

PROMISING DIRECTIONS FOR THE TREATMENT OF COMPLEX CHILDHOOD TRAUMA: THE INTERGENERATIONAL TRAUMA TREATMENT MODEL

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Chronic or complex childhood trauma, such as abuse, neglect, exposure to violence or parental criminality, is strongly associated with the development of criminal behaviors later in life. This paper presents the Intergenerational Trauma Treatment Model (ITTM), a 21-session, manualized intervention designed to ameliorate the impact of chronic trauma on children's development. Treatment proceeds in three phases: psychoeducational group sessions for parents; individual sessions to address parental trauma impact; and finally child and parent intervention to address trauma-related behaviors and symptoms and promote stronger parent-child relations. Unique features of the ITTM include attention to intergenerational patterns of trauma transmission and focus on parents as the key agents of change for their children.

The association of childhood trauma and criminal outcomes in adolescence and adulthood is robust. Retrospective studies consistently find much higher rates of childhood trauma and victimization among individuals who have been arrested or charged with offences or who report engaging in illegal activities (e.g. Driessen, Schroeder, Widmann, von Schonfeld & Schneider, 2006; Grella, Stein & Greenwell, 2005; van Dalen, 2001; Weeks & Widom, 1998). Prospective longitudinal studies confirm these relationships. For example, Widom and colleagues have found that, compared to matched controls, individuals who have been victimized as children are more likely to be arrested as juveniles and to engage in higher rates of self-reported and officially documented violent and non-violent crimes in adulthood (Kaufman & Widom, 1999; Maxfield, Weiler & Widom, 2000; Widom, Marmorstein, White, 2006).

Findings such as these highlight the urgency of providing effective treatments for trauma in childhood so that criminal outcomes can be avoided. Over the past two decades, treatment for childhood trauma have evolved from individually-focused psychodynamic and cognitive models largely imported from work with adults, to methods that more appropriately recognize the developmental and familial context of children's trauma. Treatment options for childhood trauma now range widely, and include everything from individual child therapies, parent training, behaviorally-based parent-child interaction training, attachment based parent-child sessions, and trauma-focused cognitive-behavioral therapy (see reviews by Cohen, Berliner, Mannarino, 2000; Cohen, Mannarino, Murray & Igelman, 2006).

In this paper, we present another promising model for the treatment of childhood trauma: the Intergenerational Trauma Treatment Model (Copping, 1996; Copping, Warling, Benner, & Woodside, 2001). This model incorporates many of

the features of empirically-supported methods of treatment including trauma exposure, cognitive processing and reframing, stress management and parent education (Cohen, Mannarino, Berliner & Deblinger, 2000). It differs in terms of its applicability to complex trauma, the primacy placed on enhancing the caregiver's capacity to respond to children's experience of trauma and on its attention to the intergenerational nature of traumatic experiences.

Prior to introducing the ITTM, a brief review of four important aspects of the conceptualization of trauma that differ between children and adults is completed. We then provide a description of the ITTM content, intervention strategies and therapeutic processes. Finally, we present a series of arguments to support the proposed focus of the ITTM on caregivers as critical contributors to their children's recovery from trauma. We acknowledge that children have a variety of primary caregivers and that the people to whom children naturally turn in times of distress are sometimes mothers, fathers, adoptive or foster parents or caregiving relatives. Herein, we use the terms caregivers and parents interchangeably to represent these primary relationships.

Unique Characteristics of Trauma in Childhood

The diagnosis of a specific trauma-related disorder (PTSD) first appeared in the DSM-III in 1980, and was extended to children in the 1987 DSM-III-R. Since that time, models of trauma in children have developed rapidly and differences between trauma in children and adults have become increasingly recognized. Theorists, researchers and clinicians now acknowledge that children's experiences of trauma are: (1) often chronic, rather than acute; (2) associated with a wide range of symptomatic reactions that only sometimes resemble adult-based criteria for the diagnosis of PTSD; (3) significantly impacted by their caretakers response

and reaction to their traumatic experience; and (4) are frequently linked to intergenerational patterns of trauma transmission.

