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Introduction

This guide has been developed to help clinicians evaluate and treat adolescents and young adults who have experienced repeated, extended, and/or severe traumatization. We take the clinician through the process of assessment, target prioritization, selection of appropriate treatment components, and the actual conduct of therapy. The approach described in this book, *Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)*, is inherently customizable: its various treatment components are meant to be adapted to the specific history, symptoms, and problems experienced by each given client. Yet, although it does not assume that “one size fits all,” it provides a specific, organized approach to the treatment of complex trauma, regardless of which components are ultimately applied. In the appendices of this book are various forms, handouts, and group treatment examples that will assist the clinician in using ITCT-A with his or her clients. Some of these materials are also available at no charge at johnbriere.com in a slightly larger format.

Background

Complex trauma usually involves a combination of early and late-onset, sometimes highly invasive traumatic events, usually of an ongoing, interpersonal nature, frequently including exposure to repetitive childhood sexual, physical, and/or psychological abuse (Briere & Scott, 2006; Cook et al., 2005). As described in Chapter 2, the impacts of complex trauma are substantial, ranging from anxiety and depression to posttraumatic stress, interpersonal problems, and dysfunctional or self-endangering behaviors.

Especially as they present themselves in mental health clinics, schools, hospitals, and residential treatment contexts, complex trauma effects are often complicated by adverse social circumstances. 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), but also increase the likelihood of trauma exposure and often intensify the effects of such victimization (e.g., Breslau, Wilcox, Storr, Lucia, & Anthony, 2004; Chen, Keith, Airriess, Wei, & Leong, 2007). Social marginalization also means that many traumatized youth have reduced access to appropriate mental health services (e.g., McKay, Lynn, & Bannon, 2005; Perez & Fortuna, 2005; Rayburn et al., 2005).

It is a general finding of the clinical literature that people with lesser social status are more likely than others to be victimized (Briere & Scott, 2006). Among the traumas more common among those with lower socioeconomic status, in addition to child abuse, neglect, and witnessing domestic violence, are sexual and physical assaults by peers, gang or community violence, “drive-by” shootings, robbery, sexual exploitation through prostitution, trauma associated with refugee status, and loss associated with the murder of a family member or friend (e.g., Berthold, 2000; Breslau, Davis, & Andreski, 1991; Farley, 2003; Giaconia et al., 1995; Macbeth, Sugar, & Pataki, 2009; Schwab-Stone et al., 1995; Singer, Anglin, Song, & Lunghofer, 1995; Sugar & Ford, in progress).

However, despite the prevalence of complex trauma in economically deprived and socially marginalized youth, it is also true that higher-socioeconomic-status adolescents are not protected from abuse and neglect by parents and other caretakers, nor are more-advantaged schools and social environments free of interpersonal violence by adults or other young people. Noteworthy is the prevalence of sexual and physical abuse among those of higher socioeconomic status (e.g., Smikle, Satin, Dellinger, & Hankins, 1995) and the substantial risk of sexual victimization for girls and young women in university or college (Fisher, Cullen, & Turner, 2000). Even in economically less-impacted neighborhoods, adolescents run significant risk of physical assault, threats of harm, and gang activity (Singer et al., 1995). The potential presence of violence and maltreatment at all socioeconomic levels and in all cultural or ethnic groups highlights a point we will make multiple times in this book: child abuse, peer assaults, and other forms of trauma are broadly prevalent in North America and elsewhere; no child, adolescent, or young adult is necessarily exempt from such experiences, and the effects of such maltreatment permeate our entire society.

Unfortunately, although complex trauma and its effects are common, there are few empirically informed treatments specifically developed for multiply traumatized children or adolescents. This is partially 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) can sometimes be insufficient—especially if the intervention approach is not adapted to the specific experiences, psychological needs, and cultural matrix of the affected youth.

The MCAVIC-USC Experiment

This book describes an integrated, multicomponent approach to the psychological and social issues faced by young people exposed to complex trauma. It is an adaptation and expansion of a treatment model developed by a joint project of the Miller Children’s Abuse and Violence Intervention Center (MCAVIC) at Miller Children’s Hospital, Long Beach, California, and the Psychological Trauma Program of the University of Southern California, Department of Psychiatry and the Behavioral Sciences—hereafter referred to as the MCAVIC-USC Child and Adolescent Trauma Program. This four-year (2005–2009) experiment in providing culturally relevant, multidisciplinary outreach and treatment services to multiply traumatized, socially marginalized youth, was supported by the U.S. Substance Abuse and Mental Health Administration, who funded MCAVIC-USC as a Category II Center of the National Child Traumatic Stress Network (NCTSN). The resultant treatment model, Integrative Treatment of Complex Trauma, has been adapted for two different age groups: *ITCT for Adolescents (ITCT-A)* and *ITCT for Children (ITCT-C)*, the first of which is the focus of this book. Both ITCT-C and ITCT-A guides were adapted and revised over the lifetime of this project, with input from MCAVIC and USC staff, members of MCAVIC-USC’s Expert Panel of Cultural Issues, members of the community, and attendees from a nationwide NCTSN Learning Community on ITCT. Recent analyses of treatment outcome data indicate the efficacy of both ITCT-C and ITCT-A, as presented in Chapter 21 and Lanktree et al. (2010).

Overview of ITCT-A

The core components of the adolescent version of ITCT include the following:

- *Assessment-driven treatment*, using an interview-based symptom review measure (the Assessment-Treatment Flowchart [ATF; see Chapter 4]) and, when possible, trauma-specific tests, administered at three-month intervals

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- *Attention to complex trauma issues*, including posttraumatic stress, behavioral and affect dysregulation, and interpersonal difficulties
- *Customization*, involving application of different treatment components for each client, based on his or her own particular history, needs, symptoms, and cultural context
- *Multiple treatment modalities*, including cognitive therapy, exposure therapy, affect regulation training, and relational treatment in individual, group, and caretaker therapy
- *Focus on a positive working relationship with the therapist*, deemed crucial to the success of therapy for complex trauma
- *Attention to attachment difficulties* associated with early, developmental trauma
- *Cultural adaptations* of treatment components to maximize their relevance to clients from different social and ethnocultural groups
- *Early focus on immediate issues* such as acute crisis and self-endangering behaviors
- *Skills development*, in terms of building emotional regulation and problem-solving capacities
- *Titrated 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* to establish healthier functioning and to address safety concerns
- *A flexible time frame* for treatment, since the multiproblem nature of complex trauma sometimes precludes short-term therapy

Because this multimodal treatment 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 here, this is not a "how-to" manual. Instead, we offer a semistructured approach that can be adapted on a case-by-case basis by the therapist in order to meet the youth or young adult's specific developmental level, psychological functioning, and cultural/ethnic background.