# Trauma Focused Cognitive Behavioral Therapy 2 Day Initial Training

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## Requirements

- 10 hour on-line course TFCBTweb
  - https://tfcbt2.musc.edu/
- 12 hour training
- 6 hour booster in 6 months
- 12 of 14 monthly calls
- Submit and pass audiotape requirement
- Complete at least one case from start to finish with pre and post assessment measures for trauma history and symptoms

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## Audio Recording:

- The most important thing about the audio review is that it is for you not your client. That means your client should not have any pressure put upon them related to this and should not "practice" for the recording. It is most helpful to be in the habit of asking permission from the beginning of treatment to record each session and then to send us one of the processing sessions. This will allow both of you to habituate to the recording process long before the one you need to send to us. I expect there to be interruptions and "mistakes." We are not looking for a perfect recording.

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## Audio Recording:

- Please record and send your entire session- minimum of 30 minutes. The content of the session should be Trauma Processing. That means we are listening for you or your client to read through the trauma narrative, engage in PRAC skills, and then use the strategies we practiced to do some of the following:
  - Identify and address cognitive distortions
  - Identify mastery moments
  - Help client make healthy meaning of trauma
  - Identify trauma reminders
- NOTE: We are asking for one session but our assumption is that you will have more than one session, so please do not try to stuff everything into one session in order for us to hear everything!

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## Audio Recording:

- Please listen to the recording to ensure it is audible
- Please include your name, agency, and "July 2020", as well as the child's age, gender and trauma type
- You have one year from your initial training to complete the audio.
- Please send it to Leila or Donna (whichever runs your group call) encrypted as an MP3 that we can play in itunes.
- Please be sure you have your client/client's legal guardian's permission to send me the encrypted audio
- All audios are deleted as soon as we listen to them.

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- Psychoeducation and Parenting
- Relaxation
- Affective Expression and Modulation
- Cognitive Coping
- Trauma Narration and Processing
- In vivo desensitization
- Conjoint sessions
- Enhancing safety and healthy development

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## What is TF-CBT?

A hybrid treatment model that integrates:

- Trauma sensitive interventions
- Cognitive-behavioral principles
- Attachment theory
- Developmental Neurobiology
- Family Therapy
- Empowerment Therapy
- Humanistic Therapy

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## What is TF-CBT?

- Gradual Exposure IN EVERY SESSION
- Components based (complete components sequentially)
- Each component is used in all future components
- Meeting with child and parents separately and together
- Time limited, structured model: 8-26 sessions
- Therapist: Directive and active!

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## Difficulties Addressed by TF-CBT

***CRAFTS***

- **C**ognitive Problems
- **R**elationship Problems
- **A**ffective Problems
- **F**amily Problems
- **T**raumatic Behavior Problems
- **S**omatic Problems

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## Core Values of TF-CBT

***CRAFTS***

- **C**omponents-Based
- **R**espectful of Cultural Values
- **A**daptable and Flexible
- **F**amily Focused
- **T**herapeutic Relationship is Central
- **S**elf-Efficacy is emphasized

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## Cultural Sensitivity & Competence

- Being trauma informed means being anti-racist
- In assessing and treating trauma, clinicians must consider the context of any historical trauma and the impact of institutional discrimination
- Racism (current, institutional, intergenerational, historic) is trauma
- TF-CBT was not designed to treat the traumatic impacts of racism
- TF-CBT has been demonstrated to effectively treat a multitude of traumas in cultures around the world

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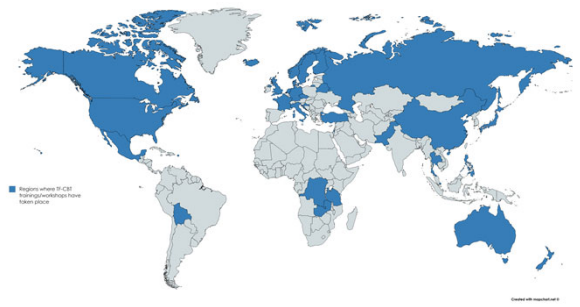
As of 2020 TF-CBT has reached these countries/regions

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## Cultural Sensitivity and Competence

- Essential to understand family's values related to religion, ethnicity and culture
- Previous treatment outcome studies (Cohen & Mannarino, Deblinger, et al.) – successful treatment for diverse ethnic and racial populations
- TFCBT studies conducted internationally (DRC, Tanzania, Zambia, Cambodia, Japan, Jordan, Norway, Germany, Netherlands)
- Culturally responsive adaptations
  - TF CBT with American Indian and Alaska Native families
    - http://www.icctc.org/
  - Culturally Modified CBT with Latino families
- Child Maltreatment article (Cohen et al., 2001)

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## Culturally-modified TF-CBT resources

- Culturally-Modified Trauma-Focused Treatment: Making TF-CBT Culturally Relevant for Hispanic Families by Susana Rivera, October 2008 (available on NCTSN website)
- Information sheet on NCTSN – https://www.nctsn.org/interventions/culturally-modified-trauma-focused-treatment
- Cross-cultural modification Zambian study http://ijmhs.biomedcentral.com/articles/10.1186/1752-4458-7-24
- Group trauma-focused cognitive-behavioural therapy with former child soldiers and other war-affected boys in the DRC https://www.ncbi.nlm.nih.gov/pubmed/23738530
- Implementing TF-CBT Among Formerly Trafficked –Sexually Exploited Girls in Cambodia https://www.mensenhandelweb.nl/system/files/documents/30%20Sep%202015/TF-CBT_Feasibility_Report_Cambodia_2011.pdf
- Spotlight on culture – many resources for working with cultural concerns
- http://www.nctsn.org/resources/topics/culture-and-trauma
- Trauma-Focused CBT for Children and Adolescents: Treatment Applications edited by Judith A. Cohen, Anthony P. Mannarino, Esther Deblinger

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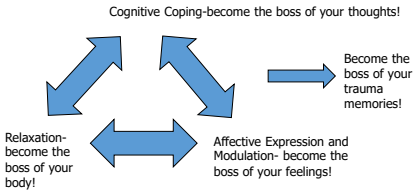
## How TF-CBT is CBT?

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**In PRAC, we work our way up the brain!**

Cognitive Coping- become the boss of your thoughts! → Become the boss of your trauma memories!

Affective Expression and Modulation- become the boss of your feelings!

Relaxation- become the boss of your body!

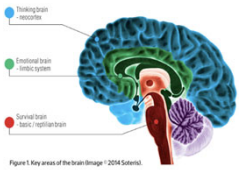


Figure 1. Key areas of the brain (Image © 2014 Soteria).

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## TF-CBT is recommended for:

- A range of traumas (traumatic loss/grief, physical abuse, etc.)
- Clinic, home, or school- based settings
- Youth between the ages of 3 and 18
  - Memory of trauma
  - Substantiated or 'more likely than not' abuse
  - Diagnosis of PTSD or PTS symptoms
  - Behavioral concerns not the primary reason for referral
  - Child currently safe (e.g., not exposed to perpetrator)
  - Non offending caregiver can participate in model

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## Three Phases to Treatment

- Safety and stabilization
- Formal Gradual Exposure / Working through
- Moving on/Consolidation

***All of treatment is GE: child and caregiver talking about child specific trauma from 1st session*

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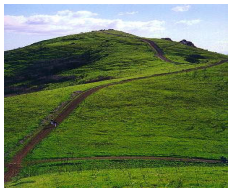
## Gradual Exposure



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## Therapist: Directive and Active

- Agenda Setting and Sticking to your Agenda
- Dealing with COWS "Challenges of the Week" vs. BOSSes "Barriers and Obstacles to Safety and Stability"
- Being Responsive & Treating Families while Staying on Track
- "If it's not fun, you're not doing it right!"

