

Kliethermes, M. D., & **Wamser, R. A.** (2012). Applications for youth with complex trauma. In J. Cohen, A. Mannarino, & E. Deblinger (Eds.), *Applications of TF-CBT for Children and Adolescents* (pp. 175- 196). New York: Guilford Press.

Introduction

Most clinicians working with a traumatized child population will encounter at least one adolescent who has experienced severe or multiple traumatic events. In fact, these teenagers represent the reality of a traumatized population (Finkelhor, Ormrod, & Turner, 2009). Not surprisingly, survivors of prolonged and repeated traumatic events often present with a more complicated symptom picture, as compared to those who were more acutely traumatized (Cook, Blaustein, Spinazzola, & van der Kolk, 2003; van der Kolk, 2005). Beyond PTSD, these adolescents have a myriad of difficulties across several domains of functioning. In an effort to better capture the reality of this symptom presentation, the term complex trauma was developed (Herman, 1992). Complex trauma has a dual definition, referring to both a specific type of traumatic exposure as well as the devastating impact that such a trauma history leaves in its wake (Cook et al., 2003). Complex trauma events are typically defined as traumas which are multiple, chronic, and interpersonal in nature and begin at an early age such as severe sexual or physical abuse, neglect, witnessing domestic violence, or the experience of a refugee camp (Cook et al., 2005). Thus, complex trauma events are best conceptualized as a subset of events typically defined as traumatic by the diagnostic category PTSD.

Exposure to complex trauma is, predictably, toxic. Resources that would have been allocated for development are instead used for survival to cope with the unstable, frightening, and overwhelming complex trauma environment (Cook et al., 2003). In the face of such stress, the youth's limited ability to cope is depleted- they lose, or never develop, the ability to regulate

themselves. In fact, dysregulation is cited as the hallmark characteristic of children and adolescents who have experienced complex trauma (Spinnazola et al., 2005). The inability to regulate oneself results in a broad range of difficulties across various contexts. The impact of complex trauma then does not easily lend itself to a specific list of behavioral symptoms. Instead, broad domains of impaired functioning have been observed including difficulties of regulation in affect, behavior, biology, attention and cognition, self, and relationships with others (Cook et al., 2005; van der Kolk, 2005). Complex trauma is not currently formally recognized by any diagnostic construct but has been described in two potential diagnostic categories, namely, Disorders of Extreme Distress Not Otherwise Specified (DESNOS) and Developmental Trauma Disorder (DTD), which have been proposed for inclusion in DSM-IV and DSM-V (Roth, Newman, Pelcovitz, van der Kolk, & Mandel., 1997; van der Kolk, 2005).

Why Adaptations of TF-CBT Are Necessary

Working with a complex trauma population has many unique challenges that necessitate adaptations to the Trauma-Focused Cognitive Behavioral Therapy model (TF-CBT; Cohen, Mannarino, & Deblinger, 2006). TF-CBT effectively addresses trauma-related symptoms, such that following treatment, the child or adolescent will return to pre-trauma functioning. For survivors of complex trauma, this goal may not be initially feasible. For many, the traumatic events began so early in life and with exhausting regularity such that there is no prior baseline to return to. For them, trauma has become a “way of life.” Further, whether the result of continuing consequences from the traumatic event or from the youth’s struggles, their environment often remains chaotic during treatment, and legitimate crises occur frequently (Cook et al, 2003). The youth may experience a placement change, enter a residential treatment facility, the parental rights of their parents may be terminated, or they may be expelled from

school. Ongoing chaos tends to characterize the lives of complex trauma survivors. These crises are often not attempts to avoid trauma-related content but instead are relevant challenges that require attention in treatment. Effective trauma-focused treatment, however, requires multiple, uninterrupted sessions focused on processing trauma-related content (Cohen, Mannarino, & Deblinger, 2006). Trauma work may then dissolve into a series of “starts and stops” as these crises occur. Continuing to only process past events irrespective of current pressing issues is ill-advised as this can result in a serious breach in the often tenuous therapeutic relationship.

The laundry list of presenting problems in a complex trauma population also necessitates adaptations to the TF-CBT model. First, complexly traumatized adolescents have often experienced a variety of inconsistent and unpredictable interpersonal experiences, ranging from inappropriate closeness, indifference, and victimization (Cook et al., 2003). Survivors of complex trauma may be distrustful of others, view others as being unpredictable, uncontrollable, and hostile. These attachment difficulties are brought with them to the therapeutic relationship (Courtois, 1999). It is not uncommon for the adolescent with a complex trauma history to initially present as being highly guarded or avoidant for weeks to months. The consistency and attunement of a good therapist may be a foreign experience to an adolescent survivor of complex trauma as even this typically benign aspect of the therapeutic relationship may be anxiety provoking (Courtois, 2004). Trauma work necessitates a solid working alliance, as, for example, exposure work ideally occurs in the context of a safe environment with a supportive therapist. Given the attachment issues that adolescents with complex trauma may present with, special therapeutic strategies may be needed to advance treatment.

