Treating Complex Trauma in Adolescents: A Phase-Based, Integrative Approach for Play Therapists

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Understanding the unique effects of complex trauma on adolescents, as well as identifying effective mental health treatment protocols, are critical for trauma-informed play therapists to practice competently. Recently in the literature, phase-based treatment has been one such protocol applied successfully to adolescents who experienced complex trauma (Cohen, Mannarino, & Deblinger, 2006). Furthermore, play-based approaches (integrating complex-trauma concepts, play, and empirically designed treatment protocols) have been asserted as a potentially beneficial paradigm (Drewes, 2011; Green, 2012). Therefore, the authors of this article present an original model—one that is integrative, play-based, and delineated in 3 phases—while remaining sensitive to the most current clinical implications in the trauma treatment outcome literature.

Keywords: complex trauma, adolescents, phase-based approach, play therapy

The term *complex trauma* captures diagnostic implications and associated symptomologies with those adolescents (ages 13 to 17 years) with multiple traumatic experiences. Specifically, complex trauma is defined by the National Child Traumatic Stress Network (2007) as "both children's exposure to multiple traumatic events, usually of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure" (p. 34). *Developmental trauma* is another term that includes children and adolescents' repeated exposure to potentially traumatic events, often perpetrated by a trusted person or adult in the youth's life (van der Kolk, 2005). Adolescents' exposure to potentially traumatic events, events that prompt a range of reactions from survivors (Ogle, Rubin, Berntsen, & Siegler, 2013), has increased in frequency and intensity over the past several years, and rates of polyvictimization have steadily increased (Finkelhor, Turner, Ormrod, & Hamby, 2009). Current research shows that adolescents exposed to multiple traumatic events often develop more severe mental and physical difficulties than

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adolescents who experience single-incident traumas (Finkelhor, Ormrod, & Turner, 2007).

The unique and diverse effects of complex trauma on adolescents, as well as effective treatment protocols, are crucial areas for trauma-informed play therapists to become familiarized with, and competently trained and supervised in, before this work can begin. Longitudinal research, such as the Adverse Childhood Experiences Study (ACES), demonstrates the effects of complex trauma on adolescents can be long lasting. There are seven domains within an adolescent's typical functioning that may be adversely affected by complex trauma: (a) attachment, (b) biology, (c) affect regulation, (d) dissociation, (e) behavioral control, (f) cognition, and (g) self-concept (Cook et al., 2005). Play therapists who counsel traumatized youth may consider utilizing a phase-based approach to address these myriad short- and long-term effects. Therefore, the objectives of this article are to (a) summarize the effects of complex trauma on adolescent development, and (b) outline a phase-based, integrative approach for play therapists to utilize when counseling adolescents affected by complex trauma.

EFFECTS OF COMPLEX TRAUMA ON ADOLESCENTS: ESSENTIAL DOMAINS OF DISRUPTION

Adolescent complex trauma involves experiencing acute or chronic trauma, like abuse and neglect, in conjunction with additional trauma incidents, like medical trauma (e.g., critical accident or cancer or emergency surgery); community trauma (gun violence or bullying); disaster events; or assault; or betrayal trauma (rape or incest; Courtois & Ford, 2009). Although complex trauma symptomology may include posttraumatic stress disorder (PTSD), many adolescents who experience complex trauma do not qualify for a trauma-related diagnosis; rather, they are diagnosed with a range of other comorbid or co-occurring diagnoses that may lead to ineffective or misguided treatment (van der Kolk & Pynoos, 2009). This section aims to outline some of the presenting issues and symptoms that play therapists may encounter when treating adolescents affected by complex trauma so they may engage in accurate psychodiagnostic assessment and in trauma-informed treatment planning.

