USC University of Southern California

Adolescent Trauma Training Center

Treating Substance Use Issues in Traumatized Adolescents and Young Adults: Key Principles and Components

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Introduction

Substance use and abuse (SUA[1]) are common problems among clinically-presenting adolescents, especially those with a significant history of trauma (Adolescent Trauma and Substance Abuse Committee, National Child Traumatic Stress Network, 2008). Such youth may not only suffer from posttraumatic stress and dysphoria, but also diminished affect regulation capacities (Deykin & Buka, 1997; Gerson & Rappaport, 2013; Giaconia, Reinherz, Paradis, & Stashwick, 2003). Although not inevitable, social marginalization can compound these effects. Social and economic deprivation—as well as racism, sexism, homophobia, and homelessness—not only produce their own negative effects on children and adults (e.g., Bassuk, et al., 2003; Carter, 2007), they also can increase the likelihood of trauma exposure and intensify the effects of such victimization (e.g., Breslau, Wilcox, Storr, Lucia, & Anthony, 2004; Chen, Airriess, Wei, Leong, 2007).

This combination of sustained psychological pain, social stressors, and few internal methods of dealing with distress frequently leads to external avoidance responses, including SUA (Briere, Hodges, & Godbout, 2010). Although drugs or alcohol can temporarily numb and distract from distress (Khantzian, 1997), they are obviously not long-term solutions, and lead to problems of their own. Most relevant to trauma recovery, SUA can interfere with trauma processing (Briere & Scott, 2014; Cohen, Mannarino, Zhitovasb, & Caponec; 2003) and thereby produce chronicity in both domains: unresolved posttraumatic symptoms and ongoing SUA.

This guide provides clinicians with specific tools and perspectives helpful in the treatment of SUA issues in traumatized youth. It is intended to serve as an addendum to existing trauma treatment approaches, as opposed to representing a complete therapy on its own. However, the principles and intervention suggestions offered here are adapted and expanded from a specific approach to trauma therapy for youth, *Integrative Treatment of Complex Trauma for Adolescents* (ITCT-A; Briere & Lanktree, 2012, 2013).

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[1] *This acronym is used here it because the more common term, Substance Use Disorder (SUD), implies a medical condition. The notion of SUA is more consistent with a depathologizing approach. It also sidesteps what is "use" and what is "abuse," and allows drug and alcohol use to be seen on a continuum.*

ITCT-A is an evidence-based, multi-component, and extendable treatment model, involving semi-structured protocols and discrete intervention modules that are customized to the specific issues, capacities, culture, and socioeconomic embeddedness of each client. In a study of both ITCT-A and its companion intervention system for children (*Integrative Treatment for Complex Trauma for Children* [ITCT-C]; Lanktree & Briere, 2008), multiply traumatized, socially marginalized children and adolescents demonstrated significant reductions in anxiety, depression, posttraumatic stress, anger, dissociation, and sexual concerns as a function of time in treatment (Lanktree, Briere, Godbout, Hodges, Chen, Trimm, Adams, Maida, & Freed, 2012; Lanktree, Godbout, and Briere, 2012). The interested reader may download the 2nd Edition of the ITCT-A treatment guide from the internet at no cost: attc.usc.edu.

The current guide delineates and expands upon ITCT-A approaches to substance use in traumatized youth. It owes a special debt of thanks to Lisa Najavits, Ph.D., who developed the *Seeking Safety* model (Najavits, 2002, 2009)—an empirically validated intervention package designed to assist substance using trauma survivors[2]. More generally, it reflects research and clinical experience regarding ways in which trauma therapy can be adapted and adjusted to the specific issues and needs of substance-involved youth. The suggestions offered here are intended to be integrated into a variety of different clinical approaches to traumatized youth, since different clinicians may fruitfully employ different types of therapy in work with traumatized adolescents. Thus, for example, suggestions about the timing, pace, or intensity of treatment for SUA-involved youth are equally relevant to the use of exposure in cognitive-behavioral therapy as they are to the conduct of relational or psychodynamic therapy.

[2] *Although this guide does not explicitly use the handout-driven topics and related methodology of Seeking Safety, the philosophy and approach offered here is highly concordant with—and influenced by—Najavits's (2002) innovative approach. Further, aspects of the Seeking Safety model can easily be integrated into the psychoeducation component presented in this guide.*

Central Principles of SUA-Relevant Trauma Treatment

Do Not Screen Substance Users Out of Therapy or Terminate Treatment Because of Relapse Back into SUA

The usual clinical recommendation is that those involved in serious substance use be drug and alcohol abstinent for some time before undergoing trauma therapy. This is because those using drugs or alcohol traditionally do not do that well in trauma treatment; both because the numbing effects of substances may interfere with the processing of trauma memories in therapy, and because heavy substance use is often associated with poor treatment compliance and attendance (Ouimette & Brown, 2003). Although these concerns are valid, the sobriety requirement is problematic for many clients, including traumatized adolescents, who may be quite reluctant to discontinue the use of agents that successfully numb distress, and thus would not be able to access trauma treatment with a sobriety requirement. In addition, especially in underserved environments, substance abuse treatment programs are often costly and hard to find, and waiting lists are generally long. The frequent unavailability of such programs for adolescents living in marginalized social contexts can therefore reduce access to trauma therapy when abstinence is a requirement.

For these reasons, clinicians should encourage clients to avoid significant SUA, but not require it—the youth is taken as he or she is, and assisted within the constraints of what he or she will accept or tolerate. In our experience, youth who abuse large quantities of alcohol or regularly use "hard core" drugs (e.g., heroin, methamphetamine) have a harder time attending and using trauma-focused treatment, but may benefit, nevertheless, if treatment is customized for their specific issues and requirements. Such treatment is often slower going, and the effects of SUA become additional treatment targets. However, there is little reason to give up on SUA-involved youth, or terminate treatment because he or she has relapsed back into drugs or alcohol. In many cases, trauma survivors' involvement in drugs or alcohol is, in part, a response to past or recent trauma exposure, and trauma therapy may eventually reduce or eliminate their reliance on psychoactive substances. The remainder of this guide outlines principles and interventions that may increase the likelihood of successful treatment.

Safety First

Many traumatized youth, especially those involved in SUA, are at serious risk of victimization, injury, or even death at the time of seeking therapeutic services. This danger may reflect the risks associated not only with SUA, but also community violence, gang activity, criminal behavior, or prostitution, as well as specific life threats from previous perpetrators, sexual partners, stalkers, parents, or drug dealers/abusers. Young women are at significant risk of being raped or otherwise sexually abused by relatives, partners, and strangers (Elwood, Smith, Resnick, Gudmundsdottir, Amstadter, et al., 2011; Rickerti & Wiemann, 1998)—risk that may increase if they habitually use drugs or alcohol (Koenig, O'Leary, Doll, & Pequenat, 2003; Resnick, Walsh, Schumacher, Kilpatrick, & Acierno, 2013). In addition, the SUA-involved adolescent may be self-endangering; either passively through unsafe sexual practices, driving under the influence of substances, or involvement in other risky behaviors (Koenig et al., 2003; Substance Abuse and Mental Health Services Administration, 2010; Steinberg, Grella, Boudov, Kerndt, & Kadrnka, 2011); or through more actively suicidal behaviors (Epstein & Spirito, 2009).

