| Treatment Description | Acronym (abbreviation) for intervention: RLH  
Average length/number of sessions:  
The intervention involves six-to-eighteen months of weekly therapy sessions (one session per week for a total of 36 to 108 hours including child and parent/guardian sessions whenever possible). Number of sessions depends on safety, developmental level, extent and number of traumas, attachments, legal status, and stability of the child.  
Aspects of culture or group experiences that are addressed (e.g., faith/spiritual component, transportation barriers):  
Chapter by Chapter guidelines in the *Real Life Heroes Practitioner's Manual* provide specific tips to integrate each child's family and cultural heritage into life story work from assessment through the conclusion of treatment including service planning targeting community integration. Activities and tools engage strengths within the child’s family, community resources, and cultural heritage, including stories of overcoming adversity, faith, ties to religious organizations, and spirituality. A *Heroes Library* provides books geared to children with different ethnic backgrounds grouped by three reading levels. The *Practitioners Manual* also has specific chapters providing guidelines for adaptations for adolescents, preschool children, children with disabilities, and families with adopted children.  
Trauma type (primary): Neglect, Physical and Sexual Abuse, Abandonment, Losses, Placements, Domestic Violence, Disasters, Terrorism or War, especially relevant for Complex Trauma  
Trauma type (secondary): Medical  
Additional descriptors (not included above):  
*Real Life Heroes* utilizes an activity-based workbook to help children with traumatic stress build the skills and interpersonal resources needed to re-integrate painful memories and to foster healing after abuse, neglect, family violence, severe illness, losses, deaths, or abandonment. The workbook utilizes creative arts and life story work to engage children and caring adults in trauma and attachment-centered therapy and to rebuild (or build) positive, enduring relationships between hurt (and often hurting) children and adults committed to guiding children into adulthood. The curriculum integrates nonverbal and verbal modalities and helps children and caring adults move step-by-step from trauma narratives to life stories highlighting mastery, helping others, and nurturing relationships.  
*Real Life Heroes* was especially designed for children in child and family service programs who frequently lack safe, nurturing homes and secure relationships with caring and committed adults. The model assists therapists and family members to recover and enhance family and cultural strengths and to promote safety planning, affect management, social skill building, attachments, and trauma processing. The model can be used by programs and agencies as a prescriptive methodology to address primary goals including preventing placements, reuniting families, finding and engaging alternate committed families for children in foster or group care who cannot return to biological parents.
### GENERAL INFORMATION

#### Target Population

<table>
<thead>
<tr>
<th>Gender:</th>
<th>☐ Males</th>
<th>☐ Females</th>
<th>☑ Both</th>
</tr>
</thead>
</table>

**Ethnic/Racial Group** *(include acculturation level/immigration/refugee history—e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)*: RLH is easily adapted to enhance family and cultural strengths of children and families and can be used with refugees, immigrants, and children in a range of countries. The *Life Storybook* and the accompanying textbook, *Rebuilding Attachments with Traumatized Children*, were translated into Chinese with modified drawings for children of Chinese heritage.

**Other cultural characteristics** *(e.g., SES, religion)*: Useful for all SES and many religions

**Language(s):** English and Chinese

**Region** *(e.g., rural, urban)*: Rural, Urban, Suburban

**Other characteristics** *(not included above)*: School-age children, early adolescents, and caring adults who have experienced losses, family violence, disasters, severe and chronic neglect, physical and sexual abuse, repeated traumas, and ‘post-traumatic developmental disorder.’ In addition, children in, or at risk for, placement in foster family care, residential treatment, detention centers, psychiatric hospitals, as well as families involved with adoption or post adoption programs. In pilot studies, children typically presented with anxiety, depression, PTSD, disruptive behaviors, sexualized behaviors, and functional impairment in multiple areas.

#### Essential Components

**Theoretical basis:** RLH was based on research on traumatic stress and attachment disruption. The model incorporates core components of evidence-supported trauma and attachment-centered therapies adapted for children who have experienced multiple traumas, Complex Trauma, including physical and sexual abuse, severe neglect, and abandonment and for children who may lack a safe, non-offending parent willing and able to work in trauma therapy and a secure home. Creative arts activities foster nonverbal and later verbal re-integration. Life story work provides structure for engaging and sharing with safe, caring adults and re-shaping children’s perceptions of themselves and their families. The model incorporates tenets in desensitization therapies—that enabling children to remain safe with a trusted therapist during prolonged safe exposures to ‘tough times’ can lead to reduction in traumatic stress symptoms.

