A comprehensive review of interventions for children who have experienced developmental trauma is provided in the 2013 book, *Treating Complex Traumatic Stress Disorders in Children and Adolescents* [1]. Providing effective treatment for developmentally traumatized children and families requires interventions that are empirically supported scientifically and clinically[2]. NCTSN centers and their community partners implement several empirically-supported or promising child trauma interventions that have been specifically developed or adapted to help children and families recover from the adverse developmental impacts of trauma, including:

- Attachment, Self-Regulation, and Competency (ARC)[3]
- Families OverComing Under Stress (FOCUS)[4]
- Integrative Treatment of Complex Trauma, ITCT[5])
- Structured Psychotherapy for Adolescents Recovering from Chronic Stress (SPARCS)[3]
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)[3,4]
- Trauma Focused Cognitive Behavior Therapy (TF-CBT)[6]
- Trauma and Grief Components Therapy (TGCT)[7]
- Trauma Systems Therapy (TST)[8]

Note that this is a only partial list of promising approaches to psychotherapy for developmentally traumatized children, youth, and families (e.g., see also Abuse Focused CBT, Child Parent Psychotherapy, Real Life Heroes, Parent-Child Interaction Therapy, Strong Families/Coping Resources, and other models described on www.NCTSN.org and by Ford & Courtois[1]).

Synopsis of Selected DTD-focused Child Trauma Interventions

Attachment, Regulation and Competency (ARC)[3] is a core components-based intervention for children/youth ages 0-21 that: (a) supports caregiving systems to build trauma-informed caregiving skills and enhance caregiver-child relationships (Attachment); (b) supports children to develop the skills to manage emotions and physiological arousal, accurately read social cues including interpersonal threats; and appropriately communicate their needs (Regulation); and (c) builds capacities associated with resilience (Competence). ARC has been disseminated in over 260 agencies across 45 U.S. states and internationally. ARC has demonstrated efficacy across multiple pilot and field trial outcome studies for maltreated children.[38-40]

Families OverComing Under Stress (FOCUS www.**focus**project.org**)**[41] designed to help families[42-43] identify and build existing strengths and positive coping strategies, increase parents' and children's understanding of how family members react to stress, bridge estrangement and misattributions, build communication skills, and enhance parent mutual support. Longitudinal outcome data demonstrate sustained trajectories of reduced psychological health risk symptoms and improved indices of resilience in children, civilian, and active duty military parents following receipt of FOCUS. Improvement in psychological health outcomes occurred in both military service member and civilian parents, including reductions in parental anxiety and depression symptoms and in unhealthy family functioning, and reductions in emotional and behavioral symptoms and increases in prosocial behaviors for both boys and girls[41].

Integrative Treatment of Complex Trauma (ITCT) is a multicomponent trans-theoretical treatment for developmental trauma in children [44] and adolescents[45] ages 6-21 years old. ITCT is

relationally focused, using the therapeutic relationship to address distorted relational schema and remediate attachment-level difficulties, per the tenets of complex trauma theory and the Self Trauma Model [46]. ITCT uses an Assessment-Treatment Flowchart (ATF), and a Problems-to-Components Grid (PCG) select treatment components for *safety interventions, psychoeducation, affect regulation training, titrated exposure to traumatic memories, cognitive and emotional processing, interventions with caretakers, family therapy, trigger identification and intervention, mindfulness skills development*, and *attachment/relational interventions*. ITCT was empirically supported in a study of traumatized inner city children living with high levels of community violence. ITCT recipients reported statistically and clinically significant improvements in anxiety, depression, post-traumatic stress, anger, dissociation, and sexual concerns [47].

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)[3] is a 16-session group intervention for traumatized adolescents experiencing critical developmental impacts such as addiction, self-harm, and risky behavior. SPARCS capitalizes on adolescents' growing independence, peer connections, and moral/ethical reasoning using "*Four C's"* to enhance self-regulatory, problem-solving, and communication skills by 1) *Cultivating Awareness* through mindfulness, 2) *Coping Effectively*, 3) *Connecting with Others*, and 4) *Creating Meaning* and purpose, with active learning techniques including role plays, in-vivo practice, and take-home worksheets. In a study conducted by the Illinois Department of Children & Family Services, adolescents in foster care receiving SPARCS (compared to standard services) were: 1) 50% less likely to run away; 2) 25% less likely to experience placement interruptions (e.g. arrests, hospitalizations); 3) less likely to engage in risk behaviors measured by the Child and Adolescent Needs & Strengths; and 4) less likely to drop out of treatment.