Impairment in Attachment

The relevance of attachment in typical adolescent development from the play therapy paradigm has recently been addressed in the literature (Green, Myrick, & Crenshaw, 2013). Researchers have found that early caregiving relationships provide the context within which adolescents come to understand themselves, others, and themselves in relation to others. When the attachment relationship is secure, adolescents see themselves as loveable and the world as a positive and predictable place (Bowlby, 1982). They develop a sense of curiosity, autonomy, and trust. Children are at increased risk for developing insecure attachments when the parent–child relationship is the source of the trauma, as is often the case with

complexly traumatized youth. In these cases, children experience interpersonal relationships that are inconsistent and unpredictable. These relationships may include inappropriate and intrusive closeness, neglect or indifference, and abusive experiences (Cook et al., 2005). As a result, youth develop a low tolerance for managing stress and are often unwilling to seek assistance from others when their own internal resources are depleted.

The effects of insecure attachment on adolescents because of complex trauma can be deleterious, particularly in peer relationships. In a recent study (Hamby, Finkelhor, & Turner, 2012), childhood maltreatment was closely associated with teen dating violence. Similarly, other studies have noted that adolescents are at an increased potential for experiencing dating violence when both adolescents in the relationship are insecurely attached (Orcutt, Garcia, & Pickett, 2005). This is true regardless of interpersonal violence. Attachment wounds and disrupted attachment are not always caused by trauma, but they almost always lead to interpersonal insecurity, trust issues, and other relational difficulties.

Impairment in Biology

Youths' brains continue developing and changing as much as their physiological state during adolescence (Broderick & Blewitt, 2010). Complex trauma changes adolescents' brain neural proliferation and causes physiological alterations in the brain structure and function of key neural networks related to responses affiliated with stress (Green, 2012; Lanius, Vermetten, & Pain, 2010). During a threatening event or series of events over time, the brain initiates a complex, full-body response to the experience, commonly known as the *fight-or-flight response*. Perry (2003) theorizes that traumatized adolescents move through experiences of calm, vigilance, alarm, fear, and terror as the threat intensifies. Other researchers have posited an extended response cycle called the *freeze-flight-fight-fright-flag-faint response* (Schauer & Elbert, 2010). The cascade postulates that during complex trauma, adolescents (a) momentarily experience an inhibited startle response, (b) attempt to flee or fight, (c) experience simultaneous arousal and physical immobility, and finally (d) experience a "shut down" phenomenon, in which they may dissociate or even faint as a response to the overwhelming threat the trauma has inflicted on the brain and body.

For adolescents who have survived complex trauma, their brains and bodies may have endured these cycles many times, with significant neurological effects. Studies with adolescents have found associations between maltreatment and reduced corpus callosum measurements and frontal and prefrontal lobe abnormalities. Such findings coincide with difficulty in executive function and the integration of left and right hemispheric functions (Saltzman, Weems, & Carrion, 2006). Physical health issues have been associated with complex trauma (e.g., Brown et al., 2010; Dube et al., 2009), and a recent epigenetic study found that abused children's gene expressions were different than nonabused children's at nearly 3,000 sites (Yang et al., 2013). According to Perry (2003), complex trauma in adolescents inhibits (a) the frontal lobe region of the brain, Broca's area, which affects language communication, and (b) neurological pruning, which may impact the adolescent's

ability to regulate the autonomic nervous system. The next section expounds upon neurological impacts of trauma in adolescent brains via thoughts and memory impairment.

Impairment in Cognition

The effects of complex trauma on the developing adolescent brain may also negatively alter cognitive functioning, including memory, focus and attention, concentration, and language development. Studies have demonstrated a positive relationship between trauma exposure and overgeneralized autobiographical memory retrieval (Moore & Zoellner, 2007), as well as a decrease in the production of specific memories. These cognitive deficits are a way for the brain to avoid negative emotions related to trauma memories.

There is a great deal of overlap between symptoms demonstrated by adolescents with attention deficit hyperactivity disorder (ADHD) and those with complex trauma histories. For example, symptoms of ADHD such as hyperactivity, inattention, and disorganization look similar to posttraumatic responses such as hyperarousal, intrusive thoughts, and avoidance. Indeed, studies have found higher rates of complex trauma, including physical and sexual maltreatment, in adolescents diagnosed with ADHD compared with adolescents without ADHD (Conway, Oster, & Szymanski, 2011). Other studies have noted the increased likelihood of an ADHD diagnosis among complex trauma survivors (e.g., Husain, Allwood, & Bell, 2008).

