

# Integrative Treatment of Complex Trauma for Adolescents (ITCT-A): A Guide for the Treatment of Multiply-Traumatized Youth

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## Chapter 1 Introduction

This guide has been developed to assist clinicians in the evaluation and treatment of adolescents who have experienced multiple forms of psychological trauma, typically in the context of negative living conditions such as poverty, deprivation, and social discrimination. Socially marginalized, multiply traumatized adolescents often suffer from the intersect of two injurious phenomena: sustained exposure to an invalidating social environment, and the cumulative effects of repeated maltreatment – in some cases early psychological neglect and usually multiple instances of interpersonal victimization.

### 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, et al., 2004; Chen, et al., 2007). Equally important, such marginalization typically means that traumatized youth have less access to appropriate mental health services (e.g., Perez & Fortuna, 2005; McKay, Lynn, & Bannon, 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, 2004; Giaconia, & Cohen, 1995; 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, 2006; Cook, et al., 2005). As described in Chapter 1, the impact of complex trauma include anxiety and depression; dissociation; relational, identity, and affect regulation disturbance; cognitive distortions; somatization; “externalizing” behaviors such as self-mutilation and violence; sexual disturbance; 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 context in which this guide was written: The MCAVIC-USC Child and Adolescent Trauma Program

This guide was developed 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 as a Category II (Treatment and Service Adaptation) Center of the National Child Traumatic Stress Network (NCTSN) in 2005. Both MCAVIC and USC have significant experience in the treatment of complex trauma, especially in the context of culturally diverse, economically disadvantaged populations.

#### Overview of Integrated Treatment of Complex Trauma (ITCT) for adolescents

The ITCT child version. ITCT was first developed for children by MCAVIC in 2001, as part of its Category III funding by SAMHSA. The ITCT children version has been developed and adapted to assist culturally diverse clients. Frequently, clients are also coping with stress associated with immigration (from Mexico, Central America, Pacific Islands, and Southeast Asia) and separation from primary caretakers who may remain in their country of origin. ITCT especially stresses multidimensional/complex trauma reactions and comorbidities, and additional stressors such as diminished socioeconomic resources, racial discrimination, and unsafe communities. ITCT has been adapted for use in urban schools in economically impoverished areas, including alternative (e.g., storefront) school settings. This approach can be used in a wide range of settings, including outpatient and child trauma clinics, hospital units, 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 has been associated with significant symptom reduction in several studies of children and adolescents in clinic and school-based contexts.

The adolescent version. Upon MCAVIC’s collaboration with USC in 2005, the child version was adapted and expanded into a version for adolescents, specifically incorporating Briere’s (2002) Self-Trauma Model.

The core components of the adolescent adaptation of ITCT include:

- *Assessment-driven treatment*, with standardized trauma-specific measures administered at 2 to 4 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 specific symptomatology of the youth. 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.
- *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.
- *Allowance for 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.

### Sources for this treatment guide

The information presented in this guide reflects the ongoing development of a treatment program first initiated in 2001, and continuously modified since then under ongoing SAMHSA and UniHealth Foundation funding. The written content of this guide includes the contributions of MCAVIC staff (Barbara Adams, Psy.D., Lorraine Al-Jamie, MFT, Laura Benson, Karianne Chen, MFT, Nicole Farrell, MSW, Susy Flores, M.S., Sara Hernandez, Psy.D., Jeff McFarland, M.S., Andrea Sward, M.A., Laurie Trimm, B.S., and Kathleen Watkins, Ph.D.), program evaluator and consultant (Carl Maida, Ph.D.), and USC Psychological Trauma Program (USC-PTP) staff based at MCAVIC (Monica Hodges, Ph.D., and Wendy Freed, M.D.). Some material also has been adapted from Principles of Trauma Therapy, co-authored in 2006 by USC-PTP medical director, Catherine Scott, M.D..

## **Chapter 2**

### **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. More detailed discussions of the psychosocial contexts and effects of complex trauma relevant to adolescents and others can be found in Briere and Spinazzola (2005), Cook, et al. (2005), Lanktree and Briere (in press), and Pearlman and Courtois (2005).

#### 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 oppressive, 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, abusing major substances, or involved in various forms of risky behavior.

#### Environmental risks

When complex trauma occurs within the context of socioeconomic deprivation or social marginalization, it is rarely true 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 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 intervention.

The traumatized adolescent's environment may be noteworthy not only for 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 a peer, or by gang members, 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., 1998).

The primary self-endangering behaviors seen in adolescents suffering from complex trauma exposure include suicidal behavior, intentional (but nonsuicidal) self-injury, major substance abuse, eating disorders, dysfunctional sexual behavior, excessive risk-taking, and involvement in physical altercations (Briere & Spinazzola, 2005; 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 may also 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 statistical risk of being assaulted later in life (Classen, Palesh, & Aggarwal, 2005). This phenomenon may result in a scenario well-known to clinicians who work with 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. In this regard, self-endangerment – as much as dangerous environments – requires the clinician to focus on safety as much as symptom remission.

### Longer-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 traumas 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 other instances, 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 longer-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, 2005; Cole & Putnam, 1992; Cook, et al., 2005; Herman, Perry, & van der Kolk, 1989; Janoff-Bulman, 1992; Myers, et al., 2002; Putnam, 1997, 2003; van der Kolk, et al., 2005).

As noted earlier, these various symptoms and coping strategies are sometimes referred to as “Complex PTSD” (Herman, 1992), “Disorders of Extreme Stress” (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. The model presented in this treatment guide, Integrated Treatment for Complex Trauma (ITCT), allows the clinician to address these various difficulties in a relatively structured way, that is, at the same time, customizable to the specific clinical presentation and needs of the individual adolescent client.

## Chapter 3

### Assessment

As outlined in the last chapter, abused or otherwise traumatized adolescents may experience a panoply of symptom, 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, 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 trauma exposure history and current psychological symptoms or problems. However, information may also be collected on caretaker and family functioning, the youth's developmental history, primary attachment relationships, child protective services involvement and placement history, current school functioning, history of losses, medical status, coping skills, 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.

#### 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 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, 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?
- 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 he or she involved in a gang? If so, how dangerous is the situation, both to the client and to others?

#### 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 questioned regarding trauma exposures will also determine the extent to which a more complete account is provided.

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), 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. Including in the Appendix of this guide is a version of the Initial Trauma Review (Briere, 2004), adapted for adolescent clients.

#### 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, medication) might be most helpful. Further, when the same tests 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, tapping a variety of different symptoms, rather than a single measure, and to take mediating demographic, social, and cultural issues into account.

Standardized trauma assessment measures are almost always preferable to those without norms or validation studies. These tests may involve either 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 difficulties accurately assessing the adolescent’s internal experience, especially if the adolescent, for whatever reason, avoids describing those experiences to the caretaker (Lanktree, et al., (2008). For these reasons, it is recommended that the assessment of traumatized adolescents use both self- and caretaker-report 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).

### Psychological tests

Perhaps the most commonly used generic measure in the assessment of traumatized youth is the Child Behavior Checklist (CBCL; Achenbach, 1991), which has separate Parent Report, Teacher Report, and Youth or Young Adult Self-report versions. Other good indices of general functioning for adolescents are the Behavioral Assessment System for Children (BASC-2; Reynolds & Kamphaus, 2006), adolescent versions of the Psychological Assessment Inventory (PAI-A; Morey, 2008) and Minnesota Multiphasic Personality Inventory (MMPI-A; Butcher, et al., 1992). Standardized tests for specific symptoms or disorders include the Child Depression Inventory (CDI; Kovacs, 1992), Suicidal Ideation Questionnaire (SIQ; Reynolds, 1988), and Tennessee Self-Concept Scale (TSCS; Roid & Fitts, 1994).

Standardized, trauma-specific self-report measures for adolescents can be divided into those for *youth ages 12-17*, i.e., the Trauma Symptom Checklist for Children (TSCC; Briere, 1996); those *for adolescents aged 18-21*, i.e., the Trauma Symptom Inventory (TSI; Briere, 1995), Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001), and the Inventory of Altered Self-Capacities (IASC; 2000); and measures *for all adolescents* (aged 12-21), i.e., the Trauma Symptom Review for Adolescents (TSRA; Briere, in press) and the UCLA PTSD Index for DSM-IV (UPID; Pynoos, Rodriguez, Steinberg, Stuber, and Frederick, 1998).

