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Residential Treatment

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UNIQUE FEATURES OF RESIDENTIAL TREATMENT THAT REQUIRE TF-CBT APPLICATIONS

More than 100,000 children[1] in the United States currently receive mental health treatment in residential settings. These children ("residents") typically spend from 4 months to 2 years in residential treatment facilities (RTF). This chapter focuses on trauma-focused cognitive-behavioral therapy (TF-CBT) applications in RTF, but these applications may also apply to children receiving treatment in group homes or long-term inpatient treatment programs.

Two distinguishing features of RTF require unique TF-CBT applications: (1) The primary reason for RTF placement is to address severe externalizing behavior problems; and (2) RTF direct care milieu staff members are responsible for managing children's problems in the RTF milieu setting.

RTF settings exist for children with serious externalizing behavior problems that have not responded to interventions in less restrictive settings. Although RTF programs are increasingly recognizing that trauma contributes to these problems, trauma-focused treatment will likely only be viewed positively in RTF to the extent that it contributes to behavioral

[1] Many RTF only serve older youth. Please note that throughout this chapter the terms "child" or "children" is used to refer to both children and adolescents.

improvement, shorter length of stay, or other RTF-relevant outcomes. Thus, TF-CBT treatment must not only resolve trauma symptoms but contribute to resolution of the behavioral problems for which the child was sent to RTF. Therapists should clarify for residents, RTF staff, administrators, and parents how TF-CBT treatment will contribute to residents' behavioral regulation.

Parental involvement is highly variable for children in RTF. Some have intact, supportive families and their parents participate regularly in RTF treatment. More often, chaotic family living situations and maladaptive or abusive parenting contributed to the children's need for RTF care. Family disruptions also occur during RTF stays, including termination of parental rights; parents relocating out of state; caregiver relationships ending, with the child losing a long-standing relationship with the parent's significant other; or foster parents terminating fostering during RTF treatment. Any of these events may escalate children's behavioral problems in the milieu. Since direct milieu staff members' task is to manage children's problems in the RTF milieu, these workers must understand how trauma impacts children in RTF settings, how to minimize trauma reenactment in the milieu, and how to optimally support TF-CBT implementation. In this chapter, we focus specifically on direct milieu staff, but similar considerations apply to other RTF staff members (e.g., teachers) who have regular interactions with children in the RTF milieu.

Trauma Reenactment

Trauma reenactment frequently occurs in RTF settings. Trauma-informed care and TF-CBT aim to prevent trauma reenactment. Trauma reminders or triggers (cues that remind a child of one or more past traumatic experiences and then re-create negative aspects of the child's emotional, behavioral, or physical responses to the original trauma) are numerous in the RTF setting. For example, other children fighting or crying, a parent calling or failing to call, or a staff member redirecting a child in a loud voice may serve as trauma reminders. Because many children in the RTF milieu have trauma histories, multiple children may be "triggered" simultaneously and lead to one or more traumatized child losing behavioral and/or emotional control. When staff members acknowledge and validate how upset the child is and encourage him or her to use TF-CBT coping skills, the child is more likely to gain affective and behavioral regulation. However, when staff members intervene in a manner that the child perceives as a further trauma reminder (e.g., use a loud tone of voice or an intrusive or forceful physical manner), this will likely escalate rather than deescalate the child's trauma-related behavior. This response from staff members may trigger other children in the milieu, potentially leading to poor affective and/or behavioral regula-

tion among several residents or an out-of-control situation in the milieu. The following clinical example illustrates a scenario in which direct milieu staff members failed to recognize trauma reenactment, with negative consequences for the milieu. Information sheets for direct milieu staff about how to support implementation of TF-CBT skills in the RTF milieu are included as appendices at the end of this chapter.

Case Example

Jared's mother didn't call when she promised him she would. Jared got increasingly angry as it became clear that she would not call. He kicked over a chair, yelling, "I hate my f---ing mother." A staff member yelled, "Jared! No swearing here! Now pick up that chair!" Two residents said, "Hey, he can be pissed off" and "You don't know what it's like," respectively. The staff member who had yelled and one other approached the boys, and the staff member who had yelled at Jared said in a loud, threatening manner, "You all just lost your levels." Jared picked up the chair and threw it at the staff member. The two staff members then put Jared into a therapeutic hold. Two other residents who were watching the scene became angry and tried to pull the staff members off of Jared, leading to them also being placed in holds. Three additional residents then tried to defend those who were being held down. Five residents and Jared were restrained during this incident. The staff members present recalled this incident as "bad kids acting badly" while all of the residents said that the staff members "disrespected us" and "didn't care how we felt." Jared later told his therapist that when the incident started he was thinking about all the times his mother had abused him and let him down. Not calling was "just one more time she screwed with me." Recognizing trauma impact and how to implement TF-CBT coping skills may have prevented this scenario from getting out of control.

