USC University of Southern California

Adolescent Trauma Training Center

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A) Treatment Guide 2nd Edition

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Table of Contents

Introduction to the 2nd Edition

This treatment guide, now in its second edition, has been developed to assist clinicians in the evaluation and treatment of adolescents who have experienced multiple forms of psychological trauma, often in the context of negative living conditions such as poverty, deprivation, and social discrimination. The intervention described in this guide, Integrative Treatment of Complex Trauma for Adolescents (ITCT-A), is being adopted by a growing number of treatment centers for adolescent trauma survivors in the United States and beyond. Additional copies of the ITCT-A treatment guide and associated materials can be downloaded from the internet: attc.usc.edu.

Background

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 increase the likelihood of trauma exposure and may intensify the effects of such victimization (e.g., Breslau, Wilcox, Storr, Lucia, & Anthony, 2004; Chen, Keith, Airriess, Wei & Leong, 2007). Equally important, such marginalization typically means that traumatized youth have less access to appropriate mental health services (e.g., McKay, Lynn, & Bannon, 2005; Perez & Fortuna, 2005; Rayburn, et al., 2005). It is a general finding of the clinical literature that people with lesser social status are more likely than others to be victimized. Among the traumas common among those with lower socioeconomic status are child abuse, sexual and physical assaults by peers, gang or community violence, "drive-by" shootings, robbery, sexual exploitation through prostitution, trauma associated with refugee status, witnessing domestic violence, and loss associated with the murder of a family member or friend (e.g., Berthold, 2000; Breslau, 1991; Farley, 2003; Giaconia et al.,1995; MacBeth, Sugar, & Pataki, 2009; Schwab-Stone, et al., 1995; Singer, Anglin, Song, & Lunghofer, 1995).

When an individual has experienced multiple, severe forms of trauma, the psychological results are often multiple and severe as well; a phenomenon sometimes referred to as complex posttraumatic disturbance. Complex trauma can be defined as a combination of early and late-onset, multiple, and sometimes highly invasive traumatic events, usually of

an ongoing, interpersonal nature. In most cases, such trauma includes exposure to repetitive childhood sexual, physical, and/or psychological abuse, often (although not always) in the context of concomitant emotional neglect and harmful social environments (Briere & Scott, 2012; Cook, et al., 2005). As described in Chapter 1, the impacts of complex trauma include anxiety and depression; dissociation; relational, identity, and affect regulation disturbance; cognitive distortions; somatization; "externalizing" behaviors such as self-mutilation, dysfunctional sexual behavior, and violence; substance abuse; eating disorders; susceptibility to revictimization; and traumatic bereavement associated with loss of family members and other significant attachment figures.

Although complex trauma and its effects are quite prevalent in mental health populations, especially in socially deprived or marginalized populations, there are few empirically informed treatments for children and adolescents in this area. Part of this lack may be due to the challenging nature of the problem; the range of these impacts often requires a multimodal, multicomponent treatment strategy. Treatment approaches that are limited to a single modality (e.g., exposure therapy, cognitive therapy, or psychiatric medication) may sometimes be less helpful—perhaps especially, as noted above, if the intervention is not adapted to the specific psychological needs and cultural matrix of the client.

The MCAVIC-USC and USC-ATTC programs

The first edition of this treatment guide was developed from 2005 to 2008 by the Miller Children's Abuse and Violence Intervention Center (MCAVIC), an outpatient, multidisciplinary assessment and treatment center at Miller Children's Hospital in Long Beach, California, and the University of Southern California (USC) Psychological Trauma Program in Los Angeles, California. These centers came together in a joint project, the MCAVIC-USC Child and Adolescent Trauma Program, which was funded in 2005 by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a Category II (Treatment and Service Adaptation) Center of the National Child Traumatic Stress Network (NCTSN). This project continued until it lost funding in 2009, after which time the Center was forced to close, and USC's relationship with Miller Children's Hospital ended.

However, the ITCT-A treatment guide was further revised and updated from 2008 to 2011 (e.g., Briere & Lanktree, 2011; `Lanktree & Briere, 2013) based on community and

clinician feedback, and further developments in the field. In 2012, a new entity, the USC Adolescent Trauma Training Center (USC-ATTC) was funded by SAMHSA as a Category II center of the NCTSN. This project supported, among other activities and products, this final revision (2nd Edition) of the treatment guide, which is currently subject to nationwide dissemination.

Overview of Integrative Treatment of Complex Trauma

ITCT child version

ITCT was first developed for children by MCAVIC between 2001 and 2005, as part of its Category III funding by SAMHSA. Later named Integrative Treatment for Complex Trauma for Children (ITCT-C; Lanktree & Briere, 2008), this treatment model was developed and adapted to assist culturally diverse children, many of whom were also coping with stress associated with immigration (from Mexico, Central America, Pacific Islands, and Southeast Asia) and separation from primary caretakers who remained in their country of origin. ITCT-C (as well as ITCT-A) especially stresses multidimensional/complex trauma reactions and comorbidities, and additional stressors such as diminished socioeconomic resources, racial discrimination, and unsafe communities. It has been adapted for use in urban schools in economically impoverished areas, including alternative (e.g., "storefront") settings. ITCT-C can be used in a wide range of contexts, including outpatient and child trauma clinics, hospital units, residential treatment settings, regular school environments, and inner-city alternative education schools. Identified by the Complex Trauma Working Group of the NCTSN as one of the eight "promising practices" in 2004, ITCT-C has been associated with significant symptom reduction in studies of children and adolescents in clinic and school-based contexts (e.g., Lanktree, Briere, Godbout, Hodges, Chen, Trimm, Adams, Maida, & Freed, 2012).

ITCT adolescent version

Upon MCAVIC's collaboration with USC in 2005, the child version was adapted and expanded into a version for adolescents, ITCT-A, specifically incorporating the Self-Trauma Model (Briere, 2002). Core components of the adolescent adaptation of ITCT include:

- Assessment-driven treatment, with measures and/or interviews administered at 2 to 4 (typically 3) month intervals to identify symptoms requiring special clinical attention.
- Attention to complex trauma issues, including posttraumatic stress, attachment disturbance, behavioral and affect dysregulation, interpersonal difficulties, and identity-related issues.
- Use of multiple treatment modalities, potentially including cognitive therapy, exposure therapy, mindfulness/meditation training, and relational treatment, in individual and group therapy, based on the youth's specific presenting issues. Primary caretakers also participate in collateral sessions, as necessary, to help resolve their own traumatic reactions and to improve their parenting skills. Family therapy sessions are also frequently included.
- Development of a positive working relationship with the therapist; which is deemed crucial to the success of therapy.
- Relational processing of early attachment schema and current interpersonal expectations, including rejection sensitivity and abandonment concerns, issues with authority figures, and expectations of loss or maltreatment in current relationships.
- Cultural and developmental adaptations for individual client needs and cultural sensitivity to the form and meaning of trauma symptoms within different belief systems.
- Early attention to immediate trauma-related issues such as acute stress disorder, anxiety, depression, and posttraumatic stress, in order to increase the capacity of the client to explore more chronic and complex trauma issues. In some clients, this may include the use of psychiatric medication.
- Skills development, both in terms of building emotional regulation and problem-solving capacities.
- Therapeutic exposure and exploration of trauma, within a developmentally-appropriate and safe context, balanced with attention to the client's existing affect regulation capacities.
- Advocacy and interventions at the system level (e.g., family, forensic/protection,

and school) to establish healthier functioning and to address safety concerns.

- A flexible time-frame for treatment, since the multi-problem nature of complex trauma sometimes precludes short-term therapy.

Because this is a multi-modal, comprehensive treatment model that takes into account a range of psychological, social, and cultural issues, its effectiveness rests on the therapist's previous training, skill, sensitivity, creativity, and openness to the client. Although specific interventions and activities are described, this is not a structured, "how-to" manual. Instead, this guide offers a semi-structured approach that can be adapted on a case-by-case basis by the therapist to meet the youth's specific developmental level, psychological functioning, and cultural/ethnic background.

Positive outcome data regarding the effectiveness of ITCT-A with multiply traumatized youth can be found in Lanktree, Godbout, and Briere (2011).

Help with this treatment guide

The first edition of the ITCT-A treatment guide included the contributions of MCAVIC clinical staff Barbara Adams, Psy.D., Lorraine Al-Jamie, MFT, Karianne Chen, M.S., MFT, Nicole Farrell, MSW, Susy Flores, M.S., Sara Hernandez, Psy.D., Jeff McFarland, M.S., Andrea Sward, M.A., and Kathleen Watkins, Ph.D.; program evaluator and consultant Carl Maida, Ph.D.; USC Psychological Trauma Program psychiatrist Wendy Freed, M.D. and postdoctoral fellow Monica Hodges, Ph.D.; and data entry specialist Laurie Trimm, B.S.

The second edition of this guide includes significant contributions by USC-ATTC Psychologist Randye J. Semple, Ph.D., who added material on mindfulness procedures for traumatized adolescents, and helped to update, edit, and reformat the overall treatment guide. USC-ATTC Training Coordinator Karianne Chen, M.S., MFT, provided extensive editorial support, and Program Evaluator Carl Maida, Ph.D., helped develop the training feedback systems that inform ongoing revisions of ITCT-A. Former MCAVIC-USC postdoctoral fellow Natacha Godbout, Ph.D. contributed to the research underlying this model.

Chapter 1: Problems and Symptoms

This chapter provides a brief overview of the social context and psychological outcomes often associated with complex trauma in adolescents. It is important to stress at the outset that most traumatized youth will not experience all of the difficulties described below. Some, nevertheless, will encounter a significant number of these. Detailed discussions of the psychosocial contexts and effects of complex trauma relevant to adolescents and others can be found in Briere and Spinazzola (2009), Cook, et al. (2005), Courtois and Ford, (2009), and Ford and Courtois (2013).

Immediate Issues

Although many of the effects of trauma exposure are chronic in nature, and may not require rapid intervention, others are more severe, and may endanger the client's immediate wellbeing, if not his or her life. Some of these issues have to do with the adolescent's environment; his or her victimization may be ongoing, as opposed to solely in the past, and his or her social context may continue to be invalidating, if not dangerous. Other issues may reflect the impact of trauma on the adolescent's personality, internal experience, and relationships with others: he or she may be suicidal, involved in maladaptive substance use, or engaging in other forms of risky behavior.

Environmental risks

When complex trauma occurs within the context of socioeconomic deprivation or social marginalization, it is unlikely that conditions will have substantially changed at the time of therapy. The adolescent who was abused in the context of caretaker neglect or nonsupport, or who was assaulted as a result of community violence or gang activity, and who lives with poverty, poor nutrition, inadequate schools, social discrimination, and/or hard-to-access medical and psychological resources, is often struggling not only with a trauma history and social deprivation, but also the likelihood of additional trauma in the future. The fact that negative economic and social conditions increase the risk of interpersonal victimization has direct implications for treatment: as will be discussed later in this guide, optimal assistance to multiply abused or traumatized adolescent often require not only effective

therapy, but also advocacy and systems interventions (e.g., Saxe, Ellis, & Kaplow, 2007).

The traumatized adolescent's environment may be noteworthy for not only social marginalization or deprivation, but also for the continued presence of those involved in his or her victimization (Briere, 1996). If the client was sexually or physically victimized by an adult or peer, there is often little reason to assume that the danger from such individuals has passed. Hate crimes such as assaults on minorities, the homeless, and gay, lesbian, or transgendered youth are unlikely to stop merely because law enforcement has been notified. As is true for adverse social conditions, the continued presence of perpetrators in the adolescent's environment may require the clinician to do more than render treatment—ultimately, the primary concern is the client's immediate safety.

Self-endangerment

In addition to dangers present in the social and physical environment, the adolescent may engage in behaviors that threaten his or her own safety. In most cases, such self-endangerment arises from the effects of trauma and neglect. Although the youth may appear to be "acting out," "self-destructive," "borderline," or "conduct-disordered," most behaviors in this regard appear to represent adaptations to, or effects of, prior victimization (Runtz & Briere, 1986; Singer, et al., 1995).

The primary self-endangering behaviors seen in adolescents suffering from complex trauma exposure include suicidal behavior, intentional (but non-suicidal) self-injury, major substance use or abuse, eating disorders, dysfunctional sexual behavior, excessive risk-taking, and involvement in physical altercations (Briere & Spinazzola, 2009; Cook et al., 2005). Regarding the latter, the traumatized adolescent may not only seek out violent ways to externalize distress, but also may be further traumatized when others fight back, the aggression-retaliation cycle associated with gang activity occurs, and/or they become involved in the juvenile justice system. The adolescent also may experience less obviously endangering relational difficulties, such as poor sexual-romantic choices and inadequate self-protection—including passivity or dissociation—in the face of dangerous others.

Some of these difficulties may explain what is referred to in the literature as revictimization: those who were severely maltreated as children have an elevated risk of being assaulted later in life (Classen, Palesh, & Aggarwal, 2005). This phenomenon may result in a scenario well-known to clinicians who work in the area of complex trauma: the abused

and/or neglected child may, as he or she matures, engage in various activities and defenses (e.g., substance abuse, dysfunctional sexual behavior, or aggression) as a way to reduce posttraumatic distress, only to have such coping strategies ultimately lead to even more victimization and, perhaps, even more self-endangering behavior (e.g., Koenig, Doll, O'Leary, & Pequegnat, 2003). In this regard, self-endangerment—as much as dangerous environments—requires the clinician to focus on safety as much as symptom remission.

Long-Term Trauma Outcomes

In addition to the acute issues outlined above, many adolescent trauma survivors suffer the chronic, ongoing effects of previous adverse experiences. Arising from maltreatment that may have begun in early childhood (e.g., early neglect or abuse) and have continued into adolescence (e.g., victimization by peers or adults), such impacts may emerge as relatively chronic psychological symptoms, potentially presenting as one or more psychiatric disorders.

In some cases, symptomatic or "acting out" behaviors may represent coping responses to trauma. These include tension reduction behaviors, such as self-injury, repetitive or otherwise problematic sexual behavior, bulimia, excessive risk-taking, compulsive stealing, and some instances of aggression (Briere, 1996, 2002). These activities may serve, in part, as a way for the adolescent to distract, soothe, avoid, or otherwise reduce ongoing or triggered trauma-related dysphoria, as noted later in this chapter.

Whether symptomatology, skill deficits, or coping strategies, there are a number of long-term impacts of childhood and adolescent trauma. The most common and significant of these are:

- Anxiety, depression, and/or anger
- Cognitive distortions
- Posttraumatic stress
- Dissociation
- Identity disturbance
- Affect dysregulation
- Interpersonal problems
- Substance abuse

- Self-mutilation
- Bingeing and purging (bulimia)
- Unsafe or dysfunctional sexual behavior
- Somatization
- Aggression
- Suicidality
- Personality disorder

The reader is referred to the following literature reviews for more information on these trauma-impact relationships (Briere & Spinazzola, 2009; Cole & Putnam, 1992; Cook, et al., 2005; Courtois & Ford, 2009; Ford & Courtois, 2013; Herman, Perry, & van der Kolk, 1989; Janoff-Bulman, 1992; Myers, et al., 2002; Putnam, 2003; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

As noted earlier, these various symptoms and coping strategies are sometimes referred to as "Complex PTSD" (Herman, 1992), "Disorders of Extreme Stress Not Otherwise Specified" (DESNOS; van der Kolk, et al., 2005), or as evidence of a developmental trauma disorder (van der Kolk, 2005). The breadth and extent of these outcomes generally requires a therapeutic approach that involves multiple treatment modalities and interventions, as opposed to solely, for example, cognitive therapy or therapeutic exposure (Courtois & Ford, 2009). ITCT-A allows the clinician to address these various difficulties in a relatively structured way, which is, at the same time, customizable to the specific clinical presentation and needs of the individual adolescent client.

Chapter 2: Assessment

As outlined in the last chapter, abused or otherwise traumatized adolescents may experience the full panoply of symptoms, problems, and problematic behaviors. The type and extent of these difficulties vary as a function of the types of trauma the youth has experienced, when in the developmental process they occurred, and their frequency and duration, as well as other biological, psychological, and social variables that might intensify or otherwise moderate the clinical presentation. For this reason, it will rarely be true that any given adolescent will present with exactly the same clinical picture as any other adolescent. This variability means that the treatment of complex posttraumatic disturbance can only occur after some form of psychological assessment is performed.

In ITCT-A, assessment typically includes information from a number of sources, including the adolescent's self-report, caretaker reports of his or her functioning, collateral reports from caregivers, teachers, and other providers, and psychometric testing. The primary focus of assessment is the adolescent's safety level, trauma exposure history, and current psychological symptoms or problems. However, information may also be collected on caretaker and family functioning and history, the youth's developmental history, psychiatric history, cultural background, primary attachment relationships, child protective services involvement and placement history, current school functioning, history of losses, substance use or abuse, medical status, suicidal or homicidal ideations and behavior, current legal issues, coping skills, level of cognitive functioning, and environmental stressors such as community violence. Once consent for release of information is provided, the clinician can gather more complete background information from agencies interacting with the client and family, such as child protective services, schools, and other mental health agencies or professionals.

Evaluation of Current Safety

Most obviously, the first focus of assessment is whether the client is in imminent danger or at risk of hurting others. In cases of ongoing interpersonal violence, it is also very important to determine whether the client is in danger of victimization from others in the immediate future. Most generally, the hierarchy of assessment is as follows:

- Is there danger of imminent injury or death?
- Is the client incapacitated (e.g., through intoxication, brain injury or delirium, severe psychosis) to the extent that he or she cannot attend to his or her own safety (e.g., wandering into streets, or unable to access available food or shelter)?
- Is the client acutely suicidal or a danger to others (e.g., homicidal, or making credible threats to harm someone)?
- Is the client's immediate psychosocial environment unsafe (e.g., is he or she immediately vulnerable to maltreatment or exploitation by others)?

The first goal of trauma intervention, when any of these issues are present, is to ensure the physical safety of the client or others, often through referral or triage to emergency medical or psychiatric services, law enforcement, child protection, or social services. It is also important, whenever possible, to involve supportive and less-affected family members, friends, or others who can assist the client in this process. At a less acute level, questions include:

- Does the client have a place to stay tonight?
- When did he or she last eat?
- When did he or she last get a medical examination? Does he or she need medical care?
- Is he or she engaged in unsafe sex, IV drug abuse, or other risky behaviors?
- Does he or she report self-injurious behavior (e.g., self-cutting, self-burning)?
- Is there evidence of a severe eating disorder?
- Is he or she being exploited sexually or otherwise by another person? Is a child abuse report indicated?
- Is he or she involved in a gang? If so, how dangerous is the situation, both to the client and to others?
- Is he or she attending school, if relevant

Evaluation of Trauma-Exposure History

After evaluating immediate safety risks, typically next considered is the adolescent's trauma history. Common types of trauma are child abuse (physical, sexual, and

psychological), emotional neglect, assaults by peers (both physical and sexual), community violence, witnessing violence done to others, traumatic loss, exposure to accidents (e.g., motor vehicle accidents) and disasters, and serious medical illness or injury. Assessment typically involves determining not only the nature of these various traumas, but also their number, type, and age of onset.

The adolescent may not report all significant trauma exposures during the initial assessment session or early in treatment. Instead, important historical events may be disclosed later in therapy, as the child engages more fully with the clinician and experiences a greater sense of trust and safety. The manner in which adolescents, as well as caretakers, are directly queried regarding trauma exposures also will have an impact on the extent to which a complete account is provided (Lanktree & Briere, 2008).

The context in which the assessment is conducted can also affect the extent of trauma information that is disclosed by the adolescent and/or family, whether by interview or on psychological tests. For example, in school settings, the adolescent may not feel as free to divulge information due to concerns about confidentiality, including fear that his or her trauma history or symptoms will be shared with school personnel or other students. In hospital settings, where an adolescent may be assessed for psychological trauma following serious medical illness or condition (e.g., HIV infection, cancer, surgeries) or traumatic injury (e.g., the medical results of an assault or accident), the client and family's need to cope with urgent or chronic medical issues may lead them to overlook or suppress information regarding prior (or current) abuse or violence.

Because clients may interpret trauma labels in different ways, evaluation of trauma exposure is often more effective when it employs behavioral descriptions of the event (s), as opposed to merely asking about "rape" or "abuse." This is often best accomplished by using some sort of structured measure or interview that assesses exposure to the major types of traumatic events in a standardized way, since research indicates that direct inquiry about specific trauma history tends to yield more trauma exposure information (e.g., Lanktree, Briere, & Zaidi, 1991). Included in the Appendix of this guide is a version of the Initial Trauma Review (ITR-A; Briere, 2004), adapted for adolescent clients. This interview is also available on the internet: attc.usc.edu.

Evaluation of Trauma-Relevant Symptoms

An optimal assessment of adolescent symptomatology includes an estimation of current psychological functioning and potential targets for treatment. The results of such assessment, in turn, will determine whether an immediate clinical response is indicated, as well as what specific treatment modalities (e.g., cognitive interventions, therapeutic exposure, family therapy, or psychiatric medication) might be most helpful. Further, when the same tests or interview-based assessments are administered on multiple occasions (e.g., every three or four months), the ongoing effects of clinical intervention can be evaluated, allowing the clinician to make mid-course corrections in strategy or focus when specific symptoms are seen to decrease or exacerbate (Briere, 2001).

For some adolescents, multiple trauma exposures such as abuse, neglect, family and community violence, relational losses, and injuries or illnesses may occur concomitantly, resulting in a more complex clinical picture. In addition, gender-related, developmental, and cultural factors may affect how any given symptom manifests. For this reason, it is usually preferable to administer multiple tests, if possible, tapping a variety of different symptoms, rather than a single measure, and to take mediating demographic, social, and cultural issues into account.

When using psychological tests, standardized trauma assessment measures are usually preferable to those without norms or validation studies. These tests may involve caretaker reports of the adolescent's symptoms and behaviors or self-reports of their own distress and/or behavioral disturbance. In addition, such measures may be either generic or trauma-specific.

The choice of whether to use self- or caretaker-reports of adolescent symptoms can be difficult, since each approach has its own potential benefits and weaknesses. Self-report measures allow the adolescent to directly disclose his or her internal experience or problems, as opposed to the clinician relying on "second hand" reports of a parent or caretaker. However, the youth's report may be affected by his or her fears of disclosure, or denial of emotional distress (Elliott & Briere, 1994). Similarly, caretaker report of the youth's symptomatology has the potential benefit of providing a more objective report of the client's symptoms and behaviors, yet may be compromised by parental denial, guilt, or preoccupation with the adolescent's trauma (Friedrich, 2002). Caretakers also may have difficulty accurately

assessing the adolescent's internal experience, especially if the adolescent, for whatever reason, avoids describing those experiences to the caretaker, or the caretaker has had minimal ongoing contact with the adolescent (Lanktree et al., 2008). For these reasons, it is recommended that the assessment of traumatized adolescents involve both self- and caretaker-report interviews and measures whenever possible, so that the advantages of each methodology can be maximized, and the child's actual clinical status can be triangulated by virtue of multiple sources of information (Lanktree et al., 2008; Nader, 2007). For those employing psychological tests, a detailed list and review of psychological measures that can be used to assess trauma symptoms in ITCT-A can be found on the NCTSN website (http://www.nctsnet.org/resources/online-research/measures-review).

Assessment Driven Treatment

In combination, carefully selected psychological tests and/or detailed clinical interviews—along with other forms of information—can help determine the extent of the adolescent's trauma-related symptomatology, as well as any other psychological difficulties (e.g., depression) that also may be present. Understanding the adolescent's emotional experience and behavioral responses, in turn, can help the clinician devise an effective treatment regimen that is relevant to the client's specific clinical presentation and needs. When assessment is repeated over time, it can also signal the need to change or augment the treatment focus as needed. For example, ongoing evaluation may suggest a shift in therapeutic focus when posttraumatic stress symptoms begin to respond to treatment but other symptoms continue relatively unabated.

Assessment-Treatment Flowchart

The actual transformation of test and interview results, and collateral information, into a specific treatment plan occurs in ITCT-A using the Assessment-Treatment Flowchart, adolescent form (ATF-A), presented in the Appendix and additionally available on the internet: attc.usc.edu. This matrix not only helps guide the initial treatment plan, but also provides a serial reassessment of symptoms and possible interventions on a regular basis thereafter. Unfortunately, because the development of standardized measures for posttraumatic outcomes in adolescents is in its relative infancy, not all problems listed in the ATF-A have corresponding psychological tests that aid in their evaluation. In such

instances, or when psychological testing is for some reason not possible, the clinician should rely on the youth's self-report, his or her behavior and responses in the intake session and in therapy, parent report, data from other systems (e.g., legal, academic, child welfare), and interview-based clinical impressions to address ATF-A items. Completion of the ATF-A thus proceeds in the following steps:

At intake

First, review all assessment data, the adolescent's interview-based self-report of symptoms and problems, parent or caretaker interview-based report of the adolescent's symptoms and problems, collateral data such as school reports, other caregiver (e.g., health care professionals, other therapists), juvenile justice reports, etc.

Next, proceed through each of the 19 items of the ATF-A for the "Intake" column, rating the treatment priority (ranging from 1 ["Not currently a problem, do not treat"] to 4 ["Most problematic, requires immediate attention"]) for each item based on the data collected at step one.

At each following assessment period

Typically, assessments are updated every three months, unless circumstances require evaluations that are more frequent. Review the last prioritization of symptoms and problems and, based on repeat assessment, re-prioritize the focus of treatment based on the client's current clinical and social status. In some cases, reassessment and treatment reconfiguration will occur prior to a three-month assessment period, generally when some new event intercedes (e.g., a crisis or life event) or a significant treatment event (e.g., a breakthrough or newly uncovered information) alters the therapy trajectory. The ATF-A has rating columns for three assessment periods beyond the intake session, which generally corresponds to up to 9 months. Additional ATF-A pages may be added, as needed, for therapy that exceeds 9 months, or when emergent issues require assessment in shorter intervals. See later in this chapter for an example of a completed ATF-A, rated at two time-points.

Interview questions for the ATF-A

Especially for those who do not use psychological tests, but also to expand upon existing test data, we list below possible interview topics for each ATF-A item. These are

merely possibilities, however, and the clinician may choose other, equally relevant questions, especially in terms of crafting inquiries specific to the youth's circumstances, trauma history, age, culture, etc.

Table 1. Possible Interview Question Topics

ATF-A Item	Possible Question Topics
1. Safety—environmental	• Does the client have a place to stay tonight? • Is he/she afraid that someone might hurt him/her? • Does he/she feel safe at home? • Is anyone making him/her do anything he he/she does not want to do? • Is there continuing danger from past perpetrators?
2. Caretaker support issues	• Does the client feel like parent(s) or family members are "on their side?" • Does he/she feel that his/her parent(s) take good care of him/her? • Is there someone in his/her family with whom he/she can talk? • Are parent(s)/family supportive of him/her being in therapy? • Does he/she feel loved by parent(s) or family members?

ATF-A Item	Possible Question Topics
3. Anxiety	Extent of: • Anxiety or feeling scared • Panic attacks (define, if necessary) • Worrying • Feeling like something bad is about to happen • Insomnia at night because he/she is worrying about the future
4. Depression	Extent of: • Feelings of sadness • Depression • Crying over the last week • Feeling really down • Feeling hopeless about the future
5. Anger or aggression	Extent of: • Getting into fights • Feeling angry • Getting mad at people • Getting into trouble because of his/her anger • Hitting or hurting people or animals
6. Low self-esteem	Extent of: • Feeling bad about himself/herself • Self-criticism • Not liking himself/herself • Putting himself/herself down • Feeling unattractive or unintelligent

ATF-A Item	Possible Question Topics
7. Posttraumatic stress	Extent of trauma-related: • Bad dreams • Flashbacks (define, if necessary) • Feeling tense or on edge • Avoiding people or places or situations that remind him/her about bad things that have happened • Not being able to have feelings, even though he/she thinks he/she should have them
8. Attachment insecurity	Extent of: • Trust of people in general • Worry that people will leave/abandon him/her or not be close to him/her anymore • Friends in his/her social network • Need to keep people at a distance • Feeling empty inside when people aren't around him/her
9. Identity issues	Extent of: • Not really knowing who he/she is • Being confused about what he/she wants in life • Standing up for himself/herself in conflicts or arguments • Self-confidence • Understanding himself/herself and why he/she does things

ATF-A Item	Possible Question Topics
10. Relationship problems	Extent of: • Having trouble making friends • Getting into arguments with his/her girlfriend/boyfriend/friends • Staying around friends or sexual/romantic partners even when they are hurtful to him/her • Problems with people in close relationships • Relational "break-ups"
11. Suicidality	Extent of: • Thoughts about suicide • Previous suicide attempts • Wanting to die • Making suicide plans • Doing dangerous things in the hopes he/she might die
12. Safety—risky behaviors	Extent of: • Engaging in dangerous behaviors • Driving too fast • Prostitution or sex for food/shelter/drugs • Doing dangerous things for fun • Possession or use of guns or knives

ATF-A Item	Possible Question Topics
13. Dissociation	Extent of: • "Spacing out" • Watching himself/herself from outside of his/her body • Feeling like things are unreal • Doing things and not remembering them later (without substance abuse) • Feeling disconnected from things, or watching things from a distance
14. Substance abuse	Extent of: • Alcohol use • Recreational drug use (determine drugs of choice) • Abuse of prescription drugs • Trying to stop using drugs or alcohol but not being able to • Getting into trouble because of drug or alcohol abuse
15. Grief	After determining time since major loss, extent of: • Sadness about the loss of person • Missing the person • Seeing or hearing the person although he/she is not actually present • Preoccupation with, and intrusive thoughts about, the person • Pretending that the person isn't dead or gone

ATF-A Item	Possible Question Topics
16. Sexual concerns and/or dysfunctional behaviors	Extent of: • Guilt, worry, or fear about sexual things • Sexual problems • Multiple sex partners in the last three months • Involvement in sexual behavior for non- sexual reasons (e.g., attention, power, self-esteem) • Unsafe sexual behavior
17. Self-mutilation	Extent of: • Cutting on self without suicidal intent • Burning himself/herself with cigarettes or matches • Hurting himself/herself to reduce emotional distress or triggered memories • Punching walls or other immovable objects • Biting self or pulling out hair

Chapter 3: Treatment Overview

This chapter briefly outlines the primary foci of ITCT as it is applied to adolescents, above-and-beyond the specific components of therapy described in Chapters 5 to 14.