These various trauma-specific measures are described briefly below.

Trauma Symptom Checklist for Children. Normed on over 3,000 children and adolescents across a range of sociodemographic strata, the 54-item TSCC evaluates self-reported trauma symptoms in children

ages eight to 16, with minor normative adjustments for 17 year-olds. It has two validity scales and six clinical scales: *Anxiety*, *Depression*, *Anger*, *Posttraumatic Stress*, *Sexual Concerns* (containing two subscales: *Distress* and *Preoccupation*), and *Dissociation* (containing two subscales: *Overt* and *Fantasy*). There is an alternate form (the TSCC-A) that does not include any sexual items.

UCLA PTSD Index for DSM-IV. An updated version of what was formerly described as the Reaction Index, the UPID is a 48-item interview that can be administered to children and adolescents aged 7-18 years. It evaluates exposure to a variety of traumatic events, and provides a PTSD diagnosis, as well as containing additional items that assess associated features such as guilt, aggression, and dissociation.

Trauma Symptom Inventory. The TSI taps the overall level of posttraumatic symptomatology experienced by an individual in the prior six months, and can be used with adolescents ages 18 to 21. It has three validity scales and 10 clinical scales (*Anxious Arousal*, *Depression*, *Anger/Irritability*, *Intrusive Experiences*, *Defensive Avoidance*, *Dissociation*, *Sexual Concerns*, *Dysfunctional Sexual Behavior*, *Impaired Self-Reference*, and *Tension Reduction Behavior*).

Detailed Assessment of Posttraumatic Stress. The DAPS has two validity scales and 10 scales that evaluate lifetime exposure to traumatic events, immediate cognitive, emotional, and dissociative responses to a specified traumatic event, the subsequent symptoms (and diagnoses) of PTSD and acute stress disorder (ASD), and three associated features of posttraumatic stress: *Trauma-specific Dissociation*, *Suicidality*, and *Substance Abuse*. It is appropriate for adolescents 18 years of age and older.

Inventory of Altered Self-Capacities. The IASC is a standardized test of difficulties in the areas of relatedness, identity, and affect regulation. As such, it is especially relevant to the concerns and presentations of older adolescents (i.e., those aged 18 to 21) presenting with more complex posttraumatic outcomes. IASC scales are *Interpersonal Conflicts*, *Idealization-Disillusionment*, *Abandonment Concerns*, *Identity Impairment*, *Susceptibility to Influence*, *Affect Dysregulation*, and *Tension Reduction Activities*.

Trauma Symptom Review for Adolescents. The TSRA was developed specifically to tap the major issues of traumatized adolescents aged 12 to 21. It has scales measuring, among other constructs, trauma exposure, posttraumatic stress, attachment issues, dissociation, sexual issues, social isolation, tension-reduction (acting-out) behaviors, and vulnerability to revictimization. It is currently undergoing standardization trials, and is expected to be released by Psychological Assessment Resources in 2010. Prior to that point, scores on the TSRA cannot be used to determine norm-referenced level of clinical disturbance.

#### Assessment-driven treatment

In combination, a carefully selected psychological test battery – 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 of 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 data, collateral information, and clinician impressions into a specific treatment plan occurs in ITCT-A through the use of the Assessment-Treatment Flowchart (ATF, adolescent form), presented in the Appendix. 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 have corresponding psychological tests that aid in their evaluation. In such instances, the clinician must 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 generalized clinical impressions to address ATF items.

The following table lists the specific ATF items and possible assessment approaches to each item. This table can also be found in the Appendix.

<b>ATF item</b>	<b>Assessment (tests applicable only for relevant age ranges)</b>
1. Safety – environmental	Adolescent self-report in session (A-S), parent/caretaker-report in session (C-R)
2. Caretaker support issues	A-S, C-R, and clinical impressions during parent interview
4. Anxiety	A-S, C-R, CBCL, BASC-2, PAI-A, MMPI-A, TSCC, TSRA, TSI,
5. Depression	A-S, C-R, CBCL, CDI, BDI-II, BASC-2, TSCC, TSRA, TSI
6. Anger/aggression	A-S, C-R, BASC-2 (parent report), CBCL, PAI-A, TSCC, TSRA, TSI
7. Low self-esteem	A-S, C-R, BASC-2, TSCS
8. Posttraumatic stress	A-S, C-R, PAI-A, MMPI-A, TSCC, TSRA, TSI, DAPS, UPID
9. Attachment insecurity	A-S, C-R, BASC-2, TSRA

10. Identity issues	A-S, C-R, IASC
11. Relationship problems	A-S, C-R, BASC-2, CBCL, TSRA
12. Suicidality	A-S, C-R, PAI-A, TSRA, DAPS, SIQ
13. Safety – risky behaviors	A-S, C-R, BASC-2, TSI
14. Dissociation	A-S, C-R, TSCC, TSRA, DAPS
15. Substance abuse	A-S, C-R, BASC-2, PAI-A, DAPS
16. Grief	A-S, C-R

Completion of the ATF thus proceeds in the following steps:

At intake:

- (1) 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.
- (2) Proceed through each of the 17 items of the ATF 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 1.

At each following assessment period (typically every three months, unless indicated more frequently):

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 has rating columns for three assessment periods beyond the intake session, which generally corresponds to up to 9 months. Additional columns may be created as needed.

## Chapter 4

### 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 is assessment-based; initial and repeat assessments determine, as represented on the ATF, which intervention components are utilized in treatment. Consider an example of how ATF data (presented below) might initially determine, then alter treatment focus:

Based on the TSCC, UPID, and other tests, as well as the adolescent’s verbal self-report in the evaluation session, his parents’ feedback, and the therapist’s clinical impression, 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 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”).

#### Priority ranking (circle one for each symptom):

- 1 = Not currently a problem (re-evaluate at each interval): Do not treat
- 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

	<u>Assessment period</u>			
	<u>Intake</u>			
	<u>5/10/08</u>			
<u>Problem area</u>	Tx priority	Tx priority	Tx priority	Tx priority
1. Safety – environmental	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
2. Caretaker support issues	<b>1</b> 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
3. Anxiety	1 2 3 <b>4</b> (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
4. Depression	1 2 3 <b>4</b> (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

5. Anger/aggression	1 2 <b>3</b> 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
6. Low self-esteem	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
7. Posttraumatic stress	1 2 3 <b>4</b> (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
8. Attachment insecurity	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
9. Identity issues	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
10. Relationship problems	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
11. Suicidality	<b>1</b> 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
12. Safety – risky behaviors	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
13. Dissociation	1 2 <b>3</b> 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
14. Substance abuse	<b>1</b> 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
15. Grief	<b>1</b> 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
16. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
17. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

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. 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 (specifically, unsafe sexual activities) 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.

**Priority ranking (circle one for each symptom):**

- 1 = Not currently a problem (re-evaluate at each interval): Do not treat
- 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

**Assessment period**

<b><u>Problem area</u></b>	<u>Intake</u>			
	<u>5/10/08</u>	<u>8/11/08</u>	_____	_____
	Tx priority	Tx priority	Tx priority	Tx priority
1. Safety – environmental	1 <b>2</b> 3 4 (S)	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
2. Caretaker support issues	<b>1</b> 2 3 4 (S)	<b>1</b> 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
3. Anxiety	1 2 3 <b>4</b> (S)	1 2 <b>3</b> 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
4. Depression	1 2 3 <b>4</b> (S)	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
5. Anger/aggression	1 2 <b>3</b> 4 (S)	1 2 <b>3</b> 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
6. Low self-esteem	1 <b>2</b> 3 4 (S)	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
7. Posttraumatic stress	1 2 3 <b>4</b> (S)	1 2 3 <b>4</b> (S)	1 2 3 4 (S)	1 2 3 4 (S)
8. Attachment insecurity	1 <b>2</b> 3 4 (S)	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
9. Identity issues	1 <b>2</b> 3 4 (S)	<b>1</b> 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
10. Relationship problems	1 <b>2</b> 3 4 (S)	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
11. Suicidality	<b>1</b> 2 3 4 (S)	<b>1</b> 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
12. Safety – risky behaviors	1 <b>2</b> 3 4 (S)	1 2 <b>3</b> 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
13. Dissociation	1 2 <b>3</b> 4 (S)	1 <b>2</b> 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
14. Substance abuse	<b>1</b> 2 3 4 (S)	<b>1</b> 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
15. Grief	<b>1</b> 2 3 4 (S)	<b>1</b> 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
16. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
17. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

Based on the second component of the ATF, the “problems-to-components grid” (see Appendix), the various problems and symptoms described the previous chapters are linked to specific intervention approaches (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), 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 data, collateral input, and response to treatment or external circumstance.