Difficulties with memory, attention, and comprehension can translate into learning difficulties, both academically and in everyday decision making. Youth affected by complex trauma are at risk for low reading levels (Thompson & Whimper, 2010), decreased school attendance and achievement (Perlman & Fantuzzo, 2010), decreased academic engagement (Badenoch, 2008), and difficulties completing homework assignments (Slade & Wissow, 2007). Furthermore, a history of maltreatment in adolescents predicted lower expectations of one's own academic and employment success (Thompson et al., 2012).

Impairment From Dissociation

Dissociation can be a normative mental mechanism (e.g., daydreaming) or it can serve as a mental "shut down" response to overwhelming trauma. The link between dissociation and trauma has been established in various adolescent and adult populations (Dalenberg et al., 2012). For adolescents who have experienced complex trauma, dissociation automatizes behavior, compartmentalizes painful feelings and memories, and detaches oneself from emotions and awareness of self. That is, some adolescents are disconnected from thoughts, feelings, and bodily sensations, and behave without conscious awareness or choice.

Experiences of identity confusion and preoccupation with one's own thoughts and fantasies seem to be inherent in typical adolescent development, and yet are not unlike the experiences of dissociation in trauma survivors. Studies have con-

firmed that adolescents in the general population have reported disproportionate amounts of normative dissociative experiences (Tolmunen et al., 2007). The difference between normal and pathological dissociative phenomena, then, appears to be in the natural resolution of such experiences versus pathological dissociation's interference with the formation of a cohesive sense of self. When pathological dissociation is present, any number of the following symptoms may be reported or observed: blackouts, amnesia, changes or reports of changes in identity, and depersonalization and/or derealization.

Impairment in Affect Regulation

Complexly traumatized teens may demonstrate deficits in recognizing and naming emotions, expressing emotions safely, and regulating their internal experiences of affective states, particularly when compared with their nontraumatized peers (Cook et al., 2005). *Emotional* (or affect) *dysregulation* is primarily a subjective construct associated with an individual's unregulated, negative, and intense experience of varying emotional states. The inability to regulate emotions may appear even more pronounced in adolescence, when affect can be intense and often fluctuates. Those who struggle with emotional dysregulation may demonstrate maladaptive coping, lack of emotional awareness, difficulty managing impulses, and inadequate strategies to regulate emotions. So pronounced is this deficit that affective dysregulation is often cited as a hallmark trait of youth affected by complex trauma.

Attachment is a behavioral construct that provides the infrastructure for emotional development through interpersonal relationships (Bowlby, 1982). Chronic trauma adversely affects the individual's ability to continue to learn emotional development optimally and interferes with the attachment bonds already developed. The effects of chronic trauma on relational attachment are not generalizable, as they must be assessed and codified by the time or onset of the trauma, how long the trauma lasts, and the cultural and social context for the trauma. In cases of neglect, the result might be a limited emotional spectrum or blunted affect. Alternatively, in the case of abuse, recognizing and responding to anger might be a teen's best predictor of threat, and would likely be prioritized above any other emotional cues. Emotional dysregulation has been associated with increased suicidality (Rajappa, Gallagher, & Miranda, 2012), high-risk sexual behaviors, nonsuicidal self-injury (NSSI; Muehlenkamp, Peat, Claes, & Smits, 2012), and substance abuse (Weiss, Tull, Viana, Anestis, & Gratz, 2012). Closely related is *negative affect*, best conceptualized as distress involving mood or intense feeling states of anger, guilt, or anxiety. The interplay between these two concepts may result in increased behavioral problems. For example, a recent study of justice-involved adolescents found that negative affect was significantly related to violence and high-risk sexual behaviors when the teen also had difficulty understanding their emotions and using strategies to regulate their emotions.

