CHAPTER

1

Introduction to Trauma Systems Therapy

Whatever It Takes to Help a Traumatized Child

LEARNING OBJECTIVES

- To introduce trauma systems therapy for child traumatic stress
- To describe the trauma system
- To outline the *whatever-it-takes* approach to providing care
- To provide a guide for the rest of this book

ICONS USED IN THIS CHAPTER

Essential Point	Academic Point	Danger	Quotation	Case Discussion

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Gerald is a 13-year-old boy who lives with his mother and 16-year-old brother. His father is in prison for attempted murder of Gerald's mother. Gerald witnessed his father stabbing his mother 2 years previously. His father was imprisoned for this episode, but Gerald and his brother had witnessed many instances of domestic violence prior to this time. Gerald's mother has a long history of major depression and is currently quite depressed, staying in bed throughout most of the day. His brother has been arrested numerous times for assault and for car theft. Gerald's brother has also severely assaulted his mother on two occasions. Gerald's mother is terrified to set a limit on her older son's behavior for fear of being assaulted. Gerald and his brother do not get along. There are frequent arguments at home that have escalated to fist fights. Gerald has been knocked

unconscious by his brother and is perpetually in fear that his brother will "lose it" again. Gerald has frequent intrusive memories of witnessing domestic violence, is vigilant about being assaulted, and has an exaggerated startle response. He has poor sleep with frequent nightmares and very poor concentration in his awake state; he failed the sixth grade because he found it hard to focus on school. He is at risk for failing the sixth grade again this year and has told his therapist that if he fails school again, he intends to kill himself.

What do you do? What do you say? Where do you begin? If you are like most providers* who work with traumatized children and families in the United States, you work out of your office or clinic. The story of Gerald is probably very familiar to you. You probably have five Geralds in your caseload. You see him for his first intake appointment. Perhaps you see him again for a follow-up visit. If you end up treating Gerald, his attendance is spotty. He is here for a few sessions, then gone for weeks or months at a time. If he attends regularly, you are faced with the real question: HOW CAN I HELP?! Does Gerald have cognitive distortions that need correcting? Does he have serotonin reuptake receptors that need blocking? Does he have conflicts that need interpreting? Does he have avoidance that needs exposing? Does he have eye movements that need desensitizing? Maybe . . . but . . . anything that you do; any distortion that you challenge; any interpretations that you make; any medication that you prescribe; any learning that you condition . . . is undermined as soon as Gerald leaves your office. What do you do?

Gerald travels through the system. He is seen in emergency rooms, residential programs, inpatient units, and outpatient clinics. His care involves mental health, education, social service, and soon the juvenile justice systems. If you are assigned to treat Gerald, then you know that sensible treatment requires a lot of integration with each of these systems. But who has time for that? He is hospitalized and you see him again. His medications are changed, but, for the life of you, you cannot figure out what "they" did in the hospital. He is failing school. You've gone to a few school meetings and explained about the stress and chaos in Gerald's life. The teachers are tired, and they have to think about the other kids in the class. They don't really know what to do. Gerald is missing school. He is missing appointments. You consider "closing the case" but just can't bear to do it. You've filed a couple of reports with your local child welfare agency, but they are "screened out." What do you do?

There Are No Easy Answers

We wish it were easy. We wish there was that one medication. We wish there was that 12-step, eight-session therapy that would make Gerald's nightmare go away.

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*In this book we use the term "provider" to refer to any professional who provides services to traumatized children and families.

We know that you wish it, too. Sadly, what has created Gerald's nightmare is years of trauma, abuse, and neglect, some of which is ongoing. Real intervention will require rolling up your sleeves and helping to address the reality of Gerald's problems. But *how*?

This book is about an intervention model that attempts to address Gerald's needs and the tragic needs of children like him. Accordingly, intervention needs to be comprehensive, focused, and intensive. It must be in the home, in the school, and in the neighborhood. Interventions need to get to the essence of the problem and stick to it like a dog to a bone, never to let go until the work is done. Interventions must address the numerous barriers that get in the way of families accessing services. This work is not easy. It requires a lot of energy on the part of providers and a lot of support of providers from mental health agencies and service systems. Obviously, this type of work exists in a system that is far, far from perfect. There are enormous public policy concerns related to how services are delivered to traumatized children and how the service system is organized. Nevertheless, there are existing services in place in most states that can be maximized for effective treatment. This book is about using these existing services in a coherent treatment model aimed to maximize effectiveness.

> We wish it were easy. We wish there was that one medication. We wish there was that 12-step, eight-session therapy that would make Gerald's nightmare go away. We know that you wish it, too.

This book also tries to address the realities of a provider's practice. What are these realities?

- The average provider is busy, probably overworked, possibly "burning out," and has little "extra" time or resources to enhance treatment.
- The average agency that provides services is financially stretched and has few funds for the "extras" such as staff training, supervision, outcome monitoring, or home-based care.
- The average state service system is also stretched and fragmented, with insufficient communication between departments and inadequate cross-system service plans for children with traumatic stress.

We designed our intervention model with the needs of children with traumatic stress in mind, as well as the constraints of the realities of clinical practice in the United States at this particular time. Accordingly, we designed this intervention using services that are available in most states.

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The answers we propose are not "easy"; how can they be? We offer a series of solutions that are in no way perfect. Service delivery takes place in a service system that is resource poor and problematic in many ways. Nevertheless, we believe that the solutions we propose will be very helpful for providers, agencies, and service systems as we all try to figure out what to do for children like Gerald.

Whatever It Takes

There are no half measures or tentative choices that are appropriate. It's "all in" or it's not; it's "whatever it takes" or it's not; it's about looking at the reality, or it's about averting our eyes.

Ultimately, the issue of addressing Gerald's needs—in all their complexity—boils down to the answer to a simple question: Do we look away, or not? Trauma is such a deep assault on the soul of a child—and on whom he or she might become—that our choice about how to help is not unlike what we must do when we walk along a riverbank and see a person drowning. There are no half measures or tentative choices that are appropriate. It's "all in" or it's not; it's "whatever it takes" or it's not; it's about looking at the reality, or it's about averting our eyes.

What do we think is in store for Gerald—and kids like him—if he doesn't get the help he needs? We know where far too many children like Gerald are going without treatments that will address their reality. They are going to our chronic psychiatric hospitals, our substance abuse programs, our homeless shelters, our prisons, and, far too often, prematurely to our morgues. We have to do *whatever it takes* to help. We know where these kids are going. The facts are clear. We know about the numbers of kids impacted by trauma. It's no longer good enough to say that our system is too limited and there are too many barriers in the way to provide help.

Regarding the great many of *our* Geralds left alone in that river: What do we tell ourselves that makes us not address their realities or that allows us to address them with half measures?

There are, of course, so many ways in which the system is limited—and so many barriers in the way of providing effective care. The question for us all is: How can we make it work, given these limitations? There may not be *easy* answers, but there *are* answers. It's not unlike the many things we might tell ourselves in an effort to feel OK about not jumping into the water to rescue the drowning person (e.g., "What drowning person?"; "He's going down anyway, not much I can do"; "I'll walk to town and call someone better equipped to help"; "What do you expect when you swim alone in a river?"). Regarding the great many of *our* Geralds left alone in that river: What do we tell ourselves that makes us not address their realities or that allows us to address them with half measures?

