Trauma Focused Cognitive Behavioral Therapy
2 Day Initial Training

Donna Potter, LCSW

donnandjon@gmail.com

Impact of Trauma on Children

Effects of Trauma on the brain

Changes in brain chemistry lead to changes in brain growth and development

"Our brains are sculpted by our early experiences. Maltreatment is a chisel that shapes a brain to contend with strife, but at the cost of deep enduring wounds" Teicher, 2000

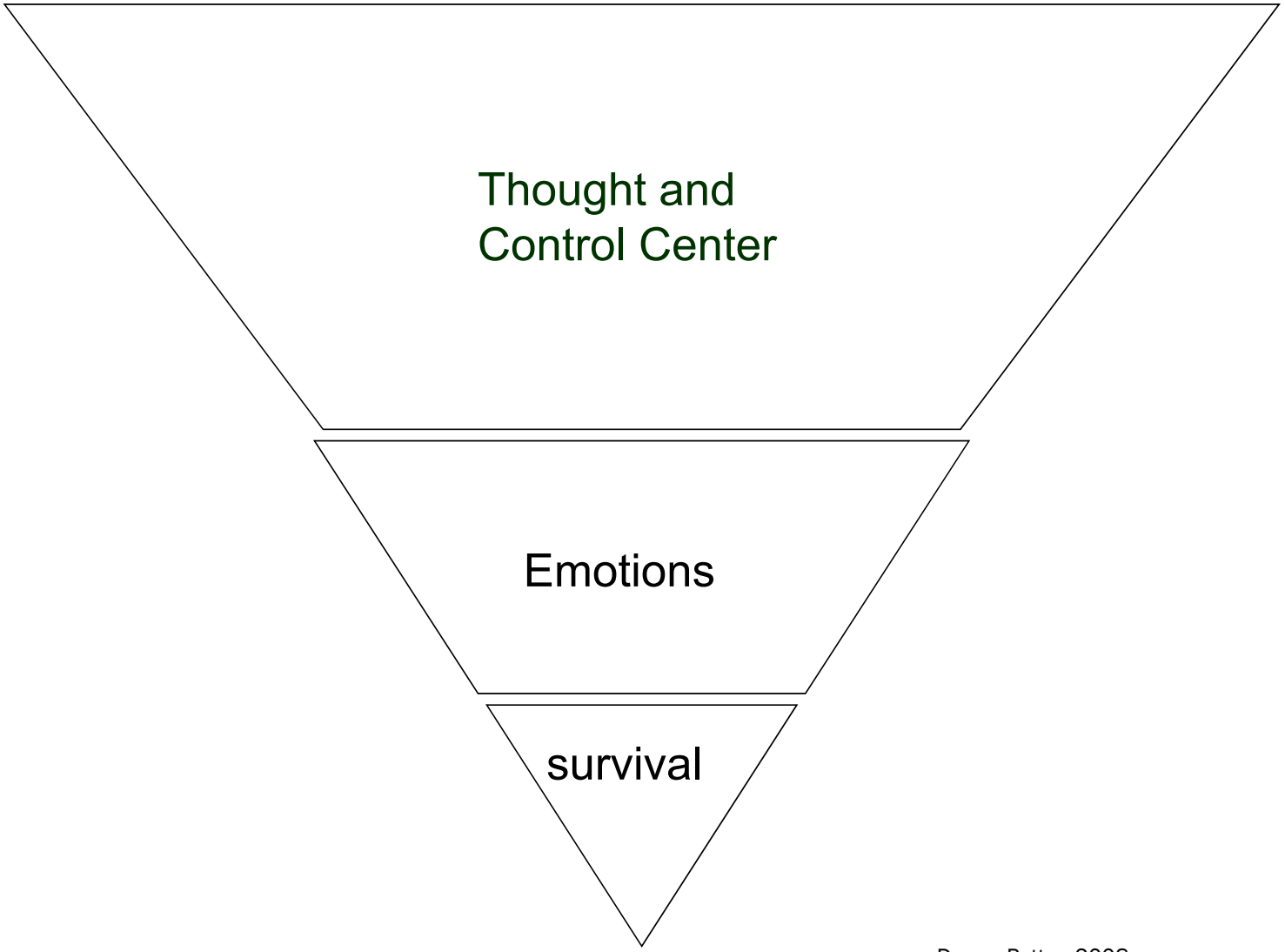
Donna Potter, 2008

What changes when you are in a constant state of alarm?

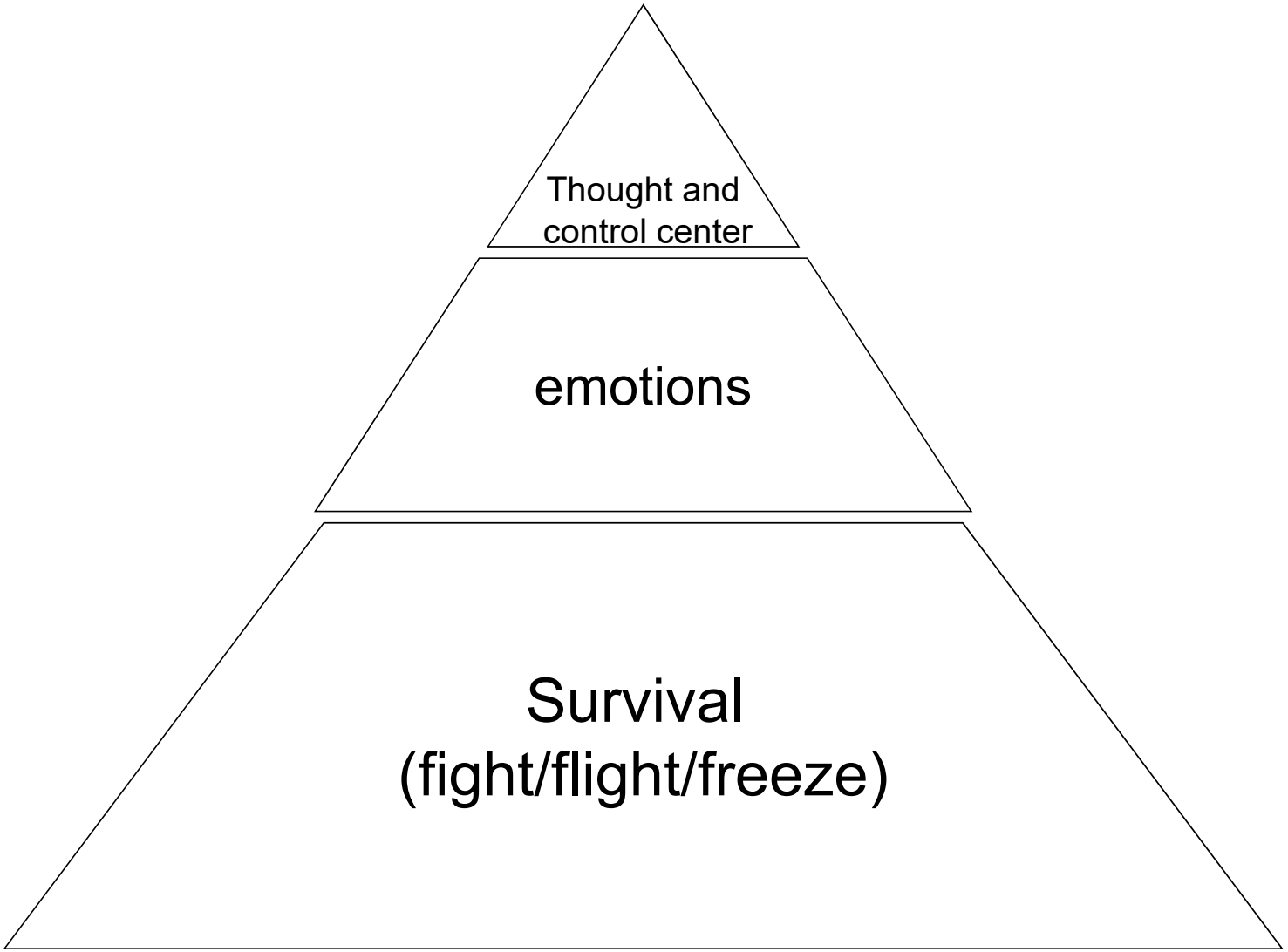
- Smaller brains
- Smaller corpus callosum
- Smaller cerebellum
- Change in how we experience pain
- Change in thyroid functioning
- Change in levels of stress hormones
- Increase in medical problems – ACE study
- Changes in hippocampal volume
- Decreased ability to concentrate & learn

  (Have to focus on keeping safe/protecting self)