For many children, trauma is not a single, frightening, unpredictable event, but rather a series of traumatic experiences (Finkelhor, Ormrod & Turner, 2007a; Terr, 1991; Widom, Button, Czaja & DuMont, 2005). Results of the CDC's Adverse Childhood Experiences survey of over 17 thousand American adults receiving services from a major Health Maintenance Organization revealed that chronic traumatic events in childhood are vastly more common than recognized or acknowledged. Among this sample of adults, 11% reported having been emotionally abused as a child, 28% reported physical abuse, 20% reported sexual abuse, 25% reported being neglected, 24% reported being exposed to family alcohol abuse, 19% exposure to parental mental illness, 12% witnessed mothers being battered and 27% reported that one or both of their parents abused drugs. Moreover, exposure to multiple forms of trauma was more common than exposure to one. Among adults reporting at least one childhood trauma (64% of the entire sample), close to 60% reported exposure to more than one and 20% reported exposure to four or more types of trauma (CDC; Felitti et al., 1998). Finkelhor and his colleagues (2007a) coined the term "poly-victimization" to describe the experiences of such children and suggested that for them, victimization is more a "condition than an event" (p. 9). Others have referred to this type of trauma as complex or chronic trauma (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, et al., 2005; Terr, 1991).

A second important difference between children and adults is their reaction to traumatic events. Among adults, traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of trauma consistent with those captured in the diagnosis of PTSD. Among children, reactions to trauma are much more variable and are captured less well by PTSD diagnostic criteria (van der Kolk, 2005; Spinazzola, Ford, & Zucker, 2005). Ackerman et al. (1998), for example, found that among 364 abused children, the most common diagnoses, in order of frequency, were separation anxiety disorder, oppositional defiant disorder, phobic disorders, PTSD and ADHD. Multiple additional studies have established the connection of childhood trauma with unmodulated aggression, poor impulse control, attentional problems, adolescent substance abuse, eating disorder, promiscuity, and other problematic behaviors and symptoms in addition to the primary symptoms of reexperiencing, avoidance, and anxiety

required for a PTSD diagnosis (van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005; Cahill, Kaminer, & Johnson, 1999; Paolucci & Genuis, 2001; Boney-McCoy & Finkelhor, 1996). These observations have lead theorists to suggest a new diagnostic category for chronic childhood trauma labelled Developmental Trauma Disorder and characterized by: (1) exposure to multiple or chronic forms of developmentally adverse interpersonal trauma, (2) triggered pattern of repeated dysregulation (either over- or under-regulation) in response to trauma cues, (3) persistently altered attributions and expectancies (e.g. distrust of caregiver, negative self-attribution, loss of expectancy that others will protect), and (4) functional impairment (van der Kolk, 2005). Although there have yet to be published field trials of this diagnosis in children, the proposed diagnosis of complex trauma for adults, which has many similar features, has received preliminary support (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997).

A third critical difference between children's and adults experience of trauma is the importance of caregivers to moderating the severity and duration of children's trauma-related symptoms. Studies have consistently found that children who have a nurturing and supportive relationship with their parents are less symptomatic following trauma than children who receive less support from their caregivers (Adams-Tucker, 1982; Conte & Schuerman, 1987; Deblinger, Steer & Lippmann, 1999; Freidrich, Urquiza & Beilke, 1986; Scheering & Zeanah, 2001; Tufts, 1984). In fact, in studies that have compared the potential influence of multiple different factors on children's trauma, such as the characteristics of abuse, identity of the offender and the frequency and duration of abuse, parental support consistently emerges as one of the most important predictors of childhood functioning (e.g. Everson, Hunter, Runyon, Edelson, & Coulter, 1989; Oates, O'Toole, Lynch, Stern & Cooney, 1994).

Finally, children's experiences of trauma are unique in terms of the role played by their primary caregivers. In cases of chronic trauma, children's caregivers are frequently direct (e.g. physical abuse, parental substance use), or indirect (e.g. exposure to domestic violence) contributors to their children's trauma (Karr-Morse & Wiley, 1997). Often, such contributions are part of intergenerational patterns of trauma transmission. In the field of family violence, this continuity is referred to as the "cycle of violence", with studies concluding that about one third of parents maltreated as children will go on to abuse or neglect their children (Kaufman & Zigler, 1987). Similar intergenerational patterns have been

noted for sexual abuse, intimate partner violence, alcohol and drug addiction, and criminality (Ehrensaft, Cohen, Brown, Smailes, Chen, & Johnson, 2003; Lev-Wiesel, 2006; Conger, Neppi, Kim, & Scaramella, 2003; Fuller, Chermack, Cruise, Kirsch, Fitzgerald, & Zucker, 2003; Murray, Janson, & Farrington, 2007). The intergenerational nature of trauma, along with the importance of caregivers to helping children regulate and cope with trauma, place children in a unique, irresolvable negative bind which has particularly severe consequences for their ongoing development (Howe, 2005).

