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Best Practice

Treating Complex Trauma in Children and Adolescents: An Evidence-Based Integrative Approach

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When an individual has experienced multiple, severe forms of trauma, the psychological results are also often multiple and severe; a phenomenon often referred to as *complex posttraumatic disturbance*. Complex trauma usually involves a combination of early and late-onset, sometimes highly invasive traumatic events, usually of an ongoing, interpersonal nature, frequently including exposure to repetitive childhood sexual, physical, and/or psychological abuse, and often occurs in the context of neglectful or disengaged parenting. (https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma).

Complex trauma, especially as it presents in community clinics, schools, hospitals, residential treatment, juvenile justice, and short-term shelter contexts, is often complicated by adverse social circumstance. Social and economic deprivation — as well as racism, sexism, homophobia, and homelessness — not only produce their own negative effects on children and adults, they also increase the likelihood of trauma exposure (e.g., sexual and physical assaults by peers or gangs, community violence, "drive-by" shootings, etc.), and may intensify the effects of such victimization (Briere & Lanktree, 2012). Perhaps, especially of late, adverse social forces also contribute to trauma and loss associated with refugee or immigration status. Social marginalization also means that many traumatized children, adolescents, and their families have reduced access to appropriate mental health services.

Despite the prevalence of complex trauma in economically-deprived and socially marginalized youth, higher socioeconomic status children and adolescents are not necessarily protected from abuse and neglect, nor are more advantaged schools and social environments typically free of interpersonal violence. In fact, the presence of victimization and maltreatment at all socioeconomic levels and in all cultural and ethnic groups means that child abuse and neglect, peer assaults, discrimination, exploitation, and other forms of maltreatment are broadly prevalent in North America and elsewhere.

Because complex trauma is, in fact, complex, it is not surprising that such experiences are associated with a wide variety of psychosocial problems, ranging from anxiety, depression, attachment disturbance, eating disorder, dissociation, and posttraumatic stress, to avoidant coping behaviors such as substance abuse, aggression, suicidality, deliberate self-injury, dissociation, and seemingly indiscriminate sexual activities (Cook et al., 2005; Ford & Courtois, 2013).

Unfortunately, although complex trauma and its effects are common and pervasive, there are relatively few empirically-informed treatments available for multiply-traumatized children and adolescents. This is partially due to the challenging nature of the problem — the range of these impacts often requires a multimodal, multicomponent treatment strategy, and may require more sessions than are typically offered to those suffering from single traumatic events without concomitant relational factors. Treatment approaches that are limited to a single modality (e.g., exposure therapy, cognitive therapy, or psychiatric medication) can be insufficient — especially if the intervention approach is not adapted to the specific experiences, psychological needs, and cultural matrix of the affected child or youth.

One example of an evidence-based approach to complex trauma in young people is *Integrative Treatment of Complex Trauma (ITCT),* which is available for children aged 6 to 12 years (ITCT-C; Lanktree and Briere, 2016) and adolescents aged 12-21 years (ITCT-A; Briere and Lanktree, 2013; 2012). In a naturalistic, non-comparison study of 151 culturally diverse, largely inner city children and adolescents with a wide range of traumas and losses, an average of 28 sessions of ITCT was associated with a mean symptom reduction of 41% across anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns (Lanktree & Briere, 2013; Lanktree et al., 2012).

ITCT is structured and component-based, and interventions are customized according to the specific age, cultural background, history, symptoms, and problems of each given client. It does not assume that "one size fits all," but provides a specific, organized approach based on periodic assessments, using an Assessment-Treatment Flowchart. Components of ITCT, which vary according to client age and symptom or problem, include *relationship building and support, safety interventions, psychoeducation, emotional regulation training* (including breath training and mindfulness)*, relational/attachment processing, trigger management, cognitive processing, and titrated exposure.* Especially in ITCT-C, family and group therapy, as well as parent training and support groups are also employed when possible.

Research and dissemination of ITCT has been almost continually funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) since 2001, as part of the National Child Traumatic Stress Network (NCTSN; *www.nctsn.org)*. Currently, the University of Southern California Adolescent Trauma Training Center (USC-ATTC; *attc.usc.edu*) is a Treatment and Services Adaptation center of the NCTSN, charged with disseminating ITCT-A to centers and clinicians throughout the United States, with a specific focus on socially marginalized adolescents whose complex posttraumatic outcomes may also include substance abuse, suicidality, or self-injurious behavior. Trainings on ITCT-C are currently available from Dr. Lanktree, and training on ITCT-A can be accessed in a web-based module at *attc.usc.edu*, or for groups, arranged through the USC-ATTC training coordinator.

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