeting. Participant A added that she allows each person to express him- or her- self. In this way, workers are receiving support in a confidential and professional atmosphere.

**Advice to agencies to become trauma-informed.** In light of time and cost constraints, Participant A recommended that agencies form creative collaborations with other agencies in order to implement more trauma-informed practices. Participant B suggested that agencies "not become dependent upon funding and reimbursement for services." Participant B stated that tapping into university resources for trainings, research, and staff will reduce the financial burden of an agency while increasing the level of expertise and ability to become *grant-supported.*

Participant C suggested that agencies become informed on the *front end.* Participant C admonishes agencies to think about reasons for making an investment in becoming trauma-informed. Participant C said to consider that the client won't need ongoing treatment if provided with effective care from the onset. Participant C added that there will be a cost to the agency; however, Participant C stressed that the "cost is part and parcel to doing this work." Participant C listed the disadvantage of clinicians missing clinical time in order to become trained; however, Participant C also stated that the advantage of training individuals in one's agency is that those individuals can then train other staff members. Additionally, Participant C warned that agencies should be aware that if clinicians do not know what they are doing, then clients can be harmed.

**Discussion of Interviews**

Given the importance of the attachment relationship, all three of the interview participants agreed that treatment for individuals who have been exposed to multiple adverse childhood experiences includes relationship-based practices. As all three experts had been trained in infant mental health (IMH), each participant explained that all of the infant mental health literature is inherently trauma-informed. One of the participants stressed that the parent-child relationship remains important into adolescence.

Generally, criteria for treatment included "stress and suffering" or exposure to traumatic events rather than meeting specific diagnostic criteria. Behavioral dysregulation was identified as a common trauma-related symptom by all three clinicians. Specific treatment programs or components used were determined by the needs of the individual client. One participant specified that decisions about which program to use should be made by the mental health professional rather than a judge or insurance company.

All three experts endorsed educating everyone about trauma, including clinicians, scholars, teachers, school personnel, law makers, law enforcement, medical personnel, rescue workers, academicians, researchers, insurance companies, members of non-profit foundations, community members, and front-office staff. Additionally, all of these individuals in the community can be collaborating in order to deliver effective and cost-efficient services.

Additionally, the experts agreed that self-care of the psychotherapist is essential for maintaining efficiency. Participants explained that self-care is essential to reduce vicarious traumatization and prevent "burn-out." Self-care strategies suggested included keeping self up-to-date with current research, receiving adequate and intensive supervision, knowing oneself, and maintaining mindfulness practices such as in Mind-Body medicine. Of course, experts endorsed taking time for social support, rest, relaxation, and pleasurable reading.

Although training professionals in an agency to use evidence-based, trauma-informed practices can be costly in terms of finances and time, the participants of this interview agreed that the investment was less costly over time. Additionally, as one participant warned, "If clinicians do not know what they are doing, then clients can be harmed."

## Chapter 4. Conclusions

### Understanding Complex Trauma

In light of the pervasiveness and the severity of physical and mental health consequences for those with histories of early-onset, chronic, ongoing, and/or multiple adverse childhood experiences, effective psychotherapeutic strategies are necessary. This summary contains the themes that have emerged in this thesis regarding the biological, social, and psychological needs of those who have experienced complex trauma.

Rather than being a *conditioned* fear or phobia (Van Horn, 2011), the trauma response is an automatic physiological cascade with subsequent psychosocial difficulties occurring when the individual's abilities to overcome stress are overwhelmed (Briere & Scott, 2015). Reactivation of this involuntary stress response accompanies reminders of the sensory memories, cognitions, or emotions of the original traumatic or loss event (Watts-English, Fortson, Gibler, Hooper, & DeBellis, 2006). Prolonged stress is toxic to brain structures and to the functioning of the metabolic and immune systems. There is a progressive and dose-related correlation between the length of the stress response and the amount of damage. Although phobias may accompany an individual's response to trauma, the phobias are not the same as the trauma-related symptoms. The resolution of the trauma-related symptoms involves calming the stress response. The deconditioning of accompanying phobias is a separate process.

Early-onset, chronic, and/or multiple occurrences of childhood adversity are known as *complex trauma* due to the deleterious effects of trauma on development (Cook et al., 2005). Negative sequelae from childhood trauma extend into adulthood as disruptions to physical and/or mental health (Felitti et al., 1998). Earlier, more frequent, and more varied presentations of adversity are directly correlated with and proportional to greater negative sequelae (Cohen, Perel, Friedman, & Putnam, 2002; DeBellis et al., 1999).

Complex trauma may affect the development of skills and beliefs typically gained in primary attachment relationships, specifically: (a) a model for healthy interpersonal relationships (Bowlby, 1969/1982); (b) healthy core beliefs about self, others, the world, and the future (Young, Klosko, & Weishaar, 2003); (c) the ability to repair a relationship after conflict (Gusella, Muir, & Tronick, 1988); (d) the ability to communicate; and, (e) a sense of agency (Blaustein & Kinniburgh, 2010). With secure attachment, the nurturing caregiver's responsive and sensitive fulfillment of the child's needs communicates implicitly that the child is worthy of having his or her needs met and

that other people can be trusted. Additionally, when the child's communicative attempts to have needs met have been successful, the child gains a sense of agency, i.e., a sense that he or she has some influence on the world. Conversely, when the child's needs are not met, as when the need for protection is not met, the child may believe that he or she is not worthy, other people are not reliable, and he or she cannot influence his or her world. Additionally, the child who has never experienced a resolution of a disrupted relationship may not believe that resolution is possible after conflict.

Due to the disruptions to attachment security, complex trauma interferes with the development of emotional and behavioral regulation (Briere & Scott, 2015; Saxe, Ellis, & Kaplow, 2007; Siegel, 2001; Van Horn, 2011) and the ability to obtain comfort from another human being (Bowlby 1969/1982). Each person has an innate capacity to *mirror* other people's emotional expressions. When the caregiver is responsive and sensitive to the child's emotional state, the child learns to identify and modulate his or her emotions. The responsive and sensitive caregiver teaches the child that another human being can be a source of comfort and an important resource for calming the stress response. When the caregiver is unavailable, either physically or psychologically, the child does not learn to identify and modulate emotions. Without emotional regulation, there is no behavioral regulation. Additionally, without the experience of being comforted by a human being, the child does not hold the belief that he or she can be comforted by a human. That is, a major resource for calming the stress response is not available for the traumatized child.

Healthy interventions for complex trauma should focus on: (a) calming the stress response; (b) repairing the disrupted attachment relationships to the primary caregivers by encouraging positive parent-child interactions; (3) the development of skills necessary for surviving and thriving; (d) improving communication abilities; and, (e) the formation of adaptive core beliefs about self, other, the world, and the future. Additionally, increasing healthy beliefs about conflict resolution and increasing comfort-seeking behaviors are also essential to helping the client achieve maximum potential.

**Regarding Treatment of Individuals with Histories of Complex Trauma**

**About the therapist.** Evidence-supported attitudes and healthy self-care behaviors of the therapist are essential for working with individuals who have histories of complex trauma. Using the knowledge of neuroplasticity, the therapist maintains a belief that the brain is capable of healing after being damaged by prolonged

stress and traumatic experiences. Trauma-related symptoms are perceived as survival behaviors rather than pathological processes.

Before attempting to care for individuals who have been traumatized, the mental health professional must take care of him- or her- self. As Building Healthy Core Beliefs (BHCB) is trauma-informed, attachment-based, and schema-focused, the BHCB clinician will have a thorough knowledge of his or her own history of attachment, trauma, grief, and personal schemas. Additionally, the therapist will have a plan for daily self-nurturance and self-compassion. He or she will participate in adequate and supportive supervision. As BHCB has a strong basis in mindfulness, it is recommended that the BHCB therapist also maintains a daily personal practice of mindfulness meditation.

Biological justification for using genuineness, empathy, and positive regard are explained by Geller and Porges using the polyvagal theory and the concept of neuroception. Sensory and motor neurons provide a bidirectional communication between the brain, the environment, and the body's organs, resulting in a visceral sense of the safety in the environment. Additionally, neurobiological research justifies the use of ventral vagal connections to calm the hyperactive stress response. The therapist employs the ventral vagal connection with his or her own nondefensive, consistent, open, and well-grounded presence helping the client to experience safety in the therapeutic relationship. This *felt safety* is a necessary component before the *deeper work of therapy* can begin (Geller & Porges, 2014). Whether or not the therapist agrees with the client's behaviors and emotions, the therapist pays attention to validating the client's experience (Linehan, 1993).

**Strengths and relationships.** The therapist will pay attention to the importance of delivering relationship-based services. The therapist will also remain dedicated to a strength-based perspective when assisting clients. The therapist serves as a secure base and safe haven for the client. Additionally, the therapist will advocate for the strengthening of relationships across all systems in the client's life.

**Monitoring emotional state.** The therapist is committed to monitoring the client for signs of *revving*, i.e., the initial stages of becoming overwhelmed. The therapist will intervene to prevent or reduce the client's experience of being overwhelmed. Additionally, the client learns to identify and monitor his or her stage of emotional regulation. The client sets his or her own pace in therapy understanding that the goal of therapy is not to become overwhelmed beyond his or her current coping abilities. Additionally, the client learns and practices skills during

regulated states in order to manage him- or her-self for those times he or she is not in a regulated state, especially skills of monitoring one's energy level, grounding, orienting to the here-and-now, considering resources and accomplishments, and expecting that progress may be slow at times and backwards at other times. Due to skill-deficits caused by the disruption to secure attachment and normal developmental trajectories, the client also practices relaxation, affect modulation, and cognitive coping skills with the therapist during his or her regulated states.

**The difference between fast and slow reactions.** The therapist helps the client to normalize reactions and gain relevant and practical skills and knowledge. The therapist teaches the client about the *slow* and *quick* pathways from external environmental stimuli to the brain so that the client can recognize the *quick and involuntary* stress response. The client also learns to accept the associated, involuntary, bodily sensations elicited by the stress response. After calming the stress response and increasing tolerance of unpleasant emotions and bodily sensations, the client will be able to access the contextual details stored in the cortex that had been gathered via the *slow* pathway.

**Basic themes of psychoeducation: Emotions, thoughts, communication, and self-compassion**. The client learns to differentiate emotions and bodily sensations from thoughts and beliefs. The client practices identifying, labeling, and managing emotions. The client increases the use of "I" message to honorably express emotions. The client learns the meaning of ambivalence. The client identifies inaccurate and unhelpful thoughts. The client increases the use of accurate and helpful thoughts. The client increases the use of positive self-talk and positive affirmations. The therapist is also encouraging self-compassion and the use of mindfulness exercises. Additionally, by enhancing the development of secure attachments, the client and his or her family develops the skills to experience ventral vagal connections at home.

**Memory packages.** The therapist helps the client to understand how memories are formed into memory packages and how memory packages combine to form perspectives or filters. The client will recognize that he or she attends to only personally relevant information because of these filters. From the knowledge of memory packages, the client also learns reasons that he or she has experienced *being upset* as conglomerations of *tangled messes*. The client also understands how implicit information affects his or her tone of voice, mood, behavior, and beliefs.

**Schema work.** The client can discover his or her own beliefs, strengths, and accomplishments. The therapist assists the client to disassemble unhealthy biases, i.e., perspectives caused by exposure to traumatic event(s). Using information from Young, Klosko, and Weishaar (2003), the therapist identifies surrendering, avoidance, or compensating behavioral manifestations of activated maladaptive schemas. The therapist uses mode work to help the client's inner vulnerable child to express him- or her- self. The therapist empowers the client's healthy inner adult to assume the role of negotiating with the detached protector and inner critic to allow the inner child to speak. Together, the therapist and the client work to build healthy core beliefs about the self finding evidence for the healthy core beliefs in the client's environment.

**Life narrative work.** After securing attachment relationships and mastering basic coping skills, the therapist will help the client to tell his or her own story with adverse experiences as only one part of that narrative. With the proper tools, the client is capable of objectively relaying both the positive and negative details of his or her journey. Gradually, the client identifies triggers and plans his or her response when avoidance of triggers is not possible. The client recognizes the point in the past when the *trigger* entered his or her *memory package*. The therapist helps the client to identify differences between the current situation and the original triggering situation. Using the new filter of healthier core beliefs, the client can express how he or she may have chosen different actions from those chosen by perpetrators in the past empowering the client to choose his or her own future course of action.

**Existential themes.** The therapist has been listening to the client's conversation regarding his or her anxiety about death, isolation, freedom, or meaning. The therapist will encourage the client to express wishes and wants. Additionally, the therapist encourages the client to take ownership of his or her emotions, thoughts, beliefs, values, desires, choices, and behaviors. Having mastered his or her *internal kingdom*, the client works in the third phase to connect or reconnect to other people. Beginning with the participation of the caregiver-child dyad, the *therapeutic circle* gradually includes a larger network of people. The client's unhealthy beliefs about other people, the world, and his or her future have been replaced with healthier beliefs. Maintenance issues are discussed as the time between sessions gradually increases. Referrals are provided. Clients and families are encouraged to return for booster sessions as needed.

**Regarding Future Directions**

As clinical populations continue to present with histories of multiple, ongoing, chronic, and/or early-onset adverse childhood experiences (ACEs), mental health professionals must be prepared to meet these clients' needs. Empirical studies should further explain the association between ACEs and physical and mental health. Informed by practice-based evidence, evidence-based practices must be disseminated and implemented. In order to care for the needs of these difficult clients, clinicians and researchers must collaborate with each other and with other resources in the communities.

## PART II. THERAPIST MANUAL FOR THE BUILDING HEALTHY CORE BELIEFS CURRICULUM

### Overview for Building Healthy Core Beliefs

This psychotherapeutic curriculum is designed to be used in individual, face-to-face sessions with students in middle school who have a history of multiple adverse childhood experiences. Although a parent or guardian's involvement in the treatment process is desirable, another adult may participate with homework activities after the legal parent or guardian has provided consent.

Building Healthy Core Beliefs is a skill-building phase one of three phases. In Building Healthy Core Beliefs, the child is preparing for the second phase, i.e., life-scripting of his or her narrative. In phase two, adverse experiences are perceived as only one part of his or her life story rather than the defining attribute of one's identity. Additionally, phase two establishes a clear distinction between (1) *Who I was*, (2) *Who I am*, and (3) *Who I want to be*. As recommended by Cohen, Mannarino, Kliethermes, and Murray (2012), phase three is a consolidation phase and will include interactions between the parent or guardian and the child. After completing the family sessions in phase three, participants will work with peer groups.

Each unit of the Building Healthy Core Beliefs curriculum (BHCB) contains materials to be utilized over the course of several therapy sessions. The therapist will allow the client to set the pace. The therapist will make every effort to not overwhelm the client. The immediate concerns of the client will be addressed prior to initiation of any program materials. The following is a list of topics for each unit in this curriculum.

Unit 1. Decision-Making
Unit 2. Beneficial versus Toxic Stress and the Stress Response
Unit 3. Emotions
Unit 4. Thoughts, Affirmations, and Mindfulness Meditation
Unit 5. Perspectives, Memory Packages, and Beliefs
Unit 6. I am loved
Unit 7. I am lovable
Unit 8. I am worthy
Unit 9. I am capable of achieving my goals
Unit 10. Review, Wrap-up, and Graduation

## Inclusion Criteria

Inclusion criteria for this program include that the child or adolescent has at least one of the psychosocial risk factors as specified by the "T" or "Z" codes in the DSM-5 (See Appendices A & B) and has consented to participate in this program. The legal guardian has also consented to allow the child to participate in this program. Additionally, the child/adolescent and/or legal guardian will have completed the Achenbach's system of measurement, i.e., CBCL-PR, and the Telesage Outcome Measure (TOMS) or other outcome measures of psychosocial functioning. Each child will also have on file the teacher's report on the child behavior checklist (CBCL-TRF). The psychotherapist will have completed the child's psychosocial evaluation including questions pertaining to exposure to adverse experiences for the child and family.

## Responsibility of Therapist Before Initiation of Building Healthy Core Beliefs

According to Young, Klosko, and Weishaar (2003), the Schema-Focused Cognitive-Behavioral Therapy (SF-CBT) therapist wants to be aware of and resolve his or her own early maladaptive schemas in order to be available for the client and the caregiver. The therapist serving as a role model of a *healthy adult* provides *limited reparenting*, a secure base for exploration, and a safe haven of protection for the client and the caregiver. Also, the clinician will become aware of his or her own history of attachment relationships. The clinician's own unresolved trauma and grief issues must also be addressed.

## For Discussion with Parent or Guardian

The therapist meets with the parent or guardian and provides an explanation of the study and overview of this program. The clinician, the child, and the parent or guardian's participation work as team members in order to help the child or adolescent. Although adolescents are naturally moving away from home to strengthen relationships with peers and other adults, the clinician emphasizes the importance of the parent or guardian to the child or adolescent. Emphasize that other relationships can be healthier when the parent and child relationship is stronger. The adolescent continues to benefit from the parent or guardian's availability and sensitivity. Encourage the parent or guardian to engage with the child in homework activities. Stress that the child or adolescent will learn the lessons more easily if allowed to *teach* the parent or guardian. Emphasize that homework activities are meant to be fun.

**The Past Influences the Present.**

Explain that *memory packages* develop during childhood and adolescence. These memory packages contain sensory memories of sights, sounds, smells, tastes, and touches. Additionally, the emotions and bodily sensations that were felt when a significant event happened may be intertwined with these sensory memories. Memory packages connect to similar memory packages, like a spider web, to shape one's thoughts or core beliefs about oneself, other people, and the world. Frequently, these *spider webs* or *schemas* developed before one had the language to understand what was happening. Frequently, people are not consciously aware of their beliefs about themselves, other people, or the world. Unconscious beliefs can influence mood, tone of voice, and behavior (Young, Klosko, & Weishaar, 2003).

**The Stress Response and the Development of Core Beliefs.**

In order to normalize the client's experiences, Cohen, Mannarino, and Deblinger (2006) stressed the importance of psychoeducation about the range of traumatic responses. It is important to not pathologize instinctive defense mechanisms. When the survival instinct is normalized, the person can learn to recognize and cope with the intrusion of the past on the present-day beliefs and behavior. When someone does not understand that his or her reactions to abnormal events was normal, the person may think that he or she is *broken, not good enough, unlovable, not capable of leading a normal life*, or *not capable of dreaming about the future*. Any thoughts similar to these are called unhealthy core beliefs.

**Survival, Memory, and Triggers**

The stress response, i.e., the *fight-or-flight* response, is an automatic and fast cascade of events to ensure survival (Levine & Kline, 2007). There is typically no involvement of the cortex, i.e., the *thinking* part of the brain, in this quick-action response system. Details of dangerous situations are stored in the cortex and may seem disconnected from the memories of bodily sensations and emotions experienced during stressful events. In other words, it is not unusual for persons who have experienced adverse experiences to forget some important details of the original event. A present-day sight, sound, smell, taste, or touch may *trigger* the stressed person's *memory package* of long ago. It may be difficult for the individual to tell the difference between a present situation and a

dangerous situation from the past. It is important for the therapist to also be mindful of the possibility of ongoing trauma in the client's life. If the client's environment is currently dangerous, the client and the parent or guardian will need help to formulate and implement an action plan ensuring the individual's safety.

**Energy and Attention Levels**

The survival instinct can *trigger* so many painful memories and emotions that the *stressed* person may have the sense of being overwhelmed. When overwhelmed, a person naturally and biologically is not capable of paying attention and concentrating, i.e., the traumatized and triggered individual is not in a *thinking and learning state*. It is important for the individual to be able to rate his or her own energy state (Table 2; Blaustein & Kinniburgh, 2010). Notice that the scale below has a "-1" rating for the "Freeze" condition. The Freeze condition is also part of the *Fight-or-Flight* response. Saxe, Ellis, and Kaplow (2007) emphasized that an individual learns new skills only in the relaxed state, i.e., between +4 and +6 on scale below. In *Building Healthy Core Beliefs*, the child or adolescent will learn new coping skills while in the relaxed state to help him or her reduce the feeling of being overwhelmed in the non-relaxed state.

Table 2. My Energy Scale (Blaustein & Kinniburgh, 2010)

| -1 | 0 | +1 | +2 | + 3 | + 4 | + 5 | + 6 | + 7 | + 8 | + 9 | +10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Freeze | Low energy | | | | Alert, Aware, Focused | | | Hyperactive | | | |

**Neuroplasticity**

Neuroplasticity means that the brain is growing and changing throughout life. The bad news is that adverse experiences can negatively alter the shape of the brain. The good news is that the brain can be positively altered through positive experiences, such as engaging in healthy relationships and mindfulness. Adolescence can be very exciting because the rapid growth of new pathways in the brain allows the adolescent to learn many new skills. Adolescence can also be frustrating for the parent or guardian because those new pathways to the *thinking* brain have not fully developed. In other words, wires can get crossed before they get straightened out. Many parents can remember how the competent nine-year-old becomes forgetful at age ten or eleven. It is beneficial for parents to remember that this *forgetfulness* means that the brain is growing.

**The Goals of the Building Healthy Core Beliefs Curriculum**

The therapist will discuss the program's goals with the parent or guardian. We will learn about the bodily sensations of the stress response, emotions, thoughts, and beliefs. We will discuss the importance of positive self-talk. We focus on strengths and positive, adaptive behaviors and beliefs because we want to build healthy pathways in the brain. Pathways in the brain are similar to pathways in a forest. The more a path is traveled, the more the soil on the path is compacted. This means that the more a behavior or belief is practiced, the stronger the pathway in the brain will be.

Encourage the parent or guardian's individual and parallel participation in units two through nine. The parent or guardian can expect a letter about the lesson after units one to nine. Encourage the parent or guardian to attend the session in unit ten in order to celebrate with his or her child or adolescent.

**Parent Permission Form and Assessments**

The parent or guardian decides whether or not to sign the permission form. The child's assent form is in the materials for the first unit. If participating, the parent or guardian completes the Healthy Core Beliefs Scale (See Appendix C) and selected questions from the Adult Attachment Interview (George, Kaplan, & Main, 1985). Additionally, the therapist assesses for the existence of psychosocial stressors using DSM-5/ ICD-10 "T" and "Z" codes (See Appendices A & B). The clinician will also assess for the existence of traumatic stress symptomatology in the child or adolescent with the Child PTSD Scale (CPSS; Foa et al, 2001) or similar scale. The therapist will emphasize to the parent or guardian that the CPSS, TOMS or other instrument of psychosocial functioning, and the parental Healthy Beliefs Scale will be repeated immediately after unit 10. The child will complete the Healthy Core Belief Scale at the beginning of each unit.

Encourage the parent or guardian to consider how he or she would rate each of the four beliefs on the Building Healthy Core Beliefs Scale (Appendix C). This scale is the author's original instrument to measure changes in the strength of the client's beliefs over the course of the program. Additionally, the scale is administered to the parent or guardian during the first and last meeting to measure any changes in the strength of the parent or guardian's core beliefs.

Express gratitude that the parent or guardian is allowing the therapist to be part of the team to help child or adolescent understand him- or her- self better. The therapist will maintain communication with the parent or guardian throughout the program through letters and phone calls. Sample letters to the parent or guardian may be found in Appendix H. The clinician may adjust the letter to the content of the caregiver's letter based on the activities and lessons completed during one daily session. Provide the parent or guardian with as much support and information as possible. The child or adolescent will choose a reward for completing at least one of the homework options. The chosen reward will be provided after the review of homework at the beginning of the next session.

## Implementation of the Building Healthy Core Beliefs Curriculum

### The Therapist's Role in Stages of Change

Building Healthy Core Beliefs (BHCB) follows the recommendations of Stallard (2005) who explained that the therapist must first determine the client's readiness to change based on the model by Prochaska, DiClemente, and Norcross (1992). According to Stallard, the role of the therapist will vary depending upon the stage of the client. In the precontemplation stage, the therapist will develop discrepancies the client presents about his or her current life situation and what he or she wants. In the contemplation stage, the therapist will assist the client in determining the pros and cons of both sides of his or her ambivalence. Specifically, the *BHCB* therapist will use the decision-matrix to help the client ascertain his or her reasons for wanting or not wanting to participate.

Additionally, Stallard emphasized that the client and the CBT therapist typically function as partners to form a working hypothesis or problem formulation in the preparation stage. This hypothesis may be in the form of a cognitive, onset, or maintenance formulation. The therapist and client use the formulation to set short-term goals which are specific, measurable, realistic, and achievable. Stallard stressed that the child's active role and sense of experimentation are highlighted.

In the action stage of Building Healthy Core Beliefs, the client is learning new skills to accomplish his or her goals. Skills gained include identifying and scaling unpleasant emotions, distorted thoughts, and maladaptive beliefs. The client will learn about balanced thinking, positive self-talk, problem-solving, and scheduling enjoyable activities. Positive reinforcement of successive approximations is utilized. The client is encouraged to recognize his

or her own accomplishments. In the maintenance stage, the child typically practices integrating the new skills into daily living scenarios. The child is prepared to cope with the inevitable relapses that will occur and the obstacles to reapplying the skills learned.

**Assessment of Maladaptive Schemas**

The Building Healthy Core Beliefs therapist intentionally does not assess *maladaptive core beliefs* using a questionnaire format because children with histories of complex trauma will typically display traits from nearly all of the 18 maladaptive schemas (Young, Klosko, & Weishaar, 2003), an overwhelming phenomenon for anyone. We also do not ignore the presence of the maladaptive behaviors or beliefs. Although not formally tested, the clinician will be informally assessing for the existence of maladaptive schemas throughout this first phase in order to adjust goals and *story characters* during the second phase. The clinician will consider whether the client is exhibiting any of the three behavioral manifestations of each of the 18 maladaptive schemas as defined by Young and colleagues. The therapist will formulate cognitive, behavioral, experiential, and therapeutic goals for each activated schema using recommendations of Young and associates. Through the use of stories where characters experience the survival-related emotions, the clinician will help the child to adopt healthier thoughts and behaviors.

