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Adolescents with Complex Trauma

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OVERVIEW OF COMPLEX TRAUMA

Most clinicians working with a traumatized child population will encounter at least one adolescent who has experienced severe, 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 compared with those who were more acutely traumatized (Cook, Blaustein, Spinazzola, & van der Kolk, 2003; van der Kolk, 2005). Beyond posttraumatic stress disorder (PTSD), these adolescents have myriad 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 that 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. Personal 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, 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 self-regulate 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 stress not otherwise specified (DESNOS) and developmental trauma disorder—which have been proposed for inclusion in DSM-IV and in the forthcoming DSM-5 (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; van der Kolk, 2005).

WHY TF-CBT APPLICATIONS ARE NECESSARY

Working with a complex trauma population has many unique challenges that necessitate different applications of 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 pretrauma 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 that there is no prior baseline to return to. For them, trauma has become a "way of life." Furthermore, whether the result of continuing consequences from the traumatic event or from their struggles, these youth's environment often remains chaotic during treatment and legitimate crises occur frequently (Cook et al., 2003). The youth may experience a placement change or 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 their lives. These crises are often not attempts to avoid trauma-related content but instead relevant challenges that require attention in treatment. Effective trauma-focused treatment requires multiple, uninterrupted sessions focused on processing trauma-related content (Cohen et al., 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 cur-

rent pressing issues is ill-advised because 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 that TF-CBT be applied appropriately to these issues. First, complexly traumatized adolescents have often experienced a variety of inconsistent and unpredictable interpersonal experiences, ranging from inappropriate closeness to indifference to victimization (Cook et al., 2003). Survivors of complex trauma may be distrustful of others, viewing others as unpredictable, uncontrollable, and/or hostile. These attachment difficulties may be brought with them to the therapeutic relationship (Courtois, 1999). It is not uncommon for adolescents with a complex trauma history to initially present as highly guarded or avoidant for weeks to months. The consistency and attunement of a good therapist may be a foreign experience to adolescent survivors 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 often excessively reactive to events in their environment. Such self-regulation difficulties typically result in significant, ongoing adversity for them. For example, emotional and behavioral dysregulation may contribute to the adolescent becoming enraged at a teacher who is criticizing him and then pushing the teacher against a wall, resulting in expulsion. 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. Furthermore, survivors of complex trauma often present with developmental capacities that resemble those of much younger children, such as difficulty identifying an affective state or even knowing when one is hungry (Ford, Courtois, Steele, van der Hart, & Mijenhuis, 2005).

In light of these issues, adolescents with a history of complex trauma is often 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 et al., 2010). Although TF-CBT was not developed specifically for complexly traumatized youth, with some adjustments it can be highly effective for this population. The PRACTICE components of TF-CBT (i.e., Psychoeducation and Parent-

ing, Relaxation, Affective expression and modulation, Cognitive coping and processing, Trauma narrative, *In vivo* mastery of trauma reminders, Conjoint child–parent sessions, and Enhancing future safety and development; Cohen et al., 2006) can be applied to address the myriad 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 modifications with regard to pacing and ordering of components. The instability of their environment and the severity of their own emotional and behavioral difficulties may 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, a common one of which is attachment problems (Cook et al., 2005). Compounding the problem, these adolescents may not bring a long-term, informed caregiver to treatment. Thus, a few helpful assessment strategies may be worth mentioning. First, in light of these survivors' complicated lives, the assessment process may be best conceptualized as peeling an onion. The therapist is advised to follow the pace of the adolescents, 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 adolescents' 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 adolescents 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 a 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 adolescents' background history. Third, as in any trauma population, the clinician is advised to be mindful of the adolescents' level of arousal. The clinician should be sensitive to triggering or flooding clients when inquiring about traumatic events and remain within the "therapeutic window" (Briere, 1996a). That is, clients 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, 2004). The assessment process can engender some feelings of distress; however, this is normal and often temporary. It is prudent for the clinician to administer measures only in his or her presence, allowing the clinician to both assess the adolescents' 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 that may have been perpetrated by more than one individual over several years. Without knowledge of adolescents' 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 because they prompt the clinician to assess for multiple traumatic events. The clinician should be aware of some of the details surrounding the traumatic event such as the child's age, length of the trauma, identity of the perpetrator, and severity of the trauma. Additionally, other developmentally adverse 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 also by the aftermath of the trauma: significant secondary adversity such as court or legal processes, removal from the home, and placement in multiple foster homes or a residential treatment facility. Thus, it is wise to have 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., Structured Interview for Disorders of Extreme Stress; 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 helpful to use assessment tools that examine multiple areas of functioning, and it is preferable to obtain information about trauma-related symptoms from multiple informants (Cohen et al., 2010). Following are some tools that may be useful in assessing the various domains of complex trauma.