Judith Herman raised this very issue many years ago in her classic book on trauma, *Trauma and Recovery* (1997):

> It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering. (pp. 7–8)

We cannot look away. We are called to act, to engage, to remember, to help, and to share the pain.

Is our perspective too harsh? A few facts to consider:

- From the general public, 52.1% of adults have reported having at least one adverse childhood experience, with 22% experiencing sexual abuse and 10.8% physical abuse (Felitti et al., 1998).
- In 2012, a nationally estimated 4.5 children died *every day* due to abuse and neglect (U.S. Department of Health and Human Services [HHS], Administration for Children and Families [ACF], Administration on Children, Youth, and Families [ACYF], Children's Bureau, 2013).
- 3.2 million children received a child protective services response in 2012 (HHS, ACF, ACYF, Children's Bureau, 2013).
- In a nationally representative sample, 60% of children were exposed to violence and 46% were assaulted within the past year (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009).
- Among New York City families receiving child welfare services, 92% of children have been exposed to at least one traumatic event and *86% have experienced multiple traumatic events.* Among mothers, 92% have experienced a traumatic event, and *19% have experienced five or more* types of traumatic events (Chemtob, Griffing, Tullberg, Roberts, & Ellis, 2010).
- Childhood exposure to adverse experiences increases the risk for alcoholism, suicide attempts, depression, drug abuse, obesity, heart disease, and cancer (Felitti et al., 1998).

Our experience tells us that many of these children have problems as complex as Gerald's (would Gerald be the most complex kid in your practice?). These children need treatment. They need treatment that addresses trauma. And that trauma treatment must address the complex reality in which they live. One hundred percent of traumatized children deserve to have us do *whatever it takes* to help them.

We must not look away. We must be all in. We must figure out how to do whatever it takes. We know who bears the burden of our averted eyes.

Our Pledge: Offering a Treatment Approach That Helps You Do Whatever It Takes

★ We understand that there is a very tough reality ahead for those who will do whatever it takes. We join you in this spirit and are with you as you take this more courageous road. This book is written to help you to be as effective as possible. We start with a pledge to you.

- We write about the reality you face as you help with the reality your children face.
- We simplify this reality only to help us focus on what is most important. We do everything we can to *not* oversimplify.
- We offer practical solutions that will work in the world in which most people practice. In order for these solutions to work, clinical care must be embedded in the right type of organizational and systems-level approach and be financially viable within these organizations and systems. We address these areas methodically, practically, and clearly.
- We aim to provide an approach that offers value to whoever uses it, based on what is most important to them. The user may be a provider, an administrator, a parent, or a child. The only evidence base that matters to us is the accumulating evidence that our approach yields this type of value.
- We write to honor the courage of those who choose to do whatever it takes and to help with *your* very real needs as you take this difficult road.

Who Are We?

We are a child psychiatrist (Dr. Saxe) and a child psychologist (Dr. Ellis) who began to work together in the late 1990s with traumatized children and families at Boston Medical Center, Boston's inner-city hospital. We are also a child psychologist (Dr. Brown) who joined several years later and became the chief trauma systems therapy trainer. The children and families we worked with at Boston Medical Center continually faced considerable social problems such as poverty, community violence, parental mental illness and substance abuse, homelessness, and racism. Many of the families we served were highly traumatized. Ten percent of children seen in our primary care clinic reported seeing a shooting or stabbing before they were 6 years old (Taylor, Zuckerman, Harik, & Groves, 1994). Sixty-two percent of adolescents seen in our emergency room (for any reason) reported a history of experiencing or witnessing violent physical or sexual assault (Kassner & Kharasch, 1999).

We had been trying to do our best for these families with outpatient therapy, including what was considered "evidence-based" treatments and the highest-quality

psychopharmacology. We directed a team of psychologists, psychiatrists, social workers, and many trainees, and were providing treatment to a great many traumatized children and families in Boston. At one point, faced with the frustration of the clinician assigned to Gerald (and a great many other children like him), we asked our team a very simple (but highly provocative) question: "Are we doing any good for the kids and families that come to us for treatment?" We saw the impulse on team members' faces to enthusiastically answer: "*Of course we are doing good!*" But people withstood the impulse and held their tongues for about 3 seconds—long enough to confirm our impressions—and then we were able to have an honest conversation.

> We began to ask a simple question: Are we helping? We were not able to provide a clear answer to that question.

The bottom line was this: Despite all our hard work, and the many hours we were putting in to try to help many people, we could not provide a clear answer to that question. There was simply no evidence to which we could appeal. Team members could describe families that did benefit from our work—but those were the families that returned to treatment. We knew that our "no-show" rate was about 50%. Furthermore, we were getting burned out. Our staff turnover rate was high. People were very frustrated. Frankly, it was feeling like we were banging our heads against the wall trying to help. We began to initiate a process of figuring out how we could do better. The first version of this book, published in 2007, was a result of that process. On the way, we investigated many different types of treatments and services for children. We also wanted our work to be helpful to others and so have worked with many people to try to operationalize our ideas into a useable format.

A huge catalyst for our efforts was our funding at the end of 2001 as an Intervention Development and Evaluation Center as part of the new National Child Traumatic Stress Network (NCTSN). This network is the nation's primary response to the problem of traumatic stress in children and provided the funding and infrastructure to help us develop this treatment that we began to call *trauma systems therapy* (TST).

The Never-Ending Story Based on a Community of Users

It is very important to understand that the ideas contained within the intervention model called TST come from an ever-widening community of users who have, over the years, agreed to work together to implement new interventions to help traumatized children and families, evaluate their utility, and then decide whether they should be integrated into the model. We began with a handful of clinicians who worked together on a clinical team in one clinical setting. Our team spent about 3 or 4 years tinkering with the model by slowly integrating and evaluating different approaches, until we felt we had a model that had a chance of helping us "do some good."

As soon as we arrived at the model we liked, we began writing the first version of our book and began to give presentations at local and national meetings about our work. Interest began to generate, primarily from providers and administrators who were asking themselves the same question we were asking: "Are we doing any good?" TST began to ride the wave of frustration such a question provokes.

Sometime in 2002 we received a call from three individuals—Susan Hansen, Cheryl Qamar, and Barbara Sorkin—who were administrators in the mental health and child welfare systems in Ulster County, New York. They had attended one of our lectures at a national meeting and thought our ideas for TST might be helpful for their work trying to provide integrated care between their county's mental health and child welfare systems. But there were several barriers in the way to our helping the Ulster County team:

- We had never even heard of Ulster County and had no idea how our intervention might be useful to them.
- We thought TST was an inner-city treatment model and had never even considered how it might be applied to a largely rural population.
- We designed TST as an outpatient mental health treatment and had no idea how it might help integrate services between county mental health and child welfare systems.

