The Attachment, Self-Regulation and Competency (ARC) Model – Bringing Trauma-Focused Care to the Therapeutic Milieu

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ARC Overview for Application with Youth in Residential Treatment Settings

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The Problem of Treating Complex Trauma

- Need for intervention that:
  - Can address continuum of exposures (layers of chronic and acute), including ongoing exposure
  - Is embedded in a social/contextual framework
  - Is sensitive to individual developmental competencies and vulnerabilities, and flexible in its approach
  - Addresses individual, familial, and systemic needs and strengths
Where does ARC come from?

- Translation of clinical principles across settings (out-px, residential, school, home-based)
  - Or…what is it that we actually do?

- “Evidence-based practice”?
  - Or…how to fit real kids into scientific boxes

- Staying true to the inner clinician
  - Or…keeping the art in treatment
Protocol vs. Component based Interventions

- Clinical Objectives Focused
- Developmentally Tailored
- Context Specific
- Individual Targets
- Menu-Driven
ARC: A Framework for Intervention with Complexly Traumatized Youth

Core principles of understanding:

- Trauma derails healthy development
- Trauma does not occur in a vacuum, nor should service provision
- Good “intervention” goes beyond individual therapy
ARC: A Framework For Intervention with Complexly Traumatized Youth

ATTACHMENT
- Caregiver affect management
  - Attunement
  - Consistent response
  - Routines and Rituals

REGULATION
- Affect Identification
  - Modulation
- Affect Expression

COMPETENCY
- Primary Components
  - Executive functions
  - Self development

TRAUMA EXPERIENCE INTEGRATION

Blaustein & Kinniburgh, 2010; Kinniburgh & Blaustein, 2005
ARC - 10 Building Blocks

- Trauma Experience Integration
- Executive Functions
- Self Dev’t & Identity
- Affect Identification
- Modulation
- Affect Expression
- Routines and Rituals
- Consistent Response
- Attunement
- Caregiver Affect Mgmt.
Who does ARC target?

- Designed to target the needs of children, families, and systems impacted by complex trauma
- Core domains translate across children/families/systems; applications and goals will vary
- Crucial importance of:
  - Keep an eye on the clinical objective, rather than the technique
  - Pay attention to relative goals and relative successes
  - Have a plan, but catch the moments
Programs Applying ARC Principles

- Anchorage CMHC (Out-px)
- Beth Israel NY (Out-px, school-based)
- B.C. Children’s Hospital (In-px)
- Bethany Christian Services (Out-px)
- Butler Center (DYS residential)
- Calgary Public Schools (Classroom / whole-school)
- Children’s Hospital L.A. (High-risk youth programs)
- The Children’s Guild (Therapeutic foster care)
- Cohannet Academy (DMH IRTP)
- Crittenton Children’s Services (Multiple programs – out-px, Head Start, Group Home)
- DV Crisis Center (DV Shelter and Advocacy)
- Gateway-Longview (Child Welfare Agency)
- Glenhaven Academy (Residential School)
- Harmony Hill (Residential treatment)
- Hertfordshire County Council (Adolescent programs)

- House of Mercy (Domestic Violence shelter program)
- Kennedy Krieger (Therapeutic Foster Care Program)
- La Rabida Children’s Hospital (Out-px)
- Lower Naugatuck Valley PCRC (DV Resource Center)
- Mosaic Children’s Services (Group Home)
- MGH Chelsea (Group/Out-px)
- New England Counseling & Trauma Center (Out-px)
- Safe from the Start (Community-based agencies)
- Southern Trust (Residential / group homes)
- Sutter-Yuba Mental Health (Out-px)
- The Trauma Center at JRI (Out-px)
- UCSF/CASARC (Out-px)
- Vermont Department of Mental Health (Outpatient programs)
- Youth on Fire (Adolescent drop-in center)
Restraint Reduction

Average Percent Reduction in Restraint Per Bed Capacity
FY 06 - FY 07

- Glenhaven, Cohannet, Butler: 54%
- Other JRI Residential Treatment Programs: -20%
Treatments Utilized in the NCTSN

- TF-CBT: 63.88%
- ARC: 4.5%
- CPP: 3.5%
- PCIT: 2.5%
- SPARCS: 17.4%
- Other / Unknown: 8.3%

Total n=966
6-Month Change in CBCL Scores

*Significant decreases on CBCL scores; no significant differences across interventions
6-Month Change in UCLA PTSD-RI Scores

- Significant decreases on CBCL scores; no significant differences across interventions.
ARC Treatment Outcomes to Date

