TF-CBT Booster Training

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1

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2

Objectives:

Clinicians will increase competence in:

1. Utilizing critical elements in TF-CBT such as gradual exposure, homework, and conjoint sessions
2. Distinguishing and addressing crises of the week and barriers to treatment
3. Recognizing vicarious trauma and utilizing different solutions
4. Formulating the necessary steps to support clients in creating their trauma narratives

3

TF-CBT Check In

- How many have a TF-CBT case?
- More than one?
- Five?
- Finished a case?
- Barriers?
- Successes?

4

5

TF-CBT: Quick Overview

- Effective tx for clinically significant PTS/PTSD
  - 20 randomized clinical trials
  - 50 scientific publications
  - Equally effective with boys/girls, different ages, different ethnicities/races
  - All trials have included some youth with Complex PTSD and many youth with some sx of Complex PTSD

6

Resources

NCTSN.org

https://tfcbt.org/

Traumatic Grief website - http://ctg.musc.edu/

http://www.nctsn.org/products/courage-remember-curriculum-guide

http://www.ncbi.nlm.nih.gov/pubmed/

BOOKS:

Treating Sexually Abused Children and Their Nonoffending Parents

Treating Trauma and Traumatic Grief in Children and Adolescents

Trauma-Focused CBT for Children and Adolescents: Treatment Applications

Child Sexual Abuse: A Primer for Treating Children, Adolescents, and Their Nonoffending Parents

7

TF-CBT Sessions Flow

Entire Process is Desensitization

Baseline Assessment

Sessions	1-4	5-8	9-12
	Psychoeducation **P**arenting Skills **R**elaxation **A**ffective Expression and Regulation **C**ognitive Coping	**T**rauma Narrative Development and Processing **I**n-vivo Gradual Exposure	**E**nhancing Safety and Future Development

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8

Critical elements in Trauma Focused Cognitive Behavioral Therapy

- Gradual Exposure IN EVERY SESSION
- Components based (complete components sequentially)
- Meeting with child and parents separately and together
- Prepare for joint session in advance
- Using agendas
- Assigning and reviewing homework
- Using role plays
- Time limited, structured model: 12-20 sessions
- Therapist: Directive and active!

9

Role plays:

1. Therapist models for parent or child
2. Child/parent practices with therapist
3. Child/parent does in conjoint with therapist coaching, or then practices the skill at home

10

GRADUAL EXPOSURE

- Gradual exposure: the process through which children and parents undergo incremental desensitization to trauma reminders, and as a result experience relief from emotional and physiological distress upon re-exposure.
- Gradual exposure occurs THROUGHOUT TF-CBT, not only during the trauma narrative.

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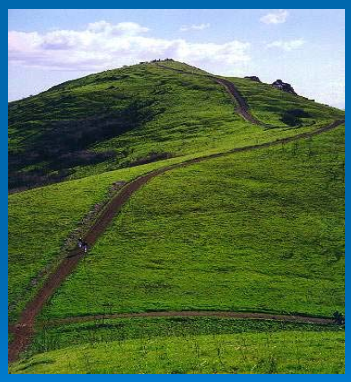
11

Gradual Exposure



12

Crisis of the week (COW) vs. (BOSS) Barriers and obstacles to safety and stability

- COW – method of avoidance that ultimately prevents TF-CBT work and/or poorly managed trauma related behavior difficulties that need to be re-directed to the Parenting component of TF-CBT
- BOSS – more serious issues that need to be addressed as soon as possible

13

MANAGING COWs

- Many therapists get derailed in providing TF-CBT by COWs, so COWs work to avoid addressing the child's trauma.
- Therapist behavior may be complicit in COWs
- "Small talk" can become a loose COW
- Therapist's conceptualization of role is important
- Recognize when COWs are a form of avoidance

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14

Why do families bring us their COWs?

- They think that is what therapy is for.
- We don't tell them not to.
- We want to "meet them where they are at" so we focus on the COW.
- They are being avoidant- COWs are WAAAAY easier to discuss than trauma!