Given this reality, the clinician must be vigilant to safety issues when working with traumatized youth, particularly those who are involved in SUA, and must be prepared to act on safety concerns before and during psychological treatment. In fact, ensuring safety should be the first requirement of trauma therapy—certainly for adolescent substance-using survivors. In this regard, we recommend initial and ongoing determination of acute safety when working with SUA-involved youth. These include assessment of any acute dangers in the client's immediate environment, such as abusive family members, extrafamilial perpetrators, pimps, gang-related activity, or unsafe living conditions, such as homelessness or high levels of community violence. Suicidality and other forms of self-endangerment should be evaluated, including those associated with obtaining or using drugs or alcohol. Physical health is another concern for some SUA-involved youth, including acute illnesses and chronic untreated medical condition such as AIDS, hepatitis C, or tuberculosis (Koenig et al., 2003). Comorbid psychological conditions also may be present, including depression, posttraumatic or acute stress disorder, mania, psychosis, or substance-related brain syndromes.

If there are acute safety issues, intervention in these areas must precede or at least

accompany treatment for less immediate psychological symptoms or problems. This may involve:

- notifying child welfare or protection services;
- advocating for the client with police or the criminal justice system;
- working with the youth to separate himself or herself from gangs, prostitution, or domestic violence;
- arranging medical evaluations and treatment, including, in some cases, medical or psychiatric hospitalization;
- early therapeutic and psychoeducational focus on self-harming or especially risky behaviors such as suicidality, deliberate self-injury, unsafe sex, and use of especially dangerous drugs (e.g., heroin, methamphetamine, OxyContin) and delivery systems (e.g., intravenous injections in general and needle sharing in particular)

Establish a Positive Therapeutic Relationship

A good therapeutic relationship is of great importance in the treatment of abused or traumatized individuals (e.g., Cloitre, Koenen, Cohen, & Han, 2002; Ford & Courtois, 2013; Lanktree & Briere, 2013), often even more so for adolescents chronically involved in SUA (Tetzlaff, Kahn, Godley, Godley, Diamond, & Funk, 2005). Because of its crucial nature, the relationship between client and therapist should be directly addressed in the same way as other clinical phenomena. Traumatized youth with SUA issues may experience significant ambivalence—if not outright distrust—regarding any sort of sustained attachment to an older, more powerful figure. Others may appear to attach very quickly, but their connection may remain insecure, based primarily on relational hunger or neediness associated with early attachment deprivation rather than a true belief in safety (Briere & Lanktree, 2013). In either instance, therapy may be slowed or compromised by insufficient trust and, as a result, reduced openness to the healing aspects of therapy. The clinician can encourage, if not accelerate, a positive therapeutic relationship in the following ways:

Relational safety

Because danger is such a part of many trauma survivors' lives, the therapist's ability to

communicate and demonstrate safety is a central component to relationship building. The adolescent is more likely to "let down his/her guard" and open himself or herself to a relationship if, repeatedly over time, there is little evidence of danger in the therapy process. As outlined in the ITCT-A treatment guide, therapist behaviors and responses that increase the client's sense of safety are likely to include nonintrusiveness, visible positive regard, reliability, transparency, and clear demarcations of the limits of confidentiality. Regarding the latter, the therapist should be as honest and open as possible, and not appear to have a hidden agenda—including a covert alliance with parents or social institutions over what the youth believes to be his or her own needs. When the clinician must report to systems beyond the adolescent, he or she should disclose this to the client and, whenever possible, gain his or her consent to do so[3]. At the initiation of treatment, the therapist also should be clear with the adolescent regarding his or her responsibility to report child abuse, client danger to self or others, or otherwise to intervene without the client's permission when certain events occur or seem likely to occur.

A visible willingness to understand and accept

A major effect of traumatization is often the sense that one is alone, isolated from others, and, in some sense, unknowable; a phenomenon that may be increased by the illicit nature and effects of some forms of SUA. Having the opportunity to interact regularly with someone who listens, and who seems to understand, can be an unusual experience for many maltreated youths—one that tends to strengthen the bond between client and therapist. This process is typically facilitated when the clinician displays attunement, empathy, and acceptance, as outlined in ITCT-A. Importantly, this last characteristic does not always mean that the therapist accepts the adolescent's behavior, for example, when he or she is involved in extreme SUA, self- or other-endangering behavior, or significant law-breaking behaviors. Instead, the acceptance is of the client's internal experience, inherent validity, and rights to well-being. This issue is complex, because SUA usually involves illegal actions and, in some cases, socially unacceptable behaviors—activities that the clinician typically will want

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[3] *Of course, the clinician has a duty to report child endangerment, regardless of whether the youth consents. However, we recommend gaining consent even in mandated situations, as a way to increase therapeutic trust. The reader is advised to consult the relevant laws in his or her state for further assistance.*

to help the client terminate. At the same time, such behaviors often generate considerable guilt, shame, and low self-esteem, such that the clinician must endeavor not to reinforce negative self-cognitions in his or her efforts to stop "bad" behavior. This balance, between (a) being clear with the client about the inadvisability of illegal or dangerous behavior, while also (b) communicating acceptance and appreciation of the client's inherent validity and entitlements to well-being, is often difficult to achieve and yet important to treatment success.

Active relatedness and emotional connection

It is important that the therapist be an active (as opposed to a passive or neutral) agent in therapy. When possible, he or she should make direct statements about the wrongness of the adolescent's victimization, and show some level of emotional responsivity to the extent that it is helpful. We recommend the clinician not give extensive, unsolicited advice, but, instead, actively assist the client in problem identification and problem-solving, generally supporting and encouraging him or her, emphasizing his or her strengths, and being consistently psychologically available.

Patience

Psychotherapy for youth with complex trauma effects rarely proceeds rapidly (Ford & Courtois, 2013), perhaps especially when chronic SUA is present. Yet, the adolescent (and sometimes the therapist) understandably wants rapid improvement. The client may become frustrated that, for example, cognitive insights do not always result in immediate behavior changes (including substance abstinence), or that an instance of talking about a trauma does not immediately desensitize emotional distress to it. Such experiences may lead to helplessness or self-criticism, as the youth interprets a lack of immediate distress reduction, or continued involvement in unhelpful behaviors like SUA, as evidence of personal failings. As the therapist counsels patience and a longer-term perspective, and remains invested in the therapeutic process, he or she communicates acceptance of the client and appreciation of the time it sometimes takes for enduring changes to emerge.

Treat Trauma Symptoms and SUA Concurrently

When treating substance using/abusing adolescents, it is often important to address

both trauma symptoms and drug-related issues at roughly the same time (Cohen et al., 2003; Najavits, 2002). Focusing on SUA alone may delay needed trauma interventions, whereas attempting trauma treatment without attending to SUA may easily overwhelm the client and motivate avoidance (Najavits, 2002). In fact, the exposure component of most trauma treatments, if not tempered with SUA treatment principles, may sometimes reinforce or even encourage drug or alcohol use as the client attempts to avoid activated trauma memories. Fortunately, several ITCT-A treatment components (e.g., trigger identification/intervention and affect regulation training, presented below) are helpful in both SUA and trauma domains, and thus can be tailored to either set of problems at any given moment in therapy.

How trauma treatment and intervention in SUA are applied in the same session varies from client to client. However, it is generally recommended that the therapist and client explicitly connect the two problems: exploring ways that SUA has been used as a defense against overwhelming trauma-related distress, as well as the fact that SUA, itself, may increase the likelihood of further trauma and psychological distress, creating a vicious cycle. As well, when discussing ways not to act on urges that result in problematic substance use, it may be helpful for the client to consider trauma-related triggers in his or her environment that make drinking or taking drugs more likely. Overall, the focus and message should be that the youth's trauma symptoms and SUA are interconnected, such that therapeutic attention to one almost inevitably will include some attention to the other.