- PTSD Symptom Reduction (Outpatient, Residential)
- Child Behavior Improvement (CBCL) (Outpt/Resi)
  - Outpatient (85% percentile to 50% percentile)
  - Residential (sig reduction Externalizing Problems; positive trend Internalizing)
- Significant Restraint Reduction (JRI)
- Significant increase in Placement Permanency (92% vs. under 50%) (ACMHS)
- Increased staff perceived competence, reduced staff burnout and turnover (VT-DMH)
ARC Intervention Components

- Integration into clinical work (structured and unstructured); individual and/or dyadic application
- Caregiver support
- Caregiver training workshops
- Group treatment
- Milieu training, consultation, and staff support
- Milieu interventions and initiatives
- Community-based applications

Importance of building an internal team to support integration goals
Attachment: The Big Picture

- **Overarching**: Develop safety and positive capacities within the child’s caregiving system

- **How?**
  - Supporting caregivers
  - Increasing knowledge and skills
  - Creating positive relationships
  - Increasing predictability
Self-Regulation: The Big Picture

- **Overarching:** Increase child/adolescent capacity to manage emotional and physiological experience

- **How?**
  - Build a language for emotions, energy, and body states
  - Build capacity to recognize these states in self and other
  - Explore and support use of tools (individual as well as external and systemic) to better manage experience
  - Increase communication resources, and capacities to use those resources effectively
Competency: The Big Picture

- **Overarching**: Support key reflective capacities, including ability to make active choices and sense of self

- **How?**
  - Notice choices, assist with problem-solving, link actions and outcomes, and reflect on cause-and-effect
  - Tune in (and support child in tuning in) to attributes, experiences, values, goals, opinions, etc.
  - Pay attention to the range of areas in which a child may build developmental mastery
Trauma Experience Integration: The Big Picture

- **Overarching**: Support self-reflective capacities, and ability to understand the self and act in the *present*, while taking into account the context of the past.

- **How?**
  - Doing all of those things we’ve just talked about…..the integration of many different skills to manage, tolerate, explore, and understand personal experience, relationships, and systems of meaning.
Main / Overarching Domain Concept:
Build safe / trauma-informed caregiving systems and safe relationships that support children / adolescents

Attunement: Core Target / Goal
Help caregivers to better understand children / adolescents

Key Sub-skills/Clinical Objectives:
- Build active curiosity
- Build reflective listening skills
- Use attunement skills in support of youth regulation
- Build pleasure / positive engagement

Techniques:
i.e., Dyadic check-ins, feeling charades, etc.
ATTACHMENT

- Caregiver Affect Mgmt.
- Attunement
- Consistent Response
- Routines and Rituals
The Main Idea: Support the child’s caregiving system – whether parents or professionals – in understanding, managing, and coping with their own emotional responses, so that they are better able to support the children in their care.
Residential Applications: Supporting Staff

- Pay attention to affect management/behavioral response at both the individual staff and systemic levels

- Normalize staff response to difficult behaviors; remind yourself and others that feeling emotion in response to your clients is NORMAL and EXPECTED

- Consider the following:
  - Forums for routine communication among staff
  - Incorporation of trauma concepts into case discussion
  - Routine processing of difficult situations (from perspective of staff support, as well as child)
  - Building mastery through experiential skill-building
  - Acknowledge vicarious trauma; build forums to address
  - Team building
  - Fun
The Main Idea: Support the child’s caregiving system – whether parents or professionals – in learning to accurately and empathically understand and respond to children’s actions, communications, needs, and feelings.
Residential Applications

- Provide training in trauma impact, including the role of triggers and the human danger response
- Make it real: Integrate trauma concepts into routine staff forums
- Develop, on a per client basis, an understanding of individual “communication strategies” and useful responses
  - (i.e., consider use of a child-specific worksheet, identifying common “push-buttons”, observable reactions, and helpful / not helpful responses; engage clients in collaborating in completion of these)
- Build systematic modulation tools into milieu settings, that are readily accessible to staff at all levels
- Pay attention to attunement across levels, and the parallel process: if something isn’t working with a particular staff member / system – try to understand why.
The Main Idea: Support the caregiving system, whether familial or programmatic, in building predictable, safe, and appropriate responses to children’s behaviors, in a manner that acknowledges and is sensitive to the role of past experiences in current behaviors.
Residential Applications