Rebecca Hubbard, 2010



Donna Potter, 2008
from Rintoul, 1999



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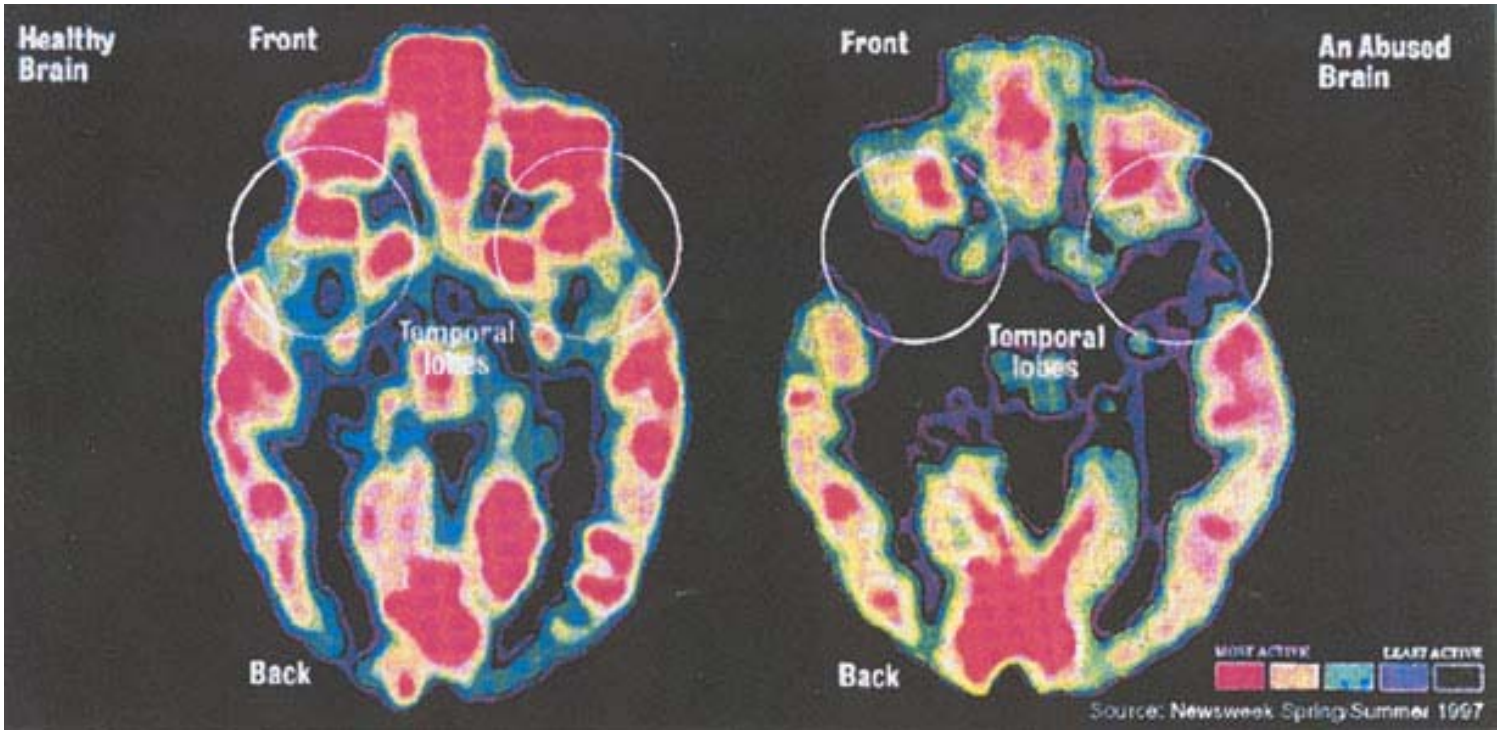
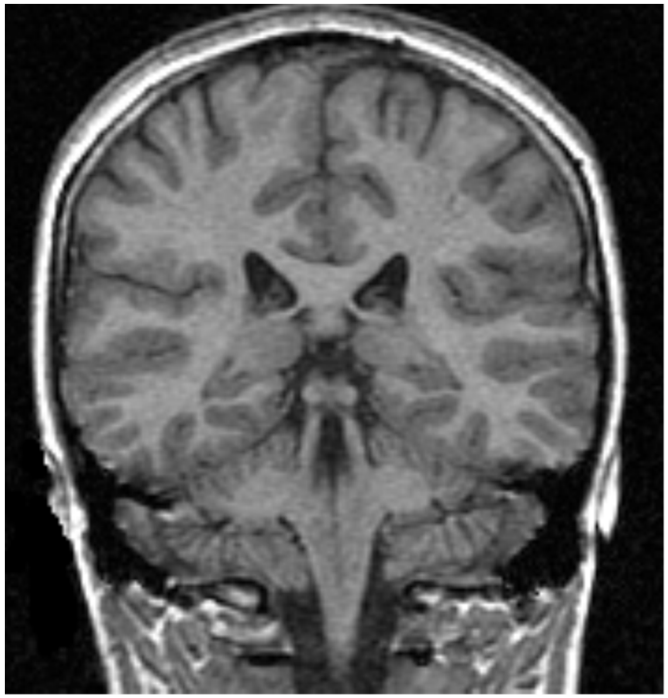
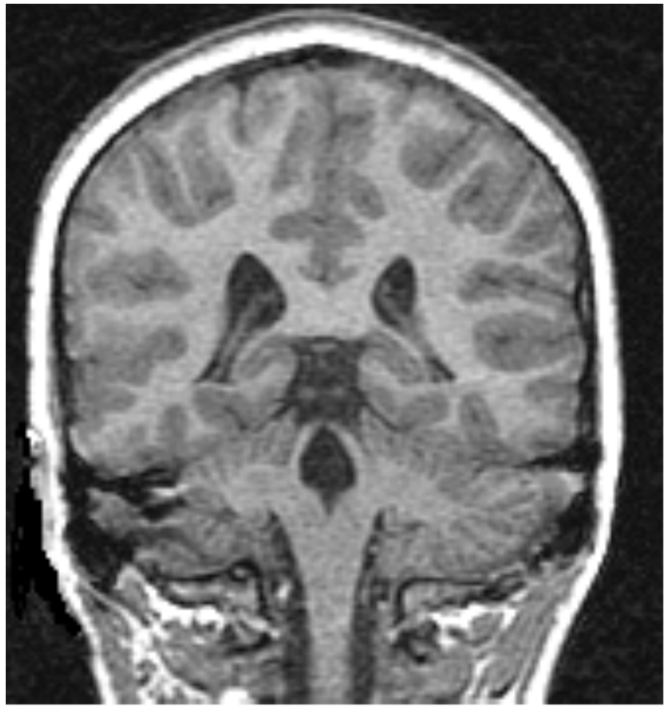

Healthy Brain
Front
Temporal lobes
Back
Front
An Abused Brain
Temporal lobes
Back
MOST ACTIVE
LEAST ACTIVE
Source: Newsweek Spring/Summer 1997

Lateral Ventricles Measures in an 11 Year Old Maltreated Male with Chronic PTSD, Compared with a Healthy, Non-Maltreated Matched Control





De Bellis et al., Biological Psychiatry, 1999.

DeBellis

At any age, effects are buffered or exacerbated by:

- Age/developmental level of child
- Parental response
- Gender
- Biology
- Environment
- Subsequent situation
- Parent child relationship

Donna Potter, 2010

At any age, the amount of dysregulation depends on

- Type of trauma exposure
- Duration of exposure
- Severity of exposure
- Frequency of exposure
- Age at first exposure
- Relationship to perpetrator

Donna Potter

Behavioral Trauma Symptoms in children

- Avoidance
- Modeling maladaptive behaviors
  - Sexualized behaviors
  - Bullying
  - Violent behaviors
- Traumatic Bonding
- Irritability
- Substance Abuse
- Self-Injury

Affective Trauma Symptoms in children

- Fear
- Sadness
- Anger
- Anxiety
- Affective Dysregulation

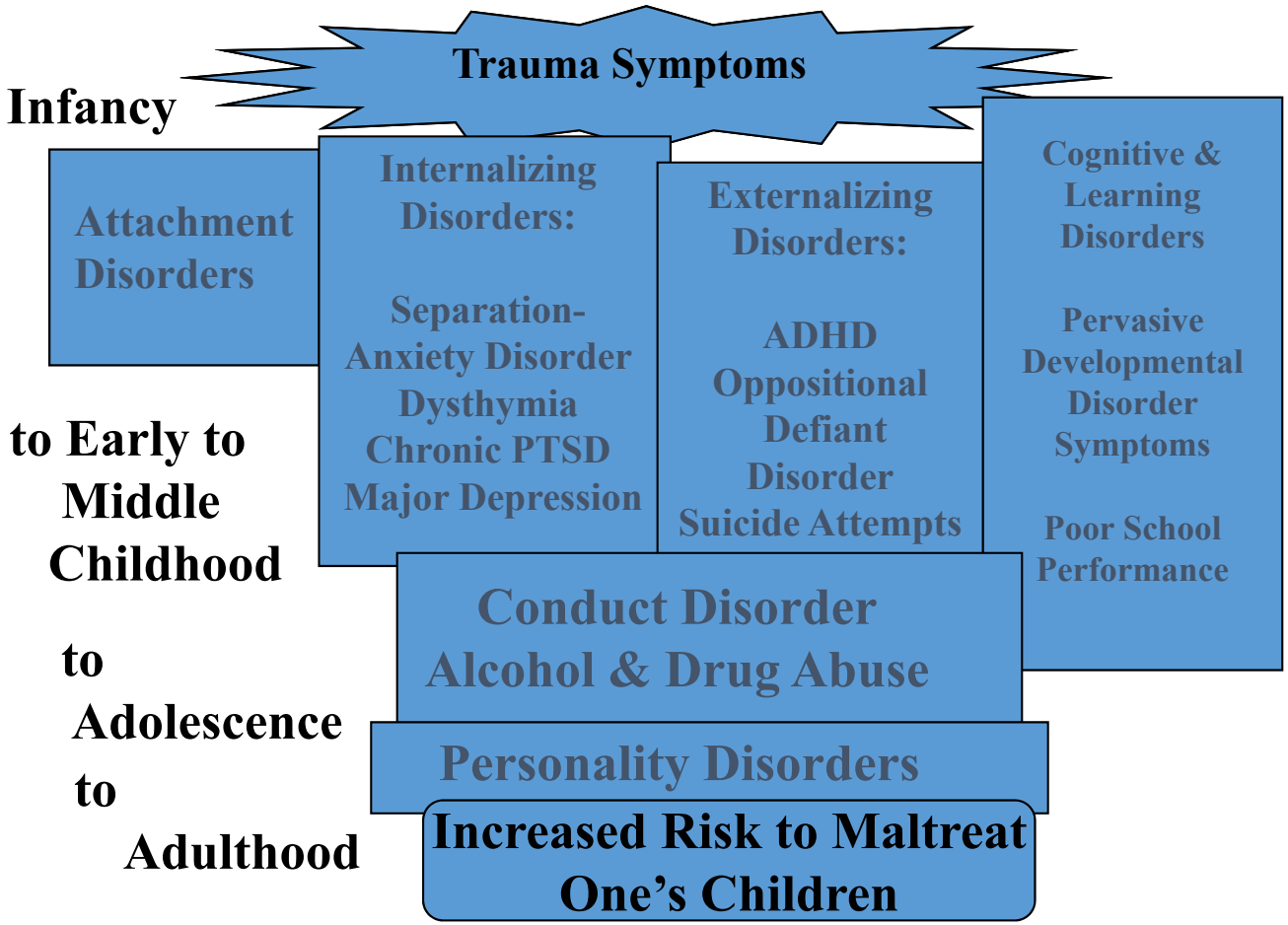
THAT INTERFERE IN FUNCTIONING

Laura Murray

Cognitive Trauma Symptoms in children

- Irrational Beliefs
- Distrust
  - Causation of trauma
- Distorted Self-Image
- Loss/Betrayal of Social Contract
- Accurate, but unhelpful, cognitions

Laura Murray



De Bellis, Dev. Psychopath, 2001

Prevalence of Posttraumatic Stress

- <20% of children with history of exposure have a psychiatric disorder
- **Resiliency is normative**
- **PTSD:** All traumatic events are not created equal…
  - School shooting 60% (Pynoos et al., 1987)
  - Sexual/physical abuse 20-65% (Adam et al., 1992; McClear et al., 1994; Saigh et al., 1999)
  - 3x greater likelihood of developing an Anxiety D/O, including PTSD, following violent death of a parent or loved one
  - Foster care alumni – rates similar to combat veterans

B. Intrusions into daily life

C. Avoidance

D. Change in Thoughts & Feelings

E. Change in Arousal & Reactivity

(associated with traumatic event)

Courtesy of Susan McLean, NC CTP Cohort 14 clinician

Complex PTSD

- Defining features:
  - Affective dysregulation
  - Interpersonal difficulties
  - Self-esteem issues
  - Self-injurious behaviors
- TF-CBT TX studies have included some youth with complex PTSD; many have had at least one defining feature.

