Resiliency Programming: An Intervention to Decrease the Effects of Trauma and Post-Problematic Behavior in Children

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Resiliency Proposal

What is Resiliency from Trauma?

"Resilience is the ability of a child to recover and show early and effective adaptation following a potential traumatic event" The National Child Traumatic Stress Network (2023). According to the American Psychiatric Association's DSM-5, trauma is defined as, "an event that involves actual or threatened death, serious injury, or sexual violence to self or others. Trauma can be experienced directly, witnessed, learned about, or through vicarious exposure. Trauma is outside the range of usual human experience and causes intense fear, horror, or helplessness" (American Psychiatric Association, 2013).

Pittsburgh Action Against Rape (PAAR) has been providing advocacy, mental health treatment, education, and outreach to Allegheny County community members who have been affected by sexual trauma for over 50 years. The Centers for Disease Prevention and Control (2022) reports, "About 1 in 4 girls and 1 in 13 boys in the United States experience child sexual abuse," and "Someone known and trusted by the child or child's family members, perpetrates 91% of the child's sexual abuse."

Child Sexual Abuse (CSA) survivors can experience several trauma-related symptoms including nightmares, panic attacks, anger/irritability, fear, negative thoughts about themselves or others, a lack of feeling safe, and feeling a loss of control of their body or emotions. These intrusive trauma-related symptoms impede the survivor's ability to succeed academically, successfully participate in activities of daily living, and form safe, healthy attachments with significant others. "Being able to feel safe with other people is probably the single most

important aspect of mental health; safe connections are fundamental to meaningful and satisfying lives," according to Bessel van der Kolk in his book *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma.*

While a child may experience these significant symptoms and poor attachment with significant others as a result of their sexual abuse, ***resiliency*** is possible, especially if the intervention and treatment occur shortly after the trauma takes place, and with-in the entire family system. Resiliency within a child is enhanced if the child has support of their family/significant others and community system, access to needed resources and coping skills, and strong and healthy relationship with their caregivers (NCTSN, 2023).

Prevalence of Youth Problematic Sexual Behaviors and Community Resources

"Problematic sexual behavior (PSB) in children is a common, yet frequently misunderstood and mishandled issue facing communities," Harris et al. (2023). This is because, in most cases, the child that is engaging in the problematic sexual behavior has also experienced significant trauma by the hands of others as well. While there is research that shows an etiological factor of PSB is a history of child sexual abuse, recent research has revealed that child PSB is more closely linked to childhood physical abuse, witnessing domestic violence, caregiver instability, and other forms of child maltreatment and neglect (Allen et al., Version 2.2) (Cossaboom, 2024). In these cases, children initiating PSB, that have also experienced significant trauma themselves, have a difficult time finding treatment. Some families avoid treatment due to fear of stigma and labeling (Massachusetts Legislative Task Force on the Prevention of Child Sexual Abuse, 2023). Then in the mental health community, a lack of

experienced and knowledgeable professionals are available to treat trauma and problematic sexual behaviors in children and leave these youth to "fall between the cracks" so to speak.

While research on youth engaging in problematic sexual behaviors is limited, Allen et al. (Version 2.2) reports in regards to interpersonal/intrusive forms of PSB (IPSB):

> In a mostly normative sample of 354 preschoolers followed longitudinally, Lussier McCuish, Mathesius, Corrado, and Nadeau (2018) found that 17% of children committed an IPSB between the ages of 3 and 5, and 12% committed an IPSB between the ages of 6 and 8. A study examining children between the ages of 4 and 11 who came into contact with the child welfare system found that 32% displayed some form of IPSB (Lévesque, Bigras, & Pauzé, 2012) (pg. 6).

Furthermore, The Massachusetts Legislative Task Force on the Prevention of Child Sexual Abuse (2023) found:

> Among the reported cases of sexual abuse against children and adolescents, over one third (35.6%) are committed by other children or teens (Finkelhor et al., 2009). And more recently, survey studies of older adolescents and parents of younger children found that as many as 70-77% of the sexual assault and sexual abuse experienced by children and teens were committed by other children or teens (Gewirtz-Meydan & Finkelhor, 2020) (pg. 3).