15

Example Agendas

Child/Teen Agenda

- ***Homework review***
- ***Jeopardy game***

  OR
- ***Myth vs Facts***
- ***Fun time (5 minutes)***

  (ie, practicing a coping skill through a game)

Caregiver Agenda

- Anything they want to add to the agenda?
- Homework review
  - Theirs
  - Child's
- Review psychoeducation sheets, plan for joint

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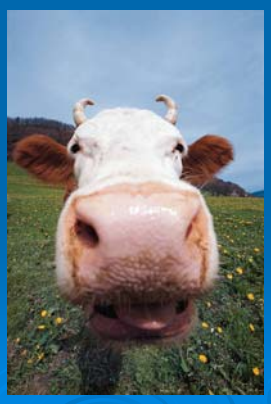
16

Crisis of the Week activity



17

Breakout scenarios

- 14 year old girl in psychoed session about sexual abuse. Goals are to assess her knowledge of and distortions around sexual abuse, provide additional information, normalize, and get her more comfortable talking directly about sexual abuse. She comes in crying and says girls at school won't talk to her today.
- 4 year old boy who witnessed 2 younger sisters die in a house fire has started his narrative. Plan for session today is to have mom read most current version. Instead, she insists on discussing some problematic behaviors (hitting, lying) that his is having at home this week.
- Following the conjoint on the trauma narrative for 7 year old boy who witnessed domestic violence, the mother reports the child is going to stop therapy because she is signing him up for soccer and doesn't think the last part of treatment (enhancing future safety) is that relevant for him anyway.
- 5 year old girl in cognitive coping component, is in foster care placement and is about to move to a new placement. How might you proceed with her treatment and new foster parents?

18

GE: PSYCHO-EDUCATION

- GE starts with the initial phone contact and assessment.
- Refer to the child's trauma by name (not "the thing that happened to you"; "your child's experience"; "this difficult time"; "your loss", etc.)
- The terms "sexual abuse", "domestic violence", "death", "physical abuse", etc. are hard to say and hear, but this is the start of GE.
- Provide accurate and hopeful information about these experiences while you refer to them by name. This pairs non-avoidance with positive information.

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19

Psychoeducation Goals

- Orient to model
  - Agendas
- Begins at first session and continues throughout course of treatment
- Provide information about PTSD, TF-CBT, trauma, common reactions, adaptiveness of sxs, normalize sxs, etc.
- Tie assessment results to treatment plan
- Explain treatment plan and rationale for skills, exposure and processing
- Provide hope
- Highlight caregiver's role

20

Explaining the model

- Basement metaphor
- Other metaphors/analogies?
  - Wound analogy
  - Pool
  - Life jacket
  - Winter coat
  - Dentist
  - Walking with a glass full of water
  - Rocks in backpack

21

Symptom Tracking

Suggestions for how to choose what to track:

- What is most distressing to your client?
- What is most disturbing to caregiver?
- Sleep is HUGE!!
- Safety!

TIPS:

1. Keep a narrow focus
2. What you track will decrease, what you don't won't.
3. Make it easy!!
   - Red, Yellow, Green
   - Make it part of your session's regular routine. Check in at the beginning!

22

Functional Behavioral Analysis… What gets the symptom started and keeps it going?

- FIRST Operationalize:
  - What are the most distressing symptoms?
  - How often are they happening?
  - How severe are the symptoms?
- THEN Analyze:
  - When are they happening?
  - What happens before the symptom?
  - What happens after?
  - How is parent/child responding to symptom?
  - Where is symptom happening?

23

Engaging caregivers activity

1. Parent is so angry about the sexual abuse that he/she repeatedly interjects regarding his/her desire to kill the perpetrator.
2. Mother expresses that she understands her son was negatively affected by his exposure to his father's violence, but she is so angry at him she just doesn't think she can work with him. He is just like his father – he is a bully and doesn't listen to a word she says.
3. Parent is so distressed and talkative, it is difficult to get a word in. Parent feels they will never be able to recover from all that they have lost due to the hurricanes and is very depressed.
4. Parent is not convinced the sexual abuse actually happened. She has known the alleged perpetrator all her life as they were childhood sweethearts. They recently reunited and she cannot believe he would sexually abuse.
5. Parent refuses participation expressing that he/she doesn't need therapy and/or can't handle hearing about child's victimization. Parent who has a just fix her attitude about child.
6. Foster parents feel that they don't really know how they can help because they weren't there when the child suffered the traumas.

24

Parenting

- Teach positive parenting strategies to manage behavior problems
- Improve relationship between child and caregiver
- Decrease parental stress
- Increase parental engagement

ROLE PLAYS! HOMEWORK!

25

https://www.youtube.com/watch?v=V93-mOwkw3I

26

Parenting

- "Not in the business of making perfect families, just helping them take one step"
- "You never know until you try if this is going to be the parent who changes"
- "Behaviors are not a reflection of parents but from trauma"

Quotes from Esther Deblinger

27

How do you Teach Behavior Management to Caregivers?