Direct care staff members are often young, have had little or no professional education about child psychopathology, and have little prior experience working with troubled children. These individuals receive annual mandated training in techniques for conflict resolution and management of problem behaviors, but because they are often spat on, called names, and kicked and/or punched by residents, they may take this personally, viewing themselves as victims of abuse by the children in the RTF rather than seeing these children as reenacting trauma that they themselves have experienced. In the absence of a trauma-informed understanding of trauma triggers, traumatic reenactment, and specific behavioral training and early-intervention practice, direct milieu staff members often experience negative emotions toward residents. To their credit, RTF programs are increasingly seeking trauma-informed care training for staff. One example is the Sanctuary model (*www.sanctuaryweb.com*), an organizational approach to providing

care for traumatized individuals. Using a trauma-informed care model such as Sanctuary in conjunction with TF-CBT likely provides an ideal approach for traumatized children in RTF settings.

UNIQUE TF-CBT ASSESSMENT STRATEGIES IN RTF

Many RTF programs now include questions about trauma exposure and trauma symptoms as part of their formal initial evaluation. However, this is not universally the case. RTF programs are required to conduct and document intake assessments in order to receive reimbursement and to meet a variety of regulations (e.g., state, county, child welfare, juvenile justice). In some cases, the assessment may be conducted by a psychiatrist or psychologist instead of the therapist, and for a variety of reasons the RTF assessment protocol may not include a formal assessment of trauma exposure or symptoms. In this case, the first challenge may be how to incorporate information about trauma exposure and symptoms into the assessment and treatment plan. In our experience, most RTF programs want to consider this information but do not have a mechanism to include it in the formal assessment protocol as a result of lack of resources. In these situations, the therapist can clinically interview the child and, if feasible, the parent or caregiver and administer the UCLA PTSD Reaction Index (RI), a freely available instrument, to assess the child's history of trauma exposure and trauma symptoms and determine whether the child has experienced trauma and whether this is a relevant focus of treatment. This information can then be incorporated with the initial evaluation at subsequent team meetings in order to update the diagnosis and treatment plan. A therapist who can conduct a trauma-informed assessment and provide TF-CBT integrated with other appropriate treatment as agreed upon by the treatment team will be a valuable addition to any RTF program.

Case Example

Merle was a 13-year-old admitted to RTF for participating in gang-related violence. She denied drug or alcohol use and urine toxicology screens were negative. Soon after admission, Merle was seen by staff apparently responding to auditory hallucinations. She initially refused to divulge the content of these voices, but eventually stated that they were coming from around the unit and the TV, and the voices kept saying that she was bad and should kill herself. She was isolative on the milieu and talked to herself. Merle slept less than 2 hours each night, and when peers approached her she became violent. Her initial diagnosis was schizophrenia, R/O atypical bipolar disorder, and Merle was started

on antipsychotic medication. When conducting a thorough trauma assessment, her therapist found that Merle had a long history of domestic and community violence, had been sexually abused by her stepfather from 3 to 10 years of age, and had more recently experienced a series of gang-related rapes. As the therapist spoke more with Merle about these experiences, it became clear that Merle was intimidated by the older males on the unit, who reminded her of the perpetrators of the recent gang rapes. Merle said that she couldn't sleep because she had recurrent fears of being raped in the RTF. The therapist asked whether the voices started before or after these rapes. Merle said, "The voices are they all who did this to me telling me I'm no good. It's me saying I deserved what they all did to me (i.e., to be raped) so I should just kill myself and leave this life." After more questioning, the therapist clarified that the "voices" were dissociative and reexperiencing phenomena rather than psychotic symptoms. The therapist explained these symptoms to Merle and changed the diagnosis to PTSD and major depression. The antipsychotic medication was discontinued and TF-CBT was started, initially focusing on enhancing Merle's feeling of safety in the RTF setting.

The most significant challenge in assessing trauma impact in RTF settings is often determining whether or not children's severe behavior problems are related to past traumatic experiences. Often, children in RTF have long histories of multiple traumas and losses—such as placements in and out of multiple foster homes; chronic experiences of physical, sexual, or emotional abuse; and/or domestic violence—and when a thorough trauma assessment is performed, these children and/or their caregivers endorse multiple trauma symptoms. The therapist is often able to discern connections between the children's behavioral problems and the past traumas they experienced (e.g., sexual offending in a youth who experienced sexual abuse; physical assaultive behavior in a youth who experienced physical abuse or witnessed domestic violence), or that the behaviors are sometimes prompted by traumatic reminders (e.g., the youth started a fight when called the same name that his abusive father used to call him). These connections can be formulated as trauma reenactment (American Psychiatric Association, 2000, p. 468), and justify the use of TF-CBT for the youth's severe behavioral problems.

Case Example

Carl was a 14-year-old admitted to RTF for gang activity. His gang behavior included violence in school and toward multiple foster parents, bullying at school, and property destruction. Carl had a long history of witnessing extreme domestic violence, including the murder of his mother by his father, and having been bullied by his father and older brothers and at school. His father regularly and severely beat his mother and was rumored to have killed a man. Carl's older

brothers were extremely emotionally and possibly physically abusive to Carl; the father encouraged this behavior, calling Carl a "sissy" and a "mamma's boy." When Carl was 9 years old, his mother and he ran away. The father came after them and shot the mother dead in front of Carl. The father was jailed, and Carl's oldest brother, because he was an adult, was given custody of Carl, and the abuse continued. At 11 years of age, Carl joined a gang "to protect me from my brothers." He ran away again at age 12 and was placed in a series of foster homes but was forced to visit with his brother. During the trauma assessment, Carl scored 14 (low) on the RI, but the therapist observed that Carl was extremely avoidant about talking about trauma experiences or symptoms during the clinical interview and she believed that Carl was minimizing these symptoms. The therapist began TF-CBT and after three sessions repeated the RI. At that time his score on the RI was 45 and he acknowledged severe physical abuse by his brothers.