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## Components- and Phase-Based Treatment

| PRACTICE COMPONENTS: | TF-CBT PHASES: |
|---|---|
| Psychoeducation; Parenting Skills<br>Relaxation Skills<br>Affective regulation Skills<br>Cognitive processing Skills | STABILIZATION PHASE |
| Trauma narration and processing | TN PHASE |
| In vivo mastery of trauma reminders<br>Conjoint child-parent sessions<br>Enhancing safety | INTEGRATION PHASE |

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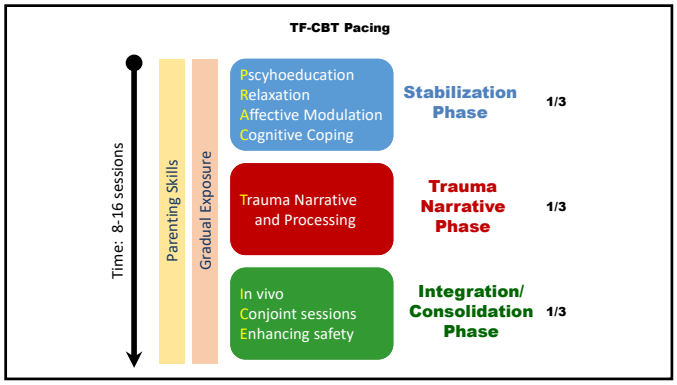


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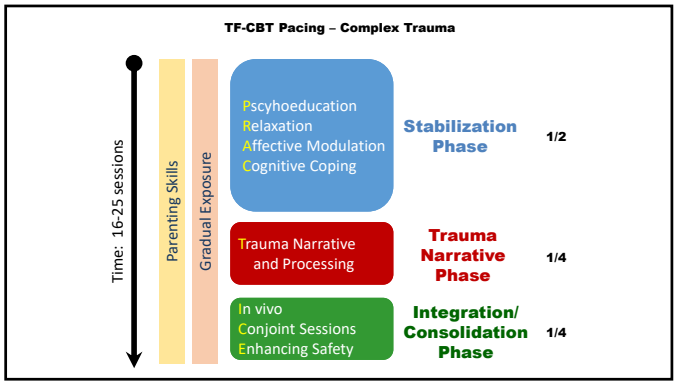


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## Treatment Research for TF-CBT

- Trauma-Focused CBT is the most rigorously tested treatment for abused children
  - 21 randomized controlled trials supporting TF-CBT
- Improved PTSD, depression, anxiety, shame and behavior problems compared to supportive treatments
- PTSD improved more with direct child treatment
- Improved parental distress, parental support, and parental depression compared to supportive treatment
- 80% of children show significant improvement in < 16 weeks

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## Treatment Manuals

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (Eds.) (2012) ***Trauma-Focused CBT for Children and Adolescents: Treatment Applications***. New York: Guilford Press

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2015) ***Child Sexual Abuse: A Primer for Treating Children, Adolescents, and Their Nonoffending Parents, 2nd edition***. New York: Oxford University Press

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2017). ***Treating Trauma and Traumatic Grief in Children and Adolescents, 2nd edition***. New York: Guilford Publications, Inc.
(First book was published 2006)



Amaya-Jackson, 07

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## 12 Musts of TF-CBT

1. Don't intervene without an FBA
2. Go into each session with an agenda
3. Get gradual exposure into every session
4. Go sequentially through the model
5. Meaningfully include caregiver in every component (parenting strategies and role plays)
6. Prepare client and caregiver separately for every conjoint
7. Keep up the pace and don't water down sessions with COWS
8. See your client weekly if at all possible
9. Wait until trauma narrative has been completely developed before challenging trauma-specific distortions
10. Wait until trauma narrative has been completely developed and processed before having a conjoint session in this component.
11. Make sure caregiver is processing with you individually during Trauma Narration and Processing
12. Trauma Narrative is NEVER homework

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## Pre- Treatment Assessment Goals

- Determine client trauma history, symptoms, and functioning
- Determine relationship between client trauma history, symptoms, and functioning
- Establish clinical diagnosis
- Develop treatment plan
- Engage client and caregiver in treatment process

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## Pre- Treatment Assessment Tasks

- **Assess client trauma history, symptoms, and functioning**
- Provide pre-treatment assessment results
- Develop TF-CBT treatment goals (operationalized symptoms)
- Conduct functional analysis of trauma symptoms targeted for treatment
- Prepare BOTH client and caregiver separately for pre-treatment assessment conjoint session

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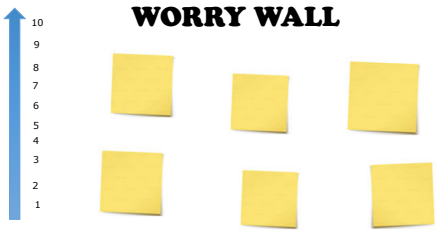


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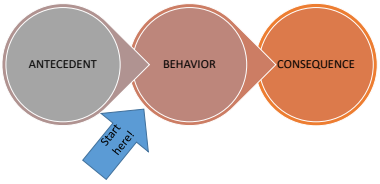
## Target trauma symptoms for treatment

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## Psychoeducation Goals

- Orient client and caregiver to TF-CBT
- Engage client and caregiver in treatment process
- Normalize impact of trauma on symptoms and functioning
- Reinforce accurate and helpful cognitions about client trauma type
- Enhance self efficacy related to trauma history and optimism regarding trauma recovery

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## Early Psychoeducation

- Normalize trauma experiences
- Provide assessment results (strengths and challenges)
- Normalize and talk about adaptiveness of symptoms
- Explain treatment rationale
- Discuss structure of treatment
- Explain caregiver involvement - confidentiality
- Provide gradual exposure- Talk about the trauma directly!
- Use analogies (wound, pool, jack in the box)
- Praise
- Predict future difficulties
- Instill hope
- Fun

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<u>Breakout</u>:
What do you know about the impact of trauma?
In small groups, discuss the most important things you would want to be sure to tell kids or caregivers about how trauma impacts people in order to:
1. normalize experiences of trauma
2. normalize trauma symptoms
BE PREPARED TO SHARE YOUR DISCUSSION IN THE CHAT BOX!

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The following slides explain trauma reminders and are taken from

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents (2010)

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**We Learn by Experience**

*(Continued)*

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NCTSN The National Child Traumatic Stress Network

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**We Learn by Experience**
*(Continued)*

*(Continued)*

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NCTSN The National Child Traumatic Stress Network

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## We Learn by Experience
*(Continued)*

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NCTSN The National Child Traumatic Stress Network

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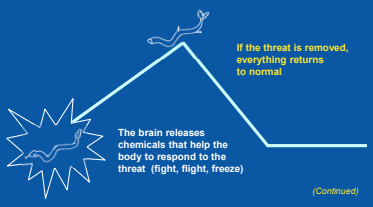
## Your Internal Alarm System

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NCTSN The National Child Traumatic Stress Network

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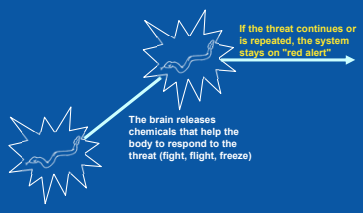
## Your Internal Alarm System
*(Continued)*

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NCTSN The National Child Traumatic Stress Network

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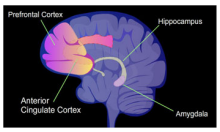
When triggered, we lose access to the thinking part of our brains.

**Amygdala** - The brain's "fear hub," which activates our natural "fight-or-flight" response to confront or escape from a dangerous situation.
- Also involved in learning to fear an event, such as touching a hot stove.




**Prefrontal cortex (PFC)**—Seat of the brain's executive functions, such as judgment, decision making, and problem solving. Different parts of the PFC are involved in using short-term or "working" memory and in retrieving long-term memories.

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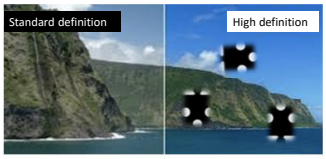
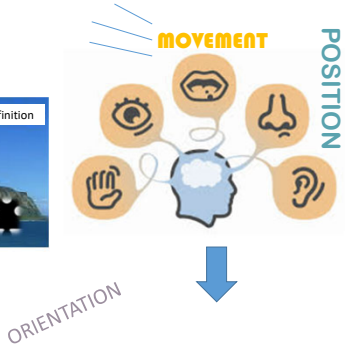
Anything can be a trigger!

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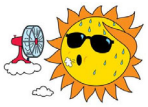
Symptoms that were protective before are no longer necessary



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Trying to ignore the symptoms/avoid trauma reminders doesn't work

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*Why* do we do Gradual Exposure?

"If you fall off your bike and have a big bloody wound and you don't take care of it, what will happen?

If you keep ignoring it, it will get infected and even more painful.
Eventually you will have to go to the doctor to have it treated and it will leave a big scar.

But if you treat it right away, it will sting a little, but then it will heal better and the scar will be so small no one will see it unless you point it out."

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*How* do we do Gradual Exposure?

**"Wading Into the Pool" Analogy:**

- Address the trauma starting the first session
- Modules gradually increase exposure to trauma
- Each session is like gradually wading into the pool
- The whole of treatment is like gradually wading into the pool

"If you jump into the deep end of a cold pool on a hot day, it feels freezing and you might want to jump back out because it is a shock to your system. But if you wade in slowly from the shallow end, you get used to it as you go and soon you can be comfortably swimming in the deep end."