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

Attention: Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 2004), Comprehensive Behavior Rating Scales (CBRS) (Conners, 2008), Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001), Teacher Report Form (TRF; Achenbach & Rescorla, 2001)

Behavior: CBCL, BASC, CBRS, 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 (Wechsler, 2004), Stanford–Binet Intelligence Scales (Roid, 2003), CBCL, BASC, CBRS, TRF

Self: MMPI-A

PHASE-BASED TREATMENT FOR COMPLEX TRAUMA

Treating adolescent survivors of complex trauma can be a complicated, overwhelming process because the demands and needs of the adolescents are often 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, particularly for youth who manifest the most severe impairments (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 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

become manageable, 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.

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 TF-CBT PRACTICE components (Psychoeducation and Parenting, Relaxation, Affective expression and modulation, Cognitive coping and processing, Trauma narrative, *In vivo* mastery of trauma reminders, Conjoint child–parent sessions, and Enhancing future safety and development) are used to facilitate the development of safety, stability, and engagement while incorporating gradual exposure by helping the adolescent identify and tolerate trauma cues. These skills can then be used to facilitate the TF-CBT trauma narrative and processing and *in vivo* mastery components, which clearly address the phase-based treatment goal of processing traumatic memories. Finally, the PRACTICE components are integrated to help the adolescent plan for and develop a healthy, balanced future that is no longer dominated by the experience of complex trauma. The skills and knowledge the adolescent gains while applying TF-CBT components to establish safety and stability and to process traumatic memories can finally be used to help the adolescent navigate through his or her "posttrauma" life in a healthy and satisfying manner. Some adjustments with regard to the order, scope, pacing, and emphasis of the PRACTICE components are described next to address the specific needs of adolescent survivors of complex trauma. Fortunately, TF-CBT was designed as a flexible model, adaptable to meet the specific needs of individual clients, and these applications are, therefore, consistent 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 complexly traumatized adolescents can be challenging. However, this phase is paramount. The importance of the therapeutic relationship cannot be overemphasized. Beyond establishing rapport with the clients, the therapist must establish trust. The former can usually be accomplished rather quickly; the latter can be more slowgoing. Although these youth often crave supportive relationships, the formation of a relationship may seem threatening because of their numerous experiences of interpersonal trauma. The therapist will often have to pass many client "tests" to demonstrate that he or she is 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. 188). 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 toward stabilization, initiating contact with the other "systems" in the clients' life, and addressing any safety concerns. Being patient and consistent is often an effective intervention in and of itself because this is often counter to what this population usually experiences. During the engagement process, the adolescents are being exposed to their discomfort with intimacy through the development of a safe and secure relationship with the therapist. Here, the adolescents are "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 clients to the relationship in a gradual, controlled fashion. The therapist needs to attend to clients' distress level during therapeutic interactions to ensure that they do not become overwhelmed and to "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 adolescents to familiarize themselves with and give appropriate control over the therapeutic environment (e.g., allowing them to pick where they and the therapist will sit). Early on, the therapist may need to be less directive and structured because doing so may be perceived as coercive and threatening by clients. 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 Safety and Future Development