Unfortunately, despite the growing prevalence of PSB, even in well populated areas, such as Allegheny County, PA, where PAAR resides, only two treatment providers in Pittsburgh, PA engage in treatment with children initiating problematic sexual behavior and also experiencing trauma (Safer Society Foundation, 2023). Some of these providers only provide treatment

following the youth being adjudicated of a crime. A need exists for providing treatment to children before the behavior leads to a criminal offense. Financial resources are needed for trauma-informed community agencies like PAAR, so that these youth can be provided with quality and effective trauma treatment. The Massachusetts Legislative Task Force on the Prevention of Child Sexual Abuse (2023) reports:

> In fact, studies show that 85-95% of children and adolescents with PSB who receive well matched interventions will not reoffend and they are at no greater risk than the general population to grow up and continue to sexually offend as adults (Caldwell, 2016; Lussier, 2017). Ignoring these behaviors and these children, and not offering them and their families the support and interventions they need, means that more children are now at risk for being harmed. Furthermore, when PSB is ignored, the children who have been harmed will not be identified and they will not be able to access the help that they need to heal from this trauma. (pg. 3).

Moreover, residential treatment for these youth that have experienced significant trauma but initiated problematic sexual behavior, may not be the answer as well. Schladale (2019) shared, "The Office of the Surgeon General (2001) has identified residential treatment as an ineffective practice for youth violence prevention" (pg 1).

Furthermore, Schladale (2009), asserts:

> Youth who have completed offense-specific treatment have the potential to return successfully to their home communities. Since recidivism rates indicate a higher risk of non-sexual criminal behavior (Langstrom & Grann, 2000; Schram, Milloy, & Rowe, 1991; Worling & Curwen, 2000) (pg. 1).

This information points further to a need for funding for quality trauma-informed treatment for youth engaging in PSB at an outpatient mental health level. PAAR is hoping to obtain funding for its Resiliency Program in order to fill this treatment gap.

Resiliency Proposal Part 1:

Serving Children Engaging in Normative Sexual Behaviors

Some children engage in *normative sexual behaviors* (NSB). Normative sexual behaviors are NOT *problematic sexual behaviors* (PSB), but are behaviors that involve the "private parts" of the body and sexual exploration (NCSBY, 2023). Normative sexual behavior can occur between children of similar ages or siblings, and it is playful, exploratory in nature, mutually initiated, and is NOT intrusive, aggressive, or coercive (NCBSY, 2023).

What is considered normative sexual behavior is different depending on the ages of the children. The Brook (2023) "Sexual Behaviors Traffic Light Tool" was developed to clarify the difference between safe and healthy behaviors (green behaviors), behaviors that may need further assessment and attention (amber behaviors), and behaviors that are not safe and need immediate intervention and action (red behaviors). See a link to this chart in the references section to learn more. Behaviors that fall into the first two categories, "green" and "amber" behaviors, will be addressed through this first part of PAAR's Resiliency Program.

Normative sexual behaviors can be alarming to parents and the community, but with proper body safety and psychoeducation for both the child, parent, and community supports, most children do not require further intervention, unless another incident such as a sexual abuse trauma has occurred. At PAAR, the children that fall into this category will receive components of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) omitting the trauma narrative if no

sexual trauma occurred. Topics covered would include: body safety and consent, secrets, online safety, healthy/assertive communication, healthy relationships, emotional literacy, coping skills and relaxation, and cognitive coping. Parents would receive extensive psychoeducation about normative sexual behaviors and support for communicating with their child sex education, healthy boundaries and communication, and providing emotional support and self-regulation.