Common Therapeutic Themes for Traumatized Children

- Betrayal of trust
- Self-blame (self-esteem issues)
- Anger
- Difficulty modulating affect
- Hopelessness

From Cohen & Mannarino (2004)

Common Parental Issues in Child Traumatization

- Inappropriate self-blame and guilt
- Inappropriate child blame
- Overprotectiveness
- Overpermissiveness
- Post Traumatic Stress Disorder/symptoms

From Cohen & Mannarino (2004)

GOAL

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

What is TF-CBT?

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

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

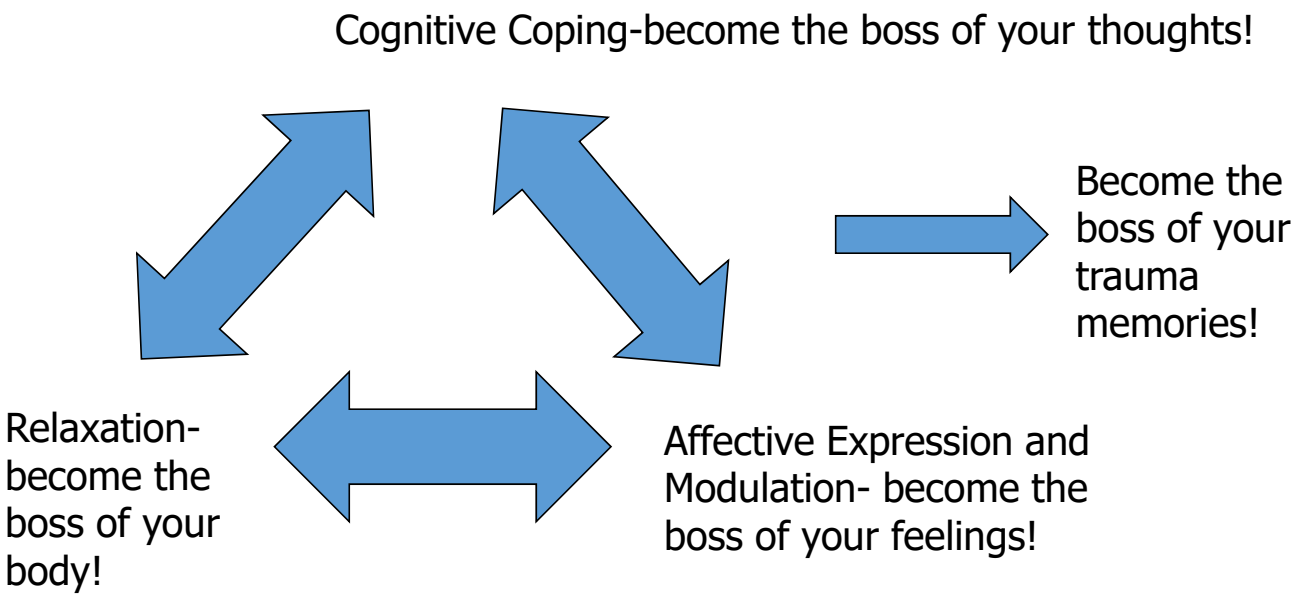
Core Values of TF-CBT

- ***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

Cultural Sensitivity & 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

How TF-CBT is CBT?



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!

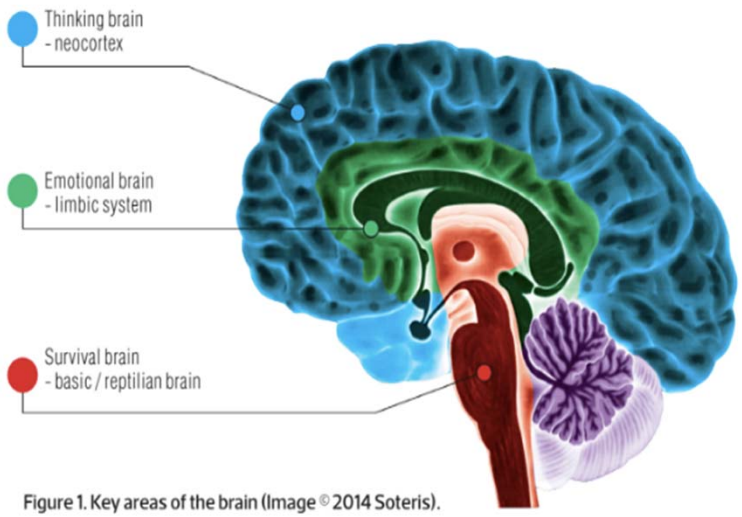


Figure 1. Key areas of the brain (Image © 2014 Soteris).

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

Three Phases to Treatment

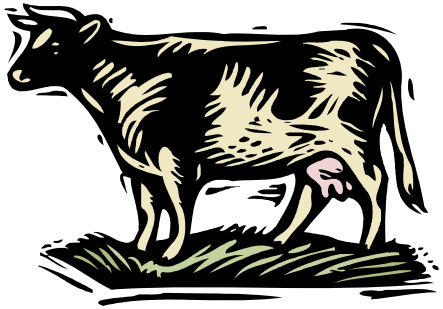
- Safety and stabilization
- Formal Gradual Exposure / Working through
- Moving on/Consolidation

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

Gradual Exposure

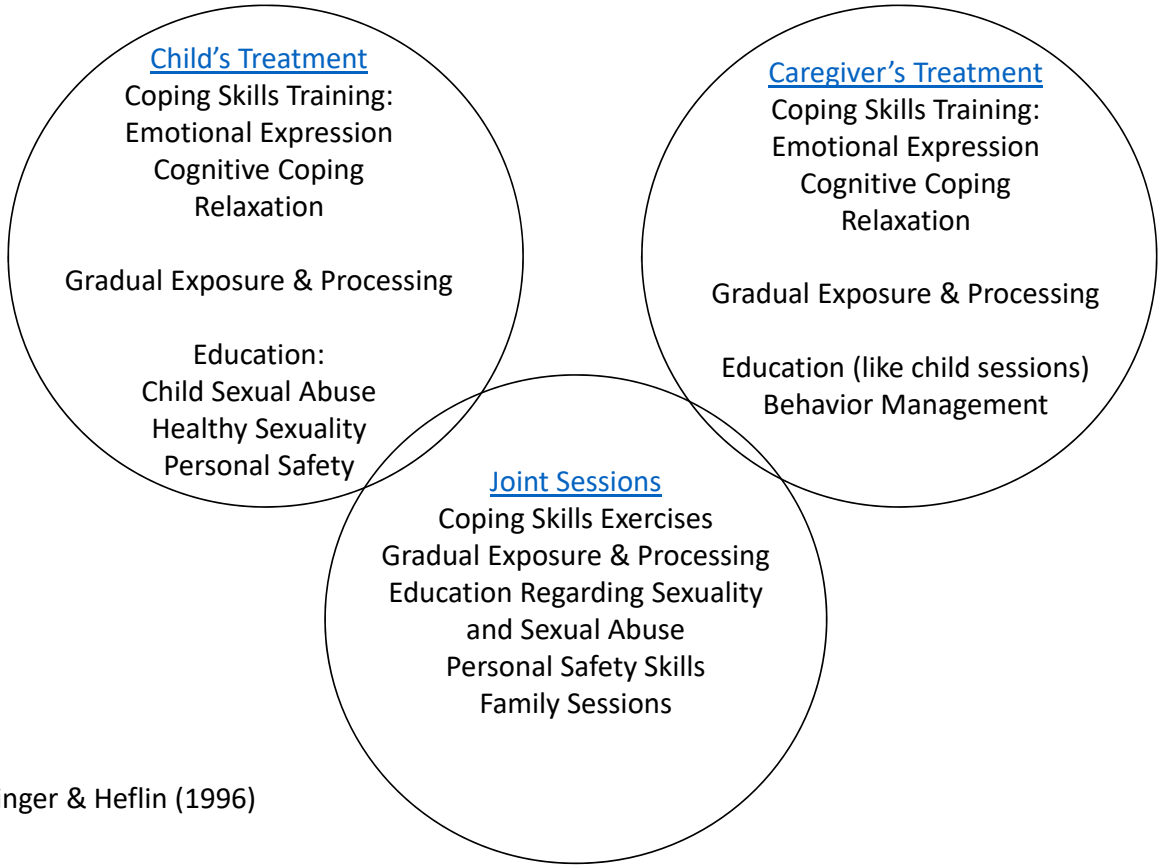
Therapist: Directive and Active

- Agenda Setting and Sticking to your Agenda
- Dealing with COWS “Crises of the Week”



- Being Responsive & Treating Families while Staying on Track

Trauma-focused Cognitive Behavioral Therapy



From Deblinger & Heflin (1996)

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

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)