Assessment-Focused Therapy

As indicated in the last chapter, ITCT-A is assessment-based; initial and repeat assessments determine, as represented on the ATF-A, which intervention components are utilized in treatment. Consider an example of how ATF-A data (presented as Figure 1. on next page) might initially determine, and then alter treatment focus:

Based on psychological testing, as well as the adolescent's verbal self-report in the evaluation session, his parents' feedback, and the therapist's clinical impressions, three symptom clusters, anxiety, depression, and posttraumatic stress, are prioritized as 4s (Most problematic, requires immediate attention). Two additional problems (anger/aggression, dissociation) are prioritized as 3s (Problematic, a current treatment priority), and the remainder of ATF-A items are rated as 2s (Problematic, but not an immediate treatment priority) or 1s (Not currently a problem (re-evaluate at each interval): Do not treat).

As treatment progresses, the client shows clinical improvement in anxiety, depression, and dissociation at assessment period 1 (i.e., at three months), leading the clinician to prioritize these problems as, respectively, "3," "2," and "2" at the next assessment period (presented as Figure 2. on following page). Further, one problem ("identity issues") is downgraded from a "2" to a "1." However, additional stressors in the client's life and other undetermined factors have resulted in increased risky behaviors and, therefore, a new rating of "3." Thus, at intake the highest level of treatment attention was anxiety, depression, and posttraumatic stress, whereas at the next assessment period the focus shifts to posttraumatic stress, followed by anger/aggression and safety—risky behaviors.

Figure 1. Initial Assessment-Treatment Flowchart

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

Assessment-Treatment Flowchart

Adolescent/Young Adult Version (ATF-A)

Client Name: _____

Priority ranking (circle one for each symptom):

1 = Not currently a problem: no treatment currently necessary
2 = Problematic, but not an immediate treatment priority: treat at lower intensity
3 = Problematic, a current treatment priority: treat at higher intensity
4 = Most problematic, requires immediate attention
(S) – Suspected, requires further investigation

	Intake			
Date	5/10/08			
Problem Area	*Tx Priority*	*Tx Priority*	*Tx Priority*	*Tx Priority*
1. Safety—environmental	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
2. Caretaker support issues	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
3. Anxiety	1 2 3 (4) (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
4. Depression	1 2 3 (4) (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
5. Anger/aggression	1 2 (3) 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
6. Low self-esteem	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
7. Posttraumatic	1 2 3 (4) (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
8. Attachment insecurity	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
9. Identity issues	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
10. Relationship problems	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
11. Suicidality	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
12. Safety—risky behaviors	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
13. Dissociation	1 2 (3) 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
14. Substance abuse	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
15. Grief	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
16. Sexual concerns and/or dysfunctional behaviors	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
17. Self-mutilation	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
18. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
19. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

Figure 2. Three-Month Assessment-Treatment Flowchart

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

Assessment-Treatment Flowchart

Adolescent/Young Adult Version (ATF-A)

Client Name: _____

Priority ranking (circle one for each symptom):

1 = Not currently a problem: no treatment currently necessary
2 = Problematic, but not an immediate treatment priority: treat at lower intensity
3 = Problematic, a current treatment priority: treat at higher intensity
4 = Most problematic, requires immediate attention
(S) = Suspected, requires further investigation

	Intake			
Date	5/10/08	8/11/08	_____	_____
Problem Area	*Tx Priority*	*Tx Priority*	*Tx Priority*	*Tx Priority*
1. Safety—environmental	1 (2) 3 4 (S)	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
2. Caretaker support issues	(1) 2 3 4 (S)	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
3. Anxiety	1 2 3 (4) (S)	1 2 (3) 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
4. Depression	1 2 3 (4) (S)	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
5. Anger/aggression	1 2 (3) 4 (S)	1 2 (3) 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
6. Low self-esteem	1 (2) 3 4 (S)	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
7. Posttraumatic	1 2 3 (4) (S)	1 2 3 (4) (S)	1 2 3 4 (S)	1 2 3 4 (S)
8. Attachment insecurity	1 (2) 3 4 (S)	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
9. Identity issues	1 (2) 3 4 (S)	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
10. Relationship problems	1 (2) 3 4 (S)	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
11. Suicidality	(1) 2 3 4 (S)	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
12. Safety—risky behaviors	1 (2) 3 4 (S)	1 2 (3) 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
13. Dissociation	1 2 (3) 4 (S)	1 (2) 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
14. Substance abuse	(1) 2 3 4 (S)	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
15. Grief	(1) 2 3 4 (S)	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
16. Sexual concerns and/or dysfunctional behaviors	(1) 2 3 4 (S)	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
17. Self-mutilation	(1) 2 3 4 (S)	(1) 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
18. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
19. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

Based on the next treatment planning tool, the Problems-to-Components Grid (see Table 2), the various problems and symptoms described the previous chapters are linked to specific ITCT-A components (e.g., cognitive processing, therapeutic exposure, psychoeducation) outlined in the following chapters. In this way, assessment and treatment, followed by repeat assessment and further treatment, are directly linked. Treatment of a specific issue only occurs if it is assessed to be a problem (i.e., has a higher ranking on the ATF-A), and treatment for that issue only occurs as long as assessment indicates it is still problematic. As a result, treatment for two different clients may differ significantly as a function of initial test or interview data, collateral input, and response to treatment or external circumstance.

Table 2. Problems-to-Components Grid

Problem Area (from ATF-A)	Treatment Components that May be Useful
Safety (environmental)	Safety training, system interventions, psychoeducation
Caretaker support	Family therapy, intervention with caretakers
Anxiety	Distress reduction/affect regulation training, titrated exposure, cognitive processing
Depression	Relationship building and support, cognitive processing, group therapy
Anger and aggression	Distress reduction/affect regulation training, trigger identification/intervention, cognitive processing

Problem Area (from ATF-A)	Treatment Components that May be Useful
Low self-esteem	Cognitive processing, relational processing, group therapy, relationship building and support, identity interventions
Posttraumatic stress	Distress reduction/affect regulation training, titrated exposure, cognitive processing, psychoeducation, relationship building and support, trigger identification/intervention
Attachment insecurity	Relationship building and support, relational processing, group therapy, intervention with caretakers, identity interventions
Identity issues	Identity interventions, relationship building and support, relational processing
Relationship problems	Relationship building and support, relational processing cognitive processing, identity interventions, group therapy
Suicidality	Safety training, distress reduction/affect regulation training, cognitive processing, systems intervention
Risky behaviors and tension reduction behaviors	Psychoeducation, safety training, cognitive processing, trigger identification/intervention
Dissociation	Distress reduction/affect regulation training, emotional processing, trigger identification/intervention
Substance abuse	Psychoeducation, trigger identification/intervention, titrated exposure, distress reduction/affect regulation training

Problem Area (from ATF-A)	Treatment Components that May be Useful
Grief	Psychoeducation, cognitive processing, relationship building and support
Sexual concerns and/or dysfunctional behaviors	Psychoeducation, trigger identification/intervention, titrated exposure, distress reduction/affect regulation training
Self-mutilation	Trigger identification/intervention, distress reduction/affect regulation training

The Primacy of the Therapeutic Relationship

Although modern trauma treatment is characterized by a number of specific techniques—many of which are presented in the Problems-to-Components Grid—research and clinical experience suggest that a positive therapeutic relationship is one of the most important components of successful therapy (Cloitre, et al., 2006; Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Lambert & Barley, 2001; Pearlman & Courtois, 2005). This is probably especially true for multiply traumatized adolescents, whose life experiences have taught them to mistrust authority and to expect maltreatment in relationships. This dynamic can be further intensified for youth who live in deprived and marginalized social environments, and/or who have experienced racism or other discrimination on a regular basis.

In this complex psychosocial matrix, client trust and openness becomes less likely at the very time it is especially needed. Some level of vulnerability and trust is necessary before the traumatized adolescent can meaningfully revisit and process painful memories. If the therapist maintains a consistently positive, caring demeanor, and indicates by his or her behavior that he or she will not maltreat, disrespect, discriminate against, exploit, or otherwise harm the client, the multiply-besieged youth may slowly come to realize that there is no immediate danger, gradually reducing his or her defenses and avoidance behaviors, and

eventually enter into a more therapeutic connection with the clinician.

For some especially traumatized and maltreated adolescents, this process may take time, requiring considerable patience on the part of the therapist. The client may test the clinician in various ways regarding his or her actual feelings and intentions for the client. There may be an expressed attitude of disinterest, or even disdain, even though the adolescent may actually be hungry for connection and validation. The client may challenge or, conversely, attempt to pacify the therapist in various ways that have proved helpful with powerful others in the past. Only when the therapist does not "take the bait" and become angry, dangerous, exploitive, seductive, or rejecting, may the youth begin to perceive the therapist, and the therapeutic relationship, as benign.

Beyond the need for the client to participate in treatment, and thus lower his or her defenses against expectations of maltreatment, the experience of a safe and caring client-therapist relationship is often a technical requirement of trauma therapy (Briere & Scott, 2012; Pearlman & Courtois, 2005). Almost inevitably, the therapeutic relationship will trigger memories, feelings, and thoughts associated with prior relational traumas, as well, in some cases, as more recent social maltreatment (e.g., experiences of racism, sexism, or homophobia). As noted in Chapter 4, when these activations and expectations can be processed in the context of a safe, supportive relationship, their power over the adolescent survivor often diminishes. In this regard, as the client experiences reactivated rejection, abandonment fears, misperception of danger, or authority issues at the same time that he or she perceives respect, caring, and empathy from the therapist, such intrusions may gradually lose their generalizability to current relationships and become counterconditioned by current, positive relational feelings. In this sense, a good therapeutic relationship is not only supportive of effective treatment, it is technically integral to the resolution of major relational traumas.

Customization

In actual clinical practice, clients vary significantly in their sociocultural backgrounds, presenting issues, comorbid symptoms, and the extent to which they can utilize and tolerate psychological interventions. For this reason, therapy is likely to be most effective when it is tailored to the specific characteristics and concerns of the individual person. Above-and-

beyond the differing symptomatic needs of one client relative to another, treatment may require adjustment based on a number of other relevant variables. Presented below are several factors that should be taken into account when providing trauma therapy to adolescent trauma survivors.

Age

Although it is sometimes implied that adolescence is a single developmental stage, in actuality the usually cited age range for this category (ages 12 to 21) comprises several smaller developmental periods. In addition, any given adolescent may be "a young" X-year-old or "an old" one, psychologically and/or physically. Further, childhood abuse may delay some children's psychological or physical development and accelerate others, and some environments may demand "older" psychosocial functioning than others.

A common error made by clinicians working with traumatized youth is to intervene as if the adolescent is older or younger than his or her actual psychological age. The older adolescent may feel that "my counselor treats me like a baby," whereas the younger (or more cognitively impaired) adolescent may not fully understand the clinician's statements, or may feel insufficient emotional connection with the therapist because the clinician is interacting with him or her in a way that is too abstract or intellectualized. Such potential problems highlight the need to provide developmentally sensitive and appropriate treatment to adolescents with trauma histories.

Gender

Although adolescent males and females experience many of the same traumatic events and suffer in many of the same ways, it is also clear that some traumas are more common in one sex than the other, and that sex-role socialization often affects how such injuries are experienced and expressed. These differences have significant impacts on the content and process of trauma-focused therapy for adolescents.

Research indicates that girls and women are more at risk for victimization in close relationships than are boys and men, and are especially more likely to be sexually victimized, whereas boys and men are at greater risk than girls and women of physical abuse and assault (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Yehuda, 2004). In addition to trauma exposure differences, young men and women tend to experience, communicate, and process

the distress associated with traumatic events in somewhat different ways (Briere & Scott, 2012). These sex-role related differences in symptom expression and behavioral response often manifest themselves during trauma-focused psychotherapy. As a result, the therapist should be alert to ways in which traumatized youth express or inhibit their emotional reactions based on sex-role-based expectations. Although the clinician should not respond to clients in a sex-role stereotypic manner, he or she should be sensitive to how gender-related socialization influences the client, and respond accordingly. In some cases, he or she may be able to offer perspectives or role modeling that allow the client to be less affected by sex-roles or gender-based assumptions.

Sociocultural matrix

Although many North American therapists are firmly rooted in the middle class, with the assumptions and perspectives that go along with that context, a significant proportion of mental health service consumers, including many adolescent trauma survivors, are embedded in a different psychosocial matrix—one that includes a range of cultural or subcultural experiences, expectations, and rules of interpersonal engagement, and that is often characterized by marginalization due to poverty, race, culture, gender, or sexual orientation (e.g., Bryant-Davis, 2005). As a result, the traumatized adolescent may present with a variety of issues beyond his or her specific trauma history; not only will he or she have been hurt by physical or sexual violence, he or she may have experienced the direct and indirect effects of social maltreatment, and may view the world from a cultural lens that differs substantially from that of the therapist (Abney, 2002; Cohen, Deblinger, Mannarino, & De Arellano, 2001; Jones, Hadder, Carvajal, Chapman, & Alexander, 2006; Marsella, et al., 1996). This is especially relevant to work with adolescents recently immigrated to the United States from Mexico or Central America, many of whom are separated from their caretakers or families[1].

Sociocultural and experiential differences between clients and therapists may easily extend to inherent disagreements regarding the requirements and process of therapy. Although the therapist may assume that the client feels safe, understood, and supported in

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[1] *Apropos of this subgroup, there are a number of shelters (e.g., Southwest Key Programs) for unaccompanied, undocumented youth who are apprehended at the U.S. border. These young people come from a variety of different cultures, and often have experienced multiple traumas, including victimization during immigration.*

treatment, these beliefs may not always be accurate. Further, the client may not subscribe to the clinician's perspective on what constitutes therapy. There may be differing expectations about how private issues are discussed during treatment, the extent to which therapy is focused on practical (as opposed to more psychological) issues in the client's life, the importance of regularly scheduled weekly sessions, or even the role of eye contact or therapist self-disclosure (e.g., Abney, 2001; Ford, 2007; Marsella, Friedman, Gerrity, & Scurfield, 1996). Differences in client versus therapist class or culture may result in clinician errors, such as the treatment provider's belief that the adolescent female client's late or missed sessions represent "resistance" or "acting out," when, in fact, the client may have multiple impinging concerns (e.g., childcare issues, a changing work schedule, or difficulties in arranging transportation) and/or a different perspective on the relative importance of being "on time". Similarly, the client may assume that the therapist is uninvolved or uncaring, when, in fact, the therapist is quite concerned about the client, but his or her culture (or training) dictates less emotional expression or visible interpersonal closeness.

The impacts of social discrimination and cultural differences are not things that the clinician can overlook when working with many traumatized adolescents. Minimally, the therapist should take into account (1) the adverse conditions and additional trauma exposure that the client may have experienced, (2) the anger and/or anxiety that he or she may feel when in contact with a therapist whose social characteristics are more representative of the dominant (i.e., White, middle class) culture, (3) differences in world-views and experiences often associated with different socioeconomic strata or cultural/subcultural membership, and (4) the actual characteristics of, and impediments in, the physical and social environment in which the client is embedded.

Affect regulation capacity

Not only should treatment be customized based on the client's symptomatic presentation and sociodemographic/cultural characteristics, there is another important psychological variable that frequently affects how therapy is delivered: the client's level of affect regulation—his or her relative capacity to tolerate and internally reduce painful emotional states. Adolescents with limited affect regulation abilities are more likely to be overwhelmed and destabilized by negative emotional experiences—both those associated with current negative events and those triggered by painful memories. Since trauma therapy

often involves activating and processing traumatic memories, those with less ability to internally regulate painful states are more likely to become highly distressed, if not emotionally overwhelmed, during treatment, and may respond with increased avoidance, including "resistance" and/or dissociation (Briere & Scott, 2012; Cloitre, Koenen, Cohen, & Han, 2002). Such responses, in turn, reduce the adolescent's exposure to traumatic material and to the healing aspects of the therapeutic relationship. As described in Chapter 7, treatment of those with impaired affect regulation capacities should proceed carefully, so that traumatic memories are activated and processed in smaller increments than otherwise might be necessary. Often described as titrated exposure or "working within the therapeutic window" (Briere, 2002), this involves (1) adjusting treatment so that trauma processing that occurs within a given session does not exceed the capacities of the survivor to tolerate that level of distress, and, at the same time, (2) providing as much processing as can reasonably occur.

Advocacy and Systems Intervention

Traumatized youth often have issues that extend beyond psychological symptomatology, per se. Some of these concerns are associated with a lack of financial and/or social resources. Others arise from ways in which the adolescent's trauma history, family difficulties, and living environment may have affected his or her interactions with external systems, such as the schools, law enforcement, juvenile justice, child protection, and social welfare agencies. The client may be involved in gang activity, prostitution, significant substance use or abuse, theft, revictimization, or violence against others.

In such situations, psychotherapy—by itself—may not be enough. For this reason, ITCT-A and other approaches to multi-problem youth typically include a social advocacy/systems intervention component. This may involve dealing with "red tape" in health or social welfare bureaucracies so that the client can receive needed services or funding, advocating for the client in a judicial hearing, helping the client to apply for U.S. resident status, or working with school personnel to keep the client in the educational system. It may include filling out forms, writing letters, making phone calls, or completing reports. In addition, for clients who are economically disadvantaged and have limited resources, ITCT-A providers with sufficient resources or funding may offer an optional range of extra-

therapeutic services (e.g., Lanktree, 2008), including

- Transportation to therapy sessions, through taxi vouchers, bus passes, or an agency van
- Food and clothing
- Advocacy and referrals for legal support and housing. In some cases, such financial assistance can significantly change the survivor's life by ending homelessness or moving him or her to a safer neighborhood.
- Emergency financial assistance for youth and families when starting back to school and for holidays.
- Access to community after-school programs and participation in organizations in the neighborhood, such as Big Brothers and Big Sisters, or the Boys and Girls Club. Caretakers may not be aware of free services in their community and these resources can supplement the advantages of ongoing therapy.

These various activities provide real-world support to the adolescent trauma survivor in the most basic and important ways, involving food, shelter, financial support, social integration, and physical/social protection; conditions that typically must be met before meaningful progress on psychological issues can be made.

Chapter 4: Relationship Building and Support

As noted earlier, a positive therapeutic relationship is of great importance in the treatment of multiply abused or traumatized individuals, including adolescents. Because of its crucial nature, the relationship between client and therapist should be directly addressed in the same way as are other clinical phenomena. It may not be sufficient merely to wait for a positive relationship to build on its own accord. Traumatized youth may experience significant ambivalence—if not outright distrust—regarding any sort of enduring attachment to an older, more powerful figure. Others 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. In either instance, therapy may be slowed or compromised by insufficient trust and, as a result, reduced openness to the healing aspects of therapy. This chapter outlines ways in which the clinician can encourage, if not accelerate, a positive therapeutic relationship.

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. Conversely, if the client perceives or believes that some form of danger (whether it be physical, sexual, or associated with criticism or judgment) is potentially present, this experience may become a trigger for memories of prior instances of victimization, betrayal, exploitation, or abandonment, that—when reexperienced in the session—may reinforce the client's mistrust and hypervigilance. Therapist behaviors and responses that increase the client's sense of safety are likely to include:

- Nonintrusiveness. The clinician is careful to time or avoid questions or behaviors that otherwise might push the client beyond where he or she is willing to go, activate feelings of shame, or violate the client's personal/cultural boundaries.
- Visible positive regard. The therapist is able to access and communicate positive

feelings about the client, and to respond to the client in ways that reinforce the client's entitlements and intrinsic value.

- Reliability and stability. The clinician behaves in such a manner that he or she is perceived as someone the adolescent can count on—to be on time for sessions, to keep therapy safe, to be available at times of need, and to be an "anchor" in terms of consistent emotional caring.
- Psychological security. The clinician cultivates a "safe space" within the therapy sessions by remaining closely attuned to the sometimes quick and subtly changing needs of the adolescent, and by communicating psychological presence/attunement, empathic compassion, and acceptance. The therapist who practices this level of "mindful" awareness (see Chapter 8) may strengthen the client's ability to tolerate intense trauma processing simply by bolstering his or her own ability to remain present and open to the adolescent's experiences.
- Transparency. The therapist is as honest and open as possible, and does not appear to have a hidden agenda—including covert alliance with parents or social institutions over the youth's own needs. Obviously, in some cases, the clinician must be responsive to systems beyond the adolescent, but when this must occur, the therapist discloses this to the client so that he or she does not appear to be operating from duplicity.
- Demarking the limits of confidentiality. In some ways similar to transparency, confidentiality issues are highly relevant to the client's overall perception of the therapist as predictable and straightforward. This means that the clinician should always 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. Although such initial discussions are sometimes difficult, and the client may view them as evidence of clinician authoritarianism or dominance, in reality, the message is the reverse—that the client can count on the therapist to try to keep him or her safe, and to clearly demarcate the rules and boundaries of therapeutic interaction so that there are few surprises.

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. Having the opportunity to interact regularly with someone who listens, and who seems to understand, can be a powerfully positive experience—one that tends to strengthen the bond between client and therapist. Therapist behaviors that may increase this dynamic include:

- Attunement. The clinician is demonstrably aware of the client's moment-to-moment emotional state during treatment, such that the adolescent feels that he or she is attended to and (by implication) worthy of such attention. In this way, the client feels "heard" by someone he or she views as important: a phenomenon that may be rare in the adolescent's life.
- Empathy. The therapist feels for the client, in the sense that he or she has compassion for the client's predicament or circumstance, without judging him or her. This is to be discriminated from pity, which implies client weakness or incapacity, and therapist superiority. It should be noted that even true therapist empathy could be problematic if it is expressed too intrusively or couched in a manner that appears artificial or as merely what would be expected of a therapist.
- Acceptance. The clinician is nonjudgmental of the client and accepts the client as he or she is. This does not always mean that the therapist supports the adolescent's behavior, for example, when he or she is involved in self-destructive or hurtful behavior. Instead, the acceptance is of the client, him or herself—of his/her internal experience, inherent validity, and rights to happiness. When the client feels accepted, he or she has the opportunity to experience relational input that directly contradicts the rejection, criticism, and invalidation he or she may have experienced from harsh family members, peers, or society. This balance between acceptance of the client and, yet, nonsupport of his or her injurious behaviors is sometimes hard to accomplish—especially with acting-out adolescents. Examples would include:
    - How do I accept and support a traumatized, hurt, and angry adolescent without endorsing or reinforcing his aggression towards others?

    - How do I support a multiply abused and exploited young woman without also supporting her negative views of herself or her suicidal behavior?
- Understanding. The therapist, partially because of his or her attunement and empathy toward the client, communicates that he or she "gets" the client—that the young person's internal experience and behavior makes sense. Feeling understood by one's therapist generally fosters a sense of shared experience and intensifies the importance and positive nature of the therapeutic relationship.
- Curiosity about the client's perspective and internal experiences. The therapist communicates an active interest in the client (as opposed to solely support and caring), with respect to his or her perspective on life, the details of his or her interactions with the world, and, most importantly, the specifics of his or her thoughts, feelings, and other internal experiences. This curiosity should not be intrusive, nor should it reflect clinician voyeurism, but rather should communicate the notion that the client's process and experience is interesting, worthy of attention, and reflective of his or her inherent worth and specialness.

Active Relatedness and Emotional Connection

ITCT-A encourages the therapist to be an active (as opposed to a passive or neutral) agent in therapy. The therapist makes direct statements about the wrongness of the adolescent's victimization, and shows his or her emotional responses to the extent that they are helpful, i.e., neither extreme nor therapist-focused. The clinician does not give extensive unsolicited advice, but he or she actively assists the client in problem identification and problem solving, supports and encourages him or her, emphasizes his or her strengths, and generally is psychologically available to the youth. This approach to therapy encourages connection, because the clinician emerges as an active, caring, and involved participant in the client-therapist relationship.

Patience

Psychotherapy for complex trauma effects rarely proceeds rapidly. 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 change, or that an instance of talking about a trauma does not immediately

desensitize emotional distress to it. Such experiences may lead to helpless and self-criticism, as the youth interprets a lack of relatively immediate distress reduction, or continued involvement in unhelpful behaviors, as evidence of personal failings. He or she may also feel that he or she is letting the therapist down, or in some way being a "bad" or unintelligent client. As the therapist counsels patience and a longer-term perspective, and remains constant and invested in the therapeutic process, he or she communicates acceptance of the client and trust in the value of the therapeutic relationship.

This process requires, of course, therapist patience as well. Despite the prevalence of short-term interventions for traumatized youth in the treatment literature, effective interventions with multiply and chronically traumatized adolescents often takes time (e.g., Lanktree & Briere, 1995). The development of a trusting relationship with a repeatedly sexually and physically abused 14 year old, for example, may require a relatively long therapeutic "track record" of safety and support, especially if he or she is also dealing with ongoing community violence, poverty, and social marginalization. There may be distrust of the therapist based on the latter's race, ethnicity, or social status. The client's attention to the therapeutic process may be adversely affected by hunger, lack of sleep (a common issue for youth raised in the context of repeated drive-by shootings, chronic maltreatment by caretakers, or the need to work long hours to support the family) or worry about other compelling, real-life issues, such as impending homelessness or the traumatic loss of a friend or family member. In addition, multiply traumatized adolescents, as noted earlier, frequently suffer from a range of different psychological symptoms or disorders, and may be involved in maladaptive substance use—a significant impediment to psychological processing of traumatic stress. As a result, the clinician must be patient in the face of what may appear to be minimal clinical progress within the first months of treatment, and should be careful to note and comment upon any signs of progress or emerging psychological strengths. Although the client's problems may be chronic and complex, and his or her current circumstances less than optimal, in many cases socially marginalized and traumatized youth can show real improvement and significant symptom remission in the context of therapies such as ITCT (Lanktree, 2008).

Chapter 5: Safety Interventions

Many traumatized youth continue to be at serious risk of victimization, injury, or even death at the time of seeking therapeutic services. This danger may reflect the risks associated with community violence, gang activity, or prostitution, as well as specific life threat from previous perpetrators, boyfriends, stalkers, parents, or drug dealers/abusers. Adolescent women are at significant risk of being raped or otherwise sexually abused by relatives, partners, and strangers. Gay or transgendered adolescents and racial/ethnic minorities may be assaulted in the context of hate crimes. In addition, the adolescent may be self-destructive; either passively through drug abuse, unsafe sexual practices, or involvement in other risky behaviors; or through more actively suicidal behaviors. The client's behaviors may increase the chance of HIV or hepatitis C infections, or, in some states, botched abortions. Homeless adolescents especially run a number of these risks, as do others who spend much of their time on the streets (see the National Child Traumatic Stress Network webpage on homeless youth, http://www.nctsnet.org/nccts/nav.do?pid=ctr_aware_homeless, and Schneir, et al., 2007). These dangers are present for most adolescents; they escalate dramatically for those who have been previously abused or otherwise traumatized. As noted earlier, childhood maltreatment and other relational traumas are associated with a greater likelihood of subsequent substance abuse, unsafe sexual practices, prostitution, suicidality, and aggression toward others, as well as a greater risk of sexual revictimization.

Given this reality, the clinician must be vigilant to safety issues when working with traumatized youth, and must be prepared to act on safety concerns before and during psychological treatment. In fact, ensuring safety is the first requirement of trauma therapy—and this certainly includes adolescent victims. The primary interventions in this area are presented below.

Suicide Assessment and Prevention

Suicidal thoughts and behaviors are relatively common among abused or traumatized individuals (Tiet, Finney, & Moos, 2006; Zlotnick, Donaldson, Spirito, & Pearlstein, 1997), perhaps especially in the context of ongoing adverse conditions (Molnar, et al., 1998). In some cases, suicidal behaviors are passive, wherein the client engages in high-risk activities

and/or fails to protect him or herself in dangerous situations. In other cases, there may be repeated suicide attempts. The therapist is advised to be vigilant to the possibility of suicidal behavior when working with traumatized adolescents, and to perform lethality assessments (e.g., Berman, Jobes, & Silverman, 2006) whenever the client discloses suicidal ideation or significant depressive symptoms. When suicidal lethality (i.e., actual likelihood of a fatal attempt) is assessed to be relatively low, intervention may be limited to discussion of the underlying reasons for considering death, and attempting to problem-solve other, less drastic options. When suicidal lethality is greater, the clinician should modify the treatment plan to include contracting for safety, increased frequency of sessions and/or phone calls, provision of emergency numbers, and increased consultation with peers or supervisors. A psychiatric consultation, medication, or hospitalization also may be indicated.

Services for Victims of Intra-Familial Abuse

Because most adolescents up to age 18 are considered children by state law, those who are being maltreated by parents or caretakers, other family members, significantly older youth, or other adults are entitled to protection by child welfare or law enforcement agencies. As well, older adolescents victimized by peers have the option of making a police report and seeking protection. Although the client may be opposed to the involvement of child protective services or the police—especially if they have had negative experiences with such officials in the past—the clinician has a legal and ethical duty to report child endangerment to such agencies (Meyers, 2002). Although there may be no duty for the therapist to report to the police victimization by peers close to the client in age, but it is usually a good idea to encourage the client to do so. In the best case, the client's safety is dramatically increased, and the perpetrator is addressed by the criminal justice system. Occasionally, in the worst case, the client may abruptly terminate his or her relationship with the therapist. More often, however, the clinician can negotiate this process with the adolescent, supporting him or her through the reporting experience, and maintaining an enduring therapeutic relationship.