- Modeling
- Role Plays with parent
- The Feedback Sandwich
- *Repeated Practice* with increasingly difficult child behavior/responses
- Watch parent with the child to see the skills in action and be able to problem solve with the parent

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28

Resources

- Off Road Parenting
- The Defiant Child
- Parenting the Strong Willed Child
- The Incredible Years
- Parent Child Interaction Therapy
- Win the Whining War

29

C onjoint parent child sessions Goals

- Move from place of shame to pride
- Increase open communication between parent and child
- Develop positive relationship
- Decrease avoidance
- Enhance therapy compliance
- Help child back to healthy developmental trajectory

30

P sychoeducation about Trauma

- Provide gradual exposure
- Use SOCRATIC METHOD to:
  - Normalize response to abuse
  - Assess knowledge
  - Reinforce accurate cognitions about abuse and begin to correct inaccurate
  - Provide information on how OTHER children who have experienced this type of trauma think, feel, act, what they worry about; who else experiences this type of trauma, who perpetrates this trauma and why

31

Socratic questioning

- Asking strategic questions, often open ended questions to gather the information the client already knows
  - Empowers client that they already have information
    1. Clarification questions
    2. Probing assumptions
    3. Probing rationale, reasons, evidence
    4. Questioning viewpoints and perspectives
    5. Probing implications and consequences
    6. Questions about the question

32

Tool for Psychoeducation: Helping caregivers and kids do the work

Socratic Questioning/Dialogue – ie., what is sexual abuse, how often does sexual abuse happen, etc.

- Steps for the therapist
  - What is your endpoint?
    - Don't have to have an endpoint
  - What questions do you ask to get them there?
  - Eventually you may/will have to provide some information, but use questioning technique as much as possible

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33

Psychoeducation Practice

Brainstorm what would be important to cover, what socratic questions could you use, what games could you play if the trauma were:

1. Crossing into the US from Mexico illegally with a coyote – 16 year old
2. Being placed in foster care – 7 year old
3. Being in a severe car accident – 13 year old
4. Witnessing a drive by shooting – 15 year old
5. Death of sister from falling out a window – 10 year old
6. House being destroyed by a fire – 4 year old
7. Being bitten in the face by a large dog – 8 year old

34

Relaxation/Coping Skills

- Reduce physiological manifestation of trauma symptoms
- Increase client distress tolerance (general and trauma-related)
- Enhance ability to use relaxation skills during trauma narrative component

35

GE: RELAXATION

- When asking about relaxation, reference child's and parent's assessment and their physiologic arousal related to trauma reminders.
- When considering different relaxation strategies (e.g., home, school, sleepovers, etc,), include "what will work best when you are reminded of (traumatic experiences)?
- Connect relaxation skills to child's other trauma symptoms
- Make a few contingencies and have the child practice these, see what works best related to trauma reminders.

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36

Affective Expression Goals

- Teaches children to recognize connection between emotion, cognition and physiological response.
- Helps children identify physiological triggers.
- Gives children the language required to fully describe their traumatic experiences.
- Helps children distinguish between different emotions.
- The more children can talk about their feelings, the less they have to act on them.

37

GE: AFFECTIVE EXPRESSION/MODULATION

- During affective expression, include question related to "which feelings did you feel when you experienced trauma?", as well as " where in your body did you feel that feeling?", "how big was that feeling?"
- During affective modulation, include exploration of affective dysregulation related to traumatic reminders, and how to re-regulate affect in this regard.
- Focus is on recognizing emotional triggers and regulating emotion, not on description of the experiences themselves.
- If trauma reminders are prominent cause of dysregulation, may not gain optimal regulation of affect until after completion of narrative.

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38

Cognitive Coping Goals

- Establish connection between thoughts, feelings, behaviors, consequences
- Identify inaccurate or unhelpful thought patterns
- Develop skills to change unhelpful thoughts
- Encourage caregivers to assist children in cognitive coping with upsetting events and to use these skills in their own everyday lives for affective modulation

39

GE: COGNITIVE COPING AND PROCESSING

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- "What are thoughts that children have when they go through that trauma type?"
- Why not change the unhelpful trauma related thoughts? Dysfunctional thoughts are more likely to be expressed during the narrative than before and it may keep children from sharing their unhelpful, maladaptive thoughts that they had at time of trauma.
- Parents are encouraged to examine trauma-related cognitions during this component.