Implications for Treatment

Differences between children’s and adults’ experience of trauma have a number of implications for efficacious treatment. As outlined by the Complex Childhood Trauma working group of the National Child Traumatic Stress Network, empirically-validated trauma-treatment models that focus primarily on reintegration of trauma are unlikely to be sufficient for chronically and multiply traumatized children (Kinniburgh, Blaustein, Spinazzola & van der Kolk, 2005). Instead, this working group has recommended that treatment of

be embedded in a social/contextual framework, sensitive to development, flexible in its approach and capable of addressing individual, familial and systemic needs and strengths (Kinniburgh et al., 2005).

A variety of models have been developed to meet these needs, all of which still require rigorous empirical validation. Examples of programs currently available include: Structured Psychotherapy for Adolescents Responding to Chronic Stress (DeRosa, 2004); Trauma Adaptive Recovery Group Education & Training (Ford, 2006); Real Life Heroes (Kagan, in press); Assessment-Based Treatment for Traumatized Children: Pathway Model (Taylor, Gilbert, Mann, & Ryan, 2006) and the Attachment, Self -Regulation & Competency Model (Kinniburgh et al., 2005). There have also been a variety of treatments suggested for specific types of chronic childhood traumas such as maltreated and violence-exposed children (see review by Cohen et al., 2006). Most of these models combine traditional trauma intervention components (i.e., psychoeducation, trauma exposure, cognitive processing and re-integration of trauma experiences, parent skills

Table 1: Intergenerational Trauma Treatment Model: Major Therapeutic Activities

Treatment Phase	Therapeutic Strategies
<p><i>PHASE A</i> 6 group-based sessions attended by children’s caregivers</p>	<p>Psycho-education on a broad spectrum of trauma-related literature</p> <p>Cognitive-behavioral framework introduced for understanding behavior and for the promotion of meta-cognition and self-reflection</p> <p>Caregiver monitoring of self-regulation and of their position relative to the child’s need for understanding and containment</p> <p>Promotion of self-efficacy through daily monitoring of change</p>
<p><i>Phase B</i> Average of 8 individual sessions with children’s caregivers</p>	<p>Cognitive-behavioral processing of traumatic or impactful experience in caregiver’s childhood; identification of trauma theme, deconstruction and disputation of the faulty belief system by the therapist, attribution of belief to childhood experiences</p> <p>Implementation of quality 1-on-1 time between caregiver and child (minimum of 3 hours a week)</p> <p>Co-development (caregiver and clinician) of hypothesis around the faulty belief(s) system developed in child as a result of impact of trauma or other impactful event.</p>
<p><i>Phase C</i> 3 to 8 sessions for the child with the caregiver present.</p>	<p>Directed sand tray stories and/or diagrams to address children’s relational bond with their primary caregivers and for exposure and reconstruction of traumatic experience</p> <p>Cognitive-behavioral processing of child’s traumatic experience; identification of dominant trauma theme, disputation of resulting faulty belief/dilemma for the child, countering of self-blame</p> <p>Active involvement of the caretaker as an observer and co-director of the therapy process</p> <p>As necessary, attachment recreation intervention to address security of relational bond between child and caregiver</p>

complex trauma needs to follow a phase-based approach with six goals: safety, self-regulation, self-reflective information processing, trauma experience integration, relational engagement and positive affect enhancement. They also recommend that treatment

training, stress management) with interventions aimed at strengthening attachment to caregivers, peers and others, developing behavioral and emotional regulation, and improving self-concept (Cook et al., 2005).