Assistance in Separating from Gangs

Gang involvement is often a double-edged sword for adolescents living in inner city environments. On one hand, it may offer protection from other gang members, and may

provide identity and a context for affiliation with peers (Cummings & Monti, 1993). On the other, it is associated with both engaging in violence and being physically injured or killed by others. Although the clinician almost always wants the client to avoid gang affiliation or to extract him or herself from gang activity, the youth may be quite ambivalent about doing so, and/or may fear retribution from gang members if he or she leaves. The therapist can probably be most helpful by working with the client in a pragmatic, problem-solving sort of way, providing opportunities for the youth to determine what he or she wants, consider his or her best options, and, if the decision is to try to leave the gang, possibly facilitating that process. In some cases, the client can be referred to groups or agencies that assist young people in finding alternatives to gang involvement and that provide a social support system that can substitute for gang affiliation. Often, these organizations also can assist youth who are at risk of becoming gang-involved.

Working with Prostitution Issues

It is not uncommon for homeless (often runaway) adolescents, especially those with histories of childhood sexual, physical, or emotional abuse, to become involved in prostitution (Farley, 2003; Webber, 1991; Widom & Kuhns, 1996; Yates, MacKenzie, Pennbridge, & Cohen, 1988). In some cases, young people are recruited and controlled by a pimp. In others, adolescents may exchange sex for drugs, food, or shelter. Although prostitution is almost always a very negative experience—in many cases requiring the youth to abuse drugs in order to continue it—and is associated with an elevated risk of assault, disease, depression, and posttraumatic stress (Farley, 2003), clinician entreaties that the adolescent just stop such behavior are often less than effective. Instead, the therapist may be most helpful by (a) providing therapeutic support and opportunities to process child abuse-related memories and assumptions, (b) facilitating nonjudgmental exploration of other possible options for survival that are less injurious than prostitution, (c) forming a safe and caring relationship that can be antidotal to the survivor's other, more detrimental and exploitive relationships with customers, pimps, and other youths caught in prostitution, (d) increasing access to social and medical services, including referral to agencies or shelters specifically created for sexually exploited youth, (e) in some cases, helping to develop safety plans (see below) regarding escape from pimps, and (f) providing assistance with any related

substance abuse problems (Schneir, et al., 2007; Thompson, McManus, & Voss, 2006; Yates, Mackenzie, Pennbridge, & Swofford, 1991). Importantly, the clinician may be able to employ these interventions proactively to reduce the chances that the at-risk client will become involved in the sex industry in the first place.

Ongoing Child Abuse, Exploitation, or Domestic Violence

If the adolescent currently lives with an abusive parent figure or a physically or sexually abusive partner, or is under the control of some other potentially violent or sexually exploitive person, it is a good idea for the therapist and client to create a "safety plan" (Jordan, Nietzel Walker, & Logan, 2004)—whether or not the client believes it is necessary. Typically, this involves developing a detailed strategy for exiting the home or environment when imminent danger is present (e.g., pre-packed bags, planned escape routes) and finding a new, safer environment, whether it be a friend's home or a local women's or homeless shelter. A preplanned escape option allows the youth immediately to enact a well thought-out plan in an emergency, without having to devise one at the last minute. Client-therapist problem-solving activities that involve safety planning are often helpful not only because they increase the survivor's safety, but also because the process itself is often empowering (Jordan, et al., 2004).

Supporting Safer Sexual Behaviors

Childhood abuse and neglect is associated with involvement in unsafe sexual behavior (i.e., involving risk of HIV/AIDS or other serious diseases, as well as revictimization), along with substance use or abuse that may, in turn, lead to risky sexual activities (Koenig, O'Leary, Doll, & Pequenat, 2003). And, obviously, involvement in prostitution may involve sexual behavior that can lead to diseases such as HIV/AIDS. In general, therapeutic interventions in this area involve providing psychoeducation on safer sex practices; increasing self-esteem and a sense of entitlement and self-determination among those coerced into unsafe sexual activities; desensitizing traumatic memories that, when activated, can lead to ongoing substance use; cognitive processing of abuse-related cognitive distortions that lead to reduced self-assertion or self-protection; problem-solving how to accomplish the greatest level of safety even while involved in prostitution; and working with specific substance abuse issues (Briere, 2003; Koenig, et al., 2003). Less effective are unrealistic attempts to push the client

to immediately cease all dangerous sexual practices (i.e., repeated insistence that the youth "just say no"), moralistic statements, scare tactics, or repetitive arguments with the client regarding his or her dysfunctional thinking. Such behaviors are especially likely to be unsuccessful when they ask the client to do something that he or she is not able or ready to do, such as resisting sexual demands or aggressive sexual behavior in situations where she or he feels little power to do so.

Referral to Shelters and Programs

A final safety intervention is referral. Because the adolescent's environment may be dangerous in the ways outlined in this chapter, especially if he or she has no access to safe, reliable, and at least semi-permanent housing, referral to a shelter may be indicated. Depending on the region, larger cities in the United States may have out-reach programs for runaway, homeless, substance addicted, prostitution-involved, unaccompanied immigrant, or physically endangered youth. Not only do such agencies offer a degree of safety, they typically provide specialized interventions for adolescents with these problems. In this regard, it is important that referral options for traumatized adolescents be "youth friendly" and able to deal with the typical problems and issues presented by this population (Schneir, et al., 2007). Unfortunately, funding and governmental support for quality programs is often limited, despite their importance. When available, they can make a serious difference for multiply traumatized youth.

Chapter 6: Psychoeducation

Although therapy for trauma-related problems often involves the processing of traumatic memories, psychoeducation is also an important aspect of trauma treatment. 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.

Therapists can assist in this area by providing accurate information on the nature of interpersonal trauma and its effects, and by working with the youth to integrate this new information and its implications into his or her overall perspective. For example, older adolescents with sexual abuse histories frequently ask about the reasons for their abuse, in an effort to address feelings that they were in some way responsible. In such instances, 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.

Handouts and Other Media

Whether it occurs in individual therapy or in a guided support group, psychoeducation sometimes includes the use of printed handouts. These materials typically present easily understood information on topics such as the prevalence and impacts of interpersonal violence, common myths about victimization, and social resources available to the survivor. The therapist should keep several issues in mind when deciding what written material to make available and how it should be used (Briere & Scott, 2012).

- The quality of the materials
- The reading level required

- The language of the materials
- The cultural appropriateness of the information or depictions
- 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, alone, may not be especially effective in changing the beliefs or behaviors of victimized individual. 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.

Books

Clinicians may also refer the client to readily available books that are "survivor-friendly." Although obviously limited to those with adequate reading skills (a significant problem for some traumatized adolescents), such books allow clients to "read up" on traumas similar to their own, and potentially experience validation around their personal experiences and concerns. Some books may be too emotionally activating for youth with unresolved posttraumatic difficulties, however, at least early in the recovery process. Others may contain erroneous information, or suggest self-help strategies that are not, in fact, helpful. For these reasons, the clinician should personally read any book before recommending it to the adolescent; not only to make sure that it is appropriate to his or her needs, and is factually accurate, but also in terms of its potential to activate significant posttraumatic distress in those unprepared for such emotional exposure.

Verbal Information during Therapy

Although written psychoeducational materials can be helpful, it is often more useful for the therapist to provide such information verbally during the therapy process. This is especially true for "street kids" and other youth who, for whatever reason, have not progressed far, or well, in the educational system. 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. Additionally, psychoeducation provided in this manner 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. These include:

- The prevalence of the trauma (e.g., in contrast to the youth's impression that only he/she has been victimized);
- Common myths associated with the trauma (e.g., that victims ask for or deserve victimization);
- The usual reasons why perpetrators engage in interpersonal violence (e.g., to address their own needs [including a desire to dominate the victim] or as a reflection of their own inadequacies);
- Typical immediate and longer-term responses to trauma (e.g., posttraumatic stress, depression, intimacy issues, or significant substance use);
- Reframing substance use/abuse and "acting out" or tension-reduction behaviors as adaptive strategies that, nevertheless, may have serious negative repercussions; and
- Resources available to the trauma survivor (e.g., printed information, self-help groups, shelters, advocacy groups, or supportive legal or law enforcement personnel). For some youth, accessing spiritual support may be helpful.

As is noted on the chapter on cognitive processing, psychoeducation is probably best understood as a component of a larger strategy: an attempt to assist the youth in updating (and/or actively countering) the understandings, beliefs, and expectations that he or she developed during earlier adverse experience. In some cases, the adolescent is provided with information that is more accurate than what he or she believes (psychoeducation). In other instances, therapy may involve opportunities for the client directly to work with these thoughts and beliefs until a more benign and reality-based understanding arises (the cognitive therapy described in Chapter 9). In many cases, these two approaches can be combined.

Chapter 7: Distress Reduction and Affect Regulation Training

Adolescents with complex trauma exposure often experience chronic and intense distress as well as posttraumatic symptomatology. Many also describe extremely negative emotional responses to trauma-related stimuli and memories—feeling states that are easily triggered by later relationships and dangerous environments. When faced with overwhelming negative emotions and trauma memories, the youth is often forced to rely on avoidance strategies such as substance abuse, tension-reduction activities, or dissociation (Briere, Hodges, & Godbout, 2010). Unfortunately, high levels of avoidance, in turn, appear to interfere with psychological recovery from the effects of trauma (Briere, Scott, & Weathers, 2005; Polusny, Rosenthal, Aban, & Follette, 2004). In the worst case, the need to avoid additional posttraumatic distress may lead the hyperaroused or emotionally overwhelmed client to avoid threatening or destabilizing material during therapy, or to drop out of treatment altogether. This scenario is exemplified by the psychosocially challenged youth who either is so involved in avoidance behaviors that his or her participation in treatment is minimal, or who attends therapy for one or two sessions, then disappears.

The interventions in this chapter have two foci: the reduction of acute, destabilizing emotions and symptoms (distress reduction), and an increase in the client's more general capacity to regulate negative emotional states (the development of affect regulation skills). This material is presented before the chapters on cognitive and exposure-based processing because, in some cases, low affect regulation capacity must be addressed before more classic trauma therapy (e.g., therapeutic exposure) can occur (Cloitre et al., 2010, Pearlman & Courtois, 2005).

Acute Distress Reduction

Acute stress reduction involves techniques that reduce triggered, overwhelming states that may emerge during therapy, such as panic, flashbacks, intrusive emotional states (e.g., terror or rage), dissociative states, or even transient psychotic symptoms. These internal processes can be frightening—if not destabilizing—to the adolescent survivor, and can diminish his or her moment-to-moment psychological contact with the therapist. At such times, it may be necessary to refocus the survivor's attention onto the immediate therapeutic

environment (with its implicit safety and predictability) and the therapist-client connection.

These interventions also may be of use to the adolescent trauma survivor outside of the therapy session. For example, learning to "ground" oneself or induce a more relaxed state may be helpful when the youth encounters potentially threatening or destabilizing experiences in his or her life, such as in conflicts with others, exposure to trauma triggers, at school, or even when applying for a job or going on a first date.

Grounding

Grounding involves focusing the client's attention away from potentially overwhelming negative thoughts, feelings, and memories. The ability to disengage from intrusive, escalating internal states can be learned, and then applied when necessary. As noted above, the therapist may teach the adolescent how to ground him or herself during treatment sessions, when triggered memories produce potentially overwhelming emotional states. This skill can then be used by the client to address destabilizing states outside of treatment. Grounding typically involves the following steps:

1. Ask the client to briefly describe the nature of his or her internal experience. For example, "Susan, is something going on/upsetting you/happening right now?" If the adolescent is clearly frightened or responding to distressing internal stimuli, but can't or won't describe them, go to Step #2 below. If he or she is able to talk about the internal experience, however, it is often helpful for him or her to label it in some fashion. This does not mean the survivor should go into extensive detail—a highly specific description of the flashback or dissociative state may increase its intensity, thereby reinforcing the response rather than lessening it. Instead, the client is encouraged to focus on the experiential process he or she is undergoing, rather than describing the content of the thoughts. The therapist can facilitate this labeling procedure by saying something like "Can you tell me what's going on, inside, right now?" or "Just tell me what your thoughts are like right now; you don't have to get into them." In this regard, a client's process response would be, "my thoughts are bouncing around inside my head and it feels like I'm going crazy," rather than a content statement such as, "I see her face and hear her voice screaming at me that it was all my fault."

2. Orient the adolescent to the immediate, external environment. This often involves two, related messages: (a) that the client is safe and not, in fact, in danger, and (b) he or she is here (i.e., in the room, in the session, with the therapist) and now (i.e., not in the past, being re-exposed to the trauma). In some cases, the client can be oriented by reassuring statements, typically using the client's name as an additional orienting device (e.g., "Susan, you're ok. You're here in the room with me. You're safe."). In others, grounding may involve asking the client to describe the room or other aspects of the immediate environment (e.g., "Susan, let's try to bring you back to the room, OK? Where are we? What time is it? Can you describe the room?"). He or she might be asked to focus his or her attention on physical sensations, such as the feeling of the chair or couch underneath him or her, or of his or her feet on the floor. The client may also find it helpful to shift attention from internal experiences to external sensory perceptions. For example, the adolescent might be invited to look carefully at the details of an object in the room (e.g., a painting on the wall), listen intently to nearby sounds, or explore a small object by touch. Some clinicians place a hand on the client's shoulder or arm, so that the sensation of physical touch can both reassure and "bring him/her out" of an escalating internal state. This is generally not recommended, however, unless the clinician knows how touch will be interpreted by the client. For some victims of sexual or physical assault, for example, touch may trigger memories of the assault, and increase, rather than decrease, negative internal states. However accomplished, the client's re-orientation to the here and now may occur relatively quickly (e.g., in a few seconds), or may take substantially longer (e.g., a number of minutes).
3. If indicated, focus on breathing or other methods of relaxation (described later in this chapter). Take the adolescent through the relaxation/breathing exercise for as long as is necessary (typically for several minutes or longer), reminding the client of his or her safety and presence in the here-and-now.
4. Repeat Step #1, and assess the client's ability and willingness to return to the therapeutic process. Repeat Steps #2 and #3 as needed.

If it is possible for therapy to return to its earlier focus, the clinician should normalize

the traumatic intrusion (e.g., as a not-unexpected part of trauma processing) and the grounding activity (e.g., as a simple procedure for focusing attention away from intrusive events), and continue trauma treatment, albeit at a temporarily reduced level of intensity. It is important that the adolescent's temporary reexperiencing or symptom exacerbation be neither stigmatized nor given greater meaning than appropriate. The overall message should be that trauma processing sometimes involves the intrusion of potentially upsetting memories, thoughts, and/or feelings, but that such events are part of the healing process.

Relaxation

One of the most basic forms of arousal reduction during therapy is learned relaxation. Strategically induced relaxation can facilitate the processing of traumatic material during the therapy session by reducing the adolescent's overall level of anxiety. Reduced anxiety during trauma processing lessens the likelihood that the client will feel overwhelmed by trauma-related distress, and probably serves to counter-condition traumatic material, as described in Chapter 10. In addition, relaxation can be used by the survivor outside of treatment as a way to reduce the effects of triggered traumatic memories. It is likely, however, that relaxation training alone is insufficient for trauma treatment (Taylor, 2003). Its primary function in ITCT-A is to augment the other components outlined in this guide.

Progressive relaxation. This technique involves clenching and then releasing muscles, sequentially, from head to toe, until the entire body reaches a relaxed state (Rimm & Masters, 1979). As clients practice progressive relaxation on a regular basis, most are eventually able to enter a relaxed state relatively quickly. Some practitioners begin each session with a relaxation exercise; others teach it initially in treatment, and then utilize it only when specifically indicated, for example, when discussion of traumatic material results in a high state of anxiety. 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 may choose to discontinue this approach, or use the breath training method described below.

Breath training. When stressed, many individuals breathe in a more shallow manner,

hyperventilate, or, in some cases, temporarily stop breathing altogether. Teaching the adolescent "how to breathe" during stress can help restore more normal respiration, and thus adequate oxygenation of the brain. Equally important, as the client learns to breathe in ways that are more efficient and more aligned with normal, non-stressed inhalation and exhalation, there is usually a calming effect on the body and the autonomic nervous system.

Breath training generally involves guided exercises that teach the client to be more aware of his or her breathing—especially the ways in which it is inadvertently constrained by tension and adaptation to trauma—and then to adjust his or her musculature, posture, and thinking so that more effective and calming respiration can occur. Below is one approach to breath training, adapted from Briere and Scott (2012).

First

1. Explain to the client that learning to pay attention to breathing, and learning to breathe deeply, can both help with relaxation and be useful for managing anxiety. Note that when we get anxious or have a panic attack, one thing that happens is that our breathing becomes shallow and rapid. When we slow down fearful breathing, fear, itself, may slowly decrease.
2. Explain that, initially, some people become dizzy when they start to breathe more slowly and deeply—this is a normal reaction. For this reason, they should not try breathing exercises while standing until they have become experienced and comfortable with them.
3. Note that the exercises may feel strange at first because the client will be asked to breathe into his or her belly.

Then

1. Have the client sit in a comfortable position
2. Go through the sequence below with the client—the whole process should take about 10 to 15 minutes. After each step, "check in" as appropriate to see how the client is feeling, and ascertain if there are any problems or questions.

    a. If the adolescent is comfortable with closing his or her eyes, ask him or her

to do so. Some trauma survivors will feel more anxious with their eyes closed, and will want to keep them open. This is entirely acceptable. If they prefer to keep their eyes open, the client can be invited to take a "soft gaze"—unfocusing the eyes while looking slightly downward at the floor about three feet ahead.

b. Ask the client to try to "just pay attention to your breathing, noting else" while doing the exercise. If his or her mind wanders (e.g., thinking about school, or about an argument with someone), he or she should gently try to bring it back to the immediate experience of breathing.
c. Ask the client to begin breathing through the nose, paying attention to the breath coming in and going out. Ask him or her to pay attention to how long each inhale and exhale lasts. Do this for 5 or 6 breaths.
d. It is usually helpful for the clinician to breathe along with the adolescent at the beginning of the exercise. You can guide him or her for each inhalation and exhalation, saying "in" and "out" to help him or her along.
e. Instruct the client to start breathing more into his or her abdomen. This means that the belly should visibly rise and fall with each breath. This sort of breathing should feel different from normal breathing, and the client should notice that each breath is deeper than normal. Do this for another 5 or 6 breaths.
f. Ask the adolescent to imagine that each time he or she breathes in, air is flowing in to fill up the abdomen and lungs. It goes into the belly first, and then rises up to fill in the top of the chest cavity. In the same way, when breathing out, the breath first leaves the abdomen, and then the chest. Some people find it helpful to imagine the breath coming in and out like a wave. Do this for another 5 or 6 breaths.
g. Explain that once the client is breathing more deeply and fully into the belly and chest, the next step is to slow the breath down. Ask the client to slowly count to three with each inhalation and exhalation—in for three counts—out for three counts. Tell him or her that there is no specific amount of time necessary for each inhalation and exhalation, only that he

or she try to slow his or her breathing. Do this for 5 or 6 breaths.

3. Ask the client to practice this type of breathing at home for 5 to 10 minutes a day. He or she should choose a specific time of day (e.g., in the morning, before work or school, before going to sleep), and make this exercise a regular part of his or her daily routine[2].

Eventually, the youth may be able to extend this exercise to other times in the day as well, especially when relaxation would be a good idea, e.g., in stressful social situations or whenever he or she feels especially anxious. Remind the client to internally count during each inhalation and exhalation, since counting, itself, often serves to trigger the relaxation response.

Visualization. A third approach to relaxation does not involve learning to breathe or relax, per se, but rather how to imagine a peaceful or pleasant scene in sufficient detail that relaxation naturally follows. The adolescent may be encouraged to sit with eyes closed and visualize a day at the beach, a mountain lake, or walking in a forest. Often, the therapist verbalizes this scene while the youth attends to it, and then the client continues to imagine it for several minutes while the therapist is silent. Later, at moments of stress, the adolescent can "go back" to the scene, if only for a few seconds or minutes. Some clinicians refer to this as the client going to their "special place," although some older adolescents may not value this terminology. Importantly, this skill is not useful in a crisis or emergency where the client must be vigilant and react quickly, but rather when the stress is expected, and the youth has a chance to do this exercise beforehand. Some clients also find this approach helpful as a sleep technique at night.

Mindfulness and meditation

This last approach is in some ways more ambitious than the others described in this chapter, because it takes more effort and practice. On the other hand, the actual technique is

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[2] *Of course, this "homework" component requires that the youth have, in fact, a safe home in the first place. Homeless youth or those living in a dangerous environment may be limited to practicing at the beginning of each therapy session. It is our experience that this modified practice schedule can still yield good results, albeit at a slower pace.*

relatively simple. Meditation accomplishes more than relaxation alone; also learned is the ability to observe one's internal experience with less judgment; to "let go" of upsetting thoughts, feeling and memories; and, with practice, to enter a state of relative calm (Germer, Siegel, & Fulton, 2012; Semple & Lee, 2011)—all skills that can be helpful for traumatized youth (Goodman, 2005). Nevertheless, not all adolescents will want to meditate, now will all therapists feel comfortable or qualified in teaching it. When reduced to a simple activity, however, meditation can be easily practiced and often is quite helpful. Because meditation training is an optional component of ITCT-A, it is presented separately in Chapter 8.

Increasing General Affect Regulation Capacity

In addition to immediate methods of distress reduction, such as grounding, relaxation, and meditation, there are a number of suggestions in the literature for increasing the general affect regulation abilities of trauma clients. All are focused on increasing the survivor's overall capacity to tolerate and down-regulate negative feeling states, thereby reducing the likelihood that he or she will be overwhelmed by activated emotions. In some cases, such affect regulation work may be necessary before any significant memory processing can be accomplished (Blaustein & Kinniburgh, 2010; Cloitre, Cohen, & Koenen, 2006; Pearlman & Courtois, 2005).

Identifying and discriminating emotions

An important aspect of successful affect regulation is the ability to correctly perceive and label emotions as they are experienced (Cloitre, et al., 2006; Linehan, 1993). Many adolescent survivors of complex trauma 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 may not be able to accurately discriminate feelings of anger, for example, from anxiety or sadness. Although this sometimes reflects dissociative disconnection from emotion, in other cases it represents a basic inability to "know about" one's emotions. As a result, the youth may perceive his or her internal state as consisting of chaotic, intense, but undifferentiated emotionality that is not logical or predictable. For example, the adolescent triggered into a seemingly undifferentiated negative emotional state will not be able to say, "I am anxious," let alone infer that "I am anxious because I feel threatened." Instead, the experience may be of overwhelming and unexplainable negative emotion that comes out of

nowhere. 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. In fact, "checking in" with the client multiple times per session is a regular part of ITCT-A. 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," involving 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 a feeling is anxiety because it follows a frightening stimulus, or anger because it is associated with resentful cognitions or aggressive behaviors. Affect identification and discrimination also may occasionally be fostered by the therapist's direct feedback, such as "it looks like you're feeling angry. Are you?" or "you look scared." This last option should be approached with caution, however. There is a risk of labeling a client's affect as feeling A when, in fact, the client is experiencing feeling B—thereby increasing confusion rather than fostering emotional identification. For this reason, it is recommended that, in most instances, 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.

Identifying and countering 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. This is most relevant in situations when thoughts trigger a strong emotional reaction, but the thought is somehow unknown to the survivor. 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). Beyond the

more general cognitive interventions described in Chapter 9, this 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, "she wants to have sex with me" when interacting with an older woman, 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. In other instances, thoughts may be less directly trauma-related, yet still increase the intensity of the client's emotional response. For example, in a stressful situation the client may have thoughts such as "I'm out of control," or "I'm making a fool of myself" that produce panic or fears of being overwhelmed or inundated.

Because triggered thoughts may be out of superficial awareness, their role in subsequent emotionality may not always be clear to the survivor. 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 understanding may reduce the power of those cognitions to produce distress or motivate problematic behavior in the present.

When the thoughts that underlie extremely powerful and overwhelming emotional states are triggered by trauma-related memories, the therapist can focus on these intermediate responses by asking questions such as "what happened just before you got [scared/angry/upset]" or "did you have a thought or memory?" If the client reports that, for example, a given strong emotion was triggered by a trauma memory, the therapist may ask him or her to describe the memory (if that is tolerable), and to discuss what thoughts the memory triggered, much in the way that is described for trigger identification and intervention in Chapter 11. Ultimately, this may involve exploration and discussion of five separate phenomena:

- the environmental stimulus that triggered the memory (e.g., one's teacher's angry

expression),

- the memory itself (e.g., maltreatment by an angry parent);
- the current thought associated with the memory (e.g., "she hates me," "I must have done something wrong," or "I'm getting blamed for something I didn't do") and the associated feeling (e.g., anger or fear),
- analysis of the etiology of these thoughts (e.g., developed in response to perpetrator statements at a time when the child had few other sources of information and relatively limited cognitive capacities), and
- the relative accuracy of the thoughts in the here-and-now: a process that will be facilitated by the client describing his or her childhood-based beliefs aloud, where he or she can hear them in the context of therapeutic support and information.

This process 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 cognitions, 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, and thereby better regulate his or her emotional experience.

Resistance to tension reduction behaviors

Another way in which affect regulation skills can be learned is by the adolescent intentionally forestalling tension reduction behaviors (TRBs) when the impulse to engage in them emerges (Briere, 1996). In general, this involves encouraging the client to "hold off," as long as possible, on engaging in behaviors such as self-mutilation, impulsive sexual behavior, or binging/purging 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 a TRB 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 tension-reduce at all.

Although somehow preventing TRBs entirely would obviously be the best course, in reality the clinician's ability to stop such behavior may be limited, short of hospitalizing the client (although this may be indicated in extreme cases). It is an unavoidable fact of clinical

life that tension-reduction and other avoidance behaviors are survival-based, and therefore not easily given up entirely by overwhelmed, multiply-victimized adolescents.
In general, it is recommended that the therapist take a clear stand on the harmfulness (but not immorality) of certain behaviors, and work with the client to eventually terminate, or at least decrease their frequency, intensity, and injuriousness. Because TRBs 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 triggering TRBs is actually bearable when experienced without behavioral avoidance. For example, if a survivor is able to forestall binge eating or acting on a sexual impulse—if only for a few minutes beyond when he or she would otherwise engage in such activity—three things may happen:

1. The client is exposed to a brief period of sustained distress, during which time he or she can learn a small amount of distress tolerance,
2. During this time period, the distress—although experienced as overwhelming—does not, in fact, do anything more than feel bad; no catastrophic outcomes ensure, and
3. The impulse to engage in the TRB may fade, since the emotionality associated with the urge to TRB often lessens if not immediately acted upon.

With continued practice, the period between the initial urge to tension reduce and the actual TRB may be lengthened, the TRB itself may be decreased in severity, and affect tolerance may be increased. Importantly, the goal of decreasing (and then ending TRBs) 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.

Affect regulation learning during trauma processing

Finally, affect regulation and tolerance can be learned implicitly during longer-term exposure-based trauma therapy. Because, as discussed in later chapters, trauma-focused interventions involve the repeated activation, processing, and resolution of distressing but non-overwhelming emotions, such treatment slowly teaches the adolescent survivor to become more "at home" with some level of painful emotional experience, and to develop whatever skills are necessary to de-escalate moderate levels of emotional arousal. As the

client repeatedly experiences titrated (i.e., not overwhelming) levels of distress during exposure to trauma memories in therapy, he or she may slowly develop the ability to self-soothe and reframe upsetting thoughts, learn that negative states are survivable, and call upon relational support. In addition, by working with the client to deescalate distress associated with activated memories, the therapist often models affect regulation strategies, especially those involving normalization, soothing, and validation. However developed, this growing ability to move in and out of strong affective states, in turn, fosters an increased sense of emotional control and reduced fear of negative affect.

Chapter 8: Mindfulness Training

This chapter briefly described the mindfulness component of ITCT-A. As noted earlier, it is an optional module because it requires some specific training and experience on the part of the therapist, and it may not be appropriate for all adolescents, especially those who are chronically overwhelmed or psychologically unstable. On the other hand, mindfulness-based interventions are increasingly applied in clinical settings, and a growing body of research supports the effectiveness of this approach in treating a variety of symptoms and disorders (Chiesa & Serretti, 2011; Hofmann, Sawyer, Witt, & Oh, 2010; Piet & Hougaard, 2011) in children (e.g., Semple & Lee, 2011) and adults (e.g., Kabat-Zinn, 1994). When included in ITCT-A, mindfulness meditation can address a number of the issues commonly seen in traumatized adolescents, including coping with stress, acute or generalized anxiety symptoms, depressive symptoms, and management of strong emotions. Mindfulness training often includes formal meditation practices, but also incorporates an attitude of acceptance toward everyday experiences that can be helpful in coping with the aftermath of trauma.

Mindfulness has been described as "paying attention, in a particular way, on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994, p. 4). Attention is a defining characteristic of mindfulness, generally focused on ongoing awareness of thoughts, emotions, and sensory perceptions. While specific interventions must be adapted to the developmental needs of adolescents in general and the specific needs of traumatized youth, some core tenets that have been established in adult work still apply.