Children seeking treatment from PAAR as a result of an "ambiguous disclosure" of sexual abuse receive this same treatment. PAAR considers an "ambiguous disclosure" to be when a child is either exhibiting the above "amber colored" sexual behaviors, or there is strong suspicion that a child may have experienced some form of sexual abuse. Potential examples include a familial pattern of sexual abuse, another person reports the sexual abuse occurred, or if there is a distinctive emotional and behavioral change in a child following an interaction with a potential sexually initiating individual. In these cases, PAAR would provide the above-mentioned modified TF-CBT treatment. If the child does disclose sexual trauma throughout the course of sessions, the therapist will proceed with processing the trauma by either a *TF-CBT Trauma Narrative, **Trauma Art Narrative Therapy (TANT), ***Eye Movement Desensitization and Reprocessing Therapy (EMDR), or *****Sensory Motor Arousal Regulation Treatment (SMART).

Resiliency Proposal Part 2:

Filling the Gap in Treatment for Youth Exhibiting Problematic Sexual Behaviors

In the last few years, there has been an increase in referrals to PAAR to serve children who have initiated problematic sexual behaviors (PSB) on other children. Currently about 25% of PAAR child therapist's caseloads include a youth that has engaged in one of the "red" sexual

behaviors on the Brook (2023) "Sexual Behaviors Traffic Light Tool". Examples of these behaviors include forcing children into sexual play or forcing children that are younger into sexual activity. At this time, PAAR therapists are currently trained in processing the sexual trauma from a survivor's perspective, and require further training in treating the "problematic sexual behavior" symptom. Given the increase in these referrals, PAAR therapists receiving more extensive training in PSB treatments is a huge need in the PAAR Child and Family Counseling Center. The American Academy of Experts in Traumatic Stress asserts that, "1/3 of sexually abused children eventually act out in sexually abusive behaviors" (MOSAC, 2023).

To further exacerbate the need, PAAR is aware of very few treatment providers in Allegheny County that are specifically trained in treating problematic sexual behavior. As discussed earlier, some existing treatment providers only serve youth that are adjudicated or are actively involved in child protective services. However, youth that engage in PSB and are not involved in systems have little to no treatment provider choices in Allegheny County, leaving a gap in treatment services. Because of this gap in services, many non-adjudicated youths that engage in PSB may only receive treatment if they are criminally charged for a crime later on in life. This presents a huge flaw in Allegheny County's mental health treatment and intervention system, as having very limited trained PSB clinicians to provide treatment interventions to children with trauma and PSB, potentially increases the likelihood of continued suffering of trauma symptoms, untreated mental health diagnoses, and possible involvement with Allegheny County's criminal system in the future. Prevention of PSB through resiliency building and PSB treatment services are desperately needed in Allegheny County. As Bessel van der Kolk (2014) quoted in his book, "*The Body Keeps the Score*", "Trauma breeds further trauma; hurt people hurt other people".

PAAR's mission is to "end sexual violence," however, this cannot occur without the funding to adequately train PAAR therapists to treat sexually problematic behaviors in youth. PAAR receiving this funding to train therapists already skilled in treating child survivors of sexual abuse is essential, as 45-80% of very young children that engaged in problematic sexual behaviors have also experienced sexual abuse themselves (ATSA, 2023). The Association for the Treatment and Prevention of Sexual Abuse further explains, "Children can engage in atypical sexual behaviors for a range of reasons including being victims of sexual abuse, experiencing physical or emotional maltreatment such as neglect or abandonment, exposure to family violence, exposure to sexuality and sexual behavior in the media, and other causes" (ATSA. 2023). PAAR becoming a treatment provider that not only provides services to children experiencing child sexual abuse, but also to children initiating problematic sexual behavior, would make access to treatment easier, possible, and free of cost for Allegheny County families.

Due to the time-intensive treatment that is required to provide services to youth with problematic sexual behaviors, PAAR will need to hire additional therapists dedicated to this work, as well as pay for on-going specialized training.