Focus Initially on Stabilization and Coping

One of the ways in which trauma therapy is especially modified for those involved in SUA is in the area of stabilization; as noted earlier, many traumatized adolescents who drink excessively or use psychoactive drugs have problems with affect regulation. Further, significant SUA is often associated with a chaotic lifestyle, tumultuous relationships, involvement in other risky behaviors, and exposure to dangerous people or circumstances during the process of getting money for, acquiring, or using drugs. The combination of a reduced ability to "handle" painful emotions before they become overwhelming, and the typical sequelae of SUA, means that the substance abusing trauma survivor is often in crisis, psychologically and/or physically unsafe, and prone to "acting out" or self-harming behaviors when stressed—which may be much of the time. For this reason, effective therapy for such

clients emphasizes relationship-building, a focus on safety, and affect regulation training as described in this guide.

Importantly, although treatment ideally includes attention to both trauma and SUA issues, in many cases emotional (and sometimes life-style) stabilization is often indicated before extensive therapeutic exploration of—and exposure to—trauma memories can begin. Unfortunately, some adolescent clients will attempt to discuss trauma memories in great detail before they have developed sufficient capacity to tolerate the associated negative emotional states. The result may be overwhelming emotional states, and even greater involvement in avoidance activities. When this occurs, especially if the client is still involved in major SUA, we recommend, like Najavits (2009), that the client's trauma disclosures be acknowledged and received as important parts of treatment, but with some sort of communication that such processing will likely occur to a greater extent later in therapy, when the client is more able to accommodate it.

Communicate Empowerment, Positivity, and Hope

Before describing specific therapeutic methods that appear helpful in working with SUA-involved trauma survivors, it is important that we consider a general philosophy of intervention—one that eschews blame and punishment, and that communicates a positive view of the client and a hopeful perspective on his or her future. Such an approach reduces the likelihood that the client will feel pathologized, morally "bad," powerless, or destined to a life of minimal satisfaction or happiness. In this regard, the goals of SUA-relevant trauma therapy are not to cure a disease or punish an offender, but rather to empower the client to do what, in many cases, he or she already wants to do: recover from painful life experiences, reduce or stop serious SUA, and have the opportunity to pursue life stability and happiness.

Avoid confrontation

Although less prevalent now than in the past, it is still common to hear of the use of confrontation in the treatment of those with SUA issues. This typically involves directly and sometimes forcefully confronting the individual with his or her denial or misrepresentation of SUA and/or its impacts on the person or those around him or her. In contrast, we suggest that there is no real place for this modality in modern trauma therapy. Confrontation presents several problems, as it (1) may easily increase, not decrease the youth's defenses and

avoidance, since it can be seen as aggressive or disconfirming; (2) implies that the client is voluntarily engaging in a bad behavior that, upon being revealed for what it is, can easily be terminated; (3) is seemingly the antithesis of the support, caring, and compassion that is a core relational aspect of most trauma treatment, and (4) may adversely affect the therapeutic relationship by implying critical judgment and devaluation. Rather than using confrontation, the clinician should help the client to understand the etiology of SUA, especially as it involves posttraumatic coping, and communicate appreciation of what the client is "up against" in terms of trying to self-medicate overwhelmingly negative internal states and battling the physically addictive effects of some drugs. From this perspective, the role of the therapist is to work with, not against, the adolescent, and to help him or her to decrease or terminate SUA while, at the same time, being able to survive trauma-related distress. The result, ideally, is to collaboratively problem-solve, not to create an adversarial relationship.

Focus on empowerment

SUA can sometimes reduce the adolescent's sense of autonomy, because what he or she is facing (trauma) does not seem to get better, and some of his or her "solutions" (e.g., SUA) create problems of their own that seem unresolvable—for example addiction, exposure to violence or exploitation by others, illness, declining interpersonal and social functioning, possible arrest and incarceration, and increasingly lower self-esteem. The various components of ITCT-A, for example trigger identification, affect regulation skills development, and mindfulness training, on the other hand, focus on skills the youth can develop to increase self-control and his or her capacity to affect life outcomes. This perspective often helps the client to feel like an active participant in therapy, as opposed to a passive recipient of treatment.

An overarching philosophy of treatment—regardless of whether or not it is focused on SUA—should be that the client is an equal partner in treatment, and that one of the goals of therapy is greater self-efficacy. This perspective is often appreciated by youth who do not trust authority and expect that letting one's guard down means revictimization. Although the relational aspects of trauma therapy can help to reduce these concerns, the fact that this approach increases self-efficacy and teaches psychological skills may make it easier initially to accept by adolescents who feel alienated and distrustful of psychotherapy, per se.

Reinforce idealism and hope

As Najavits (2002, 2009) notes, treatment for the joint effects of trauma and SUA may be more effective to the extent that they are "idealistic," encouraging the young survivor to aspire to a more positive future and regain a sense of hope. Many trauma-exposed youth, perhaps especially those involved in SUA, have been demoralized. They may view themselves as unworthy and their future as essentially hopeless. To the extent that therapy reinforces the notion that the client is intrinsically good, not bad, and helps the youth to identify self-attributes like courage, concern for others, and morality, it can confer self-esteem and self-compassion that otherwise might be illusive. Sometimes this is hard; the client involved in prostitution or gang-related activity, or the adversarial dynamics sometimes found among those addicted to drugs or alcohol, may have a difficult time noticing things he or she nevertheless did that were idealistic, such as helping a friend, worrying about someone's well-being, protecting or standing up for someone, or sharing food, shelter, or advice[4]. As the notion of being a "good person" and caring for others—regardless of one's victimization history and whether one has done "bad things"—more deeply permeate the adolescent's perspective and becomes an explicit goal for the future, self-esteem and hopefulness can accrue.

Also relevant here is the notion of *posttraumatic growth*—the phenomenon whereby trauma not only confers negative states and problems, but also can make a person in some ways stronger, wiser, and more aware of what is important in life (Tedeschi & Calhoun, 2004). Many traumatized youth believe that childhood sexual or physical abuse, or peer assaults, have made them less or worse than they were before, leading to feelings of shame, implicit badness, and unacceptability. To the extent that the therapist helps the client identify ways in which he or she triumphed over victimization by, for example, gaining useful survival skills or being more able to empathize with others who have been hurt, there may be an opportunity for shame or self-invalidation to be contradicted.

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[4] *Drug sharing, which is common among SUA-involved youth, also may seem like a positive behavior from the perspective of good intentions, even though is not actually a helpful act. This issue sometimes arises when discussing idealism with SUA clients, and must be handled with care—sincerely acknowledging the intention, but discussing the inherent problems.*

Specific Clinical Activities

Presented below are a number of recommendations regarding specific interventions that may be useful in SUA-relevant trauma treatment. In many cases, they reflect specific adaptations of modules found in the ITCT-A treatment manual, which can be downloaded from the internet at attc.usc.edu.

Provide Psychoeducation

Many adolescent survivors of interpersonal violence were victimized in the context of overwhelming emotion, narrowed or dissociated attention, and, in many cases, a relatively early stage of cognitive development; all of which potentially reduced the accuracy and coherence of their understanding of these traumatic events. In addition, interpersonal violence frequently involves a more powerful figure who justifies his or her aggression by distorting objective reality, for example by blaming victimization on the victim. These fragmented, incomplete, or inaccurate explanations of traumatic events are often carried by the survivor into adolescence and beyond. As well, many youthful trauma survivors with SUA issues misperceive, misunderstand, or avoid awareness of the characteristics and actions of the drugs they use, and may not be completely aware of the toll that SUA is taking on their lives.

Therapists may be helpful in these areas by providing accurate information on the nature of interpersonal trauma and its effects, including the need to engage in SUA, and by working with the youth to integrate this new information and its implications into his or her overall perspective. For example, accurate information on the prevalence of abuse, the typical motives of perpetrators, and socially transmitted myths regarding victim complicity may lessen the client's self-blaming attributions. Explicitly nonjudgmental and "non-preachy" information on SUA may assist the youth in identifying potential downsides to chronic intoxication and the extent to which SUA may have begun to control his or her life. See Najavits [2002, 2009] for a detailed set of psychoeducational topics highly relevant to substance-using trauma survivors.