**Key components:** The life storybook (built around the metaphor of heroes) provides a structured, phased-based approach to engage children and caring adults to rebuild safety, hope, attachments, skills, and resources necessary for trauma therapy. Creative arts activities are utilized to develop affect recognition, affect regulation skills, and replace shaming and dysfunctional beliefs with confidence, and constructive beliefs. Components include psychoeducation on traumatic stress, activities to foster attunement and trust with caring adults, development of social support, development of skills for affect recognition, affect management, trauma processing, desensitization to triggers, and sharing a coherent life story including a past, present, and future.
### Essential Components continued

The model engages caring adults to validate children by building on family strengths, fostering an understanding of traumatic stress, reducing shaming/blaming, and strengthening each child’s family and cultural heritage. The goal is to transform troubled children into tomorrow’s heroes.

### Clinical & Anecdotal Evidence

<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware of any suggestion/evidence that this treatment may be harmful?</td>
<td>Yes</td>
<td>No</td>
<td>Uncertain</td>
</tr>
<tr>
<td>Extent to which cultural issues have been described in writings about this intervention (scale of 1-5 where 1=not at all to 5=all the time)</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group.</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If YES, please include citation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kagan, 2007a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kagan, Douglas, Hornik &amp; Kratz, in press</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has this intervention been presented at scientific meetings?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If YES, please include citation(s) from last five presentations:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennessee Chapter of the National Child Advocacy Centers: Kagan, 2006</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Vizinet: Kagan, 2006</td>
<td></td>
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<tr>
<td>Are there any general writings which describe the components of the intervention or how to administer it?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If YES, please include citation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the intervention been replicated anywhere?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Other countries? (please list)</td>
<td>Taiwan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other clinical and/or anecdotal evidence (not included above):</td>
<td></td>
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</tr>
<tr>
<td>The model is being tested at several community practice sites of the National Child Traumatic Stress Network and at other child and family agencies.</td>
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</tbody>
</table>
Therapists have consistently reported positive results during eight years of case studies with children with Complex PTSD involved in home-based or clinic-based family counseling and with children who have been living in foster families and residential treatment centers due to dangerous behaviors and often repeated experiences of physical or sexual abuse, and neglect. Practitioners have also reported that use of the model contributed to reduced trauma symptoms, PTSD symptoms, and negative behaviors. In addition, children have been observed to demonstrate behaviors associated with increased attachment, trust, and affiliation. Therapists reported that the model helped them to engage children and caring adults and that the curriculum helped therapists persevere with application of cognitive behavioral therapy components over time as noted on chapter checklists and in informal feedback sessions. Use of nonverbal creative arts modalities has been helpful as a precursor to asking children to utilize words.

<table>
<thead>
<tr>
<th>Research Evidence</th>
<th>Sample Size (N) and Breakdown (by gender, ethnicity, other cultural factors)</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pilot Trials/Feasibility Trials (w/o control groups)</strong></td>
<td>N=41</td>
<td>Kagan, Douglas, Hornik &amp; Kratz, in press</td>
</tr>
<tr>
<td>By gender: Male: 59%; Female: 41%</td>
<td>By ethnicity: African-American: 26%; Hispanic or Latino: 22%; European American: 65%; Biracial: 9%</td>
<td></td>
</tr>
</tbody>
</table>

**Outcomes**

What assessments or measures are used as part of the intervention or for research purposes, if any? In current practice and clinical trials, practitioners are using the Trauma Symptom Checklist for Children (TSCC), the UCLA PTSD Index for DSM IV, and the Security Scale along with fidelity measures including a standardized session protocol/progress note that includes a checklist for critical steps. The *Real Life Heroes Practitioner's Manual* includes a detailed trauma and attachment assessment guide along with an attachment questionnaire for children. In the pilot research study (Kagan, Douglas, Hornik & Kratz, in press), assessments were conducted at baseline and four month intervals to twelve months, including interviews for children, parents/caregivers, and practitioners, the TSCC, the UCLA PTSD Index for DSM IV, the Security Scale, the Connors Parent Behavior Rating Scale (Long Version), the Parent Report of Posttraumatic Symptoms (PROPS), the Child Perceived Self Control Scale, the Hopelessness Scale, the Multidimensional Social Support Scale, and the Working Alliance Inventory. In addition, practitioners completed session and chapter checklists to assess fidelity.
### Outcomes continued

If research studies have been conducted, what were the outcomes?

In the pilot research study, results at four months (Kagan, Douglas, Hornik & Kratz, in press) included significant levels (p < .05) of improvement reported on child self-reports of trauma symptoms (TSCC) and fewer problem behaviors reported on caregiver checklists (Connors). At twelve months, significant levels of improvement were found correlating the decrease in parent reports of child trauma symptoms (PROPS) with the number of workbook chapters completed and also for child reports of increased security (Security Scale) with caring adults. These results support the effectiveness of the model. However, the lack of a comparison group, the small size of the sample, and the difficulty separating the shared variance between time and the intervention limit the scope of conclusions regarding the effectiveness of RLH on improved clinical outcomes.