While PAAR's Child and Family Counseling Center is looking to create their own resiliency curriculum, PAAR hopes to utilize aspects of some already established modalities:

Phase-Based Treatment for Pre-teen Problematic Sexual Behavior

Some PAAR therapists have been trained and started consultations for PST-PSB in pre-teens. This modality views problematic sexual behavior as "behavioral problem" involving

sexual body parts as opposed to a form of "sexual offending." Furthermore, the sexual behavior is developmentally inappropriate and harmful to themselves and others (Allen, B. et al, Version 2.2). Allen et al. (Version 2.2) found in their small pilot study that one of the most significant precipitating risk factors for children's engagement in problematic sexual behavior is having a history of physical abuse, and then also other forms of maltreatment trauma. This does exemplify a large percentage of the children often come to PAAR, having experienced multiple traumas, "complex trauma." PAAR often sees children that have experienced more trauma than just sexual abuse.

The Phase-Based Treatment for Pre-Teen Problematic Sexual Behavior encompasses three phases of treatment. The first phase is "Family Sexuality and Response." In this phase, sexual behavioral rules are established as well as a monitoring plan to promote immediate safety in the home. The therapist also engages the caregiver in a *functional behavioral analysis* to explore and gain insight into potential triggers or scenarios that lead to a problematic sexual behavior occurring and then creating a plan to mitigate these factors in the future.

The second phase of the treatment focuses on "Development of Healthy Sexuality." In this phase, the therapist explores with the family their beliefs and values about sex and sexuality. Furthermore, the therapist provides psycho-education to the caregivers about normative sexual development. The caregiver and child may then participate in conjoint sessions in which the parent provides psycho-education to the child about healthy sexual development, with the therapist's support, and answers any questions that the child may have about sex and sexuality. Finally, the third phase of treatment is "Skill Development." In this phase of treatment, the child learns healthy coping and impulse control skills. Psycho-education regarding healthy

relationships and safety in relationships is explored, as well ongoing monitoring plans for safety and sexual behavior rules in the future.

The benefits of using this model is that safety is established at the start of treatment, eliminating the child's engagement of problematic sexual behavior with-in the first few weeks of treatment. This model is good for children that do not have a disclosed history or sexual abuse. Furthermore, this model highlights for parents the role that they play in the responses of their child through the functional behavioral analysis. This model increases communication between caregiver and child about topics of sex and sexuality and promotes the child learning factual psycho-education to promote future healthy sexuality. The development of healthy coping and impulse skills also influences healthy behaviors and relationships that the child may engage in in the future.

One major disadvantage of this model is that it does not involve trauma processing for the child, or acknowledge any past traumas that the child may have experienced that influences their present day behaviors and current relationship engagement. From PAAR's trauma-informed perspective, if a child's treatment is not acknowledged or processed, then the child may continue to experience trauma triggers that may continue to negatively impact the child's life. Using a wound analogy, this approach would puts a band-aid over the wound, instead of cleaning out the wound and properly treating it. PAAR seeks to add a trauma processing therapy to the treatment that a child initiating PSB would receive.

Furthermore, further harm can be done to the child if their trauma is not acknowledged and emotions validated, which could lead to shame, lower self-esteem, and other negative outcomes. This model only serves youth of the pre-teen age category, so children younger and older would need to be treated from another modality.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for Preschool and School-Age Children with Problematic Sexual Behavior (PSB)

PAAR therapists are already trained in Trauma-Focused Cognitive Behavioral Therapy as described above, so it would be beneficial for PAAR therapists to receive an advanced training in the problematic sexual behavior treatment implementation model of TF-CBT. This model of treatment would address the concerns listed above of PBT-PSB, as the treatment would acknowledge and process the child's trauma. This modality engages the child in learning the same coping, cognitive coping, and relationship skills as the TF-CBT model described above, as well as provides space for the child to process their trauma and manage PTSD triggers.