**Unit One Instructions**

**Read or Discuss.** Read together or discuss the introduction text for unit one. The therapist will use the strategy that most effectively helps the child to understand the content. Concrete materials will increase the school-age child's understanding of these lessons (Piaget, 1962). Additionally, the use of play is recommended in order to allow the client to depersonalize his or her problems and relieve self-blame (Freeman, Epston, & Lobovits, 1997).

**Begin with the goal of accomplishing goals.** The therapist will introduce the flowchart of the Building Healthy Core Beliefs program as part one part of the long-term goal of *accomplishing goals*. The flowchart (Figure 2) includes short-term goals of setting goals, determining steps or tasks necessary to achieve goals, establishing sequencing order of the steps to be completed, and recognizing accomplishments.


Figure 2. Flowchart for Building Healthy Core Beliefs Program

**Decision-matrix.** The therapist will discuss the process of making decisions. That is, the client will consider the pros and cons before making a commitment. The therapist will explain that *pros* are advantages or benefits; and, *cons* are disadvantages, risks, or obstacles. Using the decision-matrix (Table 3), a principle from Motivational Interviewing (Miller, 1983), consider both the pros and cons of choosing one thing versus the pros and cons of not choosing the thing.

Table 3. Decision-Matrix for Choosing Whether or Not to Participate (Miller, 1983)

| Pros of participating | Pros of not participating |
|---|---|
| Cons of participating | Cons of not participating |

**Contract and safety plan.** After the client has decided to participate, the therapist will review the contract and assent form. The therapist will use language that the client understands and will emphasize that he or she may discontinue his or her participation at any time, if desired. The therapist must ensure that the client is physically safe. The clinician will help the client and the non-offending caregiver to create a safety plan. The safety plan will include warning signs for impending danger, a safe place to go in times of crisis, and a mode of transportation for the child and adult (Cohen, Mannarino, & Murray, 2011). This step is not optional and may be repeated as needed.

**Happy place imagery.** Additionally, the therapist will introduce the concept of safe place imagery. Encourage the child to picture a safe, happy place in his or her mind. Emphasize that this calming place can be an imaginary or real space. If the child will tolerate it, encourage the child to be alone in this safe, happy place.

**The Healthy Core Beliefs Scale.** Introduce and complete the Healthy Core Beliefs Scale (Appendix C). As discussed in the client's introduction, honesty is requested on each completion of the Healthy Core Beliefs Scale. Emphasize that therapist has no expectations about answers. When the child completes the scale, transfer his or her answers to the Unit-by-Unit Chart for Rating my Healthy Core Beliefs Scales (Table 5). The therapist will complete this step after each administration of the instrument.

Table 5. My Unit by Unit Chart for Rating My Healthy Core Beliefs Scale

| | I am loved | I am lovable | I am worthy | I am capable |
|---|---|---|---|---|
| Unit 1 | | | | |
| Unit 2 | | | | |
| Unit 3 | | | | |
| Unit 4 | | | | |
| Unit 5 | | | | |
| Unit 6 | | | | |
| Unit 7 | | | | |
| Unit 8 | | | | |
| Unit 9 | | | | |
| Unit 10 | | | | |

**Coping skills.** Introduce the concept that coping skills are how individuals manage difficulties in life. Emphasize that there are healthy and unhealthy coping behaviors. Inform participant that he or she will learn and practice 44 new healthy coping skills in this program. Discuss that coping skill # 1 is *thinking about favorite things.* Talk with the child about his or her favorite books, movies, television programs, hobbies, animals, and colors. Therapeutic ties are strengthened as the therapist shares his or her own favorites. This activity may be accomplished by allowing client and therapist to draw symbols of favorites on a personal crest. If magazines are available, the personal crest may be a collage of favorite pictures cut from the magazines.

**Social skills.** Introduce the importance of building social skills. Emphasize that getting to know others better by finding out their favorites is a good conversation starter. Discuss how getting started can be the most difficult part of making new friends. Additionally, it is desirable to build tolerance for differences of personal preferences, characteristics, and beliefs. The focus is on accepting that other people may have different favorites than me. When the therapist reviews the homework in the subsequent session, he or she will emphasize that the caregiver loves the child even though they have different favorites.

**Music.** The therapist will introduce coping skill # 2, i.e., listening to music. Finding out the child and family's current practices involving music may be helpful to planning future activities. Eckhardt and Dinsmore (2012) described the therapeutic qualities of listening to music and also advocated for combining music with mindfulness in order to increase the client's accessibility to emotional expression. The therapist discusses that

coping skill # 3 is active meditation. The activity *Shake, Wiggle, Jiggle, & Dance* may be used several times during this program to promote the use of active meditation. Additionally, mindful walking and mindful eating may also be used to help the client develop active meditation skills.

***Shake, Wiggle, Jiggle, and Dance* is the end-of-session during unit one calming exercise and a form of active meditation.** After the end-of-session exercise, homework options are given. Emphasize that the child will choose a treat from the prize box for completing homework. The chosen prize will be labeled with the child's name and set aside for when homework is completed. The therapist may want to keep track that child does in fact receive these rewards. Emphasize that homework is meant to be enjoyable for both child and parent or guardian. The clinician can emphasize to the child that another interested adult may participate in homework activities if parent or guardian is not available.

**Unit Two Instructions**

**Checking homework.** For each new unit, start with the Healthy Core Beliefs Scale. Check homework at the beginning of each session. Notice that the homework review is also a review of the previous session. If the child has not completed the homework, review or have the child summarize the previous session, e.g., "What did we talk about last time?" The clinician may adjust homework and parent or guardian letters to fit the content of each session. The child may choose homework activities that stimulate his or her interests. Reinforce the acceptability of the participation of an adult other than the parent or caregiver. Encourage positive adult and child interactions.

**Saber-toothed tiger and the caveperson**. The therapist will read the Saber-Toothed Tiger and Caveperson Story to the client. During the story, the younger client can color an outlined sketch of a saber-toothed tiger and a caveperson. The therapist ensures that the gender of the caveperson in the drawing matches the perceived gender of the client. Allow the young child to color the page while the therapist reads the story. The older child can color a cartoon strip containing images of a caveperson, a saber-toothed tiger, biological sketches of the cardiovascular system, the digestive system, the brain, the autonomic nervous system, the adrenal glands, the pulmonary system, the digestive system, and the skeletomuscular system. The use of graphic materials with the story helps to clarify that all individuals experience the stress response, thus normalizing the child's reactions to adversity or stress (Cohen, Deblinger, & Mannarino, 2006). Introduce the concept that bodily sensations are frequently associated with

stress, for example, fast heartbeat, rapid breathing, tight muscles, a stomachache or butterflies in the stomach. The therapist does not probe deeply when asking "Have you ever noticed your heart beating fast?" The goal of this question is to increase the child's awareness of the sensation of the heartbeat rather than to delve into traumatic themes.

**Involuntary sensations and anxiety.** Levine and Kline (2007) described the effects of stress on the ability to digest food. The therapist will allow the child to volunteer if stomachaches have been an issue. Emphasize that many functions of our body are involuntary, i.e., not under our conscious control. Stress the benefit of not having to think about breathing or the beating of the heart. Acknowledge that all people feel anxiety when not in control.

**Inattention.** Additionally, Saxe, Ellis, and Kaplow (2007) discussed the effects of stress on an individual's ability to concentrate and pay attention to his or her environment. Emphasize the child's heightened ability to attend to information that ensures his or her survival.

**Adapting the lesson on stress for the older child or adult.** This lesson may be adapted for older children and caregivers by adding biology terms to the story such as autonomic nervous system (ANS), sympathetic and parasympathetic branches of the ANS, cortisol, adrenal glands, heart rate, respiration rate, digestion, cortex and limbic system. Allow the older child or adult to supply ideas of stressful situations and personal experiences of *fight- flight- freeze* responses. Teach that the sympathetic branch of the autonomic nervous system activates the stress response. Emphasize that the syllable *sym-* means *with*; therefore, sympathetic means *with emotion* because the body is connected to emotions. If a stethoscope is available, allow the child to listen to his or her heartbeat. Also, show the client how to find his or her pulse on his or wrist or neck.

**Questions about freezing.** Allow the child to supply ideas. Record the child's answer. Securely attached child will hopefully respond that when the small child is quiet and stays in one place, his or her mother can pick him or her up and run. If student does not volunteer this answer, supply suggestion and record student's response.

**"What would you do if you were that caveperson?**" The purposes of this question are: (a) to assess the child's level of aggression and sense of vulnerability to harm; (b) to normalize any behavioral responses to prior experiences; and, (c) to stimulate the use of the child's imagination. The therapist's sensitive response is necessary to help normalize the child's reaction to previously threatening event or events.

**About rating energy levels.** With stress, there is energy. The therapist encourages the child to consider these questions: *Where does the energy go? What will I do with that energy? Will I fight, run, or do something else?*

The rating scale (Table 2) and the quick modulation strategy of "butterfly hug" or "grabbing one's shirt" are from Blaustein and Kinniburgh (2010).

Table 2. My Energy Scale (Blaustein & Kinniburgh, 2010)

| -1 | 0 | +1 | +2 | + 3 | + 4 | + 5 | + 6 | + 7 | + 8 | + 9 | +10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Freeze | Low energy | | | | Alert, Aware, Focused | | | Hyperactive | | | |

Teach that grounding means paying attention to one's own feet on the ground. The energy scale allows the child to monitor his or her own energy encouraging the child to have an awareness and some element of control over an autonomic function. Grounding is to increase an awareness of the present and orientation involves increasing awareness of the here-and-now using one's five senses (Linehan, 1993). Grounding and orientation to the present environment using the five senses are recommended by several other trauma experts including Blaustein and Kinniburgh (2010); Briere and Scott (2015); Heller and LaPierre (2012); Levine and Kline (2007); McLaren (2010); and, Morrison (2007).

**Objectives of the bubble activity**. (1) Increase the child's belief that stress is transient. The rationale is that the lack of control over one's stress response may seem permanent for the child. (2) Increase hope for relief after a stressful event. Some adverse events may be on-going from the child's perspective. (3) Additionally, blowing bubbles is an exercise for controlling breath.

**Coping skill # 4 is to recognize and accept unpleasant bodily sensations.** Recognizing and gently accepting our bodily sensations associated with stress such as heartbeat or stomachaches helps decrease the secondary stress layer added to the primary stress. As endorsed by mindfulness practitioners (Williams, Teasdale, Segal, & Kabat-Zinn, 2007), increasing awareness of bodily sensations is one of the main targets of Building Healthy Core Beliefs. The client builds tolerance for uncomfortable bodily sensations, emotions, or thoughts.

**Coping Skill # 5 is to remember past successful attempts with coping in similar situations.** Help the child to talk about other times he or she has had a similar bodily sensation, emotion, or worry. When the child remembers the resolution of previous situation, he or she can use what worked last time and that the situation did resolve. For example, if the child remembers how a stomachache or headache went away, the child will know that

this bodily sensation, emotion, or worry will most likely also get better. He or she can use the coping behaviors that worked last time. If that doesn't work, the therapist can encourage the client to try a different coping behavior.

**Coping skill # 6 is to schedule enjoyable activities.** Two important problem-solving skills, brainstorming and considering the barriers, are practiced at several points in this program. Scheduling enjoyable activities could be a non-stressful way to begin brainstorming and considering the barriers. Additionally, Riso, Maddux, and Santorelli (2007) stressed the importance of activity scheduling of pleasurable and desired events to help the client experience success with the positive data log early in treatment. Help the child to brainstorm possible fun activities. Encourage the child to write down every idea without judgment or decision. Encourage the child to discuss pros and cons of some of the activities. Help the child to choose one activity for this week. Teach the child to use a time management schedule for the week that includes the chosen activity.

**Coping skill # 7 is to schedule time with loved ones.** Additionally, this activity is to recognize the value of relationships. Discuss any barriers to spending time with loved ones and possible solutions to overcoming these barriers. Allow the client and/or the caregiver to think of possible solutions. Look at the time schedule for the week. Brainstorm possibilities for together time with loved ones.

**Coping skill # 8 is to focus on natural breathing, timed breathing, square breathing, and deep breathing**. Natural breathing means that the child pays attention to his or her natural rhythm of breathing. Clients learn timed breathing because slowing one's rate of exhalation can help bring down the heart rate. To do timed breathing, count slowly on inhalation and on exhalation. Square breathing is a very controlled breathing technique with four parts: the breath in, holding that breath, the breath out, holding that breath. Abdominal breathing is also called diaphragmatic breathing.

**Balloon activity.** To teach abdominal breathing, the therapist can use a balloon to demonstrate the activity of inflating and deflating the lungs. The child can gently place his or her hands around a balloon and pretend his or her fingers are the rib cage. The therapist will instruct the child to think of his or her lungs getting bigger as the balloon gets bigger. Instruct the child to move hands out slowly as he or she breathes in. When child exhales, child will slowly and gently squeeze balloon. The optional Castle Song (originally from the PBS television series Sesame Street) can be used to further increase attention to abdominal or diaphragmatic breathing.

**Progressive muscle relaxation is coping skill # 9 and part of the end-of-session calming exercise in unit two.** Introduce the concept of contrast, i.e., tension versus relaxation. Progressive muscle relaxation and getting my breath down to my toes, figuratively speaking. See script in child's manual. Although progressive muscle relaxation can be done from top to bottom or bottom to top, start with face muscles in order to add the metaphor of the traveling breath. The addition of the traveling breath allows the child to practice breathing exercises at the same time as completing the body scan. When unit two is more than one session, include body scan or traditional progressive muscle relaxation after one of the other sessions.

**Allowing the child to choose.** Remember to emphasize homework options and that the child is allowed to choose which activities to do. Giving the child the opportunity to make choices is very important to his or her emerging sense of agency. Also, the child chooses his or her reward from the prize box for completing and returning homework. It may be wise to allow the child to choose prize, then label and put that prize aside so that child knows what he or she can expect.

**Unit Three Instructions**

**Messages.** Start with the Healthy Core Beliefs Scale, then check homework. Emotions are a message system. Before the caveperson could talk, he or she had emotions. Saxe, Ellis, and Kaplow (2007), members of the National Child Traumatic Stress Network, emphasized that the emotional dysregulation of the traumatized child is the most important posttraumatic symptom. Saxe and associates also stressed that behavioral regulation follows emotional regulation.

**Ventral vagal connection.** As stated earlier in this thesis, the ventral vagal connection is the most efficient physiological mechanism for calming the stress response. According to Geller and Porges (2014), ventral vagal connection occurs when two individuals engage in the implicit interchange of sensitivity and responsivity. Corrective emotional experiences in the therapeutic alliance are beneficial to establishing or re-establishing a secure base and safe haven, essential elements of emotional regulation.

**Memory packages.** Gray, Maguen, and Litz (2007) noted that traumatic memories contain: (a) visceral, physiological factors; (b) beliefs about one's failure to protect self; (c) heightened vulnerability to harm in the future; (d) reduced trust in others; (e) decreased sense of fairness in the world; (f) non-appraisal-driven emotions;

and, (g) appraisal-driven emotions. Non-appraisal-driven emotions are generated in the *quick* thalamus-to-amygdala neural pathway and function to increase chances of survival in a threatening environment (Saxe et al., 2007). Appraisal-driven emotions are generated through several *slower* neural pathways involving the sensory cortex, medial temporal memory system, prefrontal cortex, and the amygdala (Saxe et al., 2007). Increasing the client's awareness of the two emotional processing systems, one quick and one slow, improves one's ability to manage the intense emotions (Saxe et al., 2007). Note that appraisals are influenced by core beliefs.

**Coping skill # 10 is to recognize, label, accept, manage, and appropriately express all emotions.** The therapist is to communicate that both pleasant and unpleasant emotions are to be accepted and tolerated. The therapist and the client will discuss the importance of being nonjudgmental about emotions, i.e., emotions are neither good nor bad. The clinician will also communicate that allowing emotions to flow is healthy.

Considering that emotions, thoughts, beliefs, and bodily sensations are tangled together in memory packages, the goal of the Building Healthy Core beliefs curriculum is to help the client to unravel the components. In this unit, the focus is on unraveling the tangled emotions. Note that unit two focused on bodily sensations, unit four will focus on thoughts, and units five through nine will focus on beliefs. The traumatized individual may have difficulty knowing what he or she is feeling.

**Labeling emotions and facial expressions.** In the first lesson of this unit, the client will learn to recognize and name four basic emotions, i.e., happiness, sadness, anger, and fear. Ekman (2003) stressed the importance of learning about the facial expressions and body language of each basic emotion. Make the face of each basic emotion. Have the client complete the statement, "When my facial expression is _____, I feel _____." Imitate facial expression of another emotion and ask, "How do I feel?" Allow the client to have a chance to imitate the facial expressions while the therapist guesses the emotion.

**Response to emotions.** Ekman also described the typically responses that people exhibit to each of the emotions. For example, sadness may generate support from others, while anger will usually push others away. Ask about client's own experiences of responses from other people. Also inquire about how client usually responds to other people's emotions.

**Function of emotions.** McLaren (2010) discussed the unique and vital functions of each emotion. I can look at the function of the emotion I am feeling and rate the intensity of that emotion. I can also look at what

happened immediately before feeling the emotion. What am I learning about myself from this situation? What do I value? Who or what do I want to protect? On what do I want to focus?

**Expand emotion vocabulary.** Variations of primary emotions include aggravation, frustrated, annoyed, enraged, disappointed, discouraged, rejected, despair, abandoned, isolated/alone, concerned, fear, frightened, terrified, horrified, happy, content, peaceful, relaxed, awed, inspired, joy, rejuvenated, refreshed, and grateful. Other emotion words can be added to this list by therapist or client. Find clear pictures of each of these emotion words either in magazines or on the internet. Although emoticons can also be used, pictures of actual faces are preferred. Ensure that all races and ethnicities are represented in the collection of emotion faces. Paste each picture onto a 3 x 3 card. Write the name of the emotion on the back of card. Use Figure 3 to help the child categorize the emotions into happy, sad, afraid, or angry. Help child to order the emotion words based on intensity. Have child write out the emotion words in order on the blanks in the unit.

**Easy-to-see emotions.** Discuss other emotions that are not variations of the basic four emotions. The easy to recognize, label, and express emotions are confusion, disgust, surprise, and feeling overwhelmed. Discuss the facial expressions, typical responses, and possible functions for each of these emotions. Also discuss the emotions that may be difficult to label or express, such as feeling embarrassed, ashamed, or guilty. Discuss the differences between shame and guilt (Brown, 2012). Shame says, "I did something bad because I am bad." Guilt says, "My behavioral choice was not healthy. I want to do something to fix it and make a better choice. For example, perhaps I am willing to say *I'm sorry*. With the emotion called guilt, the emphasis is on the behavior rather than the person. Guilt provides space for hope where there is a chance to correct one's behavior. On the other hand, the emotion called *shame* tends to decrease self-efficacy and does not help the individual to move forward.

**Apathy.** Adolescents may express feeling apathy or a sense of no caring about anything. Explore the adolescent's sense of core beliefs, i.e., believing that one is worthless or helpless may result in a general lack of agency. The therapist can help to empower the client by increasing the ability to express emotions and to know wishes and wants.

**Feeling Bored.** Adolescents often have a sense of feeling *bored.* As adolescence is a time for exploring new interests, feeling bored may be a *drive* for wanting to do something new. The interested adult can assist the adolescent during this stage by encouraging him or her to explore new interests. The adult may want to ask, "How

can I help you?" Additionally, the traumatized adolescent may experience feeling *bored* as a pleasant emotion when there is no drama in his or her life. The therapist should explore the client's meaning of *feeling bored.*

**Coping skill # 11 is to accept ambivalence.** Ambivalence is feeling two different emotions at the same time. Describe ambivalence as holding one feeling in one hand and a different feeling in other hand. Ambivalence can be confusing. Brainstorm possible scenarios where someone feels happy and sad at the same time.

**Coping skills # 12 and 13 is to practice empathy and compassion.** *Empathy* is recognizing other people's emotions. Use discussions of favorite characters from television, books, or movies to help the child to develop empathy. *Compassion is to treat other people the way I would want to be treated.* Building Healthy Core Beliefs introduces both the concepts of compassion and self-compassion (Neff, 2003; Neff & Germer, 2013). Exercises to increase compassion include role playing situations or using emotion card game where situations are read, then child or therapist respond, "In this situation, I would feel _____." Neff stressed that increasing a client's sense of self-compassion will automatically increase his or her compassion for others.

**Expressing emotions**. There are honorable and appropriate ways to express emotions. There are also inappropriate and dishonorable expressions of emotions. An appropriate and honorable expression of emotion is using the statement, "I feel _____ about _____ because _____." Dishonorable or inappropriate expressions include statements of blame or criticism. The clinician can role-play some scenarios of dishonorable versus honorable expressions of emotions.

**Art work.** Coping skill # 14 is doing art work, for example painting, drawing, coloring, or sculpting with clay. Allow child to share stories of personal experiences with art projects. Inquire about art interests of the adults in his or her life. Perhaps an adult in the child's life can help him or her to learn a new mode of art expression.

**Mixing paint colors and painting pictures representing emotions in body are the end-of-session calming exercise during unit three.** Have the child create a key for the meanings he or she has chosen for each color. Materials needed include: small bottles of acrylic paint in red, yellow, blue, white (for hues), and black (for shades); paintbrushes; drop cloth or plastic table covering; paper; paper plates for mixing; bottles of water for rinsing brushes; paper towels; string and clothes pins for drying. Have the child paint the inside of a mask with colors to represent *private* emotions and the outside of a mask with colors to represent the emotions he or she shares with the world. Assign homework.

**Unit Four Instructions**

Start with Healthy Core Beliefs Scale, then check homework. The goals in this unit are to increase the client's knowledge of accurate versus inaccurate thoughts, to increase the use of positive self-talk, to increase the use of and acceptance of positive affirmations. The client will also learn mindfulness skills of being intentionally and nonjudgmentally present in the here-and-now, grounding, and orientation.

**Coping skill # 15 is to replace *stinky thoughts* with accurate and helpful thoughts (Beck, 2011).** Use a picture of a trash can for stinky thoughts. Instruct child to write the inaccurate or unhelpful thought on the trashcan. The trashcan could be an ongoing activity whenever he or she is caught in the act of *stinky thinking*. The therapist can point out the inaccurate or unhelpful thoughts until the child can notice on his or her own. Also, the child writes cognitive distortions on paper, crumples the paper, and throws into the actual trashcan. In this unit, Beck's cognitive distortions are reworded (Amen, 2008).

**Coping skill # 16 is to use positive self-talk and affirmations** (Meichenbaum, 1977). Positive self-talk is when I choose to *say* good things to myself. Affirmations are when I *say* good things about myself or someone else. The client will also learn to recognize and accept when someone else has positively affirmed him or her. The Treasure Chest of Affirmations is an ongoing project throughout therapy and at home. It is helpful to include the client's entire family in the Treasure Chest activity at home; encourage family to remind each other of affirmations. Help the client complete a decision matrix of pros and cons of believing good things about self. Send home some blank decision matrices for the parent or guardian to use as needed. Have child write a notecard with affirmations and healthy thoughts to keep in his or her pocket.

**Coping skill # 17 is recognizing and remembering my achievements.** Send home copies of charts of chores and daily activities (free copies available at www.charts4kids.com). Parent or guardian or child can place stars or stickers (supply page of stickers) on completed items in order to recognize that he or she does accomplish tasks everyday. Additionally, this encourages the use of positive reinforcement in the home. Inform the child that a completed chart can be returned for a prize from the prize box, a school certificate of accomplishment, or a gift certificate to a local restaurant or pizza parlor. Additionally, encourage the parent or guardian to make a contract offering the child a desirable reward, e.g., going to the pizza parlor may be good end of program prize.

**Coping skill # 18 is compartmentalization and titration.** Discuss that we compartmentalized and titrated in the Unraveling Tangled Emotions activities in unit three. Emphasize that titration is breaking big chunks into smaller manageable bits and compartmentalization is saving things for later (see Heller & LaPierre, 2012).

**Coping skill # 19 is to use imagination and have hope**. Use the decision matrix to discuss the client's pros and cons of believing positive things about his or her future. Discuss the client's meaning of hope.

**Coping skill # 20 is to use mindfulness skills, including embracing the here and now** (Kabat-Zinn, 2003; Kabat-Zinn et al., 1992). Practice grounding by placing feet firmly on the ground and saying, "I belong right here, right now." Practice orientation skills by encouraging client to finish the statements "Right now, I see _____, I smell _____, I hear _____, I taste _____, I touch _____." Discuss the phrase *being grounded.*

**The Pace Card.** This author wrote these words as a compilation or summary of the concepts from mindfulness exercises. Therapist will make and laminate a notecard for the client's pocket entitled *Pace Card*. The client is encouraged to keep the *Pace Card* in his or her pocket and to read it when becoming overwhelmed. Have an extra copy of the *Pace Card* next to the tissue box in the therapy room. Remind the client that he or she is learning some important coping skills and that it is not the purpose of our sessions to overwhelm him or her. Instruct the client to raise a finger and take out *Pace Card* when sensing a feeling of becoming overwhelmed. The therapist can read the *Pace Card* as the child reads along or the child may choose to close his or her eyes and listen.

