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Adolescent **T**rauma **T**raining **C**enter

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A): An Implementation Guide for Organizations

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Chapter 1. Beginning the Implementation Process

Introduction to the ITCT-A Implementation Guide

The ITCT-A Implementation Guide was developed by the University of Southern California Adolescent Trauma Training Center (USC-ATTC), Torrance, California, and was supported by grant #1U79SM080022-01 from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. This guide provides detailed information for organizations interested in adopting ITCT-A, for example, identifying steps needed for implementation, offering staff training guidelines, providing organizational support, and sustaining implementation through supervision, consultation, and clinician certification. In most cases, direct training and consultation with USC-ATTC staff members will be integral to implementation. However, the guide may also be used by lead agencies who are training other mental health service professionals and organizations, using Learning Community or Learning Collaborative models (see Chapter 3). This implementation guide is organized into seven chapters.

Chapter 1. Beginning the Implementation Process

Chapter 2. Getting Started

Chapter 3. Planning and Conducting Trainings

Chapter 4. Organizational Support

Chapter 5. Clinical Support and Sustainability

Chapter 6. Becoming a Level I Certified ITCT-A Clinician

Chapter 7. Challenges to Implementation

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A) was developed by John Briere, PhD and Cheryl Lanktree, PhD for the University of Southern California Adolescent Trauma Training Center (USC-ATTC) to address complex trauma in culturally diverse, economically disadvantaged adolescents and young adults. This treatment model is generally used in outpatient clinic settings and involves individual therapy that typically takes place over six to nine months. ITCT-A, however, has been adapted and implemented in a variety of settings, including short-term shelters, residential treatment programs, juvenile justice settings, schools, medical inpatient and outpatient units, and private practices. Although ITCT-A was developed

in the context of an inner-city environment, it also has been used effectively in smaller urban communities and rural settings throughout the United States.

As described in the second edition of the ITCT-A Treatment Guide (Briere & Lanktree, 2013), ITCT-A is a structured, multi-component, assessment-driven approach to treating complex trauma in youth aged 12 to 21 years. The ITCT-A guide is also being used with young adults up to the age of 24. There is also a child version available, ITCT-C (Lanktree & Briere, 2013). It utilizes interventions that are customized according to the specific age, gender, cultural background, history, symptoms, and problems of each given client. In many cases, this includes attending to issues of discrimination and disenfranchisement associated with cultural background, poverty, race, sexual orientation, or gender.

Components of ITCT-A 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. Family and group therapy, as well as parent training and support groups are also used as needed and when possible.

A key aspect of ITCT-A is its regular and continuous monitoring of treatment effects over time. This involves initial and periodic evaluation of a client's symptomatology in a number of different areas, as well as assessment of his or her ongoing level of support systems and coping skills, family/caretaker relationships, attachment issues, and functional self-capacities.

Advocacy is an important intervention for these clients, and every effort is made to collaborate with community agencies to coordinate necessary services (e.g., medical, schools, social services, housing, and legal) for clients and their families. The client's social and physical environment is also carefully monitored for evidence of increased stressors or potential danger from revictimization or broader community violence.

ITCT was first identified as a "promising practice" in 2004, by the Complex Trauma Work Group of the National Child Traumatic Stress Network (NCTSN). 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 as a function of time in treatment (Lanktree & Briere, 2013; Lanktree et al., 2012).

ITCT-A certification for clinicians is available. The USC-ATTC national training requirements are described in Chapter 6. Certification may be important for individual clinicians wishing to strengthen their clinical skills or for organizations for which reimbursement of services for traumatized clients is contingent on using an evidence-based treatment.

Complex Trauma

ITCT-A was developed specifically to treat more complex forms of trauma. ITCT-A clients typically have experienced multiple incidents and forms of maltreatment and adversity, often referred to in the treatment literature as *complex trauma*. Adverse childhood experiences often include combinations of:

- child physical and/or sexual abuse;
- physical and/or emotional neglect;
- family violence;
- community violence;
- traumatic loss associated with the murder of a family member or friend;
- medical trauma;
- trauma associated with immigration;
- sexual exploitation through prostitution; and
- trauma associated with discrimination due to gender, race, and/or sexual orientation.

Adverse experiences often begin at an early age, are chronic, and may be exacerbated by insecure attachments to primary caretakers and limited access to financial, social, emotional, and physical resources.

Overview of the Four Phases of Implementation

Figure 1 summarizes the steps involved in implementing ITCT-A, which is organized into four phases. Phase 1 helps ascertain if ITCT-A is right for your organization and assesses organizational readiness. Phase 2 describes pre-training considerations and procedures. Phase 3 outlines the training components and structure. Phase 4 describes post-training activities, including provision of ITCT-A clinical supervision and consultation, and the national training requirements for clinicians to be certified in ITCT-A.