Impairment in Behavioral Control

Undercontrolled and overcontrolled behavior often develops as a result of complex trauma. Overcontrolled adolescents have learned to inhibit behavior that might be displeasing to the abuser and to comply with demands to decrease the likelihood of abuse. They may be susceptible to anxiety or personality disorders that value rigidity, compliance, and inflexibility. When behaviors are undercontrolled, impulsive rather than rational, they can lead to psychiatric diagnoses, legal problems, and an increased risk of further psychosocial difficulties (Finkelhor et al., 2007; Ford, Elhai, Connor, & Frueh, 2010).

Internalizing Behaviors

Anxiety and depressive disorders often co-occur with trauma-related symptoms. Symptoms consistent with PTSD are frequently seen in this population, although not all complexly traumatized adolescents will meet diagnostic criteria. Other anxiety disorders are also common; in one study of war-affected adolescents, 26.8% sought mental health services for generalized anxiety (Betancourt et al., 2012). Maltreated adolescents self-report higher rates of depressive symptoms than their nonmaltreated peers, and associations between childhood trauma and suicidal behavior have been found (Bruffaerts et al., 2010). In many cases, internalizing symptoms are related to trauma-related cognitions and subsequent views of self (Briere & Spinazzola, 2005).

Externalizing Behaviors

Externalizing problems, such as hostility, defiance, impulsivity, aggression, and high-risk behaviors, are also common. Traumatized adolescents may be diagnosed with ADHD, conduct disorder, oppositional defiant disorder, substance use disorders, and provisional personality disorders. Ford, Chapman, Connor, and Cruise (2012) note that although the profiles may warrant the diagnoses, many complex trauma survivors respond reactively as opposed to maliciously in an attempt to defend themselves. Furthermore, youth who experience hyperarousal in moments of fear may demonstrate resistance, defiance, and aggression as their fear intensifies (Perry, 2003).

NSSI is often reported among adolescents who have experienced potentially traumatic events in their lives (Zetterqvist, Lundh, & Svedin, 2013). NSSI often serves as a *tension reduction behavior*, or a means of providing temporary distraction or relief (Briere & Spinazzola, 2005). High-risk sexual behavior and substance abuse have also been categorized as tension-reducing behaviors. Both male and female adolescents with histories of complex trauma are more likely to engage in early sexual behavior, less likely to use contraception, and more likely to experience an unintended pregnancy than nontraumatized peers. Similarly, there is substantial research linking comorbidity between substance abuse and complex trauma (e.g., Dass-Brailsford & Myrick, 2010). Finally, adolescents who experience

complex trauma are vulnerable to revictimization. There are many theories that account for such a relationship, including the notions that individuals miss cues before or during dangerous situations, or have learned to relate to others in maladaptive ways.

Impairment in Self-Concept

The cognitive appraisal of potentially traumatic events is closely tied with posttraumatic outcomes. When adolescents are repeatedly exposed to physical and emotional harm, rejection, neglect, and violations of personal safety and integrity, they may come to experience themselves as helpless, worthless, and unlovable. Such beliefs contribute to low self-esteem, which has also been associated with aforementioned behavioral outcomes such as aggression and delinquency (Donnellan, Trzesniewski, Robins, Moffitt, & Caspi, 2005).

Adolescents who experience complex trauma may feel isolated, believing their experience is unique (Broderick & Blewitt, 2010). They may report feeling different from their nonabused peers or fear they are damaged permanently (Meiser-Stedman et al., 2009). They may struggle to relate to others and choose to distance themselves from family and peers (Eckes & Radunovich, 2007), have low expectations for their futures (Thompson et al., 2012), or see the world as unsafe and unjust. The interpretation of posttraumatic symptoms can also impact adolescents' views of self. In addition to enhancing feelings of loss and lack of control, trauma survivors sometimes see intrusive symptoms (e.g., flashbacks) as a sign they are "going mad." They may also interpret emotional numbness as a sign they are forever damaged and will never again be able to experience closeness with others.