Whether it occurs in individual therapy or in a guided support group, psychoeducation sometimes includes the use of printed handouts, books, DVDs, and client-

oriented websites. These materials typically present easily understood information on topics such as the prevalence and impacts of interpersonal violence, common myths about victimization, the effects of SUA, and social resources available to the survivor (see, for example, the National Child Traumatic Stress Network [NCTSN] factsheets at: www.nctsnet.org/products).

The therapist should keep several issues in mind when deciding what written material to make available and how it should be used. These include the quality and accuracy of the materials, the reading level required, the language of the materials for those who are not fluent in English, the cultural appropriateness of the information or depictions, and the risk of insufficient cognitive-emotional integration—especially if the materials are merely handed-out without sufficient discussion or application to the client's own history or current situation.

Most importantly, handouts should be considered tools in the psychoeducation process, not stand-alone sources of information. Didactic material, in isolation, is not likely to be especially effective in changing the beliefs or behaviors of victimized individuals (Briere, 2003). Instead, the therapist should ensure that the information is as personally relevant to the youth as possible, so that whatever is contained in the handout or media is directly applicable to his or her life, and thus has greater implicit meaning.

In fact, although written psychoeducational materials can be helpful, it is often more useful for the therapist to provide such information verbally during the therapy process, where it can be discussed and personalized to the youth's specific situation. This is especially true for those who, for whatever reason, have not progressed far, or well, in the educational system and may not have sufficient reading skills. Because the information is directly imbedded in the therapeutic context, it is often more relevant to the client's experience, and thus more easily integrated into his or her understanding. Psychoeducation provided in this manner also allows the therapist more easily to monitor the client's responses to the material, and to clear up any misunderstandings that might be present.

General focus of psychoeducation

Whether through written or verbal means, clinicians often focus on several major topics when working with adolescent (and other) trauma survivors who are involved in SUA. These include:

- The prevalence of the trauma;
- Common myths associated with interpersonal victimization;
- The usual reasons why perpetrators engage in interpersonal violence (e.g., to address their own needs or as a reflection of their own inadequacies);
- Typical immediate and longer-term responses to trauma (e.g., posttraumatic stress, anxiety, depression, dissociation, intimacy issues, or significant substance use);
- Gender issues, such as sex role stereotypes and social messages about how (or whether) males and females should react to trauma, express distress, and seek assistance;
- Reframing SUA and other problematic behaviors as adaptive strategies that, nevertheless, may have serious negative repercussions;
- Negative effects of SUA, presented in manner that is not judgmental or fear-based;
- If relevant, the effects of racism, sexism, poverty, homophobia, and social marginalization as they relate to both trauma exposure and SUA; and
- Resources that might assist the trauma survivor, such as self-help groups (including, if appropriate, Narcotics Anonymous or Alcoholics Anonymous), shelters, advocacy groups, relevant religious or spiritual organizations, and supportive legal or law enforcement personnel.

Increase Metacognitive Awareness

Metacognitive awareness, one aim of Mindfulness-based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2013), can be described, in part, as the ability to discriminate between one's activated thoughts or feelings based on the past and one's accurate perceptions of the present. Although this might appear to be an esoteric notion, it can have strong relevance in work with teens struggling with SUA and/or other "acting out" behaviors. In general, metacognitive awareness involves the capacity to observe one's internal processes objectively, without becoming trapped by them—learning to identify what is true in the current environment, and what are merely thoughts and feelings associated with the past, masquerading as responses to the present.

In this regard, trauma survivors are often easily triggered into thoughts, memories, and emotions associated with previously hurtful events. When these triggered phenomena emerge into current awareness, they are often not identified as activated memory material, per se, but rather are interpreted as information about the present. For example, a traumatized youth might be triggered by minor relational conflict or unavailability in a love relationship, and subsequently experience rage or intense feelings of abandonment associated with prior childhood abuse or neglect. When these thoughts or feelings intrude into the present, they may be seen as evidence that the contemporary individual hates him or her, wants to end the relationship, or even that he or she has been correctly identified as worthless or bad. In such circumstances, the survivor may become quite reactive, and engage in behaviors that deaden the activated emotional states (e.g., SUA or dissociation) or respond with self-injury, aggression, or other "impulsive" behavior. From the client's perspective, he or she is responding to the current environment with problem-solving activities; in reality, he or she is confusing the past with the present, and engaging in contextually inappropriate (i.e., not present-centered) behavior.

In this context, metacognitive awareness would reflect the youth's growing ability to detect such triggered states as triggered states, rather than real-time responses to the present. From this perspective, even compelling thoughts and feelings can be seen as events of the mind, which may or may not be relevant to what is actually true in the here-and-now. This reduced identification with internal processes as necessarily "real" can help the adolescent manage the intensity of strong emotions by (1) identifying thoughts and feelings for what they are—transient, intrapsychic experiences, and (2) learning that he or she doesn't need to believe (or react to) everything he or she thinks or feels. In the current example, the adolescent might recognize that the boy- or girlfriend probably was not abandoning him, or viewing him as worthless, but rather only mildly annoyed—or perhaps even responding to something not related to the client at all. In this way, the youth may transition from "I am perceiving criticism and rejection" to "I am being triggered" or even "I am remembering the past, which is not actually relevant here."

The relevance of this process to SUA is significant. Extensive SUA is often engaged in to defend the survivor from triggered emotional states, typically those associated with painful memories. In many cases, however, it is not just the memory that motivates

substance use. The emergence of self-hating, fearful, or angry cognitions can seem so "real" that they drive the survivor to any source of refuge—including the numbing or distracting effects of drugs or alcohol. To the extent that learning metacognitive awareness allows the survivor to understand that he or she is not currently being abused or abandoned, and that intrusive feelings of helplessness, hopelessness, or low self-esteem may represent the triggered past, as opposed to the present, the need for SUA may decrease. In part, this represents the realization that if a given thought or feeling is actually "just" a triggered memory, then there may be little in the current situation that requires avoidance or other problem-solving behaviors. On the other hand, sometimes the youth's current environment *is* dangerous or abusive, in which case triggered responses may be more or less appropriate. Even in such instances, however, the ability to discriminate triggered thoughts from accurate real-time perceptions can increase the youth's optimal response to the immediate environment.

Two major ways in which the adolescent trauma survivor can develop metacognitive awareness are through *mindfulness training* and exposure to the ITCT-A treatment module referred to as *trigger identification and intervention* (see also Briere & Scott, 2014). Mindfulness training is increasingly used as an evidence-based intervention for children and adolescents to decrease reactivity and increase emotional stability (Broderick & Jennings, 2012; Semple & Lee, 2011). Often involving meditative practices, it cultivates metacognitive awareness as the client learns to watch his or her thoughts and feelings come and go, in an objective, noninvolved way. Over time, the youth typically comes to realize that thoughts and feelings are not always reflective of immediate reality. This insight tends to reduce reactivity, and thereby decreases the need of the survivor to engage in SUA or other avoidance activities. For example, Marsha Linehan's (1993) *Dialectical Behavior Therapy* is a treatment model in which mindfulness training and related activities have been shown to decrease involvement in a range of maladaptive behaviors, including substance abuse (Dimeff & Linehan, 2008; Robbins & Chapman, 2004).