Intergenerational Trauma Treatment Model (ITTM)

The Intergenerational Trauma Treatment Model (Copping, 1996) represents an alternate model for treatment of complex trauma in childhood. It differs from previous models in its combination of cognitive-behavioral and psychoanalytically informed strategies for understanding and intervening with families and with its focus on parents as the mechanism of change for their child. The ITTM consists of 21 manualized sessions and is designed for parents of children between the ages of 3 and 18. It was developed in Hamilton, Ontario and currently being implemented across 14 clinics in Ontario, Canada (www.traumatreatment.ca). There is an associated 100-hour structured training program that includes introduction and training on the model and ongoing clinical supervision over the first year of implementation.

The ITTM is offered in three distinct phases. *Phase A* is a six-week course entitled *The Trauma Information Sessions*. *Phase B* involves approximately eight individual parent sessions aimed at addressing impact of the caregivers' most traumatic or impactful childhood experience and on improving caregiver capacity to relate to, and contain, their children's experience of trauma. Subsequently, in *Phase C*, the caregiver and the clinician are engaged together to provide the child with between three and eight sessions of trauma treatment. Main features of each Phase are summarized in Table 1.

Phase A: Trauma Information Sessions.

Phase A is provided as a series of six 90-minute sessions presented groups of up to 50 caregivers. Sessions are psycho-educational in nature, guided by principles of trauma, attachment, and cognitive behavioral therapy. Specific topics of presentation include: information on trauma; differences in the experience of trauma for children and adults; importance of caregivers to children's response to trauma; caregivers positioning in their relationship with their children; thoughts, feelings and actions associated with cycles of self-defeating behaviors, and anger and emotional regulation. Caregivers receive articles, diagrams, charts, and homework assignments after each session. The Trauma Information Sessions are designed to achieve four goals. These are: (1) to develop caregiver empathy for their child's experience, (2) to reposition caregivers' to be better able to provide their child with security and containment, (3) to improve caregiver self-regulation and disengage them from

conflict with their child, and (4) to develop caregiver hope, self-efficacy and motivation for change.

Two aspects of the Trauma Information Sessions distinguish them from other psychoeducational groups on childhood trauma. A first important characteristic is the containment provided to the caregiver. An important barrier to children receiving treatment for trauma is dysregulation of the caregiver around the child's trauma (Kim, Noll, Putnam & Trickett, 2007). With this in mind, Phase A sessions have been carefully designed to contain caregiver affect and develop caregiver's self-regulation. Sessions are offered in a large group format where parents' capacity to learn is emphasized. Emotional dysregulation in parents is contained by restricting opportunities for personal story telling, co-regulation of caregiver affect by the clinician, and though the use of diagrams to capture abstract concepts in a concrete and containable format.

A second important feature is the level and intensity of homework assigned. Caregivers attending Phase A are gradually asked to complete increasing amounts of homework; first reading, then short exercises, then charting aspects of their relationship with their child and finally all previous aspects of homework plus self-exploration and monitoring. Homework assignments have multiple functions. They help parents integrate information being presented in the information sessions and begin the process of change. They also place caregivers in the position of having to commit significant resources to promoting change in themselves and their families. Finally, homework exercises act as a screen for caregivers who are not able to contain their affect sufficiently to complete homework or commit sufficient resources to intervention. These caregivers are then counselled individually or are referred to another program to develop their capacity to attend and complete Phase A.

Phase B: Caregiver Treatment Sessions.

Phase B consists of an average of eight individual sessions with children's caregivers. Sessions begin with an assessment of caregiver understanding of material from Phase A and of possible barriers to caregivers' ability to engage fully in intervention, such as active addiction to drugs or alcohol, ongoing domestic violence, debilitating depression or anxiety, or the possibility of separation of child and caregiver. When there are significant barriers to caregivers' progress, ITTM treatment will be paused and specific alternative interventions pursued (e.g. counselling for addiction).