A PHASE-BASED, INTEGRATIVE PLAY THERAPY APPROACH WITH ADOLESCENTS

The potential issues that occur across developmental domains highlight the need for a treatment addressing the complicated nature of complex trauma. The complex trauma literature describes three overarching phases of treatment, including (a) *stabilization and safety*, (b) *trauma processing*, and (c) *reconnection*. In the first phase, treatment goals include enhanced symptom control, affect and impulsive-control skills building, psychoeducation regarding symptoms and treatment, and the establishment of a collaborative therapeutic alliance. Additionally, clients may begin to understand the role that trauma history plays in self-destructive behaviors. Once clients are sufficiently stable, they may begin processing traumatic memories, exploring cognitive distortions, and expressing previously avoided emotions. It is in this phase that clients develop a coherent narrative of their past, establish mastery over their emotions, and begin to see themselves more accurately and less negatively (Courtois & Ford, 2009). The final stage of treatment involves reconnecting patients with aspects of themselves and working toward life goals, such as healthy relationships and productive activities. The phases are not meant to be linear; rather, most researchers state that there should ideally be alternation

between phases, and that safety and alliance are addressed throughout all the stages of complex trauma treatment (Brand et al., 2012; Green, 2012). Only recently has the recommendation for phase-based treatment been extended to adolescents who have experienced complex trauma (Cook et al., 2005). For example, the authors of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006) have discussed the ways in which treatment components can be reorganized to address the needs of complexly traumatized youth (Cohen, Mannarino, Kliethermes, & Murray, 2012).

Integrative play therapists may incorporate insight-based, age-appropriate approaches (i.e., Jungian play therapy) into empirically supported approaches to psychotherapy (Green, 2012). Play therapy provides the child or adolescent with a developmentally appropriate means of improving affect regulation, self-efficacy, problem solving, and formation of trust within the therapeutic relationship. Play therapy may be useful as an adjunctive psychotherapy when addressing disrupted adolescent development, specifically following trauma, because of resulting neurophysiological changes that impede verbal expression and require nonverbal retelling of their trauma narrative through nonverbal play (Badenoch, 2008). Integrating play therapy with cognitive–behavioral protocols has been recommended for treating traumatized adolescents. It allows, as a central goal, an empathic, therapeutic relationship to be nurtured. Moreover, the integration of play therapy with phase-based treatment may enable clinicians to expand their repertoire of supportive interventions to promote safety, the resolution of traumatic material, and a healthy transition to future life. The following sections delineate a phase-based, integrative, play-therapy approach to conceptualize the treatment of complex trauma in adolescents. One final point: Play therapists are encouraged to work collaboratively within a multidisciplinary team of medical and mental health professionals when treating complex trauma. Mental health therapists should ideally generate a collaborative treatment approach that follows best practices and are closely aligned and congruent with the medical, pediatric psychiatry, and neurophysiological aspects of care.

Phase 1: Safety and Stabilization

The first phase of treatment involves adolescents (a) reducing their self-destructive behaviors, (b) understanding and managing symptoms, (c) engaging in self-care, (d) developing a working alliance with the therapist, and (e) regulating painful affect and destructive impulses. The trauma literature states that the first mode of intervention for traumatized adolescents begins with relaxation (Badenoch, 2008). The autonomic nervous system must be calmed free of anxieties before further treatment within the phase-based approach can be executed. Specifically, play therapists should typically start their trauma-informed treatment with activities to sooth and relax the adolescent, such as guided imagery, progressive muscle relaxation, or meditation. This work cannot be underestimated and must be paced sensitively to avoid overwhelming the adolescent by working with dense, traumatic material too soon. The cognitive resolution of potentially traumatic events through constructing a "trauma narrative" is not indicated or psychologically safe, perhaps,

for clients who are clinically depressed, suicidal, or engaging in self-injurious behaviors. Thus, safety and stabilization is not only the first phase of treatment but also the central, ongoing aspect within the gestalt of trauma-informed treatment.