Fortunately, Susan, Cheryl, and Barbara are persistent people and convinced us to visit Ulster County and help them implement our treatment model there. Our visit surprised us on multiple counts, particularly how similar to our experience the clinical issues were in the families they were trying to help. Although figuring out how to adapt and implement TST in Ulster County was not easy, we helped them create a program that met their needs, helped a lot of children and families, and has been sustained for almost 12 years (at the time of this writing). Our first published outcome study was based on a cohort of children from Boston Medical Center and from Ulster County. Our experience in Ulster County taught us a number of very important things:

- Our ideas about trauma systems (described next) are quite useful outside the setting where they were developed.
- Our ideas could be extended and improved based on their use. By partnering with other agencies, we could create an ever-widening community of developers who could work with us to improve the TST model based on collective experience. At the time of this writing we have what we call a *TST Innovation Community* comprised of 25 agencies in 13 states and the District of Columbia, that continually work with us to improve TST based on this diverse experience (described in Chapter 16).
- Organizational issues are pivotal. TST is implemented within an organization or a group of collaborating organizations. Each organization has

its own human resource, financial, and political needs. Each organization has unique sets of stakeholders who must be mobilized for TST to be implemented and sustained. All of these issues required an organizational planning process. We describe this planning process in Chapter 8.

Whenever we implement TST, we learn how to make it more useful, and we now have access to an ever-widening community of TST innovators to help us adapt, evaluate, integrate, and implement. We feel very lucky to have such partners and, because of them, TST has been adapted for problems and for settings we had hardly considered: rural settings, residential care programs, crisis units, shelters for unaccompanied refugee minors, foster-care programs, child welfare prevention programs, school-based programs, refugee programs, and programs for children hospitalized with injuries and illnesses. Early partners such as Adam Brown at Children's Village in Dobbs Ferry, New York, helped work out the details of TST for residential care; Bob Abramovitz and Mary Dino at the Jewish Board for Family and Children's Services in Manhattan helped adapt TST for foster care; Kelly McCauley and Sherry Love of KVC Health Systems, Inc. in Kansas helped adapt TST for both residential care and child welfare; Bob Kilkenny and Lisa Baron from the Alliance for Inclusion and Prevention in Boston helped adapt TST for schools; and Liza Suarez of the University of Illinois at Chicago helped adapt TST for children with substance abuse and traumatic stress. Most recently, Erika Tullberg and Adam Brown worked out the details for how TST can best address the considerable problem of secondary traumatization.

TST started from a community of developers based at Boston Medical Center. Drs. Saxe and Ellis both left Boston Medical Center in 2007. Dr. Saxe now chairs the Department of Child and Adolescent Psychiatry at New York University School of Medicine and Directs the NYU Child Study Center. Dr. Ellis now directs the Center for Refugee Trauma and Resilience at Boston Children's Hospital. TST is now based in our new institutions and in institutions, agencies, homes, and schools around the United States.

TST has become a never-ending story based on an ever-widening community of users joined with a spirit to do *whatever it takes* to help traumatized children. We hope you will consider joining our community and contribute to the telling of our story.

What Is TST?

TST is both a clinical model for the treatment of children with traumatic stress (broadly defined) and an organizational model for the successful implementation of the TST clinical model based on the way organizations work. It has a defined position on the core clinical problems of traumatic stress in children and a defined position on how organizations can best support and sustain their TST program.

The Core Problem: The Trauma System

Traumatic stress occurs when a child is unable to regulate emotional states and in certain moments experiences his or her current environment as extremely threatening even when it is relatively safe. This happens when the child's brain regulation of emotional states is disturbed. In Chapters 2 and 3 we describe how this disturbed capacity to regulate emotional states leads to a child experiencing what we call a *survival-in-the-moment state*.

A survival-in-the-moment state is defined as:

an individual's experience of the present environment as threatening to his or her survival, with corresponding thoughts, emotions, behaviors, and neurochemical and neurophysiological responses.

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When there is a real threat to survival, then a survival-in-the-moment state is extremely adaptive. When there is not a clear threat to survival, then a survival-in-the-moment state can be extremely maladaptive. Here lies a very big problem for the child with traumatic stress:

1. He or she has a great propensity to shift into survival-in-the-moment states even when the present environment is relatively safe.

2. He or she also commonly lives in environments that can become truly unsafe and/or filled with reminders of past unsafe (traumatic) environments.

In order to effectively treat traumatized children, both of these problems must be addressed effectively.

system A group of interacting, interrelated, or interdependent elements forming a complex whole. (*American Heritage Dictionary, Fourth Edition*, 2000)

Accordingly, TST involves interventions that address what we call a *trauma system*. A trauma system emerges in response to disruption in the natural systemic balance between the developing child and his or her social environment. A trauma system is comprised of:

1. A traumatized child who experiences *survival-in-the-moment* states in specific, definable moments.

2. A social environment and/or system of care that is not able to help the child regulate these *survival-in-the-moment* states.

Our treatment explicitly addresses these two core problem domains. Because the social environment (e.g., family, school, peer group, neighborhood) ordinarily

has a core function of helping a child to contain emotions or behavior, it is assumed that a child's inability to contain emotions or behavior means there is a diminished capacity of one or more levels of that social environment to help the child. Similarly, a child's inability to regulate emotional states also implies an inadequacy in the system of care to help the child contain emotions or behaviors. This failure has three possible sources: (1) The child has not yet accessed the system of care, (2) the child is "falling through the cracks," or (3) the services the child is receiving are insufficient in some way to help him or her contain those emotions or behavior.

TST includes an approach to assessing this "fit" between the child's regulation capacities and the adequacy of the social environment/system of care to help the child, and offers a variety of treatment modules based on the outcome of this assessment. We designed our intervention approach to help address the severe problems in children's environments and to do this work consistently holding in mind principles of child development and of systems of care. We designed our intervention approach with children like Gerald in mind.

Existing interventions do not offer clear approaches for addressing these severe social-environmental problems—approaches that are informed by theory about the way the social environment and the developing child interact. As is repeated throughout this book, our treatment addresses two core problem domains of the trauma system: (1) a child with dysregulated emotional states and (2) a social environment/system of care that is unable to help the child regulate these emotional states. Our intervention intensively targets the trauma system, which is why we call our intervention *trauma systems therapy*.

TST: Intervening with the Trauma System through Four Ecological Levels

In Chapters 2 and 3 we provide much detail about how survival-in-the-moment happens. We describe how specific signals in the child's present environment will evoke specific survival-laden responses in specific moments, based on a child's past history of specific traumas. You will learn how to identify the patterns by which a child transitions from his or her usual emotional state to these survival-in-the-moment states. The trauma system fits within a much broader social ecology comprised of family, school, neighborhood, and culture, and also includes the service system when problems need to be addressed. TST is an explicit social-ecological model of intervention (Bronfenbrenner, 1979) whose workings we describe in detail in Chapter 4. What does TST look like? Figure 1.1 provides this picture.