Trigger identification and intervention is a specific module in ITCT-A, in which the youth learns to recognize when he or she has been triggered by a relational stimulus, and then practices how to interpret and manage the attendant thoughts and feelings so that they do not overwhelm and motivate SUA, "acting out," or other seemingly impulsive behaviors. In cases where, for whatever reason, use of the full ITCT-A trigger identification and

intervention module is not possible, it can be approximated in repeated, explicitly nonjudgmental conversations between the youth and the therapist about what his or her triggers are, how they have affected his or her thoughts and feelings in the past, and how associated impulses to escape (e.g., through SUA) or inappropriately engage (e.g., through aggression) can be forestalled in the future. Identification of triggers is also a specific topic in *Seeking Safety* (Najavits, 2002). Whether accomplished through therapeutic interchange, the ITCT-A module, or in psychoeducation groups, this process can be facilitated through use of the *Trigger Grid*, which is described in detail in Appendix A and can be found in Appendix B. The *Trigger Grid* is also available on the internet at attc.usc.edu.

Teach Affect Regulation Skills

As described earlier, adolescents with extended trauma exposure tend to have problems with affect regulation. Affect dysregulation often presents as a relative inability to tolerate or down-regulate aversive—often trauma-related—emotional states. When these states are triggered by stimuli in the current environment, the youth may be forced to rely on external avoidance strategies such as substance abuse, self-injury, "acting out," or dissociation, in order to reduce otherwise uncontrollable emotional distress (Briere et al., 2010). As clinicians have come to understand more clearly this process, a number of interventions have been developed. Ones we especially suggest for SUA-involved, traumatized youth, are described briefly below.

Relaxation

Relaxation training is probably one of the oldest forms of affect regulation. Relaxation can be used by the client whenever he or she feels anxiety or tension, and may decrease the likelihood that he or she will have to turn to substances when triggered. Strategically induced relaxation also can facilitate the processing of traumatic material during the therapy session by reducing the adolescent's overall level of anxiety and other potentially overwhelming trauma- related distress. There are two major forms of relaxation training: progressive relaxation and breath training.

Progressive relaxation. This technique involves tensing and then releasing muscles, sequentially, from head to toe, until the entire body becomes relaxed (Rimm & Masters,

1979). As clients practice progressive relaxation on a regular basis, most are eventually able to enter a relaxed state relatively quickly. It should be noted that, in a small number of cases, the client may experience increased anxiety during relaxation training (e.g., Young, Ruzek, & Ford, 1999). In most instances, this anxiety passes relatively quickly, especially with reassurance. When it does not, the clinician should discontinue this approach, and perhaps use the breath training method below.

Breath training. When stressed, many individuals breathe in a more shallow manner, hyperventilate, or, in some cases, temporarily stop breathing altogether. Breath training generally involves guided exercises that teach the client to be more aware of his or her breath—especially the ways in which it is inadvertently constrained by tension and adaptation to trauma—and to adjust the speed and depth of his or her breathing so that more effective and calming respiration can occur. The client is taught to breathe in and out in a measured way, typically counting to three on the in-breath and three or four on the outbreath. Although initially taught in sessions, the client is asked to practice at home and in stressful situations. Over time, he or she learns to breathe more slowly and deeply, which is associated with a calming of the autonomic (sympathetic) nervous system (Hanson, 2009). The ITCT-A treatment guide includes instructions on how to conduct breath training, adapted from Briere & Scott (2014). Alternatively, the client can employ the mindful breathing exercise described later below.

Identify and discriminate emotions

An important aspect of successful affect regulation is the ability to correctly perceive and label emotions as they are experienced (Cloitre, et al., 2002; Linehan, 1993). Some adolescent trauma survivors have trouble knowing exactly what they feel when triggered into an emotional state, beyond, perhaps, a sense of feeling "bad" or "upset." In a similar vein, some youth may not be able accurately to discriminate feelings of anger, for example, from anxiety or sadness. As a result, the client may perceive his or her internal state as consisting of chaotic, intense, but undifferentiated emotionality that is not logical or predictable. Not only may the unknown quality of these states foster a sense of helplessness, it often prevents the adolescent from making connections between current emotional distress and the environmental or historical conditions that produced it. Without such insight, the youth is

unlikely to be able to intervene in the causes of his or her distress or improve his or her situation.

The clinician may be helpful in this area by regularly facilitating exploration and discussion of the client's emotional experience. Often, the young survivor will become more able to identify feelings just by being asked about them on a regular basis. On other occasions, the therapist can encourage the client to do "emotional detective work," inviting attempts to hypothesize an emotional state based on the events surrounding it, or the bodily states associated with it. For example, the client may guess that one feeling is anxiety because it follows a frightening stimulus and another is anger because it is associated with resentful cognitions or aggressive behaviors. In general, it is recommended that the therapist facilitate the client's exploration and hypothesis testing of his or her feeling state, rather than telling the client what he or she is feeling. The critical issue here is not usually whether the client (or therapist) correctly identifies a particular emotional state, but rather that the client explores and attempts to label his or her feelings on a regular basis. Typically, the more this is done as a general part of therapy, the more skillful the adolescent survivor may become at accurate feeling identification and discrimination.

Identify and counter thoughts that underlie negative emotional states

Not only should the client's feelings be monitored and identified, the same is true for his or her thoughts. Affect regulation capacities often can be improved by encouraging the client to identify and counter the cognitions that exacerbate or trigger trauma-related emotions (Linehan, 1993). This typically involves the survivor learning how to identify whatever thoughts mediate between a triggered traumatic memory and a subsequent negative emotional reaction. For example, an adolescent survivor of sexual abuse might think, "he wants to have sex with me" when interacting with older men, and then experience revulsion, rage, or terror. In such cases, although the memory itself is likely to produce negative emotionality, the associated cognitions often exacerbate this response to produce more extreme emotional states and a greater need for dysfunctional coping such as SUA.

As the client is made more aware of the cognitive antecedents to overwhelming emotionality, he or she can learn to lessen the impact of such thoughts. In many cases, this is done by the client explicitly disagreeing with the cognition (e.g., "nobody's out to get me" or "I can handle this"), or by repeatedly labeling such cognitions as "old movies" rather than

accurate perceptions. In this regard, one of the benefits of what is referred to as *insight* in psychodynamic therapy is often the self-developed realization that one is acting in a certain way by virtue of erroneous, "old" (e.g., trauma- or abuse-related) beliefs or perceptions. This metacognitive understanding may reduce the power of those cognitions to produce distress or motivate problematic behavior in the present.

The identification of catastrophizing cognitions is often best facilitated when the exploration is done primarily by the adolescent, with nonjudgmental, guiding support by the therapist as needed. As the client learns to identify these thoughts, place them in some realistic context, and view them as remnants of the past (rather than being data about the present or future), he or she is indirectly developing the capacity to intervene in extreme emotional reactivity, thereby better regulating his or her emotional experience and reducing the need for dysfunctional avoidance.

Encourage resistance to avoidance behaviors

Another way in which affect regulation skills can be learned is by the adolescent intentionally forestalling avoidance behaviors like SUA when the impulse to engage in them emerges. In general, this involves encouraging the client to "hold off," as long as possible, on engaging in behaviors such as drinking, drugging, self-injury, or impulsive sexual behavior that he or she might normally use to down-regulate triggered distress, and then, if the behavior must be engaged in, doing so to the minimal extent possible. It is often helpful to remind the youth that the intense emotionality behind the impulse to engage in SUA or other avoidance behaviors is often quite short-lived, in many cases lasting only for seconds or minutes, and thus merely "waiting as long as you can" may eliminate the need to engage in the tension-reducing behavior at all.

Because SUA and other avoidance responses serve to reduce distress, client attempts to delay their use provide an opportunity to develop a small amount of affect tolerance, as well as a growing awareness that the distress that would otherwise trigger SUA is actually bearable when experienced without behavioral avoidance. With continued practice, the period between the initial urge to drink or use drugs and the actual onset of SUA may be lengthened, the SUA may be decreased in severity, and affect tolerance may be increased. Importantly, the goal of decreasing (and then ending) SUA and other dysfunctional coping is seen as not stopping "bad" behavior, per se, but rather as a way for the client to learn affect

regulation and to get his or her behavior under greater personal control.