Trauma Affect Regulation: Guide for Education and Therapy (TARGET)[3] provides a neuroscience-based psychoeducation that explains how the brain can become stuck in survival mode after developmental trauma, using non-technical language and graphics tailored to engage children and adult laypersons. TARGET utilizes a sequence of 7 skills for re-setting the brain from survival to learning mode, organized by two acronyms with special meaning for trauma survivors, SOS (a practical shorthand for mindful re-focusing on sustaining values, relationships, and sense of self) and FREEDOM (a series of self-awareness challenges that enhance simultaneous recognition of *stress reactivity* and *resilience-promoting cues, emotions, thoughts, goals, and behavioral options*. TARGET can be delivered as a one-to-one, group, conjoint family, or milieu therapy intervention. Results of four randomized clinical trial studies and two quasi-experimental effectiveness evaluations of TARGET with adolescents and adult caregivers demonstrate its efficacy in reducing PTSD, depression, anxiety, anger, hopelessness dissociation, and blame, and enhancing hope, self-efficacy, forgiveness, secure attachment, and emotion regulation.[49] In two field trial studies, TARGET delivered as a group and milieu intervention was associated with reductions in violent incidents and punitive discipline (e.g., restraints, seclusion) and recidivism, and improvements in sense of hope and engagement in rehabilitation.

Trauma Focused Cogntive Behavior Therapy (TF-CBT)[6] is an individual child trauma therapy (with parent and parent-child sessions) based on 8 sequential components described by the acronym PRACTICE: Psychoeducation, Parenting skills, Relaxation, Affective Expression

and Modulation; Cognitive Coping; Trauma Narrative Processing; *In Vivo* Mastery of Trauma Reminders; Conjoint Child-Parent Sessions; Enhancing Future Safety and Development. TF-CBT can be flexibly adapted to address critical adverse developmental impacts of trauma (e.g., adding DTD interventions from Dialectical Behavior Therapy or TARGET), and has shown sustained benefits with victimized children in research[50] and community implementation[51-52] studies. Several thousand child interventionists have been trained in TF-CBT internationally, and preliminary clinical guidelines for its application[53] will serve as a framework for the DTD-CPG.

Trauma and Grief Components Therapy for Adolescents (TGCTA)[54] is a modularized assessment-driven individual or group therapy for traumatized and traumatically bereaved youth. Module I: psychoeducation; Module II: guidelines for trauma narrative construction and sharing; Module III: grief resolution; Module IV: developmental progression and relapse prevention. Outcome data show reductions in PTSD symptoms among youth and large reductions in facility incident reports where TGCTA was implemented[7]. In a randomized trial with violence exposed Bosnian adolescents and in open trials with gang-involved youth, TGCTA reduced posttraumatic PTSD, depression, and traumatic grief reactions and improved school behavior [55].

Trauma Systems Therapy (TST)[8] is a clinical and organizational model providing conjoint family and individual therapy that guides traumatized children through 3 treatment phases (Safety, Regulation, and Beyond Trauma Treatment) to recover from emotional/behavioral dysregulation and to help caregivers in that child's social environment to become better able to help and protect that child. TST's conceptual model is unique in addressing not only the traumatized child's survival dysregulation, but also the role of the social environment, mobilizing a multi-disciplinary team to provide: 1) emotional regulation and cognitive/trauma processing skills; 2) home/community-based care; 3) legal advocacy; and 4) psychopharmacology. When implemented with traumatized children in low-income urban and rural communities, 72% of youth who completed TST had 50% less need of crisis-stabilization services in a 15 months follow-up; hospitalization rates were 36% lower and 23% shorter than before TST was implemented[57]. When implemented with low-income urban families, TST was associated with 90% retention in treatment after 3 months, versus only 10% of families receiving standard services. A 5-year TST implementation with foster families demonstrated that fidelity to TST by an entire team is necessary to improve mental health and stabilize foster placements.

Need for Trans-Model Guidelines for DTD-focused Child/Family Trauma Treatment

However, effective treatment for developmentally traumatized children and families also requires that interventions are delivered with *"clinical creativity, guided by sound clinical theory, evidence-based assessment, wise clinical judgment, and an evolving evidence base."*[2] This involves more than simply providing a single intervention for all children and families because there is no "one size that fits all:" *each traumatized child and family is unique in their trauma history, personal and ethnocultural characteristics and background, and developmental problems and strengths*. Therefore, in order to select and deliver the child trauma intervention(s) that best fit and benefit each unique child or family, thoughtful and sensitive clinical assessment and decision-making are essential – as the 2015 NCTSN Position Statement on Basic Clinical

Competencies for Child Trauma (see below) emphasizes, it is neither sufficient nor acceptable to provide fixed trauma interventions in a rote manner. *Individualized clinical planning is essential.* However[9-10], *there currently are no systematic practical guidelines to assist child trauma interventionists in selecting and delivering evidence-based interventions in an individualized manner that best fits and benefits each unique child and family.* These guidelines represent an evolving effort by professionals, youths, and families to fill that gap.