We first warn you: It's a complex picture! Please don't be daunted by it. We "unpack" these layers over the course of this book. For now, take a look at Figure 1.1 and then the outline of its various elements.
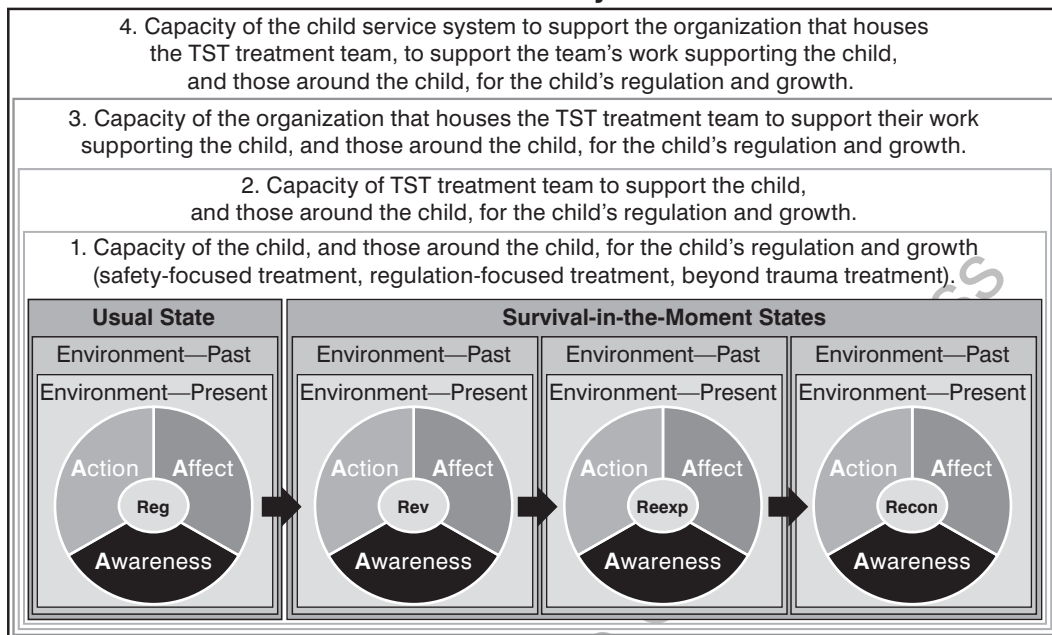
The Trauma System

4. Capacity of the child service system to support the organization that houses the TST treatment team, to support the team's work supporting the child, and those around the child, for the child's regulation and growth.
3. Capacity of the organization that houses the TST treatment team to support their work supporting the child, and those around the child, for the child's regulation and growth.
2. Capacity of TST treatment team to support the child, and those around the child, for the child's regulation and growth.
1. Capacity of the child, and those around the child, for the child's regulation and growth (safety-focused treatment, regulation-focused treatment, beyond trauma treatment).

Usual State	Survival-in-the-Moment States		
Environment—Past	Environment—Past	Environment—Past	Environment—Past
Environment—Present	Environment—Present	Environment—Present	Environment—Present
Action **A**ffect **Reg** **A**wareness	**A**ction **A**ffect **Rev** **A**wareness	**A**ction **A**ffect **Reexp** **A**wareness	**A**ction **A**ffect **Recon** **A**wareness

FIGURE 1.1. The TST picture.

Patterns of Survival-in-the-Moment

The boxes in Figure 1.1 labeled "Usual State" and "Survival-in-the-Moment States" describe the transition from the child's usual state to survival-in-the-moment. As we discuss in Chapter 3, these states are represented by four essential building blocks, each of which have a characteristic level of nervous system arousal: Regulating (Reg), Revving (Rev), Reexperiencing (Reexp), and Reconstituting (Recon). We call these the 4 R's and each are defined by three qualities of experience that we call the 3 A's—Affect, Action, and Awareness—all of which change based on what is going on in the child's environment at the time (environment—present). The way these shifts occur and, in particular, what causes the shifts can be understood through the child's experience of past environments, including traumatic environments (environment—past). What is critically important about all of this is the process by which a child transitions from her or his usual state (defined by the first R, regulating) to a survival-in-the-moment state (defined by the sequential transition through Revving, Reexperiencing, and Reconstituting). We return to this process, repeatedly throughout the book. The details of how the environment is arranged to support, or not support, the child's regulation and growth are described in Chapters 4 and 5, and the process for assessing this complex system is the focus of Chapter 9.

Four Levels of Ecological Intervention

1. **The capacity of the child, and those around him or her, to sustain, or fail to sustain, the child's regulation and growth.** The natural social environment is populated with people who ordinarily spend time with the child—parents, teachers, coaches, etc. Ordinarily, those around the child will be able to help him or her manage adversities, including trauma. Sometimes help beyond this naturalistic network is needed to support the child's regulation and growth, and this is when clinical intervention may be indicated. TST provides this clinical approach in three phases—safety-focused treatment, regulation-focused treatment, and beyond trauma treatment—discussed in detail in Chapters 12, 13, and 14, respectively.

2. **The capacity of the team supporting the child and those around him or her.** The child and those around him or her are supported by a multidisciplinary TST treatment team, with a defined approach to conducting the work (described in Chapter 7).

3. **The capacity of the organization supporting the team.** The TST treatment team is supported by an organization, or group of organizations. We have a very specific approach to ensure that the organizations in which this work is based can support and sustain their TST Program. The TST organizational approach is described in Chapter 8.

4. **The capacity of the service system supporting the organization.** Organizations that support TST treatment teams operate within a service system, the realities of which must be understood and well integrated so that the host organizations can fully support and sustain their teams. The realities of this service system are described in Chapter 4 and the integration of these realities within an overall organizational approach is described in Chapter 8.

Making It Work: The TST Organizational Model

We wrote our first edition of this book without a defined organizational model. We quickly learned, through our experience in Ulster County and in many of our early disseminations, that good clinical ideas only go so far. A clinical model such as TST is implemented in organizations with definable needs and reasons for supporting the implementation of a TST program in the organization. If the TST program is not developed with a good understanding of these needs and how the TST program will address them, then the program is unlikely to be properly implemented and sustained over time. As is described in Chapter 8, the implementation of TST requires an organizational plan struck in collaboration between TST developers and the right set of stakeholders from the organization. In particular, an organizational leader with sufficient authority must be included and the plan must be set to deliver on items the organization's leadership and staff identify as very important (whatever they may be).

Who Can Benefit from TST?

We've designed TST to address a very broad range of problems that traumatized children experience. It's not just for children with posttraumatic stress disorder (PTSD; more on the problems with PTSD in Chapter 3). It's for children who meet the following criteria:

1. A child with a plausible trauma history, and
2. A child who has difficulty regulating emotional states that are plausibly related to this trauma history.