While recognition of the central role of trauma reenactment in severely traumatized youth is crucial, it is also important that therapists not automatically attribute all behavior problems to trauma. Some youth only experienced trauma in the distant past and do not have any apparent trauma symptoms other than severe behavior problems, and there is no apparent connection between the current behavior problems and the past trauma. Unless more information becomes available to suggest trauma etiology, therapists should not assume that current behavior problems are related to or will be resolved by engaging in trauma narrative and processing work.

Case Example

Tom, a 16-year-old living with his single mother and two younger brothers, was admitted to RTF specializing in sexual offending after he raped his neighbor. He had also raped several other girls (acquaintances), but because of his gang activity, they had been afraid to report this. Tom was also displaying threatening behavior toward his mother. He had a history of trauma—being in a car accident as a young child and having witnessed community violence. His score on the RI was 13, but his primary trauma symptoms were irritability, gang-related hypervigilance, and angry outbursts. The therapist did not believe TF-CBT was appropriate.

UNIQUE TF-CBT ENGAGEMENT STRATEGIES IN RTF

Engaging the family in TF-CBT while the child is in RTF may require unique strategies for several reasons. The child's severe behavioral problems may

have exhausted the parents, leading them to feel both relieved and guilty about agreeing to residential placement for the child. The family may not understand why trauma should be a treatment focus for severe behaviors; if the family is chaotic or a parent experienced and/or perpetrated multigenerational trauma, the parent may feel blamed or defensive about the idea of trauma-focused treatment (e.g., "I went through this when I was a kid and I never acted up like this"). The RTF may be far from the child's home, making it difficult for the family to participate in therapy in person. Engagement strategies for these situations are described shortly.

Experiencing a child's severe behavior problems or having to place a child in a residential setting brings parents heartache and feelings of failure as parents. Therapists must first communicate that they do not negatively judge the parents based on the child's negative behaviors or the family's history. Providing TF-CBT is based on the premise that past traumatic experiences provide at least a partial explanation for the child's problematic behaviors. This "no shame and no blame" approach can be helpful for parents who feel that they have been ineffective or "bad" parents in not being able to control the child's problematic behaviors.

It is important to validate and acknowledge that the child's behavior has caused the parents significant distress. By relieving the parents' immediate burden of managing these behaviors, RTF admission may contribute to parental engagement over time. Psychoeducation about trauma impact may diminish child blame. Using the analogy of service members with violent outbursts after returning from the war in Iraq may be helpful to explain the behavioral impact of PTSD to parents who have never heard of this trauma manifestation. Pointing out that PTSD is both a response to trauma and a brain disorder (i.e., trauma causes biological changes that maintain behavioral and emotional changes) may help parents to better understand their child's behaviors. For the parent with a personal trauma history who says "I didn't act up this way," it may be helpful to first validate his or her resilience, drawing the parallel to the fact that most service members do not develop PTSD. The therapist can then point out ways in which children respond differently to benign experiences such as starting kindergarten (i.e., some do well, others have problems).

TF-CBT has been provided via phone to parents that live too far away to attend sessions regularly. In addition, newer technology is making it easier for RTF programs to engage parents long-distance. For example, Skype and similar free downloadable programs allow any family with a home computer to access the RTF therapist at the appointed therapy hour. Therapists can now schedule sessions remotely via computer with parents and conduct TF-CBT parent sessions in which the therapists can "see" the parent and during conjoint sessions the parent and child can "see" each other. Although not exactly the same experience as face-to-face therapy, for families who

wish to participate in their children's TF-CBT treatment, this is a feasible alternative, and many families are happy to have choices through which to learn parenting and other skills during the therapy hour.

UNIQUE TF-CBT APPLICATIONS IN RTF

Unique considerations for applying TF-CBT in RTF settings include when to begin TF-CBT; how to combine TF-CBT with other RTF treatment modalities; how to include RTF direct care staff in TF-CBT; and how to optimally apply TF-CBT for children and youth in RTF settings.

When to Start TF-CBT

TF-CBT is typically started in RTF only after (1) the child has been integrated into and adjusted to the RTF setting (e.g., the child understands the milieu's level system and other basic rules); (2) the therapist or another clinician has completed the assessment and ascertained that trauma is relevant to treatment; and (3) stabilization of acute psychosis, suicidality, self-injury, or other acute conditions has occurred. In a very short-term RTF program (e.g., 4 months), there is often insufficient time to completely stabilize the child before starting TF-CBT. In this situation, the pacing of integration, assessment, and stabilization occurs much faster than in longer term RTF settings. Such programs can be extremely successful at providing TF-CBT if trauma treatment is well integrated into the structure of the program and a concerted effort is made to involve family members in treatment. For example, a 4-month RTF program for severely multiply traumatized Latino teens with comorbid substance abuse disorders in Laredo, Texas, has successfully implemented TF-CBT with more than 50 youth, who demonstrated significant improvement in trauma and substance abuse problems.