**Building a Castle in My Mind or Space Station Meditation is the end-of-session calming exercises during unit four.** Inspiration for this castle meditation comes from Teresa of Avila and Louisa May Alcott. In 1577, Teresa of Avila coined the term *interior castle* as a metaphor for the soul. Additionally, Louisa May Alcott wrote a poem stating that she wished to conquer no kingdom except the *one within.* The castle or space station in this meditation is a metaphor for the child's mind. The child is creating a mental space for him- or her- self. Establishing this castle in the mind allows a safe place to contain painful realities so that the child can process little bits at a time and at their own pace. There is a place for hopes and dreams, i.e., at the top of the tower. The castle or space station story expands as the child advances through the therapy program. Eventually, there will also be a place for locking up the scary things, i.e., the dungeon. Characters will take the roles of the modes described by Young, Klosko, and Weishaar's (2003), i.e., the vulnerable child, the defender or guard, the awkward knights, and the king/ queen/ president as the healthy adult image. The space station meditation is a variation of the castle theme.

**Instructions for the meditation exercises.** The therapist slowly recites the meditative story while the child closes his or her eyes. If child does not want to close his or her eyes, allow the child to color a picture of a castle or space station scene. The purposes of this meditation are: (a) to build imagination; (b) to set one's personal boundaries; and, (c) to have a positive and nonthreatening meditation experience. At the end of each session, remember to emphasize homework options and reward choices.

**Unit Five Instructions**

**Perspectives.** Start with Healthy Core Beliefs Scale, then check homework. Display *windowpanes* on transparencies or pieces of framed, clear plexiglass. The object is for the child to be able to look through the picture to understand the concept of schema as a filter. Windowpanes or *schemas* are like filters, windows, or colored eyeglasses. Discuss each of the four frames, one at a time. Say, "In this windowpane, I see: (1) lollipops, flowers, butterflies, puppies, and sunshine; (2) storm clouds and heavy rain; (3) only danger and warning signs; and, (4) divided world where people are either all *good* and all *bad.* The first perspective could be called overly optimistic, the second would be overly pessimistic, the third would be hypervigilance, and the fourth would be splitting.

Discuss the problem or problems with each of these windowpanes. If not volunteered, pose the following questions: *What happens when something bad happens while a person is looking through the first windowpane*, i.e., optimism? One possible answer is depression, i.e., the inability to handle reality as it is. *What will be missing for the person looking through the second windowpane*, i.e., the pessimistic perspective? One answer might be the beautiful things of the world. *What is wrong with only paying attention to the danger?* Think about the stress response and the physiology of being always on alert, i.e., it is not healthy for the person's heart, digestive system, and well-being. Splitting the world may seem like a good plan to help the traumatized child stay away from the people who are not safe. Hopefully, client will volunteer that we each have strengths and limitations. If I label someone as a bad guy, I would be judging without knowing the entire story. Emphasize that it is important to separate one's behavior from the person. We do not want to judge people. It is important to judge behavior in order to keep ourselves safe.

**Making the *windowpanes* for the castle or space station.** *The past influences my beliefs* (Young, Klosko, and Weishaar, 2003). The clinician may need to help the client employ coping skills so as not to allow the client to

become overwhelmed and retraumatized. Remember to stress the importance of using the *Pace Card* when necessary. Also emphasize that this activity may stop at any point by saying "Stop!" or raising one's finger.

**Optional "what if" activity.** One way to reveal core beliefs is to use the classical cognitive-behavioral therapy (CBT) activity is called the Downward Arrow Technique (Beck, 2011). Play "What if…" whenever the client says something bad will happen. The therapist will ask, "What if (that bad thing) does happen? What will that mean to you?" Absolute statements, such as "I am a failure" are usually statements about core beliefs.

**Coping skill # 21 is to *allow other people to help me.*** Draw attention to allowing help from other people. Experiences of persons with traumatic histories may not have been of other people being helpful. For some, other people may have been harmful. The therapist may need to encourage the use of detective or investigative reporter games so that the child finds the helpful people in his or her life. Emphasize the safety of the therapeutic environment and the availability of school personnel to help client during school hours. Emphasize the other resources in the community for helping outside of school or office hours, for example, the local crisis line.

**Coping skill # 22 is to say *I did not choose what happened to me in the past; however, I choose my response to the past. I choose my own behavior in the future*.** Help the client to separate an adverse event from his or her personal reactions and behaviors. Emphasize how strong those emotions can be when thinking about or discussing events that happened in the past. Sometimes the unresolved emotions from the past may feel just as strong as when the adverse experience happened. Stress that it is okay to feel emotions and remind the client that emotions are like bubbles. Encourage the client to separate the big, tangled knot of emotions into sad, afraid, angry, and happy. Use the energy scale, -1 to +10, to rate the intensity of each of the emotions. Typically, fighting an emotion does not cause it to go away or lessen in intensity.

*Even though I may want to run away, fight, or freeze, I will work though this when the time is right for me.* Explain that we *work through* what happened to us in the past at our own rates. *Working through* means making sense of the memories, unpleasant emotions, and uncomfortable bodily sensations from the past event. *Working through* also means that I can re-examine events from the past with my improved thinking and coping abilities.

*I may choose to think about the past when I have learned more skills.* Emphasize that the time will be right when he or she is ready. Discuss that learning skills is a good focus for now and that it is acceptable to put away anything that is too difficult for now.

**Coping skill # 23 is to use the statement "*I would have preferred...*" (Burns, 2006) to discuss how child would have made different choices than other people.** This question allows the client to identify the perpetrator's actions as behavior and as distinct from the client's sense of self. The activities in this lesson should be kept in the third person. Read scenarios where person, other than child, chose an unhealthy behavior. Discuss consequences of the character's choices. Have the child respond how he or she would have chosen differently by completing the statements, "I would have preferred _____" or "I would have chosen to _____".

**Coping skill # 24 is journaling**. Encourage the child to write about thoughts, feelings, bodily sensations, perspectives, and beliefs. Homework for unit 5 includes journaling. Have the child decide on the time of day to journal. Encourage child to not worry about spelling or sentence structure. Encourage child to write or draw about thoughts, beliefs, opinions, and feelings. Child may write about what he or she sees, smells, hears, tastes, or touches this week. Encourage child to write poem or song lyrics. Emphasize that journal is a private space and that he or she is not required to share what is written or drawn.

**Unit Six Instructions**

**Comfort.** Start with Healthy Core Beliefs Scale, then check homework. Coping skill # 25 is to *become more aware of spending time with the people who are supportive and comforting and to increase my awareness of feeling comforted by others*. Emphasize that support from other people is comforting. Help the child to recognize the people who are actually supporting him or her in the present. Coping skill #25 builds from #21. #25 emphasizes the comfort from other people. Receiving comfort from another human being is not an automatic activity for the child who has experienced complex trauma. Help the child to identify from whom support was expected and whether or not those individuals were able to give support. Emphasize that one individual is not responsible for another individual's choices. Help the client to not blame him- or her-self if someone else is not capable of supporting him or her. Help the client to finish the statements, "I am responsible for _____. I am *not* responsible for _____." Remind the child to say, "I would have preferred___ [or] I would have chosen to _____."

**Make a genogram of family**. Discuss the different meanings of family and discuss who does or does not live in the same house with the child. Be sensitive to the fact that children with family configurations outside the *norm* may be sensitive about this exercise. Emphasize that there are many different definitions of family.

**Make an ecomap of relationships with loved ones.** Examine different strengths of relationship with each person. Discuss that healthy relationships are mutually beneficial, supportive, and challenging; conflict does not typically end a relationship. Emphasize that for most, the resolution of conflict can help the relationship to become stronger and healthier. For some people, such as children in the foster care system, conflict in the past did end the relationship. Emphasize that toxic relationships, i.e., not mutually beneficial and supportive, must be redefined.

**Increase client's understanding of communication**. Discuss that communication includes a message, the person who sent the message, and the person who receives the message. Discuss that the intent of the person who sent the message may not be understood by the person receiving the message. Demonstrate that the use of feedback can help the sender know that his or her message was understood. Discuss that a message is more than words. Help the client to identify nonverbal aspects of messages, i.e., the emotions behind the words. Help the client to use "I" statements to express his or her emotions. Also emphasize that each individual has responsibility for his or her own emotions and that other people do not have power over *making one feel* a certain way. Use the example of an individual having a bad day and blaming the child for his or her anger. Remind child about homework and reward choices.

**Loving-kindness meditation.** For the person who is self-sacrificing, there is a great relief in releasing the sense of being responsible for other people. The loving-kindness meditation is a compassionate means to individuating oneself while maintaining a sense of caring.

**Unit Seven Instructions**

**Strengths and talents.** Start with Healthy Core Beliefs Scale, then check homework. Discuss the characteristics and talents of friends, i.e., what the client likes about others. Recognizing strengths and talents is based on the theory of multiple intelligences (Gardner, 1987). Consider that the strengths that clients desire are skills to be learned. Recognizing the strengths and talents in other people helps the client to appreciate differences in people and encourages tolerance of differences. Emphasize that healthy pride is neither boastful arrogance nor self-deprecation.

**End-of-session calming exercises for unit 7.** Add characters to the castle or space station meditations based upon therapist's informal assessment of the client's maladaptive schemas. For example, if the child displays

an abandonment schema, an abandoned child character will interact in the *castle* or *space station* with a dysfunctional, abandoning parent image. The exercise is in the third person voice to distance the child from this traumatic experience and so that the child can develop some mastery over the situation. The *king/ queen* of the castle or *president* of the space station continues to be a model of a healthy adult. The therapist will speak for the king/queen/president until the child can play that role. There is a guard in the castle or space station trying to keep the king/queen/ president from interacting with the child. The king/queen/ president will have dialogues with the dysfunctional parent image and the guard to discover their noble intentions to protect the child. The king/queen/ president will validate the dysfunctional parent and guard's desires to protect the child. The king/queen/ president will inform the dysfunctional (critical, demanding, punitive, or abandoning) parent that the king/queen/ president also wants to help the child. The king/queen/ president tells the child that he or she loves the child and believes the child to be lovable. Remind the child about homework and reward choices.

**Unit Eight Instructions**

**Basic human rights.** Start with Healthy Core Beliefs Scale, then check homework. *I am worthy of: predictability, protection, respect, respectful affection, being understood, nurturance, guidance, and encouragement to be best me I can be.* These are based on children's needs as outlined by Garbarino and Stout (1989).

**End-of-session calming exercises for Unit 8.** Similar to the end of unit seven exercise, add characters based upon therapist's informal assessment of client's maladaptive schemas. For example, if child also displays an abuse schema, an abused child character will interact in the *castle* or *space station* with the king/queen/president, after the king/queen/president interacts with the dysfunctional (critical, demanding, or punitive) parent image. The exercise is in the third person voice to distance the child from the traumatic experience so that child can develop some mastery over the situation in the imagery. The *king/ queen* of the castle or *president* of the space station continues to be a model of a healthy adult. The king/queen/ president tells the child that he or she deserves to have someone listen and understand his or her feelings and thoughts. and that he or she is worthy of respect, respectful affection, nurturance, predictability, guidance, encouragement to be best person he or she can be, protection and being understood. Remind the child about homework and reward choices.

**Unit Nine Instructions**

**Wishes.** Start with Healthy Core Beliefs Scale, then check homework. Help the child to brainstorm wishes and wants. Remind him or her to make big, bold goals. Remind the child that all ideas are accepted in brainstorming.

**Coping skill # 40 is to *choose behaviors that will help me to achieve my goals*.** Introduce the Healthy Core Belief Conflict Management Worksheet. Supply the client with some copies to use at home with parent or guardian. The client identifies stressful situations and the associated bodily sensations, thoughts, and emotions. The client learns to self-validate his or her own emotions, bodily sensations, thoughts, and associated beliefs about the stressful event. The client rates his or her own emotions or energy level from -1 to +10, with -1 meaning shut down and +10 meaning hyperactive. The client identifies coping behaviors and alternate beliefs and thoughts that would result in different emotions, bodily sensations, and energy levels.

**Sequencing tasks.** Brainstorm with the client to help him or her determine a few goals that would be useful for the stressful situation. Help the client to choose one of the goals from his or her list. Help the client brainstorm about the steps or tasks necessary to accomplish the goal. Help the client to arrange the steps or tasks in a logical order. With the client, create a time management schedule for the coming week.

**Plan celebration.** With the client, plan a celebration for the next session. Discuss the client's choices for food, drinks, games, and music. Have the client make an invitation to invite his or her parent or guardian to the celebration. Be sure to have child include the time and place of the celebration. The therapist will also write a letter to the parent or guardian to inform him or her of the activities for this unit and to express the therapist's excitement about including him or her in the celebration. If necessary, offer to help arrange transportation for the caregiver.

**Writing a letter.** End-of-session calming exercise for the last session of unit nine is to help the client to write a letter telling his or her parent what he or she has learned in the Building Healthy Core Beliefs program. The client will read this letter to his or her parent or guardian during the last session. This activity is a preview of sessions in phase three where the child will read his or her life narrative to the parent or guardian. Homework after unit nine is to encourage the client to use his or her time management schedule during the week.

**Unit Ten Instructions**

Start with the Healthy Core Beliefs Scale, then check homework. The client will read his or her letter to the parent or guardian during this last session. The client will provide feedback to the clinician about the strengths and the limitations of the program. The therapist, client, and caregiver will discuss the client's plans for the future. Contingency plans for *relapse* or difficult times could be talking with the therapist. If applicable, resources will be provided.

For the celebration, share food, drinks, music, games, and dancing. Therapist presents the client with a graduation certificate and the completed workbook from program. The homework pages would be separate from the workbook. The therapist could present a copy of the 44 coping skills on two pages of laminated cardstock. See Appendix D for list of all coping skills acquired in the Building Healthy Core Beliefs program.

## PART III. STUDENT HANDBOOK FOR BUILDING HEALTHY CORE BELIEFS

Students will complete the following pages with the guidance of a licensed psychotherapist. At no time should completion of this booklet substitute for face-to-face therapeutic sessions. The therapist should be thoroughly familiar with the checklist in the previous section including the items to consider before initiation of this program, topics to discuss with the caregiver, and the theoretical considerations and instructions for each unit.

The student is encouraged to make this handbook his or her own during sessions; however, the therapist will keep the handbook in the therapy room until after completion of the entire program. After the graduation ceremony, the student may take the booklet home.

### Unit 1. Decision-Making, Contracts, and Coping

In Building Healthy Core Beliefs, I will learn about making decisions. I will start by deciding if I want to participate in this program. I will look at the steps needed to graduate from Building Healthy Core Beliefs. I will consider the pros and cons of both participating and not participating. If I choose to participate, I will sign the contract. Each week, I will complete the Healthy Core Beliefs Scale. On a scale of one to ten, I will rate how strongly I believe each of the four healthy core beliefs about myself. I can answer honestly. There are no right or wrong answers.

The Building Healthy Core Beliefs program will last for ten sessions (Figure 2). Each week, we will focus on a different theme. Lessons and activities in each session are to help me understand myself better. Today, I will learn about making decisions and I will decide if I want to come back for nine more units. If I do want to participate I will sign a contract and make a safety plan. In unit two, we will talk about the difference between beneficial stress and toxic stress. I will also learn about the stress response. I may listen to my heartbeat. I will learn many new coping skills during the entire program. In unit three, we will unravel the tangled mess of emotions. We will talk about thoughts in unit four. Beliefs and perspectives are the topics for unit five. Units six through nine will focus on one of four core beliefs about myself: *I am loved. I am lovable. I am worthy. I am capable of accomplishing my goals.* Unit nine will include planning the celebration for Unit 10. We will review and have a graduation celebration during unit 10. During unit 10, I will be able to give my feedback about my thoughts of this program. That means, I will say what I liked about the program and what I did not like about the program.


Figure 2. Flowchart for Building Healthy Core Beliefs Program

**Lesson 1.1. Making Decisions**

Do I want to participate in this program? In Table 3, I will list the pros and cons of choosing to participate and the pros and cons of choosing to not participate in this program. Pros are advantages or benefits. Cons are disadvantages, risks, or obstacles. When people consider both the pros and cons of choosing one thing versus the pros and cons of not choosing the thing, that person is making an informed decision. Making informed decisions means that I am giving myself power to control my choices in life.

Table 3. Decision-Matrix for Choosing Whether or Not to Participate (Miller, 1983)

| Pros of participating | Pros of not participating |
|---|---|
| Cons of participating | Cons of not participating |

**Lesson 1.2. My Wants and My Wishes**

Part of decision-making is learning about what I want in life. My lists of wants will grow as time goes on. In order to make my want list, I will need to be able to make wishes. To make wishes, I will need to be able to adequately identify, understand, and appropriately express my emotions. I deserve to understand my emotions. I deserve to make wishes. I deserve to have wants. I deserve to make my own decisions about my future. By completing the Building Healthy Core Beliefs program, I will learn about my emotions so that I can understand my wishes and wants better.

1. What is it that I want? I want _____
2. Am I willing to learn new skills? What steps am I willing to take to achieve this goal? I will

   _____
3. I may need help from someone else to help me achieve my goal. I may need to learn skills in order to achieve my goal. Am I willing to ask for help? _____
4. Whom would I ask to help me? _____

   _____

   _____

**Lesson 1.3. Contracts**

A contract is an agreement between two or more people.

I, _____, agree to be in a program to find ways to help children and teenagers to understand themselves better. I will do activities involving listening to and telling stories. I will also do some exercises where I rate my beliefs on a scale from one to ten. I may play some games, do a puzzle or two, or do some art work. I will also learn some relaxation or calming activities. I may do homework such as sharing the session's lessons with my parent or guardian. For homework on some days, I may act like an investigative reporter and ask some adults in my life for their opinions. On other days, I may act like a detective to look for evidence of one sort or another. Sometimes, I may act like an actor or an actress. I can decide to stop being in this study at any time without getting in trouble.

The benefits of participating include that I will understand myself better and will have more tools to cope with life. The risks of participating could include that I may get upset during the program. I understand a licensed clinical social worker will be available to help me through my distress. I may also feel embarrassed about participating. I know that the investigator and the social worker have a plan to keep my information confidential. My therapist practices confidentiality. That means that she (or he) will not talk about what I say during sessions to other people. The times that my therapist is required to tell others about what we talk about are: If someone is hurting me or If I know I cannot keep myself or another person safe from harm. For example, if someone is in danger, we may find help for that person and for me. Also, if my therapist thinks my parent should know about something, she or he will talk to me and explain reasons for me to tell my parents.

Child's Signature: _____ Age: _____ Date: _____

Witness _____ Date: _____

**Lesson 1.4. Safety Plan**

It is important that I am safe. My therapist will check my safety often. My therapist and my parent or guardian will help me to make a safety plan for those times when I do not feel safe.

1. Am I safe right now? _____
2. Here is what I am seeing when I know I will not be safe _____

   _____

   _____
3. Here is what I am hearing when I know I will not be safe _____

   _____
4. Here is what I am smelling when I know I will not be safe _____

   _____
5. Here is what I am sensing when I know I will not be safe _____

   _____

   _____

   _____
6. Do I have a plan for staying safe? _____
7. When I see, hear, smell, or sense _____, I will:

   Call these people _____

   Go to this place _____

   Transportation to this place includes _____
8. People and phone numbers I can call to stay safe _____

   _____

   _____

   _____
9. Places I can go to stay safe _____

   _____

   _____

**Lesson 1.5. A Calm, Peaceful Spot in My Mind**

There is an actual safe place where I can go that is made of wood and bricks. There are times when my body is safe and I may want to go to an imaginary place in my mind. Going to my *happy place* in my imagination is like going on a little vacation. In this place, I am safe, comfortable, and free from any distractions. This place is for me alone. It is important that I take a few moments from time to time to go to my calm, peaceful spot in my mind. Thinking of something that is far away from all of the stresses of the world helps me to clear my head. I can imagine going to my *happy place* in my imagination whenever I choose to. After a few moments of my *happy place* in my imagination, I feel refreshed, renewed, and relaxed.

Here is some information about the *happy place* in my imagination. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Lesson 1.6. Tracking my Healthy Core Beliefs**

Each week, I will give my honest answers on the Healthy Core Beliefs Scale (Table 4). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs (Table 5). During the last session of Building Healthy Core Beliefs, the therapist and I will discuss whether or not my beliefs have changed.

Table 4. Healthy Core Beliefs Scale for Unit One

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |
| I am lovable | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |
| I am worthy | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |
| I am capable of achieving my goals | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

Table 5. My Unit by Unit Chart for Rating My Building Healthy Core Beliefs Scales

| | I am loved | I am lovable | I am worthy | I am capable |
|---|---|---|---|---|
| Unit 1 | | | | |
| Unit 2 | | | | |
| Unit 3 | | | | |
| Unit 4 | | | | |
| Unit 5 | | | | |
| Unit 6 | | | | |
| Unit 7 | | | | |
| Unit 8 | | | | |
| Unit 9 | | | | |
| Unit 10 | | | | |

**Lesson 1.7. Coping Skills**

The purpose of this program is to help me understand myself better. Sometimes it can be difficult to understand myself after bad, strange, or unusual things have happened in my life. People have many different reactions to experiencing bad, strange, or unusual things. It is okay to have my own unique reactions to the "abnormal" or unusual things that have happened in my life. When I understand that my reactions to "abnormal" events are normal, I know that I am normal. That is a pleasant thought. I'll say that thought again. When I understand that my reactions to "abnormal" events are normal, I know that I am normal. It may help for me to understand my own, unique reactions. It also helps for me to learn about coping skills.

Coping skills are what I use to manage the difficulties of my life. There are healthy and unhealthy ways to cope. Healthy coping skills are helpful and allow me to keep myself and other people safe. Using unhealthy coping behaviors can cause harm to myself or other people. Unhealthy coping behaviors may make me feel better for a little while; however, unhealthy coping behaviors are not helpful over the course of time. I will learn many healthy coping skills during the Building Healthy Core Beliefs program. This lesson contains three new coping skills. It takes time to practice the healthy coping behaviors and attitudes. Sharing what I am learning with my family will help me learn and will also help me to build a stronger relationship with my family.

**Coping skill # 1 is *thinking about my favorite things*.** Additionally, getting to know others better by finding out what they like is an important social skill. Asking about favorite things is a good conversation starter. Getting started is sometimes the most difficult part of making new friends. My friend and I will also feel closer when we know about each other's favorites. It is also important to accept that other people may have different favorites than me. Complete the following statements. Think about asking other people about their favorites.

My favorite books _____

My favorite movies _____

My favorite television programs _____

My favorite hobbies _____

My favorite animals _____

My favorite colors _____

My favorite musicians or songs _____

**Coping skill # 2 is *listening to music.*** Listening to music can be relaxing. My experiences with listening to music are _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Coping skill # 3 is *active meditation*.** Some examples of active meditation include mindful walking or mindful eating. Another example of active meditation is *Shake, Wiggle, Jiggle, and Dance.* To *Shake, Wiggle, jiggle, and* Dance, I listen to music and move around in rhythm with that music. There are no right or wrong ways to move.

**End of session calming exercise for unit 1: Shake, Wiggle, Jiggle, and Dance**. I can move around to the beat of the music. I notice how I feel when I move fast. I can also move slowly when the rhythm is slow. I will take some time to be still and focus on my breathing. I will think of the air going into my nose and then going out of my nose. I close my eyes and think about where the air is in my body. When I go slow and think about my breathing, my energy rating Table 6 is a # _____. While dancing, my energy rating on Table 6 is a # _____.

Table 6. My Energy Scale after *Shake, Wiggle, Jiggle, and Dance* (Blaustein & Kinniburgh, 2010)

| -1 | 0 | +1 | +2 | + 3 | + 4 | + 5 | + 6 | + 7 | + 8 | + 9 | +10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Freeze | Low energy | | | | Alert, Aware, Focused | | | Hyperactive | | | |

**Homework Suggestions for Unit One**

I chose _____ to be my reward for finishing at least one activity from this list.

_____ Option 1.1. With a parent or guardian, I will share lessons that I learned in this week's session.

___ Decision-making: Before I make decisions, I consider the _____ and _____.

___ Safe people and places: I know I am safe when _____.

___ It is important to make wishes so I will know what I _____ and I can set _____.

___ Moving around to calm down is called active _____.

_____ Option 1.2. With my parent or guardian, I will listen to some music and Shake, Wiggle, Jiggle, and Dance. We notice that this time together is fun and relaxing.

_____ Homework option 1.3. With your parent or guardian, discuss each of his or her favorites.

Songs _____

Musicians _____

Books _____

Movies _____

TV programs _____

Hobbies _____

Animals _____

Colors _____

Food or Beverage_____

Other favorites _____

_____

_____

_____ Homework option 1.4. I will ask my parent or guardian about what his or her wishes and wants are for me. _____

_____

_____

_____ Homework option 1.5. This is how I used a decision-matrix to make a decision.

_____

**Unit 2. Beneficial and Toxic Stress and the Stress Response**

I will give my honest answers on the Healthy Core Beliefs Scale for Unit Two (Table 7). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs (Table 5; p. 96 this document). During the last session of the Building Healthy Core Beliefs program, my therapist and I will discuss whether or not my beliefs have changed.

Table 7. Healthy Core Beliefs Scale for Unit Two

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

**Check each that applies to your week.** I shared last week's lessons about safe people and places ____, wants and wishes ____, decision-making ___, and moving around to calm down ____.

The wants and wishes that my parent or guardian and me share are _____

_____

Here is how my wants and wishes are different than my parent or guardian's wants and wishes.