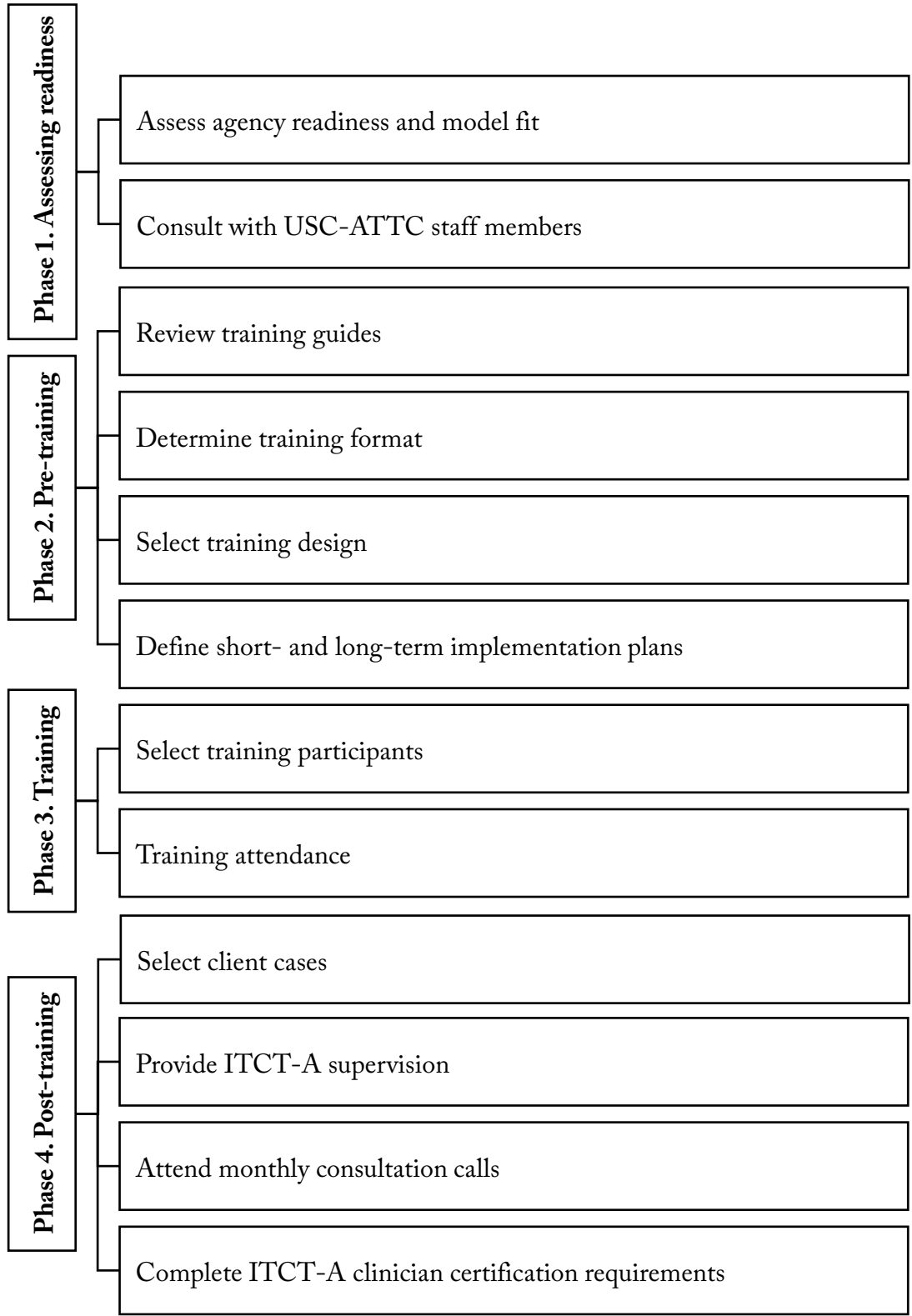


Figure 1. *ITCT-A Implementation Model*

Phase 1. Assessing readiness

Assessing agency readiness and “goodness-of-fit” of model for your agency or organization:

- Consultation with the USC-ATTC Training Director usually with organization administrator(s) and clinical director.
- Organization completes an application on-line for training and accepts responsibility for training venue and travel expenses for presenter(s).

Phase 2. Pre-training

Information for participants planning to attend the initial in-person training:

- Review treatment guides.
- Information from the organization’s consultation with the USC-ATTC Training Director and the organizational training application will inform decisions regarding the training format (e.g., one or two days); training level, the components that will be included, and possible adaptations (e.g., school, residential, unaccompanied immigrant minors, juvenile justice, cultural issues); size of venue; minimum number of attendees (especially for trainings involving out of town or out-of-state travel); and the potential to involve other local centers, such as NCTSN Category III and NCTSN Affiliates. The organization may also request training be provided at the USC Adolescent Trauma Training Center (USC-ATTC) in Torrance, California.
- Designing the training is a collaborative process. Input from the organization’s management and specific needs are taken into account. Each training is individually tailored to the needs of an organization (or group of organizations). Education and experience level of the clinicians (see chapter 3 for specifics on selection of training participants); demographics of the treatment population; and the clinic settings are addressed. All trainings cover certain core components but will vary somewhat depending upon the needs of a specific organization. Special requests, which may include emphasizing family systems work, focusing on substance use and abuse, or spending more time on assessment and evaluation issues, are factored into the final training protocol.

- The USC-ATTC and the organization discuss the stages and plans for short- and long-term model implementation, collaborative expectations of the organization, and any ongoing support that may be provided by the USC-ATTC.

Phase 3. Training

- Agencies and professionals are identified by the organization sponsoring the ITCT-A training event, and invited to register for the training through our online registration system.
- A one- or two-day training is scheduled with at least one of the ITCT-A developers or with an ITCT-A designated trainer.
- A preliminary roster of participants who registered for the training will be provided to the organization shortly before the training. This roster will be used by the organization to prepare an accurate and complete attendance list. The attendance list must be returned to the Training Director immediately after the training. Participants will be contacted to complete an evaluation and receive a personalized certificate of attendance, which they will need to complete as one of the requirements for ITCT-A clinician certification.

Phase 4. Post-training

- Post-training review and feedback from agency professionals to the USC-ATTC.
- Selecting cases appropriate for ITCT-A.
- ITCT-A supervision provided individually and/or in group supervision, along with case presentations, and team meetings to discuss ITCT-A materials.
- Agencies and individuals who have received an ITCT-A training and are using ITCT-A with clients, are invited to attend monthly consultation conference calls with other ITCT-A agencies and clinicians, and USC-ATTC staff members. Participation on these calls is required for ITCT-A certification. Requirements for certification are described in Chapter 6 of this implementation guide.
- Individual clinicians who are interested in becoming certified in ITCT-A can begin the certification application process by registering at the USC-ATTC Learning Portal. An invitation to the Learning Portal will be sent to everyone who attended an ITCT-A training that was at least 6 hours (one day). Clinicians will also be invited to

join a listserv discussion group to ask questions and dialogue with USC-ATTC staff members and other clinicians using ITCT-A.

More detailed information regarding these phases of implementation is provided in the following chapters.

Determining if ITCT-A is Right for Your Organization

Information and resources available on the USC-ATTC website (attc.usc.edu) and in the ITCT-A Treatment Guides allow interested organizations to determine whether ITCT-A training is a good fit for their treatment population and clinicians. Web resources include three downloadable guides: *Integrative Treatment of Complex Trauma for Adolescents (ITCT-A) Treatment Guide, 2nd edition* (Briere & Lanktree, 2013) and *Treating Substance Use Issues in Traumatized Adolescents and Young Adults: Key Principles and Components* (Briere & Lanktree, 2014); and *Using ITCT-A to Treat Self-injury in Traumatized Youth* (Briere, Lanktree, & Semple, 2019).

ITCT-A assessment tools; articles; recorded presentations, webinars, and videos; and other training information. Some ITCT-A assessment tools are also available in Spanish.

Information available on the NCTSN (nctsn.org) and NCTSN Learning Center websites (learn.nctsn.org) includes:

- Training guidelines
www.nctsn.org/sites/default/files/interventions/itcta_training_guidelines.pdf
- ITCT-A fact sheet
www.nctsn.org/sites/default/files/interventions/itcta_fact_sheet.pdf
- Culture-specific fact sheet
www.nctsn.org/sites/default/files/interventions/itcta_culture_specific_fact_sheet.pdf
- A fact sheet with training guidelines for children ages 6 to 12 years old (ITCT-C)
www.nctsn.org/sites/default/files/interventions/itctc_fact_sheet.pdf

ITCT-A is also frequently presented in workshops, panel presentations, and pre-meeting institutes at conferences by organizations such as the American Society on the Abuse of Children (APSAC), the International Society of Traumatic Stress Studies (ISTSS), and the San Diego International Conference on Child and Family Maltreatment.