### Implementation Requirements & Readiness

**Space, materials or equipment requirements?**

The Practitioner’s Manual lists inexpensive equipment (and low cost suppliers) recommended for this model. Creative arts materials include markers, colored pencils, paper, a two-octave xylophone, and materials useful for self-soothing, centering and mindfulness exercises such as peacock feathers. Drums for rhythm expression can be hand-made or purchased. A copy of the Real Life Heroes Life Storybook is also needed.

**Supervision requirements (e.g., review of taped sessions)?**

Biweekly consultation is highly recommended along with supervision by trained practitioners within the therapist’s agency or practice location.

To ensure successful implementation, support should be obtained from:

Richard Kagan, Ph.D. (rmkagan@nycap.rr.com) and experienced practitioners trained in use of RLH.

### Training Materials & Requirements

**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.**


All books are available from www.haworthpress.com and also from amazon.com, bn.com, and other on-line book stores. Haworth books are available in paperback and at a large discount in bulk quantities.

**How/where is training obtained?**

At national and regional conferences (e.g., APSAC and the Tennessee Chapter of the Children’s Advocacy’s Center in 2006) as well as on site in agencies by request.

**What is the cost of training?**

Typically $4000-5000 for initial two-day workshop plus expenses

**Are intervention materials (handouts) available in other languages?**

☑ Yes ☐ No

If YES, what languages? Chinese
## General Information

### Training Materials & Requirements continued

**Other training materials &/or requirements (not included above):**

Clinicians (typically MSWs) attend a two-day workshop and participate in consultation groups every other week. Childcare staff and foster parents are also involved in training as team members and caring adults and may participate in sessions or assist with ‘homework.’ Training materials include a *Life Storybook* for both children and caring adults and a *Practitioner’s Manual* that includes key objectives, an overview, step-by-step guidelines, checkpoints (essential elements), pitfalls, and troubleshooting tips to help practitioners for each chapter as well as tools and handouts for activities and trauma psychoeducation. A session summary/progress note and a bookmark (reminder list) are provided to help practitioners incorporate key components and sequence into sessions. Program has been running since 1998.

### Pros & Cons/Qualitative Impressions

**What are the pros of this intervention over others for this specific group (e.g., addresses stigma re. treatment, addresses transportation barriers)?**

*Real Life Heroes* engages child, family, and cultural strengths with its focus on identifying heroes for the child within the child's family and culture, and the emphasis on transforming troubled children into tomorrow’s heroes. Trauma psychoeducation and the workbook format decreases shame and sensitivity increasing the likelihood of children and adults beginning trauma therapy. The focus on building skills and ‘doing with’ activities within the workbook has proven attractive to children and caring adults while providing a safe structure for practitioners to introduce and work on critical elements of evidence-supported therapies for children with traumatic stress including Complex Trauma. Critical elements introduced include safety planning, affect recognition, affect modulation, self-soothing, trauma psychoeducation, resource building, countering dysfunctional beliefs, problem solving, and desensitization of traumatic events. The life story framework promotes redefinition of children’s identities from victims to heroes who help others.

The model can be utilized in a wide range of programs ranging from home-based family interventions and mental health clinics to residential treatment and psychiatric hospitals. The model can also be utilized when children lack caring, committed and non-offending parents or guardians and safe, secure homes. This makes the model especially useful in child welfare programs and with children who have moved from home to home.

*RLH* has been a particularly valuable resource for children in foster family care as well as for children who have returned from placement to parents, relatives, kinship foster homes, or adoptive families. The model can be utilized to help caring adults build or rebuild trust with children. When children lack safe, caring adults, the workbook can be utilized to help search for family members or other adults willing to help children rebuild trust and overcome traumatic stress.

**What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)?** The time needed to complete the workbook is helpful to develop and practice skills and to reinforce lasting connections with children who lack trust. However, the number of sessions is longer than other models designed for children who have safe, secure homes and non-offending parents or permanent guardians willing and able to work in trauma therapy.
# General Information

| **Pros & Cons/Qualitative Impressions continued** | Components of the model can be utilized in groups but the entire model requires a therapist working with one child and caring adult at a time with parallel tracks for children and caring adults. Ideally, sessions would include 30-45 minutes for children and 30-45 minutes for adults. This may be difficult for reimbursement. **Other qualitative impressions:** Results of the pilot study supported the hypothesized relationship between children’s increased perception of security with caring adults and a reduction in trauma symptoms over time. Specifically, the ‘doing with’ activities in *Real Life Heroes* appeared to enhance children’s perception that they were not alone and could count on support from important people in their lives. Working with therapists and safe adults on opening up and recovering memories of children being nurtured, valued, and doing good things appeared to foster the strengths needed for children and parents or guardians to reduce traumatic stress reactions and strengthen attachments. |
| **Contact Information** | **Name:** Richard Kagan, Ph.D.  
**Address:** One Pinnacle Place, Suite 200, Albany, NY 12203  
**Phone number:** (518) 426-2600 ext. 2725  
**Email:** rmkagan@nycap.rr.com  
**Website:** Under construction |