### 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 suggests that a positive therapeutic relationship is one of the most important components of successful therapy (Cloitre, et al., 2006; 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 proves 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, 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. 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 10, 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 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 with regards to their sociocultural background, 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 often 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 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 of physical abuse and assault (Kessler, et al., 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, 2006). 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 impacts the client, and respond accordingly.

### 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. 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 cultural lens that differs substantially from that of the therapist (Abney, 2002; Cohen, Deblinger, Mannarino, & De Arellano, 2001; Jones, et al., 2006; Marsella, et al., 1996).

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 treatment with him or her, 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, et al., 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," when, in fact, the client may have multiple impinging concerns (e.g., childcare, 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., Caucasian, middle class) culture, and (3) differences in world-views and experiences often associated with different socioeconomic strata or cultural/subcultural membership.

### Affect regulation capacity

Not only should treatment be customized based on the client's symptomatic presentation and sociodemographic/cultural characteristics, there is an important psychological variable that frequently affects how therapy is delivered: the client's level of affect regulation, i.e., 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, 2006; 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 10, 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 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 – while, at the same time, providing as much processing as can reasonably occur.

### Advocacy and system 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 abuse, theft, revictimization, or violence against others.

In such situations, psychotherapy – by itself – may not be of sufficient assistance. For this reason, ITCT and other approaches to multi-problem youth typically includes 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 providers with sufficient resources or funding may offer a 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 homeless 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 5

### 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 to merely 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 be 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 survivor's 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, which – 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 avoid questions or behaviors that push the client beyond where he or she is willing to go, that activate feelings of shame, or that 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 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.

- *Transparency*; The therapist is as honest and open as possible, and does not appear to be operating with “hidden agendas” – 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.
- *Demarcating 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 to otherwise intervene without the client’s permission when certain events occur or are 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 can 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? and
  - 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 as a result 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 experience*; 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 (including emotional connection)

ITCT 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 remains constant and invested in the therapeutic process, he or she has the opportunity to communicate acceptance of the client and trust in 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. 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 substance abuse – 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 6

### 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 relations, partners, and relative strangers. Openly 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, as well as through more directly suicidal behavior. 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 (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 – certainly this 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, et al., 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 himself 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 whenever the client discloses suicidal ideation. 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, a psychiatric consultation, medication, or hospitalization may be indicated.

### Child protection or law enforcement services for victims of intrafamilial abuse

Because most adolescents are considered children by state law, those who are being maltreated by parents, caretakers, or other family members are entitled to protection by child protection agencies. As well, older youth victimized by peers or adults typically 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). There is typically no duty for the therapist to report peer victimization to the police, 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 perpetrators are addressed by the criminal justice system. In the worst case, especially when the youth is mobile (e.g., homeless), 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 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 himself or herself from gang activity, the adolescent 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, facilitate 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.

### Working with prostitution issues

It is not uncommon for homeless (often runaway) adolescents, especially those with histories or childhood sexual, physical, or emotional abuse, to become involved in prostitution (Farley, 2004; Webber, 1991; Widom & Kuhns, 1996; Yates, MacKenzie, Pennbridge, & Cohen, 1988). In some cases, they are recruited and controlled by a pimp. In others, the survivor may exchange sex for drugs, food, or shelter. Although prostitution is almost always a very negative experience – in many cases requiring the client to abuse drugs in order to continue it – and is associated with an elevated risk of assault, disease, depression, and posttraumatic stress (Farley, 2004), clinician entreaties that the adolescent just stop such

behavior is 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 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 adolescents 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).

#### Safety plans in cases of 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 usually a good idea for the therapist and client to create a “safety plan” (Jordan, Nietzel Walker, & Logan, 2004). 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. 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).

#### Intervening in substance abuse

As noted earlier, substance abuse is a common problem among abused adolescents. The comorbidity of trauma symptoms and use of drugs or alcohol can be an issue for treatment, because substance use can interfere with trauma processing (Briere & Scott, 2006), and high levels of trauma symptoms can reduce the capacity of survivors to tolerate internal states without the use of drugs or alcohol. Unfortunately, the usual clinical recommendation that substance abusing clients be drug and alcohol abstinent before undergoing trauma therapy is problematic for many clients, including marginalized, multiproblem adolescents, who may be quite reluctant to discontinue the use of agents that numb distress. Instead, although ITCT for adolescents encourages clients’ avoidance of chemical dependency, it does not require it – the youth is “taken as he/she is” and assisted within the constraints of what he or she will accept or tolerate. In general, this may mean providing some level of titrated cognitive and exposure-based processing of trauma, as outlined in later chapters, but also focusing more on the development of affect regulation skills (see chapter 8) and processing of trauma-related cognitions (see Chapter 9); interventions that may, eventually, remove the need for substance abuse. A highly

recommended example of this approach is Najavits's (2002) "Seeking Safety" model for treating substance abusing trauma survivors.

### Supporting safer sexual behavior

Childhood abuse in general, and sexual abuse in particular, 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 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 substance abuse; 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 therapist 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 ready or able to do, for example, 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, large cities in the United States frequently have out-reach programs for runaway, homeless, substance addicted, prostitution-involved, 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 youth be "kid friendly" and able to deal with the typical problems and issues presented by this population. 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 7**

### **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 some 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 trauma and its effects, and by working with the youth to integrate this new information and its implications into his or her overall perspective. Although often presented relatively early in treatment, psychoeducational activities are helpful throughout the therapy process

#### 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, 2006):

- 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 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. Some books may be too emotionally activating for youths with unresolved posttraumatic difficulties, however, at least early in the recovery or treatment 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 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 to more easily 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 or as a reflection of their own inadequacies);

- Typical immediate and longer-term responses to trauma (e.g., posttraumatic stress, depression, intimacy issues, or substance abuse);
- Reframing substance 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).

As is noted on the chapter on cognitive processing, psychoeducation is probably best understood as a component of a larger strategy: the attempt to assist the youth in updating (and/or actively countering) the understandings, beliefs, and expectations he or she developed during earlier adverse experience. In some cases, the adolescent is essentially provided with information that is more accurate than what he or she believes (psychoeducation). In other instances, therapy may involve opportunities for the client to directly 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 are combined.

## Chapter 8

### 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 survivor is often forced to rely on avoidance strategies such as substance abuse, tension-reduction activities, or dissociation. Unfortunately, high levels of avoidance, in turn, appears to interfere with psychological recovery from the effects of trauma (Briere, Scott, & Weathers, 2005; Polusny, Rosenthal, Aban, & Follette, 2002). 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 overwhelmed 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 increasing 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.

#### 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 may also 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, 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 ground himself 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 adolescent to briefly describe 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 the client is able to talk about the internal experience, however, it is often helpful for him or her to generally label or broadly describe the experience. This does not mean the survivor should go into great detail -- detailed description of the flashback or dissociative state may increase its intensity, thereby reinforcing the response rather than lessening it.
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, reexperiencing 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?"). The client might be asked to focus his or her attention on the feeling of the chair or couch underneath him or her, or of his or her feet on the floor. 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 countercondition 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 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 relaxation exercises; others teach it initially in treatment, 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 (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 breath" during stress can help restore more normal respiration, and thus adequate oxygenation of the brain. Equally important, as the client's learns to breath in ways that are more efficient and more aligned with normal, nonstressed 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 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 ( 2006).