Other Considerations

Some organizations may choose to implement ITCT-A across all their programs (e.g., school, clinic, residential) and use all components of the model. However, other organizations with limited resources may choose to:

- select a subset of programs within the larger organization in which to pilot ITCT-A. For example, some organizations have identified their clients with complex trauma issues who are appropriate for ITCT-A-related treatment, while other clients may be identified as appropriate for other treatment models such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT) or Parent-Child Interaction Therapy (PCIT);
- select a subgroup of clinicians for training in ITCT-A versus training all staff members, especially if the organization does not have the resources to host an ITCT-A training at their agency for all the clinicians; or
- utilize only some of the modules of ITCT-A (e.g., affect regulation and distress reduction; psychoeducation; safety) for their clients. However, this will have implications if clinicians wish to become certified as ITCT-A clinicians. See Chapters 4 and 6 for information regarding certification.

Minimal effective implementation of ITCT-A in any format requires the use of the Assessment Treatment Flowchart for Adolescents (ATF-A or ATF-A-II) and Problems-to-Components Grid for Adolescents (PCG-A or PCG-A-II) to guide the treatment¹. These tools are available in the ITCT-A Treatment Guide and at attc.usc.edu. Some organizations also use standardized assessment measures at regular intervals. If organizations wish to implement ITCT-A in whole or in part, the clinical providers should receive ongoing supervision on ITCT-A and have opportunities to discuss the information provided in the treatment guides as it relates to their clinical work.

¹ Updated versions of several ITCT-A forms are now available, including the *ATF-A-II* and the *PCG-A-II*. Either version of these forms is acceptable for clinical use or certification materials, although we recommend the newer versions when possible.

Chapter 2. Getting Started

The first step in the process of obtaining training in ITCT-A is to review the training guidelines that are posted on the NCTSN website. These guidelines provide a summary of the minimum requirements for implementation and the recommended training prior to starting implementation. Other considerations such as the cost of training are also outlined in the NCTSN training guidelines, which are available at:

www.nctsn.org/sites/default/files/interventions/itcta_training_guidelines.pdf.

The second step is to complete the USC-ATTC online training application, found on the attc.usc.edu website under the *Trainings* tab. The application can also be obtained by emailing the Training Director, Karianne Chen, M.S., LMFT at kariannechenmft@gmail.com or attc@usc.edu.

On submission of your organization's training application, you will be contacted to schedule an initial consultation call. It is a good idea to have more than one person from your team available on this call, during which your organizational needs, treatment setting, and populations served will be discussed. Ideally, a person with authority to make organizational staffing and programmatic decisions should be present on the call. We will also discuss your post-training implementation plans.

Following this call, your application will be reviewed by the USC-ATTC training team. If there are additional questions, a second consultation call may be scheduled. For example, whether you choose a one- or two-day training, your agency's needs or specific training requests (e.g., a greater emphasis on substance use/abuse interventions) may require further discussion, as may your plans for successful implementation.

Once your application has been accepted, a date for your initial training will be scheduled and the format and specific agenda will be discussed.

Chapter 3. Planning and Conducting Trainings

Selecting Training Participants

Trainees, at the minimum, should be enrolled in a clinical master's degree program in social work, counseling or clinical psychology, marriage and family therapy, or a related field. Supervisors should be experienced in providing trauma-focused treatment. Familiarity with ITCT-A is not required, but reading the Treatment Guide in advance of the training is recommended. Separate supervisory consultation, training, and follow-up consultations with USC-ATTC are recommended, especially for supervisors who are learning the model at the same time as their supervisees.

Tailoring Training to your Environment and Population

Selecting a relatively homogeneous training cohort is preferable, given that trainings are tailored for each group of trainees. In larger organizations, where services are provided across different settings (e.g., outpatient, inpatient, residential, or school-based), it can be more productive to train each group separately. Alternatively, the initial training can be structured in such a way that the first day of a two-day training is with a larger, more diverse group, and the second day is organized with specialty tracks or according to specific topics or client populations.

The Role of Nonclinical Staff Members

For organizations that have nonclinical case managers, and/or bachelor level staff members working with youth and families (e.g., in day treatment or residential settings), we offer the option of having those employees participate in a half-day training that more broadly addresses complex trauma and substance-related issues. This training facilitates development of trauma-informed awareness for those who provide nonclinical, custodial, or case-management services to traumatized youth to promote client progress and well-being. It also allows nonclinical staff members the opportunity for case consultations appropriate to their training level and job description.

We recommend that, when possible, nonclinical staff members and line administrators receive a half-day basic training in ITCT-A. The depth and technical level provided to the therapists is not necessary for this group. Therapists and nonclinical staff members may attend an initial half-day training that includes:

- basic information about complex trauma;
- reasons why youth “act out” when distressed;
- the central treatment philosophy of ITCT-A;
- decision making regarding screening and referring/triaging clients who are appropriate for ITCT-A.
- benefits of an intake and nonclinical services that are client-centered and empathic rather than punitive or rigid;
- the triggering process, including how it can easily affect clinicians and non-clinicians working with troubled adolescents;
- self-care when working in stressful environments.

The remaining time, ideally an additional 1.5 days, would be spent with masters and doctoral level clinical trainees, clinicians, and supervisors.

One- versus Two-Day Trainings

Introductory one and two-day trainings generally cover the same material related to the core components of ITCT-A. However, a two-day training allows for more clinical practice, break-out sessions, and discussions. The longer format offers opportunities for more in-depth information and discussion on desired topics, for example, caretaker/family-related interventions, relational/attachment interventions, or strategies for timing and combining various ITCT-A interventions and modalities. The two-day format also facilitates further discussion of ITCT-A theoretical principles and case studies.

Pre-Training Preparation

It is helpful for clinicians to review the treatment guides, webinars, and other materials before attending a training—especially a one-day training—in order to get the most from the didactic presentation. The treatment guides can be downloaded free of charge at atc.usc.edu. There is also an interactive web version of the ITCT-A treatment guide, videos, and webinars available. Web-based presentations include an overview of ITCT-A, mindfulness in ITCT-A, and ITCT-A interventions for self-injurious behaviors. Some organizations may choose to schedule a pre-training, internal agency meeting to review the ITCT-A treatment guide, watch one or more webinars, and discuss whatever questions or concerns attendees might have about learning and implementing a new treatment model. It is also useful for clinicians to review their

current caseload, or intake information for new clients seeking services, to identify clients that may be appropriate for ITCT-A. This way, clinicians are able to begin implementing the model as soon after the training as possible while the information is still “fresh.”

Separation of Day 1 and Day 2 Trainings

When the organization being trained is located in Southern California, we offer an option to provide small group trainings at our facility in Torrance, California, with the first and second training days separated by approximately a month, if possible. This training design can also be conducted for larger groups at the agency’s site or another pre-arranged venue in Southern California. These trainings are structured a bit differently than a training conducted on two consecutive days. Some organizations find that having time between trainings allows clinicians to “digest” and review the material more thoroughly, and even to begin to use some of the ITCT-A tools before the second day of training. Ideally, trainees and supervisors will meet weekly between the two trainings to review the treatment guides and discuss clinical or implementation issues.