Note the word *plausible*. We don't need to know all the details of the child's trauma history. We don't even need to know with 100% certainty that a child was exposed to a trauma. The most important thing to know, given the child's clinical presentation and what the child and others tell you, is that a trauma history is plausible. Similarly, you don't need to make a psychiatric diagnosis such as PTSD to offer TST. You need to see the child experiencing dysregulation of emotional states in certain moments and see that the way the child dysregulates in those moments may plausibly be related to his or her plausible history of trauma. We provide a lot more detail about what it means to meet the TST criteria in Chapters 3 and 7. What is most important for now is to know that TST can help a lot of traumatized children who need services. We are very proud of the fact that our model can help a broad range of children with issues ranging from the most straightforward to the most complex. One thing that we and others have observed: In most agencies that serve traumatized children, the great majority of providers' and administrators' time and attention is dedicated to a very small proportion of children served. These are the children with very severe and complex problems, including a high risk for harm. We are proudest of the fact that TST appears to provide agencies unique value for exactly these children and their families.

What Is Treatment?

Consistent with the theme of this book, we define treatment as whatever it takes to help a traumatized child. Accordingly, we don't ever predetermine what will help.

We know that, eventually, we'll have to get into this basic discussion, so we may as well dive in here. What do we mean by *treatment* or *therapy*? It's important to know that we take a very broad view here, perhaps broader than most other treatment models. Consistent with the theme of this book, we define treatment as *whatever it takes* to help a traumatized child. Accordingly, we don't ever predetermine what will help. Treatment is not necessarily something that is delivered by a clinician in a clinical setting according to well-defined psychotherapeutic or psychopharmacological protocols.

Treatment is *anything* that might be delivered by *anyone* who will help. Does this mean that anything goes? Well . . . yes and no. *Yes*: Just about anything could be considered a potential treatment or element of treatment. *No*: The only thing(s) that would be considered an actual treatment or element of treatment is that which we determine will specifically alleviate the child's well-defined trauma-related problem(s). Whatever it is and whatever it takes. As we detail in the assessment and treatment-planning chapters, there is a great deal of specificity to what we eventually decide should constitute the treatment for a particular child. It's highly strategic and highly specific. It's whatever it takes to help, given our well-defined understanding of the nature of the child's problem(s).

Five Goals of the Development of TST

We designed our intervention approach to help with the severe problems in children's environments, and do this work in a way that consistently incorporates principles of child development and of systems of care. We designed our intervention approach with children like Gerald in mind. Specifically, we set four goals for designing this intervention. As TST developed, we added a fifth goal that we see as critical for the success of any TST program.

1. Treatment must be developmentally informed.
2. Treatment must *directly* address the social ecology.
3. Treatment must be compatible with systems of care.
4. Treatment must be "disseminate-able" and sustainable.
5. Treatment must add value to users.

What Does Each Goal Mean?

1. Treatment Must Be Developmentally Informed

In order to treat Gerald, you need to know certain basic principles about child development. You need to know that the types of interventions effective for a 6-year-old are very different from those effective for a 16-year-old, and also that treatment of a child with developmental delays looks different from treatment of a child without them. You must consider how such areas as attachment, emotional regulation, identity, and cognition at different ages may be approached in treatment.

These ideas are very important for a child like Gerald. What type of attachment relationships might develop for a child with a depressed mother and a very violent father and brother? What does it do to the sense of identity of a 13-year-old boy to have a father in prison and to have witnessed this father beating up the boy's mother and brother? What does it do to his sense of identity, self-esteem,

and feelings of control to have been beaten up by his father? How do these experiences, and their influence on attachments and identity formation, affect Gerald's ability to regulate his emotions? What type of peer groups is he likely to join? How does growing up in terror affect cognitive development and school performance? These types of questions need to be asked and answered in order to sensibly treat Gerald and all those like him. In Chapters 2, 3, and 4 we describe the developmental principles upon which our intervention approach is based.

> What does it do to the sense of identity of a 13-year-old boy to have a father in prison and to have witnessed this father beating up the boy's mother and brother?

2. Intervention Must Directly Address the Social Ecology

In order to treat Gerald and all those like him, you must be able to *directly* address the social ecology. If your treatment is conducted only in your office, you will be spinning your wheels for a very long time. If you try to approach Gerald's family problems by scheduling the occasional family meeting, you will probably not help anyone very much. Gerald's problems require on-site treatments that directly address the social-environmental contributors to the problem. Often families of children with traumatic stress experience significant barriers to receiving appropriate care. Intervention approaches, accordingly, must be flexible enough to surmount these barriers.

> If your treatment is conducted only in your office, you will be spinning your wheels for a very long time.

Perhaps the most successful intervention model to directly address the social ecology is multisystemic therapy (MST) for conduct disorder (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). MST uses community-based interventions to specifically target areas of a child's environment that are theoretically related to the development and maintenance of conduct problems. MST has demonstrated effectiveness for aggressive children by successfully targeting many fields in which the child interacts; "the child and family, school, work, peer, community, and cultural institutions are viewed as interconnected systems with dynamic and reciprocal influences on the behavior of family members," and are thus all engaged in the treatment process (Henggeler, Schoenwald, & Pickrel, 1995, p. 710). MST targets child and family problems in the multiple systems in which families are embedded and delivers treatments in the settings in which they are likely to have the highest impact. Services are delivered in a variety of settings, such as home, school, and the community.

> How could you approach Gerald's mental health problems from the distance of a clinic or office?

How could you approach Gerald's mental health problems from the distance of a clinic or office? His severe traumatic stress symptoms are highly reactive to conflicts and threats from his brother. His mother

is too depressed and afraid to intervene or to reasonably engage in clinic- or office-based treatment. The consequences of these traumatic stress symptoms severely affect his school performance. Community-based interventions such as the following are essential for a child like Gerald:

- The provider must work in the home, helping Gerald's mother to protect him by engaging the police, social service agencies, relatives, or whoever is able and willing to help.

- The provider must actively work with Gerald's mother to help her understand her own traumatic stress symptoms and how they are impacting Gerald, and to ensure that she receives treatment and support so that she can better protect Gerald.

- The provider must work in the school, consulting teachers and other school staff about how to best teach him and help with the construction of an individualized education program (IEP).

The failure of two school years for a child like Gerald (who has normal intelligence) is a tragedy. Chapters 4, 11, and 12 offer details about the way in which the social environment can be engaged in the treatment of traumatic stress.

3. Treatment Must Be Compatible with Systems of Care

In order to treat Gerald, you must be able to clearly link his treatment with the wider system of care. This is not easy, given how fragmented this system has become. Nevertheless, as we describe in Chapters 4, 10, and 12, a number of tools

> In order to treat Gerald, you must be able to clearly link his treatment with the wider system of care.

can help. Gerald, like many children with traumatic stress, is seen in many different service systems. Within the mental health system, children like Gerald often drift between the inpatient, outpatient, residential, and emergency psychiatry systems. Gerald is currently treated in an outpatient setting. If his suicidal impulses increase, he may be seen in the emergency or inpatient psychiatry systems. If his mother continues to be too incapacitated to protect him, the social services and residential systems may become necessary. There is a clear and reciprocal relationship between his emotional symptoms and his school functioning. His traumatic stress-related anxiety and poor concentration have interfered with his performance at school. This poor school performance, in turn, has contributed to his low self-esteem and suicidal impulses. It is hard to imagine a sensible treatment plan that does not fully integrate the educational system.

