children—a male, age 11, and a female, age 8—and their mother. They came in because of suspected abuse by the children's father, and the entire family was consumed with sadness, guilt, and responsibility. Over time, I knew that a traditional approach was not as effective because the family could not see past the trauma and personal blame to recapture the strengths that held them together.

Using a framework of TF-CBT and narrative therapy, I began a project with the family in which they created a storybook—complete with illustrations—about their trauma. I instructed them, however, that they were each a hero in the story and, thus, must reframe the story to show themselves in that light. As a whole, the family rewrote their trauma narrative and formed new ideas about themselves through telling the trauma narrative and reframing the experience. Each person took great pride in the story and the illustrations. This project fostered the momentum the family needed to heal and grow. For our termination session, I presented them with their story, spiral bound, as a reminder to always see the strengths in each other.

Brain-Based Approaches

Recent advances in brain science have opened doors to new and exciting interventions in trauma therapy. Neurofeedback, an advanced intervention that uses brain waves during counseling, is empirically supported for treating anxiety, depression, attention-deficit/hyperactivity disorder, and trauma (Marzbani, Marateb, & Mansourian, 2016). Neurofeedback works through operant conditioning to teach clients self-regulation. In addition, a technique known as brainspotting uses the principles of EMDR to activate traumatic memories through specific eye positions (i.e., brainspots). Although less researched, brain spotting does have strong anecdotal support for trauma treatment. For more information on brainspotting, visit https://brainspotting.pro.

Case Example and Applications for Hope and Healing

Ana is a 20-year-old female college student who identifies as Mexican American. She has come to counseling at her family's urging because of their concerns about her behavior following a recent traumatic event. About 6 months ago, Ana discovered her roommate dead in their shared apartment. Her roommate died by suicide after overdosing on medication. Since this incident, Ana reports elevated anxiety, fear of being alone, frequent worry—especially about the whereabouts and safety of her friends and family—and weekly recurring nightmares. Her family describes her as a "jittery," "anxious," and "always in her own head." Today, Ana is recounting a panic attack that occurred just hours ago. She states that she had plans to meet a friend after class, but when she got to her friend's apartment, there was no answer. Ana knocked on the door for 15 minutes and called her friend at least 10 times. She states that, at that point, she started to feel like she could not breathe. Her chest tightened, and she feared she was having a heart attack. The panic was relieved when her friend finally came to the door, stating that she had accidentally fallen asleep. This occasion is the first time Ana has experienced a panic attack.

In working with Ana, we have chosen TF-CBT as the primary treatment approach because of its strong evidence base, structure, and ability to address cognitive, behavioral, and affective processing needs. TF-CBT is appropriate for her age, and we like the fact that it emphasizes family involvement. Ana is close to her family and friends, and we can begin by maximizing the effectiveness of social supports and

the co-regulatory coping skills on which Ana already relies in times of distress. This is Ana's fourth counseling session. During the first and second sessions, we worked on psychoeducation around what trauma is and how the experience of finding her roommate following her suicide has affected Ana's functioning on cognitive, behavioral, affective, physiological, and social dimensions. We have also been in touch with her parents and sister who live about an hour away, and, together with Ana, we have talked to them about the plan for Ana's counseling and about how they might be involved. Ana would like them to come periodically to join her for sessions so that they can learn more about what she is experiencing and how best to support her. During the last session, we integrated a mindfulness approach to foster healing.

First, we worked on teaching Ana some simple breathing techniques for relaxation to help her regulate her autonomic nervous system when she is activated (e.g., Healthwise, 2018). We also practiced a new mindfulness strategy—mindful awareness of the five senses—designed to help Ana relax her mind and body when she feels anxious. Mindfulness techniques will be interwoven with the TF-CBT approach throughout her treatment. Today, Ana shares that she did not think to try these strategies until after her panic had escalated this morning, but we practice them again in session today, which helps her to self-regulate as she recounts this morning's events. In terms of the PRACTICE model (Cohen et al., 2006), we have now addressed Steps 1 and 2, psychoeducation and relaxation. We will continue to revisit these as we progress through counseling.

Given Ana's recent panic attack, our focus today and for the next couple of sessions will be on establishing Ana's sense of "safe space" and continuing to build and practice her self-regulatory coping strategies to give her tools and a sense of agency over her physiological response to trauma triggers. Next, we will move to affective expression and regulation and help Ana identify the emotions she is experiencing when she is both activated and calm. She will learn emotion regulation and cognitive coping strategies to show her how her thoughts and feelings are connected and how she can manage them effectively and intentionally. Ultimately, we will move into helping Ana tell her trauma story—perhaps through a creative technique such as sand tray use (Blankenship, 2017) or musical chronology (Duffey, 2005; Duffey, Lumadue, & Woods, 2001)—as we begin to reintroduce trauma-related associations in a new and safer context. Throughout, she will practice her new skills in self-regulatory coping and will work together with her family to reestablish a sense of security in her world.

Future Directions and Emerging Research

From traditional cognitive-behavioral approaches to the newer brain-based techniques, a recent shift in how we understand and treat trauma marks a new wave of treatment approaches that integrate cutting-edge neurophysiological research with time-tested strategies known to promote cognitive, behavioral, and affective processing. Thus, the study of trauma and its treatment grows richer through a deeper understanding of the brain-body connection and its role in traumatic response. Researchers—including Bessel A. van der Kolk (2014), Peter A. Levine (2008), and Stephen W. Porges (2011)—are paving the way for these new intersections through innovative theories of trauma that tie its lasting effects to dysregulation of the human body's primitive stress response system. Somatic experiencing (Levine, 2008) and the polyvagal theory (Porges, 2011) are gaining traction among trauma-focused practitioners, and van der Kolk's advocacy for mind-body inter-