Learning Communities and Learning Collaboratives

The principles and practices of ITCT-A can be learned in a comprehensive way by participating in an ITCT-A *Learning Community* (LCom) or *Learning Collaborative* (LC). In both an LCom and an LC, a pre-training phase is included. These training protocols typically involve an application phase, a pre-training phase, and an initial two-day face-to-face learning session followed by regular consultation calls. LCs also include reporting of monthly metrics, two or three additional two-day learning sessions, ongoing consultation calls, and a post-training phase. Figure 2 shows an example of a Learning Collaborative that was developed by the Children's Advocacy Services of Greater St. Louis in 2018.

When supervisors and clinicians are learning the model at the same time, we recommend that clinical supervisors also attend pre-training consultation calls, a supervisory training track (if available), and participate in additional consultation calls after the training(s) that focus on supervisory issues.

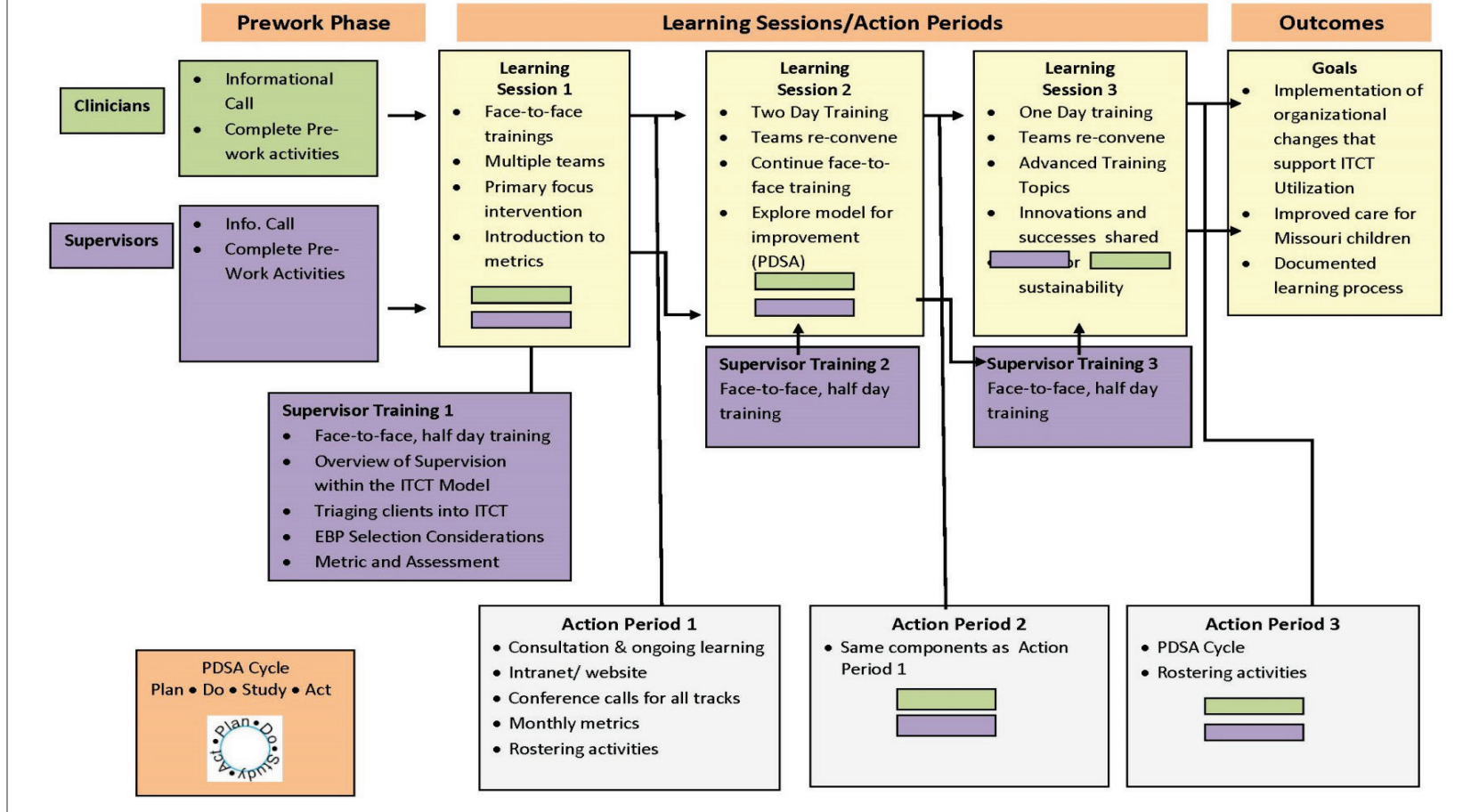


Figure 2. Missouri KidsFirst ITCT 2018 Learning Collaborative Overview²

² Children’s Advocacy Services of Greater St. Louis, University of Missouri-St. Louis. Reprinted by permission.

Planning for Ongoing Implementation Support

When adopting a new clinical intervention, it is advisable to map out a plan beforehand for ongoing support during implementation. We encourage all ITCT-A trained clinicians to participate in the monthly consultation calls hosted by USC-ATTC or other designated organizations. It can be helpful to schedule a group supervision session for your agency's clinicians before or after these consultation calls, especially during the initial months following training. In addition, we recommend each agency conduct weekly ITCT-A group and/or individual supervision sessions. Many agencies are required to provide supervision for unlicensed clinicians who are accruing clinical hours toward licensure. In our experience, reviewing clinical issues and ITCT-A assessment tools such as the ATF-A (or ATF-A-II) and PCG-A (or PCG-A-II) in supervision facilitates more effective selection, prioritization, and application of ITCT-A components. Consultation and supervision sessions can also incorporate discussion of intervention components from the Treatment Guide.

Ideally, clinical supervisors overseeing ITCT-A implementation should meet with their supervisees weekly to discuss cases and go over treatment and implementation-related issues. We also recommend that supervisors, along with their clinicians using ITCT-A, participate in the monthly USC-ATTC consultation calls, and, as needed, additional consultation calls with the USC-ATTC training team or a designated trainer. Participation in monthly USC-ATTC consultation calls is also a requirement for ITCT-A clinician certification.

It is also important that if non-clinical staff members (e.g., case managers) are involved in the referral process, they be trained on and included in discussion regarding decision points about screening and referring/triaging clients who are appropriate for ITCT-A. This will help the agency manage referrals effectively; help set up the clinical providers for success in facilitating appropriate assignment of cases to ITCT-A, and ultimately help clients get the appropriate treatment for their presenting problems.