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. When it is possible for the client to undergo more extensive or formal mindfulness training, we (like others) generally recommend that the teacher be fully qualified to teach meditation, usually by virtue of formal teacher training and a daily meditation practice (Crane, Kuyken, Hastings, Rothwell, & Williams, 2010; Segal, Williams, & Teasdale, 2013). As noted elsewhere (Briere & Scott, 2012), we also suggest that the client's more intensive meditation training be conducted by someone other than the treating clinician, typically in a group format. In this way, the

treating clinician does not have to be as highly trained in meditation and can tend to the more pressing clinical issues often presented by traumatized clients (Briere, in press). The two most common group mindfulness training models are Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2013) and Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1994), both of which are frequently offered by established meditation or mindfulness training centers.

As noted earlier, meditation is not appropriate for all clients at all times (Briere, 2012). It may be contraindicated, for example, for adolescents who are currently in unstable environments or experiencing extreme emotional distress. Severe depression or anxiety disrupts concentration and can make it very difficult to maintain attention on breath or body meditations. A minority of adolescents who have been physically or sexually abused may find that focusing on the body can intensify flashbacks or physiological hyperreactivity. Those who are currently abusing alcohol or substances may find it difficult to maintain a consistent practice or experience little benefit from it. For these reasons, the clinician should always conduct a careful evaluation before beginning mindfulness training.

Mindfulness of the breath

Assuming that there 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 place where you can be alone without interruption for at least 10 minutes or longer. 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. Sit comfortably, with your body balanced on its own weight, not leaning against the chair or the wall. You can lie down, if you wish, but this may make you sleepier, which can make it harder to concentrate.
3. See if you can close your eyes, or at least lower your eyelids. If this makes you anxious, it is fine to leave them open. If you want to keep your eyes open, use a "soft" (unfocused) gaze, with eyes directed downward about 3 feet ahead of you.
4. Focus your attention on your breathing and only on your breathing: feel the air

going into your lungs, note 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 breath. Their mind wanders. That's okay. It's just what minds do. Don't criticize yourself when this happens, just briefly notice that you were thinking, 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 they 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 return to watching 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. 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 can function as a basic relaxation technique and may help the youth moderate emotional distress or physiological hyperarousal.

Mindfulness of thoughts and emotions

Beyond focusing on the breath, mindfulness also can be of thoughts and feelings. Catastrophic thoughts easily escalate the intensity of emotional reexperiencing. The practice of mindful awareness allows the client to see clearly, without judgment, what is happening in his or her mind in the present moment. Some trauma-related thoughts and emotions are

past focused—that is, the adolescent's attention is focused on the previously experienced traumatic events. Others are future focused, such as anticipatory anxiety and behavioral avoidance of places or people associated with the traumatic experiences. In contrast, mindfulness is the cultivation of present-focused attention. For this reason, the present-centered focus of mindful awareness allows the adolescent to be less caught up in thoughts about the past and worries about the future.

Exercises like the one above therefore involve not only attention to the breath, but also to the mind, teaching the youth to "watch thoughts and feelings go by," noticing what arises in the mind, but then letting the thoughts or feelings go as he or she returns his or her attention to the breath. As the client gains skill in this domain, the therapist can change the exercise slightly, giving more attention to the idea that as thoughts and feelings come and go, they are "just" events in the mind, not necessarily reflecting truth or reality. It may be helpful to note to the youth that:

> *Thoughts are just what the mind does. It thinks, all the time. Sometimes the thoughts make sense, sometimes they don't, but all they are, are thoughts. The same goes for feelings, they are just feelings. Thoughts and feelings feel "real," and they are. They are real thoughts and real feelings. But, sometimes they don't tell the truth.*

Taking a step back from one's own thoughts in this way can be a liberating experience. Thoughts become merely events in the mind, and not necessarily evidence of any current reality. This reduced identification with internal processes (sometimes referred to as metacognitive awareness) can help the adolescent manage the intensity of strong emotions by identifying thoughts and emotions for what they are—transient, intrapsychic experiences, not necessarily evidence of what is true or real. By practicing looking at thoughts as "just thoughts"—ever changing and often unrelated to what is happening in the present—the adolescent learns that he or she doesn't need to believe (or react to) everything he or she thinks.

Metacognitive awareness can be reinforced after meditation periods, by having occasional discussions with the client about the idea that cognitions are just thoughts, not facts. We (Briere & Lanktree, 2011) suggest paraphrasing some version of the following:

When you are meditating, it is good to notice when you are thinking. When you meditate, your thoughts kind of come and go, in your mind, right? That's normal, that's what your mind does—it makes thoughts. Lots of them. But, these thoughts are just thoughts—they come out of nowhere, we think them, and then they go away. Then new thoughts come.

[engage the youth in discussion of his or her own experience]

When you meditate, let those thoughts come and go, and remember that they are just thoughts, not always facts about anything that is real. Sometimes we get into trouble by thinking that our thoughts are true. Sometimes they are, but sometimes they aren't. Sometimes, these thoughts are things you learned a long time ago that aren't true. Just let them be thoughts, coming and going. They are just thoughts, memories, things you say to yourself that, lots of times, don't have much to do with your life right now. Just notice them, and then go back to paying attention to your breath.

In this way, mindfulness becomes, among other things, an aspect of affect regulation: if the client's emergent or triggered thoughts or feelings are not necessarily accurate perceptions, but rather "just" productions of the mind and history, then they can be less frightening, anger-inducing, or depressing. Similar to trigger work (described in Chapter 11), mindfulness allows the youth to be less reactive in response to internally-experienced, trauma-related material or processes, as he or she comes to see that they are only what they are.

Chapter 9: Cognitive Processing

As noted earlier, victims of interpersonal violence can be prone to a variety of negative cognitive phenomena, including self-blame, guilt, shame, low self-esteem, overestimation of danger, and other negative beliefs and perceptions. The adolescent survivor of childhood physical and emotional abuse may view his or her maltreatment as just punishment for being "bad," and may suffer guilt and a poor self-image. A teenage woman battered by her partner may assume that she deserves to be beaten. Individuals who have been repeatedly exposed to situations in which they were helpless to escape or otherwise reduce their trauma exposure may develop a sense of having little power to affect future potentially negative events. Some adolescent survivors view their posttraumatic symptoms as evidence of being mentally ill. Victims of sexual trauma often feel ashamed and isolated by their experiences, partially as a function of socially-transmitted myths about rape.

In general, cognitive therapy of posttraumatic disturbance involves the guided reconsideration of negative perceptions and beliefs about self, others, and the environment that arose from the trauma. As these negative assumptions are reevaluated, a more affirming and empowering model of self and others can take their place. At the same time, the client may develop a more detailed and coherent understanding of the traumatic event, a process that is generally associated with clinical improvement.

Cognitive Reconsideration

In ITCT-A, trauma-related cognitive disturbance is generally addressed through a detailed verbal exploration of the traumatic event and its surrounding circumstances. As the survivor repeatedly describes the trauma in the context of safety and acceptance, he or she, in a sense, relives the past while viewing it from the perspective of the present. By verbally recounting the traumatic event, the adolescent (with the assistance of the therapist) has the opportunity to "hear" the assumptions, beliefs, and perceptions that were encoded at the time of the trauma, and to compare them with what he or she now knows. Together, the client and therapist can then work to create a more accurate cognitive model of what occurred. In Self-Trauma and ITCT language, this process is referred to as cognitive reconsideration (Briere & Scott, 2012).

Cognitive reconsideration may foster more positive self-perceptions, as the client comes to reinterpret former "bad" behaviors, deservingness of maltreatment, and presumed inadequacies in a more accurate light. For example, the client who has always interpreted her behavior just prior to a rape as "sluttish" or "asking for it" may gain from the opportunity to relive and review what actually happened, and to see if her judgments about herself seem valid. Exploration of the events prior to the rape may reveal that she was not behaving in a "seductive" manner, nor is she likely to recall actually wanting to be abused or otherwise hurt.

In addition, increased awareness of what one could reasonably have done at the time of the trauma—i.e., what one's options actually were—can be antidotal to inappropriate feelings of responsibility, self-blame, or self-criticism. For example, describing memories of childhood abuse in detail—while at the same time listening to them from the perspective of an older adolescent—may lead the adolescent to the realization that he or she had few options other than accommodation at the time of the abuse. The notion that "I should have done something to stop it," for example, can be countered by a greater understanding of the size and power differentials inherent in an adult forcing himself on a 7-year-old child.

Finally, blaming or shaming statements made by an assailant may eventually lose their power when examined in the context of a safe environment. Many victims of interpersonal violence tend to, on some level, accept rationalizations used by the perpetrator at the time of the assault. These include rapist statements that the adolescent victim was asking to be sexually assaulted, child abuser statements that physical abuse was merely appropriate punishment for bad behavior, or the youth exposed to chronic emotional abuse who internalizes perpetrator comments that he or she is bad, fat, ugly, or worthless. As the client and therapist discuss the circumstances of the event, and consider perpetrator statements in the absence of current danger or coercion, the objective lack of support for these statements may become more apparent to the client.

Because the therapist may see these cognitive distortions more clearly than does the client, he or she may feel pressed to voice an opinion regarding the lack of culpability of the victim or the obvious cruelty of the perpetrator. This is understandable, and, in small doses, appropriate. Rarely, however, will such statements, in and of themselves, substantially change the client's opinion. In fact, clinical experience suggests that cognitive therapy is unlikely to be helpful when the clinician merely disagrees (or argues) with the client about his

or her cognitions or memories, or makes definitive statements about what reality actually is. Rather, cognitive interventions are most effective when they provide opportunities for the client to experience the original trauma-related thoughts and self-perceptions (e.g. feelings of responsibility and guilt when recalling being beaten by a parent), while, at the same time, considering a more contemporary and logical perspective (for example, that the beatings were, ultimately, about the parent's chronic anger, alcoholism, and feelings of inadequacy, and not due to the client's failure to be a good child or show proper respect).

As suggested by various writers, the reconsideration of trauma-related assumptions, expectations, or beliefs is probably most effective when it occurs while the adolescent is actively remembering the trauma and reexperiencing the thoughts and feelings that he or she had at the time (Resick & Schnicke, 1993). Merely discussing a traumatic event without some level of emotional memory activation is less likely to change the cognitions related to the memory. In contrast, active recall and description of a traumatic event probably trigger two parallel processes: observation of one's own trauma-related attributions regarding the specifics of the event, and activation of the emotions associated with the event. The second component of this response is covered in detail in the next chapter, under the heading of titrated exposure. However, it is important to acknowledge it here because emotional activation allows the client to more directly to relive the traumatic event, such that any cognitive interventions are more directly linked to specific memories of the trauma.

There are two major ways that the youth can remember and, to some extent, reexperience traumatic events during the process of treatment: by describing them in detail and by writing about them. In the first instance, the therapist asks the client to describe the traumatic event or events in as much verbal detail as is tolerable, including thoughts and feelings he or she experienced during and after victimization experience. As noted in Chapter 10, this is an important component of titrated exposure. It also facilitates cognitive processing, however, if it includes discussion of conclusions or beliefs the survivor formed from the experience. In response to the client's description, the therapist generally asks open-ended questions that are intended to make apparent any cognitive distortions that might be present regarding blame, deservingness, or responsibility. As the client responds to these questions, the therapist provides support and encouragement, and, when appropriate, carefully offers information or psychoeducation that might counter the negative implications

or self-perceptions that emerge in the client's responses (see Chapter 6). The client might then have responses that lead to further questions from the therapist. Or, the topic might shift to the client's emotional processing of the implications of any new information, insights, or feelings that arose from the discussion process.

The second major form of cognitive processing involves the use of "homework." As described in the next chapter, the adolescent is asked to write about a specific topic related to the trauma, bring it to the next session, and read it aloud in the presence of the clinician. In this way, the client has the opportunity to continue therapeutic activities outside of the session, including desensitization of traumatic memories and continued cognitive reconsideration of trauma-related assumptions and perceptions. In addition, research suggests that the mere act of writing about an upsetting event, especially if done on multiple occasions, can reduce psychological distress over time (Pennebaker, 1993; Pennebaker & Campbell, 2000). See Chapter 10 for an example of trauma processing homework, *Written Homework about My Trauma*.

It should be noted, however, that although therapeutic "homework" is a mainstay of various cognitive-behavioral therapies, self-exposure to trauma-related thoughts or feelings (i.e., without a therapist present) may be challenging, if not overwhelming, for some adolescent survivors. If writing about a trauma activates extreme fear, self-hatred, or other sufficiently strong negative states, certain youths (e.g., those with low affect regulation capacity) may become "retraumatized"—sometimes then engaging in deleterious avoidance or tension-reduction behaviors, such as maladaptive substance use, self-injury, or binge eating. This is not a common scenario; most traumatized adolescents appear capable of processing trauma-related memories and cognitions on their own, between sessions. Nevertheless, it is recommended that such homework be offered only to those survivors who appear able to tolerate it.

Similarly, written homework about past traumas is best done when the home environment is stable and safe. If the youth is homeless, or if there is even a slight chance that the perpetrator of the trauma (or some other abusive family member) might get access to a description of what he or she did to the client, the clinician should ask that the homework be done within the session only, where safety can be guaranteed.

The goal of writing and/or verbally presenting trauma narratives is to activate the

client's memories of the traumatic event and to facilitate their cognitive processing. During the therapy session, such discussions are guided by a series of gentle, usually open-ended inquiries that allow the client progressively to examine the assumptions and interpretations he or she has made about the victimization experience. Typical questions stimulate detailed discussion of:

- The youth's thoughts during and after the trauma, including why he she came to think those things at that time
- Ways in which those thoughts may have become current assumptions, despite
    - their relatively unexamined nature and
    - the fact that aspects of the trauma may have prevented clear thinking at the time (e.g., the need for survival, the client's youth/relative lack of power when the event occurred, and/or the ability of the perpetrator to control the client's thinking)
- Whether negative cognitions about himself/herself "make sense," given what the adolescent now knows and given the perspective associated with the client's now greater age and current greater safety
- Whether, in light of the specific aspects of the trauma (e.g., the client's youth, lesser power/strength/social entitlements, relative unavailability of help, etc.), there was much the client could have done other than what he or she did do
- Whether he or she actually deserved what happened (e.g., was what happened appropriate punishment, abusive behavior, or a good way to treat a child)
- Whether, in fact, he or she "asked for it," including whether the client can recall wanting to be raped, beaten, or maltreated, or, if the trauma was sexual victimization, whether he or she can remember actually desiring sexual contact with the abuser
- Whether the adolescent's judgments of himself or herself can be generalized to others (e.g., if the trauma happened to another child, would the survivor come to the same conclusions about the other child's badness/stupidity/unacceptability)
- To the extent that that the adolescent seems to have internalized the statements of the perpetrator or the responses of other unsupportive people, whether these individuals would generally be people whom the client would take seriously or

trust regarding their opinions on other topics

The intent of such cognitive exploration is for the youth to update his or her trauma-based understanding—not to incorporate the therapist's statements or beliefs regarding the true state of reality or the client's "thinking errors." Although therapist feedback about the presumed reality of things may sometimes be helpful, much of the knowledge the client acquires in therapy is best learned from himself or herself. By virtue of the opportunity repeatedly to compare "old" trauma-based versions of reality with newer understandings, especially in the context of a safe and supportive environment, the client can often revise his or her personal history—not in the sense of making things up, but by updating assumptions and beliefs that were made under duress and never revisited in detail. Importantly, good cognitive therapy is not an argument between client and therapist; instead, it represents an opportunity for the adolescent to reconsider previous assumption and beliefs in the context of current safety, support, gentle inquiry, and new information.

The therapist may stimulate these discussions as the description of the trauma unfolds, or after the client's verbal rendition is completed. Often the latter approach is especially helpful: encouraging the client to describe the trauma in detail, and then following up with questions and detailed exploration. In doing so, the client can fully expose himself or herself to the story, with its associated emotional triggers, and the therapist has a better chance of determining what the client thinks about the trauma without the rendition being affected by therapist responses.

However accomplished, the intent of cognitive therapy in this area is to assist the client to explore, fully and accurately, his or her beliefs or assumptions, without lecturing, arguing, or labeling such beliefs as "wrong." Instead, such cognitions should be viewed (and reflected back to the client) as entirely understandable reactions to overwhelming events that involved extreme anxiety and distress, incomplete information, coercion, confusion, and, in many cases, the need for survival defenses. Trauma-related cognitions should be treated not as the product of client error, but rather as logical initial perceptions and assumptions that require updating in the context of safety, support, and better/new information. Not only does such a therapeutic stance tend to be more effective than merely informing the client of his or her misperceptions of reality, it is less likely to alienate chronically traumatized youth who may have been on the wrong end of authoritarian power dynamics for many years.

While addressing cognitive distortions about the event and what it means to the client, the clinician also may encounter distortions the client has formed regarding the meaning of symptoms he or she is experiencing. In general, these involve beliefs that the intrusive-reliving, numbing/avoidance, and hyperarousal symptoms of traumatic stress represent loss of control or major psychopathology. In the style outlined above for trauma-related cognitions, the therapist can facilitate cognitive reconsideration of these perceptions or beliefs—especially after some level of psychoeducation has transpired—by asking the adolescent about

- what might be a non-pathologizing explanation for the symptom (e.g., the survival value of hypervigilance, or the self-medicating aspects of substance use/abuse),
- whether the symptom(s) actually indicate psychosis or mental illness (e.g., whether flashbacks are the same thing as hallucinations, or whether it is really "paranoid" to be fearful about trauma-reminiscent situations, especially if trauma is still possible), and
- whether it is better to actively experience posttraumatic stress (especially reexperiencing) than to "shut down" or otherwise avoid trauma memories (Briere & Scott, 2012).

These and other questions may stimulate lively, clinically useful conversations, the goal of which is not for the clinician's view to prevail, but for the client to explore the basis for (and meaning of) his or her internal experience.

Development of a Coherent Narrative

In addition to the cognitive processing of traumatic memories, therapy can provide broader meaning and context. Client descriptions of past traumatic events often become more detailed, organized, and causally structured as they are repeatedly discussed and explored in therapy—including during cognitive reconsideration. Increased narrative coherence is often associated with reduced posttraumatic symptoms (Foa, Molnar, & Cashman, 1995; Siegel, 1999). As the client is increasingly able to describe chronologically and analytically what happened, and to place it in a larger context, he or she may experience

an increased sense of perspective, reduced feelings of chaos, and a greater sense that the universe is predictable and orderly, if not entirely benign. Creating meaning out of one's experiences may provide some degree of closure, in that they "make sense" and thus may not require further rumination or preoccupation. Finally, a more coherent trauma narrative, by virtue of its organization and complexity, may support more efficient and complete emotional and cognitive processing. In contrast, fragmented recollections of traumatic events that do not have an explicit chronological order and do not have obvious cause-effect linkages can easily lead to additional anxiety, insecurity, and confusion—phenomena that potentially interfere with effective trauma processing.

The development of a coherent narrative usually occurs naturally during the cognitive aspects of trauma-focused therapy. As the traumatic event is discussed repetitively and in detail, a process sometimes referred to as context reinstatement may occur. Specifically, a detailed trauma description often triggers recall of additional details that, over time, provide a story that is more internally consistent and "hangs together."

Although a more coherent narrative often arises naturally from repeatedly revisiting the trauma in therapy, the clinician can work to increase the likelihood of this happening. This generally involves gentle, nonintrusive questions regarding the details of the trauma, and support for the client's general exploration of his or her thoughts and feelings regarding the event—in the same manner described earlier for cognitive processing. In partial contrast to cognitive processing interventions, however, narrative interventions explicitly support the development of broader explanations and a "story" of the traumatic event, its antecedents, and its effects.

Cognitive changes arising from non-overwhelming emotional activation during treatment

Not all cognitive effects of trauma therapy involve verbal reconsideration of traumatically altered thinking patterns—it is also possible for the survivor's beliefs to change during the process of remembering and processing upsetting memories (Foa & Rothbaum, 1998). In the context of processing traumatic memories in therapy, the client repetitively experiences three things: (1) anxiety that is conditioned to the trauma memory, (2) the expectation that such anxiety signals danger and/or is, itself, a dangerous state and must be

avoided, and yet (3) an absence of actual negative outcome (i.e., he or she does not actually experience physical or psychological harm from anxiety or what it might presage). This repetitive disparity (a technical term that will be discussed in more detail in the next chapter) between the expectation of anxiety as signaling danger and the subsequent experience of non-danger probably changes the expectation over time. Beyond its cognitive effects on beliefs and assumptions associated with the specific trauma memory, the repetitive experience of feeling anxious during trauma therapy—in the context of therapeutic safety—probably lessens the disruptive power of anxiety, per se. In many cases, the client becomes less anxious about anxiety—coming to see it as merely an emotion and not necessarily as a harbinger of danger, loss of control, or psychological disability. To paraphrase one young survivor, "I thought feeling all this stuff would kill me. It doesn't."

Chapter 10: Titrated Exposure

In addition to the cognitive interventions described in the last chapter, most trauma treatments include some form of therapeutic exposure. Therapeutic exposure refers to a procedure wherein the client is exposed, during therapy, to memories of a traumatic event, and then the emotional responses that emerge are desensitized or habituated over time until they no longer can be activated by the memory. A specific type of therapeutic exposure, titrated exposure, 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. In this context, the Self-Trauma Model refers to the therapeutic window and intensity control, both of which are described below.

The Therapeutic Window

The therapeutic window represents the psychological midpoint between inadequate and overwhelming activation of trauma-related emotion during treatment. It is a hypothetical "place" where therapeutic interventions are thought to be most helpful (Briere & Scott, 2012). Interventions within the therapeutic window are not so trivial or non-evocative that they provide inadequate memory exposure and processing, or so intense that they become overwhelming. In other words, interventions that consider the therapeutic window are those that trigger trauma memories (i.e., through therapeutic exposure) and promote processing, but do not overwhelm internal protective systems and motivate unwanted avoidance responses. Because many traumatized adolescents with complex posttraumatic outcomes have affect regulation problems, the therapeutic window is an important aspect of ITCT-A.

Interventions that undershoot the therapeutic window are those that either completely and consistently avoid traumatic material, or are focused primarily on support and validation with a client who could 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 and, therefore, 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 distress. Interventions that are paced too quickly may overshoot the window because they do not allow the adolescent to adequately accommodate and desensitize previously activated material before triggering new memories. When therapy consistently overshoots the window, the 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. The youth 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. Although the clinician may interpret these behaviors as "resistance" or "borderline behavior," such avoidance often represents appropriate protective responses to therapist process errors. Unfortunately, the client's need for avoidance can easily impede treatment by decreasing his or her exposure to memory material and the ameliorative aspects of therapy.

In contrast, effective therapy for traumatized adolescents provides titrated exposure to traumatic material while maintaining the safety and support necessary eventually to extinguish trauma-related emotional responses. By carefully adjusting the amount of therapeutic exposure so that the associated emotional activation does not exceed the survivor's emotional capacities, treatment within the therapeutic window allows the client to slowly process trauma memories without being retraumatized and needing to "shut down" the process.

Intensity control

Intensity control refers to the therapist's awareness and relative control of the level of emotional activation that occurs within the session. It is recommended that—especially for adolescents with affect regulation difficulties—emotional intensity be highest at around mid-session, whereas the beginning and end of the session should be at the lowest intensity. Ideally, at the beginning of the session, the youth gradually enters the process of psychotherapy; by the middle of the session, the focus has shifted to relatively more intense processing and activation; at the end of the session, the client is sufficiently de-aroused that she or he can re-enter the outside world without needing later avoidance activities. The

relative safety of psychotherapy sessions may allow some clients to become more affectively aroused than they would outside of the therapeutic environment. As a result, it should be the therapist's goal to leave the client in as calm an affective state as is possible—ideally, no more emotionally aroused than he or she was at the beginning of the session.

The need for the adolescent to experience upsetting feelings and thoughts during trauma-focused treatment requires that the therapist carefully titrate the level of emotional activation the client experiences, at least to the extent that this is under the therapist's control. From the therapeutic window perspective, intense affect during treatment pushes the client toward the outer edge of the window (i.e., toward an increased possibility of being overwhelmed), whereas less intensity (or a more cognitive focus) moves the client toward the inner edge (i.e., toward reduced exposure and emotional processing). The goal is to keep the survivor near the "middle" of the window—to feel neither too little (i.e., to dissociate or otherwise avoid to the point that abuse-related emotional responses and cognitions cannot be processed) nor too much (i.e., to become flooded with previously avoided emotionality that overwhelms available affect regulation resources and is retraumatizing).

Constraints on therapeutic exposure

As noted throughout this guide, exposure to trauma memories and the attendant distress can be quite challenging. In most instances, therapeutic exposure is tolerable to the extent that it occurs within the therapeutic window. In some relatively rare cases, however, almost any level of memory processing overshoots the window, irrespective of the clinician's efforts. When this occurs, it is usually because (a) the trauma is so recent or severe that emotional activation is innately overwhelming, (b) the client has insufficient affect regulation capacities, and/or (c) the client generally suffers from such high levels of comorbid emotional distress, interfering symptoms, or negative cognitive preoccupation that the additional (i.e., trauma-related) distress is incapacitating.

For these reasons, detailed exploration of traumatic material is not always appropriate. As noted by various authors, therapeutic exposure to trauma memories may be contraindicated for those experiencing very high levels of anxiety; severe depression; acute psychosis; major suicidality; overwhelming shame associated with the traumatic event; especially impaired affect regulation capacity; very recent and substantial trauma exposure; or major substance use or intoxication (e.g., Bryant & Harvey, 2000; Cloitre, et al. 2002;

Najavits, 2002; Pitman, et al., 1991). In addition, some adolescents live in environments that are so dangerous and continuously traumatizing that they are unable to experience the safety that is required for successful trauma processing. When any of these conditions exist, the clinician is advised to focus on the various other components outlined in this guide—especially safety interventions (Chapter 5), distress reduction and affect regulation skills development (Chapter 7) and cognitive interventions (Chapter 9)—before considering therapeutic exposure. In some cases, psychiatric medication also may be indicated (Scott, Jones, & Briere, 2012; Stamatakos & Campo, 2010) before active memory processing can safely occur.

Components of Titrated Exposure

Assuming that none of the constraining conditions presented above are in force, or that they have been sufficiently diminished, formal titrated exposure can be initiated. For the purposes of this treatment guide, the processing of traumatic memory within the therapeutic window will be divided into five components: exposure, activation, disparity, counterconditioning, and desensitization/resolution. These components do not always follow a linear progression. In fact, in some cases interventions at a "later" step may lead to further work at an "earlier" step. In other instances, certain steps (e.g., counterconditioning) may be less important than others (e.g., disparity). And, finally, as described in Chapter 7, the therapy process may require the client to learn (or invoke previously learned) affect regulation techniques in order to down-regulate distress when emotional responses inadvertently become overwhelming.

Exposure

In the current context, exposure refers to any activity engaged in by the therapist or the client that provokes or triggers client memories of traumatic events. Several types of exposure-based therapies are used to treat traumatic stress. The approach described in this guide asks the client to recall non-overwhelming but moderately distressing traumatic experiences in the context of a safe therapeutic environment. This approach usually does not adhere to a strict, pre-planned series of extended exposure activities. This is because the youth's ability to tolerate exposure may be quite compromised, and may vary considerably as a function of outside life stressors, level of support from friends, relatives, and others, and,

most importantly, the extent of affect regulation capacities available to him or her at any given point in time. In Self-Trauma language, the "size" of the therapeutic window may change within and across sessions.

In general, therapeutic exposure involves the adolescent recalling and discussing traumatic events with the therapist, and, in some cases, writing about them at home and then reading them aloud in the next session. Although some other forms of trauma therapy focus on memories of a single trauma (e.g., of a motor vehicle accident or physical assault), and discourage much discussion of other traumas, the approach advocated in ITCT-A is considerably more permissive. It is quite common and acceptable for trauma survivors to "jump around" from one memory to another, often making associations that are not immediately apparent to the therapist—or even, in some cases, the client. Especially for youth with histories of multiple, complex, and extended traumas, the focus of a given session may move from a rape experience to earlier childhood maltreatment to an experience of violence during an arrest. A young man caught in prostitution may begin the session with a memory of being assaulted by a john (customer), and find himself, 20 minutes later, describing being physically abused by his father when he was a child.

The broader exposure activities of the therapy described here reflect the complexity of many trauma presentations. Although an adolescent may come to treatment in order to address a recent assault experience, it may soon become apparent that either (a) an earlier trauma is actually more relevant to his or her ongoing psychological distress, or (b) the distress is due to the interacting effects of multiple traumas. A young heroin user, for example, might seek treatment for the effects of a violent rape by an acquaintance, and soon discover that this rape activates memories of a number of other distressing experiences, as well as the childhood incest experiences that may have partially determined his or her current addiction. In such instances, insisting that the survivor focus exclusively on a single trauma during therapy, or even on just one trauma at a time, may be contraindicated, or not well appreciated by the client. As well, recollections of early trauma are often fragmented and incomplete, if not entirely nonverbal in nature, precluding the youth's exposure to a discrete, coherent memory, per se. Instead of being limited to discussions of a single trauma, it is suggested that the adolescent be allowed to explore—and thereby expose himself or herself to—whatever traumatic material seems important at a given time, or whatever memory (or

part of a memory) is triggered by any other memory.

Explaining the value of titrated exposure. Although exposure is widely understood to be a powerful treatment methodology by clinicians, the adolescent may respond negatively to the idea of revisiting traumatic memories. Prior to therapy, the survivor may have spent considerable time and energy controlling his or her distress by avoiding people, places, and situations that trigger posttraumatic intrusions, and by trying to suppress or numb trauma-related distress. As a result, exposure techniques, wherein the client is asked to intentionally reexperience events and emotions that he or she has been avoiding, may seem counterintuitive, if not anti-survival.

