As a psychologist and team leader working within Child and Youth Mental Health, I often received referrals of foster children who were displaying a wide range of extremely problematic behaviours. These youth frequently arrived with a bewildering array of assessments, a long list of diagnoses, multiple medications, and a frustrated and confused Care Team. From a mental health perspective, we often felt overwhelmed. The evidence-based therapies in which we were trained were usually not effective with this population. My perspective on these kids changed when I began to understand the profound effect that trauma has on the child’s developing brain.

Many children and youth in foster care worldwide demonstrate seriously disruptive behaviour that overwhelms their caregivers. Recent studies indicate that over 70% of children in foster care have suffered from multiple, overlapping traumas (Greeson, et. al., 2011). For many, the resulting lags in social, emotional, and behavioural development set them on a path for markedly poor life-long outcomes. When such children and youth enter the care system, they often go on to experience further trauma as a result of the challenges they present, such as repeated placement breakdowns and subsequent moves to staffed care (Chamberlain et al, 2006). Typical approaches to help using professional services such as evidence-based therapies, psychotropic medications, and the DSM-5 diagnostic model are often ineffective.

What is missing? It is our conviction that a deep understanding of the effects of significant trauma on the developing brain—complex or developmental trauma is essential for effective intervention. A growing body of literature highlights the wide-ranging effects of complex trauma on the developing brain through childhood, adolescence, and into adulthood (Anda et al., 2006; Kisiel et al., 2014; Perry, 2006; Perry, 2009). Organizations such as the National Child Traumatic Stress Network and the Child Trauma Academy provide education on the comprehensive developmental challenges that complex trauma histories produce.

THE COMPLEX CARE AND INTERVENTION PROGRAM (CCI)

In response to this challenge, my team at Complex Trauma Resources (CTR) and I developed the CCI Program. CCI goes beyond simply offering a therapeutic intervention or a trauma-informed assessment. It is a “comprehensive, child-specific, trauma-specific, attachment-focused, and developmental model” (Geddes et al, 2014) that offers a theoretical perspective, an assessment tool, and practical strategies for intervening with the child. The CCI program takes a comprehensive view of the effects of trauma, building upon the symptom domains identified by Van der Kolk (2005) and others (Cook, Blaustein, Spinazzola, & Van der Kolk, 2003) in their proposal for a new diagnosis of Developmental Trauma Disorder. We’ve adapted from and expanded that original list and created the CTR Seven Developmental Domains:

The CTR 7 Developmental Domains

- Neurological and Biological Maturity
- Over-reactive Stress Response
- Emotional Regulation
- Attachment Style and Relationships
- Identity Development
- Behavioural Regulation
- Cognitive and Language Development

Our goals in forming the CCI program to address complex trauma (Geddes, et al., 2014) were as follows:
- Provide a common language and understanding of complex trauma for caregivers and case management decision makers in child welfare settings;
• Provide a comprehensive, trauma-focused Functional Developmental Assessment to guide interventions and monitor progress;
• Provide assessment-based, child-specific intervention planning which bridges case planning, caregiving approaches, and therapeutic approaches;
• Focus on the Care Team as the key service delivery unit for the child. Ground level implementation of the CCI program therefore involves teaching Care Team members about the importance of brain development and the effects of trauma. Train them in a new way of understanding the child or youth and their care needs based on their unique complex trauma history and current presentation;
• Recognize the primary importance of foster parents, family members, and other caregivers in the healing of trauma through therapeutic interventions provided in attachment-based daily care of the child.

Our Complex Trauma Resources team actively provides consultation and case support throughout B.C. for children and youth ranging from 4-17 years of age. All of these children and youth are referred to CCI because of serious emotional and behavioural problems. Most are involved in the foster care system, although we also work with an increasing number of adopted children from international adoptions and from foster care. We have worked with children living in family-style homes and those in staffed homes. What we see over and over again is that typical caregiving approaches are unlikely to work and, on the positive side, that intervention plans and strategies based on an understanding of the neurodevelopmental effects of trauma are often extremely effective.

CCI PROGRAM RESULTS

Data collected over the past six years indicate strongly positive behavioural changes in a majority of the referred children—including decreases in frequency and severity of negative behaviour and improved stability in placements. Even better, the children in our CCI program begin to close developmental gaps with their peers across the seven Developmental Domains. Professionals, caregivers, and service partners report increased knowledge, decreased stress, and greater job satisfaction when using CCI with a particular child. It is common for us to sit with a Care Team for a six-month or one-year review and hear statements such as, “This is not the same child who was in my home last year” or “I’ve been feeling hopeless about this boy for years and could not imagine how things could ever go so well.”