_____

At least once this week, we used the decision-matrix. ___ My parent or guardian and I listened to some music this past week. ____ My favorite type of music is _____ My favorite song is _____

My parent or guardian's favorite type of music is _____

My parent or guardian's favorite song is _____

Despite the fact that we like different types of music, does my parent or guardian still like me or love me? _____

Is it acceptable for people to have different preferences? _____

**Lesson 2.1. Stress is a Challenge in My Day**

Stress can be beneficial or toxic. Beneficial stress gets me going, keeps me focused, and helps me to accomplish my goals. I have beneficial stress when I _____

Coping, as discussed in unit one, is the way that I handle my stress. People use many different techniques to cope with stress. Some examples of healthy coping behaviors include listening to music, dancing around, going for a run or a walk, taking a bath, talking with a friend or talking with a trusted adult, writing in my journal, or reading a book. My coping behaviors include _____

Stress is toxic when the challenge is beyond my current coping ability. I have toxic stress when _____

_____

**Lesson 2.2. The Saber-Toothed Tiger and the Caveperson**

Since the dawn of humanity, the human brain has been hardwired to respond to stress by fighting, running away, or freezing. This stress response is called the Fight, Flight, or Freeze response. Think of a caveperson running from a saber-toothed tiger. The caveperson sensed danger and needed to either fight that saber-toothed tiger or quickly run away. If he could neither fight nor run, then he froze. What do you think is happening in the caveperson's body and brain to get him ready to fight or run away? _____

For one thing, the heart starts beating faster to send blood to the muscles. The caveperson feels that fast heart beat. Have you ever noticed your heart beating fast? You can listen to to your own heartbeat with a stethoscope. Also, you can feel your pulse when you place two fingers on your wrist.

Does that caveperson in the story need energy to eat while he or she is running away from the tiger? __ No. Therefore, the blood automatically flows away from the digestive system and to the muscles. This means that when I am having a stress response, my stomach is turned off. If the caveperson tried to eat while running, he or she might get a stomachache. Have you ever had a stomachache when you were upset? _____

When I sense that my heartbeat is fast or slow, or that my stomach hurts, or that my muscles are tight, I am experiencing bodily sensations. Bodily sensation is a fancy way of talking about those things I am feeling in my body. Many functions in my body happen automatically. For example, I do not have to think about my heart beating. My heartbeat and my breathing are two activities of my autonomic nervous system. Autonomic means automatic. I

may feel anxious or scared when my heartbeat and breathing get fast because I am not controlling these automatic functions. Many people feel anxious about thinking that they do not have control. It is important to think that I have control over something in my life. It is okay that I do not control my autonomic nervous system. We will talk more later about things that can be controlled.

When I realize that my autonomic nervous system is helping me to stay alive, I can feel grateful and confident that these bodily sensations will help me to survive. To survive is to stay alive. I feel glad that I do not have to always think about breathing or making sure my heart is beating. Not having to think about those things allows me to think about other things. What is the caveperson thinking when he or she sees the saber-toothed tiger? _____ Do you think the caveperson is thinking about his or her bodily sensations? _____ Probably not. He or she is probably very focused on his goal of _____ (getting away or surviving). What emotions might the caveperson be feeling? _____ Would the caveperson have trouble concentrating on schoolwork while he is running away or fighting? _____

Now imagine that the caveperson is a small boy or girl. That small child's muscles are not big enough to fight. The small child is not big enough to run fast enough to survive. The small child probably freezes when he or she is in danger. How does freezing help that small child to survive? _____ Some children who froze in dangerous situations when they were younger may feel anxious that they would freeze again in the next threatening situation. Do you think that if someone froze at the sight of a saber toothed tiger as a young child that he or she would freeze again in the future? _____ When that small child grows up, would he or she be capable of responding differently? _____ What would you do if you were that caveperson? Would you run away, fight, or freeze? _____

**Lesson 2.3. Recognizing and Regulating my Energy**

Lots of energy is available when the stress response is activated. The purpose of that energy is to run away or fight in threatening situations. What happens to all that energy if I do not run or fight? I know that I want to channel my energy in healthy ways. In order to learn how to channel my energy, I rate the intensity of my energy on a scale from -1 to +10 where -1 means shut down or freeze and +10 means hyperactive (See Tables 8 & 9).

Table 8. My Energy Scale When I Sense the Need to Run away or Fight (Blaustein & Kinniburgh, 2010)

| -1 | 0 | +1 | +2 | + 3 | + 4 | + 5 | + 6 | + 7 | + 8 | + 9 | +10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Shut down | Low energy | | | | Focused: Alert and Aware | | | High Energy or Hyperactive | | | |

Table 9. My Energy Scale When I am in the Freeze Mode (Blaustein & Kinniburgh, 2010)

| -1 | 0 | +1 | +2 | + 3 | + 4 | + 5 | + 6 | + 7 | + 8 | + 9 | +10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Shut down | Low energy | | | | Focused: Alert and Aware | | | High Energy or Hyperactive | | | |

When I sense the need to run away or fight, my energy rating is # _____. When I am in freeze mode, my energy rating is # _____. When I sense my energy number getting very high or that I am shutting down, it may be helpful to "shake it off" or I can give myself a "butterfly hug." To make a "butterfly hug" I cross my arms over my chest and gently tap my fingers on my shoulders. In order to get my energy to the space where I can be focused, I can put my feet on the ground, and say "I hear _____, I see _____, I smell_____, I taste_____, I touch_____ ." This exercise is called grounding and orienting to my surroundings. Grounding and orienting to my surroundings helps me know that I belong in this place at this time.

1. Would this be true or false? I would be able to solve a math problem while fighting or running. _____
2. Please answer yes or no. I have felt stress when trying to concentrate on schoolwork. _____
3. Again, please answer yes or no. My ability to concentrate on schoolwork is good enough. _____
4. I have experienced the stress response when _____
5. When I experience stress, I usually (Choose one) fight, run away, or freeze. _____

**Lesson 2.4. Relaxation**

Once I decide that there is no more threat, my heartbeat and breathing rate slow down. At this point, I am able to relax and eat some food. I also am capable of concentrating on other things like my schoolwork or learning new skills. Relaxation is also an automatic activity in my brain and body. Specifically, the parasympathetic branch of my autonomic nervous system is responsible for the changes in my body to help me to relax. For example, my heartbeat slows down, my breathing rate slows down; my blood can flow again to my digestive system. After the stressful situation went away, I noticed that my stress response went away. When something comes and goes, that

means it is not permanent. Like bubbles popping, the stress just goes away. Goodbye toxic stress! It is a good idea that I schedule activities that I know can help me to get rid of some toxic stress, for example, by blowing bubbles.

**Lesson 2.5. Bubbles, Stress, and Emotions**

I like to blow bubbles. When I blow bubbles, I take a deep breath in, way down deep into my stomach. My stomach actually goes out or expands so that I can get more air into my lungs. Let's try that now. When I blow the bubble, I want to slowly release my breath. If I let the air out slowly, I can blow an awesome bubble. What happens to the bubble? _____ Is the bubble permanent? ____ Is stress permanent? ____

**Lesson 2.6. Accepting my Bodily Sensations**

Coping skill # 4 is to recognize and accept unpleasant as well as pleasant bodily sensations. I will remember to check with my parent or guardian to be sure that my stomachache or fast beating heart does not require medical attention. I recognize and gently accept my bodily sensations such as fast heartbeat or stomachaches caused by stress. If I fight the bodily sensations or have anxiety about having bodily sensations, I add an extra layer of stress to my anxiety. I know how my body responds to stress. My heartbeat gets _____. My breathing gets _____. My stomach _____. My ability to concentrate is _____. I know that these bodily sensations are not permanent.

**Lesson 2.7. Knowing I Can Because I Already Have**

Coping Skill # 5 is to remember past successful coping with similar situations. I can talk about other times I have had similar bodily sensations, or emotions, or worries. I remember how everything turned out. For example, I remember how my stomachache or headache went away. I know that this bodily sensation, or emotion, or worry will most likely go away. I can use the coping behaviors that worked last time I was sensing or feeling this bodily sensation, emotion, or worry. If that doesn't work, I can try a different coping behavior. For now, I will gently accept all of my bodily sensations.

**Lesson 2.8. Plan to Do Fun Things**

Coping skill # 6 is to schedule enjoyable activities. I can brainstorm possible fun activities. Brainstorming means that I write down all the ideas that pop into my head. Brainstorming is not a time for making judgments. I remember that there are no wrong answers when brainstorming. Although I write every idea on the list, I will not do everything I write down. If I am brainstorming with someone else, I also write down all their ideas even though I may not agree with the other person. _____

_____

I will consider any barriers to participating in the enjoyable activities. For example, perhaps I will want to get my work done first. These are the barriers that may prevent me from doing enjoyable activities I planned _____

_____

I will handle these barriers by _____

I will plan a time management schedule for this week that includes at least one of the enjoyable activities on my list.

**Lesson 2.9. Plan Time with the People Who Matter to Me**

Coping skill # 7 is to schedule time with loved ones. It is important to recognize the value of our relationships. Humans are social beings by nature and we all need each other. Discuss any barriers to spending time with loved ones. _____

Also discuss possible solutions to overcoming barriers. _____

Look at the time schedule for this week. Brainstorm possibilities for together time. _____

_____

I will include time to be with my family in my schedule by _____

**Lesson 2.10. Focused Breathing**

Coping skill # 8 is focused breathing. Sometimes, focused breathing is about observing my natural breathing rhythm. I can also focus on timed breathing, square breathing, or abdominal breathing.

*Natural breathing.* When I pay attention to my own natural breathing without changing anything about the breathing, I am practicing natural breathing. It is important for me to pay attention to my own natural rhythms. I can

pay attention to where in my body my breath is going. For example, moving into my nose, my throat, my lungs, then out from my lungs, into my throat, and out through my nose.

*Timed breathing.* I can count how long it takes for me to breathe in, then count how long it takes to breathe out. I can also decide on the time. I can breathe in to the count of four, then breathe out to the count of four. I can change the timing. I can try to take longer to breathe out than it breathing in. I exhale slowly through my nose so that I do not hyperventilate.

*Square breathing*. Like a square has four sides, I think 4-4-4-4. I breathe in to the count of four. I hold my breath to the count of four. I breathe out to the count of four. I hold my breath to the count of four. Then, I start again. The sides of a square can be any length. I could do square breathing to a count of 2-2-2-2.

*Abdominal breathing is diaphragmatic breathing.* The diaphragm is a muscle between the abdomen and the chest. I focus on using my *stomach* or *abdominal* muscles to pull air in. As I expand my stomach and chest outwards, I breathe in. When my diaphragm moves down, there is more space in my chest for my lungs to expand (like a balloon). I can breathe in lots of air. When I pull my abdominal muscles in, my diaphragm goes up, and I push air out of my lungs. My lungs are deflated because there is less room for air (like a deflated balloon).

To help me practice abdominal or diaphragmatic breathing, I can think of the castle song from Sesame Street. "A king and a queen, once lived in a castle. On top of my stomach, that castle was found. When I breathe in, they live high on the mountain. When I breathe out, they live low to the ground. Well, I breathe in, up goes the castle. I breathe out, the castle goes down. Breathe in, high on a mountaintop. Breathe out, low on the ground."

**Lesson 2.11. Progressive Muscle Relaxation**

**Contrast.** Coping Skill # 9 is to use Progressive Muscle Relaxation. Progressive muscle relaxation is a meditation where muscles are intentionally tensed then relaxed. The intentional tensing and relaxing of muscles is progressive because I proceed in a logical fashion, either top to bottom or bottom to top.

**End-of-session calming exercise for unit two: Breathing down to my toes.** Thinking about contrast helps me to be more aware or mindful. When thinking of my muscles, the contrast is between tensing or contracting my muscles, for example making a fist, versus relaxing my muscles. In the example that means relaxing my fist. Start with tensing your face muscles, then relax face muscles, think of breath going into your nose and to your face

then moving out from your face and out through your nose. Tense up the neck muscles, then relax neck muscles, think of breath going into your nose and down to the neck, hold it, then imagine breath moving out past the neck and out through the nose. (Pause)

Tense up your shoulders, then relax shoulders, think of breath going into your nose, down your windpipe and to your shoulders, then imagine breath moving out of your shoulders, up through your windpipe, and out through your nose (Pause)

Tense up your arms & hands, then relax your arms & hands. Again, imagine moving the breath into your nose, down your windpipe, into your arms & hands, then imagine moving the breath out of your arms & hands, up your windpipe, out through your nose.

Now, tense up your chest and back muscles, then relax chest and back muscles. Think of your breath going into your nose, down your windpipe and into your lungs as deep as you can go, hold it, then imagine your breath slowly moving out and up. (Pause) Push your stomach way out as you breathe in through your nose, down your windpipe, into your lungs, and into your abdomen. (Pause) Then slowly pull your abdomen in as you allow your breath to slowly move out from your abdomen, up through your lungs, up through your windpipe, and out through your nose. Practice breathing down into your abdomen. Imagine the breath going a little deeper each time you breathe in. (Pause)

Tense up your upper legs or thighs, then relax your upper legs or thighs. Imagine breath moving in through you nose, down your windpipe, into your lungs, into your abdomen, down to your upper legs. Then imagine that breath slowly moving from upper legs, through abdomen, through chest, through windpipe, through nose. (Pause)

Think of taking a really deep breath into your nose, lungs, abdomen, upper legs, and down to your knees. It is okay to take a few tries to get your breath to travel all the way down to your knees. Hold up your finger when it gets down to your knees. (Pause) Slowly, move that breath up through your upper legs, your stomach, through your lungs, through your nose and out. Hold your finger up when the breath is out. (Pause) Tense up your lower legs and your feet muscles. Now relax your feet muscles. Do your best to slowly bring that breath all the way down to your feet and toes. (Pause) Slowly move that breath up out. (Pause) Take five slow breath cycles in and out. (Pause) Be aware of the calm. Be aware of how relaxed your body feels right now. When you are ready, open your eyes.

**Homework Suggestions for Unit Two**

I chose _____ to be my reward for finishing at least one activity from this list.

_____ Option 2.1. Teach your parent or guardian about focused breathing, such as natural, timed, or abdominal.

(1) Natural focused breathing is paying attention on purpose and nonjudgmentally to my breath.

(2) Timed breathing is counting how long it takes to breathe in, then counting as I breathe out.

(3) Square breathing: I think of the square. I count to __ as I breathe in, hold for __ seconds, then breathe out to the count of _____, and hold for _____ seconds.

_____ Option 2.2. Teach your parent or guardian about the contrast of tensing muscles versus relaxing muscles.

_____ Option 2.3. What are your parent or guardian's favorite coping strategies or ways to deal with stress?

_____

_____ Option 2.4. Discuss with your caregiver some fun activities that you might do together. For example,

(1) Sharing a book or watching a television program together, then discuss what each person liked or did not like about the book or show. _____

(2) Pick a recipe and work together in the kitchen to follow recipe. What did you cook? Did it taste good?

_____

(3) Go for a walk together. Where did you go? What did you see?

_____

(4) Throw a ball back and forth to each other. _____

(5) Have your parent or guardian teach you a game that he or she played as a child, such as jacks, marbles, kick the can, hoola-hoop, skating, or pick up sticks. _____

_____ Option 2.5. I will be a detective during this week to find evidence that I use coping skills. I can write a few words about each time I used that coping skill. So far, we have learned about these coping skills: think of favorite things; listen to music; active meditation, for example, Shake, Wiggle, Jiggle, and Dance; schedule enjoyable activities; recognize the value of relationships; schedule time with loved ones; recognize and accept unpleasant bodily sensations caused by the stress response; and, focused breathing. I will remember to check with parent or guardian to be sure that my stomach ache or fast beating heart does not require medical attention.

**Unit 3. Emotions**

I will give my honest answers on the Healthy Core Beliefs Scale for Unit Three (Table 10). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs (Table 5; p. 96).

Table 10. Healthy Core Beliefs Scale for Unit Three

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |
| I am lovable | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |
| I am worthy | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |
| I am capable of achieving my goals | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

**Check homework.** If you have completed at least one of these activities, you may receive your reward.

I taught my parent or guardian about focused breathing (natural, timed, square, and abdominal). _____

I taught my parent or guardian about the contrast of tensing muscles versus relaxing muscles. _____

My parent or guardian's favorite coping strategies (ways to deal with stress) are _____

My parent or guardian and I brainstormed about some fun activities we might do together. My parent or guardian and I decided to _____

I was a detective during this week. Here is some evidence that I use coping skills:

_____ _

Here are some specific examples of how I used coping skills this past week:

_____

**Lesson 3.1. Emotions are Messages**

We may feel emotions in our bodies; however, emotions are not the same as bodily sensations. Emotions are a message system that existed before human beings as a species developed languages. Individuals have used emotions before learning to talk. Emotions help people to know what is important. In other words, my emotions help me to know what I want in life. Listening to my emotions can help me to set my goals.

At times, people experience unpleasantness when feeling sad, angry, fearful or happy. Rather than judge emotions as being *good* or *bad*, it is wise to say that an emotion is pleasant or unpleasant. This attitude means that I am being nonjudgmental about emotions. Learning to tolerate unpleasant as well as pleasant emotions helps me to learn and grow. If I do not pay attention to the message, the emotion seems to start *yelling* louder and louder. Blocking emotions causes problems.

Coping skill # 10 is to recognize, manage, and appropriately express all emotions. Labeling an emotion with a specific word is the first step. It is important that I learn to identify different types of emotions because each one has a different function. In this unit, I will learn to label and consider the message or the function of each emotion. I will learn how other people respond to each emotion. I can look at what happened immediately before feeling the emotion. I can ask myself, "What am I learning about myself from this emotional situation? What do I value? Who or what do I want to protect? On what do I want to focus?"

**Lesson 3.2. Unraveling Tangled Emotions**

**Facial expressions.** *Act out* the facial expression and bodily posture for each emotion. Discuss how *making the face* is connected to feeling that way. When my facial expression looks like a happy face, I feel _____. On the other hand, when I make an angry expression on my face, I feel _____. If I make an expression for scared or frightened, I may feel _____. When I make a sad face, I feel _____.

Sometimes I may feel so many emotions at the same time, I cannot tell what I am feeling. I may only know that I am upset. It may help to *break it down* into the four primary emotions: glad, sad, mad, and afraid. Although other emotions may also be present, it is wise to start with the four primary emotions. Fill in the blanks in this unit and on each of the squares in the Unraveling Tangled Emotions chart (See Figure 3).

| Mad = Anger | Glad = Happy |
|---|---|
| -1…0…+1…+2… 3… 4… 5… 6… 7… 8…+9… +10 | -1…0…+1…+2… 3… 4… 5… 6… 7… 8… +9… +10 |
| Facial expression:<br>Eyebrows _____<br>Lips _____<br>Bodily sensation:<br><br>Other people's response to my anger:<br><br>I respond to someone else's anger by:<br><br>Function of anger: To protect my boundaries.<br>To protect my loved ones.<br><br>Questions to ask myself when I am angry:<br>What needs protecting?<br>What am I protecting?<br>Who am I protecting?<br><br>Action: I set my boundaries.<br><br>Variations of anger: | Facial expression:<br>Eyes _____<br>Lips _____<br>Bodily sensation:<br><br>People I talk to when I feel happy:<br><br>Other people's response to my happiness:<br><br>I respond to someone else's happiness by:<br><br>Function of happiness: Allows me to connect, to learn, to grow, to find meaning and purpose in life. I appreciate happiness when I feel it and do not expect happiness to be my only feeling.<br><br>Questions to ask myself when I am happy:<br>What do I enjoy doing?<br><br>Action: I schedule time for enjoyable activities.<br><br>Variations of happy: |
| **Afraid = Fear** | **Sad** |
| -1…0…+1…+2… 3… 4… 5… 6… 7… 8… +9… +10 | -1…0…+1…+2… 3… 4… 5… 6… 7… 8…+9…+10 |
| Facial expression:<br>Eyebrows _____<br>Lips _____<br><br>Bodily sensation:<br><br>Other people's response to my fear:<br><br>People I talk to when I feel afraid:<br><br>How I respond to someone else's fear:<br><br>Function: To increase focus<br>Questions to ask myself when I am afraid:<br>On what do I need to focus?<br>What do I expect to happen?<br>Action: I focus on doing what will help me achieve my goals.<br><br>Variations of fear: | Facial expression:<br>Eyebrows _____<br>Lips _____<br><br>Bodily sensation:<br><br>Other people's response to my sadness:<br><br>People I talk to when I feel sad:<br><br>I respond to someone else's sadness by:<br><br>Function: To realize what and whom I value.<br>To allow myself to grieve.<br>Questions to ask myself when I am sad:<br>What or who have I lost? What or who do I miss?<br>What specific qualities or activities do I miss?<br>Is there a different way to accomplish my goal?<br><br>Action: I give myself time to grieve.<br>Variations of sad: |

Figure 3. The Unraveling Tangled Emotions Chart

**Fear.** Fear helps me to focus. For example, if I am afraid that I will fail a test, I will focus on studying. If I fear that I will get in a car accident on the wet and slippery road, I will focus on my driving. I feel fear when _____. Here is where I will want to focus in order to honor that fear _____.

**Sadness.** Sadness helps me realize what is important to me. Sadness flows through me when I grieve to help me let go, release, or change my relationship to the person, thing, or expectation I have lost. I feel sad when _____. This sadness helps me to know that _____ is important to me.

**Anger.** Anger is activated when my physical or emotional boundaries are violated. Anger helps me to protect my boundaries. Anger helps me to protect my loved ones or myself. Anger drives me to action. When I learn to appropriately express my anger, I protect myself and I learn to strengthen my boundaries. I will learn about being assertive enough without being inappropriately aggressive.

**Happiness.** Happiness is the spice of life. I may find meaning where I find happiness. I feel happy when _____ or I feel happy about _____. I do not expect happiness to be the only emotion I experience. People who chase only after happiness usually do not find it. Happiness usually has a way of finding me when I am busy living my life, doing my work, and loving people.

**Lesson 3.3. Accepting Ambivalence**

Coping Skill # 11 is to accept ambivalence. Ambivalence is feeling two different emotions at once. I can picture ambivalence as holding one feeling in one hand and another feeling in the other hand. Ambivalence can be confusing. For example, I may feel both sad and glad at the the end of a school year because _____ _____ Here is a another scenario where I may feel happy and sad at the same time_____

**Lesson 3.4. Expanding my Emotion Vocabulary**

**Different words express different intensities and combinations.** Instead of using only four emotion words, I can learn to use other words to describe feelings. For example, instead of using only the word *sad,* I may

want to say, “The girl feels disappointed.” Other words for variations of primary emotions include abandoned, aggravated, angry, annoyed, anxious, awed, concerned, content, depressed, despair, disappointed, discouraged, elated, enraged, fear, frightened, frustrated, grateful, happy, horrified, inspired, isolated/alone, joy, peaceful, relaxed, regret, rejected, rejuvenated, refreshed, resentment, stress, tense, terrified. Notice that these different words for the four basic emotions have a certain sense of intensity. Some of these words also indicate a combination of two or more of the basic emotions. For example, disappointed may be a combination of sad and angry.

**Intensity of emotions.** I will cut out emoticons or pictures of faces displaying variations of the four basic emotions. I will place each picture of emotional expression in the happy, sad, angry, or fearful square on Figure 3. Within each of the four categories, I order the emotion words from least intense to most intense.

Mad: _____

Sad: _____

Glad: _____

Afraid: _____

**Lesson 3.5. How People Respond to Expressions of Emotions**

It is also important to pay attention to how other people respond to different emotions. Other people usually respond to my sadness by _____.

When someone feels sad, I usually _____. I would prefer for other people to respond to my sadness by _____.

Other people usually respond to anger by _____.

When another person feels angry, I usually _____.

I would prefer for other people to respond to my anger by _____

_____.

Other people usually respond to fear by _____.

When someone feels afraid, I usually _____.

I would prefer for other people to respond to my fear by _____

_____.

Other people usually respond to happiness by _____.

When another person feels happy, I usually _____.

I would prefer for other people to respond to my happiness by _____

_____.

**Lesson 3.6. Confusion, Disgust, Surprise, and Feeling Overwhelmed**

Emotions other than the variations of the primary four that are easy to recognize, label, and express include confusion, disgust, surprise, and feeling overwhelmed. Other emotions that I think are easy to recognize, label, and express are _____.

**Confusion.** Make facial expression for confusion. Other people respond to my expression of confusion by _____. The function of confusion is _____.

When I see that someone else is feeling confused. I respond by _____.

**Disgust.** Make facial expression for disgust. People usually respond to expressions of disgust by _____

_____

The function of disgust is _____

**Surprise.** Make facial expression for surprise. Other people respond to my surprise by _____.

The function of surprise is _____.

I usually respond to surprise by _____.

**Feeling overwhelmed.** Make facial expression for feeling overwhelmed. Other people respond to my sense of feeling overwhelmed by _____

I respond to feeling overwhelmed by _____

_____.

The function of feeling overwhelmed is _____.

**Lesson 3.7. Embarrassment, Shame, Guilt, or Boredom**

Other emotions that may be difficult to label or express include embarrassment, shame, guilt, or boredom.

These are the emotions I consider difficult to recognize or express _____.

**Embarrassment.** Make facial expression for embarrassment. I feel embarrassed when _____

_____

Other people respond to my expression of feeling embarrassed by _____

I respond to feeling embarrassed by _____

The function of feeling embarrassed is _____

**About shame.** Notice that feeling guilty and feeling shame are different. When I feel guilty, I know that I didn't behave in the way that I wanted to behave. If I feel guilty, I can apologize and make amends. Hopefully, the other person can forgive me. Even if the other person does not forgive me, I can forgive myself. Forgiving myself means that I can move on and choose other behaviors in the future. On the other hand, shame has a focus on my personal character rather than my behavior. If I feel shame about what I have done, I think that I did the behavior because I am a *bad* person. Shame says there is something wrong with me. It is more helpful to admit to my guilt and focus on my behavior. I can change my behavior.