The development of a psychologically healthy, therapeutic relationship with an adolescent is crucial during this first phrase of treatment. Such a relationship with an adolescent may provide an opportunity for a *corrective emotional experience* (Green, Myrick, & Crenshaw, 2013); and for teens affected by complex trauma, this is the core of psychotherapeutic change (Cohen et al., 2012). One study found that traumatized adolescents ranked (a) long-term working therapeutic alliances, (b) open discussions with trusted adults, and (c) access to nonjudgmental, caring individuals as the most beneficial treatment strategies. As the therapeutic relationship may be one of the first positive bonds the traumatized adolescent experiences, caring may sometimes take the form of setting and reinforcing boundaries in therapeutic, noncritical ways. Experts in the field of complex trauma suggest responding to safety concerns calmly, matter-of-factly, and seriously, while gently pushing the client toward change. Understanding the teen's difficulty in managing affect and traumatic memories, while setting firm limits on unsafe behavior, is of paramount importance.

Self-care is an important aspect of stabilization. In the "My Body Needs" activity (Myrick, 2010), adolescents draw pictures of themselves and identify parts for which they care or show care. For example, a client may draw or write about nutrition near the stomach, draw a jacket on the drawing to reflect dressing appropriately for the weather, and draw a comb near the hair. *Care tags* (Smith, 2008) promote the understanding and healthy expression of needs, thoughts, and feelings. Adolescents create tags that include the following statement: "When I feel _____ [behavior, action, or situation], I am feeling _____, and I need _____."

Many traumatized adolescents will not have the self-awareness to complete this activity early in treatment; it can be an ongoing process in therapy. Further, some adolescents will need the therapist to ask direct questions such as, "What would I see when you were feeling angry?" or "What helps the anger go away?" These probes may assist adolescents with identifying and expressing internal or emotional turmoil. Nikki,[1] who was sexually abused by her biological father, found this play-based activity particularly powerful when she shared it with her foster mother. The activity allowed them the opportunity to talk about Nikki's needs; subsequently, they used the care tags as a way to "slow down" arguments, identify feelings, and determine healthy ways to meet Nikki's needs.

Safety contracts are a concrete way to set limits upon dangerous behavior while fostering accountability and responsibility. Some adolescents enjoy writing their plan, which might include calling a social support, using relaxation or imagery skills learned in sessions, engaging in a pleasant activity, and going to a safe place (i.e., local ER) if feelings become unmanageable. Other adolescents create a *distraction box* that includes favorite activities, "coping cards" of helpful statements, and calming objects. Megan had endured sexual abuse by her stepfather and several placements with different foster parents. She enjoyed making a distraction box that was "just for [her]." In it, she included a rock to represent walks outside, spices for

[1] All identifying information of patients has been altered to protect confidentiality.

cooking, a relaxing CD, movie stubs to represent a social activity, and coping cards with positive self-statements. Over time, she added a thank-you card from a teacher and pictures with new friends.

Phase 2: Trauma Processing

The stabilization and safety phase of treatment varies by adolescent, and therapists are again reminded to pace treatment carefully and base it upon individual adolescents' decisions of when and how to move forward. Stabilization can range anywhere from a few weeks in treatment, to many months focused on decreasing unsafe behaviors and managing crises. Once adolescents are sufficiently stabilized, however, they can move toward the next phase of treatment, *trauma processing* or *trauma experience integration* (Blaustein & Kinniburgh, 2010; Green, 2012), wherein adolescents are challenged to apply their newly learned stabilization skills as they come to understand their life experiences in a new way (Cohen et al., 2012). Trauma processing is no longer the primary goal of posttrauma treatment, nor is it expected or overly encouraged by the therapist. Preparation for the intensity of this phase of treatment is important before beginning any discussion of traumatic material, and there are no expectations placed on the adolescent in terms of pace or topic. The adolescent leads his own way to the healing, and therefore determines if he chooses to share his trauma story or not. If the adolescent willingly, and without subjective or indirect persuasion, wants to share the trauma narrative, Cohen and colleagues (2012) recommend the therapist helping the adolescent to identify a central theme among the traumatic experiences to process, rather than trying to identify the "worst" singular event. They recommend developing a *life narrative* through which adolescents can begin with their earliest memories and proceed forward, processing the way in which trauma has been incorporated in their lives.