Training ITCT-A Trainers

Level 1 ITCT-A clinician certification is a necessary prerequisite for anyone who would like to attend the ITCT-A Train-the-Trainers (TTT) program planned for 2020-2021. Graduates of the TTT program will be qualified to provide ITCT-A training in their community. Requirements and information about gaining certification as an ITCT-A trainer are under development and will be posted on the USC-ATTC website when finalized.

Chapter 4. Organizational Support

Any organization seeking to implement the ITCT-A model must have administrative and clinical leadership support. All levels of an organization's leadership team should agree on a comprehensive implementation strategy before scheduling any training, particularly when the allocation of funds and resources for treatment programs and staffing is being determined. Discussion of financial considerations, time needed to train and supervise staff members, and the organization's capacity to provide ongoing clinical support will be needed. These may include considerations of additional advanced trainings, scheduling clinicians' time for consultation and supervision, staff retreats, encouraging therapist self-care, and assigning reasonable caseloads, which are crucial throughout all stages of implementation.

Time for Training

The time needed to train clinicians will vary, depending upon the specific training design chosen by your organization. Refer to Chapter 3 of this guide and the ITCT-A training guidelines posted on the NCTSN and USC-ATTC websites. Minimum pre-implementation training consists of participation in a one-day in-person training and reading the ITCT-A Treatment Guide. The time needed to review the 17 chapter manual varies depending on the clinician's familiarity with ITCT-A theoretical bases and core components. Many clinicians and supervisors will read through the entire treatment guide but then return to specific chapters as they apply to particular clients. If clinicians wish to pursue certification in the model, they will need to allocate additional time to meet other training requirements. One-day trainings are 7.5 hours (6 hours of training with lunch and breaks). Two-day trainings are 15 hours (12 hours total training time). The monthly USC-ATTC consultation conference calls are 90 minutes each.

Time for Supervision

When beginning implementation, weekly ITCT-A specific supervision is recommended in addition to your agency's usual supervision requirements. Although not required, these may consist of 1 hour of weekly individual supervision and/or 2 hours of weekly group supervision, especially for clinicians who have less experience treating complex trauma and/or those who are unlicensed. When possible, both individual and group supervision should be considered, although it is not required. As noted previously, some agencies provide both types of supervision

in order to meet state-mandated requirements for unlicensed clinicians. Based on the experience of the ITCT-A co-developers, when possible, both types of supervision even for licensed clinicians provide invaluable opportunities for learning and support.

Support for Clinical Staff Members

Organizational support improves the well-being and expertise of clinicians and can reduce employee turnover. Although not specific only to organizations offering ITCT-A, many organizations suffer from high turnover, which is costly and interferes with providing consistent, quality treatment. Experienced ITCT-A supervisors have noted the benefits of supervision, consultation, and on-going training for team-building and peer support. In-person weekly team meetings and group supervision or web-based meetings with USC-ATTC or designated ITCT-A trainers offer non-stigmatizing opportunities for clinicians to discuss the challenges and stresses that may arise when working with multiply traumatized adolescents, to support each other on difficult cases, and discuss self-care. Although some employee turnover is inevitable, taking the time and investing resources to enrich the work environment will often be paid back by greater therapist investment and longevity with an organization.

Other Staffing Issues

If no agency staff members have the credentials needed to interpret psychological tests, additional costs may include hiring a psychologist to conduct, supervise, or interpret the results of psychological testing. Should organizations wish to collect data for analyses of effectiveness or outcomes, a data entry person may be needed. Organizations may also seek additional consultation from USC-ATTC staff members regarding assessment strategies and data collection/analyses.

For clinicians wishing to receive certification, additional time is needed to complete the required webinars and online tests, prepare written and oral case reports, and attend monthly consultation calls. Granting time for clinicians to become ITCT-A certified may be prioritized when organizations fully support the implementation of ITCT-A; when reimbursement for treatment services is contingent on certification; and/or organizational memberships such as the Children's Advocacy Centers of the National Children's Alliance or external funding agencies require treatment using evidence-based programs (EBP). Note that, because the USC-ATTC is funded by SAMHSA as a Category II Treatment and Service Adaptation Center of the NCTSN, no fees are charged to provide training to individuals or agencies. Associated costs

(e.g., speaker's airfare, lodging, meals, and ground transportation) are borne by the agency receiving the training.

Ongoing Expenses

Ongoing expenses related to the implementation of ITCT-A include the purchase of trauma-informed screening and assessment instruments that, although not required to implement ITCT-A, may be beneficial in conducting more comprehensive evaluations and determining client progress. The NCTSN website provides a list of useful measures and resources.

Chapter 5. Clinical Support and Sustainability

Ongoing Training

We recommend that ITCT-A clinicians and supervisors continue to attend trainings coordinated or provided by USC-ATTC in addition to attending local or national conferences that offer presentations on the assessment and treatment of complex trauma. Some of these presentations may also focus on complex trauma in children and/or adults, not solely adolescents and young adults, which provides a life-span perspective of complex trauma.

Video Consultation Calls

An important source of clinical training and organizational support is the monthly video consultation calls offered by the USC-ATTC and approved collaborative partners to ITCT-A clinicians. These virtual meetings are available to all clinicians who have attended a one-day ITCT-A training. Attendees participate from throughout the United States, individually or in an agency group. These calls include consultation with USC-ATTC trainers, case presentations, and discussion with participants from other agencies about challenging clinical issues. Some meetings include brief didactic presentations from USC-ATTC staff members on different topics. Past presentations include titrated or paced trauma processing, addressing attachment disturbance, caretaker and family-related interventions, and mindfulness in ITCT-A. The calls also provide opportunities for individuals and organizations to share implementation challenges and successes, and to take advantage of logistical and program knowledge and experience from agencies that have more experience with this treatment model.

Clinical Supervision

Regardless of the clinician's level of experience or education, it can be helpful for all ITCT-A therapists to have ongoing supervision and/or consultation. Individual or group supervision within an organization offers opportunities for peer support, further training through discussions, and case presentations that demonstrate the use of ITCT-A. Clinicians who have been trained in ITCT-A but are not yet licensed, may especially gain from additional training and supervision. This can include an increased understanding of the core components, theoretical background, specific interventions, and applications of ITCT-A components to specific cases, gaining familiarity with some cultural adaptations of ITCT-A, and learning

specific methodologies for treating youth who especially use avoidance behaviors (e.g., substance abuse, self-injury) in response to posttraumatic stress.