The PSB implementation model of TF-CBT further includes behavioral parent training skills in the psycho-educational component to further establish safety monitoring plans at home and sexual behavior rules. This model also provides emphasis on sex education, normative sexual development and prevention plans (NCSBY, 2024). Opportunity for the child to process their own sexual trauma is providing considerations for thoughts of shame related to problematic sexual behavior, again, addressing some of the disadvantages of the PBT-PSB model (Mitten, 2024).

In addition to the advantages listed above of having the opportunity for trauma processing and addressing reactions of shame, the advantage of this modality is that it would expand upon a base modality already prominent in PAAR treatment, TF-CBT. As a result, this modality would provide opportunity to incorporate interventions from TANT, SMART, EMDR, and other ****creative art and play interventions. Among the disadvantages of this modality is that it is only meant for trauma related PSB, which might mean PAAR would use PBT-PSB for

the non-trauma PSB. Another disadvantage is that the treatment is meant for youth ages 3-12, which means treatment for ages 13 and above would be need to be served by another modality.

EMDR Trainings to Treat PSB

As discussed above, many problematic sexual behavior modalities treat the behaviors, but not the underlying trauma that a young person has experienced. For example, Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB) is a treatment model for PSB utilized by an Allegheny County neighbor to treat problematic sexual behavior. Unfortunately, its evidence-based research focuses on decreasing recidivism rates and does not acknowledge the mental health status of those youth (MSTPSB, 2023) (Borduin et al., 2021) (Borduin et al., 2016).

Dillard, R., Maguire-Jack, K, Showalter, K., & Wolf, K.G. (2019) assert, "Children and youth who engage in problematic sexual behaviors often have traumatic histories of maltreatment and other adverse childhood experiences". Ricci and Clayton (2016) have also indicated higher levels of adverse childhood experiences (ACE), childhood traumas, in individuals engaging in sexually problematic behavior. This points to youth needing problematic sexual behavior treatment that also incorporates treatment of their own trauma as well.

Eye Movement Desensitization and Reprocessing (EMDR) works from an Adaptive Information Processing model. Shapiro (2001) explains:

> When someone experiences a severe psychological trauma, it appears that an imbalance may occur in the nervous system, caused perhaps by changes in neurotransmitters, adrenaline, and so forth. Due to this imbalance, the information-processing system is unable to function optimally and the information acquired at the time of the event,

> including images, sounds, affect, and physical sensations, is maintained neurologically in its disturbing state. Therefore, the original material, which is held in the distressing, excitatory state-specific form, can be triggered by a variety of internal and external stimuli and may be expressed in the form of nightmares, flashbacks, and intrusive thoughts – the so-called positive symptoms of PTSD (p 31).

Overtime, we may develop negative cognitions, implicit beliefs, about ourselves, others, and the world as result of these traumatic experiences as a survival and adaption skill. For instance, if caregivers throughout life have harmed an individual or been neglectful or unreliable, that person may develop the belief that "no one can be trusted" to protect themselves from future harm in the future. This implicit belief, however, could shape how a person behaves and responds to situations moving forward in life.

Ricci and Clayton (2016) suggest that EMDR therapy can target "offense drivers" that lead to engagement in problematic sexual behavior. Ricci and Clayton (2016) propose:

> The adaptive information processing model inherent in eye movement desensitization and reprocessing (EMDR) trauma therapy is theorized to reorganize the maladaptively stored clustering of cognitions and emotions related to overwhelming or traumatic experiences such as childhood sexual abuse. We suggest EMDR therapy as a means of restructuring distorted implicit cognitions and personal vulnerability factors which are theorized to drive offending behavior. (pg. 1)

From this model, applying EMDR to a population of individuals initiating problematic behavior could prevent future problematic behaviors due to resolving the implicit belief and offensive drivers triggering the behavior. The EMDR training, *ROOT CAUSES: Applying the Offense Drivers Model to EMDR Therapy and Compulsive Sexual Behavior Disorder (CSBD)*, would

educate clinicians further about this. The training reviews the etiological pathways of compulsive sexual behavior, the offense driver model, and then the application of using EMDR to treat problematic sexual behavior (EMDR Advanced Trainings and Distance Learning, 2021).