Dysregulation characterizes the complex trauma population and often permeates various domains of functioning including, affect, behavior, cognition, and self-concept (van der Kolk,

2005). These youth are excessively reactive to events in their environment. Such self-regulation difficulties typically result in significant, ongoing adversity for these youth. For example, emotional and behavioral dysregulation may contribute to the adolescent becoming enraged at a teacher who is criticizing them and then pushing the teacher against a wall resulting in expulsion from the school. Aggressive behavior toward a foster parent may result in the disruption of that placement and subsequent placement in a residential facility. Again, these scenarios could create interruptions in TF-CBT treatment and in particular, make the gradual exposure work choppy, inefficient, and potentially unsuccessful. Further, survivors of complex trauma often present with developmental capacities that resemble those of a much younger child such as difficulty identifying an affective state or even knowing when one is hungry (Ford, 2009).

In light of these issues, the adolescent with a history of complex trauma is ill-equipped to jump into trauma-focused treatment. However, TF-CBT is the most researched evidence-based practice for treating children and adolescents exposed to traumatic events (Cohen, 2010).

Although TF-CBT was not developed specifically for complexly traumatized youth, with some adaptations, TF-CBT can be effective for these adolescents. The PRACTICE components of TF-CBT (i.e., Psychoeducation, Parenting, Relaxation, Affective Regulation, Cognitive Coping, Trauma Narrative and Processing, In Vivo Exposure, Conjoint Sessions, and Enhancing Future Safety and Development; Cohen, Mannarino, & Deblinger, 2006) can be adapted to address the myriad of impairments observed in this population. However, when these youth enter treatment they may not be optimally prepared to benefit from these types of interventions without some adaptation. The instability of their environment and the severity of their own emotional and behavioral difficulties may greatly interfere with their ability to receive the full benefit of a short-term, structured treatment targeting symptoms of posttraumatic stress.

Assessment of Complex Trauma Events and Outcomes

Complexly traumatized youth often present to treatment with a chaotic environment, several experiences of traumatic events, and a variety of chronic difficulties, one of which is often attachment problems (Cook et al., 2005). These adolescents may not, however, bring a long-term, informed caregiver to treatment. Thus, a few helpful assessment strategies may be worth mentioning. First, in light of the complicated lives these survivors have lived, the assessment process may be better conceptualized as an unfolding onion. Therapists are advised to follow the pace of the adolescent, obtaining what information is available (Ford et al., 2005). The therapist is unlikely to obtain all of the relevant information in the first three sessions. For these survivors, it may take months for them to trust the therapist to discuss their current difficulties. As treatment progresses, the adolescent's symptom presentation and functioning may appear worse (Taylor, Gilbert, Mann, & Ryan, 2008). This may not reflect a deterioration of behavior but instead is a by-product of the adolescent being more honest about or even aware of their difficulties.

Second, in the absence of a traditional caregiver, the therapist is advised to attempt to obtain relevant information from other sources such as a caseworker or teacher. However, sometimes crucial information is lost due to "systemic flux" (e.g., caseworker changes). Adolescents are often reluctant or unable to provide early life information; therefore, the therapist may have "gaps" in the adolescent's background history. Third, as in any trauma population, the clinician is advised to be mindful of the adolescent's level of arousal. Clinicians should be sensitive to triggering or flooding the client when inquiring about traumatic events and remain within the "therapeutic window" (Briere, 1996a). That is, the client should neither be over or underwhelmed, while still providing relevant clinical and historical information. The

therapist is also advised to inquire about traumatic events in a supportive although neutral way (Courtois, 2008). The assessment process can engender some feelings of distress; however, this is normal and often temporary. It is prudent to only administer measures in the clinician's presence, allowing the clinician to both assess the adolescent's level of arousal as well as ask important follow-up questions.

Assessing Traumatic Exposure. For a complex trauma population, a thorough assessment of exposure to traumatic events is important. By definition, they have experienced multiple traumatic events which may have been perpetrated by more than one individual over several years. Without knowledge of an adolescent's complete exposure to trauma, trauma-related difficulties could be misattributed to a single traumatic event. Obtaining this history, however, is not easy. The therapist should not assume that inquiring about traumatic events will result in a disclosure (Courtois, 2004). Structured assessment tools can be useful as they prompt the clinician to assess to multiple traumatic events. Clinicians should be aware of some of the details surrounding the traumatic event such as the child's age, length of the trauma, the identity of the perpetrator, and the severity of the trauma. Additionally, other developmentally adverse, but non-Criterion A events, such as emotional abuse, separations from caregivers, exposure to caregiver substance abuse, or mental illness should be inquired about. Complexly traumatized adolescents too often have been deeply affected by the aftermath of the trauma as they may experience significant secondary adversity such as court or legal processes, being removed from their home, multiple foster placements or going to a residential treatment facility. Thus, it is wise to take a broader sense of what "trauma" consists of for this population.