For this reason, an important aspect of trauma therapy is pre-briefing: explaining the rationale for therapeutic exposure, and its general methodology, prior to the onset of formal treatment. Without sufficient explanation, the process and immediate effects of exposure may seem so illogical and stressful that the adolescent client may automatically resist and avoid, including, in some cases, terminating therapy. On the other hand, if exposure can be explained so that he or she understands the reasons for this procedure, it usually is not hard to form a positive client-therapist alliance around this approach and a shared appreciation for the process. Although the way in which exposure is introduced may vary from instance to instance, the clinician should cover the following main points when preparing clients for exposure work (Briere & Scott, 2012):

- Unresolved memories of the trauma often have to be talked about and reexperienced, or else they may not be fully processed and will be more likely to keep coming back as symptoms or unwanted feelings.
- Although the adolescent understandably would like to not think about what happened, and may have been avoiding upsetting feelings about the trauma, such avoidance (a) is usually impossible to maintain (hence the presence of symptoms), and (b) often blocks processing and thus, ironically, serves to keep the symptoms alive.
- If the client can talk about what happened enough, in the safety of treatment, the pain and fear associated with the trauma is likely to decrease. The clinician, however, cannot promise that this will occur.

- By its nature, exposure is associated with some level of distress, and some people who undergo exposure experience a slight increase in flashbacks, nightmares, and/or distressing feelings between sessions. This is normal and usually not a bad sign. At the same time, the youth should inform the therapist when this occurs, so that he or she can monitor whether exposure has been too intense.
- The clinician will work to keep the discussion of these memories from overwhelming the client, and the client can choose to stop talking about any given memory if it becomes too upsetting (an option usually not offered in more classic, prolonged exposure approaches). The youth need only talk about as much traumatic material as he or she is comfortable with. However, the more he or she can remember, think, feel, and talk about non-overwhelming memories during therapy, the more likely it is that significant improvement will occur. Because therapeutic exposure can exceed the therapeutic window, the therapist should "check in" with the client on a regular basis during this process, making sure that he or she is feeling in sufficient control and is not becoming overwhelmed.

Homework. As noted in the last chapter, trauma therapy sometimes includes "homework" assignments for clients who can tolerate between-session exposure exercises. This adjunct to session-based treatment typically involves the client writing about the traumatic event when at home (or wherever might be safe), and then reading it aloud in the next session. Along with providing additional opportunities to examine and process cognitions initially associated with the event (per Chapter 9), this activity requires that the client access the original trauma memory in order to write about it, and thus provides significant therapeutic exposure. This exposure is then repeated when the client reads the narrative aloud to the therapist.

Adapting from Resick and Schnicke's (1993) book on cognitive processing for rape victims, the therapist is invited to copy the handout found in the Appendix (Written Homework About My Trauma; also available on the internet: attc.usc.edu) and provide it to the client, saying something like:

> *Here is the homework sheet we discussed. Try to write down answers to all the questions about the [rape/shooting/abuse incident/etc.] and what happened afterwards. Include as much detail about it as you can remember, and be as specific*

as possible. After you're done writing, read it to yourself at least once before our next session. If it is too upsetting to read all at once, try reading as much as you can, and then read the rest later, when you are ready.

The adolescent may be asked to repeat this writing exercise on several different occasions over the course of treatment, either completing the exercise for a different trauma on each occasion, or repeating the exercise on multiple occasions for the same trauma. The specific timing and frequency of these writing and reading exercises may vary according to (a) the adolescent's capacity for written expression, (b) his or her readiness to directly confront the trauma, and (c) his or her immediate emotional stability and affect regulation capacity. The therapist's response to hearing the client's story should be characterized by support, validation, and appreciation for the client's willingness to engage in a potentially difficult task. He or she should also be prepared to provide grounding or other stabilization techniques in the event that this exercise (especially reading the homework aloud) produces significant emotional distress.

Obviously, this approach is not possible for those unable to read and write, for non-English speakers, or for who are too cognitively debilitated (e.g., by psychosis, severe depression, or hyperarousal). The total number of times this exercise is done may increase if there are several different traumas in need of emotional processing. In general, the clinician may find that these written renditions become more detailed and emotionally descriptive upon repetition, and that the client's emotional responses when reading the assignment aloud become less extreme over time. It should be reiterated, however, that "homework" involving exposure to trauma memories (and thus the associated feelings and thoughts) is only indicated for those adolescents who are unlikely to be overwhelmed by such activities. In many cases, it is probably best to discuss this activity to the client, and to get his or her opinion about whether it would be possible and useful, rather than just prescribing it. As with any other exposure intervention, the client has the absolute right to refuse to engage in exposure homework.

On occasion, the clinician may choose to augment (or even replace) the "homework about my trauma" with other exercises, such as writing (but typically not sending) a letter to the perpetrator or others involved in the trauma, or writing about trauma-related thoughts and feelings in a journal, and then reading this material to the clinician in the following

session. Typically, the more opportunities the client has to put his or her experiences into written form, the more chances he or she has to recall (and thus expose himself or herself to) the painful past in a safe, more structured and constrained way.

Activation

If treatment is to be effective, some degree of activation must take place during exposure. Activation refers to emotional responses that are triggered by trauma memories, such as fear, sadness, or horror, and trauma-specific cognitive reactions, such as intrusive negative self-perceptions or sudden feelings of helplessness. Other related memories and their associated affects and cognitions may be triggered as well. A young woman who is asked to describe a childhood sexual abuse experience, for example, undergoes therapeutic exposure to the extent that she recalls and describes aspects of that event during the therapy session. If these memories trigger emotional responses conditioned to the original abuse stimuli (e.g., fear or disgust), or associated cognitive intrusions (e.g., "I am so gross"), or stimulate further memories (e.g., of other traumas, or other aspects of the abuse triggered by remembering certain aspects of it), therapeutic activation can be said to have taken place.

Activation is usually critical to trauma processing—in order to extinguish emotional-cognitive associations to a given traumatic memory, they must be (a) activated, (b) not reinforced, and, ideally, (c) counterconditioned. As a result, therapeutic interventions that consist solely of the narration of trauma-related memories without emotional activation will often fail to produce symptom relief. In order for optimal activation to occur, there should be as little avoidance as is reasonably possible during the exposure process. On the other hand, as noted throughout this guide, too much activation is also problematic because it generates high levels of distress (thereby linking memory to current emotional pain, rather than to safety or positive feelings) and motivates avoidance (thereby reducing further exposure and processing).

Because activated cognitive-emotional responses are, to some extent, the crux of trauma work, the following sections describe several interventions aimed at controlling the level of activation during treatment. The goal, in each case, is to work within the therapeutic window—to support emotional and cognitive activation that is neither too little nor too much for optimal processing. It is important to note that the interventions described

hereafter relate to verbal—as opposed to written—therapeutic exposure. Although activation upon reading previously written trauma narratives is possible, it is typically less overwhelming, and somewhat more difficult for the therapist to modulate during the session.

Increasing activation

The therapist typically seeks to increase activation in instances when, despite available affect regulation capacity, the client appears to be unnecessarily blocking some portion of his or her emotional responses to the traumatic material. It is common for avoidance responses to become so overlearned that they automatically, but unnecessarily, emerge during exposure to stressful material. In other instances, gender roles or socialization may discourage emotional expression in an individual who could otherwise tolerate it. When avoidance is not required for continued emotional homeostasis, yet appears to be blocking trauma processing, several interventions may be appropriate. In each case, the goal is increased awareness and, thus, increased activation. First, the therapist may ask questions that can only be answered in a relatively less avoidant state. These include, for example:

- "What were you feeling/how did it feel/ when that happened?"
- "What are you feeling now?"
- "Are you having any thoughts or feelings when you describe [the trauma]?"

In such cases, the avoidance may decrease, yet never be acknowledged—an outcome that is entirely appropriate, since the primary intent is to keep activation at a reasonable level, not to label the client's reaction as problematic.

Second, the clinician can indirectly draw attention to the avoidance, without stigmatizing it, and ask the client to increase his or her level of contact during the process of activation. This is often most effective when the client's avoidance, or the power of the triggered emotions to overwhelm, has previously been identified as an issue in therapy. This may involve encouraging suggestions such as

- "You're doing well. Try to stay with the feelings,"
- "Don't go away now. You're doing great. Stay with it."
- "I can see it's upsetting. Can you stay with the memory for just a few more minutes? We can always stop if you need to."

In other cases, for example, when dissociation is just one possibility, or when the client is more prone to a defensive response, the therapist may intervene with a question-statement combination, such as:

- "How are you doing? It looks like maybe you're spacing out a little bit."
- "It looks like you're going away little bit, right now. Are you?"

Although calling direct attention to avoidance is sometimes appropriate, it tends to break the process of exposure-activation, and probably should be used only when less direct methods of encouraging activation (and thus reducing avoidance) have not been effective.

A third way that the clinician can increase activation is by increasing the intensity of the emotional experience. Often, this involves requesting more details about the traumatic event, and responding in ways that focus the youth on emotional issues. As the client provides more details, the opportunity for greater activation increases—both because greater details often include more emotionally arousing material, and because greater detail reinstates more of the original context in the client's mind, thereby increasing the experience of emotions that occurred at the time of the trauma.

Decreasing activation

If the therapist inadvertently triggers too much activation, or is unsuccessful in keeping the client's emotional activation to a tolerable level, the therapeutic window will be exceeded. This can be problematic because, as noted earlier, clients with reduced affect regulation capacities typically should not be exposed to especially upsetting memories until their ability to regulate negative emotions improves. In general, when material exceeds the therapeutic window, the appropriate response is to either redirect the client to a less upsetting topic, or, more subtly, directing the conversation to less emotionally charged, typically more cognitive, aspects of the trauma. Once the client's emotionality has returned to baseline, careful exposure activities may be resumed, if appropriate.

Occasionally, over-activation (overshooting the window) may produce responses that are not sufficiently addressed by changing the focus or intensity of the therapeutic conversation. For example, the youth may experience a transient dissociative response, engage in an angry emotional outburst, or begin to cry in a withdrawn manner. When such

responses are extreme, the therapist should generally stop exposure-activation and focus stabilizing interventions (e.g., breathing exercises, grounding, placing the process in perspective) in order to reduce the impacts of whatever is engendering the response. In fact, if overshooting appears to be relatively common with a given client—despite the clinician's ongoing attempt to titrate emotional exposure—it may be appropriate to focus on affect regulation development and/or cognitive processing for a number of sessions, returning to emotional processing when the client's capacity to tolerate the distress associated with exposure-based procedures has notably increased.

Therapist activities that decrease activation might appear to deprive the client of the opportunity to address the emotional sequels of major trauma. Such restraint, however, is one of the responsibilities of the therapist. If the clinician suspects—based on observation of the client—that activation is likely to exceed the therapeutic window in any given circumstance, it is important that he or she ensure safety by reducing the intensity and pace of the therapeutic process. This does not mean that the clinician necessarily avoids trauma processing altogether; only that the work should proceed slowly and carefully, or be temporarily delayed. Fortunately, the need for such a conservative approach is usually transient. As the traumatic material is slowly and carefully processed, progressively fewer trauma memories will have the potential to activate overwhelming affect, and, as described in Chapter 7, the client's overall capacity to tolerate distress will grow. And, as a side effect, the client-therapist attunement and communication often associated with this process tend to reinforce the therapeutic relationship, thereby providing further stabilization.

Disparity

Exposure and activation are typically not, in and of themselves, sufficient in trauma treatment. There also must be some disparity between what the client is feeling (e.g., activated fear associated with a trauma memory) and what the current state of reality actually is (e.g., the visible absence of immediate danger). For conditioned emotional responses to traumatic memories to be diminished or extinguished over time, they must consistently not be reinforced by similar danger (physical or emotional) in the current environment.

As described earlier, safety should be manifest in at least two ways. First, the adolescent should have the opportunity to realize that he or she is safe in the presence of the

therapist. This means safety not only from physical injury and sexual exploitation, but also from harsh criticism, punitive responses, boundary violations, or under-appreciation of the client's experience. Because the client may tend to over-identify danger in interpersonal situations, the absence of danger in the session must be experienced directly, not just promised. In other words, for the client's anxious associations to trauma memories to lose their power, they must not be reinforced by current danger or maltreatment in the session, however subtle.

Second, safety in treatment includes protection from overwhelming internal experience. The client whose trauma memories produce destabilizing emotions during treatment may not find therapy to be substantially different from the original experience. As noted earlier, overwhelming emotion may occur because one or both of two things are present. First, the memory is so traumatic and has so much painful affect (e.g., anxiety, rage) or cognitions (e.g., guilt or shame) associated with it that unmodulated exposure produces considerable psychic pain, or second, the survivor's affect regulation capacities are sufficiently compromised that any major reexperiencing is overwhelming. In each instance, safety—and therefore disparity—can only be provided within the context of the therapeutic window. Because processing within the window means, by definition, that exposure to memories does not exceed the client's ability to tolerate those memories, reexperiencing trauma in this context is not associated with overwhelming negative affect, identity fragmentation, or feelings of loss of control.

It should be noted that it is not enough that disparity be present in the session; it also must be perceived as such. Thus, for example, although the 15-year-old incest survivor may be safe from abuse or exploitation during the psychotherapy session, he or she may not easily perceive that to be true. Instead, the hypervigilance associated with posttraumatic stress, or characteristics of the clinician that are similar to those of the abuser (e.g., gender, age, race, appearance) may cause the client to believe that he or she is in danger. In many cases, it is only after repeated experiences of safety in such contexts that the client will come to reevaluate his or her impressions and truly note disparity. Because highly traumatized youth may reflexively view interpersonal situations as dangerous, and may have a myriad of potential triggers that can produce fear, it may take considerable time in therapy before the curative aspects of disparity are able to unfold. As a result, the multi-traumatized "street

kid," the survivor of severe and chronic child abuse, or the refugee child previously sold into the sex trade may require consistent, reliable treatment that far exceeds the parameters of classic short-term trauma therapy.

Counterconditioning

Not only is it important that there be a visible absence of danger during trauma processing, in the best circumstances there also should be positive phenomena present during therapy that are relatively antithetical to the experience of physical or psychological danger. Thus, for example, a teenager in therapy for problems related to ongoing domestic violence may expect her therapist to be critical or rejecting. When her fears are met not only with the absence of those things in treatment (i.e., the disparity associated with therapeutic safety), but occur, in fact, in the presence of acceptance, validation, and nurturing, the activated distress may diminish in intensity because it is incompatible with the positive feelings that arise in therapy. As a result, the emotional associations to memories of being battered are not reinforced, but instead are weakened by contradictory, positive feeling states that are present as the memories are evoked.

It is in this domain that a caring therapeutic relationship is most important. The more positive and supportive the relationship, the greater the amount of positive emotionality available to counter-condition previous negative emotional responses. For example, as the chronically unloved adolescent survivor interacts with a reliably caring therapist, the negative associations to relatedness, intimacy, interpersonal vulnerability, and attachment figures are repeatedly elicited and then, in a sense, contradicted by the ongoing experience of affection and protection within the therapeutic process. In this regard, it is often not enough that the therapist does not hurt or exploit; it is also important that attunement and caring be present. Such clinician responses must, of course, be carefully monitored and constrained so that they do not involve any level of intrusion, boundary violation, or self-gratification—any of which may convert counterconditioning into an absence of disparity.

A second form of counterconditioning may be the experience of safe emotional release. Crying or other forms of emotional expression in response to upsetting events typically produces relatively positive emotional states (e.g., relief) that can counter-condition the fear and related affects initially associated with the traumatic memory. In other words,

the common suggestion that someone "have a good cry" or "get it off of your chest" may reflect cultural support for emotional activities that naturally counter-condition trauma-related emotional responses (Briere, 2002). From this perspective, just as traditional systematic desensitization often pairs a formerly distressing stimulus to a relaxed, anxiety-incompatible state in an attempt to neutralize the anxious response over time, repeated safe and validated emotional release during exposure to painful memories may pair the traumatic stimuli to the relatively positive internal states associated with emotional expression in a protected environment. For this reason, optimal trauma therapy typically provides gentle support for—and reinforcement of—expressed emotionality during exposure activities. The level of emotional expression in such circumstances will vary from person to person, partially as a function of the client's affect regulation capacity, personal history, and socialization. The therapist should not "push" for emotional expression when the client is unable or unwilling to engage in such activity, but should support it when it occurs.

Desensitization and Resolution

Together, the process of remembering painful (but not overwhelming) events in the context of safety, positive relatedness, emotional expression, opportunities for introspection, and minimal avoidance can serve to break the connection between traumatic memories and associated negative emotional and cognitive responses. As this occurs, environmental and internal events that trigger memories of traumatic experiences will no longer produce the same level of negative response. Once processed, traumatic memories become, simply, memories. Their ability to produce great distress is significantly diminished. In the case of the multiply trauma-exposed person, however, the process usually does not end with the resolution of a given memory or set of memories. Instead, other memories, often those that are associated with even greater distress, tend to become more available for discussion—at which point the process may begin anew.

Chapter 11: Trigger Identification and Intervention

Many of the difficulties that trauma-exposed adolescents experience arise when stimuli or situations in their immediate environment trigger upsetting memories, with their associated thoughts and emotions. Once these memories are triggered, the adolescent may experience a cascade of thoughts involving, for example, helplessness, imminent danger, betrayal, abandonment, or need for retribution. Along with these may be emotions the adolescent experienced at the time of the trauma, such as fear, anger, shame, or sadness. The end effect of these processes may be an episode of "acting out" or tension reduction as a way for the youth to reduce internal awareness of these experiences. For example, a young man is insulted by a peer, which triggers (often implicit) memories of parental maltreatment and extreme, unfair criticism, which, in turn, activates feelings of low self-esteem and thoughts about "getting even." These thoughts and memories may then activate anger and motivate an action (e.g., aggression) that is out of proportion to the actual insult by the peer. He has been triggered and now is involved in an act that is more relevant to his childhood than his current situation. Examples of other triggers and responses are (1) the break-up of a dating relationship triggering early memories of abandonment with associated desperation and emptiness, leading to a suicide attempt; (2) a consensual sexual activity triggering flashbacks of childhood sexual abuse, resulting in intense fear or disgust, or (3) criticism at work by an employer triggering physical and psychological abuse memories, resulting in the youth throwing something and quitting his or her job.

This tendency for current events to trigger extreme emotions and behaviors related to childhood maltreatment is a serious problem for some adolescents. The suggested clinical approach to this issue could have appeared under previous chapters on affect regulation training, cognitive interventions, or therapeutic mindfulness, but is outlined separately here because of its importance.

Trigger awareness and intervention can help the survivor maintain internal equilibrium in his or her daily life by teaching him or her how to identify and address triggers in the environment that activate posttraumatic reliving. Successful trigger identification during ITCT-A can facilitate a greater sense of control and better interpersonal functioning by helping the adolescent to avoid or alter situations in which triggering might be likely, or,

in the event triggering has occurred, to change his or her experience of—and response to—the associated internal cascade of negative thoughts and/or feelings. The adolescent is supported in learning to (a) identify instances when he or she is being triggered, (b) reframe triggered reactions as archaic, as opposed to contemporary (i.e., "real" versus "not real"), and then (c) respond to these archaic/"unreal" experiences as, in fact, internal events rather than accurate perceptions of the external world. In this way, trigger identification and intervention works in a similar manner as the metacognitive awareness aspect of mindfulness training described earlier: triggered reactions are recontextualized as merely thoughts or feelings, associated with prior events, which may have no actual relevance to the current situation.

Trigger identification and intervention training usually occur during the therapy session, and are then called upon later when the survivor encounters triggers in his or her environment. In other words, it is often difficult to figure out exactly what to do when one has been triggered; it is better to have previously identified the trigger, its meaning, and its solutions in the context of therapeutic guidance and support, and then call upon that information as needed.

In session, the client and therapist work through the Trigger Grid, presented in the Appendix as "What triggers me" (also available on the internet at: attc.usc.edu). Some clients may easily identify their primary triggers, whereas others may require considerable time before they are able to do so. Typically, the Trigger Grid is revisited at multiple points in treatment, as the youth becomes aware of additional triggers as therapy proceeds. Some goals are for the client to:

- learn about triggers, including their historic nature
- identify specific instances during which he or she has been triggered,
- determine, based on these times,
  - (a) what seem to be the major triggers in his or her life and
  - (b) how to identify when he or she is being triggered
- detect the "unreal," non-here-and-now nature of triggered thoughts and feelings, i.e., that they are more relevant to the past than the present, and
- problem-solve strategies that might be effective once triggering has occurred.

In response to the trigger grid, adolescents typically identify a number of trauma-related triggers, including, for example,

- interpersonal conflict
- sexual situations or stimuli
- angry people
- intoxicated people
- perceived narcissism
- seemingly arbitrary criticism or accusations
- rejection
- perceived abandonment
- feeling ignored or dismissed
- 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
- sirens
- footsteps
- unwanted physical touch
- gunshots
- the sound of crying

One of the more challenging parts of the trigger grid for the adolescent trauma survivor is the question, "How 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. In others, however, the reexperiencing may be more subtle, such as feelings of anger or fear, or intrusive feelings 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 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 carry with them memories of a past trauma;
- an unexpected alteration in awareness (e.g., depersonalization or derealization) as these thoughts/feelings/sensations occur; or
- a situation in which the adolescent often gets triggered

The section on "What Happened After I Got 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 grid is "What I Could Do After I Get Triggered That Would Make It Better and I Wouldn't Get So Upset or Mad" answered for each of the major triggers that the client has identified earlier. Possible answers to this section are:

- changing the scenario or using "time-outs" during especially stressful moments (e.g., leaving a party when others become intoxicated; intentionally minimizing arguments with authority figures; learning how to discourage unwanted flirtatious behavior from others)
- analyzing the triggering stimulus or situation until a greater understanding changes one's perception and thus terminates the trigger (e.g., carefully examining the behavior of an individual who is triggering posttraumatic fear, and eventually becoming more aware of the fact that he/she is not acting in a threatening manner; or coming to understand that a given individual's seemingly dismissive style does not indicate a desire to reject or ignore as much as it does interpersonal awkwardness)
- increasing support systems (e.g., bringing a friend to a party where one might feel threatened, or calling a friend or AA sponsor to "debrief" an upsetting situation)
- positive self-talk (e.g., working out beforehand what to say to oneself when triggered, such as "I am safe," "I don't have to do anything I don't want to do," or "this is just my past talking, this isn't really what I think it is")

- relaxation induction or breath control, as described in Chapter 7
- engaging in physical activity, such as doing exercises, dancing, or yoga
- strategic distraction, such as starting a conversation with a safe person, reading a book, or going for a walk, as a way to pulling attention away from escalating internal responses such as panic, flashbacks, or catastrophizing cognitions.

As the adolescent 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 beforehand, the triggered survivor less often has to figure out what to do—instead he or she can call on the fruits of previous problem-solving and, to the extent it is possible in any given triggering circumstance, respond in a more effective and self-protective manner.

Chapter 12: Interventions for Identity Issues

As noted early in this guide, survivors of early and severe childhood trauma or neglect often complain of problems associated with an inability to access, and gain from, an internal sense of self. This may present, for example, as (1) problems in determining one's own needs or entitlements, (2) maintaining a consistent sense of self or identity in the context of strong emotions or compelling others, and (3) having direct access to a positive sense of self when external conditions or people are challenging or negative.

Many of these difficulties are thought to develop in the early years of life, when the parent-child attachment relationship is disrupted by caretaker aggression or neglect (Bowlby, 1988). In addition to possible negative impacts on the developing child's psychobiology (Pynoos, Steinberg, & Piacentini, 1999; Schore, 2003), childhood abuse and neglect can motivate the development of adaptations and defenses that, in turn, reduce the child's development of a coherent sense of self (Briere & Rickards, 2007; Elliott, 1994).

Probable etiologies for identity disturbance include early dissociation, other-directedness, and the absence of benign interactions with others (Briere, 2002). Dissociating or otherwise avoiding trauma-related distress early in life may block the survivor's awareness of his or her internal state at the very time that a sense of self is thought to develop in children. Further, the hypervigilance needed by the endangered child in order to ensure survival means that much of his or her attention is directed outward, a process that detracts from internal awareness. When introspection occurs, it is likely to be punished, since (a) such inward focus takes attention away from the environment and, therefore, increases danger, and (b) greater internal awareness means—in the context of ongoing trauma—greater emotional distress (Briere & Scott, 2012). Finally, most theories of self-capacities stress the role of benign others in the child's development—one may have to interact with caring others in order to form a coherent and positive sense of oneself (e.g., Stern, 2000). This is thought to occur when the loving and attuned caretaker reflects back to the child what the child appears to be feeling or experiencing, responds to the child's needs in a way that reinforces their legitimacy, and treats the child in such a manner that he or she can infer positive self-characteristics. As the child develops into an adolescent, the growing complexity of his or her interactions with the social environment ideally bestows a growing

sense of self in the context of others. Unfortunately, this progression into an increasingly coherent identity may be less possible for those who were deprived of positive parenting. Self/identity issues are often exacerbated in adolescence, when many young people—abused or otherwise—experience significant tumult as their sense of identity undergoes significant change. In this context, adolescents with abuse-related difficulties may especially suffer.

Because much of self-development appears to involve interactions with caring others, the therapeutic relationship can be a powerful source of stimuli and support for the client's growing sense of self. In this context, the clinician may work to accomplish several tasks.

Provide Relational Safety

Introspection is, ultimately, a luxury that can only occur when the external environment does not especially require hypervigilance. For this reason, the clinical setting should provide those aspects of safety outlined previously in this treatment guide. Not only should the client feel physically safe, he or she should experience psychological safety—the clinician should be psychologically noninvasive, consistently supportive and psychologically available, careful to honor the client's boundaries, and reliable enough to communicate stability and security. When these conditions are met, the youth is more likely to trust the interpersonal environment enough to explore his or her internal thoughts, feelings, and experiences.

The process of discovering that one is actually safe in treatment, however, may be protracted. Many survivors of severe childhood or adolescent trauma, for example, "street kids," adolescents caught in the sex trade, and others exposed to years of victimization, may have to be in treatment for some time before they can accurately perceive the safety inherent in the session (see the discussion of disparity in Chapter 10). Similarly, as described in Chapter 13, characteristics of the therapist (e.g., older age, gender, role as an authority figure) or the therapy (e.g., seeming demands for emotional intimacy or vulnerability) may trigger memories of abuse that must be addressed to some extent before the adolescent can accurately perceive an absence of danger in the therapy session. Even then, this sense of relative safety may wax and wane.

Support Self-Validity

Also helpful is the therapist's visible acceptance of the adolescent's needs and

perceptions as intrinsically valid, and his or her communication to the client regarding the client's basic relational entitlements, per Chapter 5. To some extent, this may appear to contradict the need to challenge the client's negative self-perceptions and other cognitive distortions. However, the approach advocated in this guide is not to argue with the client regarding his or her thinking errors about self, but rather to work with the client in such a way that the he or she is able to perceive incorrect assumptions and reconsider them in light of his or her current (therapy-based) relational experience. For example, even though the adolescent may view himself or herself as not having rights to self-determination, these self-perceptions will be contrary to the feelings of acceptance and positive regard experienced in the therapeutic session. Such cognitions, when not reinforced by the clinician, are likely to decrease over time. Equally important, as the message of self-as-valid is repeatedly communicated to the client by the therapist's behavior, client notions of unacceptability are relationally contradicted, especially in the context of therapist caring.

This general focus on the client's entitlements can help to reverse the other-directness the survivor learned in the context of abuse or neglect. During most childhood abuse, attention is typically focused on the abuser's needs, the likelihood that he or she will be violent, and, ultimately, on the abuser's view of reality. In such a context, the child's needs or reality may appear irrelevant, if not dangerous when asserted. In a safe, client-focused environment, however, reality becomes more what the client needs or perceives than what the therapist demands or expects. When the focus is on the client's needs, as opposed to the therapist's, the youth is often more able to identify internal states, perceptions, and needs, and discover how to "hang on to" these aspects of self even when in the presence of meaningful others (i.e., the therapist). By acting in such a way that it becomes clear to the adolescent that his or her experience is the ultimate focus, and by helping the client to identify, label, and accept his or her internal feelings and needs, the therapist helps the client to build a coherent and less negative model of self—to some extent in the way parents would have, had the client's childhood been more safe, attuned, and supportive.

Support Self-Actualization versus Social Devaluation

In many cases, it may be important to encourage discussion of the youth's beliefs, experiences, and perceptions regarding gender, race, cultural background, sexual orientation,

gender identity, and other sociocultural issues. These discussions ideally reinforce the client's self-determination and work against cultural stereotyping or discrimination. The process of discerning who one is in the social matrix, and how one should relate to culturally-based expectations, may not always be straightforward. For example, although the adolescent may have the appearance of a specific culture/ethnic background, he or she may identify with another culture or may have a sense of belonging in more than one culture if he or she has a mixed racial/cultural background. Gay, lesbian, or transgendered youth may have conflicting experiences of self, reflecting socially-transmitted messages about the unacceptability of any sexual orientation not classically heterosexual. They may have undergone years of socialization to view "normal" sexuality as involving attraction to members of the opposite-sex based on their biological gender, and to assume that relational success is heterosexual marriage and the bearing of children. Similarly, youth whose ethnicity has been regularly devalued by Anglo-American culture, whether based on skin color or cultural background, may have internalized what are essentially self-hating perspectives. In all these cases, the culturally-aware clinician can work with the youth to develop self-perceptions that are positive and empowering, generally through cognitive reconsideration of injurious or invalidating assumptions.