The gentle challenging of the adolescent's cognitive distortions or misattributions is important in this phase of treatment, as outlined in TF-CBT and other cognitive–behavioral therapies (CBTs). Although this cognitive work often begins in the safety and stabilization phase, it is during the formation of a life narrative that cognitions may be more frequently discussed and challenged. Some teens vacillate between a belief they can avoid traumatic material and a desire to free themselves from the knowledge of their trauma (Cozolino, 2010). Fears of feeling powerless and views of oneself as being inherently "bad," for example, may also contribute to the way in which the adolescent's life narrative is constructed. These complex beliefs can be addressed within the safe space of the play therapy treatment at a pace the adolescent can regulate.

For some adolescents, expressing themselves through nonverbal expressive arts, as opposed to traditional talk therapy, is less threatening. Furthermore, adolescents talking about traumatic experiences in psychotherapy are insufficient for the mind and brain to integrate images and cognitions into a unified whole (Green, 2012; van der Kolk & d'Andrea, 2010). Zack chose to create his trauma narrative about parental neglect and multiple placements in the form of a series of comic strips. His sister, Shannon, preferred to write a song to play on her guitar.

Van der Oord, Lucassen, Van Emmerik, and Emmelkamp (2010) discussed how cognitive–behavioral writing therapy (CBWT) combines personal self-expression through creative and narrative writing. Additionally, CBWT integrates evidence-informed CBT tenets, such as psychoeducation, cognitive restructuring, encouraging adaptive coping, and social sharing (Green, 2012).

The authors have utilized play therapy, especially with sand trays and miniatures, as a means for adolescents to share and visualize their inner feelings, if they choose, and to do so at their own pace and direction. Missy divided the sand tray in two, using miniatures to create the family she wished she had on one side, and she placed the symbols of trauma on the other side of the tray. This sand picture served as a gentle catalyst for Missy to discuss her emotions, such as thinking herself undeserving of a loving family and seeing herself as stuck in the throes of the complexities inherent within the trauma. Drawing and painting can also be used by play therapists during this phase; Andrew found it soothing to paint abstractly and symbolically express his feelings related to the feelings associated with years of physical abuse. Faith drew "before" and "after" pictures that led to her emotions about being permanently damaged, weak, and different. The trauma narrative process presents an opportunity for adolescents to construct a coherent narrative of their life and their traumatic experiences through creative processes that emphasize healthy expression through verbal or nonverbal means.

Phase 3: Reconnection and Reintegration

Once adolescents have completed their life narrative, processing cognitions and feelings associated with their experiences, the final phase of treatment involves reconnection and reintegration into the world and healthy nontherapeutic relationships. Effective trauma-informed psychotherapy with adolescents increases experiences of bodily excitation in the present moment, as opposed to rigidly adhering to the facilitation of the trauma narrative. Therapists partially facilitate this process by assisting adolescents with tasks that imbue self-mastery of trauma exposure, thereby tolerating affective states safely and effectively. Specifically, the integration of play-based interventions with adolescents provides creative opportunities to increase present-moment integration of the multisensory experience (Green, 2012; van der Kolk & d'Andrea, 2010).

Although the first two phases are somewhat specific in terms of the goals and skills, the third is less delineated or structured. For a majority of complexly traumatized adolescents, skills building, developing a treatment alliance, and challenging trauma-infused beliefs are necessities in treatment, whereas needs in the final phase are more individualized. Treatment goals may change to address specific issues, such as identity, spirituality, and the future. One adolescent client, Johnny, worked through issues of sexuality and developing healthy romantic relationships, whereas another client, Sammy, worked on increasing independence and setting career goals in his later sessions. Both had experienced several abusive and neglectful relationships with caregiving adults. Thus, the common factor in both therapies was a focus on resilience, wellness, and strengths. Adolescents often apply their new skills and test ideas spontaneously with the play therapist during this final phase as they develop a sense of identity.