When someone does something to harm me or someone I love, I will probably feel angry. I may also feel surprised, sad, or disappointed about the person's behavior. After I honorably express my anger, surprise, sadness, or disappointment, I can choose whether or not to forgive that person. Even if that person does not apologize to me, I can forgive him or her. Forgiving others does not mean that I think it was okay for them to do what they did. When I forgive someone else, I choose to not hold any resentments towards that person. In understanding that all people make mistakes, I allow the other person the opportunity to move on and choose better behaviors in the future.

Consequences naturally come from actions. Forgiveness does not take away consequences. When I forgive someone, there are still consequences for what he or she has done. Even though I may not hold any resentments, I may want to keep my distance from that person. I can forgive someone and maintain my right to protect myself, others, and my boundaries. It is okay for me to be cautious. I decide how close I will allow other people to get to me.

**Guilty.** Make facial expression for feeling guilty. Other people respond to my expression of feeling guilty by _____

The function of feeling guilty is _____

I respond to feeling guilty by _____.

**Boredom.** Make facial expression for feeling bored. Other people respond to my expression of feeling bored by _____. I respond to feeling bored by _____. To me, feeling bored means _____. The function of feeling bored is _____. Here is how other people could help me when I am feeling bored _____. Perhaps I am bored because there are no complications in my life right now. _____.

**Lesson 3.8. Expressing Emotions**

Some expressions of emotions are appropriate and honorable because the expression does not harm another person or myself. Inappropriate and dishonorable expressions of emotions harm other people or myself and do not solve any problems. I benefit by appropriately and honorably expressing my emotions. It is appropriate and honorable to say, "I feel angry about _____ because _____." When I use "I" statements such as this, no one gets hurt and two people can work on solving the problem. It is appropriate and honorable to say, "I feel afraid about _____ because _____." Admitting that I am sometimes afraid is admitting that I am human.

It is appropriate and honorable to say, "I feel sad about _____ because _____." It is okay to feel sad. It would be abnormal to never feel sadness or to ignore my sadness. I may want help if I am grieving the loss of a loved one or if my sadness stays around for a very long time and interferes with my daily life.

If I feel so sad that I am thinking of killing or harming myself or someone else, I want to immediately call my local helpline at _____ or the national crisis line at 1-800-273-TALK. If I know that I cannot control myself, I may choose to go to the emergency room of a hospital. The trained people who answer the phone or see me in the emergency room want to listen to me. These people have promised to keep confidential whatever I tell them unless someone is hurting me or I cannot keep myself or someone else safe from harm.

**Lesson 3.9. Empathy and Compassion**

**Coping Skill # 12 is to practice empathy.** *Empathy* is recognizing other people's emotions. When I think about characters in my favorite stories from books, television, or movies, I can think about the emotions those characters are feeling. Here is a list of my favorite characters and some of their feelings_____

_____.

**Coping Skill # 13 is to show compassion for other people.** I imagine what it would be like in the other person's shoes. When I exercise compassion, I respond to others the way I would want them to respond to me if I were feeling the same way. Here is how I would respond to each of the characters that I listed above. _____. When I exercise self-compassion, I treat myself the way I would treat loved ones. I show myself compassion by _____.

**Coping skill # 14 is doing art work.** Examples of art work include painting, drawing, coloring, sculpting with clay, knitting, crocheting, needlepoint, embroidery, macramé, beading, woodworking, making stain glass windows, welding, carpentry, and more. Here are some examples of how people I know do art work _____ _____ _____.

**End-of-session calming exercise after unit three sessions: Doing art work.** We will mix and paint colors of our emotions in a mask. I will paint colors representing my private emotions that I do not share with other people inside the mask. I will paint colors representing the feelings I choose to show the world on the outside surface of the mask. It is okay if I choose different meanings for each color than other people would choose.

Table 11. Key of my Meanings for Each Color Created by Me

| Color | Meaning |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Homework Suggestions for Unit Three**

I chose _____ to be my reward for finishing at least one activity from this list.

_____ Option 3.1. With a parent or guardian, discuss the name and the function of each emotion. Play the face imitation game. Did your parent or guardian also feel the same as the face he or she was making? _____

_____ Option 3.2. Find at least one relative or neighbor who has a special hobby, such as painting or drawing for fun, knitting or crocheting, woodworking, furniture finishing. The special hobby I would like to learn about is _____.

_____ Option 3.3. Keep a tally of your emotions this week using Table 12. Also rate your energy when you felt each emotion. Did you accept each emotion without judging it?

Table 12. Weekly Tally Chart of Four Basic Emotions

| | Happiness<br>-1…..5….+10 | Sadness<br>-1……5….+10 | Fear or Concern<br>-1.....5…. +10 | Anger<br>-1…..5…. +10 |
|---|---|---|---|---|
| Sunday | | | | |
| Monday | | | | |
| Tuesday | | | | |
| Wednesday | | | | |
| Thursday | | | | |
| Friday | | | | |
| Saturday | | | | |

**Unit 4. Thoughts, Affirmations, and Mindfulness Meditation**

I will give my honest answers on the Healthy Core Beliefs Scale for Unit Four (Table 13). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs (Table 5; p. 96). During the last session of the Building Healthy Core Beliefs program, my therapist and I will discuss whether or not my beliefs have changed.

Table 13. Healthy Core Beliefs Scale for Unit Four

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

**Check homework.** If you have completed at least one of these activities, you may receive your reward.

Answer yes or no. I taught my parent or guardian about emotions.

This week, I nonjudgmentally accepted # ___ of my # _____ emotions this week.

Nonjudgmental means _____

I noticed that my emotions were not permanent. _____

I used fear this week to focus on _____

I used my anger to set my boundaries this week when _____

_____

I was sad this week when _____

I noticed happiness this week when _____

**Lesson 4.1. Healthy Thinking**

Coping skill # 15 is to replace *stinky thoughts* with accurate and helpful thoughts. Some thoughts in my brain are helpful and based on reality. These thoughts are accurate. Other thoughts may not be accurate or may not be helpful, I call these *stinky thoughts*. Examples of stinky thoughts that belong in the trashcan include:

a) Mind reading means thinking I know what someone else is thinking.
b) Predicting the future means thinking I know what will happen in the future.
c) Ignoring the positives and focusing on the negatives
d) Using words such as *should* or *have to* or *must* or *ought*
e) Using words such as *always* or *never* or *everyone* or *every time*
f) Using words like *can't*
g) Thinking I must act on every thought that pops into my head
h) Thinking with my feelings.
i) Labeling myself or others
j) Blaming others for my difficulties
k) Blaming myself for the behavior of others
l) Maximizing or viewing what is happening now as a catastrophe
m) Minimizing my feelings or thoughts at this moment
n) When I think that an event that happened once will repeatedly happen
o) All-or-nothing thinking

I am putting my Stinky Thoughts in the trashcan. I am on the lookout for Stinky Thinking because I am a good detective about what is healthy for me. Stinky Thinking is not healthy thinking. The best way to think less stinky thoughts is to replace them with healthy, accurate thoughts. I will keep a list of healthy, accurate thoughts in my pocket.

a) I do not know what someone else is thinking.
b) I will think about my thoughts.
c) My future has not been pre-written.
d) I do influence my future.
e) I accept that there are both pleasant and unpleasant realities in life.
f) I will think before acting. Rather than quickly reacting, I will pause and choose my own actions.
g) I will take responsibility and ownership of my behavioral choices.
h) I will replace *should and have-to* with *I want to…*
i) I will replace *always* or *never* with *sometimes* or *once in a while* or *occasionally*
j) I have control over my own behavior.
k) Wise mind = Rational mind + Emotional mind
l) I accept my limitations.
m) I forgive my own mistakes.
n) I believe that it is okay to make mistakes sometimes.
o) I accept other people's limitations.
p) I forgive other people's mistakes.
q) I accept and learn from both my pleasant and unpleasant emotions.
r) I recognize my strengths, talents, achievements, and accomplishments.
s) I recognize and appreciate other people's strengths, talents, achievements, and accomplishments.

**Lesson 4.2. Two Opposites and Both Are True**

Dialectical is a complicated word for an idea that is very much like ambivalence. Remember ambivalence from the lesson on emotions means that someone can feel two different emotions at the same time. Dialectical means that two seemingly opposite things can both be true. Some examples include how I view myself.

The first dialectical example is that I may accept and appreciate myself the way I am *and* I want to work to change something about myself. Do I think both sides of this dialectical are true for me? _____

What do I think is opposite about the two sides of acceptance and change? _____

_____

Here's what I appreciate about myself: _____

_____

_____

Here's what I want to change about myself: _____

_____

_____

The second dialectical example is that I love someone *and* I dislike or hate this person's behavior. Do I think both sides of this dialectical are true for me? _____

What do I think is opposite about the two sides of this statement? _____

_____

_____ is someone I both like and dislike. I like that _____

_____

I dislike that _____

_____

Some other examples of dialectical truths include: _____

_____

_____

_____

_____

**Lesson 4.3. Positive Self-Talk and Affirmations**

Coping skill # 16 is to use positive self-talk and affirmations. I may notice that some thoughts seem to become a script in my head. An actor or actress uses a script to act out a part in a play. People often allow scripts that were written by other people to dictate how to see the world, what to say, and what to do. Self-talk is that voice in my head or the things I tell myself. That voice in my head may tell me critical or punishing words. That voice in my head may demand too much from me. Perhaps, I may demand too much from myself. Those critical, punishing, and overly demanding thoughts are not helpful.

On the other hand, positive and helpful thoughts are called affirmations. It is helpful to have an entire storeroom full of positive, accurate, and helpful thoughts to replace those critical, overly demanding, or punishing thoughts. It is more helpful for that voice in my head to say kind, supportive words. It is okay to treat myself the way the gentlest and most loving person in the world would treat me. What would the most loving person in the world say to me right now? _____

_____

_____

I can also say kind, loving, helpful, and accurate words to other people. My family and I can make a Treasure Chest of Affirmations by writing positive thoughts about a family member on small pieces of paper. I can also write kind thoughts about myself. We can place these positive affirmations in my family's Treasure Chest of Affirmations. On a regular basis, I can take out one of the affirmations to read. I may place one or two affirmations in my pocket to remind myself about the many good things about me. On Table 14, I will record the pros and cons of believing and not believing good things about myself.

Table 14. Matrix of Pros and Cons of Believing Good Things About Myself

| Pros of believing good things about myself | Pros of not believing good things about myself |
|---|---|
| Cons of believing good things about myself | Cons of not believing good things about myself |

**Lesson 4.4. Giving Myself Credit**

Coping Skill # 17 is recognizing and remembering my achievements. When faced with a difficult emotion or situation, I think of what I did to survive. I remember what does and does not work. I learn from my mistakes. Remember that we are recognizing our achievements with the flowchart. Frequently, we do not give ourselves credit for what we are doing well, e.g., getting out of bed, getting dressed, feeding and bathing, brushing teeth. I benefit from remembering that I am successfully caring for myself. I decide to continue to take care of myself. Here is how I care for myself every day: _____

**Lesson 4.5. Taking One Bite at a Time and Hope**

Coping skill # 18 is using compartmentalization and titration. Some thoughts may be helpful, except I will want to put some thoughts out of my mind for now. Intentionally saving some thoughts for later is called compartmentalization. It is healthy for me to compartmentalize. Some people actually write down lists so they do not have to think about the things on the list. Titration means that when I am ready, I will take out only small manageable pieces of information to think about.

If some thought is very scary or upsetting, I may write it down on a piece of paper and put it away in a special place in the therapy room. I do not have to think about it. I will allow my therapist to help me process any difficult thoughts when I am ready to do that work.

Coping skill # 19 is to use imagination and have hope. Hope is imagining something positive about my future. An architect must imagine a building in his or her head before the building is built. On Table 15, I will record the pros and cons of believing and of not believing something positive about my future.

Table 15. Matrix of Pros and Cons of Imagining Something Positive About My Future

| | |
|---|---|
| Pros of believing that the there will be something positive in my future. | Pros of NOT believing that the there will be something positive in my future. |
| Cons of believing that the there will be something positive in my future. | Cons of NOT believing that the there will be something positive in my future. |

**Lesson 4.6. Mindfulness**

Coping skill # 20: Mindfulness means paying attention on purpose to here and now without being judgmental. Mindfulness has three word parts _____ + _____ + _____. Mind means _____. The suffix *–ful* means full of. The suffix *–ness* means the condition of being. The here means _____. The *now* means _____ and *not being judgmental* means _____. I do not want to miss this moment for it will not come again.

Important mindfulness skills include grounding and orientation. Grounding means being very aware that both of my feet on ground connected to the earth. Being grounded says that I belong right here, right now. I think being grounded means _____

Orientation skills also help me to be more aware of the here and now. I concentrate on each of my five senses to pay attention to what I am seeing, smelling, hearing, tasting, and touching at the present moment.

I see _____

I smell _____

I hear _____

I taste _____

I touch _____

The rule in therapy is that the student sets the pace. I can take the pace card out and read it when I'm beginning to feel overwhelmed. If I have had enough of serious talk for one day, I raise one finger and the seriousness stops.

**The Pace Card.** I will remember that I will go at my own pace. When the intensity of my feelings is getting too high, I will stop, notice both of my feet on the ground, I will pay attention to what I am seeing, smelling, hearing, tasting, and touching, I consider my touch points of my hands, elbows, shoulders, and bottom. I remember my supports and my strengths. I remember my accomplishments and my ability to take things one small step at a time. I think about compartmentalizing these feelings, thoughts, and sensations. I breathe in and I breathe out. I think about how it is normal to feel as though every time I take one step forward, I take two steps back. I breathe in and I breathe out. I think of my safe and happy place. I focus on my breath. I gently nudge away any other thoughts that enter my safe space. I breathe in and I breathe out.

Lesson 4.7. Building a Castle in My Mind

Close your eyes. Think about the slow and easy rhythm of your breathing. Pay attention to the air as it passes through your nose. Feel your breath as you slowly let it out. Breathe in slowly all the way down to your belly button. As you breathe out slowly, your stomach muscles are contracting. Take a deep breath in, all the way down to your toes. Continue to think about your slow and easy breathing rhythm. Feel your feet against the floor. Feel your bottom in your seat. Bring attention to the position of your shoulders, your arms, your hands, your fingers, and your feet at this moment in time. Gently push aside any thoughts other than breathing.

Now, we will take a journey in your imagination. In your mind, you will slowly stand up and walk to the door. When you open the door, you will magically be in a castle. You are the only person allowed inside this castle. This is the castle of your mind. This is your own space. You are the king/queen of this castle. This castle looks the way only you can imagine it will look. The walls of this castle are strong and keep out all other people. You notice that you are in the central part of the castle. There is no ceiling above you. You can feel the warm sunshine on your face. The cool breeze lightly brushes your cheek. You breathe in this peaceful breeze. You know this is a safe and happy place for you.

You are happy to look around this central place in your castle, called the "castle keep." You notice a garden with any food you may want to eat. You also notice a water source inside the keep. You imagine that you hear the running of the water. You decide to water the garden. What else do you see in the castle keep? _____

As you look around the walls of this castle, you notice doors. There are rooms behind those doors and you will decide whether or not you want to enter any of those rooms. You decide to walk over to open one of the doors. The door you open leads to a stairway. You climb the stairs. Up and up and up you go. Tell me when you have reached the top of this tall tower. This is the castle's turret. You like it up here because you have a view of all the land stretching out in all four directions around your castle. You see that your castle is on top of a hill. Several different lakes surround your castle. The fields and trees beyond the lakes are many different shades of green. The sky above is as blue as can be. Puffy white clouds drift across the blue sky. What shapes can you see in the clouds?

(Pause) You decide to go back downstairs. You walk down and down and down. You get to the level of the castle courtyard. You go to another door and there is a staircase going down. You walk down and down and down. You notice this is the dungeon. It is dark down here. You decide to return to the castle courtyard. You climb up

[slowly] and up [slowly] and up. You reach the ground level of your castle, walk out the door to the courtyard. Close the door behind you. Tell me when you are back in the sunshine. [pause] At the far end of the courtyard, you notice the door to get back to this classroom. You walk to that door, open it, walk through, and you are back in this room. When you are ready, you slowly open your eyes.

Remember there are no right or wrong answers to these questions. Personal preferences are important. What did you think about this castle-building activity? _____ What did you like about this activity? _____ What did you not like about this activity? _____

This is a meditation. Meditation exercises help to build important skills in our brains. Meditation exercises are a form of mindfulness. We did Shaking, wiggling, jiggling, and dancing in our first session. That is also a form of mindfulness meditation. Notice the difference between the two types of meditation. _____

Sometimes, people use meditation exercises when feeling stressed. It becomes a mini-vacation; it doesn't cost anything and takes five minutes. What would be the benefit of taking mini-vacations? _____

_____

Mindfulness exercises increase our ability to sharpen our focus or attention. Mindfulness exercises calm our minds and develop our imagination. Imagination is important because _____

_____

The main point of mindfulness exercises is to increase our ability to focus on the present time and place. Some people say that the present is a gift I give to myself. If I'm thinking too much about the past or the future, I'll miss the present. I'll miss this gift. Here's what I think about missing the present: _____

_____

Remember going up to the turret & down to the dungeon in the mindfulness exercise? Going down to the dungeon is like thinking about the past. We would not want to ignore the dungeon. We also do not want to spend all of our time there. There is something important in the dungeon. We'll talk about that later. Going up to the turret is symbolic of thinking or dreaming about the future. It is healthy to take some time to dream about the future. What would happen if I spent all of my time dreaming about the future? _____

_____

I can have some *closets* in my castle to store thoughts that I do not need to think about now. I will take out only small manageable pieces at a time to think about. I will allow my therapist to help me process any difficult thoughts. This process is called compartmentalization and titration.

**Homework Suggestions for Unit Four**

I chose _____ to be my reward for finishing at least one activity from this list.

_____ Option 4.1. Discuss the lists of stinky thoughts and healthy thoughts

_____ Throw *Stinky Thoughts* into the Trashcan

a. Mind reading is thinking that I know what someone else is thinking.
b. Predicting the future means thinking that I know what will happen in the future
c. Ignoring the positives or focusing on the negatives
d. Using words *should* or *have to* or *must* or *ought.*
e. Using words like *always* or *never* or *everyone* or *every time*.
f. Using words like *can't*.
g. Thinking I must act on every thought that pops into my head.
h. Thinking with my feelings.
i. Labeling others or myself.
j. Blaming others for my difficulties or taking the blame for someone else's behavior
k. Maximizing or viewing what is happening now as a catastrophe
l. Minimizing my feelings or thoughts at this moment
m. When I think that an event that happened once, will repeatedly happen.

_____Keep healthy and accurate thoughts.

a. I do not know what someone else is thinking. I will think about my thoughts.
b. My future has not been pre-written. I do influence my future.
c. I accept that there are both pleasant and unpleasant realities in life.
d. I will replace *should, have-to* with *I want to…*
e. I will replace *always* or *never* with s*ometimes* or *frequently* or *once in a while* or *rarely.*
f. I will replace *can't* with *I do not want to….* or *I would prefer to …* or *I have not learned that skill yet. Would you teach me?*
g. I will think before acting. Rather than quickly reacting, I will pause and choose my own actions.
h. Wise mind = rational mind + emotional mind.
i. Self-worth is not based on what someone does. A human being is not a human doing.
j. I will take responsibility and ownership of my behavioral choices.
k. I believe I can manage what is happening now;
l. I accept my limitations. I forgive my own mistakes. I believe that it is okay to make mistakes.
m. I accept other people's limitations. I forgive other people's mistakes.
n. I recognize and appreciate my strengths, talents, achievements, and accomplishments.
o. I recognize and appreciate other people's strengths, talents, achievements, and accomplishments.

_____ Option 4.2. Discuss the meaning of self-talk and the importance of saying nice things to myself.

_____ Option 4.3. Discuss the importance of affirmations to help each other build positive self-talk.

_____ Option 4.4. Decorate a shoebox to use as the family's Treasure Chest of Affirmations.

_____ Option 4.5. Encourage each family member to write affirmations about the other family members.

_____ Option 4.6. Discuss the reasons people take one bite at a time and how that relates to managing memories. Discuss how difficult it can be to talk about the past.

_____ Option 4.7. Discuss that mindfulness is intentionally and nonjudgmentally paying attention to the present. Discuss the meanings of intentional and nonjudgmental.

_____ Option 4.8. Discuss what is special about the here and now.

_____ Option 4.9. Teach your caregiver about grounding and discuss what being grounded means.

_____ Option 4.10. Show your caregiver how to become orientated using the five senses.

**Alternative Meditation. Space Station Meditation**

Close your eyes. Think about the slow and easy rhythm of your breathing. Pay attention to air as it passes through your nose. Feel your breath as you slowly let it out. Breathe in slowly all the way down to your belly button. As you breathe out slowly, your stomach muscles are contracting. Take a deep breath in, all the way down to your toes. Continue to think about your slow and easy breathing rhythm. Feel your feet against the floor. Feel your bottom in your seat. Bring attention to the position of your shoulders, your arms, your hands, your fingers, and your feet at this moment in time. Gently push aside any thoughts other than breathing.

In your imagination, we will take a journey to a space station. Your chair is your own special space ship. Ready, set, feet on ground and hang on tight. Keep breathing. The ceiling is opening up. 10-9-8-7-6-5-4-3-2-1 Blast off! We're going up and up and up. Breathe slowly and take in this view. Your spaceship goes past the clouds and slowly up through the atmosphere. Above the atmosphere, you notice how clearly you can see the planet earth. Wow! The earth is so blue! You travel to the space station of your mind. Your special rocket chair docks at your space station. You are the only person allowed inside this space station. This is your own space. You are the president of this space station. You unbuckle yourself, open a door, walk through the door, and close that door behind you. After the air is properly pressurized in this transitioning chamber, you step through a door and into your space station. This space station looks the way only you can imagine. The walls of this space station are strong and keep out all other people. You notice that you are in the central, gathering place of the space station. There are several large viewing windows to watch the stars and comets. You notice the air temperature is just right. You breathe in this peaceful air. You know this is a safe and happy place for you.

You are happy to look around this gathering place in your space station. You notice a tall wall of glass with a garden behind it. This is the hydroponics lab. All the food you will need is grown in this hydroponics lab. You step inside the hydroponics lab and notice a water source. You hear the running water. You decide to water the plants. You walk back out to the gathering place.

As you look around your space station, you notice doors. There are rooms behind those doors. You decide to open one of the doors. This door leads to a stairway. You climb the stairs. Up and up and up you go. Tell me when you have reached the top of the stairs.____ This place is like a *crow's nest* on a pirate's ship. You like it up here because you can see everything stretching out in all four directions around your space station. There are stars; there are millions of stars! There are a few comets passing by. Oh look, there's a galaxy.

You decide to go back downstairs. You walk down [slowly] and down [slowly] and down. Tell me when you are at the level of the gathering place. ____ You go to a different door and there are ladders going down into the technical equipment of the space station. You do decide to go down [slowly] and down [slowly] and down. It is dark down here. You decide to climb back up to the gathering place. You climb up [slowly] and up [slowly] and up. When you reach the main level of your space station. Walk out the door to the gathering place. There is the tall wall of glass behind you. At the far end, you notice the door to get back to the rocket chair that travels back to this classroom. Sit down in your chair, hang on tight, and tell me when you are back in this room. When you are ready, you slowly open your eyes.

There are no right or wrong answers to these questions. Personal preferences are important. What did you think about this space station meditation? _____

What did you like about the space station meditation? _____

What did you not like about the space station meditation? _____

Meditation exercises, a form of mindfulness, help to build important skills in our brains. Shaking, wiggling, jiggling, and dancing is an active form of mindfulness meditation. Imagining a place in the mind is a quiet form of mindfulness meditation. Paying complete attention to what I am doing in the moment is another form of mindfulness meditation. Here is what I notice is different about these different types of meditation. _____

_____

People sometimes use meditation exercises to take mini-vacations when feeling stressed. Do I think that mini-vacations could be helpful for me? _____

_____

Mindfulness exercises increase our ability to sharpen our focus or attention. Mindfulness exercises calm our minds and develop our imagination. Imagination is important. Here's what I think about imagination.

_____

_____

The main point of mindfulness exercises is to increase our ability to focus on the Here and Now. Some people say that the present is a gift I give to myself. If I'm thinking too much about the past or the future, I'll miss the present. I'll miss this gift. Here's what I think about the present. _____

Remember going up to the crow's nest and down to the technical space in the space station meditation? Going down to the technical rooms is symbolic of thinking about the past. We would not want to ignore the technical rooms. We also do not want to spend all of our time there. There is something important in the technical rooms. We'll talk about that later.

Going up to the crow's nest is symbolic of thinking or dreaming about the future. It is healthy to take some time to dream about the future. What would happen if I spent all of my time dreaming about the future? _____

I can have some *closets* in my space station to store thoughts that I do not need to think about now. There are many other rooms in my space station. I will take out only small manageable pieces at a time to think about. This is called compartmentalization and titration. I will allow my therapist to help me process those difficult thoughts at a time when I feel ready.

**Unit 5. Perspectives, Memory Packages, and Beliefs**

I will give my honest answers on the Healthy Core Beliefs Scale for Unit Five (Table 16). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs (Table 5; p. 96). During the last session of the Building Healthy Core Beliefs program, my therapist and I will discuss whether or not my beliefs have changed.