Integrating TF-CBT with Other RTF Treatment Modalities

Multiple mental health interventions are provided in RTF. Optimal methods and timing for integrating TF-CBT with existing RTF interventions are now being examined and developed. For example, one method for integrating TF-CBT into the RTF milieu or level program (developed and pilot tested in collaboration with RTF milieu staff and therapists) is through the use of TF-CBT coping cards (Figure 3.1). Staff members receive education about TF-CBT skills and how to support their implementation prior to using these cards. The therapist completes the coping card with children as they learn and practice new TF-CBT skills in treatment, and instructs children to carry the card with them wherever they are in the RTF. When a child shows signs

Name: _____

Relaxation skills (date learned):

Feeling management skills (date learned):

Behavior management skills (date learned):

Thought management skills (date learned):

FIGURE 3.1. TF-CBT coping card.

of regulation problems, any staff member asks the child for his or her coping card, identifies a TF-CBT coping skill the child is currently using, and encourages the child to use one or more skill. The child then earns points in the level system for successfully implementing any skill on the card to regain regulation. (The child loses points for not having the card with him or her.) This is also a good method by which to emphasize in an ongoing manner to residents, staff, parents, and other stakeholders the connection between implementing TF-CBT and improving children's behavioral problems.

Many RTF programs that are implementing TF-CBT already use a group trauma format. A typical approach is to delay starting TF-CBT until youth complete the trauma group. This decision is based on the premise that providing both individual and group trauma-focused treatment concurrently is likely to be redundant and also on concerns that youth may become overwhelmed by talking so much about trauma issues. These RTF programs do not provide evidence-based group trauma treatments but rather a variety of different untested approaches, and in our experience youth often continue to have high levels of trauma symptoms after the end of trauma groups, suggesting that starting with individual TF-CBT may be a more effective approach. However, to date RTF programs have not been amenable to starting with individual TF-CBT except for individual residents who missed the starting date for group or were deemed inappropriate to join the group.

In contrast, many other RTF interventions are effectively provided concurrently with TF-CBT. For example, many programs provide targeted treatment for juvenile sexual offenders who also have significant trauma symptoms, and some are implementing TF-CBT concurrently with treatment for offending behaviors. Therapists in these programs report that providing TF-CBT in conjunction with treatment that addresses the sexual offending behavior is optimal for these youth because it helps them to understand and feel understood regarding the connection between their personal traumatic experiences and their subsequent offending.

Case Example

John was a 14-year-old adjudicated to RTF as a result of sexual assault of a 13-year-old cousin during a weekend visit with his aunt and uncle. This was his first sexual offense. During the initial assessment, John acknowledged domestic violence and "other" traumas but would not disclose what these were. His RI score was 58, in the very severe range. He eventually disclosed severe chronic sexual abuse by his father and older brothers. His mother witnessed this on many occasions but never intervened. John received TF-CBT in conjunction with treatment for sexual offending. During the trauma narrative, he said, "The worst part of all was that my mother let my dad and brothers do that to me and she never lifted a finger to help me. That made me into nothing. I don't know why no one ever loved me in that house." Through this concurrent treatment, John was able to understand his own abuse, feel compassion from his therapist and other staff for these painful experiences, and also understand the process through which he abused his cousin and take responsibility for this abuse. This allowed him to make the connection between his own pain as a victim and what his cousin must have felt. He wrote a letter to his aunt, uncle, and cousin telling them about his previous abuse and asking them if they could ever understand and if there was a way he could somehow make amends.

Including Direct Care Staff in TF-CBT When Parents Are Not Involved

Although TF-CBT significantly improves symptoms when provided only to the children (Deblinger, Lippmann, & Steer, 1996; Weiner, Schneider, & Lyons, 2009), additional benefits are derived when a caring adult participates in TF-CBT with them. For example, including parents in TF-CBT significantly improves children's depression and behavior problems (Deblinger et al., 1996), and increased parental support is a strong predictor of children's trauma-related symptoms (Cohen & Mannarino, 1996, 2000). Despite efforts to engage parents, about half of the children in RTF do not have ongoing parental involvement in treatment. For these children, including direct care staff in TF-CBT treatment may be beneficial if both parties are agreeable. In situations where there is no parent participating in treatment, the therapist can ask the child whether he or she would like to ask a specific milieu staff member to participate. Usually, but not always, in RTF programs in which each child is assigned a primary milieu staff member, the child will select this individual to participate in treatment. The therapist should explain the guidelines for participation to the staff member and the child. Specifically, the child and staff member must agree that the worker will not break confidences shared during therapy and will still enforce the rules in the RTF fairly and impartially. During treatment sessions with the

direct care staff member, the therapist works in a somewhat parallel manner as with a parent (i.e., identify the child's trauma triggers and plan how the staff worker might implement TF-CBT skills in the RTF). Direct care staff may need extra preparation and support for hearing children's trauma narratives before participating in conjoint sessions because they may not have previously heard these in such detail. However, many direct care staff report a new level of understanding and compassion for RTF patients after participating in TF-CBT treatment.