Following assessment, caregivers are asked to identify their most impactful childhood experience. The caregiver completes detailed diagrams of the thoughts, feelings and actions associated with this experience in the past, present and with specific goals outlined for the future. From these charts, the trauma theme (e.g., aloneness, abandonment, victimization) that most aptly captures the salient features of that caregiver's specific interpretation and experience is highlighted. The trauma theme then forms the core material for treatment where the predominant faulty belief system of the caregiver is identified, deconstructed, and reconstructed. Caregivers are guided through the process of re-structuring their faulty belief systems through deconstruction and disputation by the therapist and self-monitoring. Once parents have a full understanding of their own trauma theme, intergenerational patterns of transmission of trauma are explored and caregivers are actively engaged in speculating about how their own trauma might be impacting the life of their child. At the conclusion of Phase B, caregivers complete diagrams to represent their hypothesis about their children's experience of trauma and how their own trauma theme may have influenced their children's interpretation and response. Other key activities of Phase B include the implementation of quality one-on-one time between the caregiver and child and, as necessary, specific training in emotional regulation and/or therapeutic work to resolve complex caregiver grief.

Phase B activities have benefits to both the caregiver and the child including increased empathy, emotional regulation, and hope for the potential of breaking intergenerational patterns of trauma transmission, improvements in children's feeling of emotional safety and security and corresponding reductions in child behaviors and symptoms, and increased positive interaction of parent and child. All treatment activities are provided in a series of sequential steps so that if, at any point, the caregiver has not experienced improvement, the clinician can review and repeat until the caregiver has experienced and maintained success in achieving the desired outcome. Phase B treatment is terminated when the clinician judges that the caregiver understands and has made changes in their own faulty belief system, has empathy for the child's traumatic experience and resulting understandable behaviors and symptoms, has successfully disengaged from conflictual interactions with their child, and has the developed emotional attunement with the child and the capacity to provide containment for the child's traumatic experience(s) and symptoms.

Phase C: Child-Therapist Sessions Co-Directed by Therapists and Caregivers.

Phase C consists of three to eight sessions for the child with the caregiver present. Each session begins with a 10-minute meeting between the therapist and the child's caregiver to review homework, share observations, and plan for the session. The child and therapist then work together for 30-40 minutes on processing trauma and attachment-related issues while the caregiver observes. In the final 10 to 20 minutes of the session, the caregiver and therapist again meet without the child present to discuss the child's reactions and revelations during the treatment session, to reflect on and interpret children's behaviors, and to develop homework assignments for the intervening week. Just as the caregiver received support from the clinician to make positive changes in his/her life experience, the caregivers' role is now to take the position as an emotionally attuned, supportive, competent, co-lead for the child in treatment.

During Phase C, therapists and children complete six separate narratives covering children's relationship with their main caregivers and culminating with their experience and understanding of at least one traumatic event. Children's ability to construct narratives is facilitated by use of either a sand tray with miniature figures (Thompson, 1990) or with drawings and diagrams. The therapist works with the child to identify the faulty sense-making (or faulty belief system) that is developing as a result of the child's interpretation of the traumatic event, directly and logically counter faulty sense-making, and reconstruct the child's beliefs. Caregivers are engaged in helping children become more aware of faulty sense-making, monitor their adherence to faulty beliefs and consolidate positive changes in their understanding. Additional interventions are provided, as necessary, to support caregivers in helping their children regulate their emotion, interrupt negative behavioral patterns or address unresolved traumatic grief.

For the majority of children (approximately 75%), the above Phase C activities are sufficient to correct children's attributions and beliefs and reduce behaviors and symptoms to non-clinically significant levels. For a minority, additional interventions are required. Decisions about additional treatment are made largely on the basis of children's organization around attachment and the development of self (as revealed in children's narratives, parent report, and therapist observation). Children whose behaviors and symptoms persist following initial trauma treatment, and who have issues around attachment and self-

organization proceed to option 2 exercises of Phase C. Typically, the background of these children includes traumatic experience perpetrated by their primary caregiver, such as physical abuse, profound neglect, or abandonment by the caregiver once or multiple times in the children's history, that are likely to have had a disorganizing impact on the development of attachment between caregiver and child.

When such issues are present, the child and caregiver are engaged in therapeutic activities to recreate significant attachment events from child's past. Children and caregivers identify the development period at which the disorganizing trauma occurred and then begin to develop stories about responsive and nurturing caregiver responses to the child at that developmental period. For example, for a child with a classically disorganized attachment to their primary caregiver, intervention would begin by creative narratives of responsive, available, nurturing, accepting caregiving in infancy. The child would then be engaged in playing out these created stories using sand tray or diagrams and eventually in role-plays with their caregivers. These interventions provide the child and caregiver with a chance to "re-write" the script of the child's life, at least in the child's experience of their current life context, which in turn, allows the child to develop greater coherence and self-organization, builds a foundation for stronger parent-child relationships, and reduces child behaviors and symptoms.