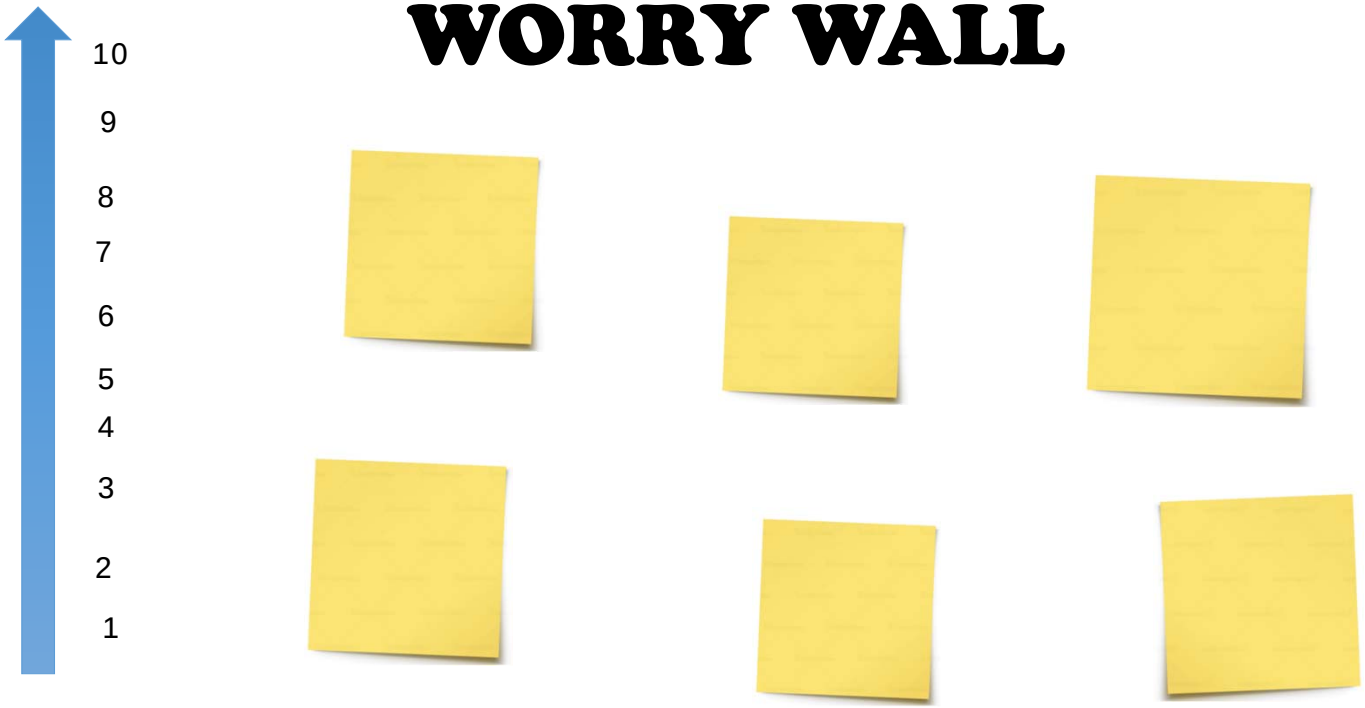
Pre- Treatment Assessment Goals

- 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

Pre- Treatment Assessment Tasks

- Assessed client trauma history, symptoms, and functioning
- Provided pre-treatment assessment results
- Developed TF-CBT treatment goals (operationalized symptoms)
- Conducted functional analysis of trauma symptoms targeted for treatment
- Prepared BOTH client and caregiver separately for pre-treatment assessment conjoint session

WORRY WALL



First, operationalize the symptoms separately with client AND caregiver

Consider INTENSITY, SEVERITY, DURATION

Operationalizing Symptoms

Help them give a detailed description of each symptom

- What does it look like to others?
- What does it feel like to you?

Operationalizing Symptoms: Which symptoms should be the focus?

- What is most distressing to your client?
- Which one happens most often?
- What is most disturbing to caregiver?
- Which symptom interferes most with daily functioning?
  - Do different symptoms interfere in functioning in different domains?
- WHICH SYMPTOMS ARE ACTUALLY CONNECTED TO THE TRAUMA????
- Sleep is HUGE!!
- Safety!

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

Psychoeducation Tasks

- Enhanced knowledge and helpful beliefs about general impact of trauma
- Introduced TF-CBT model
- Enhanced knowledge and helpful beliefs about client trauma type
- Prepared BOTH client and caregiver separately for Psychoeducation conjoint session

The following slides are taken from

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

We Learn by Experience

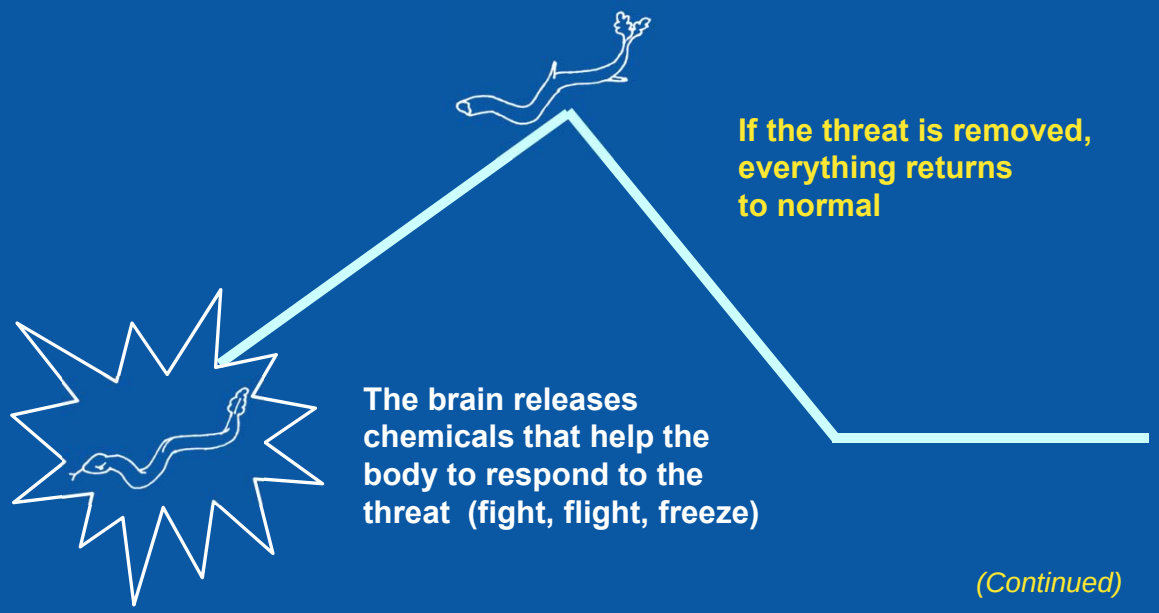
(Continued)

We Learn by Experience
(Continued)

(Continued)

We Learn by Experience
(Continued)

Your Internal Alarm System



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Your Internal Alarm System
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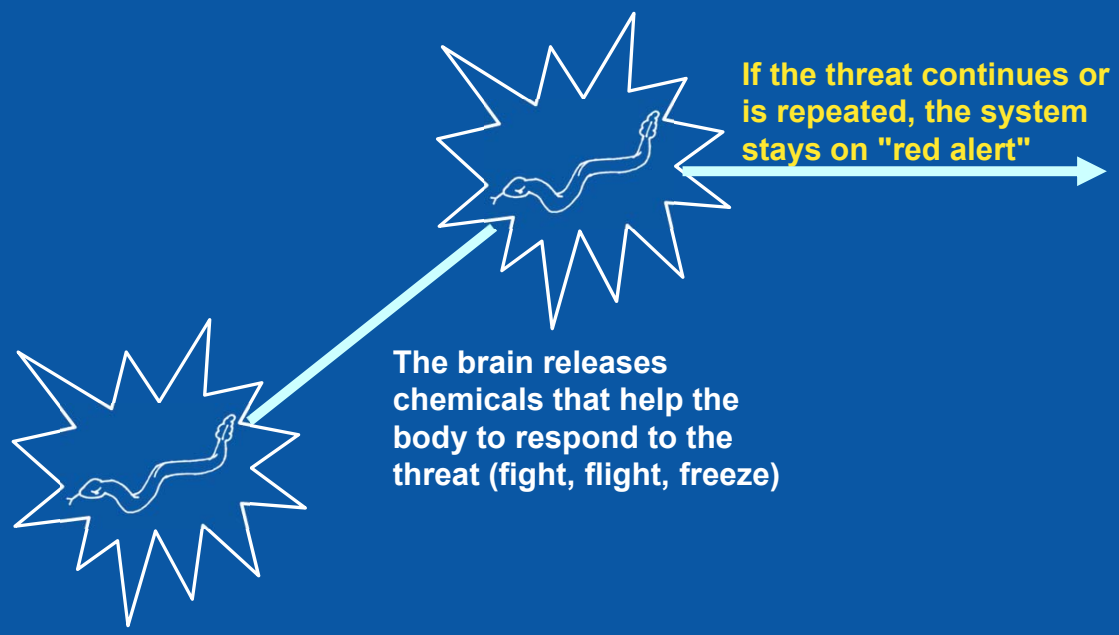
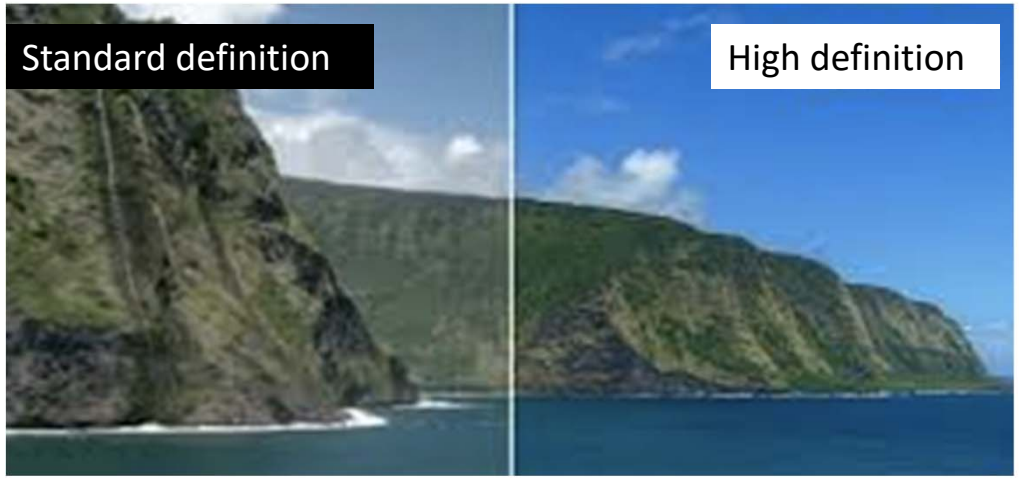
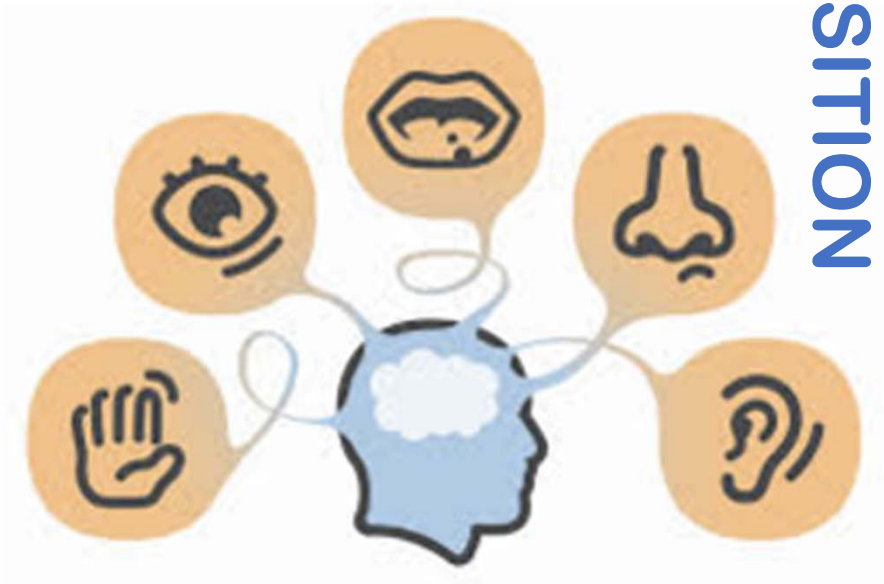