The enhancing safety and future development component of TF-CBT may need to be prioritized early as a result of 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 and to identify safe people and places in addition to providing 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 them to identify appropriate people they trust and are willing to 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 to the presence of potential danger), and common coping mechanisms (both healthy and unhealthy). The youth and caregivers are helped to understand the adolescent's emotional and behavioral dysregulation as overreactions to stress rather than as willful misbehavior. It is also helpful to describe the concept of trauma triggers. The adolescent needs to be helped to learn how to react differently from his or her 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 he or she interacts 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 in the therapist's interactions both with the client and with the caregiver. 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 who plays a significant role in the youth's life. Commonly, this is accomplished by increasing the frequency of safe, positive interactions between caregiver and 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. Because of the tendency for distrust, the adolescent is likely to be suspicious of the therapist's contact with various systemic entities. The therapist should be

relatively transparent with the adolescent, informing the client about whom the therapist is contacting, 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 in the past. 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 his or her 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 than cognitively based activities (e.g., imagery, positive self-talk). Self-soothing and distraction techniques may also be helpful because the adolescent may be more familiar with these and may already use them in some fashion, such as listening to music, playing video games, or taking a hot bath. However, the adolescent may need help using these strategies in a more systematic fashion and developing awareness of the potential for overuse (e.g., failing to study for a test as a result of playing video games all night).

Affective Regulation

Affective regulation 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 he or she is experiencing during sessions and the therapist's modeling of effective expression and regulation of his or her own emotions in session. Here, the therapist begins to introduce some of the following concepts: the role of emotions in daily life; all emotions are valid and acceptable language for different emotional states; emotions can be experienced at different levels of intensity; multiple emotions can be experienced at the same time; negative affect states are temporary and can be tolerated; and effectively communicating emotions can alleviate their intensity and help secure support from others. This component may be initially challenging because many adolescent survivors present with emotional numbing or dissociative responses. These responses are best conceptualized as 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 awareness of 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 he or she experiences during stressful situations may increase the likelihood of becoming distressed and engaging in problematic behavior. The adolescent can also develop cognitive coping strategies (e.g., positive self-talk), which can be used to improve one's response to stressful life events. Furthermore, using the cognitive triangle to process current stressors may also help the therapist and adolescent identify various triggers or "signals of danger" that are contributing to the distress the adolescent is 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 the adolescent survivor 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, Neppl, Goldberg-Lillehoj, Jung, & Ramisetty-Mikler, 2006). Thus, these sessions are likely critical for stabilization. Because of 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 adolescents 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, Ellis, & Kaplow,

2007), and allow the therapist to model appropriate supportive behavior. Consistent contact with a supportive, appropriate caregiver will facilitate counterconditioning of the adolescents' experience of being victimized by prior caregivers. Furthermore, conjoint sessions can facilitate the caregiver's ability to coach the adolescents to use coping skills. Conjoint sessions in TF-CBT are also used for the adolescents 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 adolescents' self-regulation difficulties. Assuming a supportive reaction, this conjoint work helps decrease the adolescents' reluctance to discuss future self-regulation difficulties with the caregiver.

Achieving "Good-Enough" Stability

Deciding to transition to processing traumatic memories (moving to the trauma narrative) can be difficult for therapists. 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 and many youth actually cannot attain optimal stability until they process their traumatic experiences. Instead, the goal of the therapist is to determine whether 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 retraumatizing.

FACILITATING TRAUMA PROCESSING WITH ADOLESCENT SURVIVORS OF COMPLEX TRAUMA

Psychoeducation

Psychoeducation occurs throughout the TF-CBT model, including during the trauma narrative component (Cohen et al., 2006). For the adolescent

survivor 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. As a result of 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

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 because 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, and Cognitive Coping

During trauma processing, relaxation, affective regulation, and cognitive coping components will largely take the form of review and of encouraging adolescents to apply these skills. As needed, the therapist will review the knowledge and techniques learned to help the adolescents apply those skills to the processing of traumatic memories. Specifically, the adolescents learn 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 adolescents identify and monitor their level of distress during trauma processing work (e.g., through use of the Subjective Units of Distress 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 adolescents 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 adolescents to express feelings of distress verbally or behaviorally (e.g., facial expressions), it is important for the therapist to be proactive with encouraging them 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, but it may require significant adjustments. First, many of these youth's 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 3 (Green, Crenshaw, & Kolos, 2010). Processing these memories in the traditional sense, then, is not possible. Furthermore, developing a detailed chronological account of traumatic events may be very different for this population compared with youth exposed to a more acute form of trauma because the memory 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 because doing so would result in a very long narrative that would require many sessions to complete. A general rule of thumb is to allow adolescents to guide what events or experiences should be included in the trauma narrative (Cohen et al., 2006). As mentioned, 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. Understanding underlying trauma themes and how these relate to the youth's current functioning (e.g., "None of the adults in my life protected me; they were the ones who hurt me. I always expect everyone to hurt me, so I hurt them first. That's why I'm in residential treatment") is often the most critical and meaningful aspect of trauma narration and processing for these youth.