The enhancement of positive affect is another important component of the third phase of treatment, and includes a focus on the adolescent's self-esteem and personal achievements. This can be addressed through cooperative play-based interventions. For example, therapeutic board games may allow for positive social interactions between the adolescent and therapist. Another benefit from engaging in competitive, yet cooperative, play via board games is the ongoing development of social skills. These types of nurturing and skill-based exercises may be achieved while listening to music that an adolescent identifies with, allowing him to express himself and nurture a positive, more realistic view of the self (Green, 2010, 2012).

Coloring mandalas is an expressive art therapy intervention that comprises coloring circular patterns and that can be used with a variety of therapeutic goals in mind (Green, Drewes, & Kominski, 2013). The authors of this article have used mandalas as expressive art therapy activities, in which each color used represents a characteristic the adolescent likes about himself (the adolescent chooses the colors and decides what they mean). These mandalas can be ongoing "projects" in the therapy session, and serve as a metaphor for the whole self that is made up of many parts. Research has also demonstrated mandalas to be effective in decreasing anxiety (Curry & Kasser, 2005; van der Vennet & Serice, 2012). To incorporate movement, exercise, and uniqueness in integrative play therapy, adolescents can create dances to their favorite songs and use the therapist as an audience. All of these experiences, while less trauma-specific, highlight ongoing treatment goals and foster resilience. One teen girl tried out for her school play after realizing how much she enjoyed putting on puppet performances during her play therapy sessions.

Finally, adolescents should be provided with a nonthreatening opportunity to include their nonoffending caregivers in the phase-based play therapy process whenever possible. Play therapists may facilitate family sand-tray sessions (Green & Connolly, 2009), or encourage caretakers to join in family drawings, games, or exercises, when appropriate. Including caretakers in the final phase of treatment encourages the adolescent to begin transferring their trust relationship from the therapist to the caretaker, and encourages the gradual sharing of communications about trauma (Cohen et al., 2012, p. 538).

CONCLUSION

Knowing the effects that complex trauma may have on adolescents' typical development is integral for play therapists when counseling this unique population. A complexly traumatized adolescent may require more flexibility and focus on the therapeutic relationship with empirically supported treatments than nontraumatized or singly traumatized youth. The three-phase approach outlined in this article allows for adaptability according to the needs of the client, as well as the unconditional warmth and acceptance of the play therapist. The quality of the nonjudgmental therapeutic relationship is the most salient factor of the three-phase treatment process because, through it, adolescents may begin to believe in their self-worth. In addition, they may begin to demonstrate improvements in their coping alongside the increased sense of attachment that derives from a caring relationship with a trusted adult. The therapeutic relationship may help adolescents view constructive examples of safety, stability, and

security in examples of safety, stability, and security in their world. They may, perhaps for the first time, see a positive potential future, wherein they begin to see their current world, and possibly their future one, in more hopeful and positive terms (Green, 2012).

Execution of a phase-based approach, using integrative play therapy, begins with the therapist receiving adequate training or professional development in research-based protocols, including TF-CBT. Although much of the research in treating adolescent complex trauma focuses on TF-CBT, during the writing of this article, no published studies were available measuring the efficacy of the treatment program with a complex trauma population. Therefore, treatment of complex trauma in adolescents within a phase-bases model is still early in its development: "Play therapists should receive training in research-based protocols, including TF-CBT, as well as be open and receptive to clinical supervision, when integrating play" (Green, 2012, p. 14) with this unique population. Play therapists are advised to work within a multidisciplinary team of medical and mental health professionals to align treatment goals and interventions with cross-disciplinary best approaches. Finally, therapists are encouraged to collaborate with the adolescent and the family directly on successful treatment outcomes, as the therapeutic alliance and correlated acceptance felt within this professional relationship facilitates the posttraumatic path toward growth and healing.

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