Cultivate Mindfulness

Mindfulness has been described as "paying attention, in a particular way, on purpose, in the present moment, and intentionally (Kabat-Zinn, 1994, p. 4). Attention is a defining characteristic of mindfulness, generally focused on ongoing awareness of thoughts, emotions, and sensory perceptions. Because mindfulness training teaches the client how to attend to the here-and-now, as opposed to inordinately focusing on upsetting memories of the past or worries about the future, it may reduce the anxiety and dysphoria known to motivate SUA. Further, as described earlier, metacognitive awareness typically arises from regular mindfulness meditation, thereby reducing the client's reactivity to otherwise upsetting thoughts and memories.

Although extensive mindfulness training should be provided by therapists experienced in meditation and trained in mindfulness teaching (Briere, 2013; Semple & Lee, 2011), simple mindful awareness activities—for example, the one described below—can be taught by a therapist with only minimal training, for example, having attended a meditation class and having his or her own meditation practice.

Assuming that there are no contraindications, and that the youth has a safe, stable environment within which to practice, the most basic steps of a breath mediation, which can be presented to the adolescent, are as follows (paraphrase as needed):

1. Find a quiet, safe place where you can be alone without interruption for at least 10 minutes or longer[5]. If there is danger where you live, do not meditate there. Try to use this same place every time you meditate. If you can, try to do this exercise at the same time every day.
2. Sit in a chair, or on the floor, with your back straight and your hands in your lap. You can lie down, if you wish, but this may make you sleepier and make it harder

[5] *Some readers may question such a short meditation period. However, many young SUA-involved trauma survivors have difficulty maintaining attention for the 20-30 minutes often suggested for adults. As the adolescent gains greater meditational capacity, he or she may be able to accomplish longer periods.*

to concentrate.

3. If you can, close your eyes, or at least lower your eyelids a bit. If this makes you anxious, it is fine to leave them open.
4. Focus your attention on your breathing and only on your breathing: feel the air going into your lungs, notice the pause between breaths, and then feel the air going out.
5. When your mind wants to think about other things, just remind yourself to go back to your breathing—watching and feeling the breath go in and out. People usually have a hard time just paying attention to their breathing. The mind wanders. That's okay. It's just what minds do. You don't need to criticize yourself when this happens, just notice the thoughts, and then go back to watching and feeling yourself breathe in and out. Let your thoughts and feelings come and go. You don't need to believe that your thoughts are important, or even true. They are neither good nor bad, right nor wrong—they are just thoughts and feelings that come and go. Notice them, and then go back to paying attention to your breath.
6. Try to do this for at least 10 minutes a day, every day, if you can. You can keep a clock or watch next to you to keep track of the time, but try not to look at the time too often. If it has been less than 10 minutes, just go back to paying attention to your breath. Eventually, you may want to spend more than 10 minutes mediating, or to meditate more often. It is up to you.

Although the instruction usually is for the adolescent to practice this exercise at home, it is also helpful for the client to meditate with the clinician in the first 10 minutes of each session, at least for the first few weeks, so that the therapist can monitor the client's progress and answer relevant questions. This should be done without the clinician "staring" at the client. Ideally, the therapist will meditate, or at least close his or her eyes, while the client is meditating. In addition, in-session meditation may be practiced when the client becomes anxious during treatment—both to deescalate that state, and to teach its use during anxious moments. Once the youth has learned basic mindfulness skills, he or she can be encouraged to incorporate mindfulness into his or her everyday life in less structured ways as

well, for example, by practicing mindful (here-and-now) awareness while brushing his or her teeth, eating meals, listening to music, or walking to school. Learning to refocus attention in this way also can function as a basic relaxation technique and may help the youth moderate emotional distress or physiological hyperarousal.

Urge surfing

A mindfulness technique specifically developed for those involved in SUA is *urge surfing*. A component of Mindfulness-based Relapse Prevention (MBRP; Marlatt & Gordon, 1985; Bowen, Chawla, & Marlatt, 2011), this approach teaches the SUA-involved client to apply mindfulness skills to sudden, often trauma-related cravings or urges to engage in substance abuse or other avoidance behaviors. The survivor is encouraged to see the need to drink or use drugs as similar to riding a wave: the need starts small, builds in size, peaks (often at around 10-20 minutes), and then falls away. If the client can view triggered feelings as temporary intrusions of the mind that can be ridden like a surfboard—neither fought against nor acted upon—he or she may be able to avoid problematic or self-destructive behavior, whether taking a drink, using a drug, or engaging in self-mutilation. For example, if the survivor can say to himself or herself, "this is just a thought" or "this is just an urge," as opposed to "this is my addiction, it's always here, making me use again," the thought or urge may be viewed more objectively with less sense of the inevitability of a SUA episode. In addition, knowing that many urges to engage in SUA are time-limited may provide the survivor with greater hopefulness that delaying SUA (as described earlier) may result in a positive outcome.

Titrate Exposure to Trauma Memories

When the client with SUA issues is sufficiently stable, some level of emotional processing of trauma memories should be initiated. However, the sometimes limited affect regulation capacities and ongoing challenging circumstances experienced by young trauma survivors means that therapeutic exploration of memories, which usually involves detailed discussion of traumatic events, must be carefully controlled.

Typically, therapeutic interventions that allow the client to process painful memories are subsumed under the category of *therapeutic exposure*. This term refers to activities wherein the client is exposed during therapy to memories of a traumatic event, typically by

talking about adverse experiences in a relatively detailed way, and then the emotional responses that emerge are desensitized or habituated over time, in the context of a safe environment. A specific type of therapeutic exposure, *titrated exposure*, which we especially advocate for SUA-involved trauma survivors, can be defined as therapeutic exposure that is controlled so that the activated emotions do not exceed the client's affect regulation capacity, and thus do not overwhelm the trauma survivor[6].

The therapeutic window

The therapeutic window represents the psychological midpoint between inadequate and overwhelming exposure to trauma-related emotions during treatment. It is a hypothetical "place" where emotional processing of memories is thought to be most helpful (Briere & Scott, 2014). Memories processed within the therapeutic window are not so trivial or non-evocative that they provide inadequate memory exposure, nor so intense that they become overwhelming. In other words, interventions that consider the therapeutic window are those that trigger trauma memories and promote processing, but do not overwhelm internal protective systems and motivate unwanted avoidance responses. Given the affect regulation problems of many traumatized adolescents—especially those with SUA—the therapeutic window can be an important aspect of therapeutic memory processing.

Interventions that undershoot the therapeutic window are those that consistently avoid traumatic material, or are focused only on support and validation with a client who could, in fact, tolerate greater exposure and processing. Undershooting is rarely dangerous. It can waste time and resources, however, when more effective therapeutic interventions would be possible. Overshooting the window, on the other hand, occurs when the clinician either (1) inadvertently provides too much therapeutic exposure (e.g., asks the client to discuss memories that he or she may not be ready to confront) and, therefore, triggers too much emotional activation relative to the client's existing affect regulation resources, or (2) is unable to prevent the client from flooding himself or herself with overwhelming traumatic memories. Interventions that are paced too quickly may overshoot the window because they do not allow the adolescent to adequately accommodate and desensitize previously activated

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[6] *Titrated exposure is broadly similar to the "gradual exposure techniques" advocated by Cohen et al. (2003) in their helpful review of cognitive-behavioral approaches to SUA-affected traumatized youth.*

material before triggering new memories.