Specific Strengths of the ITTM

The ITTM is consistent with many of the recommendations for treating complex trauma in children. However, there are important differences between this model in terms of the level of caretaker involvement and the focus on issues around intergenerational transmission of trauma. Each of these aspects of the ITTM is discussed in turn.

Parents are primary focus of intervention.

The first, and most important, difference between the ITTM and other treatment models addressing childhood trauma is the role of caregivers in treatment. Although the majority of current models of treatment for childhood trauma include parents, the ITTM is unique in its focus on the parents as the primary agents of change for the child. An organizing assumption of this model is that the people who are in best position to assess and address their children's trauma are children's caregivers. As reviewed, the ITTM begins with information sessions for caregivers, then takes caregivers through the process of addressing trauma, and then works collaboratively

with the parent to address their child's trauma. As such, one focus of intervention is on promoting parents' capacity for, and confidence in, addressing their children's trauma and related behaviors and symptoms (i.e. self-efficacy and empowerment). This practice contrasts significantly with the more typical practice of involving parents as informer to the therapist (e.g. individual children interventions that include a short meeting with children's caretakers to get updates on children's behaviors and progress over the week); supporter of the therapy (e.g. interventions that provide information to caretakers about children's problems and give them tasks to complete at home that will support work being done with the child individually); or co-participant in the therapy (e.g. parents and children hear the same information and work together on developing similar skills) (Hill, 2005).

There are multiple reasons for focusing on parent as the primary agent of change for children including the importance of parents for facilitating children's access to therapy and empirically-documented benefits for improved child outcome (Jones & Prinz, 2005; Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid & Hammond, 2004). However, perhaps most importantly, focusing on caregivers the primary targets of treatment has the benefit of retaining them a position of capability and mastery relative to their child. This aspect of parental involvement has been emphasized in research on the importance of parental self-efficacy and parental empowerment to child outcomes (Jones & Prinz, 2005; Hoagwood, 2005) but is likely of even greater importance to children who have experienced trauma.

One significant impact of trauma on children (as well as adults) is compromised sense of safety and security in the world. For infants, toddlers, school-aged children and adolescents, the main source of felt and actual security in the world comes from caregivers. In the face of a threat to one's sense of security, children turn to their primary caregivers to help understand and cope with concerns about their security and with emotions that arise from the threat to their felt sense of safety in the world.

Attachment theorists originally emphasized the importance of parents to children's sense of safety in the world. Although often understood as relevant only in infancy, attachment theorists emphasize that individuals' attachment and working models of relationships continue to differentiate over time (Cicchetti, Toth & Lynch, 1995) They further emphasize that particular events are likely to prompt re-evaluation and re-organization of attachment-based relational assumptions. The experience of

trauma represents one such event. Conceptualizing trauma as a challenge to the primary attachment relationship is obvious in cases of abuse or neglect of an infant or very young child by their primary caregiver, or in families where infants are receiving their primary care from a caregiver suffering from alcoholism, suicide attempts or criminality (Hughes, 2003; Liebermann & Knorr, 2007). However, even when traumatic events are independent of children's caregivers (e.g. sexual abuse by a neighbour), children turn to their primary caregivers following trauma to help them regulate overwhelming emotions and regain their sense of safety and security in the world. If their caregivers are unable to assure them of safety and help them regulate their emotion, then children are likely to lose confidence in the security of their bond with their caregiver and begin to re-evaluate their working models of relationships (i.e., "I thought that this was a person who could protect me, but maybe I am all alone and cannot rely on anyone to understand me and make me feel safe").

Since traumatic events challenge the relational bond between children and their primary caregivers, one aspect of treatment needs to be addressing possible disruptions in the security of the relationship between children and their caregivers; specifically, ensuring the caregivers are adequately attuned to their children and that they are effectively co-regulating their trauma related affect (Kinniburgh et al., 2005). Given this therapeutic goal, retaining parents in their position of capability and mastery relative to their children may be a particularly valuable therapeutic intervention for these children.