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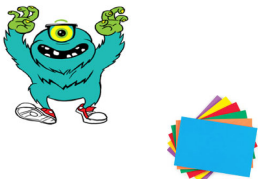

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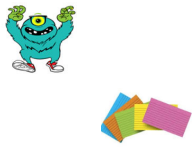

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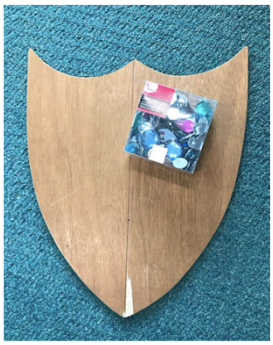

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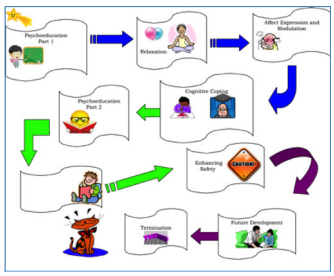
**TF-CBT Candy Land Map**

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## P sychoeducation about specific trauma/s

- 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
  - Build new associations

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## 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

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## Psychoeducation about specific trauma type(s)

- What is child sexual abuse (or other trauma)?
- How do children feel when they've been sexually abused (traumatized)?
- Who is sexually abused (traumatized)?
- Who is affected by sexual abuse (this type of trauma)?
- Who sexually abuses children? (or physically abuses/neglects, etc)
- Why does sexual abuse (or this type of trauma) happen?
- Why don't children tell?
- How do perpetrators trick kids?
- What are worries some kids might have after the trauma?



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# Demonstration and Practice

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## Psychoeducation for Younger Kids

- Body drawings/gingerbread men to teach about sexual abuse
- Map/pictures of children to teach about prevalence/statistics
- Picture of smaller and bigger people to teach about whose fault sexual abuse is
- Pictures of different kids to teach that you can not tell if a child has been sexually abused
- Books about trauma experiences
- Board games can assist in teaching information

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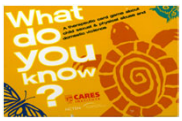
## Psychoeducation for Older Kids

- What Do You Know Card Game
- Socratic Questioning
- Games
- Talk Show
- Scavenger hunt
- Books about trauma experiences



Make it interactive!!!

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## Ideas for Tele-health

- Jeopardy
- Fact or Fiction/Proof or Phony
- Using a game (ie: Uno) and asking questions when they get a certain card
  - https://play.unofreak.com
  - wheeldecide.com
  - Drawing Guessing Game https://skribbl.io
  - Matching Game https://pairs.one/en
  - Connect 4 http://connect-4.org

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## Fact or Fiction activity about Domestic Violence

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## Fact or fiction?

Children often have mixed feelings about the person who is being violent

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## Fact or fiction?

FACT

They might feel confused because they feel love, anger, fear and respect at the same time for the person

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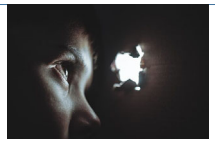
## Fact or fiction?

Witnessing domestic violence means only seeing it



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## Fact or fiction?

FICTION

Witnessing can mean SEEING violence, or it can mean HEARING threats, or fighting noises from another room. It can also mean that children OBSERVE the aftermath of physical abuse, such as blood, tears, bruises, torn clothing, and broken items

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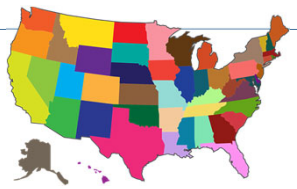
## Fact or fiction?

One in ten children in the U.S. are exposed to domestic violence, and the majority of them are under six years old.



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## Fact or Fiction?

FACT

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## Psychoeducation with Parents

- Review information sheets
- Elicit caregiver's beliefs
- Reinforce helpful cognitions
- Begin to create some cognitive dissonance with unhelpful beliefs
- Provide accurate information
- Prep for joint

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## Goals of Conjoint Sessions

- Improve parent-child communication
- Enhance child's comfort and ability to talk directly with the parent about:
  - Traumatic experience
  - Current trauma symptoms
  - Other issues the child or parent want to address

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## Conjoint Psychoeducation Session:

- Child and parent have both had preparation in advance
- Make it fun!
  - Games
  - Competition – points!
  - Child can teach caregiver
  - Praise!!!!

ONE OF THE MOST IMPORTANT JOINTS FOR TN PREPARATION!

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| Trauma Basics | Please Tell | Getting Stronger | Know the Facts |
|---|---|---|---|
| 100 | 100 | 100 | 100 |
| 200 | 200 | 200 | 200 |
| 300 | 300 | 300 | 300 |
| 400 | 400 | 400 | 400 |
| 500 | 500 | 500 | 500 |

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Is it better to learn ways to:

a) talk about sexual abuse
or
b) not talk about it

Click here for answer

a) Talk about it

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True or False?

Sexual abusers are usually
a stranger to the child

Click here for answer

False

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Trauma symptoms are things
kids experience in the their:

a) bodies (hurts)
b) heads (thoughts)
c) both

Click here for answer

Both

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## Parenting Goals

- Enhance caregiver ability to consistently engage in positive parenting strategies
- Enhance caregiver ability to manage client trauma symptoms
- Enhance caregiver ability to support client management of trauma symptoms

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## Parenting Tasks

- Facilitate effective use of praise
- Facilitate effective use of selective attention
- Facilitate effective use of contingency reinforcement

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## Research re: Treatment of Parents

Evidence that treating parent is important:

- Deblinger et al. (1996): Treating parents resulted in decreased behavioral and depressive symptoms in child
- Cohen and Mannarino (1996): Parents' emotional reaction to trauma was the strongest predictor of treatment outcome (other than treatment type)
- Cohen and Mannarino (1997): At the 12 month follow-up, parental support was significantly related to decreased symptoms in child

*Laura Murray*

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"Continued structure and predictability in the family environment in the face of stress promotes adaptive functioning in children as well as adults."

*-Cohen, Mannarino, and Deblinger, 2017*

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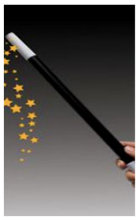
**The magic formula for addressing problematic behavior in children**

- Reduce positive reinforcement of problematic behavior/symptom
- Increase reinforcement of desired behavior
- Apply consequences for problematic behavior
- Make consequences predictable, contingent, and immediate



American Academy of Child and Adolescent Psychiatry, 2007

Practice Parameter for the Assessment and Treatment of Children and Adolescents with Oppositional Defiant Disorder

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## Functional Behavioral Analysis

- What is motivating the behavior?
  - Avoidance of pain/distress
  - Attention/connection
  - Control
  - Belonging
  - Pleasure
  - Mastery

78

## Three basic strategies

- Specific praise
- Selective attention
- Contingency management

- And then also Emotion Coaching (will discuss with Affective Expression and Modulation)

79

"Parenting skills are not difficult. Getting parents to do them is!"

*-Esther Deblinger*

80

## The magic formula for teaching skills to adults

- Provide a rationale
- Explain the skill
- Demonstrate the skill
- Engage in practice
- Plan for additional practice
- Coach through practice

81

## Specific praise

- The rationale:
  - What we attend to grows
  - Multiple ways to attend:
    - Verbal expression
    - Reflective listening
    - Non-verbal expression

82

## Specific praise

- The explanation:
  - Operationalize targeted behavior or symptom
  - Determine positive opposite of behavior or symptom
  - Praise opposite of behavior or symptom every time
  - Praise should be:
    - Purely positive
    - Genuine
    - Immediate
    - Later in addition to immediate is also good!
    - Describe what was desired
    - Describe why it was desired

83

## Specific praise

- The demonstration:
  - Get caregiver to explain client's symptom or concerning behavior
  - Get caregiver to demonstrate client's symptom or concerning behavior
  - Show caregiver how to respond
  - Ask caregiver for feedback about how he or she would personalize demonstration
  - Show again with caregiver tweaks

84

## Specific praise

- The practice:
  - Act as the client
  - Get caregiver to say words aloud to see how it feels to say them
  - Provide feedback including your own specific praise

85

## Specific praise

- The plan:
  - In conjoint session
  - At home
    - Give written homework including:
      - Rationale
      - Brief instructions
      - Tool to monitor
    - Problem-solve barriers to homework completion
    - Check on homework completion in next session
    - Complete homework sheet if not returned

86

## Specific praise

- The coaching:
  - In conjoint session

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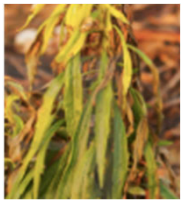
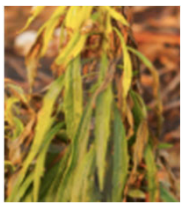
## Selective attention



- The rationale:
  - What we don't attend to diminishes *if it is designed to get our attention*

88

## Selective attention



- The explanation:
  - Determine the function of the behavior
  - Identify accidental attention (non verbal communication)
  - Label the feeling
  - Remain calm (remember coping skills)
  - Express confidence in client ability to manage
  - Praise coping

89

## Contingency reinforcement

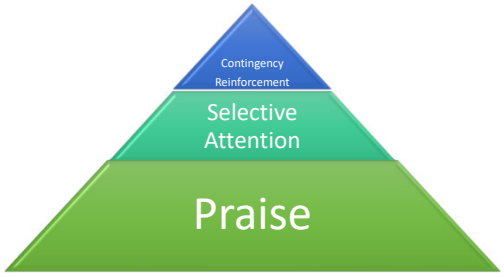
- The rationale:
  - Some behaviors are self-reinforcing
  - When costs of engaging in behavior outweighs benefits, behavior diminishes

90

## Contingency Reinforcement

- The explanation:
  - One behavior at a time
  - Give child clear rules of the game
  - Get child input about motivators
  - Reinforce
    - Consistently
    - Immediately
    - Enthusiastically

91




92

## Relaxation Goals

- Increase use of relaxation skills in general and trauma-related situations
- Increase self efficacy related to use of relaxation skills in general and trauma-related situations
- Reduce physiological manifestation of trauma symptoms
- Increase distress tolerance in general and trauma-related situations
- Enhance caregiver ability to manage client trauma symptoms
- Enhance caregiver ability to support client management of trauma symptoms

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## Relaxation Tasks

- Facilitate effective use of relaxation skills
- Facilitate caregiver ability to support client use of relaxation skills
- Prepare BOTH client and caregiver separately for Relaxation conjoint session

94

## Use the chat box

- What strategies might be useful to address hyperarousal in a young child? A school-aged child? An adolescent?