When therapy consistently overshoots the window, the trauma survivor must engage in avoidance maneuvers in order to keep from being overwhelmed by the therapy process. Most often, the youth will increase his or her level of dissociation (e.g., through disengagement or "spacing out") or cognitive avoidance during the session, or may interrupt the focus or pace of therapy with arguments, "not get" obvious therapeutic points, distract the therapist with various dramatic, sexualized, or aggressive behaviors, or change the subject to something less threatening. In the worst case, he or she may drop out of treatment, and/or increase SUA as a way to numb newly-activated posttraumatic distress. Although the clinician may interpret these various behaviors as "resistance," such avoidance activities often represent appropriate protective responses to what are, in effect, therapist process errors. Therapeutic window concerns are especially heightened for traumatized youth involved in SUA, who, by definition, are likely to have particularly severe affect regulation problems.

In contrast, effective therapy for traumatized adolescents provides careful discussions of traumatic material, while maintaining the pace, safety, and support necessary eventually to extinguish trauma-related emotional responses. By carefully adjusting the extent and intensity to which a given trauma or set of traumas is explored in treatment, so that the associated emotional activation does not exceed the survivor's emotional capacities, interventions within the therapeutic window allow the client to slowly process trauma memories without negative effects.

For the reasons outlined above, the dictum "start low, go slow" is particularly applicable to therapeutic exposure with substance-using clients. In general, we advise that clients with both trauma and SUA issues be encouraged to discuss their victimization histories in small "chunks," at their own pace, and that the clinician strive to ensure that the client's therapeutic window is not exceeded. Specifically, the clinician needs to remain emotionally attuned to the client so that any evidence of overwhelming internal states can be addressed by reduced exposure, affect regulation activities, or a switch to more cognitively-focused material. This is not to say that emotional processing should not occur. When the client is ready, it is a very important component of trauma therapy. The issue is, instead, the timing, pace, and intensity of that work.

Consider Group Interventions

Group therapy is a common modality in the treatment of SUA-affected youth. Because it calls on the experiences and responses of other group members, group treatment has multiple advantages relative to individual therapy alone. These include reduced isolation and stigmatization, normalization of material previously viewed as shameful, the development of interpersonal trust, and identification within a supportive network of other, similarly traumatized or maltreated individuals. More broadly, group therapy is an opportunity to employ peer support and interactions to help build self-esteem, enhance relationship skills, reinforce interpersonal boundaries, and teach positive coping strategies in the context of connection and structure. Group sessions for SUA-involved youth may or may not be structured according to the traumatic experiences of the group members (sexual abuse, domestic violence, etc.), but, in any event, almost always include cognitive and emotional exploration of the trauma, psychoeducation, and discussion of substance use and its relation to adverse experiences, as well as methods of avoiding SUA, including trigger identification, urge surfing, and delaying tension reduction, as described earlier. The clinician also may choose to introduce discussion topics described in *Seeking Safety* (Najavits, 2002) that directly engage the survivor in exploration of SUA issues.

In some cases, group work may allow the client to process material that would be more challenging in individual therapy. For example, youth with authority or attachment issues may not be amenable to exploring serious trauma issues in one-to-one therapy, and yet may be relatively open and receptive to such work in a group setting.

Despite these benefits, group treatment also can trigger negative emotional states associated with prior trauma or abuse. As noted earlier, some SUA-involved adolescents suffer from relatively intense symptomatology, including posttraumatic stress and painful relational memories. Especially activating for some may be descriptions by group members of traumatic events that prematurely expose the client to his or her own unprocessed memories before having sufficient affect regulation capacities to handle such material. For this reason, it is important that the SUA-involved youth be screened beforehand to determine whether he or she is appropriate for any given group or, in some cases, for group therapy at all. Guidelines for the selection of group members, based on gender, age, level of trauma, current emotional stability, and affect regulation capacity can be found in the ITCT-

A treatment guide.

We also recommend that any SUA-involved adolescent attending group therapy also have a separate, individual psychotherapist, ideally one with whom he or she has already made good progress. The inherent structure of the typical group therapy setting precludes much individualized attention from group therapists—because they must attend to the entire group, they are less available for instances where the client is significantly triggered by group interactions or discussion of potentially upsetting material. An individual therapist, on the other hand, can offer not only support and validation, but also the opportunity to more fully debrief, process, and integrate material that arose during group sessions.

Include Caretakers or Families in Treatment

In general, we suggest that the therapist consider family and/or caretaker-related factors that contribute to the youth's traumatic experiences and, in many cases, his or her SUA. It may be helpful to enlist the participation of caretakers in collateral or family therapy sessions to enhance the youth's recovery from trauma, increase safety, and foster future adaptive functioning. This is especially true for those youths who are still living with—or are otherwise still emotionally impacted by—their caretakers and families. In other cases, of course, the youth may be estranged from caretakers and family, either because of their maltreatment of him or her, or because he or she has "burned his/her bridges" to them through problematic or destructive behavior. Even in such cases, however, it is rare that the youth has no connection whatsoever with family members or is not at all preoccupied with them.

The ITCT-A treatment guide recommends specific evaluation of caretaker and family issues that may have contributed to the adolescent's prior trauma and/or his or her SUA. Traumatic experiences may include caretaker substance abuse, caretaker abuse or neglect, attachment disruption, and witnessing caretaker domestic violence. When non-offending caretakers and/or family members are amenable to participation in therapy, such interventions may be quite helpful in the youth's treatment. It is common for caretakers of maltreated youth also to have their own trauma history. In addition, there may be a multi-generational history of substance abuse. Once these dynamics are evaluated and understood by the therapist, systemic issues can be approached in a manner more conducive to the

youth's own therapy, including sessions with a primary caretaker and, in some cases, subsequent family therapy. Specific modules for trauma-relevant family and caretaker intervention are provided in Briere and Lanktree (2012, 2013). Even if a supportive (or even potentially supportive) caretaker is not available, it still may be helpful for the youth to consider his or her family history, systemic and multigenerational dynamics, and family-related traumatic experiences as they potentially contribute to his or her ongoing distress and SUA.

Expect and Manage Countertransference

A final issue associated with working with youth who have trauma histories and SUA has to do with the clinician. For any therapist, exposure to the stories and pain presented by trauma survivors can be challenging. Repeatedly being faced with the cruelty people can do to one another, let alone to children, understandably can produce strong reactions. This is especially the case if the clinician, him- or herself, has an unresolved trauma history.

Unfortunately, abused adolescents with SUA are sometimes even more likely to activate strong emotional states in the therapist. Among the issues that may arise is a sense of helplessness. SUA is not an easily treated problem, and the client's struggle with drugs or alcohol may continue into the longer-term. SUA may wax and wane over time, and may frustrate both client and therapist as it interferes with trauma therapy and leads to unwanted outcomes. Or, the client may develop several months of sobriety, only to relapse for reasons that may or may not be apparent. The guilt, shame, and low self-esteem often associated with SUA, let alone trauma, may be "contagious," as the therapist's attunement inadvertently can lead him or her to blame the client for SUA or SUA relapses. Feelings of helplessness may lead to frustration with, or anger at, the client. The clinician may also retreat to an overly authoritarian or pathologizing stance in an effort to maintain control or avoid distress.

Reactions such as these must be monitored by the therapist. Although strong countertransference in this area should be addressed by formal consultation and/or one's own therapy (Dalenberg, 2000), it is nevertheless true that some feelings of helplessness, hopelessness, sadness, and frustration are almost inevitable when treating traumatized, substance abusing youth on a regular basis. For this reason, it is very important that the therapist have others to turn to when working with trauma/SUA clients. In general, we

suggest regular supervision (especially in the case of trainees and beginning therapists), a consultation group, or even just an informed, supportive colleague with whom the clinician can share the load of this very important work.