The NCTSN recognized this challenge more than a decade ago. A Core Components Work Group (CCWG) was established by the NCTSN in order to develop a menu of "Intervention Objectives" that can be matched to each individual child and family's needs and strengths. The CCWG also identified a number of "Practice Elements" that are the core therapeutic mechanisms which can be found in many child trauma intervention models (see below) and which child trauma interventionists can select to best achieve the unique therapeutic objectives for each case. Detailed social, trauma, and treatment histories illustrating these objectives and practice elements have been written by the CCWG to describe 5 prototypical children whose families might seek therapeutic assistance from a child trauma interventionist. The case descriptions are based on the principles and practices of many child trauma interventions used in the NCTSN—including the 8 developmental trauma-focused interventions listed above—and as such serve as a useful basic teaching tool to illustrate in general how interventionists can take an integrated individualized approach to the planning and delivery of child trauma treatment. *However, in order to enable the thousands of interventionists working in or with NCTSN centers and their community partners to actually provide individualized effective child trauma treatment to the diverse children and families whom they serve,* ***two crucial additional steps and resources are needed****:*

1. ***More specific guidance is necessary in order to assist child trauma interventionists in translating the wide variety of developmental impacts of trauma into a manageable yet not over-simplified set of intervention objectives for each unique child.*** The CCWG intervention objectives are a first step, but they are generic (e.g., "gather information," "promote safety," "enhance affect, behavior, and cognitive regulation") and do not offer guidance for responding to or preventing crises (e.g., suicidality, impulsive risk taking, severe dissociation) and therapeutic impasses (e.g., distrust, avoidance, splitting) that can render even an empirically supported intervention ineffective with a traumatized child. The Center for the Treatment of Developmental Trauma Disorders (CTDTD) is addressing this gap by disseminating and supporting the use of the ***Developmental Trauma Disorder (DTD) Assessment Toolkit*** to assess 3 domains of self-regulation—(1) physiology and emotion (2) cognition and behavior, (3) relationships and identity[11] in lieu of standard psychiatric diagnoses[12]—which is a companion to this guide.

2. ***More specific guidance is necessary in order to assist child trauma interventionists in translating generic "practice elements" into actionable strategies that are acceptable to and beneficial for each unique developmentally traumatized child/family.*** CCWG practice elements (e.g., "psychoeducation about trauma," "validating, engagement, or attunement-promoting interventions," "intervention for emotion, behavior, or cognitive regulation") are not sufficiently detailed to enable interventionists to individualize therapeutic strategies in real-time interactions with clients. CTDTD therefore has developed this initial version of the ***DTD Clinical Practice Guide (DTD-CPG) Toolkit*** to inform the Network and the field. This Guide/Toolkit will evolve with input from the Network and the field over the next 5 years.

Adverse Impacts on Children of Exposure to Developmental Trauma

Although a majority of children experience some form of psychological trauma before or in adolescence, there is a sub-group who can be identified in every community (in healthcare, school, and legal as well as mental health and child welfare systems) whose core development is adversely impacted by victimization such as abuse, neglect, shattered families, or family, community, or peer violence. Developmentally traumatized children must cope with both trauma and loss or disruption of primary attachment security, placing them at risk for several sequelae.[16]

- ***Emotion and/or Somatic Dysregulation***
  - B1: Emotion dysregulation: extreme distress or difficulty in modulating distress
  - B2: Somatic dysregulation: incapacitating physical problems not medically explained
  - B3: Impaired access to emotions or body awareness/functioning
  - B4: Impaired ability to recognize/express emotions or somatic feelings/states
- ***Attentional/cognitive and/or Behavioral Dysregulation***
  - C1: Attention bias toward or away from threat
  - C 2: Impaired self-protection (risk-taking, recklessness, or intentional provocation)
  - C 3: Maladaptive self-soothing
  - C4: Non-suicidal self-injury
  - C5: Impaired ability to initiate or sustain goal-directed behavior
- ***Relational- or Self/Identity-Dysregulation***
  - D1: Self-loathing (self viewed as irreparably damaged and defective)
  - D 2: Attachment insecurity and disorganization
  - D 3: Betrayal-based relational schemas (betrayal, coercion, exploitation, rejection)
  - D4: Reactive verbal or physical aggression
  - D5: Impaired psychological boundaries (enmeshment or craving for reassurance)
  - D6: Insufficient or excessive interpersonal empathy