40

Addressing trauma related thoughts in cognitive coping

Steps for the therapist – acknowledge what you naturally want to say and pause.

1) Reflect and validate (empathic listening, normalizing, clarifying questions)
2) Review psychoeducation
3) Practice coping strategies for this thought

41

Documenting Trauma: Goals

- Gradually desensitize the client to thoughts, feelings and reminders of the trauma
- Help client to organize events
- Help client recognize, anticipate and prepare for traumatic reminders of the trauma.
- Unpair fearful associations around trauma reminders
- Contexualize events and make meaning
- Increase mastery and efficacy
- Narrative will be used for corrective information processing

42

Goals of Trauma Narration and Processing

- Reduce physiological, affective, and cognitive manifestation of trauma symptoms
- Increase distress tolerance (general and trauma-related)
- Unpair trauma reminders from overwhelming negative physiological response, affect, and cognitions
- Enhance coherence and organization of trauma memories
- Identify and correct trauma-related cognitive distortions

43

Goals of Trauma Narration and Processing (con't.)

- Increase self-efficacy regarding initial and current response to trauma
- Enhance ability to conceptualize trauma history as a coherent, meaningful narrative
- Enhance caregiver support of client regarding healthy trauma-related cognitions, self-efficacy (initial and current response to trauma), and contextualization of trauma history

44

Tasks of Individual *Trauma Narration and Processing, Part I* Sessions with Client

- Introduce trauma narration
- Incorporate trauma specific memories, including “worst” memory
- Expose client to content of previous narration sessions

45

Tasks of Individual *Trauma Narration and Processing, Part I* Sessions with Caregiver

- Introduce trauma narration
- Process all content of client’s trauma narration with caregivers each session if possible

46

Tasks of Individual *Trauma Narration and Processing, Part II* Sessions with Client

- Identify trauma reminders
- Identify cognitive distortions
- Incorporate trauma-specific psychoeducation
- Replace cognitive distortions with helpful cognitions
- Identify effective client responses
- Conceptualize trauma history as coherent meaningful narrative
- Prepare for conjoint session

47

Tasks of Individual *Trauma Narration and Processing, Part II* Sessions with Caregiver

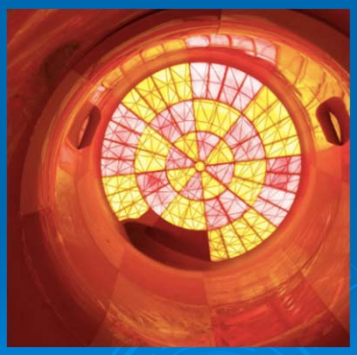
- Identify trauma reminders within narration
- Identify cognitive distortions
- Replace cognitive distortions with helpful cognitions
- Identify effective client responses at time of trauma, throughout treatment, and now
- Conceptualize trauma history as coherent, meaningful narrative
- Prepare caregiver for conjoint session

48

What's the rationale for doing a trauma narrative?

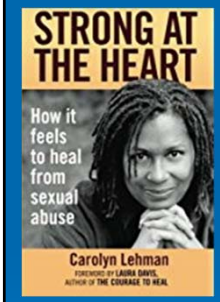
GOALS!

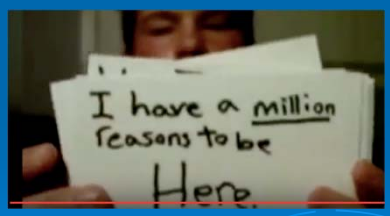
49



50

Introduce Trauma Narration





https://www.youtube.com/watch?v=ILKT-3U6c9I

51

Incorporate trauma specific memories, including "worst" memory

- Use a timeline and index cards to organize memories and enhance recollection
- Refer back to UCLA and order of events from most to least scary
- Ask, "What was the event/memory you never thought you would tell anyone?"