Furthermore, most problematic sexual behavior treatment models for youth weigh heavily on parental involvement due to caregivers managing the daily structure, supervision, and respond to the youth's emotional expression and behaviors at home. PSB therapists rely on parents to resume some of the treatment, safety and modification plans set in therapy at home. Therefore, parental understanding of trauma reactions and how they respond to their youth at home, plays a pivotal role in the success of therapy in youth.

In connection with this, Annie Monaco, LCSW, RPT and Nicole Wolasz, LCSW-R (2023), have developed an EMDR training for treatment for teens exhibiting problematic behaviors and their caregivers called *EMDR with Resistant Teens and their Caregivers: Healing Attachment Wounds and Managing Dissociative Symptoms.* This training would provide valuable information to PAAR Resiliency Program therapists in exploring psycho-education related to trauma, addressing significant behaviors, positively influencing family dynamics, exploring attachment trauma, and increasing emotional regulation. This treatment approach would allow processing of a youth's trauma, address the problematic sexual behaviors, and also involve caregivers in the treatment.

Resiliency Proposal Part 3:

Child and Family Traumatic Stress Intervention (CFTSI)

The Child and Family Traumatic Stress Intervention (CFTSI) is a therapeutic intervention administered to children, ages 7-18, and their families, in just 5-8 sessions promptly after a child

discloses a trauma. CFTSI is implemented during the peritraumatic period (12 weeks following the sexual abuse or disclosure of sexual abuse). The goal of this treatment is to prevent the development of Post-Traumatic Stress Disorder (PTSD) and increase resiliency within the child. By increasing communication, providing support and practice around coping strategies and trauma triggered behaviors, and providing psychoeducation about trauma and common symptoms to the family, PTSD is less likely to occur. CFTSI also serves as a screening tool for traumatic stress and to assess the need for longer-term interventions. CFTSI's interventions are targeted for multiple cultural, ethnic and minority populations, such as Latino, African American, Caucasian, and Multiethnic families, as well as families of low income and with complex trauma histories (The National Child and Traumatic Stress Network, 2012).

Utilizing this intervention will be beneficial to the survivors in the PAAR Child and Family Counseling Program for a variety of reasons. CFTSI provides a first response assessment and treatment tool to children recently experiencing sexual abuse. While the purpose of CFTSI is to prevent PTSD from developing in the child, it also provides a brief effective resource to families prior to them receiving a longer-term treatment. Carrie Epstein, the co-developer of CFTSI, asserts **70-80% of children completing the CFTSI sessions (5-8) do not need other therapy, and are 65% LESS likely to meet full criteria for PTSD, than children that do not receive CFTSI** (Epstein, 2023). These results indicate that using CFTSI at PAAR will decrease the amount of child sexual assault survivors who need long-term treatment, as the modality decreases the severity of traumatic stress symptoms. To accomplish this resiliency, the child survivor and their significant others will receive CFTSI from PAAR clinicians following their trauma disclosure or forensic interview, and after 8 weeks of treatment, demonstrate decreased trauma symptoms and enough resilient strategies to be discharged.

CFTSI promotes collaboration and supportive attachment between the child and significant others and assists in connecting families/significant others to the support they need in the community, an overarching value of the new PAAR Child and Family Counseling Center (CFCC). Intervention is also developed for the diverse populations identified above, as the PAAR CFCC strives to introduce therapeutic approaches that are researched as effective in marginalized communities. Finally, CFTSI will be valuable in decreasing the chance that a child will be waiting on a waiting list for trauma processing therapy for a long period of time before treatment.