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 adolescents becoming increasingly distressed and dysregulated. Therefore, the *in vivo* mastery component of TF-CBT is often of critical importance to these youth because 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 him to not act as though he was. In truth, for this population, *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 adolescents may develop a better understanding of what environmental cues are actually triggering them. Initially, it may have been clear what situations were distressing, but following trauma processing, the adolescents 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 because the adolescents will be able to use more targeted coping and problem-solving strategies.

Conjoint Sessions

Because adolescent survivors of complex trauma often do not have access to a traditional caregiver, foster parents and caseworkers may be options to fill this 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 adolescents for the sake of conjoint work. Instead, the therapist and adolescents 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 adolescents during conjoint sessions. Although the involvement of an appropriate caregiver is optimal, it should be made clear to the adolescents that they have the option of not involving a caregiver if they do not feel comfortable.

Enhancing Safety and Future Development

Ongoing safety concerns continue to be important during the trauma narrative component. Despite the therapist's best efforts, 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., wrist-cutting 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 complicated 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 adolescents 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 adolescents should also have a sense of meaning regarding their traumatic experiences. In essence, the goal is that the adolescents are 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 SAFETY AND FUTURE 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 adolescents will likely expe-

rience throughout their lives. It is important to discuss the potential for future trauma triggers that the adolescents 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 because 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 Adverse Childhood Experiences study (Anda et al., 2006), it is also important to provide adolescents with information regarding healthy lifestyle choices (e.g., diet, exercise, substance use, safe sexual practices) in an attempt to reduce the potential health risk factors associated with exposure to childhood adversity. Furthermore, these youth never learned critical life skills. They will then also benefit from access to various life skill training opportunities—including applying and interviewing for jobs, financial budgeting, and housing options—and the provision of 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 caregivers and any relevant systemic entities in facilitating adolescents' growth and development. It is helpful to work with caregivers to identify appropriate expectations and responsibilities for the adolescents as they move toward adulthood. Many caregivers have difficulty trusting the adolescents' capacity to handle new situations and may need encouragement to allow the adolescents 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 adolescents' 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 adolescents 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 adolescents' 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 these adolescents have at least one trusted individual to whom they can turn may be vital to their long-term well-being.

Relaxation, Affective Regulation, and Cognitive Coping

Here, the adolescent works to perfect 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 participate more fully 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 these components, time should also be spent preparing the adolescent to use these skills in situations that he or she 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 in 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 his or her ability to engage successfully 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 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 Safety and Future Development

In essence, when working with adolescent survivors of complex trauma, the therapist is encouraged to use all of the PRACTICE components to enhance future safety and development. However, given the increased risk of revictimization for this population, 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 the adolescent 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 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 adolescents begin to identify potential goals for their future. Ideally, the adolescents can utilize the lessons learned from their past to identify what they would like their future life to look like. For example, an adolescent who expressed anger that she was 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 his children. During this process, the therapist may also identify inaccurate or unhelpful beliefs that the adolescents have 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 adolescents in testing the accuracy and helpfulness of these thoughts and developing more balanced beliefs.

ENDING TREATMENT

In light of the adolescents' 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 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) is 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 acknowledging 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.

CONCLUSION

Most clinicians advocate for the use of a phase-based approach for complex trauma (Courtois, 2004; Ford et al., 2005; Herman, 1992). TF-CBT is the most researched evidenced-based practice for treating children and adolescents exposed to traumatic events (Cohen et al., 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 application, 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, posttrauma future for adolescent survivors 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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