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 of the first things 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 breath more slowly and deeply -- this is a normal reaction. For this reason, they should not try breathing exercises standing up 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" to see how the client is feeling, and 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.
  - b. Ask the client to try to stay "in the moment" while doing breathing exercises. 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 breath 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. With practice, the client may begin to slow his or her breath even further. 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 sequence 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), and make this exercise a regular part of his or her daily routine. The adolescent should sit or lie down at home in a comfortable position, with no distractions, for this practice.

Eventually, the youth can extend this exercise to other times in the day as well, especially when relaxation would be a good idea, e.g., before important meetings, in stressful social situations, or whenever he or she feels especially anxious. Remind the client to 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 breath 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 not all older adolescents may value this terminology. Importantly, this skill is not useful in a crisis or emergency where the client must 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.

### 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 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, 2005) – all skills that can be helpful for traumatized youth. Nevertheless, not all adolescents will want to meditate, and not all therapists will feel comfortable or qualified in teaching it. When reduced to a simple activity, however, meditation can be easily practiced and quite helpful.

The most basic steps of mediation, which can be presented to the survivor, are as follows:

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. You can lie down, if you wish, but this may make you more sleepy.
3. Close your eyes, or at least lower your eyelids.
4. Focus your mind on your breathing and just your breathing: feel the air going into your lungs, and then 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. Usually people have a hard time just paying attention to their breath. Their mind wanders. Don’t criticize yourself when this happens, just notice what you are doing and go back to watching and feeling yourself breathe in and out. Let thoughts and feelings come and go, without attaching great

importance to them. They are neither good or bad, right or wrong; they are just thoughts or feelings. Notice them, then return to your breathing.

6. Try to do this for at least 10 minutes a day, every day. 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.

#### Increasing general affect regulation capacity

Above and beyond 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 her 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 (Cloitre, et al., 2002; 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 feeling 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 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 for adolescents. 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. 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 effective 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 a cognition triggers 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 these 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 tapes" 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 -- an understanding that may lessen 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 six 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., "he/she hates me," "I must have done something wrong," or "he/she is blaming me 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 out loud, 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 of 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 as opposed to data about the present or future, he or she is indirectly developing the capacity to forestall extreme emotional reactivity, and thereby better regulating 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, engaging in behaviors such as self-mutilation, impulsive sexual behavior, or bingeing/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. Although 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 that is sometimes 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 terminate, or at least decrease their frequency, intensity, and injuriousness. Because TRBs serve to reduce distress, client attempts to delay their use provides 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 compulsion -- 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 ensue, 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, 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 repetitively 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 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 live-in 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 often 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, 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 treatment, 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*.

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 danger or coercion, the objective lack of support for these statements may become more apparent to the client.

Because the therapist is often more able to see these cognitive distortions than is 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. But, rarely will such statements, in and of themselves, substantially change the client’s opinion. In fact, clinical experience suggests that cognitive therapy is rarely 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 to client to more directly 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 that might counter the negative implications or self-perceptions that emerge in the client's responses (see, e.g., Chapter 7). 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." 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 & Campbell, 2000). See chapter 10 for an example of trauma processing homework, adapted from Resick and Schnicke (1993).

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 substance abuse, 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.

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 cognitively processing. Such discussions often center around a series of gentle, usually open-ended inquiries that allow the client to progressively examine the assumptions and interpretations he or she has made about the victimization experience.

Typical questions, in this regard, 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 survivor 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 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 to repeatedly 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 is more able to 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 more fully and accurately explore 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 by asking the adolescent -- especially after some level of psychoeducation has transpired -- about

- what might be a nonpathologizing explanation for the symptom (e.g., the survival value of hypervigilance, or the self-medicating aspects of substance 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, 2006).

These and other questions may stimulate lively and 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). 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 further 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 greater 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, 1996, 2002). Interventions within the therapeutic window are neither so trivial or nonevocative that they provide inadequate memory exposure and processing, nor so intense that they become overwhelming. In other words, interventions that take the therapeutic window into account 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 problem, the therapeutic window is an important aspect of ITCT.

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, however, waste time and resources at times when more effective therapeutic interventions would be possible.

"Overshooting" the window, on the other hand, occurs when the clinician inadvertently provides too much therapeutic exposure and, therefore, too much emotional activation relative to the client's existing affect regulation resources, or is unable to prevent the client from flooding himself or herself with overwhelming traumatic distress. Interventions that are too fast-paced 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”) during the session, or will interrupt the focus or pace of therapy with arguments, by "not getting" obvious therapeutic points, by distracting the therapist with various dramatic, sexualized, or aggressive behaviors, or by changing 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 to eventually 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, titrated 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 or negative cognitive preoccupation that the addition of 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 substance intoxication (e.g., Bryant & Harvey, 2000; Cloitre, et al. 2002; Pitman, et al., 1991; Najavits, 2002). When these conditions preclude exposure therapy, the clinician is advised to focus on the various other interventions outlined in this guide -- especially distress reduction and affect regulation (Chapter 8) and cognitive interventions (Chapter 9) -- until exposure is more indicated. In some cases, psychiatric medication also may be indicated (Briere & Scott, 2006, Chapter 11).

### The 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 8, 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 out loud 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 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 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 her current addiction. In such instances, insisting that the client focus exclusively on a single trauma during therapy, or even on just one trauma at a time, may be contraindicated and 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 trauma survivor be allowed to explore – and thereby

expose him- 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 trauma survivor 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 *prebriefing*: 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. 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, 2006):

- Unresolved memories of the trauma often have to be talked about and re-experienced, 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 feeling 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 cannot, however, 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 that he or she can 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 to 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 the memories during therapy, the more likely it is that significant improvement will occur.

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*) and provide it to the client, saying something like:

“Here is the homework sheet we discussed. Try to write answers to all the questions on it 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.

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.

### 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 aspect 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 not necessarily 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 not uncommon 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 aware of 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 aspects of the trauma. Once the client’s emotionality has returned to baseline, careful exposure activities may be resumed, if appropriate.

Occasionally, overactivation (exceeding 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 more on affect skill 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 8, the client’s overall capacity to tolerate distress will grow.

### 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, punitiveness, boundary violation, or underappreciation 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: (1) 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 (2) 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 very 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 antithetic 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 only not reinforced, they 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 countercondition

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 countercondition 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 countercondition 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/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 in the world 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) which is out of proportion to the actual insult by the peer: he has been triggered and now is involved in an act which 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 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. Regarding the latter, 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.

Trigger identification and intervention training usually occurs during the therapy session, and is 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.*" The goal is for the client to:

- (1) learn about triggers, including their "unreal" (i.e., non-here-and-now) yet understandable historic nature
- (2) identify specific instances during which he or she has been triggered,
- (3) 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, and
- (4) 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
- 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
- gunshots
- the sound of crying

One of the more challenging parts of the trigger grid for the adolescent trauma survivor is the question “*How do I know I’ve been triggered?*”? Some answers are relatively easy; for example, it may not be difficult to recognize an intrusive sensory flashback of a gunshot as posttraumatic. 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/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
- A situation in which the adolescent often gets triggered

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

The final question on the grid is “*What I could do or say to myself so that I wouldn’t get triggered, or for the trigger to be less bad,*” answered for each of the major triggers that the client has identified earlier. Among possible answers to this section are

- Changing the scenario or using “time-outs” during especially stressful moments (e.g., 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 8,
- 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 “tapes” 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 problems in determining one's own needs or entitlements, maintaining a consistent sense of self or identity in the context of strong emotions or compelling others, and 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, 1997). 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 pain. 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 increasingly coherent identity may be less possible for those who were deprived of positive parenting. Self 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 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, 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 actually discovering that one is safe in treatment, however, may be protracted -- many survivors of severe childhood or adolescent trauma, perhaps especially "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 are able to accurately perceive the safety inherent in the session (see the discussion of disparity in Chapter 10). 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 to not argue with the client regarding his or her thinking errors about self, but rather to work with the client in such a way that 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 experience 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-directedness 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 issue, 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-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 ongoing 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. Ultimately, the therapist takes on the role of the supportive, engaged, helpful attachment 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 intimate 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 himself 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, et al., 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 conflictual 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 typically 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 relate 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 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 emotionally maltreated adolescents are too young to be diagnosed with this disorder (American Psychiatric Association, 2000), 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 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.