95

## Use the chat box

- What strategies might be useful to address flashbacks in a young child? A school-aged child? An adolescent?

96

## Use the chat box

- What strategies might be useful to address difficulty sleeping in a young child? A school-aged child? An adolescent?

97

## Steps in relaxation

- Analyze context and identify triggers
- Determine what has worked in the past
- Try something new:
  1. Provide rationale
  2. Provide verbal and ideally written instructions
  3. Demonstrate skill
  4. Have client practice skill
  5. SUDS
  6. Have client share something related to the trauma experience
  7. *Write it down*
  8. SUDS
  9. Have client practice skill again
  10. SUDS
  11. Strategize how to use skill at home when not needed and then when needed

98

## Your turn!

- In small groups, take turns being clinician and caregiver
- Practice explaining why praise is important to get child to use coping skills
- Explain how to praise, demonstrate praise with caregiver acting as their child
- Get caregiver to practice

99

## Affective Expression and Modulation Goals

- Enhance affective expression and modulation in general and trauma-related situations
- Increase self efficacy related to use of affective expression and modulation in general and trauma-related situations
- Enhance ability to recognize and verbalize affect
- Reduce affective manifestation of trauma symptoms
- Increase distress tolerance in general and trauma-related situations
- Enhance caregiver ability to manage client trauma symptoms
- Enhance caregiver ability to support client management of trauma symptoms

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## Affective Expression and Modulation Tasks

- Assessed and enhanced use of affective vocabulary
- Facilitated ability to identify physiological and behavioral response to emotions
- Facilitated ability to assess and regulate affective intensity
- Facilitated caregiver ability to identify client's physiological and behavioral response to emotions
- Prepared BOTH client and caregiver separately for Affective Expression and Modulation conjoint session

101

## Assessing and Building Feelings Vocabulary

- Have children list all the feelings they know
  - Expand this list
  - Use for GRADUAL EXPOSURE activity
- Read books about feelings
- Feelings faces sheets
- Expanded feelings lists for older kids
- Charades
- Games
- Apps

***What about Gradual Exposure?***

102

## Feelings Identification Activities

- **Games:**
  - Emotional Bingo
  - Mad, Sad, Glad Game
  - The Stamp Game
  - Talking, Feeling, Doing Game
  - Moody Monsters Game
  - Guess How I Feel Game
  - Photo Feelings Fun Deck
  - Emotional Jenga
  - Charades
- **http://www.do2learn.com/organizationtools/EmotionsColorWheel/index.htm**
- **http://www.do2learn.com/games/feelingsgame/**

103

## Feelings Identification Activities

- Feelings Books
  - "My Many Colored Days" (Dr. Seuss ) https://www.youtube.com/watch?v=Lum83DLPXIw
  - "The Way I Feel (Janan Cain) https://www.youtube.com/watch?v=ITPUxVQ6UIk
  - "All My Feelings at Preschool: Nathan's Day" (Susan Conlin and Susan Levine Friedman)
  - "I Feel Silly" (Jamie Lee Curtis and Laura Cornell) https://www.youtube.com/watch?v=JofkgL7CY5A https://www.youtube.com/watch?v=NHBnHywvynM (singing version)
  - "When Sophie Gets Angry" (Molly Bang) https://www.youtube.com/watch?v=dNfd8WFDBAY
  - My Blue is Happy (Jessica Young) https://www.youtube.com/watch?v= RiFbBjs4VM
  - The Color Monster (Anna Llenas) https://www.youtube.com/watch?v=Ih0iu80u04Y
  - "When I Feel Afraid" (Cheri Meiners)
  - "Double Dip Feelings" (Barbara Cain)

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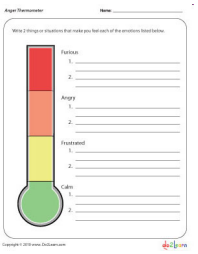
## Feelings Ratings

- Thermometer
- SUDS scale (subjective units of Distress) 0_____5_____10
- Paint chips
- Pie chart
- Cotton ball jar activity
- Sad face or happy face
- Balloons
- http://www.psychpage.com/learning/library/assess/feelings.html




***What about Gradual Exposure?***

105

## Physiological Effect of Feelings

- Color my life or person activity (draw/color where feelings are in body)
- Ask how does your body feel, how does your heart feel, how do your muscles feel
- Others?
- https://www.huffpost.com/entry/body-emotions-finnish-study-video_n_4532617

***What about Gradual Exposure?***

106

## Ideas for telehealth

- Reading a book about feelings together
- Sesame Street activities - https://sesamestreetincommunities.org/topics/emotions/
- https://wheeldecide.com/wheels/games/emotion/
- https://bingobaker.com/view/52421
- https://telehealthfortrauma.com/resources/
- For teens:
  - https://www.youtube.com/watch?v=0O1u5OEc5eY
- For school age kids:
  - https://www.youtube.com/watch?v=nTII0cyUbQo

107

## Caregiver sessions - Tune in

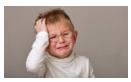
1. **Help the caregiver become aware of their own feelings**
   - Expand the caregiver's feelings vocabulary
   - Work on feelings ratings with caregiver
   - Work on the physiological effects of feelings with caregiver
2. **Discuss how they felt when they first found out about the child's trauma, or when they think about it now?**
   - Feelings intensity
   - Physiological feelings
   - What helps you when you think about it?
   - How might child misinterpret nonverbal cues when you are having the feeling related to the trauma?

108

## Caregiver sessions - Reach Out

Help the caregiver become aware of child's emotions

- How do they know when child is having an emotion?
- How can they tell where the child feels their emotion in their body?
- How can you tell the intensity of their feeling?
- How can you reflect what you see in child?
- How can you help your child get back to calm?



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## Emotion Coaching

**Tune In:** Hand to Heart
What am I feeling?
What do I need?

**Reach out**
What is my child feeling?
What do they need?

**Connect**
How can I connect my resources to my child's needs?

Adapted from Monica Fitzgerald

110

https://www.youtube.com/watch?v=xs7OWBj_GiE

111

## Conjoint Sessions

- Prepare caregiver individually for joint session
  - Praise
- Conduct a fun joint session
  - Charades
  - Contest to see who can name more feelings in one minute
  - Jenga
  - Emotions bingo

Remember to add some gradual exposure in this conjoint

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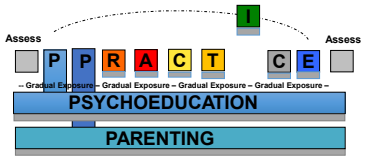
## Cognitive Coping

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## Acknowledgements


- Center for Child and Family Health
- Lisa Amaya-Jackson, MD, MPH
- Medical University of South Carolina
- TN TF-CBT Learning Collaborative
  - Kelly Wilson and Kris Dean

114

## Goals of Cognitive Coping

- Notice and share internal dialogues in the course of therapy
- Understand connections between thoughts, feelings & behaviors
- Identify and restructure/replace maladaptive thoughts ***in daily life***
- Cope with trauma reminders
- Be able to use during trauma processing for trauma-related thoughts

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

115

## Steps in Cognitive Coping

1. Help client and caregiver become more aware of thoughts
2. Teach about helpful and unhelpful thoughts and thought patterns
3. Explain the cognitive triangle with creative, neutral examples
4. Teach cognitive coping techniques to dispute unhelpful thoughts

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

116

## Step 1: Help client and caregiver become more aware of thoughts

Automatic Thoughts:
- Influence behavior
- Influence trauma symptoms
- Influence contextualization of trauma memories
- Co-exist with more obvious thoughts
- Are spontaneous
- Are usually not as noticeable as the resulting emotion
- Are connected with specific emotions
- Are brief/fleeting
- Are usually believed to be true
- Can be words or images

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

Source: Cognitive Therapy for Depression, Leslie Sokol, PhD, Beck Institute for Cognitive Therapy and Research

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## Step 1: Help client and caregiver become more aware of thoughts

How do I get kids to talk about their thoughts?