Assessing complex trauma outcomes. The broad domains of impairment observed in a complex trauma population do not easily lend themselves to a single diagnostic construct. Thus,

no assessment tool will be sufficient in describing this symptom presentation (Briere & Spinazzola, 2005). Currently, a complex trauma assessment tool (i.e., SIDES, Pelcovitz et al., 1997) exists only for adults. Clinicians are advised to make an "educated guess" about what areas of impairment are likely to be important to assess (Briere & Spinazzola, 2005). As a general rule, it is likely helpful to use assessment tools that examine multiple areas of functioning). It is preferable to obtain information about trauma-related symptoms from multiple informants (Cohen, 2010). Below are some assessment tools which may be useful in assessing the various domains of complex trauma.

Affect: Trauma Symptom Checklist for Children (TSCC; Briere 1996b), Multiphasic Personality Inventory-A (MMPI-A; Butcher et al., 1992)

Attention: Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 2004), Conner's (Connors, 2008), Child Behavior Checklist (CBCL; Achenbach, & Rescorla, 2001), Teacher Report Form (TRF; Achenbach, & Rescorla, 2001)

Behavior: CBCL, BASC, Connors, TRF

Biology: CBCL; MMPI-A (Subscale 1), Youth Self Report (Achenbach, & Rescorla, 2001)

Dissociation: TSCC, CBCL (Thought Problems subscale)

Cognition: Wechsler Intelligence Scale for Children (WISC; Wechsler, 2004), Stanford-Binet, (Roid, 2003) CBCL, BASC, Connors, TRF

Self: MMPI-A

Phase-Based Treatment for Complex Trauma

Treating adolescent survivors of complex trauma can be a complicated, overwhelming process as the demands and needs of the adolescent are varied, intense, and rapidly changing. It can be argued that no "gold standard" treatment exists for this population as of yet. However,

various experts have posited that a phase-based approach to treatment is best (Cook et al., 2005; Ford et al., 2005; Herman, 1992). In a phase-based approach, treatment is sequential, with each phase of treatment building upon the next, although they may not always proceed in a linear fashion and the therapist and client may return to a previous stage as needed (Courtois, 1999). Phase-based approaches then are sensitive to the chaos and changing needs of this population. Several phase-based approaches have been developed for complex trauma survivors. Ford and colleagues (2005) describe one approach, consisting of three phases: engagement, safety, and stabilization; recalling traumatic memories; and enhancing daily living. Briefly, in phase 1, the therapist largely works to form a working alliance and increase the youth's sense of safety. This is no small feat, in light of the often observed attachment problems and environmental instability characteristic of this population. The second phase of treatment directly focuses on trauma-related content and processing of traumatic memories, which can occur at a safe, manageable pace through titration of exposure intensity and the utilization of self-regulation skills learned in Phase 1. When symptoms of posttraumatic stress have become manageable, the therapist and client move to Phase 3, which is focused on helping the client to work toward a healthy, balanced lifestyle that is not ruled by trauma.

When working with adolescent survivors of complex trauma, TF-CBT is designed so that it can be implemented as a phase-based treatment. Specifically, the TF-CBT PRACTICE components can be implemented to address the three goals of phase-based treatment. Initially, the PRACTICE components can be used to facilitate the development of safety, stability and engagement, while incorporating gradual exposure by helping the adolescent identify and tolerate trauma cues. The skills developed through the application of the PRACTICE components to enhance safety and stability can then in turn be used to facilitate the Trauma

Narrative and Processing component. This component of TF-CBT clearly addresses the phase-based treatment goal of processing traumatic memories. Finally, the PRACTICE components can also be used to help the adolescent plan for and develop a healthy, balanced future that is no longer dominated by their experience of complex trauma. The skills and knowledge the adolescent gained while applying the PRACTICE components to establish safety and stability and to process their traumatic memories can finally be used to help them navigate through their “post-trauma” life in a healthy and satisfying manner. To address the specific needs of adolescent survivors of complex trauma some adaptations with regard to the order, scope, and emphasis of the PRACTICE components are recommended. Fortunately, TF-CBT was designed to be a flexible model that could be adapted to meet the specific needs of individual clients. Therefore, it is not believed that these adaptations are in anyway incompatible with the TF-CBT model. The following sections provide an overview of the implementation of TF-CBT with this population.

Facilitating Engagement, Safety, and Stability through TF-CBT

Fostering Engagement

Fostering engagement with a complexly traumatized adolescent can be challenging. However, this phase is paramount. The importance of the therapeutic relationship cannot be emphasized enough. Beyond establishing rapport with the client, the therapist must establish trust with them. The former can usually be accomplished rather quickly; the latter can be more slow-going. Although these youth often crave supportive relationships, the formation of a relationship may seem threatening due to their numerous experiences of interpersonal trauma. The therapist will often have to pass many tests from the adolescent to demonstrate that they are trustworthy and safe. Therefore, this stage of treatment may need to be expanded beyond what