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 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 and Briere & Scott, 2006 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.

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, include 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.

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 more simple 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 insure 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 more comfortable 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 are in any way sexually or physically threatening; the Caucasian therapist working with a young African-American man can work hard to communicate a nonracist perspective; and the economically advantaged counselor can strive to consciously avoid making assumptions or judgments based on his or her background when interacting with economically impoverished clients. And, 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 if and when 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 may have been formed in the first years of life, and therefore is not available to conscious (explicit) awareness, neither client nor 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. And, more generally, they 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 fully apprehend 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 gang member 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; a requirement that -- from the survivor’s perspective -- can be a recapitulation of past experience 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 enough to significantly 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, nondemanding 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. As noted earlier, 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 nonexploitive way, over time, until the youth can truly extrapolate safety into the future and imagine disparity. 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 may, ironically, subvert the process by communicating criticism or implied rejection.

In other cases -- 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) -- disparity may be considerably easier to establish and trauma processing may be more immediately possible. In any case, however, this is an assessment issue, as opposed to 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/she doesn't like me," "he/she will hurt/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 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 adolescent 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 emotionally processing an assault in the session 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 inappropriate sexualization or romanticization of the client, or exploitation of 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 nonreinforcement and counterconditioning 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 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 nonreinforced emotional responses, via disparity, (b) counterconditioning 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 relationship, per se, is no longer perceived as necessarily dangerous and therefore is 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 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

### Interventions with caretakers and family members

ITCT, like some other programs for traumatized adolescents, includes interventions directed at the survivor's parents/caretakers and, if necessary, his or her family. Interventions with caretakers tend to focus on one or more of four functions:

- increasing caretaker understanding of the adolescent's difficulties and behaviors, so that they may be more supportive;
- providing nonoffending caretakers with extra support, given the stress and demands associated with raising a traumatized youth;
- working to increase the caretakers' parenting skills; and
- assisting parents with significant problems of their own that interfere with their caring for the client.

Treatment may also involve family therapy, in order to help resolve intrafamilial conflicts and dysfunctional interaction patterns.

These interventions can only be helpful 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 otherwise have moved away, or (5) the adolescent's behavior has alienated the caretakers. In each case, other family members may continue to be involved with the client, or, on the other hand, may mirror the caretaker(s) antipathy, mobility, or disengagement. These various issues combine to result in fewer caretakers seeking out intervention or support than do caretakers of younger children.

#### Working with caretakers

When caretakers are willing to engage in the process, individual and group meetings can be quite helpful. Many parents experience considerable distress and sometimes desperation at their child's externalizing behavior, and/or may have almost given up hope at the severity or chronicity of his or her depression. Many lack information regarding what the effects of abuse are, and the logic behind what

appears to be psychopathology or “bad” behavior. As well, they may not understand developmental issues that complicate the adolescent’s reactions to abuse. 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. And, just as the experience of trauma is isolating for the adolescent, raising and worrying about a traumatized offspring can be as well.

ITCT provides two modalities of caretaker intervention: Individual collateral therapy and caretaker groups.

Individual parent/caretaker sessions usually occur on a weekly basis, often for 30-45 minutes per meeting, and may either 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, and psychoeducation on abuse, the adolescent’s response to it, and general developmental issues. If the caretaker(s) appears to have mental health issues (sometimes involving their own history of childhood trauma), they should be referred out for separate therapy.

At MCAVIC, caretaker groups generally run for 12 weeks, on a weekly basis. Caretakers may repeat a group module one more time, leading to a total of 24 weeks. Two types of groups are typically offered: a didactic parenting group (adapted to address specific cultural issues) and a caretaker support group.

### Working with the family

Engaging traumatized adolescents and their families into family therapy is often difficult, for the various reasons outlined above. However, especially after the youth has had some individual therapy, and the caretakers have attended parent sessions, there are often instances when family therapy is indicated, and both of the major parties are amenable to treatment. These sessions may occur concurrently with individual, collateral, and group treatment. Generally, the focus is on improving family communication patterns, exposing and attempting to resolve family conflicts that impact on the adolescent, clarifying appropriate boundaries, and attempting to increase the general level of attunement and emotional support within the family.

Cultural factors are often relevant in family sessions: 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 (often including the youth) who do not endorse these perspectives. The family may be impacted by other, systems issues, such as police or child welfare involvement regarding possible child abuse or domestic violence, 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 are 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 scape-goating, splitting, and indirect aggression can be brought to light, and hopefully reduced or eliminated over time.

The adolescent's role in all this is complex. On one level, 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. At this level, he or she 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. On the other hand, it is often the adolescent who shakes up what is already a dysfunctional family system, and who 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 of the family.

## Chapter 15

### Group sessions

Group therapy is a helpful addition to ITCT, although it is not used with all traumatized adolescents. Typically, group treatment augments individual therapy; it is generally not used in isolation<sup>1</sup>. 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. In the absence of concomitant individual therapy, these triggered cognitive and emotional states may become problematic for the client and for the group.

When group therapy is the only treatment available, some clients may become overwhelmed during the group process, generally because their therapeutic windows have been exceeded in the context other group members' disclosures or statements. 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 end result may be that the client 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 conducted at MCAVIC.

#### 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:

- 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. Homosexual/gay 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

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<sup>1</sup> 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.

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. They may, however, 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 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, 12-15 year olds versus 16 years or older. 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 effects 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.

#### Special issues

When possible, 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 lifestyles (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 “down-side” 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. 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 uncommon.

Although affect regulation matching is generally a good idea, in many cases there will not be sufficient potential members available to sort them into such groups. As a result, the clinician may have to include client's 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 (Briere, 1996). In such situations, the best that the clinician may be able to do is 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. In the worst case, employing untrained therapists 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 ½ to 2 hours, although some may be constrained to a greater or lesser time period.

Structured group therapy 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. Presented below is an example of an ITCT structured group, in this case for female sexual abuse survivors between the ages of 13 and 15 (Hernandez & Watkins, 2007).

#### *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 do not expand on this. 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, and no sexual relationships between group members are permitted.

#### *Session 2: Learning about sexual abuse.*

Topics and activities: Psychoeducation regarding common reactions to sexual abuse, including substance abuse. Learning about 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.

#### *Session 3: Learning about and expressing feelings related to the trauma.*

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

#### *Session 4: Specific exploration of trauma-related perceptions.*

Topics and activities: Collage or art activity (how others see them, how they view themselves “on the inside”).

Session 5: *Specific exploration of traumatic events.*

Topics and activities: Writing a narrative or “story” of their abuse history, generally as per Chapter 9 and the Appendix.

Session 6: *Specific exploration of trauma continued.*

Topics and activities: Sharing their narratives (pieces that they are comfortable sharing with the group), per Session 5.

Session 7: *Addressing thoughts and feelings about sex and sexuality.*

Topics and activities: Using their narrative to help them talk about sexuality and how to integrate their experiences into their lives. Discussion of current sexual issues, and their potential connection to sexual abuse.

Session 8: *Begin exploring problem solving.*

Topics and activities: General discussion of whether there are things survivors can do to improve their lives, decrease the likelihood of further victimization, and get through times when their feelings are triggered.

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.

Session 10: *Increasing self-esteem.*

Topics and activities: Exploring and identifying client’s positive qualities. Discussion of potentially “positive” outcomes of experiencing abuse (e.g., how it has made them stronger, the idea that “If I got through that, I can deal with this....”)

Session 11: *Building positive coping strategies for painful memories.*

Topics and activities: Learning to identify when one gets triggered, and if it can’t be

avoided, what can be done to cope with the trigger (generally includes a version of the trigger grid described in Chapter 11 and the Appendix). How to handle relationships and how to avoid being re-victimized.

Session 12: *Processing group*.

Topics and activities: Overview/recap of the group. Individual disclosures of what they gained from the group.