Case Example

Eleven-year-old Michael was admitted for violent acts (bullying, property damage, theft) at school. His foster parents gave notice that they were terminating foster care shortly after he came to RTF. He had experienced early exposure to domestic violence, severe neglect, physical abuse, and parental substance abuse prior to going to live with his great-grandmother at age 6. She became his legal guardian and adopted him the following year but 2 years later became too ill to care for him. Michael entered a series of foster homes, where he experienced violence and school bullying. His great-grandmother died 2 months ago, prompting serious behavior problems. During the trauma assessment, he identified this death as his worst trauma. He scored in the moderate range (37) on the RI but his therapist believed he was minimizing some symptoms. Since no caregivers were available to participate and loss was a significant issue for Michael, the therapist asked him if he would like one of the direct care staff members to participate in treatment with him. Michael chose his primary direct care staff member, Joanne, a woman who, like him, was African American. Joanne was a little nervous but very pleased that Michael wanted her to do this. During the first session with the therapist, she expressed the concern that Michael had asked her to participate so that he could "play" her in the RTF. As Joanne gained increasing insight about Michael's trauma history and triggers and how to use the TF-CBT skills to help him manage these, she looked back on that comment ruefully, saying, "I can't believe how little I understood him." Over time Joanne came up with her own ideas about how to help Michael in the RTF. For example, she became particularly adept at recognizing early signs that he was being triggered by other kids or situations and developing inventive techniques to distract him before he lost control. For example, she would sing his favorite rap songs to get his attention and then change the words (e.g., to "use your skills, baby, start to breathe"). This usually made Michael laugh. Joanne was shocked at hearing Michael's early experiences when the therapist read the trauma narrative to her. At first she didn't think she could do a conjoint session because she was "too angry at his parents to even be civil." She also told the therapist that it triggered her own issues of loss (her aunt had cancer and was dying). However, she insisted that "if that little boy lived through all

this, I can listen to it." Joanne also talked to other staff members about how to recognize when Michael was having trauma reminders and how to help him settle himself down. This, in turn, helped Michael feel more supported and safe on the milieu. At the end of therapy, Michael thanked Joanne for being there for him, telling her she reminded him of his grandma (great-grandmother) because he knew "you're always here for me." Joanne said that doing TF-CBT with Michael "helped me understand what these kids have been through, and how to help them better."

TF-CBT for Youth with Extreme Family Trauma

Many children in RTF have experienced long histories of extreme family trauma, which contributes to serious impairments in establishing trust, safety, and/or attachments. RTF staff members frequently express the belief that because of their long experience with betrayal from adults such children will not be ready to directly address traumatic experiences until they have spent considerable time establishing trust with the RTF staff. However, there is no evidence to suggest that talking about traumatic experiences impedes the development of trust. To the contrary, Sanctuary's research (*www.sanctuaryweb.com*) documents that a trauma-informed RTF environment where discussion about trauma is actively encouraged *enhances* the development of trust and a sense of safety among children and staff. It stands to reason that children whose traumas have included extreme invalidation would benefit from direct acknowledgment that their experiences occurred and that their thoughts and feelings have a reality basis. This suggests that introducing TF-CBT early in RTF treatment for such children may be helpful. Because these children are also extremely reactive to trauma reminders, and even talking about what these reminders are may trigger extreme responses, therapists may find it very helpful to decrease these children's hyperarousal by changing the order in which they introduce TF-CBT components. For example, introducing and helping children master relaxation (without gradual exposure at first) before introducing psychoeducation may be very helpful for some children. Once children have mastered relaxation and possibly affective regulation skills without gradual exposure and are able to "turn down the volume" of their anxiety, they may be better able to tolerate discussion of trauma topics. Therapists can then revisit these skills components with the addition of gradual exposure.

Case Example

Jane spent the first 5 years of her life locked in an attic closet by her mother. When Jane's mother was out of the house, her boyfriend would come to the closet with a knife and sexually abuse Jane, telling her that if she made a sound

he would kill her. When she cried, her mother would burn Jane with a hot iron. When she was discovered, at 5 years of age, Jane weighed 20 pounds and was covered in feces. She was placed in foster care, where she had severe aggression but was relatively stable for 2 years until her foster mother died of a heart attack. In her next foster placement, Jane was extremely aggressive and was physically abused by the foster mother in an attempt to get her to listen. Jane was then placed in a series of foster homes where sexual and physical abuse occurred. At 11 years of age, her behavior was out of control, leading to RTF placement. On admission, Jane endorsed physical abuse and said the worst thing that happened was her foster mother dying. She scored 71 on the RI (in the very severe range). The therapist and many staff members doubted that TF-CBT was appropriate since "her whole life has been trauma." Jane was aggressive and isolative on the milieu. After a month of nondirective therapy, the therapist found that Jane liked coming to therapy and decided to try some relaxation to address Jane's agitation and aggression. Jane was able to use relaxation during the therapy sessions, but she would not look at the therapist for more than several seconds before lowering her gaze. The therapist worked with Jane's primary milieu staff, Carlos, who also tried hard to engage Jane in milieu activities and encouraged her to use relaxation strategies on the milieu. Carlos was a muscular man whom all the residents looked up to. He dedicated himself to engaging Jane. Despite her aggression and persistent isolation, Carlos believed Jane was trying to use the relaxation strategies. The therapist noticed after two to three sessions of using relaxation that Jane seemed to be a bit more engaged in therapy. She decided to start TF-CBT at that point but to do so slowly. The therapist asked Jane whether she would like to include one of the direct milieu staff in therapy, and Jane chose Carlos. The therapist, Jane, and Carlos agreed that Carlos would participate in Jane's therapy in this way: Jane would decide what she wanted to share with Carlos, and the therapist and Jane would then meet with Carlos. If Jane gave permission, the therapist could also meet alone with Carlos to talk about what Jane was doing in therapy. The therapist started psychoeducation by introducing the What Do You Know? game, using only some of the safety cards and providing Jane with a piece of candy whenever she answered a question. Jane and the therapist talked about safety, and Jane said that she did not feel safe before coming to RTF. The therapist said, "It's hard to feel safe when the grownups who are supposed to take care of you don't keep you safe or even hurt you. But you are safe here." Jane became very anxious at this point but with the therapist's guidance was able to soothe herself using her relaxation skills. Jane then picked up one of the safety cards about "not OK" touches. Jane said, "I know all about that." When asked by the therapist what she meant, Jane said, "First Leroy (the mother's boyfriend) hurt me, then my mom burned me. They took turns." Jane briefly described the sexual abuse by her mother's boyfriend and her mother's physical abuse. The therapist told Jane how brave she was to talk about this and reassured her that she was safe in the RTF. The therapist was