would typically be allotted during TF-CBT. There is “no short-cut to developing trust” (Briere, 2002 p. 13-14). A therapist may spend up to eight sessions building engagement. However, these sessions should not be used to just “play games.” Instead, the therapist should be actively working towards stabilization, initiating contact with the other “systems” in the client’s life, and addressing any safety concerns. Being patient and consistent is often an effective intervention in and of itself, as this is often counter to what this population usually experiences. During the engagement process, the adolescent is being exposed to their discomfort with intimacy through the development of a safe and secure relationship with the therapist. Here, the adolescent is “gradually exposed” to the therapist. In this portion of treatment, the therapist should consider the therapeutic relationship to be a potential trauma cue, and expose the client to the relationship in a gradual, controlled fashion. The therapist needs to attend to the client’s distress level during therapeutic interactions to ensure that the client does not become overwhelmed and “titrate” the therapeutic relationship by varying the intensity of the interaction as appropriate (e.g., ask fewer questions, direct conversation to a more neutral topic, break up conversations with activities). The therapist may choose to allow the adolescent to familiarize themselves with and give appropriate control over the therapeutic environment (e.g., allowing the adolescent to pick where they and the therapist sit). Early on, the therapist may need to be less directive and structured, as doing so may be perceived as coercive and threatening by the adolescent. In general, engagement can be accomplished by focusing on developing a therapeutic relationship explicitly based on respect, open sharing of information, empowerment, and the installation of a sense of hope (Pearlman & Courtois, 2005).

Enhancing Future Safety and Development

The Enhancing Safety and Future Development component of TF-CBT may need to be prioritized early due to the common presence of safety concerns such as self-injurious behavior or exposure to violence or bullying. Here, the therapist will work to develop safety plans, identify safe people and places, in addition to assertiveness training and problem-solving. Given the distrust that adolescent survivors of complex trauma often have toward authority figures (e.g., police officers) it is important to work with the adolescent to identify appropriate people they trust and are willing turn to when they feel threatened. Addressing safety concerns often requires systemic work. Caring adults in the youth's life may need to be trained to address youth deficits that impact safety, or may need to be contacted to address environmental factors that are contributing to safety concerns such as bullying at school, or exposure to potential emotional abuse in a foster home.

Psychoeducation

The Psychoeducation component is initially devoted to educating the youth and applicable caregivers on the impact of stress and trauma on the adolescent's current functioning. Information should be provided regarding the definition of stress, common responses to stress and trauma, the rationale for stress responses (i.e., to alert an organism to the presence of potential danger), and common coping mechanisms (both healthy and unhealthy). The youth and their caregiver(s) are helped to understand the adolescent's emotional and behavioral dysregulation as overreactions to stress rather than as willful misbehavior. It is helpful to also describe the concept of trauma triggers. These adolescents need to be helped to learn how to react differently from their habitual fight, flight, freeze reactions (Briere & Scott, 2006). The therapist can also discuss that because of past interpersonal trauma, the adolescent has made adaptations to the way they interact with people to promote a sense of safety. Time should be

spent helping the adolescent and caregiver identify their own adaptive and maladaptive responses to stress. This discussion can establish the rationale, and increase buy-in, for the subsequent skill-building components.

Parenting

If a caregiver is available, parenting work occurs through the therapist modeling appropriate engagement strategies for the caregiver both in the therapist's interactions with the client and the caregiver themselves. However, often the adolescent does not present to treatment with a traditional caregiver. Thus, for this population, the "parenting" component of TF-CBT is often more accurately conceptualized as the "systems" component, and includes any caregiver or authority figure that plays a significant role in the youth's life. Commonly, this is accomplished by increasing the frequency of safe, positive interactions between caregivers and the adolescent (e.g., planning a weekly outing) and reducing the relational damage caused by negative interactions (e.g., decreasing the caregiver's reliance on physical punishment) and signals of danger (e.g., a teacher repeatedly criticizing the adolescent in front of peers). The goal is to create a "trauma-informed" system of caregivers and professionals working with the adolescent. All significant caregivers and professionals should be helped to accurately identify trauma-related behaviors as misplaced, excessive survival responses rather than as intentional misbehavior or manipulation. If all systemic entities are aware of the relaxation strategies the adolescent has learned, they can help facilitate the use of those strategies at times when the adolescent is becoming distressed. Due to their tendency for distrust, these adolescents are likely to be suspicious of the contact the therapist has with various systemic entities. The therapist should be relatively transparent with the adolescent, informing them of who the therapist is talking to, what information is being exchanged, and the purpose of that interaction.

Relaxation

Here, it is often important to validate the coping strategies that the adolescent has used previously. Previously used positive coping strategies can be incorporated and the therapist should demonstrate understanding for the use of less adaptive strategies. The therapist should note that the strategies represented the adolescent's best efforts to deal with stress, although it may be associated with some negative consequences (e.g., getting into legal trouble for marijuana possession). Extensive time may be needed to help the adolescent recognize the difference between "stressed" and "relaxed" states, as their neurobiological "alarm" system is typically overreactive (Ford, 2005). Therefore, physically-based activities that accentuate the difference between tension and relaxation (e.g., yoga, stretching, progressive muscle relaxation) may be initially more beneficial as opposed to cognitively-based activities (e.g., imagery, positive self talk). Self-soothing and distraction techniques may also be helpful, as these are often strategies that they are more familiar with and may already utilize in some fashion, such as listening to music, playing video games, or taking a hot bath. However, these adolescents may need help using these strategies in a more systematic fashion, and developing awareness of the potential for overuse of these strategies (e.g., failing to study for a test due to playing video games all night).