### **Sequence and session-level structure of trauma-focused psychotherapy**

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 (ATF), and applying the Problems-to-Components Grid (PTC), 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 of ITCT. 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, provide relevant processing activities as needed, reassess the client's current state, de-escalate emotional responses, if needed, and provide end-of-session closure.

In general, we suggest that therapy for traumatized adolescents involve one 50-60 minute individual session per week, in addition to group or family sessions that may occur on a weekly to monthly basis. 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. Adapting from Briere and Scott (2006), some version of the following is appropriate for the individual therapy session:

- Pre-session: The ATF 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.
- Opening (5-15 minutes):
  1. Spend a few minutes making contact with the client. 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. Have intrusive or avoidance symptoms increased significantly since the last session? If yes, 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. 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, 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 internal 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.
  4. If the client's level of activation remains high, work to de-escalate his or her emotional arousal. This may include an increasing focus on nonemotional issues, further cognitive (but not emotional) processing, breathing/relaxation and/or grounding per chapter 8.
- Ending (Last 5-15 minutes):

1. Remind the client (if necessary) of the potential delayed effects of trauma processing, including 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. Provide closure statements (e.g., summing up the session) and encouragement.
5. Explicitly refer to the time and date of the next session.
6. End with some communication of caring, appreciation, and/or hope.

## References

- Abney, V.D. (2002). Cultural competency in the field of child maltreatment. In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, T. Reid, & C. Jenny (Eds.). *The APSAC handbook on child maltreatment, 2<sup>nd</sup> Edition*. Newbury Park, CA: Sage Publications.
- Achenbach, T.M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 Profile*. Burlington: University of Vermont, Department of Psychiatry.
- Allen, J.G. (2001). *Traumatic relationships and serious mental disorders*. Chichester, England: Wiley.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders (4<sup>th</sup> ed., Text Revision)*. Washington, D.C.: Author.
- Amir, N., Stafford, J., Freshman, M.S., & Foa, E.B. (1998). Relationship between trauma narratives and trauma pathology. *Journal of Traumatic Stress, 11*, 385-393.
- Baldwin, M.W., Fehr, B., Keedian, E., Seidel, M., & Thompson, D.W. (1993). An exploration of the relational schemata underlying attachment styles: Self-report and lexical decision approaches. *Personality and Social Psychology Bulletin, 19*, 746-754.
- Bassuk, E.L., et al. (2003). Social deprivation. In B.L. Green, M.J. Friedman, J.T.V.M. De Jong, S.D. Solomon, T.M. Keane, J.A. Fairbank, B. Donelan, & E. Frey-Wouters (ed.). *Trauma interventions in war and peace: prevention, practice, and policy* (pp. 33-55), New York: Kluwer/Plenum.
- Berthold, S.M. (2000). War traumas and community violence: psychological, behavioral, and academic outcomes among Khmer refugee adolescents. *Journal of Multicultural Social Work, 8*, 15-46.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.
- Briere, J. (1995). *Trauma Symptom Inventory (TSI)*. Odessa, Florida: Psychological Assessment Resources.
- Briere, J. (1996). *Therapy for adults molested as children, Second edition*. New York: Springer Publishing Co.
- Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC)*. Odessa, Florida: Psychological Assessment Resources.
- Briere, J. (2000). *Inventory of Altered Self Capacities (IASC)*. Odessa, Florida: Psychological Assessment Resources.

- Briere, J. (2001). Evaluating treatment outcome. In M. Winterstein & S.R. Scribner (Eds.). *Mental health care for child crime victims: Standards of care task force guidelines*. Sacramento, CA: California Victims Compensation and Government Claims Board, Victims of Crime Program, State of California.
- Briere, J. (2001). *Detailed Assessment of Posttraumatic Stress (DAPS)*. Odessa, Florida: Psychological Assessment Resources.
- Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, T. Reid, & C. Jenny (Eds.). *The APSAC handbook on child maltreatment, 2<sup>nd</sup> Edition*. (pp. 175-202). Newbury Park, CA: Sage Publications.
- Briere, J. (2003). Integrating HIV/AIDS prevention activities into psychotherapy for child sexual abuse survivors. In L. Koenig, A. O'Leary, L. Doll, & W. Pequenat (Eds.), *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention*. Washington D.C.: American Psychological Association.
- Briere, J. (2004). *Psychological assessment of adult posttraumatic states: Phenomenology, diagnosis, and measurement, 2<sup>nd</sup> Edition*. Washington, DC: American Psychological Association.
- Briere, J. (in press). *Trauma Symptom Review for Adolescents*. Psychological Assessment Resources.
- Briere, J., & Elliott, D.M. (2003). Prevalence and symptomatic sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect*, 27, 1205-1222.
- Briere, J., & Rickards, S. (2007). Self-awareness, affect regulation, and relatedness: Differential sequels of childhood versus adult victimization experiences. *Journal of Nervous and Mental Disease*, 195, 497-503.
- Briere, J., Scott, C., & Weathers, F.W. (2005). Peritraumatic and persistent dissociation in the presumed etiology of PTSD. *American Journal of Psychiatry*, 162, 2295-2301.
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: Sage.
- Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress*, 18, 401-412.
- Breslau, N., Davis, G.C., & Andreski, P. (1991). Traumatic events and post-traumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry*, 48, 216-222.

- Breslau, N., Wilcox, H.C., Storr, C.L., Lucia, V.C., & Anthony, J.C. (2004). Trauma exposure and posttraumatic stress disorder: a study of youths in urban America. *Journal of Urban Health, 81*, 530-544.
- Bryant, R.A., & Harvey, A.G. (2000). *Acute Stress Disorder: A handbook of theory, assessment, and treatment*. Washington, D.C.: American Psychological Association.
- Butcher, J. N., Williams, C. L., Graham, J. R., Archer, R. P., Tellegen, A., Ben-Porath, Y.S., & Kaemmer, B. (1992). *MMPI-A (Minnesota Multiphasic Personality Inventory–Adolescent): Manual for administration, scoring, and interpretation*. Minneapolis: University of Minnesota Press.
- Carter, R.T. (2007). Racism and psychological and emotional injury: recognizing and assessing race-based traumatic stress. *Counseling Psychologist, 35*, 13-105.
- Chen, A., Keith, V., Airriess, C., Li, Wei. & Leong, K. J. (2007). Economic vulnerability, discrimination, and Hurricane Katrina: Health among Black Katrina survivors in eastern New Orleans. *Journal of the American Psychiatric Nurses Association, 13*, 257-266.
- Classen, C.C., Palesh, O.G., & Aggarwal, R. (2005). Sexual revictimization: a review of the empirical literature. *Trauma, Violence, and Abuse: A Review Journal, 6*, 103-129.
- Cloitre, M. Koenen, K.C., Cohen, L.R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: a phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology, 70*, 1067-1074.
- Cloitre M., Cohen L.R., & Koenen K.C. (2006). *Treating survivors of childhood abuse: psychotherapy for the interrupted life*. New York: Guilford.
- Cohen, J.A., Deblinger, E., Mannarino, A.P., & De Arellano, M. A. (2001). The importance of culture in treating abused and neglected children: an empirical review. *Child Maltreatment, 6*, 148-157.
- Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*. NY: Guilford.
- Cole, P. M., & Putnam, F. W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology, 60*, 174-184.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*, 390-398.
- Cummings, S. & Monti, D.J., (eds.) (1993). *Gangs: The origins and impact of contemporary youth gangs in the United States*. Albany, NY: State University of New York.