In the ITTM, caregivers' position as the secure foundation for children is promoted in a number of ways. First, the importance of parents to children is directly affirmed by having parents attend therapy without their children first, and then by involving parents as participants and co-directors of their child's therapy. Children are only seen alone for the purposes of assessment, and in possible cases of emergency or crisis intervention (e.g. child or caregiver reports child suicidal intent or maltreatment). Second, parents are directly taught skills for skills needed to improve caregiver attunement with their child and promote co-regulation of children's trauma-related emotion. Finally, parents are engaged in co-directing the therapy given to children, so the therapeutic benefits can be obtained without disruption of this critical relationship. In these ways, the ITTM helps the parent regain, or retain, their position as the safe base for their child in their dealing with trauma. Similar goals for intervention (though with different activities) are emphasized for infants and young

children with attachment disorders, or at-risk for attachment disorders (Madigan, Hawkins, Goldberg & Benoit, 2006; Lieberman & Van Horn, 2005, Lieberman, Van Horn & Ippen, 2006), but have seldom been carried forward into work with older children and adolescents.

Recognition of the Intergenerational nature of trauma.

A second unique feature of the ITTM as a method for treating trauma is its explicit recognition of the strong intergenerational component to the experience of trauma in families. As previously reviewed, the existence of intergenerational cycles of trauma is well established in the empirical literature. Thus, chronically traumatized children may be reacting to trauma perpetrated by one or more of their primary caregivers. Alternatively, non-offending parents with unresolved trauma in their own childhood may be caring for children.

In families where cycles of violence are being repeated, or where early attachment between parent and child is compromised due to particularly severe unresolved trauma impact in the caretaker, poor parental responsiveness to children's trauma might be expected. These parents are particularly unequipped for the inter-subjectivity and attunement necessary to help resolve behaviors and symptoms associated with children's exposure to trauma (Hughes, 2003). Moreover, due to ongoing challenges to the parent-child relationship, children in these families are likely to respond to trauma with particularly high levels of behaviors and symptoms, further increasing the challenge to their primary caregivers to maintain empathy, attunement and containment (Kozłowska, 2007).

Even when cycles of violence are avoided and early parent-child attachment is secure, parents with unresolved trauma in their history may have specific deficits in terms of their ability to respond effectively to their children's trauma. Unresolved maternal trauma has been associated with deficits in maternal sensitivity and responsiveness, higher levels of maternal harshness, and with a variety of problems in adaptation, such as depression, anxiety, PTSD and addiction that reduce their ability to respond empathetically to their children (Kim, Noll, Putnam, & Trickett, 2007; Schechter, Zygmont, Coates, Davies, Trabka, McCaw, et al., 2007). More specifically, because of their unresolved traumatic experiences, these parents are likely to react to their children's trauma with particularly high levels of their own distress and/or have restricted emotional awareness around certain aspects of children's emotional experience (Hughes, 2003; Nader, 1998).

A child's needs following trauma can also trigger a caregiver's own memories of loss, rejection, abandonment, abuse or diminish their parenting abilities.

Caregivers with a history of exposure to political trauma such as the holocaust, war, genocide, political persecution, or cultural subjugation may fit this pattern of responding. These parents often know, in a way that others do not, that the world can be a dangerous place and that humans are capable of sadistic and indifferent cruelty and feel a corresponding imperative to keep their children safe from harm. As a result, these caregivers may be more easily overwhelmed by their children's exposure to a traumatic event, particularly if their children's traumas share any characteristics with their own experience (Wiseman, Metzler & Barber, 2006). Even in the context of a secure attachment between child and caregiver, these parents may be unable to identify with their children's fears (which will likely be very different from their own) or regulate their emotions to a sufficient degree to provide containment for this child (Yehuda, Halligan & Grossman, 2001). Thus, children of these parents may feel abandoned or criticized following trauma exposure, and develop behaviors and symptoms reflecting both trauma experience and insecurity, guilt and fear resulting from their parents' lack of attunement and containment following the trauma exposure.