Affective Regulation

Affective regulation for adolescent survivors of complex trauma is typically focused on increasing the adolescent's awareness of and ability to express and manage emotions in day-to-day life. In this phase, affective regulation primarily occurs through the therapist's use of attunement to help the adolescent identify and express the emotions they are experiencing during sessions and the therapist's modeling of effective expression and regulation of their own

emotions in session. Here, the therapist begins to introduce some of the following: the role of emotions in daily life; that all emotions are valid and acceptable, language for different emotional states; that emotions can be experienced at different levels of intensity; that multiple emotions can be experienced at the same time, that negative affect states are temporary and can be tolerated; and that effectively communicating emotions can alleviate their intensity and help secure support from others. This component may be initially challenging as many adolescent survivors present with emotional numbing or dissociative responses. These responses are best conceptualized as being protective adaptations that are no longer adaptive. The therapist may have to spend more time highlighting the function of emotions; that is, that emotions provide useful information about the environment.

Cognitive Coping

The cognitive coping component is initially focused on helping the adolescent to increase their awareness of their cognitions during stressful experiences. The therapist may teach the cognitive triangle and use it to analyze recently experienced conflicts or crises. This process helps the adolescent to realize that thoughts they experience during stressful situations may increase their likelihood of becoming distressed and engaging in problematic behavior. The adolescent can also develop cognitive coping strategies (e.g., positive self talk) that can be used to improve their response to stressful life events. Furthermore, using the cognitive triangle to process current stressors may also help the therapist and adolescent to identify various triggers or “signals of danger” that are contributing to the distress they are experiencing in the moment. Additionally, this component can be used to process current stressors and crises to help achieve the goal of stabilization while also providing practice for later processing of traumatic memories during the trauma narrative. Furthermore, current stressful situations experienced by adolescent

survivors of complex trauma often involve the presence of trauma cues (e.g., a chronically, emotionally abused adolescent being criticized by a teacher). Therefore, in true TF-CBT fashion, gradual exposure is also incorporated into the stabilization process.

Conjoint Sessions

Assuming the presence of a caregiver, conjoint work in TF-CBT is also used to facilitate engagement and stability. Research supports the importance of caregiver inclusion in the reduction of behavior problems within TF-CBT (Deblinger, Lippman, & Steer, 1996) and general treatment Spoth, Nepl, Goldberg-Lillehoj, Jung, & Ramisetty-Mikler, 2006). Thus, these sessions are likely critical for stabilization. Due to disrupted attachment, the relationships between adolescent survivors of complex trauma and their caregivers are often strained and dysfunctional (Briere & Spinazzola, 2005). Complex trauma also typically occurs in the context of a caregiving relationship. For adolescent survivors of complex trauma, the simple act of engaging with a caregiver may be a trauma cue resulting in dysregulation. Therefore, conjoint sessions provide valuable “in vivo” opportunities to gradually expose the adolescent to these cues and further the development of a supportive, appropriate caregiving relationship that will help to better address dysregulation. These sessions are used to practice decreasing “signals of danger” while increasing “signals of care” (Saxe et al., 2007), and allow the therapist to model appropriate supportive behavior. Consistent contact with a supportive, appropriate caregiver will facilitate counterconditioning of the adolescent’s experience of being victimized by prior caregivers. Furthermore, conjoint sessions can facilitate the caregiver’s ability to coach the adolescent to use coping skills. Conjoint sessions in TF-CBT are also used for the adolescent to share their experience of stressful situations with the caregiver, including informing the caregiver of the various trauma triggers they have identified, thus helping the caregiver to develop a better

understanding of the factors behind the adolescent's self-regulation difficulties. Assuming a supportive reaction, this conjoint work helps decrease the adolescent's reluctance to discuss future self-regulation difficulties with the caregiver.

Achieving "Good Enough" Stability

The decision to transition to processing traumatic memories can be difficult. Prior to doing so, it is important that the adolescent has made significant progress with regard to the establishment of engagement, safety, and stabilization. It is prudent to delay the initiation of trauma processing if the therapist is aware of significant upcoming changes or stressors such as a placement change, termination of parental rights, or reunification. The adolescent's environment needs to be sufficiently stable and safe for the therapist to determine that a significant interruption in the Phase 2 process of recalling traumatic memories is unlikely. However, perfect stability is not required, as "crises of the week" will likely continue to occur. Instead the goal of the therapist is to determine if the adolescent has achieved "good enough" stability. The therapeutic relationship should be stable, allowing the therapist to continue to serve as a model for "safe and nonintrusive co-regulation" while facilitating the adolescent's ability to more directly process traumatic memories (Ford et al., 2005). Finally, the adolescent needs to have demonstrated sufficient mastery of self-regulation skills to tolerate direct exposure to traumatic memories; otherwise exposure can be re-traumatizing.