CASE EXAMPLE

Let me share the case of nine-year-old Jacob with you. This is not a real case, but is an amalgamation of real cases with details changed so the children remain anonymous. The CCI approach provides intervention plans which are simple and manageable for the team and comprehensive in meeting Jacob’s needs.

Background: Jacob is a nine-year-old Caucasian boy living in a specialized foster home along with his younger brother. Both came into foster care about three years ago due to extreme neglect. Jacob’s mother suffered from acute bi-polar mental illness and was often suspicious and paranoid. At one point, she lived in her car with the boys for over a year, travelling from community to community, and begging for food and gas money. When the children were removed from her care, their apartment was described as “extremely filthy and disgusting.” The boys were sometimes locked in a closet for hours on end. They lived with their current foster parents, Judy and Dave, for approximately two years, following an initial year in care in which they moved three times between temporary homes. Jacob’s life has settled significantly in the past year. He has become calmer and more connected with his foster parents, although he remains guarded and withdrawn. Jacob will spend hours playing with small army figures or cars with his brother. He loves watching educational videos about animals and has a good memory for what he watches. At the same time, he avoids books with words; preferring picture books.

Strengths: Jacob has a strong memory for both auditory and visual information. He is kind and protective with his younger brother and loves to play with the family dog. Judy commented that his happiest time of the day seems to be when he’s in his nightly bath playing with bath toys.
Challenges: At school, Jacob shows little of the quiet and shy side seen at home. Jacob has trouble getting along with other students and has few friends because of his inappropriate remarks and behaviour. He is distracted by almost everything going on around him and is described as being “on high alert.” When pushed to do his work, Jacob digs his heels in—often tearing up his worksheets or running around the classroom interfering with others. Many times, Jacob simply puts his head on his desk and ignores the teacher, or crawls under his desk. His printing is almost unreadable. A one-on-one educational assistant has made little difference. Jacob is trailing his peers significantly in basic academics with poor reading, writing, and math skills.

A recent psychoeducational assessment placed Jacob in the low average range of cognitive functioning but at an extremely low level of academic skills. During the assessment, Jacob often wanted to quit, saying “I’m stupid.” He was diagnosed with various learning disabilities and it was recommended that he be placed on a stimulant medication to help him concentrate.

Assessment and Intervention Plan: During our Care Team-Based Functional Developmental Assessment, it became clear to the team that Jacob’s development was quite delayed across all of the seven domains in comparison to his “typical” peers. This gave us a picture of Jacob as being more like a three to four-year-old emotionally and cognitively at this time. Since this had come about through pronounced lack of safety and stability, we believed that Jacob could make gains across all of the developmental domains if we could protect him from stress, deepen attachment, and provide opportunities for growth. It became apparent to the team that Jacob was not developmentally ready for a school environment. He found the classroom to be too stimulating and overwhelming. His life of neglect had resulted in a lack of the experiences which would prepare him for formal learning and left him feeling stupid and defeated. In a sense, his immature brain was not yet ready for formal learning.

Our initial plan included the following:

- Give priority to decreasing stress and helping Jacob’s physiological alarm systems to quiet down;
- Make adjustments to caregiver attention to include more physical touch, more side-by-side time throughout the day, and more warm and engaging routines;
- Coach foster parents in the use of empathy;
- Remove Jacob from school and start a homeschool program with Judy;
- Focus on making learning fun and not stressful. Play lots of learning games covering “pre-academic” skills;
- Read to him multiple times every day without requiring that he try to read himself. (Reading out loud to children is a powerful way to prepare them for reading and writing.) It was also an opportunity for more snuggle time with Judy and Dave;
- Use his interest in animals to create unit studies where he would watch videos, colour in animal outlines, dictate stories about animals, use animal figures for math, etc. Post his creations on the fridge to create a feeling of success.

Outcomes: Judy quickly found that Jacob loved to learn as long as she didn’t call it “school time.” He poured himself into his unit studies, starting with animals and then branching into other areas. He loved having his work displayed and telling Dave and his brother about it at the end of the day. Snuggle reading times became one of his favourites and Jacob often didn’t want the books to end. He became more connected with his foster family and was noticed to “come out of his shell.” After a few months, Judy noticed that Jacob was starting to pick up books on his own and asking her to show him what the words sounded like. Within a short time, he began to read simple books and by the end of one year he had completely caught up with his peers in reading and basic math. Judy connected with a homeschool group for fun activities each week and noticed that Jacob was learning social skills and making friends.

I hope that this article and case study gives you a sense of the approach we take with the CCI Program. I look forward to sharing this work in more detail at the BCASW Conference.

References available upon request.

Chuck Geddes is the Clinical Director of Complex Trauma Resources. He will be the morning keynote speaker on Saturday, November 5 at the 2016 BCASW Conference.

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