- Use KID LANGUAGE!
- ADJUST TO THEIR DEVELOPMENTAL LEVEL, BE CREATIVE!
  - What do you think about when you're _____(insert feeling)?
  - Are there any thoughts or pictures that go through your mind?
  - What popped into your head? What did you say to yourself?
  - What went through your head?
  - Use a cartoon bubble and fill it in
  - We talk to ourselves in private all the time. What were you saying to yourself when X happened?
  - If I were to play an audiotape back of what you were telling yourself, what would I hear?
  - T.V. (feeling, thinking, doing channels)

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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What's he saying?

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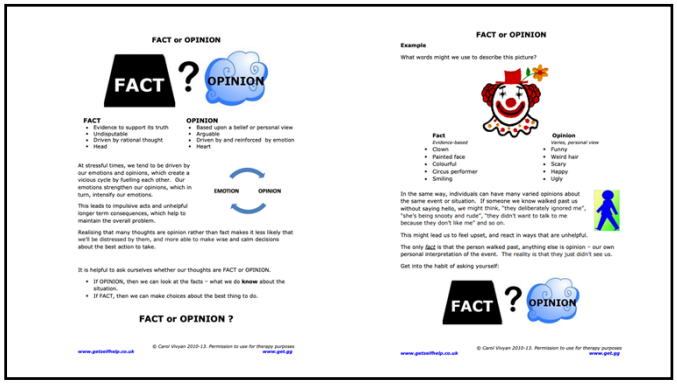

FACT or OPINION

FACT ? OPINION

**FACT**
- Evidence to support its truth
- Indisputable
- Driven by rational thought
- Head

**OPINION**
- Based upon a belief or personal view
- Arguable
- Driven by and reinforced by emotion
- Heart

At stressful times, we tend to be driven by our emotions and opinions, which create a vicious cycle by fuelling each other. Our emotions strengthen our opinions, which in turn, intensify our emotions.

EMOTION OPINION

This leads to impulsive acts and unhelpful longer term consequences, which help to maintain the overall problem.

Realising that many thoughts are opinion rather than fact makes it less likely that we'll be distressed by them, and more able to make wise and calm decisions about the best action to take.

It is helpful to ask ourselves whether our thoughts are FACT or OPINION.

- If OPINION, then we can look at the facts – what we do **know** about the situation.
- If FACT, then we can make choices about the best thing to do.

FACT or OPINION ?

www.getselfhelp.co.uk © Carol Vivyan 2010-13. Permission to use for therapy purposes www.pnl.gg

FACT or OPINION

**Example**

What words might we use to describe this picture?

**Fact**
*Evidence-based*
- Clown
- Painted face
- Colourful
- Circus performer
- Smiling

**Opinion**
*Varies, personal view*
- Funny
- Weird hair
- Scary
- Happy
- Ugly

In the same way, individuals can have many varied opinions about the same event or situation. If someone we know walked past us without saying hello, we might think, "they deliberately ignored me", "she's being snooty and rude", "they didn't want to talk to me because they don't like me" and so on.

This might lead us to feel upset, and react in ways that are unhelpful.

The only fact is that the person walked past, anything else is opinion – our own personal interpretation of the event. The reality is that they just didn't see us.

Get into the habit of asking yourself:

FACT ? OPINION

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## Step 2: Teach about helpful and unhelpful thoughts and thought patterns

- Unhelpful/helpful
- Cold prickly/warm fuzzy
- Oscar the Grouch/Elmo
- Eeyore/Tigger
- Wolves
- Poison/ Antidote

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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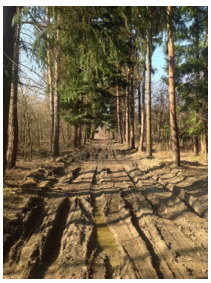
## Step 2: Teach about helpful and unhelpful thoughts and thought patterns

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

122

## Step 2: Teach about helpful and unhelpful thoughts and thought patterns



**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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## Step 3: Explain the Cognitive Triangle

- Thoughts influence our feelings.
- Feelings influence our behavior.
- Behavior influences outcomes.
- If we change our thoughts, we can change outcomes!
- We can change our thoughts/restructure thoughts to decrease our symptoms and better tolerate them

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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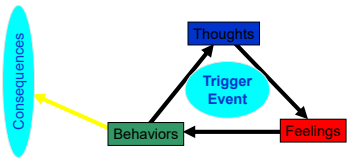
## The Cognitive Triangle




**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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## What this looks like with kids

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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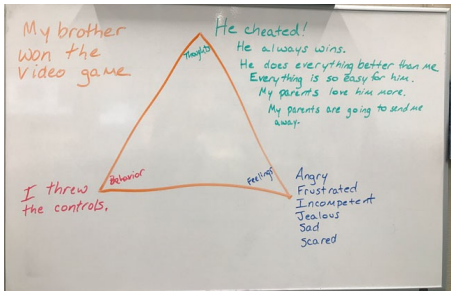


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## Thoughts and Feelings

**Clinician Instructions**

- This PowerPoint contains 6 slides to assist in the explanation of how thoughts, feelings, and behaviors are connected in a given situation.
- The last 2 slides are templates to invite the child to apply these concepts to one of their own experiences.
- Feel free to change the images to be as relevant as possible to the child.

Resource created by the MUSC Telehealth Outreach Program

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# Telehealth

https://www.youtube.com/watch?v=pWp6kkz-pnQ

https://www.youtube.com/watch?v=m2zRA5zCA6M&feature=youtu.be

130

## Thoughts → Feelings!

What feelings would follow this thought?

That dog is staring at me. He looks mean. I bet he wants to jump on me or bite me!

**FEELING =**

Resource created by the MUSC Telehealth Outreach Program

131

## Thoughts → Feelings!

What feelings would follow this thought?

That dog is looking at me. He seems interested and friendly. I bet he wants to play!

**FEELING =**

Resource created by the MUSC Telehealth Outreach Program

132

## Thoughts → Feelings!

What feelings would follow this thought?

That dog is staring at me. He looks mean. I bet he wants to jump on me or bite me!

**FEELING =**

**ACTION =**

Resource created by the MUSC Telehealth Outreach Program

133

## Thoughts → Feelings!

What feelings would follow this thought?

That dog is looking at me. He seems interested and friendly. I bet he wants to play!

**FEELING =**

**ACTION =**

Resource created by the MUSC Telehealth Outreach Program

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## Thoughts → Feelings!

What feelings would follow this thought?

Add a situation/image

**FEELING =**

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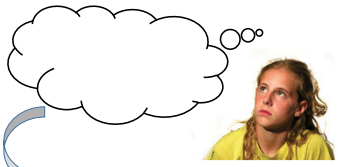
135

## Thoughts ⇨ Feelings!

What feelings would follow this thought?

Add a situation/image



**FEELING =**

**ACTION =**

Resource created by the MUSC Telehealth Outreach Program

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## Step 4: Teach cognitive coping techniques for disputing unhelpful thoughts

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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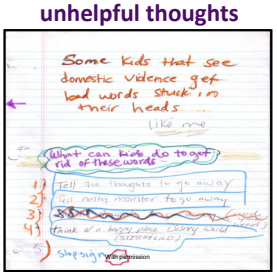
## Step 4: Teach cognitive coping techniques for disputing unhelpful thoughts




**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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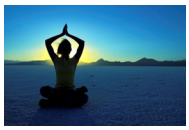
## Step 4: Teach cognitive coping techniques for disputing unhelpful thoughts

- Positive self statements
  - When I'm not there, my mama keeps her own self safe!



**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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## Step 4: Teach cognitive coping techniques for disputing unhelpful thoughts

- **Thought Interruption**
  - Use when overwhelmed with trauma reminders
  - Temporary measures early in treatment
  - Teaches child control over their thoughts
    - Changing the channel
    - Saying "go away" or "snap out of it"
    - Imagining a stop sign
  - Replace unwanted thought with a positive one

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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## Step 4: Teach cognitive coping techniques for disputing unhelpful thoughts

- Examine contradictory evidence/facts
- Identify helpful vs. hurtful thoughts
- Test the accuracy of thoughts
- Use the Socratic method
- Role play real life social interactions

**Rule:** no challenging trauma-specific thoughts with children until after trauma narrative!

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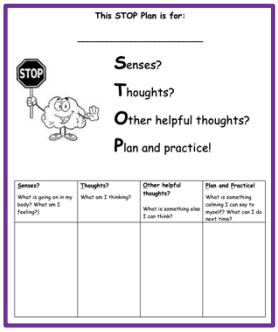
Putting it all together


This STOP Plan is for:

_____

**S**enses?
**T**houghts?
**O**ther helpful thoughts?
**P**lan and practice!

| Senses? What is going on in my body? What am I feeling?) | Thoughts? What am I thinking? | Other helpful thoughts? What is something else I can think? | Plan and Practice! What is something calming I can say to myself? What can I do next time? |
|---|---|---|---|
| | | | |

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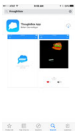
## Free TF-CBT Apps!