Closing Statement:

One of the main goals of PAAR's Child and Family Counseling Center's ***Resiliency Program*** is to provide children and their caregivers time-sensitive support following sexual trauma. Providing psycho-education and resources to both the caregivers and the child survivor is essential in working to prevent the onset of post-traumatic stress symptoms by increasing resiliency in children. PAAR's *Resiliency Program* will help fill the gaps in the education system, providing psychoeducation to families who are concerned about *normative sexual behaviors*, as well as fill the gap in treatment for children engaging in *problematic sexual behaviors* to stop the cycle of trauma. Most youth that have engaged in PSB, have also experienced their own trauma, and require specialized trauma-informed treatment that very few treatment providers in Allegheny County offer.

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

Trauma-Focused Cognitive Behavioral Therapy will remain a primary therapeutic modality utilized at the PAAR Child and Family Counseling Center, as multiple prestigious organizations, including the National Institute for Health and Care Excellence (NICE), the American Psychological Association (APA), and the World Health Organization (WHO), recommend it treating trauma in children (Barron, 2018). TF-CBT is an evidenced-based therapy that utilizes structured components of psycho-education, relaxation, affective modulation skills, cognitive coping, trauma narrative and processing, in vivo mastery of trauma reminders, and enhancing safety and social skills with the child, along with psycho-education, parenting skills and conjoint parent and child sessions, actively involving parents in the treatment. The treatment is for individuals ages 4-21, and usually lasts 12-25 sessions (The National Child Traumatic Stress Network, 2012). The Centers for Disease Control and Prevention (2019) reports, "TF-CBT effectively reduces symptoms of PTSD, depression, fear, anxiety, shame, and behavioral problems. It also reduces parental emotional distress and depressive symptoms and is associated with improvements in parenting behaviors."

The benefits of utilizing TF-CBT is that it follows a set curriculum, but various other modalities can be used as interventions with-in the treatment such as art therapy, sand tray therapy, and play therapy. It involves parents and caregivers in the treatments, and the therapy is short-term, 12-15 sessions. The basic "PRAC" skills, psycho-education, relaxation skills, affective modulation skills, and cognitive coping, can be utilized in therapy sessions with children that PAAR considers to be "ambiguous disclosures," meaning there is evidence to suspect sexual abuse but no clear disclosure. Some drawbacks to using TF-CBT is that it is so structured, that sometimes therapists feel confined in using more creative and non-direct approaches to therapy with children. It offers a LGBTQ implementation manual. It does not

offer any ethnic/racial minority implementation manuals yet, but one of the developers, Dr. Anthony Mannarino, has reported in consultations with the PAAR clinical team that one is being developed and an article with recommendations has been released.

**** Trauma Art Narrative Therapy (TANT)**

As explained by Trauma Art Narrative Therapy (2021), Trauma Art Narrative Therapy (TANT) is a structured cognitive exposure technique for the purpose of narrating traumatic events and providing symptom resolution." TANT uses art to reduce PTSD symptoms from both simple and complex traumas. This technique has been researched to show a significant decrease in PTSD and depression symptoms (Trauma Art Narrative Therapy, 2021). Utilizing this technique at the Child and Family Counseling Center compliments the "trauma narrative" intervention with-in the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) format. Disadvantages to consider are that the creators of this technique do not recommend using it if the clients are experiencing psychosis, suicidality or self-harming (Trauma Art Narrative Therapy, 2021).

*****Eye Movement Desensitization and Reprocessing Therapy (EMDR)**

Eye Movement Desensitization and Reprocessing Therapy (EMDR) is already a primary therapeutic modality at PAAR for adults, in which most PAAR therapists are already trained; however, more specialized training utilizing EMDR in children should be offered to the Child and Family Counseling Center therapists. EMDR therapy allows the brain the opportunity to naturally reprocess unprocessed trauma memories in the brain utilizing bilateral stimulation

instead of talk therapy. The goal is to neutralize negative cognitions, physiological sensations, and the negative emotional charge of the trauma.

The World Health Organization (WHO) recommends EMDR in the treatment of PTSD in children (World Health Organization, 2013), and many studies, including Karadag, Gokcen, Sarp (2020), have found that EMDR therapy in children and adolescents decreases anxiety and PTSD symptoms. Utilizing EMDR with children can involve parental collaboration, exploring behavioral skills, attachment issues, and developing positive parenting skills (Adler-Tapia & Settle, 2012).