The NCTSN *Position Statement on Prerequisite Clinical Competencies (Excerpts)*

Effective treatment must … enable children who have experienced developmental trauma to recover from these fundamental problems with self-regulation. Effective treatment begins with and must continuously provide several core therapeutic conditions that transcend any specific therapeutic intervention—and that must be successfully done in order for any therapeutic model to be effectively delivered to each unique child and family client. The NCTSN has articulated 7 core therapeutic competencies that all therapists must have (i.e., training, expertise, continuing education/consultation) in order to effectively treat any child or family.

The dissemination of standardized, effective, trauma-informed clinical interventions is a central means by which the NCTSN seeks to advance the standard of care for traumatized children and increase the nation's capacity to meet the needs of these children. The safe and effective implementation of these interventions requires proficiency in several basic areas … *The NCTSN regards these prerequisite clinical competencies as the foundation for competency in any clinical intervention disseminated through the NCTSN.*

1. Basic Assessment: The capacity to efficiently and accurately gather the most relevant clinical information that will be used to determine the most appropriate problem(s) to be addressed in treatment, and the various factors that may facilitate, or impede, a child's likelihood to benefit from treatment. …
2. Risk Assessment: The capacity to efficiently and accurately gather clinical information to determine a child's likelihood to harm him or herself and/or others. …
3. Case Conceptualization: The capacity to integrate the assessment information to derive a good-enough understanding of the child's most important problems and strengths ...
4. Treatment Planning: The capacity to use information from case conceptualization to determine the most effective and feasible clinical approach(es) …
5. Treatment Engagement: The capacity to form a workable treatment alliance …
6. Treatment Implementation: The capacity to consistently deliver a course of treatment based on a defined treatment plan and available treatment guidelines.
7. Treatment Quality Monitoring: The capacity to appraise progress and outcomes of treatment based on objective information and to adjust the treatment approach …

Critical Clinical LEARning (*C-CLEAR)*

Child interventionists use 3 domains sof micro-interventions when they apply evidence-based treatments to help traumatized children and their families recover from DTD's adverse impacts:

(i) engagement, grounding, and orienting (***EGO***) strategies for optimizing collaborative working alliance, preventing or de-escalating crises, and enhancing self-regulation capabilities;

(ii) trauma memory and present-centered processing (***TMPP***) strategies; and

(iii) strategies to support client Well-being, Achievement, Resilience, and Mastery (***WARM***).

Examples of micro-interventions include (with source intervention[s]):

- What's the one thing about yourself that you feel proudest about? [ARC, FOCUS, ITCT, SPARCS, TARGET, TGCT TST ***Engagement***]
- Let's just slow down and do some belly breathing together. Can you feel your breath going in and out? [ARC, ITCT, SPARCS, TARGET, TF-CBT, TST ***Grounding***]
- What's your one most important goal right now, what do you want to have happen? [ITCT, SPARCS, TARGET ***Orienting***]
- Let's figure out what triggers the stress reactions when you (a) lose time (b) blackout (c) space out, (d) feel like you're outside looking down at your body [ARC, ITCT, SPARCS, TARGET ***Trauma Present Centered Processing***]
- You were able to think very clearly and made sure your sister was safe even though you were really scared that your step-father was going to your mother [FOCUS, ITCT, TARGET, TF-CBT, TGCT ***Trauma Memory Processing***]
- When you feel an urge to cut yourself, what do you do to recognize and cope with feeling (a) angry, (b) sad, (c) scared, (d) lonely, (e) all messed up, (f) spaced out? [ARC, ITCT, SPARCS, TARGET, TST ***Well-being, Achievement, Resilience, Mastery*]**

As shown in the above examples, each micro-intervention is based on and linked to specific strategies from the 8 child developmental trauma intervention models.

Each micro-intervention also is linked to branching options based on the client's potential responses, including both *positive* responses indicative of increasing self- regulation and resilience and *negative* responses requiring therapeutic management.