52

Expose client to content of previous narration sessions

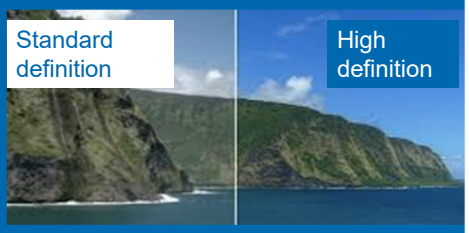
- Summarize non-trauma-related material
- Track SUDS each time

53

Identify Trauma Reminders

54

Identify Trauma Reminders



55

Identify Cognitive Distortions

56

FACILITATING DETAILED NARRATIVES

Review the child's description

- Help the child to describe more details
  - What happened next?
  - And then?
- Go slow. Repeat back to them what you are writing
- Encourage child to describe thoughts, feelings and body sensations related to the trauma

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57

GRADUAL EXPOSURE HINTS

- Help child re-create the scene
- Avoid asking questions
  - Do you remember?
  - Can you do this?
- Be patient with pauses and silence
- Do not plan GE for the end of session

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58

TIPS FOR FACILITATING DETAILED NARRATIVES

- **Ask broad, open-ended questions**
  - What were you thinking?
  - What were you saying to yourself?
  - How were you feeling?
  - What happened next?
  - What did you see/smell/hear?

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59

TIPS FOR FACILITATING DETAILED NARRATIVES

- **Make clarifying and reflective statements**
  - Tell me more about it…
  - I wasn't there, so tell me…
  - I want to know all about…
  - Repeat the part about…
  - Tell it to me like a story/movie…
  - Tell me what was happening frame by frame…
  - Put me in your skin. I want to be there with you knowing exactly what it was like for you.
  - So, your uncle began touching your vagina…
  - So, when your mom stabbed your daddy..

60

My uncle came into my room to kiss me goodnight. He pulled down the covers and touched me down there. I felt scared. I pretended I was asleep. When he was done, he left. The next morning I got up and my uncle said, “Good morning, how are you?” and I said, “Fine”. I went to school.

61

My uncle came into my room to kiss me goodnight. ***I felt good.*** He pulled down the covers and touched me down there, ***on my vagina.*** I felt scared ***and dirty, and thought why is he doing this, he’s my favorite uncle.*** I pretended I was asleep. When he was done ***touching my vagina,*** he left. The next morning I got up and my uncle said, “Good morning, how are you?” and I said, “Fine”. ***Inside I felt scared and I didn’t know what to say or do.*** I went to school.

62

Managing Avoidance: TN and Other Components

- Agendas/Structure – from beginning of the model
- Building in rewards for focusing and being brave
  - Examples of rewards you've used?
  - Managing time for rewards (5 min.)
- Building in gradual exposure from the beginning
- Review goals of model
- Finding out what the client loves and excites them; building into the TN (Poems, art, music…)
- Make it clear it is time-limited
- Liberal use of praise
- Caregiver buy-in and encouragement

63

Tips for Managing Avoidance Around the TN (cont.)

- Use books
  - Please Tell (little ones)
  - Strong at the Heart (females; sexual abuse)
  - Journaling books (sexual abuse: In my Own Words, others)
- Consider limited choices each session, and not a timeline
- 80% kids who do TF-CBT get better (didn't meet criteria for PTSD at study conclusion)
- 80% of caregivers/kids say the TN was the most helpful part of treatment on an open-ended questionnaire at treatment completion

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64

EVALUATING TRAUMA NARRATIVES

- Did the child describe the trauma in extreme detail?
  - Developmental, cognitive considerations
- Re-read book for accuracy and dysfunctional thoughts.
- Identify "hot spots" or "stuck points" or "worst moments"
  - Problematic cognitions
  - Cues that elicit fear, anxiety, depression
  - Cues that prompt emotion avoidance
  - Places where narrative "skips," lacks detail, or changes in quality
- Aim for genuine emotional arousal, emotion regulation, and appropriate emotional expression.
  - permission to curse, use 'bad' language
- Rate distress before, during, after trauma descriptions.
- Repetition of the narrative is necessary.

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65

What's Missing?

He followed me off the bus. I could hear him behind me laughing with some other kids. I thought he might have been talking about me and I felt uncomfortable. My heart was beating fast. I was wishing my friend Bella was with me but she had to stay after school that day. I knew no one would be home when I got to my door and I started planning how I would run in the house fast and slam the door. It was a nice day and I remember thinking it was weird that no one else was outside. I wondered why the bus driver hadn't told them to stay on the bus because this wasn't even their stop. Then he said, "Hey! I want to come inside." I didn't want him to. He pushed me down on my bed. He was heavy and I couldn't breathe. I kept thinking I wish my brother would call. I was looking at my phone the whole time. It never rang.