The following are some concrete suggestions for maximizing the effectiveness of ITCT-A group supervision/consultation meetings:

- Use a standard presentation form to help the clinician prepare for the presentation and organize the most relevant information in advance.
- Review formal assessment measures and informal assessment data and integrate into case conceptualization and treatment planning.
- Hear it in the clinician's own words –What is the problem? What feedback is the clinician requesting?
- Apply the ITCT-A framework to the case presentation (e.g., how to conceptualize client/problem/symptom presentation/progress in treatment).
- Continually reference the Assessment Treatment Flowchart (ATF-A or ATF-A-II) and the Problems-to-Components Grid (PCG-A or PCG-A-II).
 - What are the current ATF-A or ATF-A-II priorities and how have priorities shifted over time?
 - What interventions from the PCG-A or PCG-A-II has the clinician tried? How effective were these interventions? What interventions would the clinician like to learn more about?
- Refer to the ITCT-A manual, webinars, training materials, and related chapter(s).
- Explore how the case is impacting the clinician, encouraging reflection and self-care. Help highlight progress to which the clinician may not be attending.

Peer Consultation Groups

Clinicians who are in private practice or in a setting with few other clinicians might consider creating or joining a local peer-consultation group. Clinicians can contact USC-ATTC to find others in their area who have been trained in ITCT-A. If there are insufficient ITCT-A therapists in the area, we recommend joining the ITCT-A discussion listserv, and if available, a general trauma clinician group. Clinical work with traumatized adolescents can be challenging and sometimes stressful. Clinicians are less likely to experience burnout when they seek supervision, peer support, and consultation, and participate in trainings, trauma-related conferences, and professional organizations.

Self-Care

Although clinicians are often quite skilled at providing care to others, they are sometimes less adept at caring for themselves, which can result in burnout and impaired therapeutic effectiveness. Implementation support for ITCT-A includes ways in which an organization can encourage therapist self-care. Effective organizations provide:

- appropriate and supportive supervision and consultation;
- a varied work day, including time for breaks, documentation, and phone calls;
- required days off and use of vacation days;
- structure in the clinical environment, including training in specific ITCT-A-related protocols and tools; clear and reasonable expectations regarding documentation of interventions and client progress; and regular review of ongoing cases with supervisors and/or colleagues;
- balanced and reasonable caseloads, with a client mix that reflects greater and lesser clinical acuity; screening and referral procedures that limit or eliminate waiting lists; and established protocols and mechanisms for handling crises;
- if possible, a range of settings (e.g., school, outpatient clinic) and modalities (individual, family, group therapy) to provide opportunities for diverse work responsibilities;
- ongoing training and professional development, including training and supervising others as appropriate, and observing and being observed doing therapy;
- support for personal activities that increase psychological resilience, such as encouraging clinicians to attend their own therapy; and/or to attend mindfulness, meditation, or yoga classes;
- encourage involvement in professional organizations, such as the American Professional Society on Abuse of Children, the International Society of Traumatic Stress Studies, and/or the National Child Traumatic Stress Network.

Increasing Sustainability

Many of the agencies and organizations using ITCT-A are members of the National Traumatic Stress Network (NCTSN), or may be funded by other government entities, or private foundations. Such funding is almost always limited and can sometimes result in the loss of clinical positions or even the closing of viable programs. Although this implementation guide is

more focused on program and training issues, sustainability is a critical concern for any clinic or treatment provider. Our experience as program developers with a long record of funding but, like other centers, have also lost funding and been forced to close has shown us that certain qualities and actions seem to be associated with agency longevity. These include:

Funding support. Funding for the USC-ATTC is currently provided by SAMHSA’s support of the NCTSN. Other governmental agencies and private foundations may also find that ITCT-A, which is based on a multi-cultural, diversity-focused model, has immediate relevance to millions of disenfranchised and marginalized youth in America’s cities and rural environments. In this sense, a “selling point” for ITCT-A is its ability to customize itself to the needs of multiply traumatized young people who are of great concern to society; not only because they are suffering, but also because of their disproportional involvement in the criminal justice, substance abuse treatment, and emergency medical or mental health systems.

Other resources. Some agencies have also obtained funding through “victims of crime compensation” funds available from some state or local governments, typically for individual clients. In California, for example, minors who suffer emotional injuries from witnessing or experiencing a violent crime may be eligible for up to \$5,000 for mental health counseling, and family members may also be eligible for medical, mental health, and financial support. This usually requires new expertise in billing for services, but may provide additional income for agencies that treat traumatized youth.

Program evaluation. Some funding agencies require evidence that a given program is effective for the clients they are assisting. Although ITCT-A has been shown to reduce symptoms by an average of 40% in a large culturally diverse, inner-city sample (Lanktree et al., 2012), agencies may wish to conduct research in their own setting to ascertain the effectiveness of ITCT-A with their setting and treatment population. Research staff members at USC-ATTC are available to assist agencies or organizations in developing treatment outcome studies.

Building collaborations with community partners. Programs that deliver ITCT-A are likely to be more successful if they collaborate with other local youth service organizations. These might include schools, hospitals, clinics, law enforcement agencies, homeless shelters, child protection services, and community advocacy groups. In collaboration, ITCT-A providers can offer expertise about the mental health issues associated with complex trauma in youth, provide consultation, and if certified, conduct ITCT-A trainings for other service providers. It may also

be helpful for an agency to establish or participate in an existing community advisory board that includes neighborhood representatives, family members of former clients, mental health clinicians, teachers, medical personnel, law enforcement, child protection, clergy, and other professionals in the community. In general, the more these community partners interact, collaborate, offer cross-consultation, and share training opportunities, the more invested they will be in your agency's ongoing support and funding. USC-ATTC can provide consultation in this area, as can other ITCT-A programs with collaborative experiences.

Chapter 6. Becoming a Level I Certified ITCT-A Clinician

Therapists may choose to be certified as an ITCT-A clinician to enhance their clinical skills, or because an agency or funder expects it. The USC-ATTC has recently revised most of the ITCT-A tools described in the Treatment Guide. These tools are also used when completing several of the certification requirements. Clinicians are strongly encouraged to use the new versions, which are available for download on the USC-ATTC website, from the ITCT-A discussion group listserv, and the Learning Portal.

The requirements to become a Level I Certified ITCT-A Clinician are shown below. Please read these requirements carefully. If you have any questions, please contact the USC-ATTC Training Director, Karianne Chen, MS, LMFT at kariannechenmft@gmail.com. The certification application and confirmation of each of the criteria listed below must be done using the online Learning Portal system.

Individual clinicians may request a Learning Portal account by emailing the Director of Programs, Randye J. Semple, PhD at atc@usc.edu. Please provide your full name, agency name, and preferred email address.