Table 16. Healthy Core Beliefs Scale for Unit Five

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

**Check homework.** If you have completed at least one of these activities, you may receive your reward.

_____ Option 4.1. I shared the Stinky Thoughts Trashcan activity with my parent or guardian.

_____ My parent or guardian and I discussed the list of healthy thoughts.

_____ Option 4.2. We discussed the meaning of self-talk and the importance of saying nice things to myself.

_____ Option 4.3. We discussed the importance of affirmations to help each other build positive self-talk.

_____ Option 4.4. We decorated a shoebox to use as the family's Treasure Chest of Affirmations.

_____ Option 4.5. Each of my family members wrote at least one affirmation about each member of the family

_____ Option 4.6. We discussed the reasons people take one bite at a time and how that relates to managing memories. We discussed that discussing past memories can be painful and difficult.

_____ Option 4.7. We discussed that mindfulness is intentionally and nonjudgmentally paying attention to the present. We discussed the meanings of intentional and nonjudgmental.

_____ Option 4.8. We discussed what is special about the here and now.

_____ Option 4.9. I taught my caregiver about grounding and discussed what being grounded means.

_____ Option 4.10. I showed my caregiver how to become orientated using the five senses.

**Lesson 5.1. Perspective**

In the first activity of this unit, we will look at four windowpanes or frames. In the first windowpane, there are lollipops, flowers, butterflies, puppies, and sunshine. People using this windowpane choose to only look for the beautiful things in the world, such as flowers and butterflies. In this worldview, the person places a high value on happiness and perfection. The beautiful and wonderful things in the world that I pay attention to are _____ _____.

Some people only want to see the *good* in the world. If I think there should only be good in world, what happens when I pick a rose and get pricked by a thorn, get bitten by a dog, get stung by a bee, or get in a car accident? _____
Do I think that *bad* things should only happen to bad people? _____

The second windowpane is a picture of dark storm clouds and heavy rain. The person with this worldview focuses on all the *bad* things in the world. The person using this perspective wants to be realistic about the world. I also know about some unpleasant things in the world including _____ _____
What would I be missing if I only looked at the unpleasant things in life? _____

The third windowpane shows only danger signs. My danger signs are _____ _____. It is important that I am aware of danger and that I have a safety plan. What is unhealthy about only paying attention to danger? For one thing, my body experiences the stress response almost all the time. It is not healthy for my body to always be in a stress mode. Also, _____.
There is a way to pay attention for signs of danger and learn to change loud alarms to gentle whispers of caution.

The fourth windowpane shows the world divided into *good* and *bad.* What is the problem with this perspective? _____
Are people actually either all *good* or all *bad*? Is it possible for each person to have a little bit of both sweetness and stinkiness? Does each person have both strengths and challenges? Do people have the chance to choose healthier and more loving behaviors? Is there forgiveness? Is it okay for people to be different from one another? Is it okay for people to choose different favorites?

**Lesson 5.2. Memory Packages**

Before I could be aware of anything, my brain was busy organizing and making sense of what I was observing about the world. I do my observing with my five senses: seeing, hearing, smelling, tasting, and touching. Memories made from my five senses are called sensory memories. After a significant event, my brain bundles up all of my sensory memories, emotions, bodily sensations, and thoughts about the event. My brain has created a *memory package* with this bundle. Similar experiences also get attached to this memory package. Another name for the bundle of memory packages is *schema*. My schemas are my *filters* or *windowpanes* for how I see the world. It is not possible to pay attention to absolutely everything in the world. My schemas will help me to focus my attention on things that are important to me. Sometimes this is healthy. Other times I may be paying attention to things that are not healthy for me. Some examples are below. If this reading becomes overwhelming, we can stop. I will indicate that I want to stop by raising my finger and reading my *Pace Card*.

If Sally's needs were not met as a child, she may focus exclusively on getting her needs met. Other people may think she is controlling or manipulative. Actually, she is just a child trying to do the work of an adult. On the other hand, she may think she is worthless and that she does not deserve to get her needs met. Sally may take care of everyone else at the expense of taking care of herself. Sally's perspective is shaped by her experiences of not having her needs met. Sally's behavior is usually based on this perspective even if she is not aware of her perspective. Does Sally deserve to have her needs met?

If Roger's first caregiver was not available for him as a young child or if his first caregiver abandoned him, he may believe that everyone will disappoint or leave him. He may not allow other people to get close to him. On the other hand, Roger may be very clingy and worry when people leave the room or the house. Roger may believe that people leave because he is not *good enough* and may overcompensate by trying to become *good enough.* Roger's perspective is influenced by his experience of being abandoned. How will believing that everyone will leave him affect Roger's ability to have healthy relationships?

If Ruthie was abused as a child, she may have trouble trusting other people. She may try to hurt others before they can hurt her. On the other hand, Ruthie may think she deserved the abuse. Her coping behavior may be to take extra special care of other people. She may treat other people the way she wants to be treated. Ruthie's perspective is shaped by her experiences of abuse. Did Ruthie deserve to be abused?

If Clarence was frequently criticized as a child, he may feel like a failure and think he cannot do anything right. He may feel helpless or powerless. Clarence may try to overcompensate for this belief by trying to be perfect. On the other hand, Clarence may not try his best. The perspective of Clarence has been built from his experiences of being criticized. Clarence's self-talk may reinforce or strengthen that perspective that he is powerless. Will Clarence be able to change his self-talk?

If Debbie was severely punished as a child, she may think she deserved the punishment. She may punish herself. If she overcompensates for having been severely punished, Debbie may not allow anyone to tell her what to do. Debbie's perspective has also been shaped by her past. Is it helpful for Debbie to punish herself? Did Debbie deserve severe punishment? Is Debbie to blame for the severe punishment? How could Debbie learn to be kind to herself?

Everyone has had experiences that were painful. Whenever anything similar reminds a person of the sensory memories or bodily sensations in his or her memory package or schema, all of the intense feelings about the painful event can be re-experienced as though the event is happening in the present. The person may also sense all of the bodily sensations from when the bad thing happened. Remember how the brain has tied all those sensory memories, bodily sensations, and emotions together. This experience can be overwhelming. This is a natural process helping someone to defend him- or her- self.

It is helpful to pay attention to what reminds me about something from the past. The triggers I know about are _____

_____

I will continue to pay attention to what triggers memory packages from long ago.

It is also important to recognize when the stress response has been triggered. When I am in a relaxed, non-stressed state, I practice my skills for calming the stress response so that I can use those skills when I have been triggered. I remember to be kind to myself. I know emotions come and go. I know the stress response comes and goes. I know stress is not permanent. I have hope for my future.

**Lesson 5.3. Core Beliefs**

As we learned in the last lesson, my perspective is like the windowpane I look through. How I see the world or my perspective affects my moods, thoughts, and beliefs. When I do not understand my normal reactions to abnormal events, I may think that I am broken, not good enough, unlovable, not capable of leading a "normal" life, or not capable of dreaming about the future. This type of thought about myself is an unhealthy core belief.

My core beliefs are part of my perspective. Some experiences cause people to believe that they are not *loved, unlovable, not worth*y, or *not capable*. Sally, Roger, Ruthie, Clarence, or Debbie may believe some unhealthy core beliefs because of their experiences. Whether or not someone remembers the experiences that led to the unhealthy beliefs, it is important to identify the unhealthy beliefs and seek healthier beliefs. Although it is difficult to change core beliefs, it is not impossible.

In the last unit, we learned about stinky thoughts. The stinky thoughts are right there on the surface, in my consciousness. My core beliefs are not as easy to identify as the stinky thoughts. The core beliefs are deep in my core, deep within my brain. Some of those core beliefs are so *sneaky*. Most people are not aware of these *sneaky beliefs*. The problem with sneaky beliefs is they do not ask my permission to control how I see the world, other people and myself. Believing sneaky beliefs can mess up my perspective or scratch my windowpane. I do not want the sneaky beliefs to control my view of the world, other people, and myself. I want to control how I choose to see the world, other people, and myself. I want to choose my own perspectives. I will choose my own perspective by choosing to believe healthy core beliefs.

Something interesting is that I do not have only a conscious mind. I also have an unconscious mind. My unconscious mind is so smart. My unconscious mind takes care of so many things for me. For example, my unconscious mind takes care of my heartbeat. I am glad that I do not have to think about keeping my heart beating. My unconscious mind is always trying to help me to survive. Those sneaky beliefs cannot hide from my smart, unconscious mind. I am going to trust my smart, unconscious mind to help me. I am going to help my conscious mind to become aware of my core beliefs.

I can choose to give my attention to building healthy beliefs about myself. I may want to be just as sneaky as those beliefs. Playing the role of a detective, I will look for evidence in my life of an alternative and healthier belief. In other words, I am choosing to look through a windowpane or perspective that is healthier for me. I may

need to work really hard. That's okay. I have done difficult things in the past. I can work hard and put my mind on believing healthy things about myself. It helps to know that sometimes those sneaky beliefs were formed before I could talk. I was too young to understand what was happening. Now, I am old enough to use my words and to seek for some answers. I am old enough to understand things differently now.

Playing the role of an investigative reporter, I will ask important questions. I will look at how each belief was necessary when I was younger. My beliefs and the behaviors I used to cope with those beliefs helped me to survive. It is good that I survived. I will remember that I am a survivor. I will examine each aspect of the belief and understand how I might not need those *sneaky beliefs* at this point in my life. It is not easy to change my perspective. It is also not impossible. Just because something is difficult does not mean I won't try. I have done plenty of things in the past that were difficult. For example, I _____

**Lesson 5.4. Other People Can Help Me**

Coping skill # 21 is to allow other people to help me. I will allow these people to help me _____

_____

_____

**Lesson 5.5. Freedom is Choosing My Own Responses**

Coping skill # 22 is to believe and say, "I did not choose what happened to me in the past; however, I choose my response to the past. I choose my own behavior in the future." On a scale from one to ten, with ten being *I believe this statement very much*, I rate the statement, "I did not choose what happened to me in the past; however, I choose my response to the past. I choose my own behavior in the future." at a #_____. I think _____

_____

Right now, I feel all of these feelings _____

_____ The most intense feeling is _____

On a scale from 1 to 10 with 10 being the most intense, the intensity level of this feeling is _____

Coping skill # 23 is to use the statement, "I would have preferred..." to discuss how I would have made different choices than other people in the past. Here are some things I would have preferred _____

_____

**End-of-unit five calming exercise: Make two drawings on transparent film**. The first drawing is my perspective when I was younger. On another transparency, I will draw how I choose to view the world in the future. I can choose to be optimistic, pessimistic, or have a balanced perspective. I can choose to view the world as divided with *good* on one side and *bad* on other. I can choose to put individuals into these divided categories. Alternatively, I can choose to see that there are pleasant and unpleasant realities in the world and that each person has strengths and limitations. I know that some people are safe and some people are not safe. I choose to be with safe people as much as possible. I will learn about how to relate to people who are not safe with the help of my parent/guardian, therapist, counselor, teacher, or _____. I may choose to love some people by keeping a safe distance between him or her and me.

I may have a sense of hypervigilance or always on the lookout for danger. This hypervigilance may seem like loud sirens. Also, I may startle easily. Alternatively, I can turn the loud sirens into helpful whispers in my ear. I will look at the present circumstances with awareness of how my past influences my perspective and beliefs. I can be aware of how the circumstances of the present are similar to and different from the past. I can protect myself now by using my fear to help me focus on important details. I can use my anger to protect myself. I will remember my strengths and limitations. I will use my safety plan when necessary. I will use my words to express myself. I deserve protection.

**An artist's view of perspective.** Perspective has a slightly different and related meaning in the art world. One-point perspective in artwork emphasizes: (1) foreground or the things that are up close and near; and, (2) background or things that are far away. The concept of foreground and background is related to our lesson on perspectives in life because we put some things in our foreground and keep other things in the background. The things that are in my foreground are _____ and my background are _____.

**Coping skill # 24 is journaling.** When I journal, I write about my thoughts, feelings, bodily sensations, perspectives, or beliefs. Perhaps I write "I would have preferred …" or "I would have chosen to…" statements.

**Homework after unit 5:** I will journal this week. I will not worry about spelling or sentence structure. I will write or draw my thoughts, beliefs, opinions, and feelings. I may write about what I see, smell, hear, taste, or touch this week. If I feel inclined, I will write a poem or some song lyrics. My journal is my private space. I am not required to share what I have written or drawn in my journal. I do not have to tell anyone about my journal.

**Homework Suggestions for Unit Five**

I chose _____ to be my reward for finishing at least one activity from this list.

_____ Homework option 5.1. I pretend to be a detective during this week to find evidence that proves a healthier core belief about myself. I keep track of my evidence on a notecard. On one side of the notecard, I write the sneaky beliefs I have about myself. The sneaky belief I choose to work through this week is _____. On the opposite side of the notecard, I choose a healthier core belief I would prefer to believe about myself. My healthier belief is _____
I write a few words about each episode that proves the healthier belief. I will remember to continue looking for evidence to support the healthy belief. _____

_____ Homework option 5.2. This week, I pretend to be an investigative reporter and I ask these questions.

"What happens when you have believed healthy things about yourself?" _____
_____

"Who has helped you to believe healthy things about yourself?" _____
_____

_____ Homework option 5.3. This week, I pretend to be an actor or actress. I act as though I believe this healthy belief _____
I noticed this was different when I acted like I believed. _____.

_____ Homework option 5.4. This week, I will allow _____ to help or teach me. He or she taught me _____
_____

_____ Homework option 5.5. This week, I write in my journal and do not worry about spelling.

**Unit 6. I am Loved**

I will give my honest answers on the Healthy Core Beliefs Scale for Unit Six (Table 17). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs (Table 5; p. 96).

Table 17. Healthy Core Beliefs Scale for Unit Six

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

**Check homework.** If you have completed at least one of these activities, you may receive your reward.

_____ Homework option 5.1. I pretended to be a detective during this week to find evidence that: _____ and I found _____

_____ Homework option 5.2. This week, I pretended to be an investigative reporter and I asked: "What happens when you have believed healthy things about yourself?" _____ "Who has helped you to believe healthy things about yourself?" _____

_____ Homework option 5.3. This week, I pretended to be an actor or actress, I acted as though I believed this healthy belief _____

_____ Homework option 5.4. This week, I allowed _____ to help or teach me.

_____ Homework option 5.5. This week, I wrote in my journal and did not worry about spelling

**Lesson 6.1. Defining the Statement, *I am Loved***

I begin this lesson by rating the statement "I am loved" on a scale from 1 to 10 where one means I don't believe this statement at all; four means that I think this statement is sometimes true; seven means that I believe this statement most of the time; and 10 means that I strongly believe statement or it is true all the time. _____

My thoughts about the statement "I am loved." _____

People may show love by using words. Examples of loving words are "I love you" and _____

Some people prefer to show love by their actions, such as cooking, going to work, or doing chores. Examples of loving actions _____

Some people show love by being strict and having high expectations for me. _____

Other people may show love by giving gifts. Special object(s) that remind me of someone who loves me are _____

_____

People may show love by giving a hug or a fist bump. I recognize that there are different levels of closeness. I may want some people to hug me and not others. A *fist bump* or a *high-five* may be more appropriate sometimes. My personal opinion of physical affection is _____. I am comfortable with hugs from these people: _____. I am not comfortable with physical affection from these people: _____.

Some people may show love by paying attention to me. I especially like when _____

_____

This is how do I like to be shown that someone loves me _____

This is how I show love to family members _____

This is how I show love to friends _____

The names of the people who love me _____

I show love to myself by _____

Now I rate the statement "I am loved" again on the scale from 1 to 10. _____ In this lesson, we learn that some things are about how I choose to define them.

**Lesson 6.2. My Support Network**

Coping skill # 25 is to become more aware of spending time with the people who are supportive and comforting. Support from other people is comforting and helps me to cope with many difficulties in life.

Here is another dialectical truth: Some people may love me and not be capable of supporting and comforting me. Sometimes, we expect support from some people who do not or cannot give support. I know I cannot change someone else. I may want to change my expectations when that other person is not supportive.

I will recognize the people who are actually supporting me now. I can choose to spend time with the people who are supportive of me. These people live in the same house as me _____

These family members do not live in the same house as me _____

These are the people who are capable of being supportive _____

These are the people who can be comforting _____

With my therapist, I will make a special picture to show the different strengths of the relationships that I have with each person in my life. To do this, place your name in the circle in the center of Figure 4. Place other people's names in circles around you. Draw a line from you to each person. Draw thick, double lines (==) to those with whom you have strong relationships. A broken line can mean a broken relationship (---| |---). A crooked line can represent relationships that are stressful (VVV). A dotted line can mean that you want to have a better relationship with that person. (……). You can put more than one line between people.

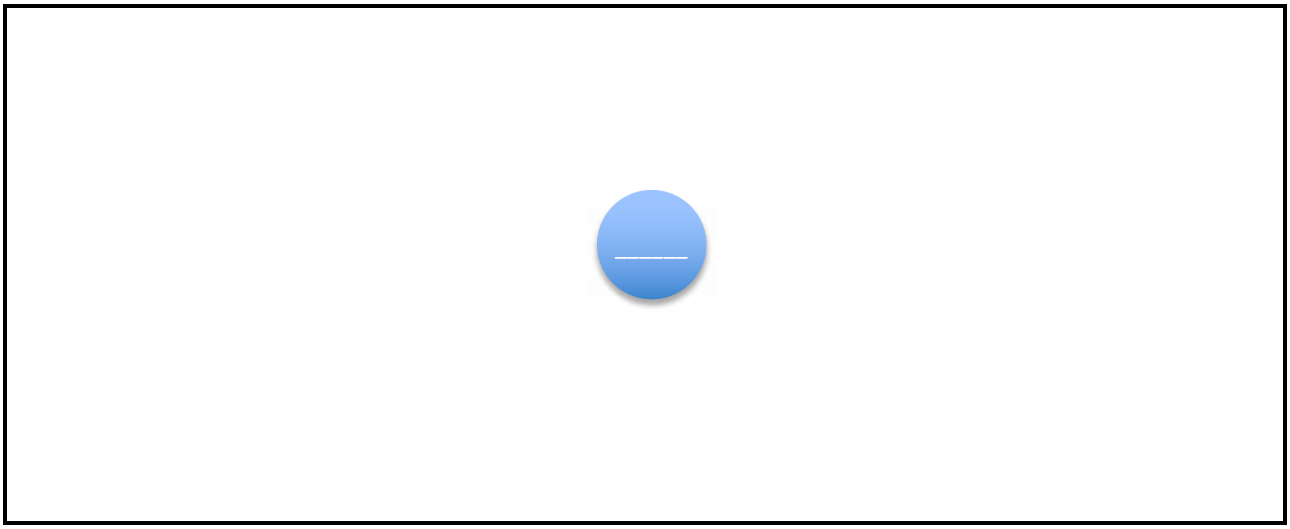


Figure 4. Picture of My Relationships

**Lesson 6.3. Conflict in Relationships**

Conflict does not mean the end of the relationship. Conflict is part of human nature. The important thing is to know how to resolve that conflict. In fact, resolving conflict can help build stronger relationships. When we communicate honestly, there will be times that we will have arguments. Conflicts mean that we are growing and learning about ourselves and each other.

When my loved ones and I have an argument, we usually _____

When there is a conflict, does each person get a chance to express himself or herself without getting interrupted?

_____

Does each person in the conflict express thoughts by using "I" statements instead of "you" statements? _____

_____

Does each person try to understand the feelings that the other person is expressing? _____

_____

A compromise means that each person gets some of what he or she wants. When I make a compromise, I may have to *give up* some of what I want. The other person is also *giving up* somewhat. Each person can brainstorm about what he or she is willing to give up. Those things that each person is willing to give up are called *negotiable* items. Each person can also make a list of those things that are not negotiable. Non-negotiable means what he or she is not willing to give up. Remember there are no right or wrong suggestions in brainstorming.

Use the example of the house rules. These are the non-negotiable rules of the house _____

_____

_____

_____

These are the negotiable rules of the house _____

_____

_____

The times when I can speak to my parent or guardian about the negotiable rules are _____

_____

_____

**Lesson 6.4. Communication Basics**

**The what and the who in communication.** Communication involves a message, the person sending the message, and the person receiving the message. Messages are sent through words, body language, tone of voice, and facial expressions. The receiver may be confused about the message when words do not match the sender's tone of voice, body language, and facial expressions. Think of an example where the words someone says do not match the tone of voice. Say, "I am fine" several different times. Change feeling each time. Say it with angry feeling, sad feeling, fearful feeling, and happy feeling.

**The intention of the message.** Are all messages understood in the same way that the sender intended? ___ Do people always allow their feelings to be expressed on their faces? _____ Some reasons that people may not want to allow their feelings to show are _____ How could the person sending the message make sure his or her intention is known? _____

**I communicate about me.** The use of "I" statements is very important in communication. I cannot know what someone else is thinking or feeling because I cannot read minds. Additionally, I do not want to give control of my behavior or feelings to someone else. For example, someone else cannot *make me* do or feel anything. If I say, "You make me mad." I am giving control of my feelings to someone else. How would you respond if I said, "You make me mad"? _____

On the other hand, if I say, "I feel angry when _____ because _____." I am accepting responsibility and ownership of my own feelings. For example, I can say, "I feel angry when you yell at me because I want to find a solution and the yelling does not help me find a solution that is acceptable to both of us." The outcome of using this "I" statement would most likely be _____

**Message sent may not equal message received.** How could the person receiving the message inform the person sending the message what he or she understood? _____ Feedback is letting the other person know what is heard. I can repeat back what I think I heard or I can put what I heard into my own words. I can practice by putting that last sentence into my own words. _____ When someone gives me feedback, I have asked for the feedback and the feedback contains information that I can control. There is a difference between criticism and feedback. Criticism is commenting on something that the other person has no control over. When I hear criticism I usually _____.

**A message is more than words.** I can also listen for the feelings or emotions that the speaker is not saying with words. What is the feeling of the speaker if he or she has clenched fists, tight lips, and his or her eyebrows are pulled in and down toward the nose while saying, "I want to find a solution"? _____

What is the feeling if the speaker's lips are turned down at the outer corners, the eyebrows are pulled down at the outer edges, and the shoulders are droopy while saying, "I want to find a solution"? _____

How do I respond to the statement "I want to find a solution" when the speaker is angry? _____

_____

How do I respond differently to the statement "I want to find a solution" when the speaker is excited? _____

_____

How do I respond differently to the statement "I want to find a solution" when the speaker is sad? _____

_____

The reasons I do not take responsibility for other people's emotions are _____

_____

The reasons I do not try to change other people's feelings _____

Feelings exist. I accept that feelings may be pleasant or unpleasant. I do not like to see other people experiencing unpleasantness. However, I recognize that feelings come and go. I allow feelings to run their course. I recognize the function of feelings. I allow other people to feel and own their own feelings. I know that they must hear their own messages from their feelings. Other people are also learning and gaining information from their feelings. I would not take that away from the other person. I can listen to someone else's experience of his or her feelings and I do not own those feelings. I can communicate that I understand what the person is saying. Communication on the emotional level helps us to form healthy relationships.

**End-of-session calming exercise for unit six: Loving-kindness meditation**

Close your eyes and imagine yourself sitting in a room with a chair opposite you. Imagine that someone you love walks into the room from a doorway on one side of the room. That person sits in the chair opposite you. You wish good health, kindness, and happiness to that person. The other person wishes you good health, kindness, and happiness. You shake that person's hand. The person stands up and walks out the room through a doorway on

the other side of the room from where he or she walked in. You can do this with as many people as come into your mind. Eventually, you can do this exercise with those whom you have conflicts.

If you want to say something more than the loving-kindness words to someone, discuss this with your therapist. Your therapy session is a good time to have those difficult, pretend conversations. Your therapist can help you through the difficult conversations and help you to decide whether or not you really want to have that conversation with the actual person. For now, concentrate on loving and kind words.

**Homework Suggestions for Unit Six**

I chose _____ to be my reward for finishing at least one activity from this list.

_____ Homework option 6.1. This week, I pretend to be an investigative reporter and I ask these questions. "How do you like to be shown love?" _____

_____

"Who gives you emotional support?" _____

_____

_____ Homework option 6.2. I say, "I love you" to _____

_____

_____ Homework 6.3. As a detective this week, I notice these emotions behind people's words or actions.

_____

_____

_____ Homework 6.4: Pretending to be an actor or actress, I act as though I do believe that *I am loved*. Here is what happened _____

## Unit 7. I am Lovable

I will give my honest answers on the Healthy Core Beliefs Scale for Unit Seven (Table 18). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs Scales (Table 5; p. 96). During the last session of the Building Healthy Core Beliefs program, my therapist and I will discuss whether or not my beliefs have changed.

Table 18. Healthy Core Beliefs Scale for Unit Seven

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

**Check homework.** If you have completed at least one of these activities, you may receive your reward.

_____ Homework option 6.1. I chose to be an Investigative Reporter this week. Other people told me these answers about how they like to be shown love. _____

_____

_____

_____ Homework option 2: I said, "I love you" to these individuals _____

_____

_____ Homework 6.3: Detective: I noticed these emotions behind people's words or actions this week.

_____

_____

_____ Homework 6.4: Actor/Actress: Here is what happened when I acted like I believed that *I am loved*._____

_____

**Lesson 7.1. Defining the Statement, *I am Lovable***

I begin this lesson by rating the statement *I am lovable* on a scale from 1 to 10 where one means *I don't believe this statement at all*; four means that *I think this statement is sometimes true*; seven means that *I believe this statement most of the time*; and 10 means that *I strongly believe statement* or *it is true all the time*. _____

My thoughts about the statement *I am lovable*. _____

_____

_____

How is the statement *I am likable* different than the statement *I am lovable?* _____

_____

_____

A likable person has these characteristics: _____

_____

_____

_____

Is it possible to love someone and not like some characteristics or behaviors of that person? _____

_____

_____

I have these likable traits _____

_____

I have these lovable traits _____

_____

Now I'll rate each of my likable and lovable traits from 1 to 10. I can write the number above each trait. I know that I can choose which behaviors of others that I would like to imitate. I would like to have these traits _____

_____

I do not want these traits _____

_____

Again, I rate statement *I am lovable* on the scale from 1 to 10. _____ .