MOVEMENT

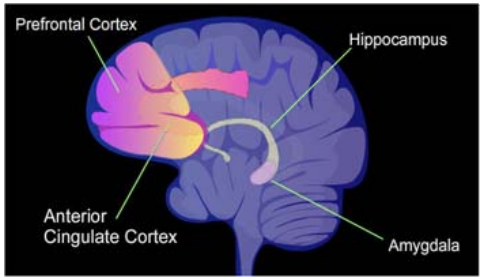
POSITION



ORIENTATION

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

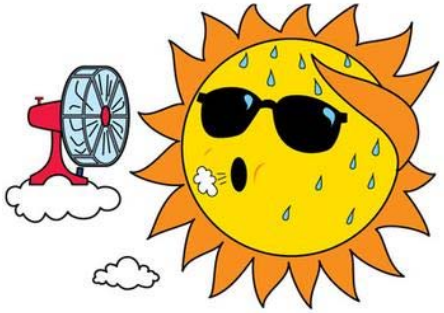
- **Amygdala** - The brain's "fear hub," which activates our natural "fight-or-flight" response to confront or escape from a dangerous situation.
  - Also involved in learning to fear an event, such as touching a hot stove.



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.

Symptoms that were protective before are no longer necessary

Parka Analogy



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

Oxford
ASSORTED GLOW COLORS
Ruled Index Cards
300
Oxford
ASSORTED GLOW COLORS
Ruled Index Cards
300

Oxford
ASSORTED GLOW COLORS
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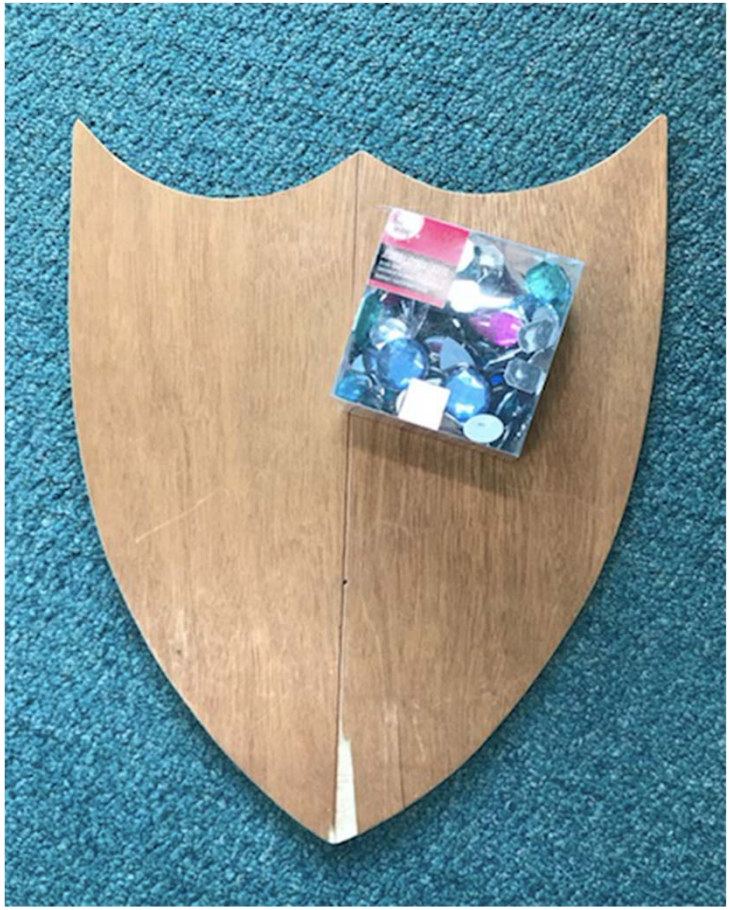
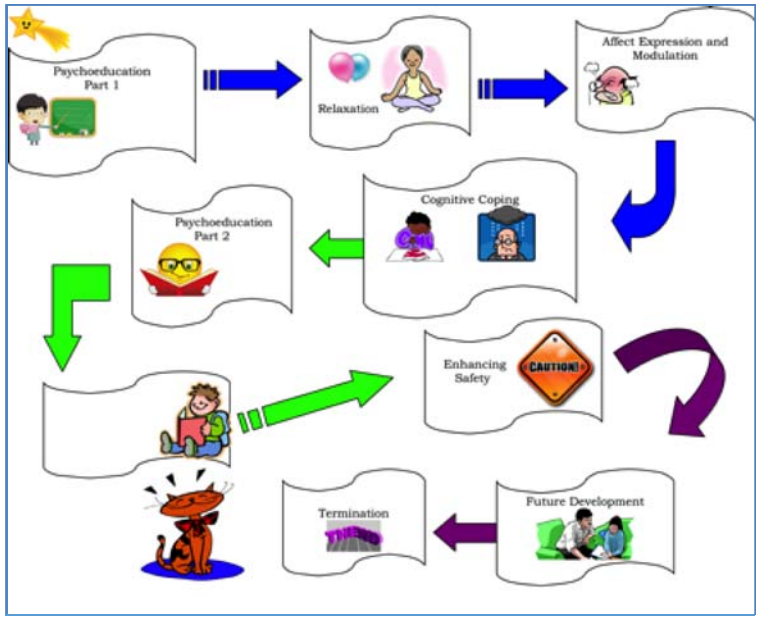


TF-CBT Candy Land Map



* See Resources Tab in NC POP

Why do we do Gradual Exposure?

The "wound" analogy:

"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."

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."

TF-CBT is like learning how to surf:

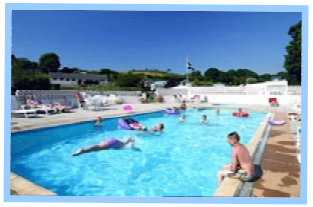
- Build your strength
- Get the right equipment
- Start with little waves

Psycho-education: Parent

- Reduce parental distress
- Common parental issues following trauma
  - Inappropriate self-blame/guilt
  - Over-Protectiveness
  - Over-Permissiveness
  - PTSD symptoms
- Highlight critical role caregiver involvement has in improving child's positive outcomes

Now, you try …

- Work in dyads at your table; take turns being the therapist.
- Therapist 1: Choose an analogy that normalizes symptoms. Practice using it.
- Switch roles.
- Therapist 2: Choose a different analogy and use it to explain TF-CBT.
- Therapist 1: Use an analogy to explain the function of avoidance.



Information to cover in psycho-education

- 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?

Psycho-education Activities

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 adult to teach who abuses kids
- 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

Psycho-education for older kids

- What Do You Know Card Game
- Socratic Questioning
- Games
- Talk Show
- Fill in the blank sheet
- Books about trauma experiences’

Make it interactive!!!

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

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 insure 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

Role plays:

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

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

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

Potential Topics for Additional Conjoints

- Psychoeducation about trauma
- Safety planning
- Healthy sexuality
- Attributions about the experience
- Healthy relationships
- Conflict avoidance
- Preparation for court testimony

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?

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

Parenting Tasks

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

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

Effective Commands

- Cue child to pending command: “Owen, please…”
- Make it simple
- Make it developmentally appropriate
- Phrase it positively
- Give it in a neutral tone of voice
- Provide an explanation BEFORE command is given
- Give one command at a time
- Praise immediately after compliance

Effective Praise

- Be enthusiastic
- Be genuine
- Be specific
- Be present-focused and purely positive (no back-handed compliments!!)
- Be consistent/predictable
- Be immediate
- Focus on effort not outcome

Effective Reinforcers

- Tailored specifically to the child
  - What does this child REALLY love?
- Positive parental attention is the best reward
- Privileges
- Small, realistic, frequent rewards work best
- Stay away from food and trinkets unless it’s an emergency!

Purely Ignore

- Sounds easy, but harder to do than providing a consequence
  - Requires superb patience and faith
  - If the child doesn’t think you’re ignoring him/her you’re not doing it right
- Once you ignore, don’t cave or you’ll make it worse the next time
- BE PREPARED: Ignored behaviors will often get initially worse

Effective Consequences

- Natural consequences (use first if available, safe, and developmentally appropriate)
  - Consequence happens to the child without you
  - Ex. Child refuses food, goes hungry, eats later
  - Bad ex. Child (3 year old) misses event because took too long
- Logical consequences
  - Time out
    - Ages 2-6
  - Work chores
    - Ages 7-12
  - The “iron-clad contract”
    - Adolescence

Effective Consequences cont.