ready to end the session when Jane asked, "Aren't we going to tell Carlos?" The therapist followed up, asking Jane what she wanted to tell Carlos. Jane said that she wanted to tell Carlos about the abuse she had just disclosed to the therapist. After listening to Jane's disclosure, Carlos told her how brave she was and that he was really proud of her for sharing this. He also told her that he and the other staff would keep her safe in the RTF. Jane continued to make slow but steady progress in TF-CBT, including eventually creating a detailed trauma narrative of her early trauma experiences and sharing this with Carlos. However, Jane was not able to tolerate placement in a foster home (presumably because of her early extreme traumatic experiences in nuclear family settings) and was eventually placed in a long-term group home setting, where she did very well.

Unpredictable Discharges

In RTF discharges may occur unpredictably based on child protection, family, and/or insurance decisions, leading to poor or no discharge planning. Specific to TF-CBT, the therapist may have no opportunity to end treatment in an optimal fashion or to arrange for treatment transfer. If the child is in the middle of the trauma narrative, this would be the least optimal circumstance for ending treatment, and in such cases the therapist should try to have one to two final sessions in order to bring TF-CBT treatment to some sort of closure before the child leaves the RTF program. If this is not feasible, the therapist might be able to arrange for these meetings via phone or Skype after discharge.

CLINICAL CASE DESCRIPTION

Luisa, a 15-year-old Hispanic, was referred to a residential substance abuse treatment facility by her probation officer after having spent 2 weeks in a juvenile detention center. This latest stay in juvenile detention followed a long string of arrests. Adolescents referred by the legal system are typically accompanied to the facility by their probation officer rather than a parent; however, in this case, Luisa's mother and father were both present for the admission process. During this meeting, her parents informed the therapist of Luisa's legal problems, including running away, truancy, and other status offenses that began at the age of 11 and reportedly became an increasing source of concern because of the growing level of risk. They reported separate incidents of self-injury that on several occasions resulted in Luisa being admitted to psychiatric behavioral centers for evaluation. Now, at the age of 15, Luisa's other high-risk behaviors included inappropriate sexual relationships and drug use. Prior to the age of 11, Luisa experienced several traumatic events, including exposure to domestic violence throughout

her childhood, community violence, and the loss of a close family member. After receiving this information, the therapist held an individual session with Luisa to introduce integrated substance abuse and trauma treatment. Luis identified her index trauma as losing someone who was like a second mother to her.

Psychoeducation

The average length of stay at the facility is 4 months, during which time the residents participate in individual, group, and family sessions. The first month of treatment focused on providing Luisa with psychoeducation on substance abuse and trauma, with each topic addressed in relation to the other. The therapist conducted group sessions that fostered a general understanding of trauma and substance abuse among Luisa and her peers. Group sessions also enabled the residents to share how they used drugs to manage distressing emotional states. Luisa adapted well to these sessions, talking openly about feelings of anger and sharing her understanding of how traumatic experiences might be influencing her current difficulties. In a later session, Luisa reported to the group that the discussions made her "feel understood and not crazy."

Individual sessions began with providing psychoeducation about Luisa's grief symptoms and trauma reminders. Luisa described that she had coped with grief by using Rohypnol to erase feelings of sadness and by becoming aggressive with family when she didn't have the drug. When arguments arose, feelings related to the loss of her family member intensified, and she would seek an escape through drug use. The therapist helped Luisa understand these behaviors as responses to trauma reminders. Withdrawal symptoms from Rohypnol and other drugs were identified, and relaxation skills were taught and incorporated as alternative ways of coping with trauma reminders. Reemergence of trauma symptoms and how to cope with these more positively was also discussed as a part of her recovery. This not only permitted Luisa to understand emotional dysregulation as a consequence of drug abuse but also opened up the need to address underlying trauma issues.