66

GRADUAL EXPOSURE WITH CAREGIVERS

- Sharing the child's "work" with caregivers
  - Don't wait until the end of treatment!
  - Use hierarchy- start with more innocuous parts (about the author, advice to others)
  - Gradually show them TN materials; read what the child has written, show pictures
    - Address confidentiality
  - Elicit parent's reactions, feelings
  - Provide a safe place to ask questions and express a range of emotions and thoughts, even the socially undesirable ones
  - Work with caregivers on changing their unhelpful and maladaptive thoughts about the trauma/child's narrative

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67

Positive Ending (8 year old)

Chapter 10
Why I am a Wonder Girl!

My therapist, Ms. Shelley, she always says that I am a wonder girl. I think it is because I told how Daddy Jim was seeing us when he wasn't supposed to be seeing us and even when I didn't always want to work on talking about hard things, I really tried. She is really proud of me and I am really proud of myself, too. Even though I told I don't brag about it or anything. Right now I am really shocked because this is my last chapter. Y'all might be shocked, again remember, that I am an eight year old girl writing this book and that is INCREDIBLE!! Do not and I mean DO NOT be afraid to tell if you are sexually abused. It's ok to think about what happened sometimes, but you can also try to do things like breathing or thinking of a place that makes you happy and that might make you feel better. I could have not done this if it were not for my therapist, Ms. Shelley. I thank all of the people have encouraged me to keep on working hard, like Ms. Ella, Peggy, my foster sisters, my Mom, my sister, Ms. Shelley and Ms. Jennifer.

68

Trauma Narrative role play

69

COGNITIVE PROCESSING OF THE TRAUMA

- Explore inaccurate or unhelpful cognitions about the trauma and the feelings that accompany them
  - Inaccurate thoughts (ex: "the sexual abuse was my fault")
  - Unhelpful thoughts (ex: "you can never tell when a drive-by shooter might hit you")
  - Inaccurate AND unhelpful thoughts (ex: "it's my fault my mother was killed in the hurricane. I should have made her evacuate sooner.")
- Look for thoughts that are permanent, pervasive and personalized
- Also focus on helpful and adaptive cognitions in narrative

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70

Cognitive Processing

- Responsibility Pies
- Best Friend Role Play (imagine best friend has similar negative thoughts and they need to try to help the best friend feel better by challenging the negative thoughts)
- You be the Therapist
- Logical Questioning/Socratic questioning
- Examining the Evidence
- Psycho-ed review
- Regret vs. responsibility
- Cognitive triangle
- Creating lists, definitions

71

How to Challenge Thoughts/Beliefs

Steps for the Therapist:

- Identify what you want to say to them
- Don't say it
- Validate what's valid
- Develop understanding of the belief
- Help the youth/caregiver become aware of how the belief might be a problem
- Identify a more accurate/helpful belief for the caregiver/child
- Use specific techniques to help them get there

Monica Fitzgerald, 2010

72

Example: Maladaptive Allocation of Blame in Physical Abuse

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73

If unacceptable…

What questions do you want to ask?

How do we help the child re-allocate blame?

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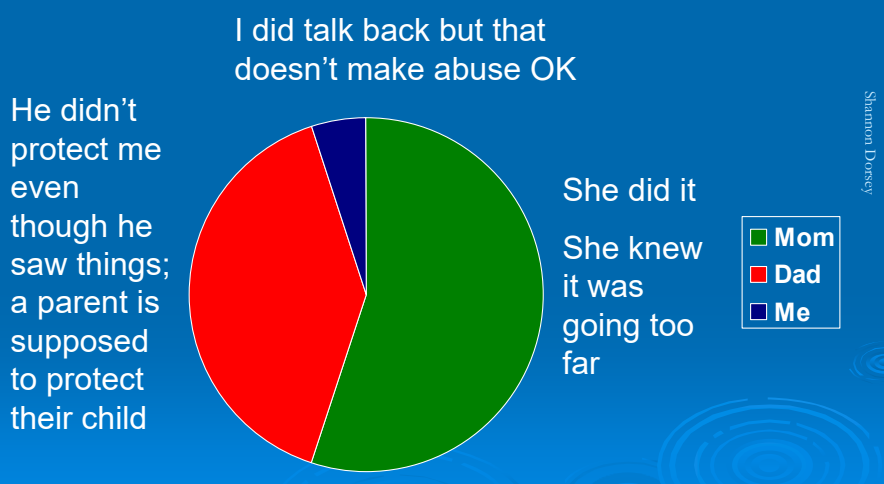
74

Example: Adaptive Allocation Blame in Physical Abuse



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75

Role Play: Cognitive Reprocessing

- A 15-year-old named Linda was exposed to domestic violence. She has finished her TN. Based on a recent narrative session, you learn that she struggles with thoughts about what might have happened if she had just come home on time after school the day that her mother was assaulted. She has the most trouble getting past the fact that her being late was what sparked the argument that ultimately caused her mother to be assaulted and hospitalized.