- DeRosa, R., Habib, M., Pelcovitz, D., Rathus, J., Sonnenklar, J., Ford, J., Sunday, S., Layne, C., Saltzman, W., Turnbull, A., Labruna, V., & Kaplan, S. (2006). *Structured Psychotherapy for Adolescents Responding to Chronic Stress*. Unpublished manual.
- Elliott, D.M. (1994). Impaired object relationships in professional women molested as children. *Psychotherapy, 31*, 79-86.
- Elliott, D. M., & Briere, J. (1994). Forensic sexual abuse evaluations of older children: Disclosures and symptomatology. *Behavioral Sciences and the Law, 12*, 261-277.
- Farley, M. (Ed.), (2003). *Prostitution, trafficking, and traumatic stress*. New York: Haworth Maltreatment & Trauma Press.
- Foa, E.B., & Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20-35.
- Foa, E.B., Molnar, C., & Cashman, L. (1995). Changes in rape narrative during exposure therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 8*, 675-690.
- Foa, E.B., & Rothbaum, B.O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. New York: Guilford.
- Ford, J.D. (2007). Trauma, posttraumatic stress disorder, and ethnoracial minorities: toward diversity and cultural competence in principles and practices. *Clinical Psychology: Science and Practice, 15*, 62-67.
- Friedrich, W.N. (2002). *Psychological assessment of sexually abused children and their families*. Thousand Oaks, CA: Sage.
- Germer, C.K., Siegel, R.D., & Fulton, P.R. (2005). *Mindfulness and psychotherapy*. New York: Guilford.
- Giaconia, R. M., Reinherz, H. Z., Silverman, A. B., Pakiz, B., Frost, A. K., & Cohen, E. (1995). Traumas and posttraumatic stress disorder in a community population of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*, 1369-1380.
- Grisso, T., Vincent, G., & Seagrave, D. (Eds.) (2005), *Handbook of Mental Health Screening and Assessment for Juvenile Justice*. New York: Guilford.
- Herman, J.L. (1992b). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*, 377-392.
- Herman, J.L., Perry, C., van der Kolk, B.A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry, 146*, 490-494.
- Hernandez, S., & Watkins, K. (2007). *Group therapy for sexually abused female adolescents*. Unpublished manuscript.

- Janoff-Bulman, B. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.
- Jones, R.T., Hadder, J.M., Carvajal, F., Chapman, S., & Alexander, A. (2006). Conducting research in diverse, minority, and marginalized communities. In F. Norris, S. Galea, M.J. Friedman, & P. Watson (eds). *Methods for disaster mental health research*, (pp. 265-277). New York: Guilford Press.
- Jordan, C.E., Nietzel, M.T., Walker, R., & Logan, TK. (2004). *Intimate partner violence: Clinical and practice issues for mental health professionals*. New York: Springer.
- Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, 52, 1048-1060.
- Koenig, L., O'Leary, A., Doll, L., & Pequenat, W. (Eds.). (2003). *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention*. Washington, DC: American Psychological Association.
- Kovacs, M. (1992). *Children Depression Inventory (CDI) manual*. Toronto: Multi-Health Systems Inc.
- Lanktree, C.B. (August, 2008). *Cultural adaptations to complex trauma treatment with children and adolescents*. Paper presented at the annual meeting of the American Psychological Association, Boston, MA.
- Lanktree, C.B., & Briere, J. (in press). Assessment - Psychometric - Child. In G. Reyes, J. Elhai, & J. Ford (Eds.), *Encyclopedia of Psychological Trauma*. New York: Wiley.
- Lanktree, C.B., Gilbert, A.M., Briere, J., Taylor, N., Chen, K., Maida, C.A., & Saltzman, W.R. (2008). Multi-informant assessment of maltreated children: Convergent and discriminant validity of the TSCC and TSCYC. *Child Abuse & Neglect*, 32, 621-625.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.
- Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (Eds.) (1996). *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications*. Washington DC: American Psychological Association.
- McKay, M.M., Lynn, C.J., & Bannon, W.M. (2005). Understanding inner city child mental health need and trauma exposure : Implications for preparing urban service providers. *American Journal of Orthopsychiatry*, 75, 201-210.

- Morey, L.C. (2008). *Personality Assessment Inventory – Adolescent (PAI-A)*. Lutz, FL: Psychological Assessment Resources.
- Meyers, J.E.B. (2002). The legal system and child protection. In J. E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, C. Jenny, & T. Reid (Eds), *The APSAC handbook on child maltreatment*. Thousand Oaks, CA: Sage.
- Myers, J.E.B., Berliner, L., Briere, J., Hendrix, C.T., Reid, T., & Jenny, C. (Eds.) (2002). *The APSAC handbook on child maltreatment, 2<sup>nd</sup> Edition*. Thousand Oaks, CA: Sage.
- Nader, K. (2007). *Understanding and assessing trauma in children and adolescents: Measures, methods, and youth in context*. NY: Rutledge.
- Najavits, L.M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York: Guilford.
- Ogata, S.N., Silk, K.R., Goodrich, S., Lohr, N.E., et al. (1990). Childhood sexual and physical abuse in adult patients with borderline personality disorder. *American Journal of Psychiatry*, *147*, 1008-1013.
- Ouimette, P., & Brown, P. J. (2003). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. Washington DC: American Psychological Association.
- Pearlman, L.A., & Courtois, C.A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress*, *18*, 449-459.
- Pennebaker, J.W. (1993). Putting stress into words: health, linguistic, and therapeutic implications. *Behaviour Research and Therapy*, *31*, 539-548.
- Perez, M.C., & Fortuna, L. (2005). Psychosocial stressors, psychiatric diagnoses and utilization of mental health services. *Journal of Immigrant and Refugee Services*, *3*, 107-124.
- Polusny, M. A., Rosenthal, M.Z., Aban, I., Follette, V.M. (2004). Experiential avoidance as a mediator of the effects of adolescent sexual victimization on negative adult outcomes. *Violence and Victims*, *19*, 109-120.
- Pitman, R.K., Altman, B., Greenwald, E., Longpre, R.E., Macklin, M.L., Poiré, R.E., & Steketee, G.S. (1991). Psychiatric complications during flooding therapy for posttraumatic stress disorder. *Journal of Clinical Psychiatry*, *52*, 17-20.
- Putnam, F.W. (1997). *Dissociation in children and adolescents: A developmental perspective*. New York: Guilford.
- Putnam, F. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*, 269-278.

- Pynoos, R., Rodriguez, N., Steinberg, A., Stuber, M., & Frederick, C. (1998). *The UCLA PTSD Index for DSM IV*. Los Angeles: UCLA Trauma Psychiatry Program.
- Pynoos RS, Steinberg AM, Piacentini JC (1999). A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. *Biological Psychiatry*, *46*, 1542-1554.
- Rayburn, N.R., Wenzel, S.L., Elliott, M.N., Hambarsoomians, K., Marshall, G.N., & Tucker, J.S. (2005). Trauma, depression, coping, and mental health service seeking among impoverished women. *Journal of Consulting and Clinical Psychology*, *73*, 667-677,
- Reynolds, W.M. (1988). *Suicide Ideation Questionnaire professional manual*. Odessa, FL: Psychological Assessment Resources.
- Reynolds, C. R., & Kamphaus, R. W. (2006). *Behavior Assessment System for Children*, 2<sup>nd</sup> Edition. NY: Pearson.
- Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, CA: Sage.
- Rimm, D. C. & Masters, J. C. (1979). *Behavior therapy: Techniques and empirical findings*. NY: Academic Press.
- Roid, G. H., & Fitts, W. H. (1994). *Tennessee Self-Concept Scale* [Rev. manual]. Los Angeles: Western Psychological Services.
- Runtz, M. & Briere, J. (1986). Adolescent "acting out" and childhood history of sexual abuse. *Journal of Interpersonal Violence*, *1*, 326-333.
- Schneir, A., Stefanidis, N., Mounier, C., Ballin, D., Gailey, D., Carmichael, H., & Battle, T. (2007). Trauma among homeless youth. *Culture and Trauma Brief*. Washington DC: National Child Traumatic Stress Network.  
([http://www.nctsnet.org/nctsn\\_assets/pdfs/culture\\_and\\_trauma\\_brief\\_v2n1\\_HomelessYouth.pdf](http://www.nctsnet.org/nctsn_assets/pdfs/culture_and_trauma_brief_v2n1_HomelessYouth.pdf))
- Schore, A.N. (2003). *Affect dysregulation and disorders of the self*. New York: Norton.
- Schwab-Stone, M., Ayers, T., Kaspro, W., Voyce, C., Barone, C., Shriver, T., & Weissberg, R.P. (1995). No safe haven: A study of violence exposure in an urban community. *Journal of the American Academy of Child and Adolescent Psychiatry*, *34*, 1343-1352.
- Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York: Guilford.
- Singer, M. I., Anglin, T. M., Song, L. Y., & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association*, *273*, 477-482.