Parenting Skills

Parent sessions were conducted over the phone when the caregivers were unable to travel to the facility from their home out of town. During the initial calls, the therapist collected a great deal of information in the form of behavior analyses closely reviewing the severe parent–child conflicts experienced prior to Luisa's admittance to the RTF. Educating Luisa's parents about posttraumatic reactions was a new consideration for them because, until then, problematic behaviors had been attributed to Luisa's coexisting

attention-deficit/hyperactivity disorder diagnosis and her seemingly chronic negative attitude. Familiarizing the parents with common trauma reactions was critical to enhancing their understanding of factors that may have contributed to Luisa's drug use and problematic behaviors. For example, her mother reported frequently reaching levels of frustration that led to screaming as a form of discipline. With a new appreciation for how screaming not only triggered trauma memories but also inadvertently reinforced the very behavior her mother was scolding, both parents were educated about how important their attention could be in influencing Luisa's behavior. The potential for parent–child conflicts was limited to weekend visits at the facility. Still, the parents were encouraged to plan their time with Luisa carefully to create structure and rituals that would be comforting, while also using praise and differential attention to focus on reinforcing Luisa's strengths and progress in the program. In collaboration with Luisa and therapist, specific rules of "no fighting" and "no foul language" were presented as a way of keeping order in the facility, and the facility consequences for breaking those rules even during parent–child visits were agreed upon. The therapist worked with all family members, encouraging them to practice keeping their voices down and addressing each other in a respectful manner. "I" statements were extremely effective in breaking communication barriers and creating an understanding of each other's concerns for safety. The parents also worked diligently to identify emotional cues in Luisa in an attempt to be more sensitive to her stress level and to trauma reminders. This consisted of allowing her "chill-outs" to collect herself, speaking in a calm tone, making encouraging statements in the form of praise for adaptive behaviors, and recognizing their own yelling as a trauma trigger for Luisa. The therapist highlighted Luisa's behavioral progress for the parents during all phone and in-person contacts. Luisa's improvements were attributed to consistent rule implementation throughout weekly interactions with staff and peers and to her hard work in facing and processing the traumatic loss of a family member as well as other trauma exposures she experienced at home and in the community. Luisa's parents were consistently encouraged to support Luisa's behavioral and emotional recovery by acknowledging her progress and hard work in participating in the RTF and therapy activities.

Relaxation and Stress Management

Relaxation techniques were successfully mastered in individual and group sessions. Morning yoga workouts, progressive muscle relaxation sessions, and art classes were weekly occurrences. A milieu staff member provided art lessons as a way to promote personal expression through a healthy medium. Luisa was able to ease her anxiety through physical activity while expressing her feelings through artwork. She reported feeling good about having something she could practice with others that wouldn't cause problems.

Breathing techniques were encouraged during individual sessions to calm her through a surge of negative emotion. This was an essential component for the management of unhealthy behaviors that could impede her treatment progress.

Affective Expression and Modulation Skills

During initial sessions an emotional struggle became apparent when Luisa continually shifted from crying to verbal aggressiveness. The therapist focused on keeping her in session despite the volatile nature of her words by acknowledging basic underlying feelings of grief. She would state that "all life had to offer was a puke-filled world." Such comments were considered as indicators of distress more than mere gross opposition. The therapist responded supportively to her tears, helping her to accept that crying could be healthy and a sign not of weakness but of strength, in terms acknowledging and facing painful experiences. Over time Luisa was encouraged to verbally share her distress in words, poetry, and artwork, and the therapist praised her for expressing herself without resorting to harmful behaviors.

Luisa continued to share her thoughts through disturbing imagery for several sessions. At times she would express to the counselor an emotional state through the description of what she would do to the person she was talking about. For example, if the client was talking about how her mother angered her by not taking her to visit her loved one's grave, she would describe how much physical pain her mother would feel as a consequence. Her mother would reportedly have Luisa's "blood on her hands," then realizing how she'd wronged Luisa. The therapist introduced affect expression cards to assist Luisa in identifying her dominant feeling by selecting the appropriate card. Gradually, she explored feelings elicited by general stressors as well as trauma reminders, including those that reminded of her deceased family member. The identification of positive and negative feelings associated with the lost loved one was an important part of therapy. Luisa was then able to remember positive characteristics of that person and the influence on her personality, thus providing her with a sense of connectedness. Often, the therapist encouraged Luisa to end such sessions with a self-soothing activity associated with remembering her loved one.

Cognitive Coping Skills

Luisa displayed unhealthy and volatile communication with her mother and father in the early stages of TF-CBT that indicated a need for significant work in developing cognitive coping skills. When her parents were unable to visit, Luisa expressed maladaptive beliefs that her parents were abandoning her. Through cognitive coping exercises, Luisa began to understand how her thoughts about her parents were influencing her feelings and behaviors

toward them. Fortunately, Luisa and her parents began to practice communication skills during the substance abuse family groups that were held every Saturday. Adherence to the rules of the facility also helped with timely completion of treatment. Luisa initially had trouble complying with rules as a result of disobedience at home. By monitoring her daily interactions, the therapist was able to have Luisa process behaviors in relation to her feelings and later her underlying thoughts. This was facilitated by trauma-informed milieu staff who provided the consistency necessary for Luisa to develop healthy cognitive coping skills. The therapist helped Luisa identify several unhelpful coping styles, including (1) generalization, (2) jumping to conclusions, and (3) all-or-nothing thinking. The therapist explored the accusation of abandonment with her parents in terms of "all-or-nothing" thinking, for example, "If my parents don't do exactly what I expect, they don't love me at all and are abandoning me." Luisa was able to come to a more nuanced position regarding her parents' decision to place her in RTF, and in fact agreed that they may have done this for her benefit (because they love her). Although frustrated by her reactions toward them, the parents were able to be more patient by realizing that Luisa was no longer engaging in any self-injurious behavior.