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## From COGNITIVE COPING, we know:

I wanted my mommy to catch George.

People won't be my friend if they know about George.

I think I shouldn't have looked at his penis.

Private parts are dirty.

I wish my mommy loved me as much as my friend's mommy loves her.

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## COGNITIVE PROCESSING WITH PARENTS

Slides by E. Deblinger

146

## Affective and Cognitive Processing with Parents

- Provide parents with a forum to share their feelings and thoughts related to the trauma (even the socially undesirable ones)
- Parents' thoughts and beliefs about the trauma influence their personal recovery and their effectiveness as a role model for their children
- Parents' feelings and thoughts can directly influence children's behaviors and developing beliefs about self, others and the world

CARES INSTITUTE 18 NCTSN The National Child Traumatic Stress Network

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## Eliciting and Identifying Parents' Dysfunctional Thoughts and Beliefs

- Create supportive, non-judgmental therapeutic relationship
- Observe and obtain info about parent-child interactions from child and parent
- Review presenting concerns
- Assign homework to capture and monitor thoughts
- Elicit trauma-related thoughts in session

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## Eliciting and processing trauma-related thoughts in session

- Examine thoughts which are permanent, pervasive, or too personalized
  - Permanent: " My child will never be happy again."
  - Pervasive: "No one can be trusted with my child."
  - Personalized: "This happened because I am a terrible wife and parent."
    "I am so stupid for marrying a sex offender."
- *"If my best friend had a child who experienced a similar traumatic experience, would I say to him or her what I am saying to myself?"*
- *"Would I want my child to overhear me making this statement out loud?"*

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Thoughts

Feelings _____ Behaviors

| What are your feelings? | What are your thoughts? What are you saying to yourself | Are your thoughts accurate & helpful? If not, change them to make them more helpful. | What are your feelings now? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Remember: Dysfunctional thoughts are often inaccurate; they may be too permanent, too personal, and too pervasive.**

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## Invisible Suitcase:
## Seeing clients through a trauma lens

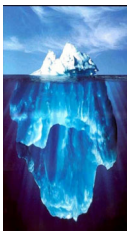
We learn by experience.

Our experiences shape our perceptions of:
- Ourselves
- Other people
- The world we live in.

National Child Traumatic Stress Network, Caring for Children who have experienced trauma: A workshop for Resource Parents – Facilitator's Guide

151

## We see the behaviors on the surface



… and overlook the beliefs underneath.

152

NCTSN, Caring for Children who have experienced trauma, A workshop for resource parents.

153

## How Caregivers can help Repack a Child's Invisible Suitcase

Consider this…

- Is it possible that the behavior that doesn't make sense in the current environment could have helped the child meet needs or survive in the past?
- Children have to feel their caregivers find **joy** in being with them to heal.

154

**What experiences and messages can I give this child to support her becoming who I want her to be at age 20?**

**How SAFE does my child feel?**

**How CAPABLE does my child feel?**

**How LOVABLE does my child feel?**

155

## Remember…

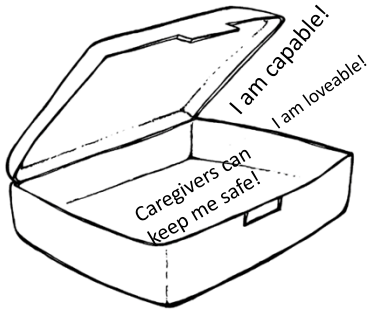
**WE LEARN BY EXPERIENCE!!**

SAFE

CAPABLE

LOVABLE

156




157

## Conjoint Sessions

- Prepare caregiver individually for conjoint session
  - Praise
- Conduct a fun conjoint session
  - "Name that negative thought pattern"
  - Child can act out triangle scenarios
  - Using the magic wand to turn unhelpful thoughts into more helpful ones

158

## Trauma Narration and Processing Goals

- Reduce physiological, affective and cognitive manifestations of trauma symptoms
- Increase distress tolerance in general and trauma-related situations
- Disrupt association between trauma reminders and negative physiological, affective and cognitive responses
- Enhance coherence and organization of trauma memories

159

## Trauma Narration and Processing Goals

- Increase helpful cognitions regarding trauma experience
- Increase self efficacy regarding initial and current response to trauma
- Enhance ability to conceptualize trauma history as 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

160

## When are children ready to work on the trauma narrative?

- When they have learned coping skills, emotional identification skills and psycho-education
- They do not have to be masters, but can use strategies to lower SUDS ratings (subjective units of distress)
- In a stable home for at least the next 5 weeks, and in a safe place

161

## Possible Types of Narratives

- Create a trauma narrative
  - Straightforward written narrative
  - Book
  - Audiotape or videotape
  - Computer story
  - Poem(s)
  - Song(s)
  - Dollhouse or puppet show

162

Suggested Steps for Trauma Narratives

1. Introduce rationale
2. Create a neutral narrative (helpful but optional!)
3. Introduce TN by reading a book (DON'T DO THIS FOR LITTLE KIDS!!!)
4. Determine the format for the child's TN
5. Initiate TN – more often with limited choice, but could also be a hierarchy of chapters to include

163

Suggested Steps for Trauma Narratives (con't.)

6. Introduce the idea that you will be the child's secretary, move through narrative slowly
7. Write a whole chapter the same day that you introduce TN (chapter 1: about child, etc.
8. Re-read the TN each session to child as part of GE
9. Re-read the TN each session to the parent as part of GE
10. Praise the child often

164

Suggested Steps for Trauma Narratives (con't.)

11. Expand the TN
12. Add thoughts, feelings and body sensations
13. Include the "worst moment"/"worst memory" – make sure to get SPECIFIC events
14. Use coping skills as needed
15. Include up to the present time

165

Suggested Steps for Trauma Narratives (con't.)

16. Include "how I have changed"; "what I have learned"; "what I would tell other kids who have experienced this".
17. Calming, fun activity at the end of session
18. Next session, reread everything the child has written and get SUDS before beginning new chapter

166

Possible chapters to include in narrative :

- Title Page- might change during process
- Introduction (about me, my family, my favorite..)
- Good Memories (before trauma, with family, with abuser)
- Trauma Details- events of trauma, disclosure, first time, worst time, time you thought you'd never tell anyone about, court, medical exam, police involvement
- Wrapping Up/Positive Ending (meaning making, what I learned, how to get through it, advice to other kids)

Jennifer Wilgocki, LCSW, National TF-CBT Trainer

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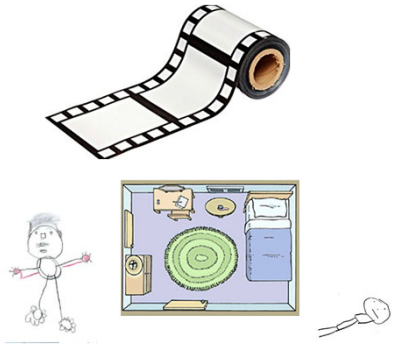

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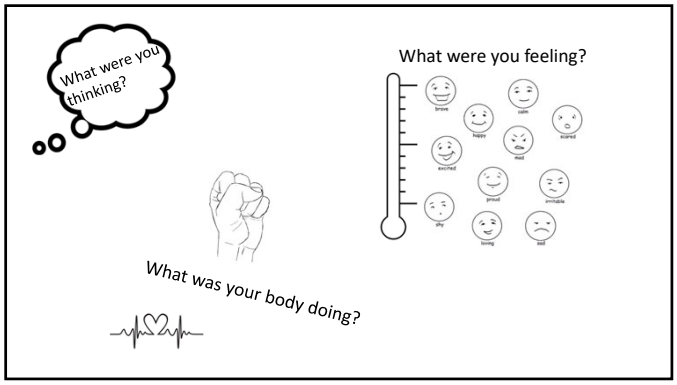



169

When something stresses me out, I rehearse how to tell – who should I tell, how should I tell, but I didn't tell til the next day. I tried everything to distract myself, watching tv, listening to the radio, I was trying to figure out how to tell Auntie mainly. I didn't feel safe to tell anyone but I thought I should tell her – I just wanted it to go away. I was worried auntie would be made at me for going back there, and call the pound and get rid of the dogs, since that was the reason I went there. I slept on and off that night, waking up every hour. I'd wake up and just go throw up. It was disgusting. I really don't like throwing up – the more I thought about throwing up, the sicker it made me. I was dizzy. I kept having to clean it up off the floor and that made me even sicker. I threw up all night long – every hour just up up up. My sides and stomach hurt. I saw terrible things in my head – like him masturbating and him making me touch his penis.

170

Don't do this!

# The Secretary:

Taking verbatim notes is really difficult!
And not helpful!

Facilitating trauma narration is NOT taking dictation

171

## The Secretary + Co-pilot

Do this!!!!