Training Requirements for Level I Certified ITCT-A Clinician

- Before completing the certification process, candidates must have:
 - Completed a master's degree (or equivalent) that includes clinical training in a mental health-related field. This may be in the fields of psychiatry, psychology, social work, marriage and family therapy, counseling, etc.
 - A state license that allows independent or supervised clinical practice. You may complete your certification requirements before receiving licensure.
- Candidates must attend at least six (6) hours of in-person training provided by the USC-ATTC (minimum one full-day workshop). The in-person training must be attended **after October 1, 2012**. Trainings attended before this date will not be credited toward certification.
 - For any in-person training completed **between October 1, 2012 and September 30, 2014**, candidates must
 - Upload a copy of your official USC-ATTC Certificate of Attendance –or–

- Complete and sign an attestation to verify the training you attended. You must specify the date of the training, location, format, and trainer.
- For any in-person training completed **after September 30, 2014**, candidates must upload a copy of their official USC-ATTC Certificate of Attendance. If you have any difficulties retrieving your certificate, please email our technical support team at attc@webinarcerts.com or call (855) 888-6094.
- Candidates must complete the web-based training on the USC-ATTC manual: *Integrative Treatment of Complex Trauma for Adolescents (ITCT-A) Treatment Guide, 2nd edition*. You must read the *ITCT-A Treatment Guide* and pass a knowledge-based quiz for each chapter with at least 80% correct responses for each chapter.
- Candidates must attend two (2) ITCT-A webinars (approximately one hour each) and pass a knowledge-based quiz for each webinar with at least 80% correct responses. Both webinars must be completed after the in-person training and the web-based training on the Treatment Guide are completed.
- Candidates must complete a written case report. Submit a sample case of an adolescent that you have treated with ITCT-A. Prepare your case report using the template provided, and complete every section. Do not include any protected health information that might identify your client.
 - **Part I.** Briefly describe the relevant history, assessment of risks, and the client's strengths. Maximum 750 words, typed, single-spaced.
 - Demographics and special service needs. Include age and gender of client.
 - Presenting problem(s) and situational context. Include symptoms and problematic behaviors.
 - History of exposure to trauma and how those events might be related to the presenting problem(s).
 - Relevant biological, developmental, and medical history.
 - Previous mental health issues and treatment. Include past and present psychiatric medications.
 - Past and present alcohol or substance use and treatment history.

- Family medical and psychiatric history.
- Family history. Describe home environment, caregivers, siblings, etc.
- Relevant social, educational, occupational, and legal history.
- Assessment of risk. Identify potentially risky behaviors as well as risk of direct harm to self or others.
- Client strengths and social support.
- **Part II.** Complete an Assessment-Treatment Flowchart for Adolescents (ATF-A or ATF-A-II). A fillable PDF form is available that you can complete and upload.
- **Part III.** Integrate information from the completed Assessment-Treatment Flowchart for Adolescents (ATF-A or ATF-A-II) and the Problem-to-Components Grid for Adolescents (PCG-A or PCG-A-II). Maximum 500 words, typed, single-spaced.
 - Outline a comprehensive treatment plan.
 - Briefly describe the course of treatment. Include the specific ITCT-A interventions used and the treatment outcome(s)
- Active participation in at least six (6) regularly scheduled video consultation calls. These consultation calls are generally held once monthly for 90-minutes. The six consultation calls do not need to be attended in consecutive months.
- During one video consultation call, present a clinical case that utilizes ITCT-A (a minimum 30-minute formal case presentation). A presentation format similar to the written case report is recommended, including at least one ATF-A or ATF-A-II.
 - Scheduling of a case presentation for a monthly call must be coordinated in advance with Karianne Chen, MS, LMFT.
- Completion of a minimum of two (2) separate ITCT-A cases with appropriate adolescent clients. A complete case must consist of at least 12 face-to-face sessions with the client, and ideally result in a natural termination.

Chapter 7. Challenges to Implementation

There can be challenges to successful implementation of any new treatment model and ITCT-A is no different. Aspects of complex trauma and/or ITCT-A that may require additional attention or adaptations include the time and effort needed to learn new clinical skills, the complex clinical presentations of many of these multiply traumatized clients, the need to adapt ITCT-A to unique treatment settings, and the need to work with staff members who are not clinically trained.

Learning the Treatment Modules

ITCT-A requires the use of a number of different treatment modules, including mindfulness and emotional regulation, cognitive and relational processing, and exposure-based methodologies. Some clinicians have not been trained in all of these approaches and may be unable to implement all of the ITCT-A modules. These interventions, which are each described in a separate chapter in the treatment guide, are relatively straightforward, and most clinicians are able to learn them without too much difficulty. Staff training in treatment components can be facilitated in weekly agency meetings, while interventions for specific clients are being discussed.

Special Considerations with ITCT-A Model Learning

New learning and changes in clinical practices are both exciting and sometimes overwhelming, demanding more of the clinician's time. Although there is a structure to ITCT-A which is component-based, the flexibility of ITCT-A can sometimes be challenging for less experienced clinicians who are accustomed to more structured treatment models. Supervisors may find that, despite initial enthusiasm for learning the ITCT-A model, some clinicians may avoid starting ITCT-A cases or use only a few aspects of the model. Reasons that providers might avoid starting to implement ITCT-A include:

- Discomfort implementing a new practice/concern due to fear that they will do something wrong or make a mistake.
- Lack of clarity regarding the theoretical principles of ITCT-A
- Understanding the ITCT-A model, but lacking clarity in regard to how to implement the model with clients (i.e., “What do I actually DO in session.”)

- Comfort with ITCT-A but a lack of clarity regarding how to document their work in ITCT-A, especially regarding reimbursement or funding requirements.

To address these potential issues, it is recommended that supervisors work with clinicians to start ITCT-A cases as soon as possible following the completion of the training.

Implementation research shows that providers use an EBP with greater fidelity and are more likely to achieve certification in the model if they start using the model as soon as possible. Once a clinician has identified cases, it is helpful to remind them that implementing ITCT-A is a learning process and to remind clinicians of the recourses for implementation outlined elsewhere in this guide. It is also recommended that there be discuss of documentation, particularly strategies for creating ITCT-A treatment goals and plans, to alleviate provider anxiety. For example, some supervisors have reported clinicians occasionally choose other treatment models, even though they believe ITCT-A will be best for a client, due to a lack of confidence documenting their ITCT-A work.

While some providers may be hesitant to begin the process of learning ITCT-A; others may be overconfident, which is also an area to attend to within the context of ITCT-A supervision. Some new ITCT-A providers incorrectly interpret the flexibility of the model as sanctioning “doing whatever I want and calling it ITCT-A”. When a supervisor suspects that a provider may label therapy as ITCT-A incorrectly, it is recommended that the provider be encouraged to review the ATF-A or ATF-A-II, to inquire about the most recent assessment of the client, and to ask for clarification about what specific decision points led the provider to particular interventions based on the Problems to Components Grid (PCG-A or PCG-A-II). In these cases, it is also sometimes helpful to review chapters from the ITCT-A manual with the supervisee during the supervision/consultation meeting.