**Lesson 7.2. Many Ways to Be Smart**

**Coping skill # 26: Recognizing my own strengths and talents.** Some people judge intelligence by test scores. Other researchers have discovered that there are many ways to be smart. I will do my best on my test, however, I will not judge myself by my scores on a test. I will look at the many ways of being smart. I also know that these are skills that I can improve with practice and guidance.

**Check all that apply.** I am smart about words ___, numbers ___, shapes ___, drawing ___, directions ___, my own body (like an athlete/ dancer) ___, eating healthy food ___, getting exercise ___, getting enough sleep ___, getting quiet time to myself ___, accepting my own feelings ___, recognizing other people's feelings ___, getting along with other people ___, science ____, nature ____, history ___, art ___, music ___, about planning ___, organizing ___, being on time ___, getting things done ___, details ___, judging whether my thoughts are accurate and helpful or inaccurate and not helpful ___, I am open to new experiences ___, I am cautious ___, I think before I speak ___, I have a sense of humor ___, I am creative ___, I think outside the box ___, I am kind to people___, I protect my loved ones___, Other, list _____

_____

_____

**Developing skills.** I have underlined any of the talents listed above that I may want to strengthen or improve. Here's how I will do that _____

_____

These are the people who can help me to develop the skills I would like to have _____

_____

My mother's special strengths include _____

_____

My father's special strengths include _____

_____

My friend's special strengths include _____

_____

My other friend's special strengths include _____

**Lesson 7.3. Healthy Pride**

**Coping skill # 27 is to recognize strengths and talents in other people, and to appreciate the differences in people. It is okay for my friends to be different than me!** I may enjoy spending time with people who have similar interests to mine. I also enjoy spending time with people who have interests that are different than mine.

Figure 5 displays the differences between hubris and self-deprecation. Healthy pride is neither hubris nor self-deprecation. Healthy pride means I recognize strengths in others and myself. I believe that all people are equally valuable. I am proud of my accomplishments and know I have worked hard to achieve my goals. With healthy pride, I do not say mean things about myself. With healthy pride, I also do not brag or boast about myself.

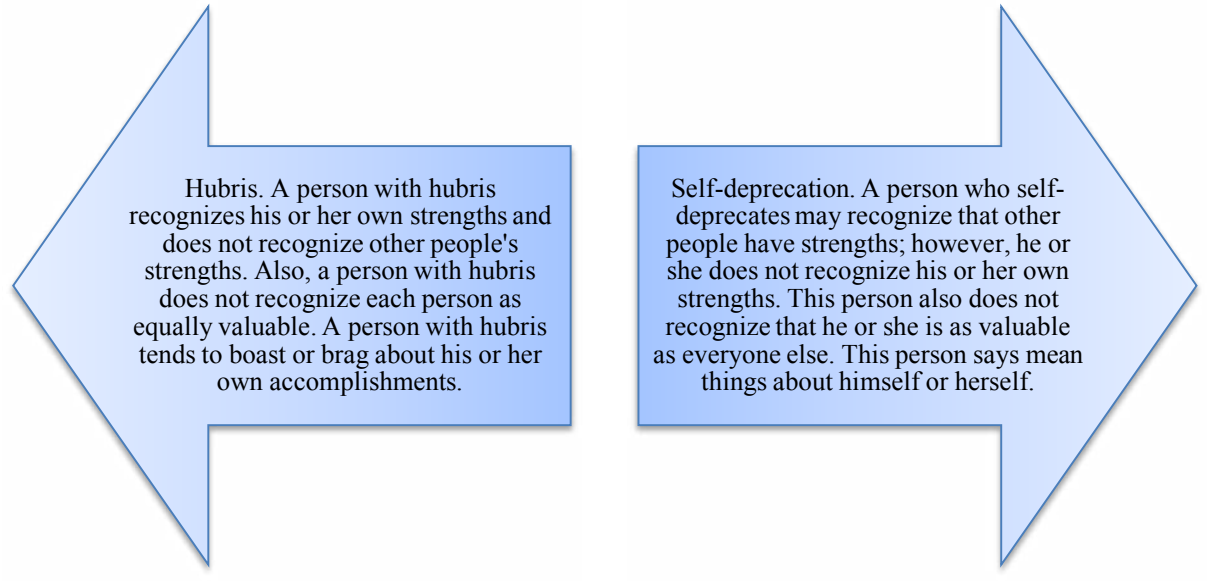


Figure 5. Healthy Pride

**End-of-session calming exercise.** Close your eyes and listen as I tell you the tale about the people who live in the castle (space station)**.** There is a king, (or queen or president), and a gallant knight-in-shining-armor (security officer). Additionally, there is a mother, father, and child who live in the castle (space station). The good king (queen or president) wants to talk with the child. The knight (security officer) will not allow the king (queen or president) to talk to the child. The parents also are not allowing the king (queen or president) to talk with the child. The king (queen or president) decide to have a talk with the knight (security officer). Then, …

**Homework Suggestions for Unit Seven**

I chose _____ to be my reward for finishing at least one activity from this list.

_____ Homework option 7.1. Using my detective skills, I find evidence about my own personal strengths.

_____

_____

_____

_____ Homework option 7.2. Using my investigative reporter skills, I ask people these questions.

"What are your personal strengths?" _____

_____

_____.

"What were your favorite subjects in school?" _____

_____.

"How have you shared your talents with others?" _____

_____

_____

_____

"What does *honoring personal limitations or boundaries* mean to you?" _____

_____

_____

_____.

"What does *forgiveness* mean?" _____

_____

_____

_____ Homework option 7.3. Using my acting skills, I pretend that I believe *I am lovable* even if I don't believe it. As a result, _____

**Unit 8. I am Worthy**

I will give my honest answers on the Healthy Core Beliefs Scale for Unit Eight (Table 19). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs Scales (Table 5; p. 96).

Table 19. Healthy Core Beliefs Scale for Unit Eight

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

**Check homework.** If you have completed at least one of these activities, you may receive your reward.

_____ Homework 7.1: Detective. I will found this evidence about my own personal strengths. _____

_____ Homework 7.2: Investigative Reporter. Here is how other people answered my questions. My personal strengths include _____

My favorite subjects in school were _____

I shared my talents with others by _____

'Honoring personal limitations' means _____

Forgiveness means _____

_____ Homework 7.3: If acted as though I believed that *I am lovable*. This is what happened _____

**Lesson 8.1. Defining the Statement, *I am worthy***

I begin this lesson by rating the statement *I am worthy* on a scale from 1 to 10 where one means *I don't believe this statement at all*; four means that *I think this statement is sometimes true*; seven means that *I believe this statement most of the time*; and 10 means that *I strongly believe statement or it is true all the time*. _____

My thoughts about the statement: "I am worthy." _____

_____

_____

I will rate each of the following statements on a scale of 1 (not true) to 10 (very true). "I am worthy of respect." _____ "I respect myself." _____ "I respect other people." _____ "Other people respect me." _____ "As a young person, I deserve to learn right from wrong.": ____ Comment: _____

"As a young person, I deserve to be encouraged to be the best me I can be." Thought rating: _____ Comment: _____

"As a young person, I deserve to be heard and understood." Thought rating: _____ Comment: _____

_____

"As a young person, I deserve to have predictable routines in my daily schedule." Thought rating: _____ Comment: _____

"As a young person, I owe it to myself to plan my daily schedule." Thought rating: _____ Comment: _____

_____

"As a young person, I deserve to have healthy food, enough clothes to keep me warm, and a roof over my head." Thought rating: _____ Comment: _____

"I deserve to be protected and safe." Thought rating: _____ Comment: _____

_____

_____

Again, I rate the statement *I am worthy* on scale of 1 (not true) to 10 (very true). Thought rating: _____ Comment: _____

_____

**Lesson 8.2. Using Coping Skills to Meet My Basic Needs**

Coping skill # 28 is to show respect and care for my own body and mind. These beliefs will be reflected in my time schedule for the week. This is how I show respect to myself. _____

Coping skill # 29 is to show respect to others. How do I show respect to others? _____

_____

_____

Coping skill # 30 is to know my own comfort levels about receiving affection. Coping skill # 31is to be assertive about rejecting unwanted affection. I know that I am worthy of respectful affection. I can request a hug from some people. I am comfortable receiving hugs from these people _____

Coping skill # 32 is to talk with people who understand my feelings and thoughts. I know I am worthy of being understood. These are the people who understand my feelings _____

_____.

Coping skill # 33 is to give my body healthy food. I drink water several times a day. I exercise regularly. I sleep 8 to 10 hours per night. I take a bath or shower once per day. I brush my teeth twice per day. I know that I am worthy of nurturance. I know that I am capable of taking care of myself.

Coping skill # 34 is to establish healthy routines for myself. I know that I am worthy of predictable routines. I plan my time schedule for the week. I go to sleep and wake up at nearly the same time each day.

Coping skill # 35 is to listen to my parent or guardian about what is healthy versus unhealthy. I know that I am worthy of guidance. While I know that I am learning to guide myself, I also know that my brain and body are going through big changes right now. My parent or guardian will help me learn to look at the *big picture for my life*. My parent or guardian can help me to balance the extreme emotions I sometimes feel.

I discuss with my parent or guardian the house rules. I learn which rules are negotiable and which rules are non-negotiable. We discuss the appropriate time, places, and manner for me to express my concerns about negotiable rules. I accept non-negotiable rules. I accept when my parent or guardian disagrees with my reasons for wanting to change the negotiable rules. I appreciate that my parent or guardian has taken the time to listen and understand my opinions. I know that the best time to talk to my caregiver about the rules is _____. I know that the best place to talk to my caregiver is _____.

Coping skill # 36 is to give myself encouragement and I hear encouragement when others are encouraging. I know that I am worthy of encouragement to be the best me I can be. I define *the best me I can be* as _____

_____

_____.

I know that I am worthy of protection. I deserve protection. I understand that people who do not make healthy choices for themselves may not be the best persons to protect me. Although I may be sad, angry, or fearful about this reality, I accept the limitations of the person not capable of protecting me. I wish good health to that person. I can still love that person. I appreciate the person who *is capable* of protecting me.

Coping skill # 37 is to look for evidence of respect, appropriate affection, being understood, nurturance, predictable routines, guidance, encouragement, and protection.

Coping skill # 38 is to act like I do believe that *I am worthy* even if I do not believe it.

Again, I rate the statement *I am worthy* on the scale from 1 (not true) to 10 (very true). Thought rating: _____

Comment: _____

_____

_____

_____

The most difficult part of this lesson has been _____

_____

_____

_____

The easiest part of this lesson has been _____

_____.

**End-of-session Calming Exercise: Characters are added to Castle or Space Station Meditation.** The king (queen or president) continues to try to talk to the child. After talking to the parents and the knight (security officer), the king (queen or president) finally talks to the child. The child tells the king (queen or president) what has been happening. The king (queen or president) assures the child that he (or she) will provide every protection for the child because the child deserves this protection.

**Homework Suggestions for Unit Eight**

I chose _____ to be my reward for finishing at least one activity from this list.

_____ Homework option 8.1. I pretend to be a detective and look for evidence that I deserve or receive:

respect _____

appropriate affection _____

understanding of my feelings _____

understanding of my thoughts _____

nurturance _____

predictable routines _____

guidance _____

encouragement _____

protection _____.

_____ Homework option 8.2. I pretend to be an investigative reporter and ask people these questions.

"How do you like to be shown respect?"_____

_____

_____

"What is the meaning of *the best me I can be*?" _____

_____

_____

_____

"Who has encouraged you to be the best you can be?" _____

_____

_ _____

_____

_____ Homework option 8.3. I pretend to be an actor or actress. If I don't believe that *I am worthy*, I will act like I do believe it. Here is how I pretend that *I am worthy*._____

**Unit 9. I am Capable of Accomplishing my Goals**

I will give my honest answers on the Healthy Core Beliefs Scale for Unit Nine (Table 20). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs (Table 5; p. 96). During the last session of the Building Healthy Core Beliefs program, my therapist and I will discuss whether or not my beliefs have changed.

Table 20. Healthy Core Beliefs Scale for Unit Nine

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

**Check homework.** If you have completed at least one of these activities, you may receive your reward.

_____ Homework option 8.1: Using my detective skills, this is the evidence that I found that I am worthy

_____

_____ Homework option 8.2. I pretended to be an investigative reporter and asked people these questions.

"How do you like to be shown respect?" _____

"What is the meaning of *the best me I can be*?"_____

"Who has encouraged you to be the best you can be?" _____

_____ Homework option 3. I pretended to be an actor or actress. I pretended that I believed that *I am worthy*. Here is what happened _____.

**Lesson 9.1. Defining the Statement, *I am Capable of Achieving my Goals***

I will rate the statement that "I am capable" on a scale of 1 to 10, with 10 meaning *I completely believe*: ___

My thoughts about the statement "I am capable" _____

The times I tend to believe that I am capable are when _____

The times when I do not believe that I am capable are when _____

In order to believe that I am capable, I will remember that I have strengths and am building skills. Also, I link actions to goals. I may use the Healthy Core Belief Conflict Management Worksheet to work through a difficult event. I consider all aspects of an event. I also write down my thoughts, feelings, and beliefs. I remember that my behavior is my choice. I give away some of my freedom when I do not choose my own behavior.

**Lesson 9.2. Learning to Become More Capable of Achieving Goals**

**Coping skill # 40 is to choose behaviors that will help me to achieve my goals.** When I say "yes" to one thing, I also am saying "no" to something else. For example, if I choose to stay up late, I may not have the energy the next day to do what I want to do. Each of my choices has consequences. I accept the consequences of my behavior. The behavior that would help me to achieve my goals is _____

This is what I would like to achieve _____ If I am not sure what I want to achieve, I will brainstorm my wishes and wants. I may also use my emotions as messages to help me understand what I want. I will make big, bold goals! Remember that all ideas are accepted in brainstorming. _____

_____

**Coping skill # 41 is to list the steps that are required to accomplish my goals.** After I choose one goal from my list of wishes and wants, I will brainstorm to list the possible steps or tasks necessary to accomplish this goal. I will write each step or task on individual note cards.

**Coping skill # 42 is to place the steps in a logical sequence of what must be done first, second, and third.** Sometimes people know what needs to be done, however, it may be difficult to think about what to do first. With my chosen goal and steps written on note cards, I will arrange tasks in a logical order and a workable action plan.

**Coping skill # 43 is to follow my action plan using a time management schedule.** Using Table 21, I will create a time management schedule for this week. If my tasks will require more than one week, I will want to use a calendar. Big projects such as term papers will require more than one week to complete. I will make an action plan and not leave all the work to one night.

Table 21. Weekly Time Schedule

| TIME | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

**Coping skill # 44 is to celebrate my accomplishments!** We will plan our celebration for the last session of this program. As with any celebration, I will want to decide on a guest list and invite those people. Today, we will make an invitation to invite parent or guardian to next session. We will also brainstorm to decide on the food, drinks, and entertainment for the celebration. Food will include _____

_____ and will be provided by _____.

Drinks will include _____ and will be provided by _____.

Music will include _____ and will be provided by _____.

Games will include _____ and will be provided by _____..

**Lesson 9.3. Healthy Core Belief Conflict Management Worksheet**

I consider all aspects of event. I also write down my emotions, bodily sensations, thoughts, and beliefs. I remember my coping tools. Also, I remember that there is freedom and power when I choose my own behavior.

**Event.** What happened? Who? Where? When? _____

What happened right before the event? _____

What happened right after the event? _____

My expectations were _____ The worst part was _____

Here is how I would have chosen to act differently than another person in this event _____.

The triggers I experienced during this event are _____.

This event may be similar to _____ in my past.

**Response.** My *emotions* about this event included_____. On a scale of -1 to +10, I felt angry at a ___ because I am protecting _____. I felt afraid, anxious, nervous, or concerned at a ___. Therefore, I will focus on _____. I felt sadness at a ___. I remember that _____ is important to me. I felt confused at a ___. I felt disgusted at a ___. I felt overwhelmed at a ___. I felt guilty at a ___. I want to make this right ___ I felt happiness at a ___. Here's what I did well. _____.

*In my body, I experienced*: fight, flight, or freeze ___ fast heart rate___ stomachache ___ tightness in my chest ___ tightness in my muscles ___ or other: _____

*My thoughts about this event* _____

Stinky thoughts included: Mind reading? _____ Predicting the future? ____ Focusing only on the negative? ___ Thinking that things will never get better? _____ Other: _____

**Healthy thoughts.** I do not know what the other person was thinking. ___ I will not worry about the future. ____ This situation will get better. ____ Other: _____

**Healthy beliefs.** I am loved _____ I am lovable. _____ I am worthy of respect. _____

I deserve to be heard and understood. _____ I deserve to be protected, guided, and supported. _____

I am capable of achieving my goals. _____I am capable of managing my own behavior in this situation. _____

Coping tools that I used to help me resolve this matter _____

I can _____ I have _____ I am _____

**Outcome.** Rather than reacting, I will use problem-solving to decide how to act. I will brainstorm different possible alternatives thoughts, actions, and emotions and consider the consequences of each possible solution.

**Option 1.** If I think_____.

I will do _____.

I will feel _____.

Will this action help me to achieve the big plan I have for my life? _____

**Option 2.** If I think_____.

I will do _____.

I will feel _____.

Will this action help me to achieve the big plan I have for my life? _____

**Option 3.** If I think_____.

I will do _____.

I will feel _____.

Will this action help me to achieve the big plan I have for my life? _____

**Option 4.** If I think_____.

I will do _____.

I will feel _____.

I will complete the decision matrix in Table 22. I choose to _____.

Table 22. Decision Matrix for Choosing Behavior After Conflict

| Pros of choosing this behavior | Pros of not choosing this behavior |
|---|---|
| Cons of choosing this behavior | Cons of not choosing this behavior |

**End-of-session calming exercise: I will write a letter telling my parent or guardian what I have learned in the Building Healthy Core Beliefs program**. I will also write about what I did and did not like about this program. I will read this letter to my parent or guardian in the next session.

Date _____

Dear _____,

**Unit 10a. Review and Graduation**

I will give my honest answers on the Healthy Core Beliefs Scale for Unit Ten (Table 23). The therapist has no expectations about what my answers should be. My therapist will place my answers on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs Scale (Table 5; p. 96). During this session, my therapist, caregiver, and I will discuss whether or not my beliefs have changed.

Table 23. Healthy Core Beliefs Scale for Unit Ten

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

This is what I liked about the program: _____

_____

This is what I did not like about the program: _____

_____

Discuss plans for future. Discuss contingency plans for difficult times in the future.

Resources that may be useful to my family or me include: _____

_____

Celebration!!! I did it! I accomplished my goal of completing this program. Enjoy the celebration and each other!

**Unit 10b. For the Parent or Guardian**

I will give my honest answers on the Healthy Core Beliefs Scale for Parent or Guardian (Table 24). The therapist has no expectations about what my answers should be. My child or teenager's answers are on the Unit-by-Unit Chart for Rating my Healthy Core Beliefs (Table 5; p. 96). During this session of the Building Healthy Core Beliefs program, my therapist and I will discuss whether or not my beliefs or my child's beliefs have changed.

Table 24. Healthy Core Beliefs Scale for Parent or Guardian in Unit Ten

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

I will complete the TOMS and the CBCL-PR. _____

This is what I liked about the program: _____

_____

_____

This is what I did not like about the program: _____

_____

_____

_____

_____

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## APPENDICES

### A. ICD-10 Codes for Abuse & Neglect (APA, 2013)

| DSM-5 | Confirmed<br>Add as 7th digit<br>A = Initial encounter<br>D = Subsequent encounter | Suspected<br>Add as 7th digit<br>A = Initial<br>D = Subsequent | Mental Health Services for Victim | Mental Health Services for Perpetrator |
|---|---|---|---|---|
| Child Neglect | T74.02X | T76.02 | Z69.010/ parental neglect<br>Z69.020/ non-parent | Z69.011/ parental neglect<br>Z69.021/ non-parent |
| Personal history (past history) of neglect in childhood | | | Z62.812 | |
| Child Physical Abuse | T74.12X | T76.12X | Z69.010/ parental abuse<br>Z69.020/ non-parent | Z69.011/ parental abuse<br>Z69.021/ non-parent |
| Personal history (past history) of physical abuse in childhood | | | Z62.810 | |
| Child Sexual Abuse | T74.22X | T76.22X | Z69.010/ parental abuse<br>Z69.020/ non-parent | Z69.011/ parental abuse<br>Z69.021/ non-parent |
| Personal history (past history) of sexual abuse in childhood | | | Z62.810 | |
| Child Psychological Abuse | T74.32X | T76.32X | Z69.010/ parental abuse<br>Z69.020/ non-parent | Z69.011/ parental abuse<br>Z69.021/ non-parent |
| Personal history (past history) of psychological abuse in childhood | | | Z62.810 | |
| Partner Violence, Physical | T74.11X | T76.11X | Z69.11 | Z69.12 |
| Personal history (past history) of partner violence, physical | | | Z91.410 | |
| Partner violence, Sexual | T74.21X | T76.21X | Z69.81 | Z69.12 |
| Personal history (past history) of partner violence, sexual | | | Z91.410 | |
| Partner neglect | T74.01X | T76.01X | Z69.11 | Z69.12 |
| Personal history (past history) of partner neglect | | | Z91.412 | |
| Partner Abuse, Psychological | T74.31X | T76.31X | Z69.11 | Z69.12 |
| Personal history (past history) of partner abuse, psychological | | | Z91.411 | |
| Nonpartner Violence, Physical | T74.11X | T76.11X | Z69.81 | Z69.82 |
| Nonpartner violence, Sexual | T74.21X | T76.21X | | |
| Nonpartner Abuse, Psychological | T74.31X | T76.31X | | |

**B. ICD-10 Codes of Environmental Stressors (APA, 2013)**

| | |
|---|---|
| Parent-child relational problems | Z62.820 |
| Sibling relational problem | Z62.891 |
| Upbringing away from parents | Z62.29 |
| Child affected by parental relationship distress | Z62.898 |
| Relationship distress with partner | Z63.0 |
| Disruption of family by separation or divorce | Z63.5 |
| High expressed emotion level within family | Z63.8 |
| Uncomplicated bereavement | Z63.4 |
| Academic or educational problem | Z55.9 |
| Problem related to current military deployment status | Z56.82 |
| Other problem related to employment | Z56.9 |
| Homelessness | Z59.0 |
| Inadequate housing | Z59.1 |
| Discord with neighbor, lodger, or landlord | Z59.2 |
| Problem related to living in a residential institution | Z59.3 |
| Lack of adequate food or safe drinking water | Z59.4 |
| Extreme poverty | Z59.5 |
| Low income | Z59.6 |
| Insufficient social insurance or welfare support | Z59.7 |
| Unspecified housing or economic problem | Z59.9 |
| Phase of life problem | Z60.0 |
| Problem related to living alone | Z60.2 |
| Acculturation difficulty | Z60.3 |
| Social exclusion or rejection | Z60.4 |
| Target of (perceived) adverse discrimination or persecution | Z60.5 |
| Unspecified problem related to social environment | Z60.9 |
| Victim of crime | Z65.4 |
| Conviction of civil or criminal proceedings without imprisonment | Z65.0 |
| Imprisonment or other incarceration | Z65.1 |
| Problems related to release from prison | Z65.2 |
| Problems related to other legal circumstances | Z65.3 |
| Problems related to unwanted pregnancy | Z64.0 |
| Discord with social service provider, including probation officer or social services worker | Z64.4 |
| Victim of terrorism or torture | Z65.4 |
| Exposure to disaster, war, or other hostilities | Z65.5 |
| Other problems related to psychosocial circumstances | Z65.8 |
| Unspecified problem related to unspecified psychosocial circumstances | Z65.9 |
| Other personal history of psychological trauma | Z91.49 |
| Personal history of self-harm | Z91.5 |
| Other personal risk factors | Z91.89 |
| Problems related to lifestyle | Z72.9 |
| Adult antisocial behavior | Z72.811 |
| Child or Adolescent antisocial behavior | Z72.810 |

**C. Healthy Core Beliefs Scale**

| I am loved | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am lovable | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am worthy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

| I am capable of achieving my goals | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1= I don't believe this at all or 1= Not true for me | | | 4= Sometimes true | | 7 = Fairly strong Often, not always | | 10 = Very strongly believe or 10 = Very true for me | | |

**D. Forty-Four Coping Skills**

# 1: Thinking about my favorite things.

# 2: Listening to music

# 3: Active meditation: Shake, Wiggle, Jiggle, & Dance

# 4: Recognize and accept unpleasant bodily sensations.

# 5: Remember past successful coping with similar situations.

# 6.: Schedule enjoyable activities

# 7: Schedule time with loved ones.

# 8: Focused breathing

# 9: Progressive muscle relaxation

# 10: Recognize, label, accept, manage, and appropriately express all emotions. I am nonjudgmental about emotions. I accept and tolerate both pleasant and unpleasant emotions.