- Write down what you want them to hear when you read it back
- Control the pace- SLOW DOWN
- Help the client cover the most difficult terrain- PRAISE
- Help them use mindfulness to tolerate distress of staying in the moment of the trauma
- Direct them away from avoidance- SELECTIVE ATTENTION
- Notice nonverbal cues of distress (SUDS)

172

## Enhance coherence and organization of trauma memories

173

## Trauma Processing Goal 1: Identify and correct trauma related cognitive distortions

- 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)
- Logical Questioning/Socratic questioning
- Examining the Evidence
- Psycho-ed review
- Regret vs. responsibility
- Cognitive triangle
- Creating lists, definitions

174

## Disputing Trauma Related Cognitive Distortions

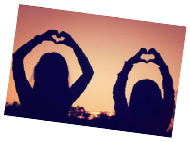
- Identify helpful vs. hurtful thoughts
- Examine contradictory evidence/facts
- Test the accuracy of thoughts
- Use the Socratic method
- Use role plays (e.g. best friend)

Courtesy of Esther Deblinger

175

## Disputing Trauma Related Cognitive Distortions

- Use of Role Plays
  - Best Friend*
  - Therapist
  - Little Sister



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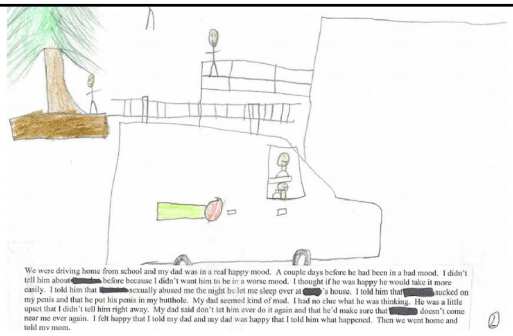



*Esther Deblinger*

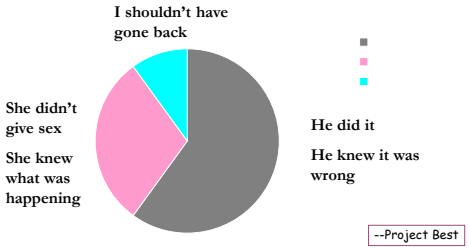
177

## Let's Practice:

I'm glad my father is in jail now. I know he hates me, but now he can't hurt me or other kids anymore. Everyone knows what he did to me. Some people think it was wrong, and some people think it was OK. I think he ruined my life. I keep asking why did I do that? I should have told him to stop. I'm really mad that I told 2 years too late.

178

Allocating Blame/Fault: Responsibility Pie
"Whose fault was the sexual abuse?"




179

Reviewing Narrative as part of Cognitive & Affective Processing

- **What additional details would you try to elicit from the child?**
- **What thoughts & feelings would you try to identify/explore?**
- **What are some cognitive distortions that child has identified?**
- **How would you address/challenge these distortions?**

Courtesy of Esther Deblinger

180

## Review Adolescent's Narrative

I came home 5 minutes after curfew & my dad was mad. When mom told him to stop yelling at me, he went off – calling us both sluts. He started threatening mom with a knife. I thought I should have told my mom how Dad bothers me every night & maybe she would have left him a long time ago. I kept saying to myself tell her – tell her! I felt angry. My mom yelled at me to call 911 & I did, but I couldn't remember our address. I stayed on the phone & the police came, but by then Dad had left. I was really scared, but I told the officer everything & my mom cried & cried.

Courtesy of Esther Deblinger

181

## Elicit more feeling, thoughts & other details

I came home 5 minutes after curfew & my dad was mad. When mom told him to stop yelling at me, he went off – grabbing me – telling mom he'll do what he wants – calling us both sluts. He started threatening mom with a knife. I felt scared and angry. I thought I should have told my mom how Dad sexually abused me every night & maybe she would have left him a long time ago. I kept saying to myself tell her – tell her! I felt angry & stupid, very stupid. My mom yelled at me to call 911 & I did, but I couldn't remember our address. I stayed on the phone & the police came, but by then Dad had left. I was really scared, but I told the officer everything & my mom cried & cried. I think she was mad at me too. I only wish I had told him no the first time he did that stuff to me.

Courtesy of Esther Deblinger

182

## Organizing the Narrative

- Help child put chapters in chronological order
- Re-read book for accuracy and dysfunctional thoughts
- Create positive ending (e.g. what was learned in counseling, personal strengths and resilience, expectations for the future)

Courtesy of Esther Deblinger

183

## Elicit & Incorporate Helpful &Productive Thoughts

I came home 5 minutes after curfew & my dad was mad. When mom told him to stop yelling at me, he went off – calling us both sluts. Mom & I are not sluts. Its my Dad who had the problem with sexually abusing children. He started threatening mom with a knife. I felt scared & angry. I thought I should have told my mom how Dad sexually abused me every night & maybe she would have left him a long time ago. I kept saying to myself tell her – tell her! I had been trying to get up the courage for a long time. I felt angry & stupid, very stupid. My mom yelled at me to call 911 & I did, but I couldn't remember our address. I stayed on phone & the police came, but by then Dad had left. I felt stupid & scared. I told the officer everything & my mom cried & cried. I thought she was mad at me. I only wish I had told him no the 1st time he did that stuff to me. I was smart to tell when I thought my mom & I were safe with the officer. Some children never ever tell. My mom was confused & upset at first, but now she is really proud of me & mad at my dad. I'm proud of my mom too.

E Deblinger

184

## Examples of Cognitive & Affective Processing

- **Sexually**
  - **"I was abused because I was too sexy"**
- **Body Concerns**
  - **"I might die of AIDS." "I might be pregnant."**
- **Interpersonal Concerns**
  - "No one would ever want to be my friend if they knew."
- Safety Concerns
  - **"I will never be safe" "Violence is just part of life."**
- Self Image
  - **"I am so stupid." "I am a slut."**

Courtesy of Esther Deblinger

185

## And for the caregiver…

- Ideally reading along in individual sessions with you without child every week
- Processing own thoughts and feelings
- Finding own *and child's* cognitive distortions, mastery, and meaning making
- Problem solving, taking notes, behavioral rehearsal for conjoint and at home
- Monitoring symptoms at home

186

## Narrative Conjoint: When are they ready?

- Child completed narrative, is 'comfortable' with it and has processed distortions
- Parent has read the narrative and can emotionally tolerate it (e.g., without sobbing or using extreme avoidant coping mechanisms)
- Parent is at least minimally supportive

187

## Narrative Conjoint Preparation

Child
- Write down any questions for parent
- Review coping
- Decide some logistics of the joint (e.g., child reads entire narrative, parent reads some)

Parent
- Narrative should be read several times including just before sharing
- Practice praising child
- Parent assisted with developing optimal answers to child's questions

188

## Timing of Conjoint Sessions

- Start conjoint sessions early in treatment
  - As part of the gradual exposure process
  - To teach parents how to effectively praise children
  - To ensure skills are practiced at home
  - To facilitate positive communication between child and caregiver
- For the trauma narrative, conjoint session should NOT occur until cognitive processing of child's trauma experience has occurred in both the child and parent's individual sessions

189

Role plays:
1. Therapist models for parent or child
2. Child/parent practices with therapist
3. Child/parent does in conjoint with therapist coaching

190

## How do you conduct conjoint sessions?

- Lots of prep work involved…
  - Meet individually with parent (e.g., 15 min.), with child (15 min.), then the conjoint session (30 min.)
- Prep with parent: prepare them to praise the child and model talking openly and comfortably; any areas of concern
- Prep with child: review coping skills and material for the conjoint session

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## Therapist's Role in Conjoints

- Did we mention Prep, prep, prep!!!!?

<u>In the Conjoint Session</u>

- 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

192

## Troubleshooting Conjoints

- What if the child doesn't want to share the narrative?
- What if multiple siblings are being treated?
- What if the parent becomes negative?

193

## In Vivo Desensitization Goals

- Decrease avoidance of innocuous trauma reminders
- Decrease distress in response to innocuous trauma reminders
- Resume daily functioning and normal developmental tasks

194

## In Vivo Desensitization Tasks

- Assessed impairment in response to innocuous trauma reminders
- Facilitated development of a stimulus hierarchy
- Facilitated implementation of *in vivo* desensitization plan with client
- Prepared BOTH client and caregiver for *In Vivo* Desensitization conjoint session

195

## The Real Ibrahim

196

## Mastering Traumatic Memories

- Two-pronged process: Trauma Narrative and In Vivo Exposure
- In Vivo Exposure: gradually combating the avoidance of *innocuous* trauma cues (e.g., the dark, school), in cases where avoidance interferes with optimal development

197

## In Vivo Exposure

- Conducted only with avoidance of innocuous cues and not in situations where avoidance of cues adaptive
- Requires an initial leap of faith for therapist, parent, and child
- Fears develop for a reason, but once the child is safe, fears interfere with the normal developmental trajectory

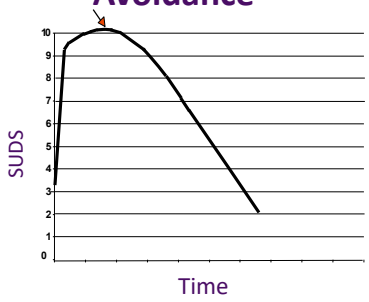
198

## Avoidance

- Powerfully self-reinforcing
- The best way to get over avoidance is through *not* avoiding
- When exposure to feared situation doesn't result in feared consequence, anxiety diminishes
- Old Adage: You fall off the horse, get back on….