The benefits of employing EMDR in children at the Child and Family Counseling Center is that most therapists are already trained in it, but it would be good practice to attend specialized trainings in conducting EMDR in children, potentially by Ana Gomez. Treatment could potentially be rather short-term, as EMDR does not follow structured curriculum sessions before reprocessing the trauma as other therapies do, other than building healthy coping skills and resources beforehand. Creative and engaging interventions like art therapy can be incorporated into the therapy. Moreover, EMDR therapy does not require the child to explicitly talk about the trauma.

Disadvantages are that the interventions utilized in EMDR a very different than traditional talk therapy, so it can sometimes be off-putting and confusing to parents, needing to acquire parent buy-in. Furthermore, body safety psycho-education curriculum is not explicitly part of the treatment, which could be helpful for children to experience to prevent future victimizations.

****** Creative Art and Play Therapies**

Additionally, PAAR therapists would benefit from attending additional trainings that teach creative interventions for children in therapy such as art therapy, play therapy, and sand tray therapy. These therapeutic interventions can be used in the rapport building phase and as interventions to compliment the evidence-based modality being used. For instance, TF-CBT follows an agenda of topics that are explored each week, such as psycho-education about body safety. Sand tray or play therapy could be utilized in addressing this topic, playing out body safety scenes with the therapist. Art therapy could be utilized in affective modulation component, drawing a picture of an angry monster and exploring unhealthy and healthy ways of the monster coping with its anger. Bratton, Ray, Rhine, & Jones (2021) explain why utilizing these therapies with children is beneficial:

Developmentally, children lack the cognitive ability to meaningfully communicate their thoughts, feelings, and experiences through the abstract means of verbal language. The concrete objects (toys, art, etc.) and other play-based experiences provided in play therapy afford children an age-appropriate and emotionally safe means to express their difficult experiences.

The disadvantages to this is that when these are used as therapies, they are meant to be non-directive. If the therapists are using it as part of TF-CBT, however, would be using it directive to achieve the TF-CBT agenda.

******* Sensory Motor Arousal Regulation Treatment (SMART)**

Sensory Motor Arousal Regulation Treatment (SMART) is a therapeutic modality created by trauma professionals and occupational therapists, to manage dysregulation in traumatized children and their families (Warner, Westcott, Cook, & Finn 2020). SMART's therapeutic process consists of three goals: Somatic Regulation, Trauma Processing, and Attachment

Building for individuals with complex trauma symptoms. Complex trauma symptoms include affective and somatic dysregulation, behavioral and attentional dysregulation, and dysregulation of self and relationships. SMART uses a *"bottom up" framework, focusing on movement and sensation, to support emotional and behavioral regulation (Warner, Westcott, Cook, & Finn 2020).

SMART at PAAR has broadened the scope of therapies that can be utilized for children with ambiguous disclosures, children who do not want to participate in talk therapy, and those that are unable to benefit from cognitive interventions due to intellectual and/or developmental functioning. The advantage of using a "bottom-up" treatment modality, is that the client does not have to cognitively understand the intervention to decrease symptoms of complex trauma. SMART does not depend on language to create positive change, therefore, the child does not have to complete a trauma narrative, or even disclose a trauma, to benefit from treatment (Warner, Westcott, Cook, & Finn 2020). SMART has been effectively implemented across all different cultures and abilities, making it a good fit for the diversity of PAAR's clientele (Warner, Westcott, Cook, & Finn 2020).

Furthermore, SMART specifically facilitates attachment between the client and caregiver. SMART does this by engaging caregivers in the treatment session. The attachment building and repair sessions are focused on establishing a secure attachment between client and caregiver. This is accomplished by using play to establish co-regulation between the child and caregiver, while building connected safety and attunement (Warner, Westcott, Cook, & Finn 2020).

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