# 11: Accept Ambivalence. Ambivalence is feeling two different emotions at once

# 12: Practice empathy. Empathy is recognizing other people's emotions.

# 13: Show compassion for other people.

# 14: Doing art work.

# 15: Replace "stinky thoughts" with accurate and helpful thoughts

# 16: Use positive self-talk and affirmations.

# 17: I will recognize and remember my achievements.

# 18: Compartmentalization and Titration. Compartmentalization is saving some thoughts for later. Titration means taking small, manageable pieces at a time.

# 19: Imagination & Hope. It is important to imagine something positive about my future.

# 20: Mindfulness is intentionally and nonjudgmentally embracing the *here* and *now*

# 21: I allow other people to help me.

# 22: I choose my response to the past. I choose my own behavior in the future.

# 23: I use statements such as: "I would have preferred..." to discuss how I would have made different choices than other people in the past.

# 24: Journaling

# 25: I will become more aware of spending time with the people who are supportive and comforting. I will increase my awareness of feeling comforted by others.

# 26: I will recognize my own strengths and talents.

# 27: I will recognize strengths and talents in others. I will appreciate differences in people.

# 28: I respect and care for my own body and mind.

# 29: I show respect to others.

# 30: I know my comfort levels about receiving affection.

# 31: I am assertive about rejecting unwanted "affection."

# 32: I talk with people who understand my feelings and thoughts.

# 33: I give my body healthy food. I drink water several times a day. I exercise regularly. I sleep 8 to 10 hours per night. I take a bath or shower once per day. I brush my teeth twice per day.

# 34: I establish healthy routines for myself. I go to sleep and wake up at nearly the same time each day.

# 35: I listen to my parent or guardian about what is healthy and what is unhealthy.

# 36: I give myself encouragement and I hear encouragement when others are encouraging.

# 37: I look for evidence of respect, appropriate affection, understanding of feelings, understanding of thoughts, nurturance, predictable routines, guidance, encouragement, and protection.

# 38: If I don't believe that *I am worthy*, I will act like I do believe it.

# 39: I believe that I am capable.

# 40: I choose behaviors that will help me to achieve my goals.

# 41: I list the steps that are required to accomplish my goals.

# 42: I place the steps in a logical sequence of what must be done first and what comes next, etc.

# 43: I follow my action plan using a time management schedule.

# 44: I celebrate my accomplishments.

## E. Institutional Review Board Approval Certificate

**ACTION ON PROTOCOL APPROVAL REQUEST**

Dr. Dennis Landin, Chair
130 David Boyd Hall
Baton Rouge, LA 70803
P: 225.578.8692
F: 225.578.5983
irb@lsu.edu | lsu.edu/irb

**TO:** Timothy Page
Social Work

**FROM:** Dennis Landin
Chair, Institutional Review Board

**DATE:** March 9, 2016

**RE:** **IRB#** 3666

**TITLE:** Meeting the biopsychosocial needs of individuals with histories of multiple adverse childhood experiences

**New Protocol/Modification/Continuation:** Modification

**Brief Modification Description:** Title change and added interviews.

**Review type:** Full ___ Expedited _X_ **Review date:** 3/7/2016

**Risk Factor:** Minimal ____X_____ Uncertain _____ Greater Than Minimal_____

**Approved**___X____ **Disapproved** _____

**Approval Date:** 3/9/2016 **Approval Expiration Date:** 12/13/2016

**Re-review frequency:** (annual unless otherwise stated)

**Number of subjects approved:** 10

**LSU Proposal Number** (if applicable)**:**

**Protocol Matches Scope of Work in Grant proposal:** (if applicable) _____

**By**: Dennis Landin, Chairman 

**PRINCIPAL INVESTIGATOR: PLEASE READ THE FOLLOWING –**
**Continuing approval is CONDITIONAL on:**

1. Adherence to the approved protocol, familiarity with, and adherence to the ethical standards of the Belmont Report, and LSU's Assurance of Compliance with DHHS regulations for the protection of human subjects*
2. Prior approval of a change in protocol, including revision of the consent documents or an increase in the number of subjects over that approved.
3. Obtaining renewed approval (or submittal of a termination report), prior to the approval expiration date, upon request by the IRB office (irrespective of when the project actually begins); notification of project termination.
4. Retention of documentation of informed consent and study records for at least 3 years after the study ends.
5. Continuing attention to the physical and psychological well-being and informed consent of the individual participants including notification of new information that might affect consent.
6. A prompt report to the IRB of any adverse event affecting a participant potentially arising from the study.
7. Notification of the IRB of a serious compliance failure.
8. **SPECIAL NOTE:**

**All investigators and support staff have access to copies of the Belmont Report, LSU's Assurance with DHHS, DHHS (45 CFR 46) and FDA regulations governing use of human subjects, and other relevant documents in print in this office or on our World Wide Web site at http://www.lsu.edu/irb*

**F. Informed Consent for Clinician Interview**

Project Title: Meeting biopsychosocial needs of individuals with histories of multiple adverse childhood experiences

Performance Site: The interviewee's place of employment
Investigators: The following investigators are available for questions,
M-F, 8:00 AM to 4:30 PM
Chris Morgan
Timothy Page
LSU School of Social Work
Phone number: 225-578-1358

Purpose of the study: By interviewing at least three experienced, trauma-informed clinicians, investigator anticipates gaining knowledge of how evidence-based, trauma-informed principles are implemented into direct practice with traumatized individuals. This proposed study is an adjunct to investigator's conceptual thesis and answers the question of how evidence-based, trauma-informed principles are integrated into direct practice.
Inclusion Criteria: Clinicians with extensive knowledge and experience treating individuals with histories of exposure to multiple, ongoing, and/or early adverse childhood experiences. Clinicians will be identified by the National Child Traumatic Stress Network and/or by local reputation.
Exclusion Criteria: Clinicians meeting the above conditions who do not wish to participate.

Description of the Study: Face-to-face interview gathering clinicians' observations about their trauma-informed practice. The investigator wishes to explore the clinicians' own reflections about: guiding theories and principles; the gap between evidence-based interventions (EBP) and direct practice; current screening instruments; diagnostic codes; statewide initiatives for disseminating and implementing EBP; training of trauma-informed mental health personnel; and, specific components of interventions.
Benefits: Interviewer will benefit from gathering information to compare the state of knowledge and the state of practice.
Risks: Although no harmful consequences are anticipated, investigator will confirm that psychological resources are available, if necessary.
Right to refuse: Participation is voluntary. At any time, the participant may withdraw from the interview without penalty or loss of any benefit to which they might otherwise be entitled.
Privacy: Results of the study may be published. Names or identifying information will be included for publication only with participant's permission. If desired, participant identity will remain confidential unless disclosure is required by law.

☐Yes, investigator of this study has permission to use my name and the content of the interview in publication. Any of my quotations will be properly cited.

Signature:_____ Date:_____

☐ I choose to remain anonymous. Investigator will not use my name in publication. The content of my interview will be cited as from an Participant C source.

Signature:_____ Date:_____

Financial Information: There is no cost for participation in the study, nor is there any financial compensation to the participants for participation.

Signatures: The study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the investigator. If I have questions about subjects' rights or other concerns, I can contact Dennis Landin, Chairman, Institutional Review Board, (225) 578- 8692, irb@lsu.edu, www.lsu.edu/irb. I will allow my child to participate in the study described above and acknowledge the investigator's obligation to provide me with a signed copy of this consent form.

Signature:_____ Date:_____

**G. Protocol for Interview with Trauma-informed Clinicians**

1. Which client populations do you serve?
☐ infant mental health ☐ preschool children ☐ children in elementary school ☐ children in middle-school ☐ adolescents
☐ young adults ☐ middle-aged adults ☐ older adults

2. What guiding theories and principles do you find most helpful in your clinical practice with traumatized clients? _____

3. Which programs or components of programs have you used with clients displaying trauma-related symptoms (check all that apply) and how has each been successful or not successful. If applicable, please describe any demographic variables, such as age, gender, race/ethnicity, or socioeconomic status. Also describe specific applications based on type of trauma.
☐ EMDR _____
☐ Cognitive-Behavioral Therapy (CBT) _____
☐ Exposure therapy/ Systematic desensitization _____
☐ Dialectical Behavior Therapy _____
☐ Trauma-focused CBT _____
☐ Trauma Systems Therapy _____
☐ Child-Parent Psychotherapy _____
☐ Parent-Child Interaction Therapy _____
☐ Circle of Security _____
☐ Attachment, Regulation, and Competency _____
☐ Attachment therapy with holding _____
☐ Inclusion of multiple generations in care _____
☐ Integrative Treatment of Complex Trauma for Children (ITCT-C) _____
☐ Real Life Heroes _____
☐ Seeking Safety _____
☐ Family Therapy _____
☐ Narrative Therapy _____
☐ Mindfulness _____
☐ Multisystemic Therapy _____
☐ Somatic Awareness _____
☐ Schema-focused CBT _____
☐ Other _____

4. Do you have any preferences for trauma screening instruments? _____

5. Have there been any efforts to promote the use of standardized screening instruments for measuring trauma exposure, presence of trauma-related symptoms, and severity of trauma-related symptoms?

6. What criteria qualifies an individual to receive trauma-informed services at your clinic? _____

7. In your opinion, what should be criteria for using trauma-informed, evidence-based intervention?

_____

8. Many children who have experienced multiple, ongoing, and/or early-onset adversity are labeled with ODD, ADHD, Conduct Disorder, etc. In your clinical experience, does trauma-informed psychotherapy help children resolve behavioral dysregulation?

_____

9. Are there any organized statewide initiatives in Louisiana to disseminate evidence-based, trauma-informed research to clinicians? _____

10. Do you have any other practical suggestions for implementing evidence-based, trauma-informed practices? Do you have any thoughts in regards to closing the gap between research and practice?

_____

_____

11. In your experience, how best can clinicians train to work with traumatized individuals?

_____

_____

12. In light of time and cost constraints, what suggestions do you have for agencies wanting to implement more trauma-informed practices? _____

**H. Sample Letters to Parents or Guardians**

Tables H1 to H9 are for use after sessions in units one through nine. Please adjust content of the letter based on the session. Letters and phone calls are primarily for maintaining therapeutic rapport with the caregivers.

Table H1. Sample Letter for Use After Unit One Sessions

Date _____

Dear _____,

In session today, _____ signed a contract to start working on the Building Healthy Core Beliefs program. We talked about considering the pros (advantages and benefits) and the cons (disadvantages, risks, or barriers) before making a decision. Ask your child about the decision-matrix. We also talked about having a safety plan so that we know who can help and where to go when we do not feel safe. Additionally, we started learning about coping skills. We will learn new coping skills each week. _____ is excited to share his/her homework with you. The main goal of the homework is to have fun with your child. It has also been proven that people are able to remember more information when they teach the information to someone else. Enjoy the week!

_____

Signature of therapist

**Homework suggestions for unit 1 of Building Healthy Core Beliefs.** Allow your child or teen to decide.

_____ Homework option 1.1. With a parent or guardian, I will share lessons that I learned in this week's session.

___ Decision-making: Before I make decisions, I consider the _____ and _____.

___ Safe people and places: I know I am safe when _____.

___ It is important to make wishes so I will know what I _____ and I can set _____.

___ Moving around to calm down is called active _____.

_____ Homework option 1.2. With my parent or guardian, I will listen to some music and Shake, Wiggle, Jiggle, and Dance. We notice that this time together is fun and relaxing.

_____ Homework option 1.3. With your parent or guardian, discuss each of his or her favorites.

Songs _____

Musicians _____

Books _____

Movies _____

TV programs _____

Hobbies _____

Animals _____

Colors _____

Food or Beverage_____

Other favorites _____

_____ Homework option 1.4. I will ask my parent or guardian about what his or her wishes and wants are for me.

_____

_____ Homework option 1.5. This is how I used a decision-matrix to make a decision. _____

_____

Table H2. Sample Letter for Use After Unit Two Sessions

Date _____

Dear _____,

In today's session, we learned that the stress response is an automatic system that helps to keep us safe. We discussed that a fast beating heart or a stomachache may be a signal that my stress response has been activated. We talked about rating energy so that we would know what to do with it. Ask your child about "feet on the ground, I hear, I see, I smell, I taste, I touch, and the butterfly hug." We also talked about the value of relationships and the importance of scheduling time with our loved ones. Your child has a time schedule for the week and may ask when it would be convenient for you to plan and participate in a fun activity together. Your child will also want to go over this week's homework with you.

_____

**Homework suggestions for unit 2 of Building Healthy Core Beliefs.** Allow your child or teen to decide.

_____ Option 2.1. Teach someone about focused breathing, such as natural, timed, or abdominal breathing.

_____ Option 2.2. Teach your parent or guardian about the contrast of tensing muscles versus relaxing muscles.

_____ Option 2.3. What are your parent or guardian's favorite coping strategies or ways to deal with stress?

_____ Option 2.4. Discuss with your caregiver some fun activities that you might do together. For example,

(1) Sharing a book or watching a television program together, then discuss what each person liked or did not like about the book or show. _____

(2) Pick a recipe and work together in the kitchen to follow recipe. _____

(3) Go for a walk together. _____

(4) Throw a ball back and forth to each other. _____

(5) Have your parent or guardian teach you a game that he or she played as a child, such as jacks, marbles, kick the can, hoola-hoop, skating, or pick up sticks. _____

_____ Option 2.5. I will be a detective during this week to find evidence that I use coping skills. I can write a few words about each time I used that coping skill. So far, we have learned about these coping skills: think of favorite things; listen to music; active meditation, for example, Shake, Wiggle, Jiggle, and Dance; schedule enjoyable activities; recognize the value of relationships; schedule time with loved ones; recognize and accept unpleasant bodily sensations caused by the stress response; and, focused breathing. I will remember to check with parent or guardian to be sure that my stomach ache or fast beating heart does not require medical attention.

Table H3. Sample Letter for Use After Unit Three Sessions

Date _____

Dear _____,

During today's session, we learned about recognizing, labeling, managing, and appropriately expressing the four primary emotions of happiness, sadness, fear, and anger. We talked about being nonjudgmental about emotions. We also briefly discussed empathy, compassion, and ambivalence. We finished the session with mixing paint colors. We discussed that doing art work is a very important coping tool for many people. Your child will look for at least one relative or neighbor who has a special hobby such as painting for fun, knitting, crocheting, or woodworking. Please share with your child or adolescent your favorite types of arts and crafts.

_____

**Homework suggestions for unit 3 of Building Healthy Core Beliefs.** Allow your child or teen to decide.

_____ Option 3.1. With a parent or guardian, discuss the name and the function of each emotion. Play the face imitation game. Did your parent or guardian also feel the same as the face he or she was making? _____

_____ Option 3.2. Find at least one relative or neighbor who has a special hobby, such as painting or drawing for fun, knitting or crocheting, woodworking, furniture finishing. The special hobby I would like to learn about is _____.

_____ Option 3.3. Keep a tally of your emotions this week using Table 12. Also rate your energy during each emotion. Did you accept each emotion without judging it?

Table 12. Weekly Tally Chart of Four Basic Emotions

| | Happiness<br>-1…..5….+10 | Sadness<br>-1……5….+10 | Fear or Concern<br>-1.....5…. +10 | Anger<br>-1…..5…. +10 |
|---|---|---|---|---|
| Sunday | | | | |
| Monday | | | | |
| Tuesday | | | | |
| Wednesday | | | | |
| Thursday | | | | |
| Friday | | | | |
| Saturday | | | | |

Table H4. Sample Letter for Use After Unit Four Sessions

Date _____

Dear _____,

This week we talked about thoughts. We learned that we do not act on every thought that pops into our heads. Some thoughts are *stinky* and belong in the trashcan. We made a notecard that your child can carry in his or her pocket with a list of healthy thoughts on one side and some affirmations on the other side. Affirmations are healthy thoughts about a person. Making a treasure chest of affirmations may be a project for the entire family.

We also talked about recognizing and remembering accomplishments. Frequently, we do not give ourselves credit for what we are doing well, for example, getting out of bed, getting dressed, eating healthy foods, drinking water, exercising, bathing, placing clothes in the hamper, and brushing teeth. Attached are some daily activity charts and stickers for keeping track of your child's accomplishments. Recognizing the small steps along the way helps us to realize that we are capable of achieving goals. Another lesson today was about compartmentalization and titration. Compartmentalization is saving some thoughts for later when we have the time and skills to work through them. Titration means that we take one small step at a time.

_____

**Homework suggestions for unit 4 of Building Healthy Core Beliefs.** Allow your child or teen to decide.

_____ Option 4.1. Discuss the lists of stinky thoughts and healthy thoughts. Throw *stinky thoughts* into the trashcan. Keep healthy and accurate thoughts.

_____ Option 4.2. Discuss the meaning of self-talk and the importance of saying nice things to myself.

_____ Option 4.3. Discuss the importance of affirmations to help each other build positive self-talk.

_____ Option 4.4. Decorate a shoebox to use as the family's Treasure Chest of Affirmations.

_____ Option 4.5. Encourage each family member to write affirmations about the other family members.

_____ Option 4.6. Discuss the reasons people take one bite at a time and how that relates to managing memories.

_____ Option 4.7. Discuss that mindfulness is intentionally and nonjudgmentally paying attention to the present.

_____ Option 4.8. Discuss what is special about the here and now.

_____ Option 4.9. Teach your caregiver about grounding and discuss what being grounded means.

_____ Option 4.10. Show your caregiver what orientation using the five senses looks like.

Table H5. Sample Letter for Use After Unit Five Sessions

Date _____

Dear _____,

Today we discussed *memory packages* and how our brains bundle together sensory memories, emotions, thoughts, and beliefs of significant events in our lives. We talked about how some of those *core beliefs* affect how we see the world, our moods, and our tone of voice. We also discussed *sneaky beliefs* that may have formed before we could talk. Our beliefs are very personal and we will respect each other's rights to not share. Even when we do not agree, we can be supportive and validate that other people are doing the best they can with what they have.

We focused this session on the statements *I did not choose what happened to me in the past; however, I choose my response to the past. I choose my own behavior in the future*. We used the statements *I would have preferred* ____ and *I would have chosen to* ____ to discuss how each person makes choices about behavior. We agreed that allowing other people to help is an important ability that takes time to develop.

_____

**Homework Suggestions for unit 5 of Building Healthy Core Beliefs.** Allow your child or teen to decide.

_____ Homework option 5.1. I pretend to be a detective during this week to find evidence that proves or disproves my core beliefs. I keep track of my evidence on a notecard. On one side of the notecard, I write the sneaky beliefs I have about myself. The sneaky belief I choose to work through this week is _____. On the opposite side of the notecard, I choose a healthier core belief I would prefer to believe about myself. My healthier belief is _____ I write a few words about each episode that proves the healthier belief. I will remember to continue looking for evidence to support the healthy belief.

_____ Homework option 5.2. This week, I pretend to be a detective and I ask other people these questions.

"What happens when you have believed healthy things about yourself?"

_____

_____

"Who has helped you to believe healthy things about yourself?"

_____

_____

_____ Homework option 5.3. This week, I pretend to be an actor or actress. I act as though I believe this healthy belief _____

_____ Homework option 5.4. This week, I allow someone else to help or teach me. _____

_____

_____ Homework option 5.5. This week, I wrote in my journal and did not worry about spelling.

Table H6. Sample Letter for Use After Unit 6 Sessions

Date _____

Dear _____,

Once again, we emphasized the importance of spending time with others who are supportive and comforting. We discussed the different ways that people like to be shown love. We talked about how hugs may be more comfortable with some people than others. We emphasized that it is okay to tell someone when I am not comfortable receiving a hug from someone else.

Ask your child to tell you about the three parts of communication. We talked about how messages can be misunderstood and how to let other people know that we understood their message. We also discussed the importance of using "I" messages. We looked at the difference between feedback and criticism. We talked about how important it is to listen to the emotions and the intentions of the speaker.

Ask your child or teenager to tell you about loving-kindness meditation. Some people seem to carry the burdens of the world on their shoulders. Loving-kindness meditation is a way to think kind and loving thoughts about someone else and then let that person *walk out of our minds*. This meditation helps each of us to accept ownership of our own thoughts and behaviors. It is also healthy to think that others think kind things about me.

For homework, your child or adolescent will ask several people how they like to be shown love. Some people like words, others like actions, and others like gifts. One of the homework options is to tell someone else that you love that person. It is very important that your child knows that someone loves him or her. How do you like to be shown love? Perhaps you could share how you like to be shown love with your child.

_____

**Homework suggestions for unit 6 of Building Healthy Core Beliefs.** Allow your child or teen to decide.

_____ Homework option 6.1. This week, I pretend to be an investigative reporter and I ask these questions.

"How do you like to be shown love?" _____

_____

"Who gives you emotional support?" _____

_____

_____ Homework option 6.2. I say, "I love you" to _____

_____ Homework 6.3. As a detective this week, I notice these emotions behind people's words or actions.

_____

_____ Homework 6.4: Pretending to be an actor or actress, I act as though I do believe that *I am loved*.

Table H7. Sample Letter for Use After Unit 7 Sessions

Date _____

Dear _____,

This week, we talked about what it means to be lovable or likable. We examined the many ways that people can be smart. We discussed how to develop skills to get better at things we do not do as well as we would like. We also talked about healthy pride and recognizing our own and other people's strengths. We reviewed how each person in the world is valuable.

_____

**Homework suggestions for unit 7 of Building Healthy Core Beliefs.** Allow your child or teen to decide.

_____ Homework option 7.1. Using my detective skills, I find evidence about my own personal strengths.

_____

_____

_____ Homework option 7.2. Using my investigative reporter skills, I ask people these questions.

"What are your personal strengths?" _____

_____

"What were your favorite subjects in school?" _____

_____

"How have you shared your talents with others?" _____

_____

_____

"What does *honoring personal limitations or boundaries* mean to you?" _____

_____

_____

"What does *forgiveness* mean?" _____

_____

_____ Homework option 7.3. Using my acting skills, I pretend that I believe *I am lovable* even if I don't believe it.

Table H8. Sample Letter for Use After Unit 8 Sessions

Date _____

Dear _____,

In today's session, we discussed the meaning of believing that *I am worthy*. We discussed that saying, "I am worthy" means that I know I deserve respect, respectful affection, guidance, and encouragement. Additionally, I deserve to be heard and understood, to follow predictable routines, to be nurtured, and to be protected. We talked about ways that each person respects him- or her-self and shows respect to other people. We talked about how parents or guardians are being respectful as they guide children to learn the difference between healthy and unhealthy behavior. Parents or guardians also show respect by providing healthy food and clean clothing. We also discussed how children and adolescents are able to show respect to parents or guardians.

We discussed that some rules are negotiable and others are non-negotiable. I encourage you to discuss your house rules with your child or adolescent. Your child may ask you which house rules are negotiable. I encourage you to inform your child or adolescent about the appropriate time and place in your home to discuss negotiable rules. Do you have preferences for how you would like your child to discuss the negotiable rules?

We practiced showing someone that his or her words are heard and understood by using feedback and "I" statements. We talked about the importance of receiving and giving encouragement and affirmations. We discussed allowing and helping each person to be the best he or she could be. We allow other people to have different thoughts and emotions.

We emphasized that each person deserves protection and that some people may not be capable of protecting others. We remember the phrases *I would have preferred that …* and *I would have chosen …* to allow other people to make different decisions. We discussed recognizing and forgiving our own and other people's limitations and mistakes. We also discussed being grateful for the people who do protect us.

_____

**Homework suggestions for unit 8 of Building Healthy Core Beliefs.** Allow your child or teen to decide.

_____ Homework option 8.1. I pretend to be a detective and look for evidence of respect, appropriate affection, understanding of feelings, understanding of thoughts, nurturance, predictable routines, guidance, encouragement, protection from others. _____

_____ Homework option 8.2. I pretend to be an investigative reporter and ask people these questions.

"How do you like to be shown respect?"_____

"Who has encouraged you to be the best you can be?" _____

_____ Homework option 8.3. I pretend to be an actor or actress. If I don't believe that *I am worthy*, I will act like I do believe it. Here is how I pretend that *I am worthy*._____

Table H9. Sample Letter for Use After Unit 9 Sessions

Date _____

Dear _____,

In today's session, we discussed the healthy belief that *I am capable of accomplishing my goals*. We talked about brainstorming and choosing behaviors that help us to accomplish our goals. As always, when we brainstorm, we seriously consider all ideas. We practiced listing steps and tasks required to accomplish our goals. We also reviewed how we decide on a logical order for the required tasks. Your child created a time management schedule for completing each of the smaller steps on his or her way to accomplishing his or her bigger goals. We also looked at a conflict management worksheet that combines all of the skills that we have learned in the Building Healthy Core Beliefs program. I encourage you and your child to complete this worksheet together when working out conflicts.

Remember that you are invited to join us for our session next week on _____ at _____. We will meet in the therapy room. We hope that you can join us to celebrate your child's graduation from this program. At the party, your child would like to read a letter to you about what he or she learned during this program. I encourage you to also write a letter to your child expressing how you feel about your child and his or her accomplishments. You may want to read your letter to your child in the session after your child reads his or her letter to you.

I also would like to hear feedback about what you and your child liked and did not like about this program. Remember that I do want your honest feedback so that we can improve services in the future.

With sincere gratitude,

_____

**Homework suggestion for unit nine.** Please help your child or teenager to use his or her time management schedule during this week. We look forward to seeing you in our next session.

## VITA

Christine G. Morgan previously earned a Master of Communication Disorders from Louisiana State University Health Science Center. She anticipates graduating with a Master of Social Work degree from Louisiana State University in May 2016. Ms. Morgan's major areas of clinical interest include working with youth and families who have been exposed to adversity, providing support services for all members of adoption or foster care triads, and helping faculty and staff to create safe havens and secure bases in the school system. Her research interests include developing and improving assessment tools and interventions for improving well-being, functioning, and overall satisfaction in life.