**The Intergenerational Trauma Treatment Model**

Information for Professionals

**What is the Intergenerational Trauma Treatment Model (ITTM)?**  
The ITTM is a 21-session complex trauma treatment program for children and their caregivers and involves the caregiver throughout the course of trauma treatment for the child.  The results appear to be effective and long lasting (Copping, Benner, Warling, & Woodside, 2003). The ITTM picks up where attachment work leaves off and interrupts the intergenerational transmission of traumatic impact onto the children. The ITTM specifically grows the caregiver’s investment in the program where commitment to the treatment process may be in question at the start. The ITTM’s methodologies assess and resolve caregiver-related issues, reduce the impact of traumatic events and strengthen the child/caregiver bond through *three phases* of treatment.  
  
Themes on the psychological and emotional impact of traumatic events, the importance of caregiver involvement throughout treatment, and the disruption in family functioning following a traumatic event, are interwoven throughout each phase of treatment. A combination of psycho-education group session, CBT diagrams, and directed Sand Tray Therapy tools, designed for children and adults, are the primary assessment and treatment techniques practiced within the ITTM.  
  
Phase A is comprised of six 90-minute Trauma Information Sessions (T.I.S.'s) presented to a group of up to 50 caregivers.  Phase B involves assessment and treatment to the caregiver, over a period of 3-7 sessions.  Assessment and treatment for the impact of the caregivers own trauma history on their interactions with the child is the core material of Phase B. Subsequently, in Phase C, the caregiver and therapist are engaged n providing 3-8 treatment sessions to the child for the traumatic events experienced and for affecting changes in the child's remaining behaviours.  The caregiver is involved through the entire treatment process.

The ITTM shares the assumption of Cognitive Behavioural Therapy that how we think about something affects how we choose to act, and that we can use understanding to help shape behaviours.  Cognitive principles are applied within every phase of the ITTM, and include 1) providing education in a supportive format, 2) empowering the caregiver to be the expert for their child, 3) re-evaluating assumptions about the effects of trauma on the child, such as sexualization, stigmatization, attributions of responsibility for the trauma, feelings of betrayal or of worthlessness, and 4) interpreting the child's problem as trauma-related, while assisting the caregiver to engage with their child in a new and more helpful way.

**What Outcomes Can Participants Expect?**

***The sooner we respond to the impact of trauma on children, the better.***

Researchers emphasize the need for early treatment intervention for trauma victims as a factor demonstrated to affect the life-long psychological symptoms and behaviours exhibited by adults, traumatized as children (Giaconia, 1995).  Preliminary research on families who have participated in ITTM have shown significant reductions for children in behavioral scales of Conduct Disorder, Separation Anxiety, and Caregiver Depression.  
  
***Parents and Caregivers feel more competent and attuned to their own and their children’s needs.***

The authors of the study hypothesize that the continuous involvement of the caregiver in the treatment process is an important component to this process.  A significant outcome of involvement was a marked reduction in parental depression.  This finding is very important.  Trauma experienced by children has an effect not just on the children, especially in terms of their attachment to their primary caregivers, but also on the caregivers themselves.

Coping with children who are prone to displaying high levels of oppositionality and other manifestations of conduct problems, traumatic memories, and repetition compulsion, anxiety, mistrust, and depression makes enormous demands on caregivers.  And when caregivers themselves have had histories of childhood trauma, these behaviours are powerful catalysts for re-awakening unresolved residues of their experiences.

***Caregiver Depression is reduced***

Our clinical observations are that caregivers’ depression causes caregivers to be less available to the children from who they care.  This absence of emotional availability leads in turn to a perceived absence of safety and a perceived reduction in the strength of the emotional attunement to the child.  This experience keeps the impact of the trauma very much alive for the child.  However, strengthening the child-caregiver attachment and emotional attunement as well as involving the caregiver throughout the treatment process, appears to have an effect no only on the child but also on the caregiver.  It may be that as the caregiver's level of depression decreases by experiencing success at the start and throughout all Phases of the ITTM, he or she becomes more emotionally available for the child.  As a result, the child may experience the perceived safety that is a precondition for any successful trauma resolution (Herman, 1992).  
  