The branching pathways linking the micro-interventions will be mapped by the DTD-CPG, such that clinicians/counselors can begin with a DTD critical challenge (e.g., a client who is self-harming) and develop a systematic strategy for interacting therapeutically with a client presenting with this challenge in order to effectively ensure the client's safety, reduce the severity of DTD dysregulation, and enhance self-regulation.

The DTD-CPG map of micro-intervention paths will be combined with Core Concepts Curriculum *Treatment Objectives & Practice Elements Matrix* (see below) in order to enable clinicians and counselors to identify micro-interventions that individualize practice elements.

The following template translates generic interventions into DTD-specific micro-interventions:

	Domains	Intervention Objectives	Practice Elements	*Clinical Practice Guide for DTD*
1	Assessment	**1. Gather Information** 2. Identify Grief & Loss	**1. Assess Trauma History/Symptoms/ Reactions** 2. Assess Presence of Trauma Reminders, Triggers, Stressors 3. Assess Safety 4. Trauma Assessment Instruments	*1. Assess DTD Emotion/Bodily, Cognitive/Behavior, Self/Relational Regulation Deficits* *2. Assess promotive, protective, and facilitative factors for self-regulation* *3. Assess causal risk, vulnerability, and inhibitory factors*
2	Safety	**1. Promote Safety** 2. Build Routines & Rituals 3. Stabilization	1. Safety Planning 2. Interventions to Build Routines & Rituals 3. Safety Promoting Interventions 4. Safety Actions	*1. Enhance emotion regulation capacities* *2. Enhance self-protection capacities* *3. Enhance accurate self-awareness* *4. Enhance relational engagement, trust, empathy, boundaries*
3	Engagement /General Assessment	**1. Develop Alliance/Engagement** **2. Explain Phases of Treatment** **3. Treatment/Intervention Planning** **4. Promote Understanding of Dimensions Important to Treatment** 5. Evaluate Treatment Model or Intervention 6. Identify Obstacles to Intervention/Treatment 7. Increase Motivation	**1. Psychoeducation about Trauma/Impact** **2. Treatment Planning** **3. Promote Therapeutic Working Alliance/ Engagement** **4. Assess individual** **5. Psychoeducation not specific to Trauma** 6. Assess Family 7. Assessment Measures 8. Assess Eligibility for Intervention/treatment 9. Assess Culture and Religion	*1. Explain mediation linking childhood trauma adaptation -> dysregulation -> DTD* *2. Identify/explain promotive, protective, and facilitative factors* *3. Identify/explain risk, vulnerability, and inhibitory factors* *4. Affirm/explain the role of the person's ethnoracial, cultural, gender, sexual identity, disabilities as moderators of DTD*

	Domains	Intervention Objectives	Practice Elements	*Clinical Practice Guide for DTD*
5	Core Interventions	**1. Enhance Affect/Emotional Regulation** **2. Enhance Cognitive Restructuring/Regulation** **3. Enhance Behavioral Regulation** **4. Enhance Capacity for Physiological Regulation** 5. Incorporate Cultural Sensitivity & Spirituality	**1. Feelings Identification** **2. Affect Regulation** 4 Family Communication **5. Behavior Regulation** **6. Cognitive Regulation** 7. Problem Solving 8. Social Skills **9. Homework** 10. Mindfulness 11. Relapse Prevention **12. Stress Reduction** **14. Non-Verbal** 15. Cultural &Spirituality	*1. Identify/affirm and restore/enhance emotion/bodily self-regulation in primary life settings/tasks* *2. Identify/affirm and restore/enhance attentional/cognitive and behavioral self-regulation* *3. Identify/affirm and restore/enhance identity/relational self-regulation*
7	Trauma Processing	**1. Promote Understanding of Connection Between Trauma and Current Experience** **2. Process Trauma Memories/Integrate Trauma Experience**	**1. Trauma-Specific Interventions/Tools** 2. Narrative Story Building **3. Interventions to Process/Integrate Trauma Memories /Experiences**	*1. Identify/affirm promotive/protective /facilitative factors* *2. Identify/affirm risk /vulnerability /inhibitory factors* *3. Identify/affirm the facilitative/protectivefunction of survival-based dysregulation* *4. Identify/affirm self-regulation*

DTD Clinical Practice Guidelines are designed to address each domain of therapy, including: (1) ***Engaging*** detached/distrustful/avoidant/angry clients, (2) ***Grounding*** clients to prevent or ensure safety and resolve severe crises, (3) ***Orienting*** dissociated, numbed, avoidant, isolated, depressed, demoralized, and angry clients to sources of safety, empowerment, and core values; (4) ***Trauma Memory Processing*** designed to enhance awareness, sense of meaning, and resolution; (5) ***Trauma Present Centered Processing*** designed to enhance awareness, sense of meaning, and empowerment; and (6) ***Well-being, Achievement, Resilience, Mastery Strategies***.