Facilitating Trauma Processing with Adolescent Survivors of Complex Trauma

Psychoeducation

Psychoeducation occurs throughout the TF-CBT model, including during the trauma narrative component. For adolescent survivors of complex trauma, Psychoeducation serves multiple purposes. The therapist should carefully and transparently explain the rationale for

trauma processing. Initially, Psychoeducation is focused on providing a rationale for the processing of traumatic memories. Due to affective numbing and cognitive distortions (e.g., exposure to violence is not a big deal because it's just a part of life), a rationale for trauma processing that focuses on desensitization may not be sufficient or effective. Instead, the rationale may need to focus on the importance of uncovering the meanings the adolescent made (e.g., other people cannot be trusted) and how that meaning affects current functioning (e.g., avoiding intimacy). Providing concrete examples of how "the past informs the present" can be very helpful. The adolescent will also receive education regarding chronic, interpersonal trauma, focusing on prevalence and relevant mediating factors, and its impact. This can be helpful in addressing inaccurate and/or unhelpful trauma-related beliefs that the adolescent may be holding (e.g., "I deserved to be beaten, I am a bad kid").

Parenting Skills

Parenting and systemic work remain important. Again, the focus is to ensure that all involved parties are utilizing appropriate engagement and behavior management strategies with the adolescent. This remains a critical issue as the adolescent's level of distress and subsequent behavioral problems may temporarily worsen when the processing of traumatic memories is initiated. All significant care providers should be warned of this possibility and trained to respond in a fashion that is supportive and positive rather than rejecting and critical.

Relaxation, Affective Regulation, Cognitive Coping

During trauma processing, Relaxation, Affect Education, and Cognitive Coping components will largely take the form of review. As needed, the therapist will review the knowledge and techniques learned to help the adolescent learn to apply those skills to the processing of traumatic memories. Specifically, the adolescent learns to utilize relaxation skills

in the context of trauma processing in order to help them manage their distress level and achieve desensitization to the traumatic memories. The affective regulation component is used to help the adolescent identify and monitor their level of distress during trauma processing work (e.g., through use of the SUDS scale) and to facilitate the richness and depth of trauma processing by giving them adequate language to describe their experience of traumatic events. Similarly, the adolescent will learn to use cognitive coping skills to help them cope with distress associated with trauma processing (e.g., positive self talk) and to process their traumatic memories more effectively by helping them identify what they thought about those events as they occurred. The application of these components during trauma processing is consistent with traditional TF-CBT. However, it should be noted that adolescent survivors of complex trauma often initially have less capacity to tolerate trauma processing than more acutely traumatized youth who experienced adequate development. Furthermore, these adolescents typically have less emotional awareness and are more likely to utilize affective numbing and dissociation as coping mechanisms. Therefore, rather than waiting for the adolescent to express feelings of distress verbally or behaviorally (e.g., facial expressions), it is important for the therapist to be proactive with encouraging the adolescent to check their distress level and practice self-regulation skills routinely throughout the session.

Trauma Narrative and Processing

For adolescent survivors of complex trauma, the Trauma Narrative and Processing component remains the core phase of TF-CBT. However, the narrative component may require significant adaptation for adolescent survivors of complex trauma. First, for these youth, many of their traumatic experiences occurred a relatively long time ago or they may not have an explicit, verbal memory of the event if it occurred prior to age three (Green, Crenshaw, & Kolos,

2010). Processing these memories in the traditional sense then is not possible. Further, a detailed chronological account of traumatic events may be very different from youth exposed to a more acute form of trauma as they may be more confused, indistinct, and sometimes very difficult to retrieve. It may also not be feasible or even appropriate to complete a detailed account of each traumatic event that the youth experienced as to do so would result in a very long narrative that would require many sessions to complete. A general rule of thumb is to allow the adolescent to guide what events or experiences should be included in the trauma narrative (Cohen et al, 2006). As mentioned above, many adolescent survivors of complex trauma do not present with classic symptoms of PTSD. Thus, desensitization in the traditional sense may not be as vital. Often the meaning attributed to the events depicted in the trauma narrative is of greater importance than repeated processing of the details of the trauma.

In Vivo Mastery

For adolescent survivors of complex trauma, their early experience of chronic trauma, often not tempered by periods of safety or adequate development, becomes the lens through which they interpret later events. Subsequently, even relatively innocuous situations tend to be littered with perceived threats of danger, which result in the adolescent becoming increasingly distressed and dysregulated. Therefore, the In Vivo Mastery component of TF-CBT is often of critical importance to these youth as they need to develop the capacity to self-regulate sufficiently to tolerate uncomfortable, but essentially safe situations. For example, an adolescent who was emotionally and physically abused by his father may become intensely dysregulated in response to his football coach taking a “tough love” approach during practice. Although the adolescent is not actually in danger, it will likely require significant self-regulation for them to not act as though they were. In truth, for adolescent survivors of complex trauma, in

vivo work often needs to be initiated early in treatment to facilitate the development of stability and engagement. However, following completion of trauma processing, the therapist and adolescent may develop a better understanding of what environmental cues are actually triggering the adolescent. Initially, it may have been clear what situations were distressing, but following trauma processing, the adolescent will likely develop a better understanding of why those situations have become triggers. This awareness may cause in vivo mastery work to become more successful as the adolescent will be able to use more targeted coping and problem solving strategies.