- Immediate
- Consistent
- Developmentally appropriate
- Tailored specifically for the child
- Short term (if not, you punish yourself as well)
- Provided without extra comment*
- Provided in a neutral tone of voice
- DON’T HOLD A GRUDGE- clean slate
- Effective repair following consequence

*Here’s where the ignoring comes in; you’ve got to give the consequence time to work or your attention will reinforce their misbehavior!

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

Relaxation Tasks

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

Functional Behavioral Analysis with Clients

Be Detectives!
Gather the Evidence!
Get in the Lab!

At Relaxation

- What triggers the symptom?
- What's worked for you before?
- When is the symptom happening?
- Are there times it's worse than others?
- What happens before the symptom?
- What happens after?
- How do you/your friends respond?
- Where is the symptom happening?

Functional Behavioral Analysis with Caregiver

What gets the symptom started and what keeps it going?

At Relaxation and Parenting

- What triggers the symptom?
- What drives the symptom?
- What perpetuates the symptom; How do you and others respond?
- What diminishes the symptom?
- What's happening in the environment?
- What strategies does your child have to stop or tolerate the symptom?
- How can the caregiver use his/her role to structure the environment for success?

Steps in relaxation

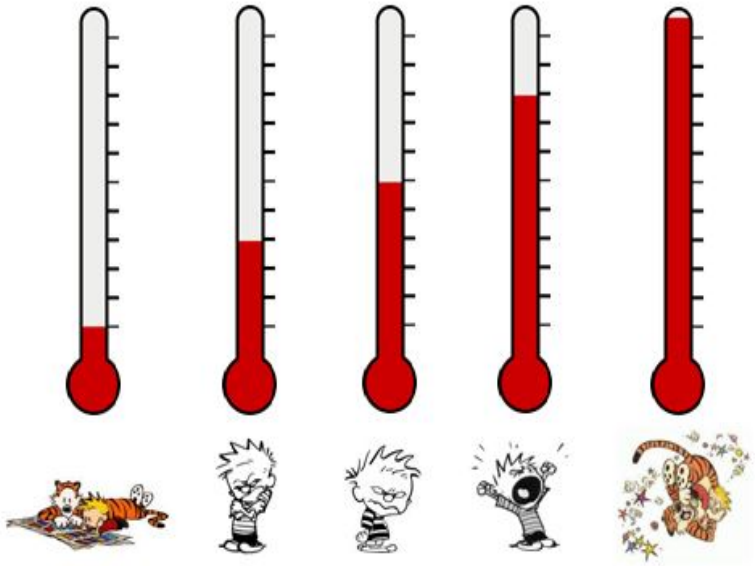
- Analyze context and identify triggers
- Determine what has worked in the past
- Try something new:
  1. Demonstrate skill
  2. Have client practice skill
  3. Have client share something related to the trauma experience
  4. *Write it down*
  5. Have client practice skill again
  6. Strategize how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

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

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

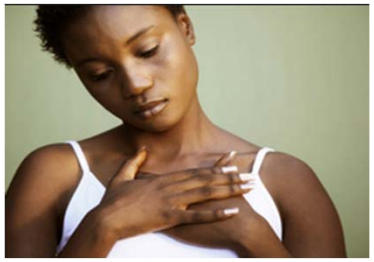


Created by Rebecca Hubbard, 2011

Affect Regulation: Parents

- John Gottman's emotion coaching
  1. Become aware of the child's emotions
  2. Recognize the emotion as an opportunity for intimacy and teaching
  3. Listen empathetically, validating the child's feelings
  4. Help the child to find words to label the emotion he is feeling
  5. Set limits while exploring strategies to solve the problems at hand

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

Cognitive Coping Goals

- Enhance cognitive coping skills in general and trauma-related situations
- Increase self efficacy related to use of cognitive coping skills in general and trauma-related situations
- Enhance understanding of links among thoughts, emotions and behaviors
- Enhance ability to share general and trauma-specific cognitions
- Reduce cognitive manifestations 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

Cognitive Coping Tasks

- Facilitated ability to address automatic negative thoughts
- Facilitated application of the cognitive triangle
- Facilitated ability to challenge patterns of cognitive distortions
- Facilitated use of cognitive coping skills
- Facilitated ability to support client use of cognitive coping skills
- Prepared BOTH client and caregiver separately for Cognitive Coping conjoint session

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

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

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

Step 1: Cognitive Work with Kids - Identifying 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!

- Turn to the person next to you.
- Agree who will go first and who will go second.
- Take 1 minute to explain automatic thoughts to a client and get him or her to share one with you.
- Don’t forget to praise!
- Now switch places and try a different strategy

Step 2: Becoming aware of helpful and unhelpful thought patterns

- Identify unhelpful 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!

Unhelpful Thought Patterns

- Yes or No Yasmine
- Over and Over Oliver
- Calamity Jane
- No-Way Nora

Cohen, J., Mannarino, A, & Deblinger, E. (2006). Treating Trauma and Traumatic Grief in Children and Adolescents (p. 112-113). New York: Guilford Press.

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

Unhelpful Thought Patterns

- All-or-nothing
- Overgeneralization
- Mental Filter
- Disqualifying the Positive
- Jumping to Conclusions
  - Mind Reading
  - Fortune Teller
- Magnification or minimization
- Emotional Reasoning
- Should/musts
- Labeling & Mislabeling
- Personalization
- Tunnel Vision

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

Unhelpful Thinking Styles

All or nothing thinking

Sometimes called 'black and white thinking'

If I'm not perfect I have failed

Either I do it right or not at all

Over-generalizing

Seeing a pattern based upon a single event, or being overly broad in the conclusions we draw

Mental filter

Only paying attention to certain types of evidence

Noticing our failures but not seeing our successes

Disqualifying the positive

Discounting the good things that have happened or that you have done for some reason or another

That doesn't count

Jumping to conclusions

There are two key types of jumping to conclusions:

- **Mind reading** (imagining we know what others are thinking)
- **Fortune telling** (predicting the future)

Magnification (catastrophising) & minimization

Blowing things out of proportion (catastrophizing), or inappropriately shrinking something to make it seem less important

Emotional reasoning

Assuming that because we feel a certain way what we think must be true

I feel embarrassed so I must be an idiot

should must

Using critical words like 'should', 'must', or 'ought' can make us feel guilty, or like we have already failed

If we apply 'shoulds' to other people the result is often frustration

Labelling

Assigning labels to ourselves or other people

I'm a loser
I'm completely useless
They're such an idiot

Personalization

"this is my fault"

Blaming yourself or taking responsibility for something that wasn't completely your fault

Conversely, blaming other people for something that was your fault

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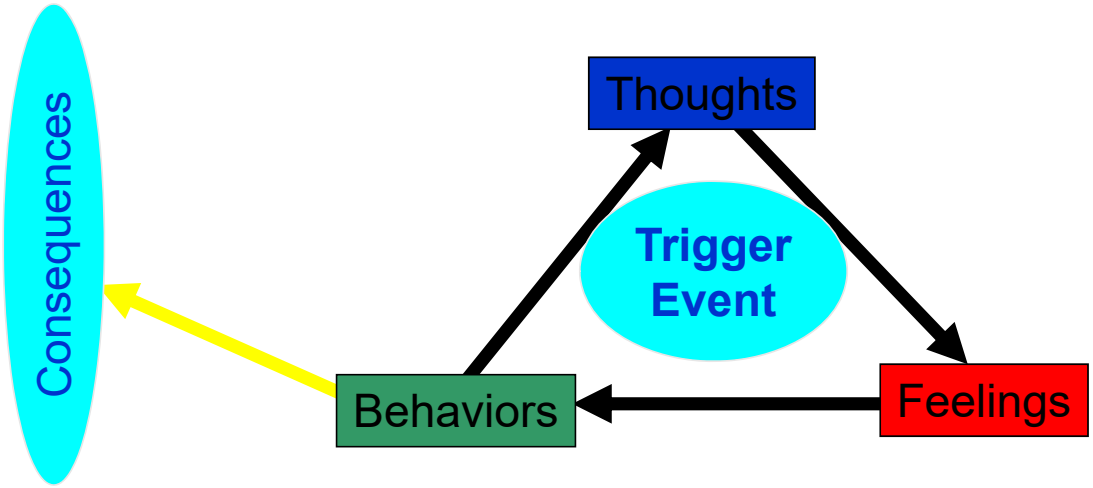
- Turn to the person next to you.
- Agree who will go first and who will go second.
- Take 1 minute to explain unhelpful thought patterns to a 7 year old client and get him or her to identify one he or she uses and give an example.
- Don’t forget to praise!
- Now switch places and take 1 minute to explain unhelpful thought patterns to a teen client and get him or her to identify one he or she uses and give an example.

Step 3: 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!

The Cognitive Triangle



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

Examples to Illustrate Cognitive Triangle

- A child did poorly on an exam at school
  - What are some reasons for this?
    - "I'm stupid" (thought) – how does this make you feel? What do you do?
    - The test was unfair (thought) – how does this make you feel? What do you do?
    - I didn't study hard enough (thought) – how does this make you feel? What do you do?

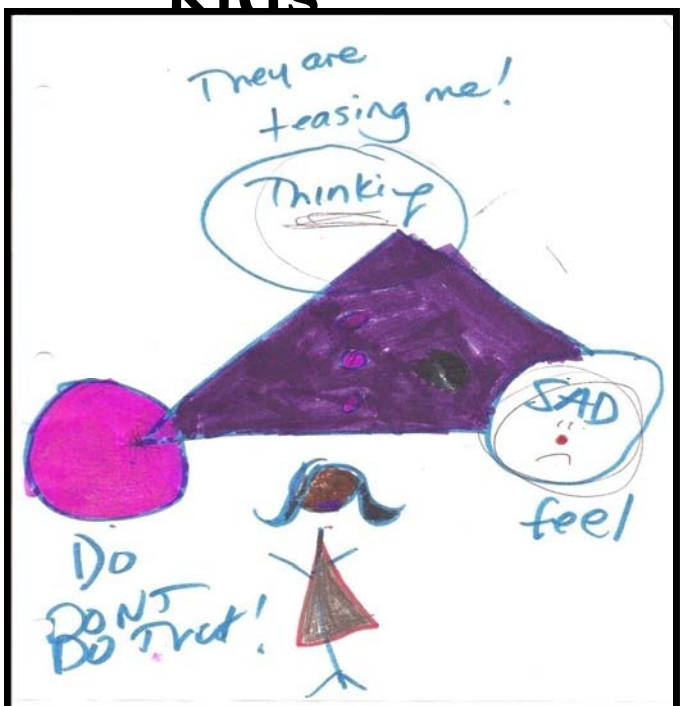
Rule: no challenging trauma-specific thoughts with children until after trauma narrative!