- Focus on long-term goals, rather than short-term behaviors: what are you trying to teach?
- Incorporate behavioral strategies which minimize power struggles; pay attention to issues such as limited child choice, problem-solving language, and use of positive reinforcement
- Be clear about rules, and keep these to the basics ("Show respect", rather than "Don’t curse", "Don’t talk back", "Don’t argue", etc.). Engage with students in a dialogue about the values underlying the rules.
- Teach staff to “choose their moments” in applying consequences. Be specific in linking consequences to rule violations, and be solution-focused: engage with students around alternatives for the future.
- Differentiate modulation from opposition; incorporate child- and/or staff-initiated modulation strategies in addition to, or instead of, consequences.
- Build (realistic) communication strategies among staff, across levels.
- Support systems in doing “post-game-analysis”: after an incident leading to consequences, try to examine the situation honestly – were there moments where something could have been caught before the escalation? What might have supported this? Consider systems-level supports as well as child-level.
The Main Idea: Build predictability through use of individual, familial, and systemic routines and rituals.
Residential Applications

- As in home routines, milieu/systems routines target daily rhythm as well as specific challenge areas (e.g., transitions, unstructured time, etc.)
- Build an understanding of the importance of predictability in daily routine; trouble-shoot planned variations, and expect response to unexpected ones
- Consider the role of modulation in building daily routine
- Consider ways individual child needs may differ from the expectations of the larger group, and ways to (realistically) address these
- Create routines which support key intervention goals (i.e., modulation, self/identity, problem-solving)
- Incorporate rituals from variety of cultures; build system-specific rituals
Domain 2: SELF-REGULATION

- Affect Identification
- Modulation
- Affect Expression
Affect Identification:

- **The Main Idea:** Work with children to build an awareness of internal experience, the ability to discriminate and name emotional states, and an understanding of where these states come from.
Considerations

- **Pair attunement with affect identification**: Caregiver attunement skills can be used to support the child in affect identification. Consider doing the work simultaneously.

- **Be mindful of cultural influences**: Culture and context impact our language for emotion, as well as our experience of it. Be cautious of making assumptions.

- **Use your own imagination and creativity** to create feelings-relevant activities.

- **Work with all caregivers** to incorporate basic feelings identification into their own interactions with the child.

- **Choose your moments**: Much of this work happens in the moment, and in conversation. Tune into opportunities to explore affect in the material children are already bringing in.
The Main Idea: Work with children to develop safe and effective strategies to manage and regulate physiological and emotional experience, in service of maintaining a comfortable state of arousal.
Residential Applications

- **Consider use of modulation strategies to facilitate key aspects of routine**
  - Down-regulation strategies at end of activities, before transitions, at end of day
  - Up-regulation/engagement strategies at the start of the day
  - Prior to transitions, sleep, etc.

- **Pay attention to the role of modulation in dysregulated behavior** – support the use of regulatory strategies prior to (or instead of) application of consequences, and prior to problem-solving

- **Incorporate modulation strategies and supports into the milieu** (i.e., basket of manipulatives in the classroom, calming-down corners, sensory room, etc.)

- **Adjunctive Activities**: Think about activities that children can take part in that naturally support modulation. Consider sports, yoga, music, drama, dance, etc.

- **Practice**: Allow time each week to practice these skills. It will take time and repetition to support the child in their ability to apply these skills “in the moment”.

- **Pay attention to parallel process** – support staff modulation as well as youth.
Affect Expression:

- **The Main Idea:** Help children build the skills and tolerance for effectively sharing emotional experience with others
Residential Applications

- Work with youth to develop “communication plans”; trouble-shoot these
- Build strategies that allow both verbal and non-verbal communication, and individual as well as full-group expression (i.e., desk/door signs, charts, etc.)
- Work with staff to differentiate the goal of expression from the method and the message; reinforce attempts to communicate, and work toward appropriate expression
- Provide forums for self-expression (journals, open-mike night, music, expressive arts)
Domain 3: Competency

Executive Functions

Self Dev’t & Identity

Dev’tal Tasks
Developmental Competencies

- Each developmental stage builds on the learning and experience of the previous stage.

- Competency and mastery of tasks at each stage lead to construction of an internal sense of *efficacy* and *achievement*; in turn, this increases confidence in approaching new tasks.