Support Self-Exploration

As therapy facilitates self-exploration and self-reference (as opposed to defining self primarily in terms of others' expectations or reactions), the abused youth may be able to gain a greater sense of his or her internal topography. Increased self-awareness may be fostered particularly when the client is repeatedly asked about his or her on-going internal experience throughout the course of treatment. This may include (as described in at various points in this guide) multiple, gentle inquiries about the client's early perceptions and experiences, his or her feelings and reactions during and after victimization experiences, and what his or her thoughts and conclusions are regarding the ongoing process of treatment. Equally important is the need for the client to discover, quite literally, what he or she thinks and feels about current things, both trauma-related and otherwise. Because the external-directedness necessary to survive victimization generally works against self-understanding and identity, the survivor should be encouraged to explore his or her own general likes and dislikes, views

regarding self and others, entitlements and obligations, and related phenomena in the context of therapeutic support and acceptance. As noted early in this guide, this exploration may be facilitated when the clinician conveys actual interest and curiosity about the client's internal states and processes.

The therapist's consistent and ongoing support for introspection, self-exploration, and self-identification allows the abused adolescent to develop a more articulated and accessible internal sense of self, and a stronger sense of self-efficacy. Ultimately, the therapist takes on the role of the supportive, engaged, helpful figure whose primary interest—beyond symptom resolution—is the development of the adolescent's internal life and self-determinism. This process, although less anchored in specific therapeutic techniques or protocols, can be one of the more important aspects of treatment.

Chapter 13: Relational Processing

The perspective offered in this treatment guide is that many of the relationship problems experienced by traumatized adolescents arise from early learning about—and adapting to—childhood maltreatment. Interpersonal issues are often especially challenging for youths, since, even for those who have not been abused or neglected, adolescence is a developmental period when relationships with peers become more important, and sexual, romantic, or pair-bonding dynamics typically emerge for the first time. Because child abuse and neglect usually involves maltreatment in the context of what should have been nurturing relationships, these relational issues and yearnings can become powerful triggers for subsequent interpersonal difficulties in youth.

One of the earliest impacts of abuse and neglect is thought to be on the child's internal representations of self and others (Allen, 2001), inferred from how he or she is treated by his or her caretakers. In the case of abuse or neglect, these inferences are likely to be especially negative. For example, the child who is being maltreated may conclude that he or she must be inherently unacceptable or malignant to deserve such punishment or disregard, or may come to see him or herself as helpless, inadequate, or weak. As well, this negative context may mean that he or she comes to view others as inherently dangerous, rejecting, or unavailable.

These early inferences about self and others often form a generalized set of expectations, beliefs, and assumptions, sometimes described as internal working models (Bowlby, 1988) or relational schemas (Baldwin, Fehr, Keedian, Seidel, & Thompson, 1993). Such core understandings are often relatively nonresponsive to verbal information or the expressed views of others later in life, since they are encoded in the first years of life and thus are generally pre-verbal in nature. For example, the young man who believes, based on early learning, that he is unlikable or unattractive to others, or that others are not to be trusted, will not easily change such views based on others' statements that he is valued by them or that they can be relied upon.

Because they become the default assumptions the adolescent carries in his or her interactions with others, these negative schema are easily activated and acted upon in current relationships, ultimately making it hard for the youth to maintain meaningful connections

and attachments with other people. As a result, formerly abused or neglected youth may find themselves in conflicted and chaotic relationships, may have problems with forming intimate peer attachments, and may engage in behaviors that are likely to threaten or disrupt close relationships.

Because relational schemas are often encoded at the implicit, nonverbal level, and are primarily based in safety and attachment needs, they may not be evident except in situations where the survivor perceives abuse-similar interpersonal threats, such as rejection, abandonment, criticism, or physical danger. When this occurs, these underlying cognitions and emotions may be triggered with resultant interpersonal difficulties. For example, a young woman who experienced early separation or abandonment may function relatively well in a given occupational or intimate context until she encounters relational stimuli that suggest (or are in some way reminiscent of) rejection, empathic disattunement, or abandonment. These perceived experiences, because of their similarity to early neglect, may then trigger memories, emotions, and cognitions that—although excessive or out of proportion in the immediate context—are appropriate to the feelings and thoughts of an abused or neglected child. This activation may then motivate behavior that, although perhaps intended to ensure proximity and to maintain the relationship, is so characterized by "primitive" (i.e., child-level) responses and demands, and so laden with upsetting emotions that it challenges or even destroys that relationship.

The most dramatic example of chronic relational trauma activations may be what, in adults, is referred to as borderline personality disorder. Those identified as having borderline personality features are often prone to sudden emotional outbursts in response to small or imagined interpersonal provocation, self-defeating cognitions, feelings of emptiness and intense dysphoria, and impulsive, tension-reducing behavior that are triggered by perceptions of having been abandoned, rejected, or maltreated by another person. Although many maltreated adolescents are too young to be diagnosed with this disorder (American Psychiatric Association, 2000, 2013), in extreme cases, their symptomatic presentation may be very similar, and some may receive this diagnosis as they grow into adulthood.

A fair portion of "borderline" behavior and symptomatology can be seen as arising from triggered relational memories and emotions associated with early abuse, abandonment, invalidation, or lack of parental responsiveness, generally in the context of reduced affect

regulation capacities (Allen, 2001; Herman, Perry, & van der Kolk, 1989; Linehan, 1993). Upon having abuse memories triggered by stimuli in his or her current context, the adolescent may then attempt to avoid the associated distress by engaging in activities such as substance abuse, inappropriate proximity-seeking (e.g., neediness or attempts to forestall abandonment), or involvement in distracting, tension-reducing behaviors, as described in Chapter 2.

The ITCT-A approach to relational disturbance parallels, to some extent, those outlined in Chapters 9 and 10 for cognitive and exposure-based interventions. In the relational context, however, the components of trauma processing occur more directly within the therapeutic relationship. Because most disturbed relatedness appears to arise from maltreatment early in life, and is often triggered by later interpersonal stimuli, it is not surprising that the most effective interventions for relational problems seem to be, in fact, relational (Pearlman & Courtois, 2005).

Among other things, the therapeutic relationship is a powerful source of interpersonal triggers. As the connection between adolescent and clinician grows, the client's increasing attachment to the therapist can increasingly trigger implicit (nonverbal, sensory/experiential) memories of attachment experiences in childhood. For many clients, these early attachment memories include considerable abuse or neglect, which may be reexperienced in the form of maltreatment-related thoughts and feelings during therapy. Because these "relational flashbacks" are largely implicit, they do not contain autobiographical information in that they represent the past, and thus are often misperceived by the adolescent as being feelings related to the current therapist-client relationship (see Briere, 2002 for more on these "source attribution errors"). Once activated and expressed, such cognitions and emotions can be discussed and processed in the context of the safety, soothing, and support associated with a positive therapeutic relationship. It is always incumbent on the therapist, of course, to make sure that such activation responses are normative aspects of relational therapy, and not triggered by negative or inappropriate therapist behaviors.

Components of Relational Processing

As in work with more simple traumatic memories, the therapeutic processing of relational memories and their associations (e.g., attachment-level cognitions and conditioned

emotional responses) can be seen as involving the exposure, activation, disparity, and counterconditioning described in Chapter 10.

Exposure

During psychotherapy, the adolescent encounters stimuli that trigger implicit memories of early interpersonal abuse or neglect. Therapy stimuli can trigger exposure to relational memories by virtue of their similarity to the original trauma; including the clinician's physical appearance, his or her age, sex, or race, and the power differential between client and therapist. Even positive feelings associated with the therapeutic relationship can trigger distress—the adolescent's caring feelings towards the therapist (or perception of similar feelings from the clinician) can activate sexual feelings or fears, and perceptions of therapist support and acceptance can trigger fears of losing such experiences (i.e., of abandonment by an attachment figure). As well, therapists, like other people, may evidence momentary lapses in empathic attunement, distraction by personal problems, fatigue, or the triggering of their own issues by some aspect of the client's presentation—any of which may inadvertently expose the client to intrusive memories of earlier maltreatment or neglect. Finally, a caring and supportive therapeutic relationship may trigger anger in the client as he or she comes to understand more fully the neglect he or she experienced as a child—anger that, in some cases, paradoxically may be focused back on the therapist as a representative parental figure.

Beyond these discrete triggers, the therapeutic relationship itself—by virtue of its ongoing nature and importance to the youth—may produce stimulus conditions similar to those of early important relationships, including the client's childhood need for attachment. To the extent that the earlier relationship was characterized by trauma, the current therapeutic relationship is therefore likely to trigger negative relational memories.

Importantly, just as noted in previous chapters for simpler trauma processing, exposure must occur within the context of the therapeutic window. The clinician may have to work actively, and pay very careful attention, to ensure that his or her stimulus value or the characteristics of the therapeutic relationship do not produce so much exposure to negative relational memories that the adolescent becomes overwhelmed. Just as the therapist treating PTSD may titrate the amount of exposure the client undergoes regarding a traumatic memory, the clinician treating relational traumas tries to ensure that reminiscent aspects of

the therapeutic environment are not overwhelming.

For example, adolescents with schemas arising from punitive parenting may require treatment that especially avoids any sense of therapist judgment. Similarly, the youth who has been physically or sexually assaulted may require (a) special, visible attention to safety issues, (b) therapist responses that stress boundary awareness and respect, or even (c) a greater-than-normal physical distance between the client's chair and the therapist's. A client with abandonment issues arising from early psychological neglect, on the other hand, may be less triggered when the clinician is especially attuned and psychologically available. On a more general level, therapists of chronically traumatized adolescents may need to devote greater attention than usual to avoiding behaviors that in some way appear to involve intrusion, control, or narcissism.

Unfortunately, some characteristics of the therapist may be such powerful triggers that the therapeutic process is especially challenged. For example, the female adolescent who has been recently sexually assaulted by a man or men may have considerable difficulty working in therapy with a male clinician: regardless of the therapist's personal qualities and best intentions, his masculine stimulus value may trigger trauma memories of assault by a male. Similar scenarios may occur when the therapist's ethnic or racial identity is the same as those who have maltreated or discriminated against the client. More subtly, the (usually middle-class) social status of the therapist may trigger negative feelings in the socially marginalized adolescent, based on a long history of not being understood, or of being judged as somehow less important, by people of the therapist's social position.

Even in these cases, however, exposure to memories involving social deprivation or discrimination often can be titrated. The male clinician treating an abused young woman can be careful to avoid interactions that could be perceived in any way as sexually or physically threatening. The Caucasian therapist working with a young African-American man can work hard to nondefensively communicate a nonracist perspective, and to support the client's expression of thoughts or feelings related to seeing a therapist whose racial identity is similar to those who have harmed him in the past. The economically advantaged counselor can consciously strive to avoid making assumptions or judgments based on his or her background when interacting with economically marginalized clients. When social differences almost inevitably emerge during treatment, the clinician can work hard to foster discussion of these

issues in the context of acceptance, support, and a willingness to challenge his or her own biases, should they appear.

Whether involving exposure to memories of childhood maltreatment by a parent or social injury by a devaluing culture, relational exposure thus refers to any aspect of the therapeutic relationship that causes the client to reexperience relational trauma memories. It is titrated exposure to the extent that the clinician modifies the degree to which that the memory is triggered, generally by avoiding activities that increase the extent to which the current therapy stimuli are reminiscent of the original trauma. In most cases, this means that although the therapeutic relationship is intrinsically similar to the survivor's early relationships by virtue of its dyadic nature, encouragement of intimacy, and relationship to early attachment dynamics, it is not similar in that the therapist is careful to avoid any behaviors or verbalizations that might imply rejection, abandonment, revictimization, exploitation, etc.

Activation

As a result of therapeutic exposure, the client experiences emotions and thoughts that occurred at the time of the relational trauma. Activated emotional responses to early relational memories during treatment are often notable for the suddenness of their emergence, their intensity, and their seeming contextual inappropriateness. Intrusive negative cognitions about self or the therapist may be activated, or attachment-related schema involving submission or dependency may suddenly appear. In some cases, such activation may also trigger sensory flashbacks and dissociative responses.

Cognitive-emotional activation can be easily understood by both client and therapist when it occurs in the context of discrete trauma memories, such as those of an assault or disaster. When activation occurs in the context of triggered relational stimuli, however, the actual "reason" behind the client's thoughts and feelings may be far less clear. Because the original trauma memory (a) may have been formed in the first years of life, and therefore is not available to conscious (explicit) awareness, or (b) may be so associated with emotional pain that it is immediately avoided, neither client not therapist may know why the client is feeling especially anxious or angry, or why he or she is suddenly so distrustful of the clinician. In fact, in instances where such activations are dramatic, they may appear so irrational and contextually inappropriate that they are seen to some as evidence of significant

psychopathology. Ultimately, however, these activations are logical, in the sense that they represent conditioned cognitive-emotional responses to triggered relational memories, albeit ones that may not be traceable to specific childhood events. More generally, these activations are necessary to effective treatment. Trauma memories, relational or otherwise, can be processed only when exposure activates cognitions and emotions that are then addressed through disparity, as described below.

Disparity

Although the adolescent trauma survivor thinks and feels as if maltreatment or abandonment is either happening or is about to happen, in reality the session is safe, and the therapist is not abusive, rejecting, or otherwise dangerous. Although this component is often critical to trauma processing, youth who have been victimized interpersonally—especially if that victimization was chronic—may find disparity difficult to apprehend fully at first, let alone trust. There are a number of reasons for this. First, those exposed to chronic danger often come to assume that such danger is inevitable. The "street kid" or victim of chronic abuse may find it very difficult to accept that the rules have suddenly changed and that he or she is safe—especially in situations that bear some similarity to the original dangerous context, such as in a relationship with a powerful other. Second, in many cases, the original perpetrator(s) of violence promised safety, caring, or support as a way to gain access to the victim. As a result, reassurance or declarations of safety may seem like just "more of the same," if not a warning of impending danger. Finally, therapy implicitly requires some level of intimacy, or at least vulnerability from the client. This requirement—from the survivor's perspective—can be a recapitulation of past experiences of intimate demands and subsequent injuries.

For these and related reasons, not only must disparity/safety be present, but the adolescent must be able to perceive it. Although occasionally frustrating for the therapist, this sometimes means that considerable time in therapy is necessary before sufficient trust is present to allow true relational processing. For example, the survivor of extended maltreatment may require months of weekly therapy before letting down her guard sufficiently to participate in trauma therapy. The therapist should be prepared in such cases for client disbelief or immediate rejection of statements like "you are safe here" or "I won't go away." This does not mean that the clinician shouldn't make such statements (when they are

accurate, and expressed in a nonintrusive, non-demanding way), but the therapist should understand that such declarations rarely alter cognitions that have been repeatedly reinforced by prior adversity.

In fact, for those hypervigilant to danger in interpersonal situations, disparity cannot be communicated; it must be demonstrated. Therapist statements that he or she should be trusted can even have the opposite effect on traumatized clients—because they have heard similar promises or protestations from ill-meaning people in the past, such statements may make them feel less safe, not more. Instead, when working with young survivors of chronic relational trauma, the therapist must behave in a reliably safe and non-exploitive way, over time, until the youth can experience an enduring sense of safety. Behaving in a way that actually communicates disparity means that the therapeutic environment must be the antithesis of how injurious others have been in the adolescent's past—involving reliability and connection rather than abandonment; relational safety rather than maltreatment or exploitation; a pro-diversity, culturally competent perspective rather than one that supports discrimination or social marginalization; and so on.

The exposure-activation-disparity process may proceed in a step-wise fashion for the relational trauma survivor. Early in therapy, he or she may occasionally (and often inadvertently) reveal some small degree of vulnerability or suffering to the therapist, and then reflexively expect a negative consequence. When this vulnerability is not, in fact, punished by the therapist, but is met with support and some carefully titrated level of visible caring, the adolescent may slowly lower his or her psychological barriers and express more thoughts or feelings. As these responses are likewise supported, and not exploited or punished, the client's willingness to process pain in "real time" (i.e., directly, in the presence of the therapist) generally increases. It should be stressed that this may take time, and therapist expressions of impatience ironically may subvert the process by communicating criticism or implied rejection.

In other cases, disparity may be considerably easier to establish and trauma processing may be possible sooner. For example, when the client has experienced less extreme or less chronic relational trauma, when the conditions surrounding the victimization are clearly quite different (and perceivable as such by the client) than in therapy, or when there were supportive people in the client's environment in addition to the perpetrator(s). However, this

is an assessment issue, rather than something that can be automatically assumed.

Counterconditioning

Relational triggering of negative emotional states occurs at the same time as the adolescent experiences positive emotional states associated with growing attachment to the therapist. When counterconditioning was described in Chapter 10, the healing aspect of this phenomenon was described as the simultaneous presence of both (1) the activated distress associated with traumatic memory exposure and (2) the positive feelings engendered by a positive therapy environment. When relational trauma is being processed, counterconditioning is potentially even more important. In this regard, activated negative relational cognitions (i.e., "he or she doesn't like me," "he or she will hurt or abandon me," or "I'll be taken advantage of if I become vulnerable") and feelings (e.g., associated fear of authority figures or intimacy) are directly—and, therefore, potentially more efficiently—contradicted by positive relational experiences. In other words, there may be something especially helpful about having fears and expectations of maltreatment in the specific context of nurturance and acceptance. In the language of earlier psychodynamic theory, such real-time contradiction of activated schema and feelings may provide a "corrective emotional experience."

There is also a potential downside to the juxtaposition of negative expectations and positive experiences in therapy, however. Just as positive experiences in therapy may contradict earlier held beliefs about close relationships, it is also true that activated, negative relational cognitions can at least temporarily prevent the client from identifying and accessing the positive relational phenomena that occur in therapy. Fortunately, this is rarely an all-or-none experience; in most cases, even the distrustful or hypervigilant youth will slowly come to reevaluate negative relational cognitions when therapist support and validation are visibly and reliably present. As is the case for client difficulties in perceiving therapeutic safety, the incremental process of "letting in" therapeutic caring and positive regard (and, thereby, positive attachment experiences) may require considerable time in treatment.

In some cases, activation of early thoughts and feelings may cause the client to "regress" to a more basic level of relational functioning with the therapist. However, it is important that the therapist understand this as attachment-level reliving, in the same way as a flashback to an assault is reliving. As described earlier, the goal is to work within the

therapeutic window—providing sufficient relational contact, support, and positive regard that the client has the opportunity to reexperience implicit childhood memories in the context of a distress-diminishing state. At the same time, however, the clinician must not provide so much quasi-parental support that early trauma-related distress is too strongly activated, or the youth's dependency needs are reinforced in a way that is detrimental to growth. The latter is probably best prevented by the therapist's continuous examination of his or her own needs to protect and/or rescue the client. In addition, obviously, the possible emergence of attachment-level feelings in the therapist requires special vigilance to the possibility of inappropriately sexualizing or romanticizing the client, or exploiting the client to meet the therapist's unmet attachment (including parenting) needs. Any such "countertransference" (referred to as counteractivation in the Self-Trauma model; Briere, 2002), if acted upon, both destroys disparity (i.e., eliminates safety) and reinforces trauma-related emotions and cognitions.

Desensitization

The adolescent survivor's repeated exposure to relational trauma memories, triggered by his or her connection with the therapist, in combination with the reliable non-reinforcement and counter-conditioning of his or her negative expectation and feelings by the therapeutic relationship, leads to a disruption of the learned connection between relatedness and danger.

As described in Chapter 10, the process of relational exposure, activation, disparity, and counterconditioning, when repeated sufficiently in the context of the therapeutic window, often leads to the desensitization of trauma memories. This probably involves a series of processes, including (a) extinction of non-reinforced emotional responses, via disparity, (b) counter-conditioning effects, involving some form of "overwriting" the association between memory and emotional pain with new connections between memory and more positive feelings, and (c) an alteration in the capacity of relational stimuli to trigger trauma memories (i.e., insight or new information that changes the client's interpretation of interpersonal events). Regarding the last point, positive therapeutic experiences may change the ability of relationships or interpersonal intimacy to automatically trigger early abuse memories, since relationships, per se, are no longer perceived as necessarily dangerous and are therefore, less reminiscent of childhood abuse or neglect.

However this occurs, the overall effect of the progressive activation and processing of implicit relational memories and their cognitive and emotional associations during ITCT-A is to change the youth's reaction to his or her interpersonal world. Successful therapy, in this regard, means that the client is more able to enter into and sustain positive interpersonal relationships, because connection with others no longer triggers the same levels of fear, anger, distrust, and negative or avoidant behaviors. As a result, the client's interpersonal life can become more fulfilling and less chaotic—a source of support rather than of continuing stress or pain.

Chapter 14: Intervening in Maladaptive Substance Use[3]

As noted at various points in this treatment guide, substance use and abuse (SUA[4]) is a relatively common problem among abused adolescents. Youth with trauma histories, perhaps especially those exposed to severe child abuse, often suffer from not only posttraumatic stress, but also diminished affect regulation capacities. This combination of sustained psychological pain and few internal methods of dealing with it frequently lead to external avoidance responses, including SUA. Although drugs or alcohol can temporarily numb distress, they are obviously not long-term solutions, and often create problems of their own. Most relevant to trauma recovery, SUA can interfere with trauma processing (Briere & Scott, 2012) and produce chronicity in both domains: unresolved posttraumatic symptoms and ongoing SUA, if not addiction.

As indicated by the Problems-to-Components Grid (see Chapter 3), ITCT-A offers several treatment components that the literature indicates are helpful in treating substance use problems. However, clinicians have noted the need for adaptation of ITCT-A components for young trauma survivors who also have SUA issues. This chapter outlines these various adaptations of ITCT-A, especially calling upon the work of Lisa Najavits, Ph.D., who has developed the *Seeking Safety* model (Najavits, 2002)—an intervention package specifically designed to assist trauma survivors involved in SUA.

Seeking Safety (Najavits, 2007) was designed to be used alongside other treatments, as needed. Given the many overlaps between *Seeking Safety* and ITCT-A (e.g., flexibility of administration; few screening requirements; allowance for comorbidity; multiple components; psychoeducation; focus on safety, empowerment, and cultural sensitivity), there

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[3] *An expanded, free-standing version of this chapter, "Treating Substance Use Issues in Traumatized Adolescents and Young Adults: Key Principles and Components" (Briere & Lanktree, 2014) is available on the internet at no cost: attc.usc.edu.*

[4] *This acronym is specific to ITCT-A. We use it because the more common term in the literature, Substance Use Disorder (SUD), implies a medical, diagnosable condition (see, for example, DSM-5). The notion of SUA is more relevant to the depathologizing focus of ITCT-A. It also sidesteps the somewhat arbitrary distinction between what is maladaptive "substance use" and what is "substance abuse," and allows drug and/or alcohol use/abuse to be seen more as a continuum.*

is little question that *Seeking Safety* is an effective add-on for adolescents undergoing ITCT-A. For this reason, we recommend that adolescent trauma survivors involved in significant SUA receive ITCT-A and concurrently attend *Seeking Safety* groups, if possible. In some cases, however, this cannot occur, because no *Seeking Safety* programs are in operation near the survivor's home, the client does not want to attend an explicitly SUA-related program, or there is a long waiting list. Given such barriers, the remainder of this chapter describes special issues and interventions that can be used when applying ITCT-A, most of which are central aspects (or at least compatible components) of *Seeking Safety*.

Special Recommendations for Adolescents Involved in SUA

When working with adolescent trauma survivors with serious SUA issues, we suggest the following:

Do not screen out the majority of substance abusers, or terminate treatment because of relapse back into SUA

The usual clinical recommendation is that substance-abusing clients should be drug and alcohol abstinent before undergoing trauma therapy. This is because those abusing 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. 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. In addition, especially in underserved environments, substance abuse treatment programs are often hard to find, not always of high quality, and waiting lists are generally long. The frequent unavailability of substance abuse treatment programs for adolescents living in marginalized social contexts can mean an absence of trauma therapy when abstinence is a requirement.

For these reasons, ITCT-A encourages clients to avoid significant SUA, but in most cases (i.e., as long as the client is not severely addicted) does 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 alcohol or regularly use "hard core" drugs (e.g., cocaine or methamphetamine) have a harder time attending and using trauma-focused

treatment, but may, nevertheless, benefit 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 substance using youth, or terminate treatment because the client has relapsed back into drugs or alcohol. In many cases, trauma survivors' involvement in drugs or alcohol is, in fact, partially due to trauma exposure, and trauma therapy may eventually reduce or eliminate their reliance on psychoactive substances. The remainder of this chapter outlines some principles that may increase the likelihood of successful treatment.

Treat trauma symptoms and SUA concurrently

When ITCT-A is used with substance involved adolescents, it is important to address both trauma symptoms and drug-related issues at roughly the same time. Focusing just on SUA, alone, may delay needed trauma interventions, whereas attempting trauma treatment without attending to SUA may easily overwhelm the client and/or neutralize trauma treatment. In fact, the exposure component of ITCT-A (Chapter 10), if not tempered by SUA treatment principles, may reinforce or even encourage drug or alcohol abuse as the client attempts to avoid activated trauma memories. Fortunately, several ITCT-A treatment components (e.g., trigger identification/intervention and affect regulation training) are helpful in both SUA and trauma domains, and 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, creating a vicious cycle. As well, when discussing ways not to act on urges that result in substance use, it may be helpful for the client to consider trauma-related triggers (e.g., through use of the Trigger Grid) in his or her environment that make drinking or drug-taking more likely. Overall, the focus and message should be that the youth's trauma symptoms and SUA are interconnected, such that therapeutic attention to either almost inevitably includes 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; most traumatized adolescents who drink excessively or frequently use psychoactive drugs have problems with affect regulation, as noted in Chapter 7. Further, significant SUA may be 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" emotions without becoming overwhelmed and the typical sequelae of SUA means that the substance using trauma survivor is often in crisis, psychologically and/or physically unsafe, and prone to "acting out" or self-harm behaviors when stressed—which may be much of the time. For this reason, ITCT-A for such clients especially involves the relationship-building, safety focus, affect regulation training, and titrated exposure described in Chapters 4 through 10. Also important will be psychoeducation, as presented in Chapter 6, so that the client has the opportunity to see the connections between trauma and SUA, recognize common triggers for both trauma memories and the urge to use drugs or alcohol, be aware of community resources (including self-help and 12-step-like groups), and, in general, have access to information that normalizes his or her experience and reduces feelings of guilt and shame about what are, ultimately, coping responses. See Najavits (2002) for the many ways in which cognitive interventions, coping skills development, and psychoeducation can be used to help trauma clients involved in SUA.

Importantly, although treatment should include attention to both trauma and SUA issues, therapeutic exposure to trauma memories, as described in Chapter 10, should not occur before the client is stable and has adequate coping capacities. Indeed, in most cases, treatment should initially emphasize the stabilization components described above, with therapeutic exposure to trauma memories occurring later, once the client is sufficiently safe and able to tolerate activated trauma memories. Some exposure will almost always occur, however, whenever the client refers to his or her trauma history. When this happens early in treatment, when the client is still involved in major SUA and is not yet stable enough for sustained emotional processing, we recommend, like Najavits (2007), that the client's trauma disclosures be acknowledged and received as important parts of treatment, but with some sort

of communication that such processing should happen to a greater extent later in therapy when the client is more able to accommodate it. Again, this does not mean that the client is discouraged from discussing traumatic things from the past; only that such disclosures do not result in extended discussions or processing until it is appropriate to do so. This balance of honoring and validating the youth's desire to talk about trauma, which, in fact, is an important component of connecting his or her past to her current SUA (and other) problems—and yet not processing this material in depth too early in treatment—is part of the art of good therapy, ITCT-A or otherwise.

Avoid confrontation

Although less prevalent now than in the past, it is still not uncommon to hear of the use of confrontation in the treatment of substance abusers. This typically involves confronting the individual with their denial or misrepresentation of their SUA and/or its impacts on the person or those around him or her. In contrast, there is no real place for this modality in ITCT-A. From our perspective, confrontation presents several problems, as it (1) may easily increase, not decrease the youth's defenses and avoidance, since it can be seen as shaming, aggressive, or disconfirming; (2) implies that the client is voluntarily engaging in a bad behavior that, upon being revealed for what it is, can be simply terminated; (3) is seemingly the antithesis of the support, caring, and compassion that is considered a core relational aspect of ITCT-A, and (4) may adversely affect the therapeutic relationship.

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 he or she is "up against" when trying to self-medicate overwhelmingly negative internal states. From this perspective, the role of the therapist is to work with, not against, the adolescent, and to help the youth to do what he or she often wants to do—to decrease or terminate SUA while, at the same time, being able to survive trauma-related distress. The result, ideally, is to problem-solve, not to create an adversarial relationship.

Focus on empowerment

SUA can sometimes deplete the adolescent's sense of autonomy, because what he or she is facing (trauma) does not seem to get better, and his or her solutions (SUA) create problems of their own that seem unresolvable, such as addiction, exposure to violence or

exploitation by others, declining interpersonal and social functioning, medical issues, possible arrest and incarceration, and increasingly lower self-esteem. The various components of ITCT-A, for example trigger identification, affect regulation training, and mindfulness, on the other hand, focus on skills the youth can develop to increase self-control and his or her capacity to affect life outcomes. Often this perspective helps the client to feel like an active participant in therapy, as opposed to a passive receiver of treatment.

Overall, an overbridging philosophy of treatment in ITCT-A, regardless of whether or not it is focused on SUA, is 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 ITCT-A can help to reduce these concerns, the fact that this approach increases self-control and teaches psychological skills may make it easier to initially accept by adolescents who feel alienated and distrustful of psychotherapy, per se.

Reinforce idealism and hope

As Najavits (2002) notes, treatment for the joint effects of trauma and SUA may be more effective to the extent that it is "idealistic," encouraging the trauma survivor to aspire to a more positive future and regain a sense of hope. Many trauma exposed youth, including those involved in SUA, have been demoralized and view themselves as unworthy and their future as essentially hopeless. To the extent that therapy reinforces the notion that the client is essentially good, not bad, and helps the youth to identify and further develop 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 drug-related prostitution or gang-related activity, or the adversarial dynamics sometimes found among the homeless, 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[5]. As the notion of being a "good

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[5] *Drug sharing, which is quite common among drug-using youth, also may seem like a "positive" behavior from the perspective of good intentions (sharing a mechanism for positive feelings with another), but obviously is not an actually helpful act. This issue sometimes comes up when discussing idealism with SUA clients, and must be handled with care: sincerely acknowledging the intention, but discussing the inherent problems.*

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 may accrue.