76

Large Group Activity

Old Thought: *If I had come home on time, then my mom would not have been hurt.*

Possible Endpoint:

What I want to tell her

Turn into eliciting questions

77

Working with themes

- When working with complex trauma – what trauma should I focus on in TF-CBT?
  - Might be hard to identify the "worst" trauma
  - Use the opportunity to integrate and make meaning of multiple trauma experiences that often share common threads
  - Help the client find the unifying theme

78

Working with Shades of Gray

- Our goal is to restore balance
- We do not want to try to tip the scales completely to the other side for three main reasons:
  1. Tends to increase defensiveness
  2. Even if successful, the new belief is often no more realistic and/or helpful than the original one
  3. Healthy meaning is usually found in “gray” thinking, not “black and white” thinking

Kliethermes

79

The Importance of Balance

Safety

I’m never safe----------I’m always safe

All people are dangerous----------All people are safe

The world is not safe----------The world is safe

Trust

I can’t trust myself at all----------I trust myself completely

I can’t trust anyone----------I trust everybody

Kliethermes

80

The Importance of Balance

Intimacy

I can't be close to anyone----------Everyone is my best friend

Power/Control

I'm always weak----------I'm always strong

It's all my fault----------Nothing is my fault

Esteem

I'm worthless---------- I'm perfect

Kliethermes

81

Narrative Conjoint: When are they ready?

- Child completed narrative and processing and is 'comfortable' with it
- Parent has read the narrative before and after the processing and can emotionally tolerate it (e.g., without sobbing or using extreme avoidant coping mechanisms)
- Caregiver can hear the narrative without making blaming or other types of negative statements
- Caregiver is able to answer child's questions about the trauma and aftermath
- Prep, prep, prep!!!!
- Practice/Role Plays to ensure success

Laura Murray

82

Narrative Conjoint: How to manage the session

In the Conjoint Session

- Be a "coach"
- Allow parent and child to communicate directly with each other with as little intervention as possible
- Intervene if clinically necessary: shape the parent's behavior and direction

Laura Murray

83

Enhancing Future Safety and Development

- Goals:
  - Risk reduction
  - Competency building
    - Mastery! Then next time, same event no longer causes feelings of extreme fear, helplessness and horror
  - Reparative experience

Role plays!

This component may come earlier in the model if there are safety concerns

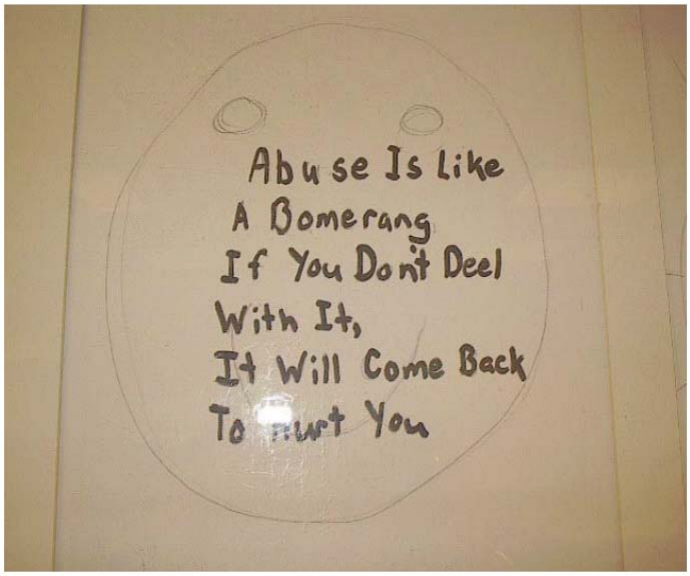
84

Safety and Healthy Development Practice

What could you do to help this client stay safe in the future?
Role plays? Games?
What might triggers be for this client?
How could you help this client with healthy development?

- 16 year old girl who has experienced sexual abuse as a child from her uncle and as a teen from her boyfriend
- 15 year old boy who has experienced domestic violence
- 8 year old client who has been in multiple foster placements, experienced physical abuse and neglect and is about to move into a new home
- 10 year old who was bullied and also experienced physical abuse
- 13 year old who immigrated from Guatemala due to community violence

85



86

87

Vicarious Trauma & Clinicians

88

Milton Erickson used to say to his patients…

- "My voice will go with you."
- What he did not say was that our clients'voices can also go with us. Their stories become part of us – part of our daily lives and nightly dreams. Not all stories are negative – indeed a good many are inspiring. The point is that they change us.