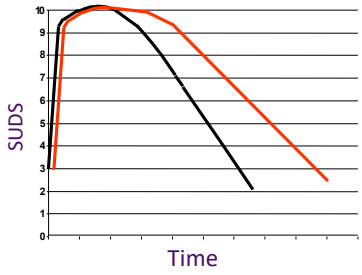
199

## Avoidance



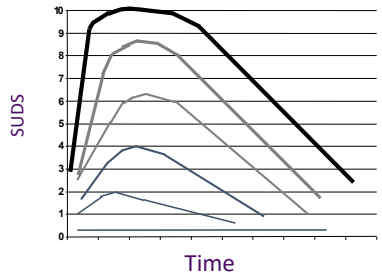

200

## Exposure-Avoidance vs. Habituation




201

## Exposure-Habituation




202

## In Vivo Desensitization Has Two Parts

Increasing exposure to feared stimulus
+
Use of coping strategies
=
successful mastery of trauma reminder

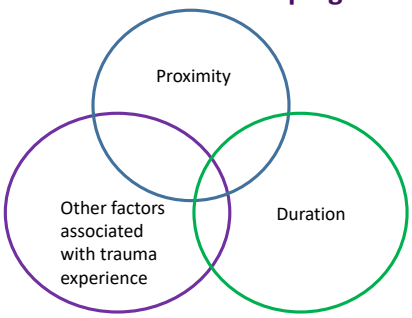
203

## How Do You Do It?

1. Do your functional analysis!
2. Find out as much as you can about the feared situation (more in a moment)
3. Get 'buy in' and involvement from key participants: (parents, school personnel, etc.)
4. Develop a plan that eases the child into facing the feared cues
   - Make plan specific
   - Include rewards
   - Predict difficulty
5. Plan should progressively increase exposure
6. Pair exposure with relaxation
7. Decrease SUDS with relaxation *a little* before moving on to next level of exposure

204

## For consideration in developing hierarchy:



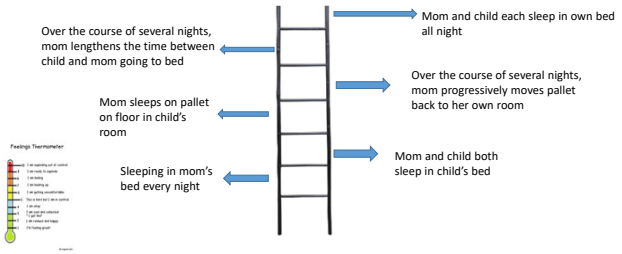

205

## Sleep Refusal

1. Empathize with caregivers
2. Discuss the commitment involved in following through, using a trauma informed lens.
3. Create hierarchy
4. Plan for rewards
5. Help caregiver plan around ignoring difficult behavior when in bed (i.e.. whining) and focusing on praising desired behavior
6. Plan for coping skills that child can use, and coping skills parent can use when they are worried or frustrated about how the in vivo work is going
7. Encourage caregiver not to go in when child calls, but only when quiet
8. Remind caregiver it might take a few challenging nights to get through this, there might be setbacks

206

## Another example of sleep refusal




207

## Enhancing Future Safety and Healthy Development Goals

- Reduce risk of client-specific trauma recurrence
- Increase self efficacy regarding ability to address future threatening situations
- Enhance effective client and caregiver communication regarding safety and development
- Reduce impact of trauma history on future development

***if there is a current risk to client's safety at any point in treatment, that should be addressed immediately beginning with the caregivers

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## Enhancing Future Safety and Healthy Development Tasks

- Assigned enhancing future safety and development homework
- Facilitated development of safety skills
  - Boundaries
  - Assertiveness
  - Communication
- Addressed potential impact of trauma on future development
- Prepared BOTH client and caregiver for enhancing future safety and development conjoint session

209

## What are Personal Safety Skills in the case of sexual abuse?

- Skills that help children identify and respond effectively to inappropriate sexual touches in the future.
- Skills that target individual safety needs of children with trauma histories.
- Skills covered in the Deblinger and Heflin book include:
  - Right to say No
  - Getting Away
  - Telling someone
  - Not keeping secrets

210

## Why Personal Safety Skills Training is Important

- Some evidence that children who have this type of training are more likely to use self-protection techniques and to disclose victimization attempts.
- There are opportunities for non-offending parents to get involved in training kids about safety issues, which have been shown to be helpful for kids.
- Teaching these skills helps kids know what to do in times of trouble and generally helps to increase their confidence.

*(Finkelhor, Asdigian, & Dziuba-Leatherman, 1995). The effectiveness of victimization prevention instruction: An evaluation of children's responses to actual threats and assaults. *Child Abuse and Neglect*, 19(2), 141-153.

211

## When to Introduce Personal Safety Skills in the Model

- Timing is crucial…
  - For some kids who are very anxious and have difficulty buying into treatment, you may need to introduce it early in therapy because it is easy to tolerate.
  - For most kids, it is recommended that it be introduced after gradual exposure to cut down on any unwanted "side effects."

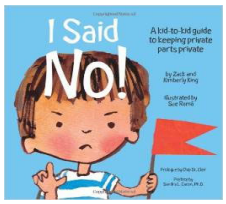
212

## Beginning Skills Training

- Brainstorm with kids about ways they might respond if touched inappropriately
- "Most kids aren't really sure what they should do if someone touches them in a not-OK way because no one has ever taught them what to do. Do you have any ideas about things you might try to do if anyone touched you again in a way that is not-OK?"

213

**Safety skills specific to cases involving sexual abuse**




- Body Ownership
- Body Awareness
- Discussion of OK vs. not-OK touches

214

**Additional Safety Skills Specific to Interpersonal Violence:**

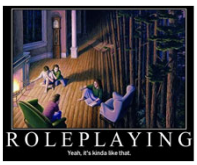
- Right to say No
- Getting Away
- Telling someone
- Not keeping secrets

*Dehlinger and Heflin, 1996*

215

3 strikes!

DEMONSTRATIONS!




scenarios

Confident walking

216

## Enhancing Personal Safety

Remember that personal safety skills are individualized but address these things:

- Resource people
- Internal/external cues signifying danger
- Assertive communication
- Problem solving

217

## Smoke alarm metaphor for the

**"Uh-oh feeling" or "Spidey Sense"**

- What do you do when you hear a smoke alarm? *Get to safety! Check it out when you hear it. First get away. Might be a false alarm, but first check it out with a grown up you trust.*
- Why? What does a smoke alarm mean? *Smoke alarms alert us to danger- that there could be a fire!*
- Sometimes there is smoke but no fire. Why are they so sensitive? *They let us know we need to get away before the flames get out of control*
- If the smoke alarm keeps going off, eventually you might be tempted to take out the batteries (numbing)
- You have your own personal smoke alarm inside you. Unfortunately, it doesn't make all that racket. It's usually silent, so you have to know what it feels like when it goes off (uh-oh feeling).

*Ashley Fiore*

218

## Healthy Development

**Preparing the parent**

- Help parent understand that avoiding talking about sex-ed = sex is shameful
- Learn parents' values
  - What info did parent receive about sex-ed, from whom, what was that like?
  - How do they feel about how they learned that info?
  - How do they feel about providing info for their child?
  - What do they want their child to know?
  - Where do they stand on: Masturbation, premarital sex, teen dating, etc.

Leila Keen, 2009

219

## Healthy Development

**Preparing the parent**

- Assess parental readiness
- Discuss teachable moments
- Discuss parents' thoughts and/or concerns about providing info to child
  - Practice cognitive coping to dispute dysfunctional thoughts underlying anxiety and embarrassment
  - Would they rather their child hear about sex-ed from peers?

http://www.plannedparenthood.org/parents/
http://www.noplacelikehome.org/
http://www.talkwithyourkids.org/pages/

Leila Keen, 2009

220

## Sex education/healthy sexuality with kids

- Books
- Websites
  - Adam Ruins Everything
    - https://www.youtube.com/watch?v=1ikXim4wevc
  - http://www.sexetc.org/
  - http://www.iemily.com/
  - http://www.gurl.com/
  - http://www.youngwomenshealth.org/
  - http://www.plannedparenthood.org/info-for-teens/

Leila Keen, 2009

221

222

## Post Treatment Assessment Goals

- Assure treatment goals have been met
- Identify further treatment needs
- Enhance self efficacy

223

## Post Treatment Assessment Tasks

- Assessed trauma history, symptoms, and functioning
- Provided post-treatment assessment results
- Developed post-TF-CBT plan
- Prepared for TF-CBT termination
- Celebrate!

224