Conjoint Sessions

As adolescent survivors of complex trauma often do not have access to a traditional caregiver, foster parents and case workers may be options to fill the caregiver role. However, these adolescents may not have a secure, trusting relationship with these individuals such that they may not wish to disclose details of their trauma history. They may also fear that the information disclosed could result in unintended consequences such as disrupting reunification with their biological parent. The therapist should not “force” a caregiver upon the adolescent for the sake of conjoint work. Instead the therapist and adolescent should collaborate on identifying possible individuals and exploring their involvement. It is the therapist’s responsibility to ensure that the possible caregivers identified possess appropriate self-regulation skills and are capable of giving an appropriate, supportive response to the adolescent during conjoint sessions. Though the involvement of an appropriate caregiver is optimal, it should be made clear to the adolescent that they have the option of not involving a caregiver if they do not feel comfortable.

Enhancing Future Safety and Development

With adolescent survivors of complex trauma, ongoing safety concerns continue to be important during the trauma narrative component. Despite the best efforts of the therapist, it is not possible to ensure that no safety concerns will arise after the processing of trauma memories has been initiated. It is necessary to occasionally discontinue trauma work if the adolescent is at risk (i.e., cutting their wrists following session). However, this is not ideal. A break from trauma processing should be done in a mindful manner. The therapist, adolescent, and caregiver (if applicable) should collaboratively reach an agreement to temporarily discontinue trauma processing work for a specified number of sessions. During that time period efforts are directed at helping the adolescent cope more effectively with the situation and working with the system to reduce risk (e.g., developing a safety plan with staff at the adolescent's residential facility). When sufficient stability has been established, trauma processing can resume.

Completing Trauma Processing

Processing the experience of complex trauma is a (forgive the pun) complex endeavor. The traumatic experiences of these youth often impact every facet of their life with seemingly unending ramifications. Therefore, determining when their traumatic experiences have been sufficiently processed is difficult. When PTSD symptoms become manageable, this phase of treatment is viewed as being complete (Cohen et al., 2006; Ford et al., 2005). The adolescent should be able to experience trauma cues without experiencing significant emotional or behavioral difficulties. They should be able to experience and recognize trauma memories and cues in the present, while being able to distinguish them as representations of past events and not indicative of current danger. The adolescent should also have a sense of meaning regarding their traumatic experiences. In essence, the goal is that the adolescent is able to identify their trauma

exposure as only a part of their life rather than the totality of it, and as an experience from which they can learn and grow as they venture into a more hopeful future.

Enhancing Future Safety and Development through TF-CBT

Psychoeducation

As typically occurs in TF-CBT, Psychoeducation is an important aspect of enhancing future safety and development for adolescent survivors of complex trauma. The focus of this psychoeducation involves identifying and normalizing the various challenges that the adolescent will likely experience throughout their lives. It is important to discuss the potential for future trauma triggers that the adolescent may not have encountered yet (e.g., graduating from therapy, sexual activity, becoming a parent, the death of a parent). It is essential that these challenges are described as being a part of the normal, anticipated process of recovery and not indicative of regression or failure. For adolescent survivors of complex trauma this is very important, as they may be more likely to continue to experience chaotic, stressful situations after the completion of TF-CBT (e.g., residential care, foster placement, dangerous communities). Given the findings of the ACE study (Anda et al., 2006); it is also important to provide the adolescent with information regarding healthy lifestyle choices (e.g., diet, exercise, substance use) in an attempt to reduce the potential health risk factors associated with exposure to childhood adversity. Further, these youth never learned critical life skills. The adolescent will then also benefit from access to various life skill training opportunities including, applying and interviewing for jobs, financial budgeting, and housing options and be provided with information regarding various resources that may be available to them as adults (e.g., assisted living programs, support groups, government funded services and programs).

Parenting

Following trauma processing, it is important to assist the adolescent's caregiver and any relevant systemic entities in facilitating the adolescent's growth and development. It is helpful to work with caregivers to identify appropriate expectations and responsibilities for the adolescent as they move toward adulthood. Many caregivers have difficulty trusting the adolescent's capacity to handle new situations and may need encouragement to allow the adolescent more freedom and responsibility within appropriate limits. For adolescent survivors of complex trauma, especially those in the child welfare system, it is very important to help systemic entities focus on planning for the adolescent's future. Adolescents "aging out" of the system often experience abrupt changes in their placement status and the services they receive. It is vitally important that the therapist help the adolescent communicate their needs to appropriate systemic entities and work with those entities to help ensure that those needs are met. The therapist may also need to work with the caregiver and/or systemic entities to determine who the adolescent's support system will be when they reach majority status. Many youth who age out of the foster care system and no longer have contact with their biological family may find themselves isolated and lacking social support. Ensuring that the adolescent has at least one trusted individual to whom they can turn may be vital to their long-term well-being.