Also relevant to traumatized youth, whether involved in SUA or not, is the notion of posttraumatic growth—the phenomenon whereby trauma not only confers negative states and problems, but also can make a person stronger, wiser, and more aware of what is important in life (Tedeshi & Calhoun, 2004). Many traumatized youth believe that their experiences of childhood sexual abuse or peer assaults have permanently corrupted or diminished them, leading to feelings of shame, implicit badness, and unacceptability—responses that can be exacerbated by chronic substance abuse. To the extent that the therapist helps the client identify ways in which he or she triumphed over victimization by, for example, gaining 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.

When appropriate, titrate exposure to trauma memories

When the client with SUA issues is sufficiently stable, the emotional processing component of ITCT-A may be initiated, albeit carefully. As noted in Chapter 10, the sometimes limited affect regulation capacities and ongoing challenging circumstances experienced by young trauma survivors means that therapeutic exposure, usually involving discussion of traumatic events, must be carefully titrated. If the youth exceeds the "therapeutic window" by experiencing more trauma-related distress than he or she can accommodate, the result may be further traumatization and avoidance. These concerns are especially heightened for traumatized youth involved in SUA, who, by definition, are likely to especially suffer problems with emotional regulation.

For this reason, the dictum "start low, go slow" is particularly applicable. In general, we advise that, even after stabilization has occurred, clients with both trauma and SUA issues be encouraged to discuss their victimization histories in small "chunks," and that the clinician use the principles outlines in Chapters 3 and 10 to make sure that the client's therapeutic window is not exceeded. As indicated in these chapters, the clinician should be emotionally attuned to the client so that any evidence of overwhelming internal states can be addressed by reduced exposure, grounding activities, or a switch to more cognitive 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. When these issues are not attended to sufficiently, the outcome may be an emotionally overwhelmed client who, in fact, may become more involved in SUA as a way to down-regulate therapy-related distress.

Expect and control countertransference

A final issue associated with working with youth who have trauma histories and SUA has to do with the clinician, not the client. 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 each other, let alone to children, understandably can produce strong reactions. This is especially the case if the clinician also has an unresolved trauma history.

Unfortunately, traumatized adolescents with SUA are sometimes even more likely to activate strong emotional states in the therapist. Among the issues that may arise are impatience and, in some cases, 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 "fall off the wagon" 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, to some extent, contagious, as the therapist's attunement and hopes for the client can inadvertently 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 youth. The clinician may retreat to an overly authoritarian or pathologizing stance in an effort to maintain control or deal with his or her own emotional responses.

These various issues must be consistently monitored by the therapist. Although strong countertransference in this area should be addressed by regular, formal consultation and/or one's own therapy, it is nevertheless true that some feelings of helplessness, hopelessness, sadness, and frustration are almost inevitable when treating traumatized, SUA-involved youth. For this reason, it is very important that the therapist have others to turn to when working with this population. In general, we suggest a regular consultation group, or even just regular access to informed, supportive colleagues with whom the clinician can share the load of this challenging but important, work.

Chapter 15: Interventions with Caretakers and Family Members[6]

ITCT-A includes interventions directed at the survivor's parents/caretakers and, in many cases, his or her family. Interventions with caretakers tend to focus on one or more of five functions:

- increasing caretaker understanding of the adolescent's difficulties and behaviors, so that they may be more supportive;
- providing non-offending caretakers with support, given the stress and demands associated with raising a traumatized youth;
- working to increase the caretakers' parenting skills;
- assisting caretakers with significant problems of their own that interfere with their caring for the client; and
- intervening in dysfunctional family dynamics to help resolve conflicts and unhelpful/non-supportive interactions.

Such goals can only be addressed if the youth has caretakers or family members who are willing to participate in treatment; a significant proportion of severely maltreated adolescents are separated and/or significantly alienated from their families. This can be because (1) intrafamilial abuse has made it difficult for the survivor to interact with caretakers (either because the youth is unwilling to do so, or because the caretaker's maltreatment is ongoing and/or includes current neglect), (2) the client has run away from home, (3) the youth is functionally emancipated, and neither party views the caretakers as having a current role, (4) caretakers are separated from one another or are incarcerated, (5) the adolescent's behavior has alienated the caretakers, or (6) the youth is in residential treatment or foster placement.

For these reasons, caretaker and family interventions are most appropriate for youth who still live in a dependent role within a family unit. Thus, it is not as relevant to youth who live on the streets or in shelters, or who, for whatever reason, are separated or

[6] *Material for this chapter was adapted from Chapters 17 and 18 of Briere and Lanktree (2011), with permission of the publisher.*

emancipated from their caretakers. Even in these cases, however, therapy involving caretakers may still be helpful, since many separated adolescents continue to have significant contact with their parents or other family caretakers (e.g., a grandparent or aunt) and thus continue to be influenced by them.

Working with Caretakers

A central goal of the ITCT-A interventions for caretakers is to increase their understanding of the youth's difficulties and behaviors, so that they may be more supportive. Many parents experience considerable distress over their child's behavior, or may have almost given up hope at the severity or chronicity of his or her depression, verbal combativeness, self-destructiveness, or aggression. Many lack information about what the effects of abuse are, and the logic behind what appears to be "bad" behavior. As well, they may not understand developmental issues that complicate the adolescent's reactions to abuse.

The caretaker's own issues often impact the course of the young person's treatment, as well. In general, low caretaker involvement and minimal or absent emotional support complicates the treatment of traumatized youth (Friedrich, 1990; Gil, 1996, 2006). For example, many younger adolescents are unable to attend sessions without their caretaker's consent, or are dependent on a caretaker to bring them to sessions. More subtly, it is important that caretakers not undermine the adolescent's therapy by belittling the process, discounting or arguing against therapist statements or recommendations, interrogating the youth after sessions, or by failing to support him or her during the treatment process.

Often, the clinician will find it necessary to improve the caretaker's ability to parent the youth, so that he or she may provide developmentally appropriate emotional support, attachment resources, positive discipline, and protection from further victimization. In this regard, it is not just child maltreatment or peer assaults that negatively impact the adolescent; it is also the degree to which he or she experiences a lack of support, caring, attunement, and protection from his or her parents or caretakers.

Given the stress and demands associated with raising a traumatized youth, caretakers should be provided with opportunities to discuss and express feelings, and reach out to helpers and peers for support. The unsupported caretaker is unlikely to be as good a parent as otherwise might be possible, and may be more reactive to the challenges of raising an

adolescent, let alone a traumatized one.

When caretakers were not involved in sexual abuse or major physical maltreatment of the child, and are willing to engage in the process, individual and group meetings can be quite helpful. As noted above, a significant number of caretakers of adolescent trauma survivors lack good parenting skills, and may treat their own children in the way they, themselves were treated in their own dysfunctional or abusive families of origin. When caretakers, themselves, have significant trauma histories, and/or suffer from significant psychological symptomatology, their care of their children may be further compromised by behavioral withdrawal, instability, substance abuse, chaotic parenting styles, or negative mood states.

Most problematic is the possibility that the disengaged or angry caretaker will discontinue therapy for the traumatized youth. For this reason, among others, the therapist should make special efforts to engage the caretaker in the therapy process. This may involve soliciting his or her opinion about the basis for the adolescent's difficulties, as well as how the therapist might be most useful to both the adolescent and the caretaker. Also important will be explicit efforts on the therapist's part to recognize and support the caretaker's feelings about the youth's trauma. By facilitating the caretaker's expression of his or her own feelings about what transpired, while not overly confronting any denial he or she may need to engage early in the process, the clinician can help the caretaker feel like an important collaborator in the child's treatment, and will increase the extent to which the caretaker can support the youth. The reader is referred to specific guidelines by Pearce & Pezzot-Pearce (2007) for facilitating support from caretakers following disclosures of abuse.

Another reason to engage the caretaker early in the treatment process is to proactively intervene in his or her response to the youth's trauma-related, problematic behavior. Stressed caretakers, and those whose childhood experience or cultural background support physical discipline, may require specific counseling and education regarding what is acceptable punishment for the adolescent's perceived transgressions. Personal or cultural values can contribute to disciplinary behavior that might escalate to physical child abuse, requiring the therapist to report the caretaker to a child protection agency. At the onset of treatment, adolescent clients and their caretakers should be informed of what legally constitutes child maltreatment, and under what circumstances a suspected child abuse report must be made.

Equally important, the therapist should explore with caretakers alternative, positive parenting practices that will not only not traumatize the youth, but also help him or her to learn more functional behaviors. Regardless of culturally- or historically family-based parenting practices, it is important for caretakers to understand that positive reinforcement for appropriate behavior can contribute to a more positive relationship with the adolescent. ITCT-A provides two modalities of caretaker intervention: Individual collateral meetings and caretaker groups.

Individual meetings

Individual parent/caretaker sessions usually occur on a weekly to biweekly basis, often for 30-45 minutes per meeting, and may be for a limited number of sessions, or may extend for the full duration of the adolescent's treatment. These sessions typically involve some combination—depending on caretaker needs—of support, parenting skills development, psychoeducation on abuse and the adolescent's response to it, general developmental issues, and ways in which the caretaker's response to the youth may be affected by their own history of abuse or trauma.

If the caretaker has mental health issues (for example, involving their own history of childhood trauma), it may be appropriate to refer them to another agency for separate therapy. However, for more disadvantaged and traumatized caretakers, it may be important for therapy to be provided at the same agency where the adolescent client attends individual therapy. When services are provided at one agency, opportunities for closer coordination and collaborative treatment planning are maximized. With appropriate consents, collaboration between the youth's and his or her caretaker's therapist may be both efficient and helpful. Finally, when both caretakers and children receive treatment at the same general time at the same place, the likelihood of regular attendance typically increases. We discuss issues associated with caretaker individual therapy later in this chapter.

Caretaker groups

Caretaker groups generally run for 12 weeks, on a weekly basis. Caretakers sometimes repeat a group module a second time, or advance to a second series of group sessions focused more on their own issues as trauma survivors. Two types of groups are typically offered in ITCT-A: a didactic parenting group, adapted to address specific cultural

issues, and a caretaker support group. In some cases, an older adolescent client is also a parent. When this is true, the youth may concurrently attend his or her own individual therapy sessions as well as participate in a caretaker group.

Didactic parenting groups. These groups can be especially helpful for caretakers who (a) can benefit from material and discussion focused on their ability to manage behavior, increase communication, and improve age-appropriate expectations of their children, yet (b) do not want to address trauma-focused issues and feelings in depth. Other caretaker groups, especially those more focused on addressing trauma-related issues, can provide support that, ultimately, facilitates the caretaker's readiness to seek his or her own individual therapy.

In some cases, grandparents, aunts, uncles or other relatives are the legal guardians and primary caretakers, because the biological parent or parents have abandoned the youth, are incarcerated, are incapacitated due to illness or substance abuse, have died, or have chosen to remain allied with an abusive partner. In such instances, there is usually much to talk about, gain support for, learn about, and process. Foster parents also should be encouraged to attend individual collateral sessions and caretaker groups. Unfortunately, a minority may not be interested—at least initially—in participating in the adolescent's treatment. Even when this is true, the therapist should make every attempt to encourage their participation in (or at least support for) the adolescent's treatment. Supportive phone calls can sometimes facilitate this process, as does collaboration with child protection workers to encourage the foster parent to attend appointments.

Caretaker support groups. These groups typically involve multiple topic areas, including interactions with systems (e.g., law enforcement), parenting, identity issues, their own history of trauma, reactions to their child's (or children's) trauma exposures, gender and cultural issues, sexuality and relationship issues, and prevention strategies. Books or other materials can be useful in caretaker support groups—especially with mothers of sexually abused adolescents. The sense of isolation and shame that a non-offending caretaker may feel can be reduced through participation in a group with other caretakers who have experienced similar issues.

The following model is used for caretakers of adolescents who have been sexually or

physically abused, or exposed to domestic violence. This is only a suggested sequence, however; more sessions may be devoted to a particular topic area, or the order of sessions may also be adjusted according to the needs of group members. We recommend 12 to 16 weeks of group sessions in this model.

Although the group presented below focuses more on the dynamics and impacts of sexual abuse, the majority of adolescents treated with the ITCT-A model have experienced more than one type of trauma, for example, exposure to domestic violence and/or substance abuse, physical abuse, emotional abuse, and community violence. When this is the case, the model below can be adjusted accordingly.

This group is typically used with caretakers who have had a successful course of parenting classes or a parenting-focused support group, and usually have attended collateral sessions so that they are more able to address their own trauma issues. Although sessions include some didactic material, and exploration of parenting issues, the focus is more on the exploration of the caretaker's own trauma history, family of origin concerns, attachment issues, as well as more general discussion and support among group members. This model is designed to increase self-awareness and positive identity, facilitate more in-depth trauma processing, explore sex role/gender issues, develop relaxation and coping skills, explore relationships with partners, and increase safety for themselves and their families. Group members may, or may not, journal their experiences in the context of the group. At the beginning or end of each session, members may choose to participate in a brief breathing exercise or relaxation activity (see Chapter 7).

Session-By-Session Structure of a Caretakers Group

Session 1: Introductions and planning

> *Topics and activities: Introductions, overview of the group, confidentiality, and rapport/trust building.*

Group members describe how they were referred to the group and why they are attending. Each member completes a written "contract" stating their goals for the group and their commitment to attend all planned weekly sessions, arrive on time, and stay for the entire session. Group guidelines about respecting one another, not interrupting, limits of

confidentiality, and limiting communication with each other to sessions are discussed. Group members complete self-portraits and share how they are feeling about participating in the group. An overview of the group sessions is provided and discussed. Group members are encouraged to provide input so that the topics for all sessions will meet their needs.

Session 2: Child abuse and domestic violence issues; dealing with systems

> *Topics and activities: Psychoeducation regarding common reactions to child abuse and domestic violence; processing activated experiences; and strategies for dealing with systems.*

Didactic information is provided regarding short- and long-term impacts of child abuse and domestic violence on children, and themselves, including symptoms, feelings, and behaviors. Because many caretakers are raising younger children as well as adolescents, developmental differences are also included in the discussion. This session may include viewing a DVD on the impacts of abuse, in order to promote more in-depth discussion and understanding about ways in which their children may have been affected. Group members also describe and debrief one another regarding their experiences and strategies for coping with various systems such as Criminal Court, Dependency Court, Family Court, law enforcement, and child protection agencies.

Session 3: Understanding the dynamics of abuse and abusers

> *Topics and activities: Activities and discussion to increase caretakers' understanding of the dynamics of abuse and those who abuse, as well as the impacts and feelings associated with child abuse and domestic violence.*

Group members discuss dynamics and impacts of sexual abuse, domestic violence, or physical abuse, on their children and their family. Members explore the impacts of trauma on their relationships (parent-child, other children in their family, and extended family). Feelings related to the offender(s), including betrayal, grief, loss, anger are explored. Members of the group discuss how the abuse happened and the reactions they had to the disclosures.

Session 4: Parenting issues and strategies

> *Topics and activities: Psychoeducation, discussion, and role plays to improve group members' parenting skills and to explore the influence of their own trauma history on parenting.*

Behavioral management strategies are discussed, along with other ways that members can increase their support and empathy for the youth. Group members consider how their own trauma history may have contributed to their parenting issues. Strategies for better boundaries and communication are discussed. Group members may role play situations they have encountered with their children, and explore better ways of resolving caretaker-child conflicts. Members discuss ways to increase their functioning as caretakers, including the development of more affect regulation skills and increased self-awareness. Importantly, this session is for problem-solving and support, not for complaints about the adolescent's "bad" behavior.

Session 5: Coping skills and self-care

> *Topics and activities: Discussion and role-plays to increase healthy coping skills, self-awareness, and ability to care for themselves and others.*

Group members discuss the idea of using coping skills in order to be less reactive with children and youth, and practice affect regulation skills and trigger identification (see Chapters 7 and 11). They also explore how they can further develop mindfulness in their parenting and in other aspects of their lives. Group members may engage in more role-plays to practice skills they have learned through the group, including ways that they can be more assertive and empowered. Caretakers explore and develop strategies and skills to increase safety for themselves and their families. This may also include developing a safety plan (see Chapter 5) to protect them from further abuse and/or violence.

Session 6: Families of origin

> *Topics and activities: Group members complete family genograms and discuss family issues and themes.*

Group member explore issues related to their own family-of-origin and attachment relationships. Each member presents their family genogram (described later in this chapter), with special attention to family-of-origin relationships, intergenerational issues related to trauma and loss, and ways in which their parenting has been influenced by their experiences while growing up.

Sessions 7 and 8: Trauma narratives

> *Topics and activities: Members share their narratives through writing activities and/or creating a collage or timeline, and discussion.*

To the extent they are comfortable doing so, each group member briefly describes his or her personal trauma or neglect history, explores how the youth's trauma (presently or in the past) may have triggered memories of his or her own victimization, and provides support for other members during this disclosure process. Beyond direct disclosures, this also may be done by sharing journal entries, writing and reading letters to the offender, or engaging in (and sharing) other writing activities. Members also may create a time-line (as described later in this chapter) or a collage, focusing on their trauma experiences and ways they have used their strengths and resources to survive traumatic experiences. Breath or relaxation exercises are especially used at the end of these sessions.

Session 9: Gender and cultural identity issues

> *Topics and activities: Group members explore their sense of self related to gender and cultural background, and practice increasing assertiveness.*

Gender issues, sex roles, cultural beliefs and background, and spirituality are discussed and explored. Members may complete a collage representing their culturally-based self-perceptions as a child or youth, as well as their current views of themselves. If relevant, discussion also may include members' experiences of racial, gender, or economic discrimination.

Session 10: Attachment relationships

Topics and activities: Group members explore their attachment relationships from childhood and in their current lives, and discuss ways to improve their attachment relationships with their children.

In this session, members describe their relationships with their children, partners, and others (e.g., friends, co-workers), and explore ways in which their childhoods may have made it difficult to form and maintain secure relationships—including with their children. Group members discuss ways in which members might improve their relationships with others, and provide supportive feedback to one another.

Session 11: Intimacy

Topics and activities: Group members discuss issues related to dating, intimacy in relationships, and maintaining their personal safety.

Trust issues are explored, and group members discuss the challenges they face in dating or ongoing relationships with romantic partners, including issues associated with sexual intimacy. Members explore self-protection and prevention strategies in instances where a partner or date might become abusive or violent, and discuss how they could increase the safety of their children and themselves.

Session 12: Ending group and planning for the future

Topics and activities: Overview and recap of the group.

Group members review the goals written in their contracts at the beginning of the group, and their progress in meeting those goals. Members may choose to share more of their journals entries written during the course of the group. Each group member briefly discusses his or her goals for the future. Members complete self-portraits and discuss positive changes they have noticed in themselves and others over the course of the group.

Caretaker individual therapy

The psychological treatment of caretakers proceeds in essentially the same way as it would for any other traumatized adult client. However, this work may be most helpful to the adolescent if the caretaker is able to explore their own trauma experiences, feelings, and reactions in much the same way that their adolescent son or daughter is hopefully doing in their own therapy sessions. The caretaker with unresolved trauma and/or a disorganized/insecure attachment to his or her child is likely to benefit from opportunities to increase affect regulation skills and self-capacities, as well as to explore and process their own traumatic experiences cognitively and emotionally. The reader is referred to recent sources on the treatment of adolescents and adults with complex trauma (e.g., Blaustein & Kinniburgh, 2010; Briere & Scott, 2012; Habib, 2009; Cloitre, Cohen, & Koenen, 2006; Ford & Courtois, 2013) for further information on how these goals might be accomplished.

Because of the interpersonal complexities, boundary issues, and role conflicts inherent in a single clinician treating multiple family members, it is strongly recommended that someone other than the adolescent's therapist be assigned to treat his or her caretaker(s). This is particularly important for the older adolescent, whose relationship with his or her therapist could be compromised if the caretaker (who may have contributed to the youth's trauma) is also seeing his or her therapist in individual collateral sessions. Similarly, if siblings are also participating in individual sessions, they should be treated by different therapists. When this is not possible within an agency, individual family members should be referred to other clinics or practitioners.

Working with the Family

The family therapy component of ITCT-A is indicated when negative family dynamics or intrafamilial conflicts have a negative effect on the adolescent's psychological functioning. These interventions are often most helpful for adolescents who have not yet left the familial home. In addition, appropriate candidates for family therapy should not be overwhelmed by posttraumatic symptoms, and should have caretakers or family members who are willing to participate in treatment and are at least somewhat supportive of the client.

As noted earlier, a significant proportion of severely maltreated adolescents are separated or alienated from their families. When this is true, the clinician should

nevertheless try to involve the caretakers in the youth's treatment as much as possible. Even if caretakers are non-protective or emotionally abusive, or are seemingly undermining the adolescent's therapy, attempts should still be made to involve them in collateral sessions—while assuring the adolescent client that, with the exceptions associated with mandated reporting and extreme suicidality, what he or she shares with the therapist is kept confidential. In the unfortunate event that needed family therapy is not possible, a therapist who can engage with caretakers and form a therapeutic alliance, while maintaining a strong therapeutic alliance with the adolescent client, is more likely to facilitate positive change in the family system and to improve the outcome of the adolescent's therapy (Gil, 1996; Karver, Handelsman, Fields, & Bickman, 2006).

Engaging traumatized adolescents and their families in family therapy may be difficult, for the reasons outlined above. However, perhaps especially after the youth has had some individual therapy and the caretakers have attended parenting (and perhaps group) sessions, family therapy is often appropriate, and the involved family members may be amenable to treatment. Generally, the focus is on improving family communication patterns, exposing and attempting to resolve family conflicts that impact the adolescent, clarifying appropriate boundaries, attempting to increase the general level of attunement and emotional support within the family, and preventing further traumatization of the adolescent.

Family therapy can facilitate system change as well as increase the youth's sense of well-being and functioning. However, it is essential that all participating members feel safe and supported. Hughes (2007) suggests that the therapist have an attitude of relaxed engagement that includes qualities of playfulness, acceptance, curiosity, and empathy (P.A.C.E.). Emotionally attuned interactions between therapist and participating family members enhance the therapeutic relationship, and model secure attachment relationships (Byng-Hall, 1999; Hughes, 2007). As ITCT-A activates these "old" attachment patterns within the context of "new" caring and attunement, trauma-related behaviors and feelings can be processed in somewhat the same manner described in Chapter 13, leading to more secure and healthy attachment relationships between caretakers and their children.

A particular challenge in doing family therapy arises when multiple children or adolescents have been victimized, are all considered primary clients, and have been assigned to individual therapists. We advise that, following a significant course of individual therapy,

all therapists and clients participate in family therapy. In such instances, or whenever working with complicated family dynamics, pre-session planning and post-session debriefing by all therapists involved becomes paramount. This includes clinicians reflecting on the therapeutic process, specific events that transpired, and countertransferential feelings, as well as being open to feedback from the other therapists and consultants/supervisors about ways in which the family's dynamics may influence the therapist's perceptions and actions, or may be mirrored in the working relationship between the co-therapists.

Cultural factors are often relevant in family and caretaker therapy. Caretakers and other family members may have been raised in social-cultural contexts in which issues like acceptance of corporal punishment, rigid sex roles, and parental authoritarianism—or seeming insufficient supervision—result in considerable strain with family members (including the youth) who do not endorse these perspectives. As noted by Gil and Drewes (2005), it is important for the therapist to transform cultural knowledge into appropriate therapeutic behaviors. The cultural background of the client and their family may vary within a given family, resulting in different family members identifying with different cultures. For example, a client who is biracial (African-American/Latino) may identify more with Latino culture because of important family relationships, whereas a sibling who is African-American/White may identify more with African-American culture. In addition, in the case of caretakers within a given supposed cultural group, for example "Latino" or "Hispanic," each may be from a different subgroup (e.g., with ancestors in Mexico, Central America, South America, Puerto Rico, or Cuba), and thus endorse widely different perspectives, histories, and languages or dialects. Religious or spiritual beliefs may also vary within the family, and can influence the extent to which family members value therapy.

For these reasons, it is often important to ask the client and family members how they perceive themselves regarding cultural or ethnic issues, as opposed to making potentially erroneous assumptions. We refer the clinician to Gil and Drewes (2005) for specific advice on how to adjust interventions according to the specific cultural background of the client and his or her family. Other resources for the therapist wanting to understand effects of cultural background and associated family values include Fontes (2005) and McGoldrick, Giordano, and Pierce (1996). All of these resources directly describe specific aspects of a wide range of cultures and provide guidelines for appropriate assessment and treatment.

The family may be impacted by other systems issues, such as police or child welfare involvement regarding reported child abuse or domestic violence, and ongoing legal processes such as family members being involved in the criminal justice system. There may be custody, dependency, foster-parent, and reunification issues that present further complications. Many of these issues and concerns can be worked out, to some extent, if there is motivation, good family communication, and sufficient support. As communication increases, all family members have a chance to understand why things are happening as they are, and how some problematic family patterns can be changed. Dynamics such as scapegoating, splitting, inappropriate or excessive expectations of the adolescent or caretaker, verbal aggression, and emotional detachment can be brought to light, and hopefully reduced or eliminated over time.

The adolescent client's role in all this is complex. On one hand, he or she is the "identified patient," officially responsible—by virtue of his or her problems, symptoms, and behaviors—for the family being in treatment. This is especially true when the youth has been abused or neglected within the family. Intrafamilial sexual abuse, in particular, seems to involve more complicated family system issues (Gil, 2006), including isolation and lack of outside support systems, extensive denial in the family, a non-offending caretaker who may be dissociated and disengaged, blurred boundaries and inappropriate roles, alliances by family members with the perpetrator, secrecy, poor communication, and lack of empathy for each other. In this and other instances, the adolescent client may be blamed for family dynamics that may not be his or her "fault," and, in fact, that may be the source of some of his or her behavior.

Yet, it is often the adolescent who shakes up what is already a dysfunctional family system and brings in assistance from others. He or she may inadvertently begin a process that reveals hidden family violence, abuse of other children, covert substance abuse, and significant parental psychological disturbance. As these issues are identified and processed in therapy, the youth's role as the problematic member may shift, to his or her (and the family's) benefit. Effective family therapy may result in increased support for, and understanding of, the adolescent trauma survivor, as well as more general positive outcomes for the rest or the family.

ITCT-A Family Therapy Interventions

Unfortunately, there are only a few books that specifically address family therapy with abuse or trauma survivors. These include Friedrich (1990), Gil (1996, 2006), and Pierce and Pezzot-Pierce (2007). Presented below are family interventions that have proven to be especially useful in ITCT-A.

The time-line

A version of the time-line technique can be found in Families Overcoming and Coping Under Stress (FOCUS; Saltzman, Babayon, Lester, Beardslee, & Pynoos, 2008)—a therapy model first developed for medically traumatized clients and their families. In this approach, each family member creates their own time-line, demarking all specific traumatic events or losses that he or she has experienced. Family members can explore their varied perceptions and feelings associated with traumatic experiences, and update each other's recollections of shared—but differently experienced—events. For families with multiple traumatic exposures, it may also be helpful to identify on the time-line which events have had the greatest impact on each family member. In some cases, the clinician can suggest that a "total time-line" be created, which is a compendium and integration of all the time-lines created by individual family members. In blended or fragmented families, this overall time-line may document events that some family members may not have experienced or even been aware of, and may provide insight to family members in terms of events that affect the family but are not known to all.

The genogram

One way that family members can become more aware of the intergenerational transmission of trauma and loss, as well as relationships between family members is to create a genogram (McGoldrick, Gerson, & Shellenberger, 1999). The genogram is a graphic representation of a family tree that maps out current and former members, and their relationships to one another. Depending on their complexity, genograms may denote a wide range of people, events, and even the transmission of behavior (e.g., child abuse) from parent to offspring, across multiple generations. Family members can contribute information and impressions regarding positive and negative relationships between family members, psychological traits, conflicts, abuse and violence, neglect, substance abuse, losses, deaths,

medical and psychiatric illnesses, and family themes and secrets across several generations. This activity, sometimes completed over more than one session, supports family members' exploration of their perceptions, experiences, and feelings relative to one another, while also becoming more aware of how family dynamics and history have contributed to their trauma and distress.

Family drawings

Family members can be invited to each create a drawing of their family doing something (Kinetic Family Drawing), or depicting how they might appear in a photograph (Family Snapshot). Sometimes family members will express more information regarding family relationships and issues through drawings than they might through strictly verbal communication. Information on who is included in the drawing, their size relative to one another, and their proximity and demeanor can (a) increase the therapist's understanding of family relationships and dynamics and (b) facilitate discussion and increased awareness among family members.

Role playing

This exercise involves family members playing the roles of other family members, under the therapist's guidance, with a goal of increasing their understanding or appreciation of the other person's experience. For example, a mother might role-play the adolescent son who "sits around on the couch all day," while he role-plays her "telling me what to do all the time." While taking on each other's persona, and speaking from that person's position, the mother might come to understand better the depression and hopelessness her son has experienced since the loss of his father, and the son might gain an inkling of the pressure his mother feels at now being the sole provider in the family, and her anxiety about his well-being. Not only may such interchanges increase each family member's insight, they may lead to more openness to communication, and a greater willingness to problem-solve conflicts as they inevitably emerge during family life.