***The Parent or Caregiver is seen as the Expert by the child, who will be able to help navigate through future challenges the child may face.***

The caregiver is able to act as a functional co-therapist in delivery of the ITTM phase C.  This collaboration greatly enhances the therapeutic potency of the treatment approach in that it dramatically extends the time and range of circumstances in which the child is functionally in therapy.  Reductions in levels of the child's separation anxiety are, we believe, related to this development.  
 ***The Child experiences improved behaviour, mood, and capacity***.

Changes in Conduct Disorders were targeted in the treatment intervention through a series of advanced level cognitive behavioral interventions.  Given that behavioral problems are frequently part of the symptom picture of traumatized children, reductions in such problems may serve as an important marker of trauma resolution.  Reductions in levels of conduct disorders are particularly encouraging in light of the well-documented resistance of this disorder to psychotherapeutic interventions (Kazdin, 1995).  
  
Any intervention that promises a potential decrease in conduct-disordered behaviour is, therefore, noteworthy.  The most effective treatment for conduct disorders identified to this point include parent management training and components of cognitive-behaviour therapy (Kazdin, 1993; Kazdin & Weisz, 1998; Brestan & Eyberg 1998).  The ITTM incorporates both approaches.  Because most children with conduct disorders have histories of chronic trauma (Steiner, H, 1997), a treatment of the underlying trauma that is combined with parent training and cognitive behavioral interventions holds particular promise.

|  |
| --- |
| **“As an agency, we have been excited by the results of the ITTM. Seasoned clinicians have observed outcomes with their clients that have been dramatic. The focused treatment has helped clients achieve results quickly and profoundly. The model has helped parents recognize their own individual issues in a way traditional therapy has never achieved. These clients were often in long-term family therapy with little change in the family. The ITTM helped identify the underlying issues and clearly outlined the needed shifts for families to make changes”.**  *Heather Cook, Manger of Clinical Services, Children’s Assessment and Treatment Centre, Burlington, ON.* |

* **The ITTM is currently being applied across *twelve* mental health clinics across Ontario.**
* **A rigorous clinic-based province-wide research study in conjunction with the University of Toronto and the Centre of Excellence (CHEO) is currently under way.**

**IF**

* 1. **You are** i**nterested in an ITTM presentation to you and your community partners,**
  2. **You are interested in learning more about training opportunities for your clinic staff to learn advanced clinical skills for the practice of the ITTM, or if:**
  3. **You are interested in finding out more about available training dollars for your clinic for the delivery of the ITTM in your area,**

***CONTACT: Dr. Valerie Copping at 519-830-7272 (Author and Trainer of the ITTM).***

**View the ITTM trauma treatment website at*: www.theittm.com***

**Are the Child and Family affected by the Impact of Trauma?**

Take a look at the questions below – they may help you decide if the child and family are dealing with the impact of trauma.

**Please answer ……………Yes, No,   or Maybe to each of the following questions.**

**Has the child or Caregiver:**

* *Directly experienced one or more of the following?*  
                          Physical abuse\_\_\_\_  
                          Sexual abuse\_\_\_\_  
                          Verbal abuse\_\_\_\_  
                          Emotional abuse\_\_\_\_
* *Witnessed family violence and/or abusive behavior between his/her caregiver(s)?*
* *Lost a mother, father, sibling, or friend or loved one to death (sudden or chronic)?*
* *Experienced an unexpected separation from their primary caregiver for longer than 3 days?*
* *Experienced the adoption process?*
* *Experienced a real or perceived threat to the life or safety of their primary caregiver?*
* *Experienced one or more foster home placements?*
* *Experienced abandonment by a caregiver?*
* *Experienced neglect by a caregiver?*
* *Experienced a frightening hospital experience?  
  Experienced an unexpected move?*
* *Experienced inconsistent access visits by one of his caregivers where the visits are either frequently cancelled or not acted upon by the caregiver?*
* *Been discovered to have been touched inappropriately or been found touching another child inappropriately (even if approximately the same age)?*  
    
  If you answered **yes** to any of these questions, then your child or you may be presenting with symptoms and/or behaviours that are related to unresolved trauma impact.  If your child has experienced a traumatic event and is experiencing an increase in negative behaviors or a decrease in desired behavior then trauma treatment may be of help to your child and family.  
  If you did not answer **yes** to at least one question, then the trauma treatment program would not be suitable for your child and family. If you answered **maybe** to any questions, with no other **yes** answers checked then the ITTM may not be recommended.  The ITTM is best suited for children and caregivers where there are known impactful experiences. Talk to a counsellor to help you decide for sure.