Clearly, there is a great need for service integration when treating traumatized children, and there is widespread acknowledgment of this need to create integrated systems of care for vulnerable, especially traumatized, children. The

surgeon general's report on mental health specifically identifies the need for services integration:

> The organization of services . . . is the linchpin of effective treatment . . . it is not just services in isolation but the delivery system as a whole, that dictates the outcome of treatment. Among the fundamental elements of effective service delivery are integrated community-based services, continuity of providers and treatments, and culturally sensitive and high quality empowering services. (U.S. Department of Health and Human Services, 1999)

What would an integrated and highly coordinated array of community-based services look like for traumatized children?

What would an integrated and highly coordinated array of community-based services look like for traumatized children? How might the specificity of trauma-related psychopathology guide the development of this array of services? What types of problems would be most likely to change as a result of these services? Our intervention model is designed toward such an integrated and highly coordinated system of services for an individual, traumatized child guided by the specific understandings of the nature of child traumatic stress. Our intervention approach can be seen as a guide for how services and interventions ought to be put together, given a child's emotional regulation capacities and the ability of the child's social environment and/or system of care to help him or her regulate emotion.

4. Treatment Must Be "Disseminate-able" and Sustainable

In order to treat Gerald, you must be able to work within an agency or service system that supports and pays for this treatment.

In order to treat Gerald, you must be able to work within an agency or service system that supports and pays for this treatment. It is critical that new interventions be developed with the financial and human realities of the clinicians, agencies, and service systems that will use them in mind. It is relatively easy to design a "pie-in-the-sky" intervention model that is prohibitively expensive to use. A new intervention must be "disseminate-able." It must be described in a clear way and address the clinical realities of practice in this time and place and also incorporate strategies for supporting clinicians and organizations in this difficult work. Chapters 9 and 10 review some of these strategies for supporting providers and the organizations for which they work.

We designed this intervention model with the needs of children with traumatic stress in mind, constrained by the realities of clinical practice in the United States at this particular time. Accordingly, we designed this intervention using services that are available in most states: a multidisciplinary team that assesses and treats all referred children. The TST team is typical of most multidisciplinary teams of psychiatrists, psychologists, and social workers, with three exceptions:

1. It has the capacity to deliver home- and community-based interventions in addition to clinic-based treatment.
2. It includes a child advocacy attorney who serves a key consultative role in the advocacy for services.
3. It functions from a very specific and operationalized model of assessment and treatment.

The enhancement of treatment with these "exceptions" to usual practice was chosen in a way that could be implemented with limited extra resources.

1. **Home- and community-based interventions.** Most states and counties fund short-term home-based intervention. We initially integrated a home-based team funded by the Commonwealth of Massachusetts Medicaid contract with a conventional multidisciplinary clinical team. This enhancement did not cost the agency implementing TST extra resources. When TST is being implemented with children receiving child welfare services, this service is often a standard part of care, provided by caseworkers who often play this role on the team. As is described in our organizational planning chapter (Chapter 8), an important part of the initial TST implementation plan is to identify the agency and providers who will offer the home- and community-based services.

2. **Child-advocacy attorney.** Finding an advocacy attorney who can consult with providers, the agency, and the team in certain key situations is very important. There are many types of partnerships that can be forged in a cost-effective way, including with legal aid clinics, pro bono services from law firms, law schools, and retired attorneys. If we embrace a whatever-it-takes spirit in this work, we must embrace partnerships with advocacy attorneys in these and other similar situations. We detail how legal consultation is used in Chapter 13 on safety-focused treatment. For now, here are some examples of how critical this consultation can be:

    a. The team is confident that the child is currently experiencing maltreatment and is similarly confident that treatment will make very little, if any, difference unless the maltreatment is sufficiently addressed. The child welfare agency has not sufficiently addressed the problem.
    b. The child is failing in school for the second consecutive year, has normal intelligence. An IEP is not in place, and the school does not believe an IEP is necessary.
    c. A refugee child is about to be deported back to the country where she witnessed her father's murder and is becoming suicidal.

3. **Model of assessment and treatment**. Most of the rest of this book is devoted to our description of our model of assessment and treatment. This model provides a blueprint for how services and interventions ought to be assembled. Our main aim in this regard is clinical utility.

THE TRAP OF GRANT FUNDING

Many of us have been here before. We win a federal, state, or foundation services grant to implement an intervention about which we are excited. We put everything we have into writing the proposal and celebrate when we are told the grant has been awarded. We use the grant to pay for the services that comprise this exciting program because the way services are paid for in our state and county cannot possibly cover the program. We have 4 or 5 years of funding. What can be better than this?

STOP! If this describes your current situation, please ask yourself a simple question: What will happen after the grant ends?

For almost all of us who have been in this situation, the program we have given our hearts and souls to implement disintegrates. It disintegrates because it was never designed to be funded through conventional means, and, in our experience, it is usually implemented based on wishful thinking: *If we achieve the outcomes we expect, the state, county, etc., will surely pay for this.*

We wish it were different, but this almost never happens. Most programs with services paid for through grant funds disintegrate when the funding is gone. One of our main objections to the evidence-based treatment (EBT) paradigm currently employed in our field is that most interventions evaluated through randomized clinical trials have not been designed to be delivered through conventional funding means, and the clinical trials that have "proven" their "evidence-based" status were based on treatment that was paid for by the grants that funded those clinical trials. It is therefore no surprise to us that in the real world, most EBT treatments are not sustainable after the funding period ends.

We designed TST to provide services that are largely paid for through conventional means, and we strongly discourage the use of grant funds to pay for services themselves so that the program will have the best chance of being sustained after the funding period ends. Grant funds do, occasionally, pay for elements within the implementation of a TST program. When grant funds are used within a TST program, we try to keep them as limited as possible and, within the organizational plan drafted, develop a vision for whether these funds will be necessary after the grant disappears or how the funds will be replaced when the grant ends. Expenses that are occasionally paid out of grant funds include:

1. The initial TST training and consultation
2. The evaluation of the TST program
3. The time for the TST attorney
4. The time for selected members of the team, particularly the psychiatrist/ psychopharmacologist, to attend team meetings.

★ One more note about sustainability: If all the providers you have so diligently trained in the model burn out and quit, you are back to ground zero. TST is a model that is built around the idea that we must do whatever it takes to help kids. In order to sustain this kind of energy and focus in our providers, organizations must also commit to doing whatever it takes to sustain the well-being and commitment of its staff.

Providers and other individuals who are working with the child and family (e.g., foster parents, lawyers, advocates) may be impacted by trauma, either as a result of their personal experiences or through their work with trauma victims. Listening to stories of abuse, neglect, violence, and other types of trauma can cause people to develop vicarious trauma, compassion fatigue, or secondary traumatic stress. Although there are nuanced distinctions between these terms, for the most part they refer to the traumatic stress reactions one can develop as a result of working with trauma victims and the impact such symptoms can have on one's personal life and overall worldview. Throughout this book we refer to this as *secondary traumatic stress,* or STS.