Chapter 16: Group Sessions

Group therapy is a helpful addition to ITCT-A, although it is not used with all traumatized adolescents. Typically, group treatment augments individual therapy; it is generally not used in isolation[7]. This is because many adolescent survivors of complex trauma suffer from relatively intense symptomatology, including posttraumatic stress and painful relational memories—phenomena that, along with the specific activities of trauma group therapy, can be triggered by interactions with other group members. Without concomitant individual therapy, these triggered cognitive and emotional states may become problematic for the client and for the group.

Especially triggering may be descriptions of abuse incidents that prematurely expose the client to his or her own unprocessed memories, often before he or she has sufficient affect regulation capacities to handle such material. Unfortunately, the result may be that the youth becomes so flooded by negative internal states that he or she either redirects the group leaders' (and the group's) attention to his or her responses alone (thereby altering group dynamics), or leaves the group session in an emotionally compromised state. In the absence of an individual therapist to whom the client can go for support and further intervention, the net effect of group therapy for such individuals may be negative.

Assuming that individual therapy is also available, group therapy can be a powerful tool in the adolescent survivor's recovery. Below are some central principles and parameters, as well as an example of an adolescents' group. The reader is referred to Briere and Lanktree (2011) for more information on the group component of ITCT-A, including an additional 12-session group that can be used for youth in school settings.

Gender composition

It is suggested that all groups be comprised of adolescents of a single sex (i.e., separate groups for males and females). This is because mixed gender trauma groups tend to involve two challenges:

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[7] *One exception to this general rule is the "post-therapy group," where all members have been in prior individual treatment, and screening suggests that each member is able to participate without negative effects.*

First, heterosexual members of such groups tend to respond to the presence of opposite sex members with behaviors associated with sexual-romantic issues, including showing off, flirting, or discussions of male-female differences in social contexts. Lesbian, gay, bisexual, or transgendered youth may evidence the same issues in same sex groups, but various factors (including the smaller ratio of such adolescents to their specifically heterosexual peers) typically reduce the prevalence or intensity of this issue. Sexual and romantic discussions and behaviors are a healthy part of adolescent development and socialization, regardless of the individual's gender or sexual orientation. This however, may easily distract members from talking about, and processing, their traumatic pasts.

Second, survivors of trauma generally often have less difficulty exploring their pasts when in the presence of same-sex group members. This is especially true of those with sexual abuse histories, who may experience greater shame or, in some cases, even triggered memories when disclosing in the presence of opposite-sex group members. The typical preference for disclosing to same-gender groups is often equivalent regardless of sexual orientation. The issue of transgendered youth sometimes presents a problem, although this can be negotiated within the group. Often, the transgendered adolescent will choose to attend sessions with members of his or her assigned sex, as opposed to biological one.

Age composition

The clinician should consider limiting groups to members of specific age ranges, for example, 12 to 15 year olds versus 16 years or older. In general, there should be no more than a three year difference between the youngest and oldest member. This is because younger adolescents often differ from older ones in several respects: (1) they may be less mature emotionally and cognitively, such that they have different needs and capacities that affects how group treatment should occur, (2) it may be that exposure to the abuse/victimization stories of older adolescents will be too activating, and perhaps even traumatizing, and (3) younger members may be intimidated by the presence of older youth in the same group, leading to a decreased willingness to be vulnerable and open about trauma issues. Conversely, older group members often do better in groups of their peers, where they can openly discuss their concerns and issues, and where they may feel more understood by other members.

Specific issues

It is sometimes helpful to run groups with individuals who have certain issues or experiences in common. Examples of such groups are those who share histories of specific traumas (e.g., sexual abuse, hate crimes, refugee experiences) or who are especially identified with certain stressors or orientations (e.g., substance-abusing adolescents, homeless youth, or those who identify themselves as gay, bisexual, or transgendered). Race-specific groups are sometimes conducted, to the extent that members have experienced oppressive circumstances that require discussion and processing without dominant-race participants. In each of these cases, the issue is typically one of shared experience: the adolescent survivor may feel most safe and most comfortable with other youths who have been through similar experiences, as opposed to group members who cannot relate to their specific concerns, or even represent a group who has done them harm. In all cases, however, the therapist should consider the downside of homogenous groups, especially the possibility that opportunities for cross-cultural or cross-demographic discussions and/or rapprochements are missed.

Matching on affect regulation capacity

Groups should ideally consist of clients with relatively equivalent abilities to tolerate emotional distress (Briere, 1996). As noted earlier, those with very little affect regulation capacities often do better in groups with others at similar levels; generally because the therapist can make sure that the focus and process of the group is less likely to be overwhelming. When group members have been screened for similar affect regulation skills, the trauma disclosures and processing activities of any one group member is less likely to trigger another member into an excessive emotional or cognitive state; in other words, all members share generally equivalent therapeutic windows, such that undershooting or overshooting is less common.

Although affect regulation matching is generally a good idea, in some cases there will not be sufficient potential members available to sort them into such groups. As a result, the clinician may have to include clients of differing levels of emotional regulation capacity, and thus may have to pay special attention to the possibility that some members may become overwhelmed if other members fully process their trauma. Unfortunately, this means that a given therapy group may be less helpful for some members than others; especially those

whose capacities support the activation and processing of very distressing material, since they will necessarily have to be constrained to some extent in groups with individuals who have less ability to modulate strong emotional experiences. In such situations, the best that the clinician may be able to do is to screen out those adolescents with especially poor affect regulation capacity, so that (a) they will not be overwhelmed by other clients' emotional processing, and (b) group members will have greater opportunities to discuss and respond to abuse memories without worrying about—and/or stigmatizing—those who might be especially overwhelmed by such material.

Group leaders

In general, whenever possible, there should be two group leaders, both of the same gender as the group participants. Group work with trauma survivors is often quite intense, and it is rarely sufficient that only one clinician be present. Two therapists allows the clinicians to "share the work:" backing each other up when necessary, but also providing two sets of eyes and ears so that subtle and/or important group dynamics are less likely to be missed.

In contrast to the practices of some agencies, it is also important that at least one group member be an experienced clinician who has led groups for trauma survivors in the past. Because group therapy for trauma survivors can be challenging, leadership of such groups should not be an entry-level job for newly trained or accredited therapists, unless close supervision is available and one co-therapist is experienced in treating traumatized youth. In the worst case, employing an untrained therapist in group treatment, without an experienced co-facilitator, can result in negative outcomes for both group members and the clinician.

Group structure and focus

Group treatment can be open or structured. Open or "drop-in" groups admit members at any time, often do not have a specific number of sessions planned, and typically do not address a single specific issue in any given session—whatever the group members wish to discuss, as long as it is trauma-related, is accepted. Group sessions usually last for 1 to 1 1/2 hours, although some may be constrained to a lesser amount of time.

Structured group therapies usually consist of a specific series of content-related sessions, and are closed to new members—members are recruited to attend the full number

of sessions. Often, these groups meet for somewhere between eight and 16 sessions, although some agencies and clinicians offer longer session series. See Briere (1996) for a detailed discussion of open versus closed groups in the treatment of sexual abuse survivors.

An ITCT-A Group for Young Adolescent Females

Presented here is a structured, 12 week group for female sexual abuse survivors, aged 12 to 15, initially developed by Hernandez and Watkins (2007), and further expanded by Briere and Lanktree (2011). This group can be adapted for adolescent males in the same age range with only minor changes. Older adolescent groups may follow the same general format (i.e., addressing the same session areas), but should be altered to eliminate materials and activities that are less developmentally appropriate (e.g., psychoeducation using books for younger children; some art activities and games), and adding, instead, reading materials for older adolescents, and more discussions and attention to more mature topics (e.g., greater attention to dating, sexuality and safer sex, and substance abuse issues).

Pre-requisites for participation in this 12-15 year old group are (a) recent or current ITCT-A individual therapy, (b) a commitment to attend all weekly sessions, (c) interest in further processing of traumatic experiences, and (d) sufficient affect regulation skills to cope with the possibility of being triggered by the disclosures of other group members.

Session 1: Introduction to the group

> *Topics and activities: Introductions, overview of the group, confidentiality, and rapport/trust building.*

Group leaders note that all of the girls are in the group because they have been sexually abused, but generally do not expand on this further during the first session. However, group members may, if they wish, share briefly—without describing in detail—what sexual abuse experiences they have had. Early, limited disclosure can reduce anxiety associated with having to share their traumatic experiences at a later point. Rules of confidentiality are reviewed, since some of the girls may attend school together or associate with each other in other contexts. They are asked not to talk about the group outside of the group, although this cannot always be prevented. If outside communication occurs between group members, it is important that they discuss these contacts within the group setting. No sexual

relationships between group members are permitted; although this might seem unlikely for this age group, externalized sexual behavior is not especially uncommon among younger adolescent sexual abuse survivors.

In order to reduce anxiety associated with introductions, group members interview each other, in pairs, then share with the group what that member told her about herself. Group members may also draw self-portraits depicting how they feel at the start of group therapy. These self-portraits are kept by the co-therapists, and then are compared with self-portraits completed at the end of group therapy. If time permits, group members may create a list of personal goals they hope to accomplish with their participation in the group. These are kept by co-therapists, but a copy is returned to the group member so that she can refer to them and revise as needed as they proceed through the group sessions.

Session 2: Learning about sexual abuse

Topics and activities: Psychoeducation regarding common reactions to sexual abuse.

Members are presented with written information about the thoughts and feelings often experienced by sexual abuse survivors. Group members are asked to share symptoms that they have observed in themselves and in other sexual abuse survivors. Materials relevant to their trauma experiences, especially child sexual abuse and peer sexual assault, may be distributed and discussed. Materials must be age-appropriate, and reviewed by the co-therapists prior to distribution. For example, commonly used are excerpts from My Body, Myself - the What's Happening to My Body Book for Girls (Madaras & Madaras, 2000) and, for male groups, the My Body, Myself - What's Happening to My Body Book for Boys (Madaras & Madaras, 2007). Sometimes clients will also want to share the names of books or movies relevant to sexual abuse, such as I Know Why The Caged Bird Sings (Angelou, 1969) and Push (Sapphire, 1996), made into the movie Precious (2009).

Session 3: Learning about and expressing trauma-related feelings

Topics and activities: Activities to explore and express feelings, especially how clients felt before, during, and after the abuse, and upon disclosure, if relevant.

Clients are invited to write a letter to the perpetrator or person who did not protect them

(with explicit instructions not to send it, at least at that time), write a poem about her feelings, or simply list, on paper, the feelings she had before, during, and after the abuse ended or was disclosed. Group members may choose to use an art activity such as Color-Your-Life (O'Connor, 1983), using different colors in an abstract fashion to depict feelings about the abuse.

Session 4: Specific exploration of trauma-related perceptions

> *Topics and activities: Collage or art depicting how they believe others see them, how they view themselves "on the inside," their feelings about how they were affected by the abuse.*

Group members may make collages with pictures and words depicting the alcoholism of their perpetrator; unseeing, disbelieving, and nonprotective family members; other related abuse (physical abuse, domestic violence, community violence); the perpetrator, represented symbolically (e.g., by male in black and white striped prison garb, as a devil or other threatening figure); and other symbols of their trauma and the impacts on them. This tends to be a session where clients focus on visual expression of their experiences through art, which can then lead to exploration of their trauma narrative and deeper emotional processing. Group members also may create a box or folder with drawings, photos and words glued on the outside, to depict how they believe others see them, then in the same fashion, draw and/or glue photos and words on the inside of the box or folder to depict how they perceive themselves.

Session 5: Specific exploration of traumatic events experienced

> *Topics and activities: Writing a narrative or "story" of their abuse history.*

Generally as per Chapter 10, group members write about their trauma exposure, and then read it to the group. Another approach is the "hat game," involving all group members writing questions concerning sexual abuse experiences, which are then placed in a container or hat. Each group member draws a question and answers it, after which all other group members also answer the question. If a group member declines to answer, they are not pressured to do so, but are asked to express the feelings they are having and why it is difficult

to answer the question. This process can often help the recalcitrant group member answer the question in some manner, and sometimes to disclose more specific details regarding their experiences and feelings. Especially for less verbal group members, this can be the beginning of the development of a more detailed trauma narrative.

Session 6: Specific exploration of traumatic events (continued)

Topics and activities: Sharing trauma narratives with the group, as per Session 5.

This session can begin with a relaxation exercise, whereby group members focus on their breath and pay attention to their thoughts (see Chapter 7). As they further share their narratives and related feelings, the courage of each member and of others in the group is emphasized. The co-therapists invite all group members, before the session ends, to mention something positive that they noticed about each other in the processing of their trauma narrative. As this is also the midpoint of the group, and may involve disclosure of new trauma-related material, the group therapists may debrief with the clients' individual therapists, if relevant. Group members are also encourage to evaluate their progress in the group, and how they are working toward meeting their goals.

Session 7: Addressing thoughts and feelings about sex and sexuality

Topics and activities: Group members use their narrative to help them talk about sexuality and to integrate their experiences into their lives.

It is common during this session for group members to share feelings of being coerced by peers to have sex, difficulties they may be experiencing in enjoying being sexual with partners when they wish to be, sexual identity issues, and other issues related to difficulties with intimacy. Older adolescents sometimes disclose that they have flashbacks and nightmares when they are engaged in a sexual relationship, even with a partner with whom they feel safe. Psychoeducational material is often helpful at this point, normalizing sexual feelings and sexual development, describing safer sexual behaviors, and covering other related topics.

Session 8: Exploring problem solving

> *Topics and activities: This session relates in particular to safety and affect regulation/tolerance.*

A general discussion is facilitated about whether there are things that the group members could do to improve their lives, decrease the likelihood of further victimization, and get through times when their feelings are triggered. It may be helpful during this session for group members to work on their trigger grids (Chapter 11), as they identify situations that activate memories and feelings and discuss what they can do to take care of themselves at such times. Group members also may wish to identify those whom they can turn to for support, and explore how they can expand their repertoire of coping skills outside the group (e.g., physical activity, art, music, reading, writing in journals, etc.).

Session 9: Learning about boundaries and safety

> *Topics and activities: Developing a specific safety plan regarding the possibility of future abuse or other relational trauma.*

Group members describe situations where there might be a danger of physical or sexual assault. This discussion typically also includes who they identify as safe versus unsafe in their families, as well as those who can help to keep them safe, such as supportive peers, coaches, teachers, or neighbors. Because child abuse and neglect often occurs within attachment relationships and family systems, this also can be a session wherein group members explore, through family genograms (Chapter 15), how risks to their safety, and boundary violations, have occurred across generations in their family. They can then identify ways to change these patterns and be more safe in the future.

Session 10: Focusing on self-esteem

> *Topics and activities: Exploring and identifying client's positive qualities.*

This session involves discussion of any posttraumatic growth that may have occurred after experiencing abuse (e.g., how it has made them stronger, the idea that "If I got through that,

I can deal with this….").

Leaders of groups where self-esteem issues are especially paramount may choose to adjust the sequence of session topics, so that this session occurs at an earlier stage. It is often a helpful strategy to include an activity at the beginning and/or end of this session, wherein group members share their perceptions of positive attributes of the other group members. It is especially important that no one be overlooked during this activity.

An example of an activity to increase self-esteem and feelings of being accepted by others, as well as increasing compassion for and appreciation of each other, is the "balloon game." This activity is particularly helpful for younger group members, and those who are less verbal. Each group member writes one supportive message for each of the other group members, along with one self-care message for themselves, on a piece of paper. Group members fold and insert the piece of paper into a deflated balloon, blow it up, and toss it around the room. Each member then takes one balloon (not their own) and pops it. She then reads aloud the message, and discusses any feelings associated with the message.

Session 11: Building positive coping strategies for painful memories

> *Topics and activities: Learning to avoid being triggered, and, if it can't be avoided, what can be done to cope with triggered states (both what they identified on the Trigger Grid in Session 8 , as well as additional options they have come up with since completing the grid).*

Group members also discuss how to handle relationships so that they can be safe, and how to avoid being re-victimized in general. Depending on the level of affect regulation in the group, members will sometimes benefit from this session being conducted earlier in the sequence, so that they can feel greater affect regulation and self-capacities, and be better prepared to do trauma processing later on. If group members are having particular difficult with this material, co-therapists and group members may wish to extend this topic to more than one session.

Session 12: Terminating group

> *Topics and activities: Overview/recap of the group.*

In the last group meeting, members make individual disclosures about what they gained from the group. Members may also create a self-portrait which is compared with the one they created in the first session, review their goals and what they have accomplished or gained from being in the group, as well as any other material representing their progress in the group, such as music, journal writing, artwork etc. Group members are encouraged to describe their goals for the future. It is also important that all group members share in a celebration during this session which typically involves special food brought from home or that the co-leaders have provided.

If the leaders and group members wish, the group may be extended for another 2 to 4 sessions. In such cases, additional topics might include sex roles, stereotypes, and gender issues (collages, role-plays, and exploration of non-gender-stereotypic behaviors) as well as more on family relationships, including exploration of primary attachment relationships, caretaking failures and disappointments, role models, and those who did provide nurturance.

Chapter 17: Sequence and Session-Level Structure of ITCT-A Individual Sessions

This guide has described various techniques and approaches for the cognitive, emotional, and relational processing of traumatic memory. Based on initial and ongoing assessment with the Assessment-Treatment Flowchart, and applying the Problems-to-Components Grid, the clinician is advised to customize the type and extent of intervention for any given adolescent, so that the youth's specific difficulties can be addressed in a systematized manner using relevant components. At the same time, an overbridging philosophy of these guidelines has been a focus on the therapeutic relationship: both as a necessary support for the hard work of trauma processing, as well as a technical requirement for the resolution of the relational/interpersonal difficulties of many adolescent trauma survivors.

Although the actual processing and desensitization of traumatic material typically varies in degree from session to session, and certain general aspects of treatment transcend technique, per se, it is also true that therapy for trauma survivors often works best when it conforms to a basic structure. Such a framework allows the therapist to assess the client's current needs, determine treatment priorities, provide relevant processing activities as appropriate, reassess the client's current state, de-escalate emotional responses, when necessary, and provide end-of session closure.

In general, we suggest that individual therapy for traumatized adolescents involve one 50-60 minute session per week, in addition to group and/or family sessions that may occur on a weekly to monthly basis. As stated elsewhere, group and family sessions occur after the adolescent has engaged in a course of individual therapy. In a minority of cases, more than one individual session per week may be indicated, and, in some cases, family or group therapy may be more frequent or completely absent. The frequency of individual sessions may decrease to biweekly and then monthly meetings as the client improves and nears termination. Adapting from Briere and Scott (2012), some version of the following is appropriate for the individual therapy session:

Pre-session

The ATF-A should be reviewed, and principle targets for the session ascertained. These targets may change as the session unfolds, but they should not be abandoned unless necessary (e.g., when the client discloses or experiences a new trauma, or is in crisis).

Opening (5-15 minutes)

1. Spend a few minutes making contact with the client. This may include discussion of relatively neutral topics, including recent activities or events in the client's life. Authentic caring and interest should be expressed early in the session, and repeated thereafter as appropriate.
2. Inquire about any changes in the youth's life since the last session.

- Have there been any new traumas or victimization?
- Has the client engaged in any dysfunctional or self-destructive behaviors?
- If any of the foregoing is of concern, work to assure or increase the client's ongoing physical safety. Do this before (or instead of) formal trauma processing.

3. Check with the adolescent regarding his or her internal experience since the last session. Ask if intrusive or avoidance symptoms have increased significantly. If yes, determine the nature of the trigger(s) and the thoughts, feelings, and/or memories they produced. Normalize the experience and validate symptoms as internal trauma processing. If the intrusions or avoidance responses are substantial, consider decreasing the intensity of exposure and activation in the current session.
4. Based on information from the opening part of the session, revise—if necessary—the goals of treatment for the session.

Mid-session (20-30 minutes)

1. Provide emotional and cognitive memory processing, staying within the therapeutic window whenever possible. Facilitate the youth's discussion of his or her trauma history, support identification and expression of emotions when

possible. For younger clients, this may include expressive activities such as drawing, collages, etc. Communicate caring and support.

2. If significant processing turns out to be contraindicated (i.e., because it is potentially overwhelming), revert to psychoeducation, general discussion, affect regulation skill building, or focus on cognitive interventions.
3. Avoid therapist-centered activities, extensive interpretation, or lecturing. Maintain and communicate a nonjudgmental, caring, and accepting attitude.

Later in session (15-25 minutes)

1. Debrief, normalize, and validate any material (cognitive or emotional) or client responses that emerged during the session.
2. Inquire about the adolescent's experience during emotional or cognitive processing, as well as any other thoughts or feeling he or she had during the session.
3. Provide cognitive reconsideration, as needed, for additional cognitive distortions that emerged during debriefing.

Ending (Last 5-15 minutes)

1. Remind the client (if necessary) of the potential delayed effects of trauma processing, including possibly increased flashbacks, nightmares, and—for some clients—a desire to engage in avoidance activities such as substance abuse or tension-reduction behaviors. Do this in a non-catastrophizing/non-pathologizing way, and omit this step if it does not appear necessary.
2. If relevant, acknowledge and validate any relational activation and/or processing that occurred in the session. Reframe and/or normalize any conflict or relational distortions that occurred as potential evidence of good therapeutic interaction. This is not a time to engage in further relational processing, only to acknowledge and reassure.
3. Provide safety planning (if necessary) regarding dangers identified in the session, or any possible self- (or other-) destructive behavior that may emerge between sessions.

4. If the client's level of emotional activation remains high, spend a few minutes in a breathing or relaxation exercise
5. Provide closure statements (e.g., summing up the session) and encouragement.
6. Explicitly refer to the time and date of the next session.
7. End with some communication of caring, appreciation, and hope.

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Appendices

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

Initial Trauma Review

Adolescent/Young Adult Version (ITR-A)

This semistructured interview allows the clinician to cover the primary forms of trauma potentially experienced by adolescents (i.e., those between the ages of 12 and 21). The clinician may wish to paraphrase these questions in order to make them fit better into the session. However, (1) try to use the behavioral descriptors (don't just ask about "abuse" or "rape"), and (2) only ask as many questions at a given time period as is tolerated by the adolescent. Remaining questions can be asked at later points within the first few sessions. The question *How old were you the first time?* usually indicates whether or not the trauma was a form of child abuse. The questions *When this happened, did you ever feel very afraid, horrified, or helpless?* and *Did you ever think you might be injured or killed?* indicate whether the trauma meets Criterion A2 for DSM-IV PTSD or ASD.

1. [**Childhood physical abuse**] "Has a parent or another adult who was in charge of you ever hurt or punished you in a way that left a bruise, cut, scratches, or made you bleed?"

   ☐ Yes
   ☐ No

   If yes,

   "How old were you the first time?" _____

   "How old were you the last time?" _____

   "When this happened, did you ever feel very afraid, horrified, or helpless?"

   ☐ Yes
   ☐ No

   "Did you ever think you might be injured or killed?"

   ☐ Yes
   ☐ No

2. [**Sexual abuse**] "Has anyone who was five or more years older than you ever done something sexual with you or to you?"

   ☐ Yes
   ☐ No

   If yes,

   "How old were you the first time?" _____

   "How old were you the last time?" _____

   "When this happened, did you ever feel very afraid, horrified, or helpless?" [*NOTE: For sexual abuse only, this part is not necessary for PTSD Criterion A*]

   ☐ Yes
   ☐ No

   "Did you ever think you might be injured or killed?" [*NOTE: For sexual abuse only, this part is not necessary for PTSD Criterion A*]

   ☐ Yes
   ☐ No

3. [**Peer sexual assault**] "Has anyone who was less than five years older than you ever done something sexual to you that you didn't want or that happened when you couldn't defend yourself (for example, when you were intoxicated or asleep)?"

   ☐ Yes
   ☐ No

   If yes,

   "How old were you the first time?" _____

   "How old were you the last time?" _____

   "When this happened, did you ever feel very afraid, horrified, or helpless?"

   ☐ Yes
   ☐ No

   "Did you ever think you might be injured or killed?"

   ☐ Yes
   ☐ No

4. [**Disaster**] "Have you ever been involved in a serious fire, earthquake, flood, or other disaster?"

   ☐ Yes
   ☐ No

If yes,

"How old were you the first time?" _____

"How old were you the last time?" _____

"When this happened, did you ever feel very afraid, horrified, or helpless?"

☐ Yes
☐ No

"Did you ever think you might be injured or killed?"

☐ Yes
☐ No

5. [**Motor vehicle accident**] "Have you ever been involved in a serious automobile accident?"

☐ Yes
☐ No

If yes,

"How old were you the first time?" _____

"How old were you the last time?" _____

"When this happened, did you ever feel very afraid, horrified, or helpless?"

☐ Yes
☐ No

"Did you ever think you might be injured or killed?"

☐ Yes
☐ No

6. [**Partner abuse**] "Have you ever been slapped, hit, beaten, or hurt in some other way by someone you were dating or who you were in a sexual or romantic relationship with?"

☐ Yes
☐ No

If yes,

"How old were you the first time?" _____

"How old were you the last time?" _____

"When this happened, did you ever feel very afraid, horrified, or helpless?"

☐ Yes
☐ No

"Did you ever think you might be injured or killed?"

- ☐ Yes
- ☐ No

7. [**Nonintimate peer assault**] "Have you ever been physically attacked, assaulted, stabbed, or shot at by someone who wasn't a parent, date, or sexual partner?"

   - ☐ Yes
   - ☐ No

   If yes,

   "How old were you the first time?" _____

   "How old were you the last time?" _____

   "When this happened, did you ever feel very afraid, horrified, or helpless?"

   - ☐ Yes
   - ☐ No

   "Did you ever think you might be injured or killed?"

   - ☐ Yes
   - ☐ No

8. [**Torture—if the adolescent is an immigrant from another country**] "In the country where you used to live, were you ever tortured by the government or by people against the government?"

   - ☐ Yes
   - ☐ No

   If yes,

   "How old were you the first time?" _____

   "How old were you the last time?" _____

   "When this happened, did you ever feel very afraid, horrified, or helpless?"

   - ☐ Yes
   - ☐ No

   "Did you ever think you might be injured or killed?"

   - ☐ Yes
   - ☐ No

9. [**Police trauma**] "Have you ever been hit, beaten, assaulted, or shot by the police or other law enforcement officials?"

   ☐ Yes
   ☐ No

   If yes,

   "How old were you the first time?" _____
   "How old were you the last time?" _____
   "When this happened, did you ever feel very afraid, horrified, or helpless?"

   ☐ Yes
   ☐ No

   "Did you ever think you might be injured or killed?"

   ☐ Yes
   ☐ No

10. [**Medical trauma**] "Have you ever been in the hospital because you were very sick or very hurt?"

    ☐ Yes
    ☐ No

    If yes,

    "How old were you the first time?" _____
    "How old were you the last time?" _____
    "When this happened, did you ever feel very afraid, horrified, or helpless?"

    ☐ Yes
    ☐ No

    "Did you ever think you might die?"

    ☐ Yes
    ☐ No

11. [**Witnessing trauma**] "Have you ever seen someone else get killed, badly hurt, or sexually assaulted?"

    ☐ Yes
    ☐ No

If yes,

"How old were you the first time?" _____

"How old were you the last time?" _____

"When this happened, did you ever feel very afraid, horrified, or helpless?"

☐ Yes
☐ No

"Did you ever think you might be injured or killed?" [*NOTE: Not required for PTSD Criterion A*]

☐ Yes
☐ No

12. [**Other trauma**] "Has any other very bad or upsetting thing ever happened to you?"

☐ Yes
☐ No

If yes, what was it? (If more than one, pick the worst other thing that happened)

_____

_____

"How old were you the first time it happened?" _____

"How old were you the last time it happened?" _____

"When this happened, did you ever feel very afraid, horrified, or helpless?"

☐ Yes
☐ No

"Did you ever think you might be injured or killed?"

☐ Yes
☐ No

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

Assessment-Treatment Flowchart

Adolescent/Young Adult Version (ATF-A)

Client Name: _____

Priority ranking (circle one for each symptom):

1 = Not currently a problem: no treatment currently necessary

2 = Problematic, but not an immediate treatment priority: treat at lower intensity

3 = Problematic, a current treatment priority: treat at higher intensity

4 = Most problematic, requires immediate attention

(S) = Suspected, requires further investigation

	Intake			
Date	_____	_____	_____	_____
Problem Area	*Tx Priority*	*Tx Priority*	*Tx Priority*	*Tx Priority*
1. Safety—environmental	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
2. Caretaker support issues	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
3. Anxiety	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
4. Depression	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
5. Anger/aggression	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

	Intake			
Date	_____	_____	_____	_____
Problem Area	*Tx Priority*	*Tx Priority*	*Tx Priority*	*Tx Priority*
6. Low self-esteem	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
7. Posttraumatic	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
8. Attachment insecurity	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
9. Identity issues	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
10. Relationship problems	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
11. Suicidality	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
12. Safety—risky behaviors	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
13. Dissociation	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
14. Substance abuse	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
15. Grief	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
16. Sexual concerns and/or dysfunctional behaviors	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
17. Self-mutilation	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
18. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
19. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

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

Written Homework About My Trauma

This homework has to do with the trauma that you and your therapist agreed that you should write about. There might be a lot of traumas in your life, so, remember, this is just about the trauma that you and your therapist picked this time. After each question, write an answer in as much detail as you can, in the amount of space you have. When you are done, save this homework, and bring it to your next session so that you and your therapist can read it together. You don't have to answer all these questions at the same time. You can put it down and then start on it again later. If it is too upsetting to finish, you can stop and talk to your therapist about it in your next session.

1. **What happened to you?**

_____

_____

_____

_____

2. What were your feelings when it was happening?

3. What was the worst feeling after it happened?

4. What did you think when it was happening?

5. What did you think after it was over?

6. What did you do after it happened?

7. **What was the worst thing about what happened?**

8. **Is there anything about what happened that has made you stronger or better or smarter?**

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. _____

_____

_____