Examples to Illustrate Cognitive Triangle

- You're in the lunchroom and are walking over to a table where your classmates are sitting. They start laughing.
  - What are some reasons for this? What goes through your head when they start laughing?
  - How does that make you feel? What do you do?

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

What this looks like with kids



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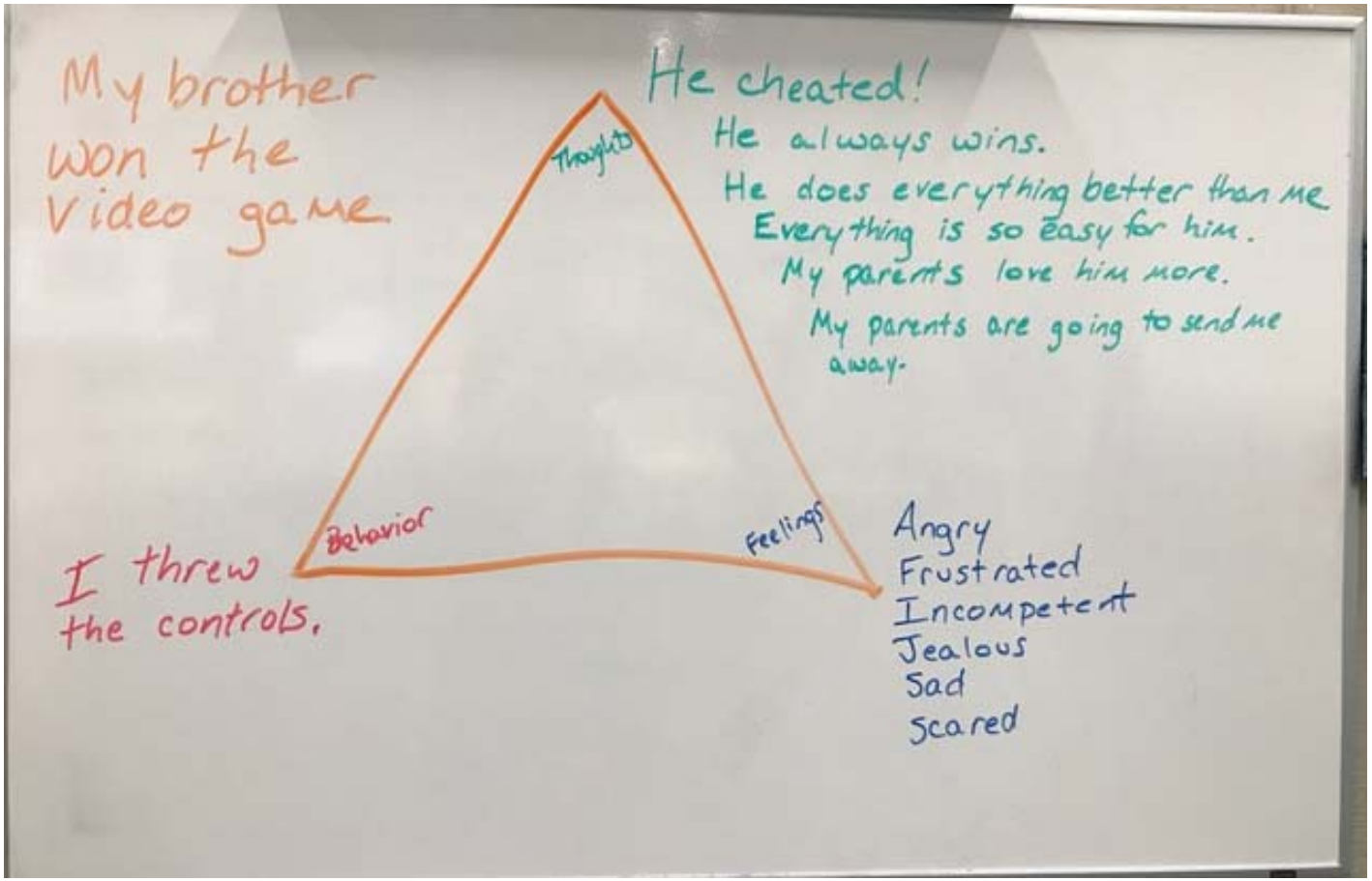
Rule: no challenging trauma-specific thoughts with children until after trauma narrative!

PEELING THE ONION

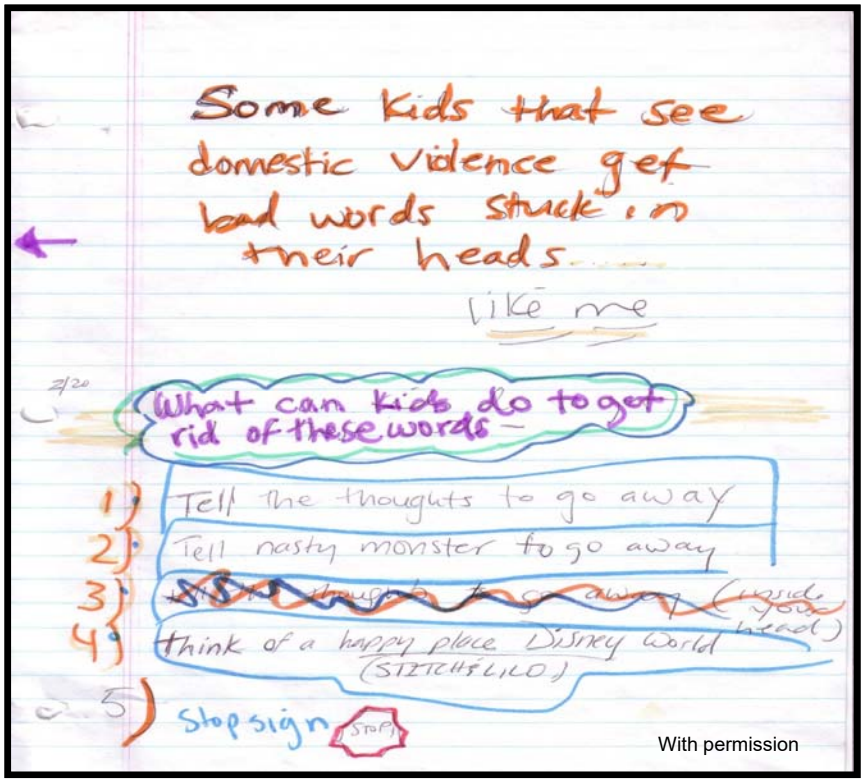

My brother won the video game
He cheated!
He always wins.
He does everything better than me
Everything is so easy for him.
My parents love him more.
My parents are going to send me away.
Thoughts
Behavior
Feelings
I threw the controls.
Angry
Frustrated
Incompetent
Jealous
Sad
Scared

- Turn to the person next to you.
- One of you is a13 year old child who has completed affective expression and modulation and one of you is the therapist
- Use an example from client's daily life to teach the cognitive triangle.
- Switch roles and use a new example so the other therapist can teach

Step 4: Teach other methods for disputing unhelpful thoughts

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

Coping with Intrusive Thoughts



With permission

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

Coping with Anxiety Related to Trauma:

- 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!

Other ways to dispute dysfunctional 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!

Thought Interruption

- Use when overwhelmed with trauma reminders
- Temporary measures early in treatment

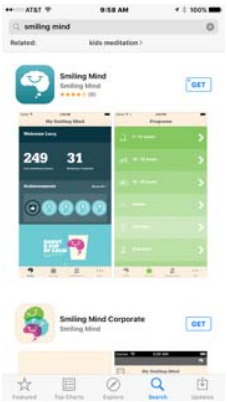
- Teaches child control over their thoughts
  - Changing the channel
  - Saying "go away" or "snap out of it"
  - Imagining a stop sign

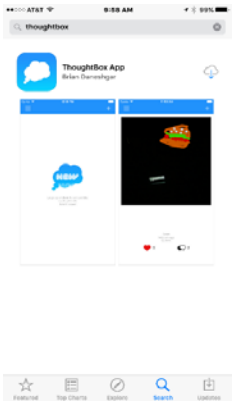
- Replace unwanted thought with a positive one

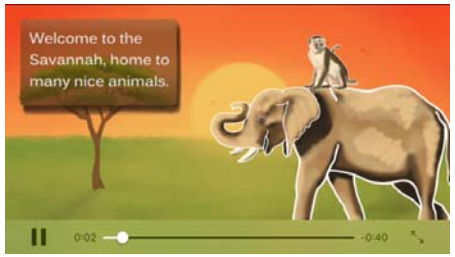
Rule: no challenging trauma-specific thoughts with children until after trauma narrative!

- Turn to the person next to you.
- One of you is the 10 year old child who has completed affective expression and modulation
- One of you is the therapist teaching cognitive coping strategies
- Teach client one of the cognitive coping strategies to manage the PTSD symptom of intrusive thoughts about the client's penile oral sexual abuse.
- Switch roles and use a new strategy so the other therapist can teach

Free TF-CBT Apps!







COGNITIVE PROCESSING WITH PARENTS

Slides by E. Deblinger

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

Eliciting and Identifying Parents' Dysfunctional Thoughts and Beliefs

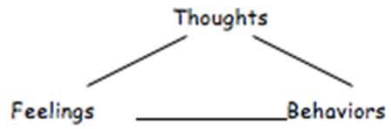
- Create supportive, non-judgmental therapeutic relationship
- Observe and obtain info about parent-child interactions from child and parent
- Review presenting concerns
- Assign homework to capture and monitor thoughts
- Elicit trauma-related thoughts in session

Cognitive and affective processing for caregivers:

- Examine thoughts which are permanent, pervasive, or too personalized
  - Permanent: " My child will never be happy again."
  - Pervasive: "I can't trust anyone with my child."
  - Personalized: "I am a terrible parent because my child was sexually abused." "I should have known that man was a sex offender."