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Appendices

Appendix A: Using the Trigger Grid with SUA-Involved Youth

(adapted for SUA clients from Briere & Lanktree, 2013a)

The Trigger Grid (TG; see Appendix B, also downloadable from the internet at attc.usc.edu) is a clinical tool completed by the client and clinician together, often with the client answering the questions and the therapist writing them down in the grid. Although the first use of the TG is usually early in discussions of triggered SUA or other dysfunctional coping responses, it can be updated on a regular basis, either at scheduled times or in sessions following a notable instance of SUA or other maladaptive behavior. Importantly, ongoing additions to the TG should be done in a nonjudgmental way, generally communicating that it is hard to stop or reduce SUA, and that "slips" or continued substance use can be used to further explore and problem-solve the triggering-SUA process. The goal of the TG exercise is for the client to:

- learn about triggers, including their "unreal" (i.e., non-here-and-now) and yet understandable historical nature;
- identify specific instances during which he or she has been triggered;
- determine, based on these times;
    - what seem to be the major triggers in his or her life
    - how to identify when he or she is being triggered
    - how some triggers might be avoided
- problem-solve strategies that might be effective once triggering has occurred.

In response to the TG, clients typically identify a number of trauma-related triggers, including, for example:

- interpersonal conflicts
- sexual situations or stimuli
- angry people
- intoxicated people
- perceived narcissism in another
- seemingly arbitrary criticism or accusations

- loss, abandonment, or rejection
- negative interactions with an authority figure
- people with physical or psychological characteristics that are in some way similar to the client's past perpetrator(s)
- boundary violations

One of the more challenging parts of the TG for the adolescent trauma survivor is the question, *"How do I know I've been triggered?"* Some answers are relatively easy; for example, it may not be difficult to recognize an intrusive sensory flashback of a gunshot as posttraumatic. More commonly, however, the reexperiencing is more subtle, such as feelings of anger or fear, sudden shame, or intrusive thoughts of helplessness that emerge "out of nowhere" during an interpersonal interaction. Among the qualities of triggered as opposed to contemporary ("real") responses are:

- a thought, feeling, or body sensation that doesn't fully "make sense" in terms of what is happening around the survivor;
- thoughts or feelings that are too intense, based on the current context;
- thoughts or feelings especially characterized by guilt or shame;
- an unexpected alteration in awareness (e.g., depersonalization or derealization) as these thoughts, feelings, or body sensations occur;
- physical reactivity such as one's heart "pounding," shortness of breath, suddenly feeling hot or blushing, prickly sensations on the back of the neck, sweaty palms, dry mouth, a sudden headache, upset stomach, etc.; and
- a situation in which the adolescent often gets triggered

The TG section on "*what happens after I get triggered?*" provides an opportunity for the client to explore the thoughts, feelings, and behaviors associated with each major trigger, so that triggering becomes more obvious to him or her, and his or her responses to the trigger are better understood as reactions to the past, not the present. This exercise may help the client to discriminate triggered states from "real" (i.e., here-and-now) ones, and thus have less reactivity to them.

The final question on the TG is "*What I could do or say to myself so that I wouldn't get*

triggered, or for the trigger to be less bad?" which is responded to for each of the major triggers that the client has identified earlier. Among possible answers to this section, are

- changing the scenario or using "time-outs" during especially stressful moments (e.g., terminating an argument or other intense situation before it escalates [in the words of one client, "just walk away"]);
- avoiding situations or locations where the client has engaged in SUA in the past, or where others are currently using drugs or alcohol;
- analyzing the triggering stimulus or situation until a greater understanding changes one's perception and thus terminates the trigger;
    - recognizing that a situation or event is likely to trigger upsetting material, and considering subsequent feelings or thoughts in that light;
    - carefully and intentionally examining the behavior of an individual who is triggering angry feelings, and considering whether there is actual support for the idea that he or she behaving in an abusive or rejecting manner; or
    - assessing one's internal state to determine whether triggering is occurring, and, if so, using that information to question the here-and-now validity of one's subsequent impulses)
- Reminding oneself that SUA, upon being triggered, often makes things worse by intensifying emotions or increasing impulsivity
- Increasing support systems (e.g., calling or texting a friend or 12-step sponsor when triggered or about to be triggered, with the explicit intent to prevent or deescalate triggered states[7])
- Positive self-talk (e.g., working out beforehand what to say to oneself when triggered), such as:
    - This is just my past talking, this isn't really what I think it is
    - I don't have to [drink/get high], I can ride this out
    - This won't last

[7] *This option is obviously only available to those owning a cell phone. However, such phones are relatively common even among economically impoverished youth.*

    - I don't have to stay here and put up with this. I can just walk away
    - This feels bad, but I know it will go away, or
    - I'm just being triggered. I can handle this
- Relaxation-induction or breathing exercise
- Remembering the lessons of meditation and mindfulness, for example
    - the trigger and subsequent thoughts are "just" replayed memory and "only" reactions to that memory – not things that necessarily have relevance to the youth's current, real-time experience
    - triggered urges to engage in SUA are almost always time limited, and can be "surfed" (experienced with some degree of detachment) until they fade
    - the longer one does not act on an impulse, the more likely it can be avoided entirely
- Strategic distraction, such as starting a conversation with a safe person, reading a book, or exercising or going for a walk, as a way to pull attention away from escalating internal responses

As the adolescent or young adult becomes more conversant with triggers and their associated feelings and behaviors, triggered states can be more recognizable as such—as replayed "movies" or ancient computer programs rather than perceptions of the contemporary "real" world. This increased distance from the triggered experience often serves to reduce the power of the feeling and lessen the likelihood that problematic behaviors will emerge. Further, by working out strategies with the therapist beforehand, the triggered survivor less often has to figure out what to do after encountering a trigger—instead he or she can call on the fruits of previous problem-solving and, hopefully, respond in a more effective and self-protective manner. As is often suggested to the survivor, the best time to figure out what to do about being triggered is rarely immediately after one has been triggered.

Although the TG remains in the client's chart, some adolescents find it helpful to create and write down their own list of triggers—and what they can do when triggered—on a separate piece of paper, or in a journal. This list of triggers and responses can then be kept by the client and referred to when appropriate.

Source: From Appendix VI of J. Briere and C. Lanktree (2011), *Treating Complex Trauma in Adolescents and Young Adults*. Thousand Oaks, CA: SAGE Publications.

What Triggers Me? (The Trigger Grid)

What Is a Trigger?

_____

_____

_____

Times I Have Been Triggered

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

7. _____
8. _____
9. _____
10. _____

What Kinds of Things Trigger Me? (What Are My Triggers?)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

What Happened After I Got Triggered? **What Triggers Me?**

Trigger #	*What I Thought After This Trigger*	*What I Felt After This Trigger*	*What I Did After This Trigger*
1			
2			
3			

Trigger #	*What I Thought After This Trigger*	*What I Felt After This Trigger*	*What I Did After This Trigger*
4			
5			
6			

Trigger #	*What I Thought After This Trigger*	*What I Felt After This Trigger*	*What I Did After This Trigger*
7			
8			
9			

Trigger #	*What I Thought After This Trigger*	*What I Felt After This Trigger*	*What I Did After This Trigger*
10			

How I Know I've Been Triggered

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

What I Could Do So That I Wouldn't Get Triggered

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

4. _____

_____

_____

5. _____

_____

_____

6. _____

_____

_____

7. _____

_____

_____

8. _____

_____

_____

What I Could Do After I Get Triggered That Would Make It Better and I Wouldn't Get So Upset or Mad

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

4. _____

_____

_____

5. _____

_____

_____

6. _____

_____

_____