TREATING COMPLEX TRAUMA in Children and Their Families

An Integrative Approach

Cheryl B. Lanktree • John N. Briere

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Introduction

Integrative Treatment of Complex Trauma for Children (ITCT-C) is an evidence-based, component-driven model that integrates a variety of theoretical and clinical approaches to the treatment of complex trauma in children. Development and evaluation of this therapy was supported by the Substance Abuse Mental Health Services Administration, through its funding of the Miller Children's Abuse and Violence Intervention Center (MCAVIC) from 2001–2005 and the MCAVIC-University of Southern California (MCAVIC-USC) Child and Adolescent Trauma Program from 2005–2009.

Although ITCT-C was originally designed for the treatment of multiply traumatized children aged 8 to 12 years, this book also includes interventions that can be adapted for children ages 5 to 7 years. There is also an adolescent version of ITCT, Integrative Treatment of Complex Trauma for Adolescents (ITCT-A), for youth aged 12–21, which is described in its associated treatment guide (Briere & Lanktree, 2013) and a separate volume (Briere & Lanktree, 2012).

ITCT-C has been empirically evaluated (Lanktree et al., 2012) and has been expanded considerably since the original treatment guide was released in 2008. This book incorporates extensive feedback from clinicians and workshop participants over the past five years, to whom the authors owe a debt of gratitude.

Because this is a comprehensive treatment model, its effectiveness is enhanced by the therapist's knowledge, skill, and openness to the client, and his or her actual enjoyment of the therapy process. Although specific interventions and activities are described, this is not a how-to manual, nor is it

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based on a "one-size-fits-all" approach. ITCT-C is designed to inspire therapists to approach the treatment of complex trauma in children from various perspectives. It offers a range of treatment components that are applied based on the results of ongoing assessment (using the Assessment-Treatment Flowchart for Children), and allowing for adaptations based on the client's age, developmental level, level and type of symptomatology, and cultural/ethnic background.

Unlike some other approaches for traumatized children, wherein treatment is limited to 12 to 16 weeks or less, ITCT-C is extendable to whatever period of time is most helpful in reducing the child's trauma-related difficulties. In many cases, the effects of complex trauma are unlikely to remit in the span of several months—especially when the client suffers from a number of different symptoms and problems, there is a risk of further victimization, other environmental stressors are common, and attachment issues are prominent. In such cases, ITCT-C may easily require treatment periods which extend to 6 months or longer. Nevertheless, ITCT-C has been adapted to settings where shorter-term treatment interventions are required, for example, where there are funding constraints or where short-term treatment is the only option (e.g., drop-in clinics, homeless shelters, residential treatment facilities).

ITCT-C is relationally based, incorporating tenets of complex trauma theory (e.g., Ford & Courtois, 2013), attachment theory (e.g., Bowlby, 1988), cognitive behavioral approaches (e.g., Cohen, Mannarino, & Deblinger, 2006), and the Self Trauma Model (e.g., Briere & Scott, 2014). Because it is oriented toward the treatment of complex trauma, it can be used to address the effects of a wide range of adverse experiences, including child abuse and neglect, traumatic bereavement, assaults by peers, community violence, witnessing parental domestic violence, parental substance abuse, and trauma associated with severe illness or injury. It also includes a focus on the various impacts of insecure caretaker-child attachment relationships as they add to, compound, or intensify the psychological effects of traumatic experiences.

There are a variety of treatment components within this model, for example, affect regulation training, titrated exposure to traumatic memories, cognitive and emotional processing, and attachment/relational interventions, all of which are differentially utilized according to each child's specific problems or issues. As compared to interventions for adolescents (e.g., ITCT-A), ITCT-C has a stronger emphasis on symbolic and expressive play approaches, the option of shorter individual therapy sessions for the child, greater emphasis on collateral and family sessions to facilitate appropriate caretaker support and parenting skills, and more of a focus on insecure attachment as it plays out in child-caretaker relationships.