Over time, family visits improved through the application of relaxation, affective modulation, and cognitive coping techniques. Reviewing past experiences with stressors was the start of managing unhealthy thought processes and behaviors. Similarly, daily interactions with peers and staff became an opportunity for practicing cognitive coping. Luisa at first described it as "seeing the future and keeping upsetting things from taking over." This task proved difficult at first because of her aggressive forms of expression; however, the implementation of relaxation and coping skills provided reinforcement to continue not to jump to conclusions about what her peers thought of her, but rather to explore the possibility that they were responding to her own behaviors to them. As Luisa used cognitive coping more, she noticed improved interactions with peers in the RTF and her aggressive behaviors decreased. Luisa noticed positive results through improved interaction with her parents and peers, problems that she once considered significant stressors. Client and parent sessions took place during the time that Luisa began to focus on her trauma narrative. A goal for each meeting was set to preserve a healthy understanding of her trauma-related issues.

Trauma Narrative

Luisa took a creative approach to developing her trauma narrative. Written in a mix of English and Spanish, she chose to write about her deceased loved ones in prose with accompanying drawings. The imagery she used aptly described her emotional states and associated thoughts about her multiple losses. Bound together like a book, the prose reflected her life changes

through several specific traumatic experiences, including thoughts, feelings, body experiences, and how her behaviors and interactions with family and peers were affected as a result of each of these traumas.

The therapist spoke with Luisa's parents throughout the development of the trauma narrative. Concerns over her choice of words were normalized as a part of trauma and grieving. Accepting Luisa's appropriate expression of negative emotions ("feeling bad") was imperative for her parents to be able to support for full therapeutic benefits to occur. Her parents struggled with this as they still feared that these feelings would lead to self-injury; however, Luisa was able to reassure her parents that talking about these feelings openly was the best way to prevent such behaviors. The final chapter was more optimistic about her outlook on coping with the loss of her family members and other traumatic experiences. This demonstrated Luisa's capacity to cope with intense feelings of trauma and grief within the context of a supportive relationship and with the growing support she felt from her parents.

Luisa's progress in treatment resulted in her being allowed three separate visits home. The therapist would follow up after each visit in an attempt to assess potential risk factors. The parents reported some struggles with implementing house rules, yet noted significant improvement in Luisa's impulse control and their overall interactions with her. Luisa agreed, stating that she "is trying to make better decisions but it won't happen overnight." Luisa was also able to begin to acknowledge her parents' ongoing efforts to help her despite their own struggles and learned to express her appreciation to them as well through words of praise. Drug-related triggers were reportedly manageable for Luisa since she had decided to comply with probation for her well-being.

Enhancing Safety

Throughout treatment, residents keep a daily journal. Two weeks prior to graduation, the therapist and Luisa processed her efforts using the journal along with her trauma narrative. She was able to identify the development of safer modes of coping within her own writing. She remembered what she was feeling during each entry, speaking of it as a past form of expression. The therapist informed her that upon returning home these feelings had the potential to arise with the same intensity. Safety planning then became the primary focus of finalizing therapy. Luisa's safety plan included how to safely cope with future social stressors, accessibility to drugs, and emotional triggers. Luisa's parents were involved in her safety plan to help her implement coping skills. Upon her discharge from treatment, outpatient services were arranged for continued support her in substance abuse recovery. Luisa's safety plan included family and community support resources.

Treatment Progress

Luisa spent a total of 3 months at the facility. During this time, she experienced increased self-awareness in terms of personal safety by identifying emotional triggers related to her trauma. This helped transformed her communication style from verbal aggression to one of healthy expression. Her parents also displayed progress by becoming more sensitive to Luisa's trauma triggers and using improved parenting and communication skills learned throughout treatment. Her parents were also far more inclined than previously to be an active part of Luisa's substance abuse recovery process. Overall, the integration of substance abuse treatment and TF-CBT enabled Luisa to successfully address the two major issues of distress in her life in a trauma-informed manner and with a highly positive outcome.

CONCLUSION

While youth in RTF settings have very high rates of trauma exposure, only recently have treatment providers in these settings recognized the potential influence of trauma on the development and escalation of behavioral, emotional, and substance difficulties among RTF clients. Surprisingly, many youngsters who have had numerous outpatient and inpatient experiences report TF-CBT as the first therapy experience during which childhood traumas were acknowledged and directly and openly discussed. Despite their seeming fragility, many youth in RTF respond positively to addressing traumatic childhood experiences with the objective of helping them understand the relationship of these experiences to current difficulties, processing distressing trauma-related thoughts and feelings, and developing coping skills to manage everyday stressors as well as trauma reminders. Ideally, TF-CBT not only should be offered in the RTF setting but should continue at least briefly in aftercare, particularly if caregivers were not able to actively participate with the youth during their RTF stay. The case examples presented here highlight both the challenges and the extraordinary benefits of offering TF-CBT in RTF settings.

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