Relaxation, Affective Regulation, Cognitive Coping

Here, the adolescent works to perfect their Relaxation, Affective Regulation, and Cognitive Coping skills and generalize them to a larger range of situations. At this point in treatment it is expected that the adolescent is poised to more fully participate in developmentally appropriate activities and take on new responsibilities (e.g., dating, employment, college). This combination of unfamiliar situations and increased expectations will likely be distressing for the adolescent. Therefore, coaching the adolescent to utilize the previously learned skills to better

cope with these situations is of paramount importance. Furthermore, given the future orientation of this component, time should also be spent on preparing the adolescent to use these skills in situations that they may encounter after therapy has been completed. For example, with an adolescent who is interested in having children in the future, the therapist may focus on increasing the adolescent's awareness of how self-regulation skills can be applied to parenting (e.g., remaining regulated when confronted by misbehavior).

In Vivo Mastery

As in traditional TF-CBT following the trauma narrative, In Vivo Mastery associated with future safety and development is largely devoted to increasing the adolescent's comfort level with potentially stressful or unfamiliar situations. In particular, the In Vivo Mastery component might be implemented if the adolescent's distress regarding a specific situation or activity was interfering with their ability to successfully engage in important life activities. For example, an adolescent who is fearful of using public transportation, yet will need to do so in order to hold a job, may be encouraged to engage in a process of systematic desensitization (e.g., riding the bus alone for gradually increasing lengths of time).

Conjoint Sessions

When addressing future safety and development, conjoint sessions are intended to build upon the conjoint work completed during the earlier phases and to project that work into the future. Specifically, the focus is on increasing the caregiver's ability to successfully support and coach the adolescent through future life challenges. During this component the adolescent can share their goals and plans with the caregiver, who will have been coached by the therapist to provide an encouraging, supportive response to the adolescent's initiative. Subsequently, the adolescent and caregiver can work together to achieve the goals that have been set forth.

Enhancing Future Safety and Development

In essence, when working with adolescent survivors of complex trauma, the therapist is encouraged using all of the PRACTICE components to enhance future safety and development. However, given the increased risk of revictimization for adolescent survivors of complex trauma, it is essential to provide the adolescent with appropriate safety and prevention skills that can be applied to future life situations (e.g., dating, moving away from home). As in traditional TF-CBT, this component focuses on the primary safety/prevention skills of danger awareness, assertiveness, problem-solving, and seeking help. It is essential to provide these adolescents with information regarding healthy relationships and sexuality. Psychoeducation can also be provided to help the adolescent understand some of the factors associated with complex trauma that may increase their risk of revictimization (e.g., substance abuse, poor interpersonal boundaries, impulsive decision making). Previously learned self-regulation and problem-solving skills can then be reviewed in the context of addressing these risk factors for revictimization.

The therapist can also help the adolescent begin to identify potential goals for their future. Ideally, the adolescent can utilize the lessons they have learned from their past to identify what they would like their future life to look like. For example, an adolescent who expressed anger that they were not better protected might show interest in a career in law enforcement. An adolescent who grew up in the foster care system might set a goal of being a successful parent who retains custody of their children. During this process the therapist may also identify inaccurate or unhelpful beliefs that the adolescent has about their future (e.g., I can't wait to have kids, because then I'll have someone who'll always love me). As during the trauma narrative component, the therapist should assist the adolescent in testing the accuracy and helpfulness of these thoughts and developing more balanced beliefs.

Ending Treatment

In light of the adolescent's interpersonal experiences, the termination of the therapeutic relationship is very important. This may be their first healthy "goodbye" experience. The therapist should then plan for this early in treatment and revisit as necessary throughout. Termination may trigger feelings of loss or abandonment. Ideally the therapist can help the adolescent process their feelings about this and recognize how the end of this relationship is different from previous experiences. The conclusion of treatment should occur in a predictable manner, over which the adolescent has some appropriate control (e.g., picking the activity for the final session). The therapist should present termination as an achievement. The notion that the therapeutic relationship continues after the end of sessions, albeit in a different form, is also an important concept. Given the attachment-related difficulties of this population, providing concrete examples of this continued relationship (e.g., giving the adolescent a photograph of the therapist and adolescent together) are particularly helpful. Genuine disclosure of the therapist's feelings regarding the end of treatment can also be appropriate and beneficial; modeling appropriate expression of feelings associated with the completion of treatment (e.g., sadness, pride, hope) and the ability to maintain a mental representation of the therapeutic relationship (e.g., stressing that the therapist will not forget the adolescent) are keys to successful termination.

Conclusions

Most clinicians advocate for the use of a phase-based approach for complex trauma (Herman, 1992; Courtois, 2008; Ford et al., 2005). TF-CBT is the most researched evidenced-based practice for treating children and adolescents exposed to traumatic events (Cohen, 2010). Furthermore, as demonstrated in this chapter, the TF-CBT model is consistent with a phase-based approach to the treatment of complex trauma. Specifically, the PRACTICE components,

with appropriate adaptation, can be implemented to enhance stability, safety, and engagement, to facilitate the processing of traumatic memories, and to aid in the development of a healthy, balanced, “post-trauma” future for the adolescent survivor of complex trauma. Thus, it seems wise to consider such a well supported therapeutic model when addressing the mental health needs of complexly traumatized adolescents.

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