In addition to individual therapy, ITCT-C can involve collateral, family, and group therapy. Weekly collateral sessions with primary caretakers are

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integral to the model. Because of the critical role of caretakers in the younger child's life, ITCT-C may also facilitate trauma recovery for the primary caretaker(s) in their own individual therapy, group sessions, or collateral treatment. In such cases, treatment may include the caretaker's processing of traumatic experiences—both their own as well as the impacts of the child's victimization—so that they can become more attuned to the child's needs and develop a more secure caretaker-child bond. This approach also includes optional parent education classes, which are provided for caretakers struggling with parenting issues, as well as group sessions for caretakers involving trauma-related psychoeducation, trauma processing with peer support, and exploration of relationships and family systems.

As described in Chapter 17 and elsewhere, ITCT-C has been adapted for children in urban school environments, including "alternative" or "storefront" settings for high-risk students. The primary modality in such contexts is group therapy, with individual crisis counseling and shorter-term therapy sessions provided when needed. Teachers, school counselors, and social workers also receive consultations, training, and support. Parents are engaged whenever possible, but school-based interventions may be limited by less access to parents due to the schools' hours of operations, as well as caretakers' work demands, transportation problems, and, on occasion, discomfort with going to school sites.

ITCT-C particularly targets economically disadvantaged and culturally diverse children, many of whom are coping with additional stressors associated with poverty, unsafe communities, and social marginalization. Frequently, ITCT-C clients are dealing with immigration issues, acculturation challenges, separation from primary caretakers—some of whom may remain in their country of origin, and attachment/relationship problems associated with being reunited with family members after a period of separation. At the same time, however, ITCT-C is also used in settings with clients who may not be as economically or socially disadvantaged, and who may not be facing the same degree of external stressors.

Importantly, the client's history of insecure attachment relationships and negative relational schema is addressed in his or her individual ITCT-C sessions. The therapeutic relationship invariably triggers trauma-related thoughts, feelings, and memories in the child, which, in the context of safety and security, can be processed and counterconditioned.

Empirical Support for ITCT

A treatment outcome study (Lanktree et al., 2012) conducted over a period of several years evaluated the effectiveness of ITCT (both ITCT-C and

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ITCT-A) in reducing trauma-related symptomatology in a culturally diverse, largely inner-city sample of 151 children and adolescents. Most children were seen in a clinic environment, although some attended the school-based adaptation. In most cases, caretakers attended collateral therapy as described in Chapter 15.

A significant majority of these children had experienced multiple types of trauma, typically some combination of childhood sexual or physical abuse, psychological maltreatment, emotional neglect, family violence, loss of a loved one, community violence, and parental substance abuse, often compounded by caretaker-child attachment issues. In addition, some were referred by local hospitals and clinics following a traumatic medical condition (e.g., HIV/AIDS), injury (e.g., gunshot wound), or invasive medical procedure (e.g., amputation).

Although this study did not include a control group, clients' scores on the *Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation,* and *Sexual Concerns* scales of the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) decreased an average of 41% ($p < .001$) over an average of 6 to 7 months. There were no differences in treatment effectiveness in relation to gender, number of traumas, ethnicity, or whether the client received ITCT-C or ITCT-A. However, longer-term treatment was associated with greater symptom reduction, as per other research in this area (e.g., Lanktree & Briere, 1995).

Structure of This Book

This treatment guide defines and describes complex trauma and its effects, followed by a discussion of the ITCT-C approach to psychological assessment, including the Assessment-Treatment Flowchart for Children (ATF-C). The reader is then introduced to the ITCT-C Problems-to-Components Grid (PCG-C), which assists the clinician in applying the results of the ATF-C to create a specific treatment plan for the child. Remaining chapters then present the treatment components that, as identified by the PCG-C, can be used to implement a customized approach to the child's specific needs. These components are: *Relationship Building and Support, Safety Interventions, Psychoeducation, Advocacy and Systems Interventions, Distress Reduction and Affect Regulation Training, Facilitating Positive Identity, Cognitive and Emotional Processing, Relational/Attachment Processing, Interventions with Caretakers, Family Therapy,* and *School-Based Adaptations*. Finally, a chapter on ITCT-C supervision and therapist self-care is presented, followed by appendices containing ITCT-C tools and worksheets.

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