Therapeutic Strategies Provided by DTD-related Child Trauma Interventions

- Engagement Strategies: ARC, FOCUS, ITCT, SPARCS, TARGET, TF-CBT, TGCT, TST
- Grounding Strategies: ARC, FOCUS, ITCT, SPARCS, TARGET, TF-CBT, TGCT, TST
- Orienting Strategies: ARC, ITCT, SPARCS, TARGET, TGCT, TST
- Trauma Processing: Memory Strategies – ITCT, TARGET, TF-CBT, TGCT
- Trauma Processing: Present-Centered Strategies – ARC, FOCUS, SPARCS, TARGET, TST

- WARM Strategies: ARC, ITCT, SPARCS, TARGET, TF-CBT, TGCT, TST

The 8 focal DTD child trauma intervention models provide modalities for the delivery of therapeutic services, and to meet the needs of children of a variety of ages:

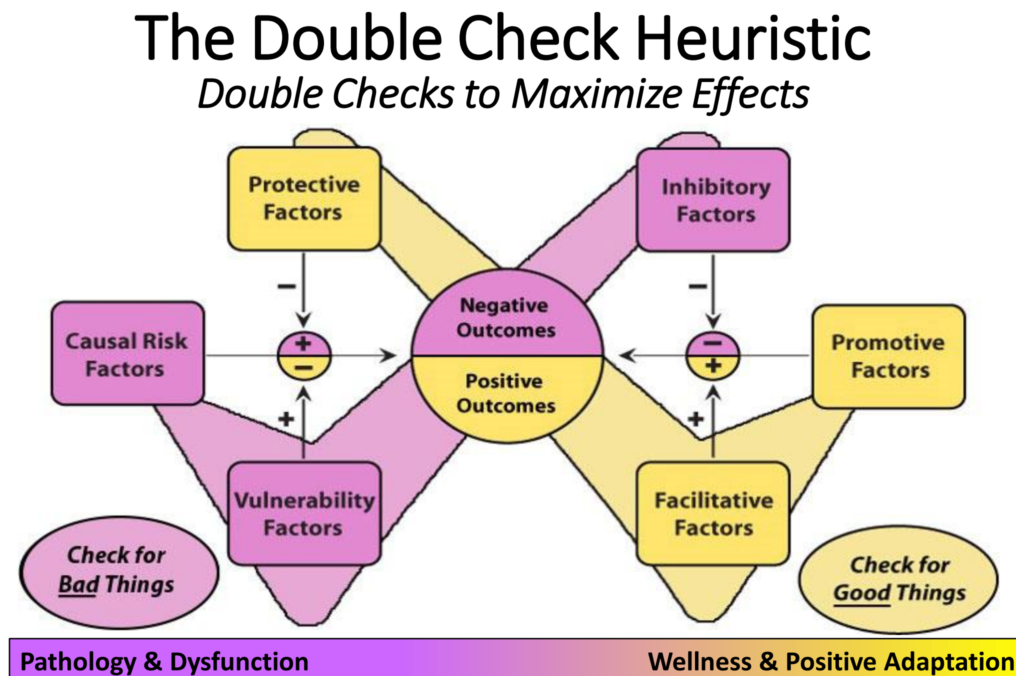
Therapy Modalities Utilized by DTD-related Child Trauma Interventions

- Individual Therapy: ARC, ITCT, TARGET, TF-CBT
- Group Therapy: ITCT, SPARCS, TARGET, TGCT
- Conjoint Family Therapy: ARC, FOCUS, ITCT, TARGET
- Milieu Therapy: ARC, TARGET, TST

Developmental Epochs Served by DTD-related Child Trauma Interventions

- Early-Middle Childhood: ARC, FOCUS, ITCT/C, TARGET, TF-CBT, TST
- Pre/Adolescence – Young Adult: ARC, FOCUS, ITCT/A, SPARCS, TARGET, TGCT, TST

The DTD Clinical Practice Guidelines provide a practical framework for child/family traumatic stress therapists to "double check" themselves as each session and phase of therapy progresses, drawing on the heuristic developed by Layne and colleagues to attend to risk/inhibitory and vulnerability factors (sources of or triggers for traumatic stress reactions) and protective and facilitative factors (sources of adaptive reactions and functioning).



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