- Stern, D.N. (2000). *The Interpersonal World of the Infant: A View from Psychoanalysis & Developmental Psychology*. New York: Basic Books.
- Taylor, S. (2003). Outcome predictors for three PTSD treatments: exposure therapy, EMDR, and relaxation training. *Journal of Cognitive Psychotherapy*, *17*, 149-161.
- Thompson, S. J., McManus, H., & Voss, T. (2006). Posttraumatic stress disorder and substance abuse among youth who are homeless: Treatment issues and implications. *Brief Treatment and Crisis Intervention*, *6*, 206-217.
- Tiet, Q.Q., Finney, J.W., & Moos, R.H. (2006). Recent sexual abuse, physical abuse, and suicide attempts among male veterans seeking psychiatric treatment. *Psychiatric Services*, *57*, 107-113.
- Van der Kolk, B.A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, *35*, 401 – 408.
- Van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F. S. , McFarlane, A., & Herman, J. (1996). Dissociation, affect dysregulation and somatization: The complexity of adaptation to trauma. *American Journal of Psychiatry*, *153*, 83-93.
- Van der Kolk, B.A., Roth, S.H., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, *18*, 389-399
- Webber, M. (1991). *Street kids: The tragedy of Canada's runaways*. Toronto: University of Toronto Press.
- Widom, C. & Kuhns, J. (1996). Childhood victimization and subsequent risk for promiscuity, prostitution, and teenage pregnancy: A prospective study. *American Journal of Public Health*, *86*, 1607-1612.
- Yates, G.L., MacKenzie, R., Pennbridge, J., & Cohen, E. (1988). A risk profile comparison of runaway and non-runaway youth. *American Journal of Public Health*, *75*, 820–821.
- Yates, G.L., Mackenzie, R.G., Pennbridge, J., & Swofford, A. (1991). A risk profile comparison of homeless youth involved in prostitution and homeless youth not involved. *Journal of Adolescent Health*, *12*, 545–548.
- Yehuda, R. (2004). Risk and resilience in posttraumatic stress disorder. *Journal of Clinical Psychiatry*, *Suppl 1*, 29-36.
- Young, B.H., Ruzek, J.I., & Ford, J.D. (1999). Cognitive-behavioral group treatment for disaster-related PTSD. In B. H. Young and D. D. Blake (eds.), *Group treatments for post-traumatic stress disorder* (149-200). Philadelphia: Brunner/Mazel, Inc.

Zlotnick, C., Donaldson, D., Spirito, A., & Pearlstein, T. (1997). Affect regulation and suicide attempts in adolescent inpatients. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36, 793-798.

## Appendices

## Initial Trauma Review – Adolescent version (ITR-A)

This semi-structured 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 PTSD or ASD.

1) [Childhood physical abuse] “*Has a parent or another adult who was in charge of you ever hurt or punish 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 question] “*Has anyone who was 5 or more years older than you ever do 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?*”

Yes\_\_ No\_\_

[NOTE: For sexual abuse only, this part is not necessary for PTSD Criterion A]

*"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 5 years older than you ever do 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 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\_\_

**7) [Partner abuse]** *"Have you ever been slapped, hit, or 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\_\_

**8) [Non-intimate 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\_\_

**9) [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\_\_

**10) [Police trauma]** *“In this country, 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\_\_

**11 . [Witnessing trauma questions]** *“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?”* [Not required for PTSD Criterion A]

Yes\_\_ No\_\_

## Assessment–Treatment Flowchart: Adolescent version (ATF-A)

**Client name** \_\_\_\_\_

Priority ranking (circle one for each symptom):

- 1 = Not currently a problem (re-evaluate at each interval): Do not treat
- 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

### Assessment period \_\_\_\_\_

#### Intake

<u>Problem area</u>	_____	_____	_____	_____
	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 stress	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. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)
17. Other: _____	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)	1 2 3 4 (S)

## Assessment-to-ATF grid

ATF item	Assessment (tests applicable only for relevant age ranges)
1. Safety – environmental	Adolescent self-report in session (A-S), parent/caretaker-report in session (C-R)
2. Caretaker support issues	A-S, C-R, and clinical impressions during parent interview
4. Anxiety	A-S, C-R, CBCL, BASC-2, PAI-A, MMPI-A, TSCC, TSRA, TSI,
5. Depression	A-S, C-R, CBCL, CDI, BDI-II, BASC-2, TSCC, TSRA, TSI
6. Anger/aggression	A-S, C-R, BASC-2 (parent report), CBCL, PAI-A, TSCC, TSRA
7. Low self-esteem	A-S, C-R, BASC-2, TSCS
8. Posttraumatic stress	A-S, C-R, PAI-A, MMPI-A, TSCC, TSRA, TSI, DAPS, UPID
9. Attachment insecurity	A-S, C-R, BASC-2, TSRA
10. Identity issues	A-S, C-R, IASC
11. Relationship problems	A-S, C-R, BASC-2, CBCL
12. Suicidality	A-S, C-R, PAI-A, TSRA, DAPS, SIQ
13. Safety – risky behaviors	A-S, C-R, BASC-2, TSI
14. Dissociation	A-S, C-R, TSCC, TSRA, DAPS, TSI
15. Substance abuse	A-S, C-R, BASC-2, PAI-A, DAPS
16. Grief	A-S, C-R

## **Problems-to-components grid**

<b><u>Problem (from ATF)</u></b>	<b><u>Treatment components that may be useful</u></b>
1. Safety (environmental)	Safety training, system interventions, psychoeducation
2. Caretaker support	Family therapy, intervention with caretakers
3. Anxiety	Distress reduction/affect regulation training, titrated exposure, cognitive processing, medication
4. Depression	Relationship building and support, cognitive processing, group therapy, medication
5. Anger/aggression	Distress reduction/affect regulation training, trigger identification/intervention, cognitive processing
6. Low self-esteem	Cognitive processing, relational processing, group therapy, relationship building and support
7. Posttraumatic stress	Distress reduction/affect regulation training, titrated exposure, cognitive processing, psychoeducation, relationship building and support, trigger identification/intervention, medication
8. Attachment insecurity	Relationship building and support, relational processing, group therapy, family therapy
9. Identity issues	Relationship building and support, relational processing
10. Relationship problems	Relationship building and support, relational processing, cognitive processing, group therapy
11. Suicidality	Safety training, distress reduction/affect regulation training, cognitive processing, systems intervention
12. Risky behaviors and tension-reduction behaviors	Psychoeducation, safety training, cognitive processing, titrated exposure, trigger identification/intervention
13. Dissociation	Distress reduction/affect regulation training, affect regulation training, emotional processing, trigger identification/intervention
14. Substance abuse	Trigger identification/intervention, titrated exposure, distress reduction/affect regulation training, medication
15. Grief	Psychoeducation, cognitive processing, relationship building and support

## **Written homework about my trauma**

This homework has to do with the trauma that you and your therapist agreed that you should write about. 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 sheet, 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? Please write as much about it as you can, below.**

**2. What were your feelings when it happened? What was the worst feeling?**

**3. What did you think right when it started happening? What did you think after it was over?**

**4. What happened afterwards? What did you do?**

**5. What did people say to you, after it happened, if they found out?**

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

**7. Is there anything about what happened that made you stronger or better?**

## What Triggers me?

**Times I have been triggered (pick up to 5):**

1.

2.

3.

4.

5.

**What happened after I got triggered:**

**Trigger #**

**What I thought after this trigger**

**What I felt after this trigger**

**What I did after this trigger**

1.

2.

3.

4.

5.

**What kinds of things trigger me:**

1.

2.

3.

4.

5.

**How I know I've been triggered:**

1.

2.

3.

4.

5.

**What I could do or say to myself so that I wouldn't get triggered, or for the trigger to be less bad:**

1.

2.

3.

4.

5.