Ironically, the intergenerational nature of trauma has often led to recommendations that parents not be included in their children's treatment. Specifically, parents' poor self-regulation and compromised attunement with their child have been seen as a significant detriment to therapy. For example, Sperling (1997) suggests that parents who are unable to use input, reject therapists' initial suggestions, or who are likely going to be a challenge to therapy and are best left uninvolved in children's treatment. In their integrated parent-child CBT approach, Runyon et al. (2004) suggest that children should be encouraged to share their trauma narratives with their caregivers only "if clinically appropriate" (p. 76). The ITTM takes the opposite position – that the weakening of the relational bond between parents and children is likely a key contributor to children's trauma-related behaviors and symptoms and that addressing parent's trauma is a critical part of treatment for children. In fact, from a relational standpoint, it may be argued that the most important parents to include in treatment are those with unresolved trauma so that security in the parent-child relationship can be developed or repaired alongside treatment children's trauma-related cognitions and reactions.

The ITTM addresses the intergenerational nature of trauma in two main ways. As previously discussed, both the structure and content of the ITTM is designed to help parents build or regain a strong relational bond with their child so that they are better able to provide a secure holding environment for their children's trauma and related behaviors and symptoms. The ITTM also recognizes that many of the caregivers attending intervention will have difficulties regulating and experiencing their own trauma-related affect. For this reason, once caregivers have gone through Phase A and developed an understanding of their importance to their children's emotional security, motivation to be this secure base, and efficacy for change, individual sessions are held with the therapist and the parent to help address unresolved trauma impact in the parent (Phase B). Treatments offered in this phase are designed to both reduce the impact of intergenerational trauma and to provide caregivers with a model for working therapeutically with their child to resolve trauma in Phase C.

Conclusions

Empirically validated treatments for complex, chronic childhood trauma are critically needed. A survey of the practice of a large number of clinicians treating childhood trauma estimated that 78% of children on clinician caseloads have been exposed to multiple and/or prolonged trauma. Although a common presenting pattern, there was very little consistency in the treatment approaches used for this population. Common treatments for children included individual weekly sessions, coping or self-management skills training, parent-child or family therapy, play therapy and expressive therapies, with no clear consensus among clinicians regarding the relative effectiveness of available modalities (Spinazzola et al., 2005). Results such as these have prompted initiatives to improve consistency and efficacy of practice with chronically traumatized children. Most notably, the Complex Childhood Trauma working group of the National Child Traumatic Stress Network has developed a series of recommendations for general areas of intervention and is actively promoting research in this area (Kinniburgh et al., 2005).

The Intergenerational Trauma Treatment Model is one promising method of intervention for complex childhood trauma. This model is consistent with recommendations of the Complex Trauma Working Committee and has the advantage of providing clinicians with a manualized, phase-based method of reaching treatment goals. The model includes activities addressing the attachment between

child and caregiver, regulation of caregiver and child affect, safe expression and processing of trauma experiences and the development of parents' competencies and self-efficacy. Psychoeducational, cognitive-behavioural and attachment-informed strategies of intervention are employed. The ITTM also advances the field in terms of its focus on the primacy of parents to children's change and on directly addressing the intergenerational nature of trauma.

Research on the ITTM is proceeding. A study of pre- to post-treatment change established that completion of the ITTM is associated with significant reductions in child conduct disorder, problems in social relations and caregiver depression (Copping et al., 2001). Ongoing research explores the efficacy of ITTM as compared to treatment-as-usual and is examining mechanisms of change for children and caregivers. Such research will continue to be critical to advancing the field of treatment for chronic childhood trauma and for helping identify critical components of chronic trauma intervention.

Continued improvements in treatment for childhood trauma are likely to have important impacts on rates of juvenile and adult criminal behavior. One of the few empirically rigorous prospective studies of the impact of reducing childhood trauma on criminal outcomes is the Elmira study of home visitation by Olds and colleagues. Results of this ongoing longitudinal study have confirmed that prevention and early intervention for child abuse and neglect has very meaningful impacts on children's criminality. At 15 years of age, for example, children without intervention were 10 times as likely to have been adjudicated as a person in need of supervision and twice as likely report having been arrested. Effects were even more pronounced among youth born to low-SES unmarried mothers (Olds et al., 1998) and among those where maltreatment was successfully prevented (Eckenrode et al., 2001). Clearly, further efforts and investments need to be made to address chronic childhood trauma to thereby prevent criminality in adolescence and adulthood.

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