In order to create stronger programs and ultimately to better serve children and families, organizations need to do whatever it takes to acknowledge and support the needs of staff and administrators. TST Treatment Principle 8, "Take care of yourself and your team," addresses this important reality.

5. Treatment Must Add Value to Users

★ The more we help organizations implement TST, the more we see that the idea of *value to users* is central. People have choices. They select solutions to the problems they face based on the plausibility that the selected solution will help with those problems, and they quickly revise their choice if the selected solution does not appear to help. There are many types of users of TST programs: children, parents, foster parents, clinicians, clinic administrators, child welfare workers, and child welfare administrators, to name a few. Each user has his or her own goals for engaging with TST, based on the problems he or she is facing.

> There is a universal truth: If a solution chosen for a given problem does not add value in a sufficiently compelling way to a person, based on that person's definition of the problem, then he or she will seek a different solution.

There is a universal truth: If a solution chosen for a given problem does not add value in a sufficiently compelling way to a person, based on that person's definition of the problem, then he or she will seek a different solution. With this universal truth in mind, we aim to provide value to the users of TST. This aim works at both the clinical and the organizational level in very similar ways. Our treatment engagement strategy, ready–set–go (described in Chapter 11), is based on this idea, as is a core part of our organizational engagement approach (described in Chapter 8).

Outline of the TST Manual

This book is to be read as a manual for implementing the TST intervention approach for children with traumatic stress. The book has four sections:

- I.   Foundations
- II. Getting Started
- III. Doing Trauma Systems Therapy
- IV. Improving Trauma Systems Therapy

Part I (Chapters 2–5) describes the theoretical background necessary to implement TST. **Part II** (Chapters 6–8) describes the principles of TST and how the organizations and team that will implement TST get set up to apply these principles. **Part III** (Chapters 9–15) describes the activities providers and teams need to perform to "do" TST, and includes the practical elements of assessment, treatment planning, and treatment implementation. **Part IV** (Chapters 16–18) describes the process of improving TST through innovation by a community of individuals and agencies that use TST. In this section we also describe ideas for innovating the TST principles so that our treatment model can be used for problems other than traumatic stress.

Part I. Foundations

These chapters lay the foundation for understanding the trauma system, described previously. Starting with the biological processes underlying survival-in-the-moment and the way in which these processes influence regulation, we move up and down the layers of the trauma system to understand how a child's regulation and growth can be supported (or not supported) by the people, organizations, and service systems that surround him or her.

Chapter 2. Survival Circuits

The trauma system includes the basic biological processes that are evoked when a traumatized child experiences his or her survival to be at stake in definable moments. In those moments ancient systems of the brain and the body are engaged to help the child survive. These powerful systems are extremely adaptive, but they cause problems when they activate in situations when the child's survival is not actually at stake. We call this system the *survival circuit* and describe how it works in this chapter.

Chapter 3. The Regulation of Survival-in-the-Moment States

The trauma system also includes the process that occurs when a traumatized child shifts from his or her usual state of emotion to what we call

survival-in-the-moment states. This shift relates to a bottom-line function of the survival circuit, described in Chapter 2: to recognize patterns related to information from the social environment and from the body to "decide" if there is sufficient threat in the environment. Once a threat pattern is recognized, thoughts, emotions, behaviors, and underlying chemical and physiological systems shift dramatically, and everything in the child is focused on maintaining survival; that's what we mean by *survival-in-the-moment*, and a core part of treatment is to help the child to regulate these states so they are not expressed in situations that are not truly threatening. This chapter details these survival-in-the-moment states and the importance of regulating them.

Chapter 4. The Social Environment and the Services System

Survival-in-the-moment states are expressed in specific contexts that are either truly threatening or are safe enough but remind the child (consciously or unconsciously) of his or her trauma experience. This chapter offers an account of the various interacting components of the social environment, including the family, school, peer group, neighborhood, and culture. These components of the child's natural social environment are understood in relation to the first level of the trauma system: That is, we focus on how these areas of the social environment can serve to promote or diminish the self-regulation capacities of the child. We also examine how elements of the services system may impact this work.

Chapter 5. Safety Signals

The traumatized child's main source of hope is related to the type of relationships to which he or she has access. Are there people in his or her life who the child perceives to be in his or her corner? Are there people whom the child can trust? Such people emit what are called "safety signals," and if there are enough of these signals, the traumatized child can be helped to regulate emotion in a host of environments. The parent–child relationship and the therapeutic relationship are two critical relationships through which safety signals, and the child's ability to recognize them, can be leveraged. This chapter discusses the importance of those safety signals in promoting the child's regulation and growth.

Part II. Getting Started

Once the foundations are well understood, it's time to get ready to help. Where to start? First we review the 10 principles of intervention that ground all the work in TST. We then describe how these principles are delivered by a team of providers, and how this team needs to be supported by the agency in which it works. As described, TST is always delivered by a team of providers that operates—together—in specific ways. In order to be able to do this work, organizations need to support their providers and teams in specific ways. All of these needs and requirements are described in the chapters of Part II.

Chapter 6. Ten Treatment Principles

This chapter outlines the 10 principles that anchor TST treatment. These principles are:

1. Fix a broken system.
2. Safety first.
3. Create clear, focused plans that are based on facts.
4. Don't "go" before you are "ready."
5. Put scarce resources where they'll work.
6. Insist on accountability, particularly your own.
7. Align with reality.
8. Take care of yourself and your team.
9. Build from strength.
10. Leave a better system.

Chapter 7. The Treatment Team

The treatment team is an essential component of TST. This chapter describes the importance of having a multidisciplinary treatment team for conducting the work that needs to be done, including the strategies needed for creating a supportive team environment. The chapter suggests how the team should operate to guide treatment toward achieving fidelity to the TST principles.

Chapter 8. Organizing Your Program

The TST treatment team operates within an organization or several organizations that have agreed to collaborate with each other. How will this team be supported to do this difficult work? What does the organization or organizations need to know about TST so they may help it fit and stick? How can TST be adjusted to best fit within the needs of the organization or organizations that use it? How can TST help address secondary traumatic stress experienced by those working within the organization and by the organization itself? TST is only implemented when there is a defined organizational plan that works out these issues. This chapter describes the process of getting to this organizational plan.

Part III. Doing Trauma Systems Therapy

Once a team is set to implement TST and an organization is set to support that team, the team and its providers work with children and families to deliver TST in a set of defined steps. Fidelity to TST is defined by how closely the implementation of these steps follows the TST model. What are these steps? Each is detailed in a separate chapter in this part.

Chapter 9. Assessment

To deliver an intervention that will truly address the complexity of a traumatized child's problems, the right type of information must be gathered to know what to do. This chapter offers a clear approach to gathering information to answer five questions that will form the child's treatment plan. The five questions are:

1. What problem(s) should be the focus of the child's treatment?
2. Why are these problems important, and to whom?
3. What interventions will be used to address the child's problems?
4. What strengths can be used to address the child's problems?
5. What can interfere with addressing the child's problems?

Chapter 10. Treatment Planning

Once the information is gathered from our TST assessment, we are ready to answer those five questions that will form the basis of our treatment plan. This chapter offers guidelines for using the information gathered in Chapter 9 to answer these questions and to arrive at these decisions.