- When children are exposed to chronic trauma, energy that is normally invested into development of competencies is instead invested in survival.
Executive Functions

The Main Idea: Work with children to act, instead of react, by using higher-order cognitive processes to solve problems and make active choices in service of reaching identified goals.
The Main Idea: Support children in exploring and building an understanding of self and personal identity, including identification of unique positive qualities, building of coherence across time and experience, and support in the capacity to imagine and work toward a range of future possibilities.
Considerations

- Consider group as well as individual identity goals for all domains; i.e.:
  - Unique self:
    - What characteristics does each child contribute?
    - What makes this setting unique? (Group values, goals, etc.)
  - Positive self:
    - Support and reinforce child successes
    - Establish community pride; set collaborative group goals
  - Coherent self:
    - Notice and normalize differences in child presentation and experience across moments and setting
    - Notice coherence and fragmentation among group members
  - Future self:
    - Support individual youth in setting and working toward future goals
    - Set programmatic / community goals, and support members of the system in working toward these
The Main Idea: Work with children to actively explore, process, and integrate historical experiences into a coherent and comprehensive understanding of self in order to enhance children’s capacity to effectively engage in present life.
Children are not simply a composite of their deficits, but are whole beings, with strengths, vulnerabilities, challenges, and resources.

ARC provides a framework that seeks to recognize factors that derail normative development, and to work with children, families, and systems to build or re-build healthy developmental pathways.
Bringing Trauma-Focused Care to the Therapeutic Milieu

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- A program of Justice Resource Inst.

- Est. 2001; 32 total beds
- Co-educational program serving adolescents ages 12 – 22
- Located in Marlborough, MA
- 766 Approved Private School
- Serving students with complex trauma, mental illness, and behavioral struggles
- Developed through the cutting edge work of Dr. Bessel van der Kolk, provides individualized, trauma-focused treatment
- Serve school districts, state agencies, and private referrals
Introduction

- Program was facing significant challenges
  - Restraint utilization
  - Critical incidents
  - Staff training and retention
  - Strayed from clinical model
  - Increasingly more challenging referrals
  - Other examples: Level systems, restrictions, physical plant, earning privileges/trips
- Change was needed...
Implementing a Treatment Model

- MUST be a program-wide initiative
  - Start with Mission/Vision
  - Must guide ALL decision making and initiatives
- Viewing problems, questions, and decision making through an “ARC Lens”
Implementing a Treatment Model

- **Role of leadership**
  - Administrative Team
  - Bringing everything back to the Mission
  - Creating a powerful and cohesive team
    - Need to trust that those people understand and can share the key points of the treatment model
  - Changing the language
Implementing a Treatment Model

- Disseminating the message
  - Training – BIG commitment!!
  - Commitment to extending the information outside of trainings – how do you get the information to “the masses?”
  - Example:
    - Training modules where staff rotate through
    - Consultations with trainers and clinicians
    - Supervision
    - Changes in scheduling
    - ARC Challenges – Make it fun!
Implementing a Treatment Model

- Remove obstacles
  - Through assessments, will likely find that some things in your program do not fit with new model
  - Need to be willing to make changes
  - Examples: Closed door timeouts, restrictions
- ASSESSMENTS are keys to change
Implementing a Treatment Model

Communication

- Look for ways to communicate around the new model within the context of your current systems
  - Same systems, new language and lens
- Then, assess if more communication would be beneficial
  - Examples: addition meetings, interdepartmental forums, department specific meetings
- Proactive communication and planning vs. reactive communication and planning
  - Being proactive is more work!!
  - Prepare people for this – need to put in more to get more
- Use data to inform practice – share with the masses
Implementing a Treatment Model

- **Reality…**
  - Making significant programmatic changes is very difficult
  - ARC (and many other treatment models) are most effective when implemented long-term
    - Short-term hurdles can be defeating
    - Not unreasonable to question direction and plan

- **Meeting Opposition**
  - Not all employees will be willing/able to adapt to the change
  - Need to be willing to train, teach, and support, but also to make hard choices
Program Specific Examples

- Assessments of:
  - Program rules:
    - Hats
    - Music
    - Personal Contact
    - Point/Level System
    - “Check-ins”
  - Philosophy of “they need to earn it” vs. “give them what they need”
Program Specific Examples

- **Competency**
  - Created Competency Coordinator position
    - Someone needs to take ownership
  - Better use of resources – previously had been overtime, drain on direct care staff, negatively impacting off site trips
  - Competency Fair

- **Vocational**
Commitment to Model

- All program staff must be committed to the model
  - Time consuming to implement something new
  - Meetings, trainings
  - Resources – willing to allocate them when needed

- Being willing to take CALCULATED risks
  - Following thorough assessment
  - Fit with Mission and ARC Lens?
Specialty Interventions

- Program also adopted specialty interventions that work in conjunction with the ARC Model
  - SMART (Sensory Motor Arousal Regulation Therapy)
  - Trauma-Informed Yoga
  - Neurofeedback

- How are these followed through on?
  - Have to commit to the time, training, and resources
    - Training of staff
    - Supervision of providers
    - Infusing into milieu
Case Presentations

Of former students AT and KB