Mahoney, 2003

89

Helping-induced Trauma: What do we call it?

Secondary Traumatic Stress

- Compassion fatigue
- Syndrome of symptoms nearly identical to PTSD
- A traumatizing event experienced by one person becomes a traumatizing event for the second person" (Figley, 1999)

Counter-transference

- Does not occur outside of client-therapist relationship, occurs w/o exposure to traumatic material, may be due to clinician's own issues

Vicarious traumatization

- profound changes in the core aspects of the therapist's self" (Pearlman & Saakvitne, 1995)

Burnout

- physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations , occurs from working w/ any difficult population (Pines & Aronson, 1988, p. 9)

90

Vicarious Trauma

The negative effects of caring about and caring for others"

- "A shift in the inner experience of the therapist that comes about as a result of empathic engagement with the clients' traumatic material.
- "Emotional contagion"
- Transforms clinicians sense of self and the world. Many aspects of the therapist and his life can be affected including:
  - * Tolerance of emotions
  - * Deeply held beliefs about self and others
  - * Interpersonal relationships
  - * Internal imagery
  - * Experience of physical presence in the world

(Pearlman & Saakvitne, 1995)

91

SYMPTOMS OF VICARIOUS TRAUMA

Feelings?

Thoughts?

Behaviors?

92

Common symptoms of VT or STS

Feelings
- Overwhelmed, drained
- Angry and sad about client's abuse, even after session is over
- Anhedonia
- Isolated
- Bystander guilt

Thoughts
- Preoccupied with thinking about client outside of work
- Hopeless, pessimistic, cynical
- Doubt competence about clinical skills, low self-esteem
- Feel more vulnerable, concerns about safety, trust, intimacy & control
- Intrusive imagery of the client's traumatic material

Behavior
- Distanced in sessions, try not to hear traumatic stories in session
- May experience similar symptoms to client (somatic symptoms, intrusive imagery
- Impairment in personal and professional relationships
- High distress
- Difficulty maintaining boundaries with client
- Increased use of drugs/alcohol

Meichenbaum

93

Contributing Factors

- Personal history of trauma
- Exposure to traumatized populations
- Lack of experience and training
- Large caseloads
- Lack of clinical/personal support in workplace, isolation
- Clients who were traumatized in childhood
- Feeling that clinical work is not helping client

94

Interventions: Personal Strategies

- Increase self-observation – recognize signs of stress
- Identify changes in your ideas/beliefs about the world
- Cognitive reprocessing : normalize what you are going through
- Rituals for leaving work at the office
- Maintain a personal life, get therapy, use coping skills, tend to your own spiritual needs, find activities that have concrete outcomes and foster a sense of accomplishment.
  - "Three good things"

95

Interventions: Professional Strategies

- Set realistic expectations to increase feelings of accomplishment, set specific achievable goals for each session (agendas!)
- Remind yourself of the treatment rationale of TF-CBT
- Throughout therapy – focus on resilience, contextualizing info in trauma narratives, helping client to find meaning and hope
- Remember that **it is not your responsibility to fix clients**
- Arrange supervision
- Debrief with colleagues
- Participate in training opportunities
- Try to get a balanced case load
- Develop professional connections
- Develop a balanced work life
- Remain aware of your goals

96

Interventions: Organizational Strategies

- Be proactive in reducing vicarious trauma
- Arrange adequate resources – team meetings, supervision, promote education and training
- Create an atmosphere of respect
- Implement evidenced-based interventions
- Adequate pay and benefits

(Chrestman, 1995)

97

An Option to Try: **Three Good Things**

1. Find three minutes during your last 2 wakeful hours of the evening.
2. Write down 3 things that *went well* that day.
3. Write down your part in making each happen.
4. Write down the positive emotion you associate with this experience.

(Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. American Psychologist, 60, 410-421.)

98

Small Test of Change (STOC): Three Good Things

- 7 day commitment
- 3 minutes per day
- Outcomes in RCT: empirical evidence: trends *better than* Prozac!
- Outcomes sustained 6 months later!

99

Index Card Activity

- On one index card, write down 3 things you get out of this work
- On the other index card, write down 3 things that are challenging about this work
- We will share all of them anonymously

100