Clinical Complexity and Acuity

Because ITCT-A is often conducted with youth who have been repeatedly traumatized, and may live in harsh environments and social circumstances, the typical ITCT-A client may suffer from significant, acute psychological distress with associated impairments in functioning. He or she is also likely to be dealing with a variety of socioeconomic stressors, including poverty, ongoing violence, institutionalized racism, discrimination based on gender or sexual orientation, and diminished resources. As a result, the ITCT-A clinician is sometimes confronted with the client’s acute and complex difficulties, including safety concerns, oppositional or conduct

problems, or involvement in risky behaviors. These types of problems are more common in clients who may be responding to extreme stress or trauma. The clinician may also see more cultural, linguistic, academic, and economic challenges. This complex clinical picture requires on-going formal and informal assessment and unique treatment plans and goals for each client. Clinicians are often required to make clinical decisions in the moment and adapt the ITCT-A model to meet the individual client's immediate and long-term needs. While this flexibility is welcomed by many therapists, some therapists, especially those who are newer to the field or more familiar with implementing manualized treatment models, may feel overwhelmed by ITCT-A treatment and session planning. The extended trauma, neglect, and social discrimination experienced by many ITCT-A clients often requires more than eight or ten sessions – in many, if not most cases, 16 or more. In the Lanktree et al. (2012) outcome study, clients attended an average of 6.9 months of ITCT. Progress is rarely linear for individuals with complex trauma, and it may be difficult for new ITCT-A clinicians to identify, measure, and document as well as communicate to stakeholders. All of these issues typically mean that ITCT-A therapists do best in the context of supervision, consultation, support, and ongoing training.

Adapting to the Treatment Setting

Some organizations, such as those who work with homeless youth, are in the juvenile justice system, or who work with unaccompanied minors, may operate in homeless shelters or homeless outreach programs, schools, detention or incarceration settings, or crisis centers. Clinicians may only be able to provide a few sessions before the youth moves on, and the sessions may not resemble the classic clinic-based therapy hour. In these situations, the full ITCT-A intervention model will not be possible.

Fortunately, treatment adaptation in response to various client issues and environmental contexts is a major focus of ITCT-A (Briere & Lanktree, 2013). Attention is given to client sociodemographic factors such as race, religion, education, gender identity, sexual orientation, and culture, in addition to the client's clinical acuity and capacity for emotional regulation, and the setting in which treatment is taking place. For example, if only short-term interventions can be used due to organizational or funding constraints, ITCT-A clinicians will focus more on safety, increasing affect regulation and distress reduction skills, and if appropriate, provide referrals for longer-term trauma-focused treatment elsewhere. It may be inappropriate in these circumstances to encourage the client to engage in intense trauma processing. ITCT-A stresses

regular staff consultation and training. Topics such as cultural sensitivity, social advocacy, casework, legal or immigration issues, safety training, child protection, and crisis intervention are discussed.

The Importance of Nonclinical Staff Members

ITCT-A is often implemented in contexts in which administrators and support staff have a central role in treatment. This may include executive directors, administrators, and clerical staff, in addition to other nonclinical support staff (e.g., case-managers, intake coordinators, residential care workers, community volunteers, and peer advocates). Although implementing ITCT-A in an organization obviously involves significant training of clinicians; our experience has taught us that it is important for administrators and other nonclinical staff members to “buy in” to the ITCT-A model. It is also important that all stakeholders have a sound understanding of the ways that complex trauma affects youth. Nonclinical staff members who work directly with clients, although not providing therapy, can support—or undermine—successful treatment.

Due to the complex needs of clients involved in ITCT-A, it is essential that administrators review or develop agency policies that clearly define the role of ITCT-A clinicians and expected implementation practices related to ITCT-A. For example, a core aspect of ITCT-A is advocacy and system intervention, which often goes beyond the traditional therapist role. It is important that agency directors communicate expectations regarding acceptable methods for this advocacy work (e.g., attending in-person meetings, phone calls, letter writing), the necessary authorizations to communicate with other systems, and how this often non-billable time is documented and factored into clinicians’ productivity expectations. Collateral supports (e.g., group treatment, parenting groups, caregiver individual therapy, psychiatry, case management) are often indicated for ITCT-A clients, so identification of what services can be offered within the agency as well as actively developing collaborative relationships with community partners is highly recommended to support the implementation of ITCT-A.

Many ITCT-A clients may benefit from a longer course of treatment. Administrators should consider and communicate agency expectations or restrictions regarding the scope and duration of treatment and attendance expectations for clients. ITCT-A clients also often present with complex needs related to safety and stability (e.g., self-harm, substance use, aggressive behavior). It is important for administrators to clearly define decision points related to when a

client is “stable enough” to be seen in their setting for ITCT-A, ensure that safety procedures are in place, and identify supports needed by the clinician to manage challenging behaviors.

Conclusion

ITCT-A is an evidence-based, multimodal therapy that integrates treatment principles from the complex trauma literature, attachment theory, the self-trauma model, affect regulation skills development, and components of cognitive behavioral therapy. It involves structured protocols and interventions that are customized to the specific issues of each client, since complex posttraumatic outcomes are notable for their variability across different individuals and different environments. Non-controlled outcome research suggests that those receiving ITCT-A experience significant treatment effects on posttraumatic stress, anxiety, depression, anger, sexual concerns, and dissociation (Lanktree et al., 2012).

The multimodal, flexible, client-centered aspects of ITCT-A likely increase its acceptability and effectiveness in work with marginalized youth, but also require the clinician to learn how to use specific assessment measures and apply a range of customized interventions. Use of this implementation manual, along with the ITCT-A treatment guides—in the context of adequate clinician support and consultation/supervision—increases the likelihood that multiply traumatized clients will experience meaningful improvements in psychological and social symptoms and problems.

References

- Briere, J., & Lanktree, C. B. (2013). *Integrative treatment of complex trauma for adolescents (ITCT-A): A guide for the treatment of multiply-traumatized youth* (2nd ed.). Los Angeles, CA: University of Southern California-Adolescent Trauma Training Center, National Child Traumatic Stress Network, U.S. Department of Substance Abuse and Mental Health Services Administration.
- Briere, J., & Lanktree, C. B. (2014). *Treating substance use issues in traumatized adolescents and young adults: Key principles and components*. Los Angeles, CA: USC Adolescent Trauma Training Center, National Child Traumatic Stress Network, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Briere, J., Lanktree, C. B., & Semple, R. J. (2019). *Using ITCT-A to treat self-injury in traumatized youth*. Los Angeles, CA: University of Southern California-Adolescent Trauma Training Center, National Child Traumatic Stress Network, U.S. Department of Substance Abuse and Mental Health Services Administration.
- Lanktree, C., & Briere, J. (2013). Integrative Treatment of Complex Trauma. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents: scientific foundations and therapeutic models* (pp. 143-161). New York: Guilford Press.
- Lanktree, C., Briere, J., Godbout, N., Hodges, M., Chen, K., Trimm, L., . . . Freed, W. (2012). Treating multitraumatized, socially marginalized children: Results of a naturalistic treatment outcome study. *Journal of Aggression, Maltreatment & Trauma, 21*, 813-828. doi:10.1080/10926771.2012.722588