Chapter 11. Ready–Set–Go

Providers and their teams may feel they are close to making decisions on what to do in treatment based on what they have learned in Chapters 9 and 10, but their decision can never be made without the right type of partnership with the family. How much does the problem the team wants to address relate to the problems the child and family see as most important? How much does the team understand the practical barriers to successful implementation of treatment? This chapter discusses the potential difficulties of engaging families in treatment, and reviews an approach to partnering with families to make the best decisions about what to do in treatment.

Chapters 12–15. Treatment Implementation

Once the right type of information has been gathered, and the team uses that information to develop preliminary ideas on how treatment will be conducted and partners with the family to finalize these decisions, everything is lined up for success. Now: What do you do to achieve success? These next four chapters are designed to answer this question. TST is "done" in three sequential phases of implementation based on what is needed. Each phase defines a specific theme of trauma treatment and includes a set of specific treatment activities that are initiated and/or delivered within the given phase. Through learning how to implement the activities described in Chapters 9–11, you will know which TST phase

is the best place to start. Chapters 12–14 will tell you what to do in each phase. The phase in which you start is based on what is needed. Chapter 15 provides the approach to psychopharmacology within TST, how psychotropic agents may be used to support the work (and the child) in each of the three treatment phases, and the role of the psychiatric consultant on the TST team.

Chapter 12. Safety-Focused Treatment

The primary goal of the safety-focused phase of TST is to establish and maintain the safety and stability of the child's social environment and to minimize risk to the child and others based on the child's difficulty regulating emotional and behavioral states. This intensive home-/community-based phase of treatment is always offered if the child is at risk to be harmed or is at risk to harm him- or herself or others. This phase of treatment is organized around the following set of activities: *Establish Safety*, *Maintain Safety*, and *Care for Caregivers*. *Establish Safety* is designed to make sure the child's environment is safe enough. *Maintain Safety* is designed to make sure that the level of safety that has been established is real and will last. *Care for Caregivers* is designed to provide the right type of support for caregivers to make the needed changes. Two guides, the Safety-Focused Guide (for clinicians; see Appendix 7) and the HELPers Guide (for caregivers; see Appendix 8), structure the treatment in this phase.

Chapter 13. Regulation-Focused Treatment

The primary goal of the regulation-focused phase is to give the child sufficient skills to manage emotional states when triggered by stimuli from his or her social environment. Unlike treatment delivered in the safety-focused phase, treatment delivered in the regulation-focused phase may occur in the clinic or office. Regulation-focused treatment is offered when the child continues to have difficulties regulating emotional states even when the environment is safe enough. This phase of treatment is focused on developing the child's emotional regulation skills and is organized by the following set of activities: *Build Awareness*, *Apply Awareness*, and *Spread Awareness*. The *awareness* we seek to *build*, *apply*, and *spread* is about what stimuli leads to the dysregulation and about what strategy the child—and those around him or her—may use to achieve regulation once the child is stimulated. This phase is organized by two guides: the Regulation-Focused Guide (for clinicians; see Appendix 9) and the Managing Emotions Guide (for children and families; see Appendix 10).

Chapter 14. Beyond Trauma Treatment

The primary goal of the beyond trauma phase is to work with the child and family to gain sufficient perspective on the trauma experience so that the trauma no longer defines the child's view of the self, world, and future. The phase is comprised of learning cognitive skills and processing the trauma. This phase

of treatment is typically offered when the social environment is stable and the child is sufficiently able to regulate emotional states. The goals of this phase of treatment are guided by the mnemonic STRONG: **S**trengthening cognitive skills, **T**elling your story, **R**eevaluating needs, **O**rienting toward the future, **N**urturing caregiving, **G**oing forward. This phase is structured by two guides: the Beyond Trauma Guide (for providers; see Appendix 12) and the Cognitive Awareness Log (for children and families; see Appendix 13).

Chapter 15. Psychopharmacology

Psychotropic agents are occasionally helpful for supporting the work conducted in each of the treatment phases. This chapter details the indications for these agents within TST, how they may be used in each phase, and the principles and practice of psychopharmacology within TST.

Part IV. Improving Trauma Systems Therapy

As we've discussed previously in this chapter, TST is a never-ending story based on a community of users who are continually tinkering with the model to make it better able to address their needs. The contributing members of this community share the information they discover about improvements to TST with anyone who may benefit. Over time this collaborative process has created a powerful process of continually improving TST so that it may benefit a wide and diverse community of users. Our approach to improving TST is based on a lead-user model of innovation described by Eric von Hippel in his book Democratizing Innovation *(2005). Accordingly, Chapter 16 is called "Democratizing Trauma Systems Therapy," and in it we describe this process and provide examples of TST innovations and adaptations based on this approach. Chapter 17 provides ideas for the most radical innovation yet: using the TST approach for intervening with disorders that don't involve trauma.*

Chapter 16. Democratizing Trauma Systems Therapy

In this chapter we describe how TST has been used in a variety of settings and how we work with a growing community of users. We use this chapter to explore how the process of innovation works within TST, such that the innovations of users are continually integrated into our model and TST becomes this never-ending story that helps people do *whatever it takes* to help traumatized children. In this chapter we highlight some of these innovations and adaptations in real-world settings.

Chapter 17. Extending Trauma Systems Therapy Beyond Trauma

Children with many emotional, behavioral, and developmental disorders have difficulty regulating emotional states in certain definable moments. Children with autism, for example, may become dysregulated when required to manage social information that is too much for them. Children with attention deficit

hyperactivity disorder may become dysregulated when they are expected to organize their lives in a way in which they are not capable. Children with depression may become dysregulated when they need to manage situations in which loss occurs. In this chapter we describe how ideas related to TST for traumatized children may be relevant to the treatment of problems beyond trauma.

Chapter 18. Conclusions

The book ends with a concluding chapter that highlights the possible roles that TST can play in the system of care and the public policy concerns relevant to creating an effective and integrated system of care for traumatized children.

Use of Icons

Throughout this manual we use icons to guide you through the elements of our interventions. The icons should be read as symbols that provide "at-a-glance" ideas concerning what a given section is about. The following table describes the six icons that are used in this manual. Each chapter begins with a table indicating the icons that are used in that chapter.

	ICON KEY	
	Essential Point	An *essential point* indicates a section that contains information that **must** be understood to master the TST treatment approach.
	Academic Point	An *academic point* indicates a section that contains information that is interesting or academically important but is not absolutely necessary for mastering the TST approach.
	Quotation	A *quotation* is a piece of writing taken from others that we believe is very important to illuminate the TST treatment approach.
	Case Discussion	*Case discussions* are used liberally throughout this manual to illustrate our treatment approach. We believe case discussions are particularly important to understand the concepts described in the manual.
	Useful Tool	A *useful tool* is used in our treatment sections to highlight an intervention technique that is highly useful.
	Danger	A *danger icon* indicates a potential pitfall of practice. This icon should serve as a warning to pay attention to the section (or skip at your own peril!).