Cognitive and affective processing for caregivers:

- *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?"*



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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UMDNJ-SOM NJ CARES Institute

- Turn to the person next to you.
- Agree who will go first and who will go second.
- Take 2 minutes to get the caregiver to complete the cognitive triangle homework.
- Don’t forget to praise!
- Now switch places and take 2 minutes to get the caregiver to complete the cognitive triangle homework.

Self statements…

can become self fulfilling prophecies…..

Invisible Suitcase:
Seeing clients through a trauma lens

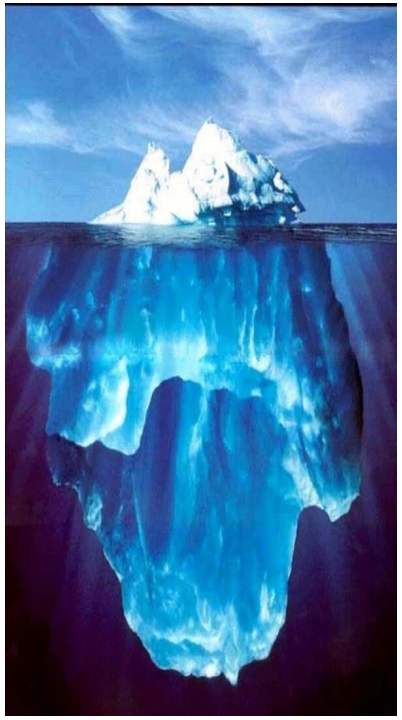
We learn by experience.

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

We see the behaviors on the surface



… and overlook the beliefs underneath.

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

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.

How SAFE does my child feel?

How CAPABLE does my child feel?

How LOVABLE does my child feel?

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

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
- Increase helpful cognitions regarding trauma experience
- Increase self efficacy regarding initial and current response to trauma
- Enhance coherence and organization of trauma memories
- 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

Trauma Narration and Processing Tasks

- Introduced trauma narration
- Incorporated trauma-specific memories in narration
- Elicited “worst” trauma memory
- Exposed client to content of prior Trauma Narration and Processing sessions
- Identified trauma reminders within trauma narration
- Identified cognitive disto
- Incorporated trauma-specific psycho-education
- rtions
- Replaced cognitive distortions with helpful thoughts
- Identified effective client responses
- Conceptualized trauma history as a coherent, meaningful narrative
- Prepared client for Trauma Narration and Processing conjoint session
- Prepared caregiver for Trauma Narration and Processing conjoint session

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

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

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

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

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

Suggested Steps for Trauma Narratives (con't.)

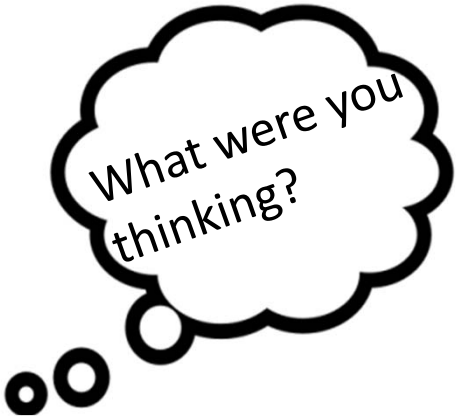
16. Include "how I have changed"; "what I have learned"; "what I would tell other kids who have experienced this".
17. Calming, fun activity at the end of session
18. Next session, reread everything the child has written and get SUDS before beginning new chapter

Possible chapters to include in narrative :

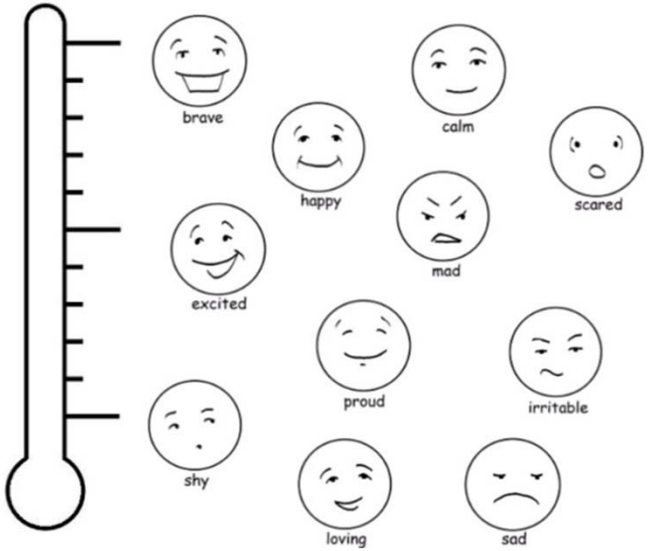
- Title Page- might change during process
- Introduction (about me, my family, my favorite..)
- Good Memories (before trauma, with family, with abuser)
- Trauma Details- events of trauma, disclosure, first time, worst time, time you thought you'd never tell anyone about, court, medical exam, police involvement
- 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

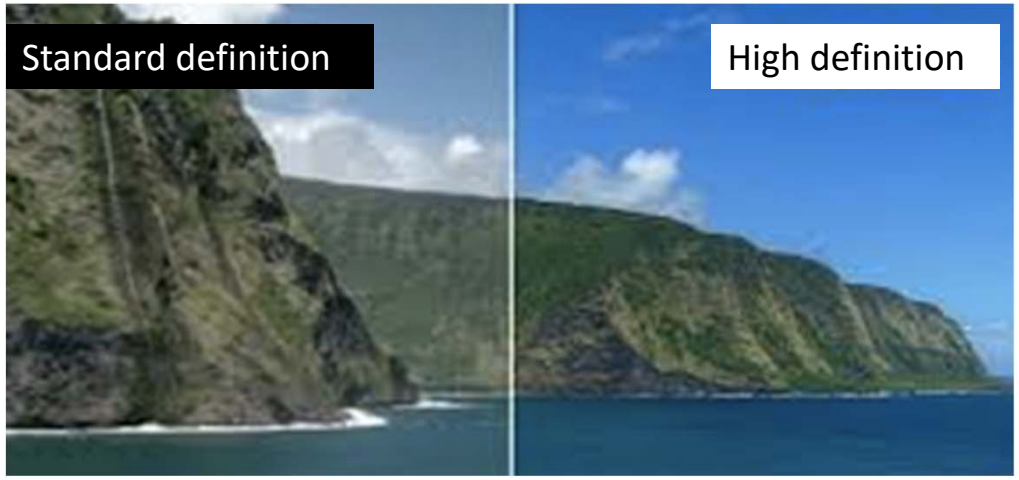
MOVEMENT
POSITION
ORIENTATION



What were you feeling?

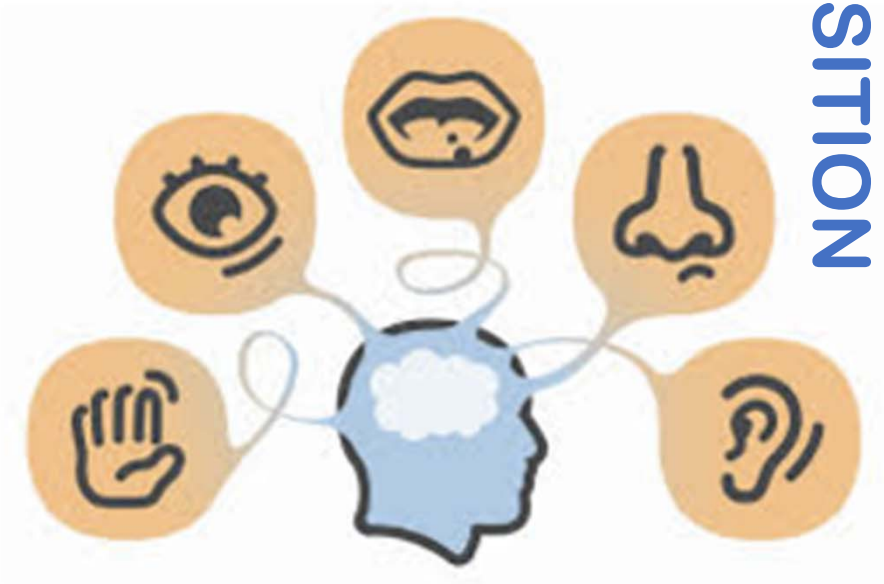


What was your body doing?



MOVEMENT

POSITION



ORIENTATION

Neutral Event vs. Traumatic Event

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.

Don't do this!

The Secretary:

Taking verbatim notes is really difficult!
And not helpful!

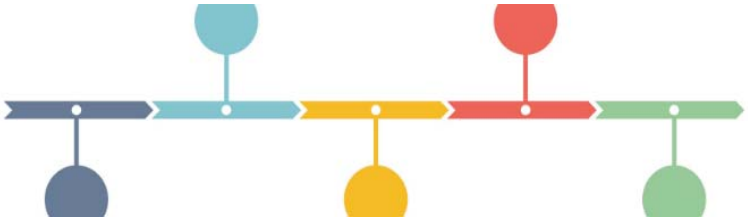
Facilitating trauma narration is NOT taking dictation

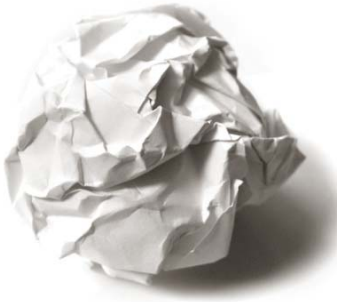
The Secretary + Co-pilot

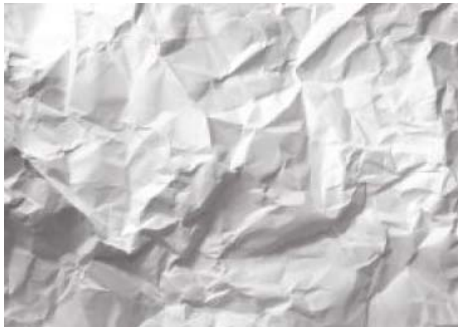
Do this!!!!

- 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)

Trauma Processing Goal 1: Enhance coherence and organization of trauma memories







Trauma Processing Goal 2: Identify and correct trauma related cognitive distortions

Dispute Dysfunctional Thoughts

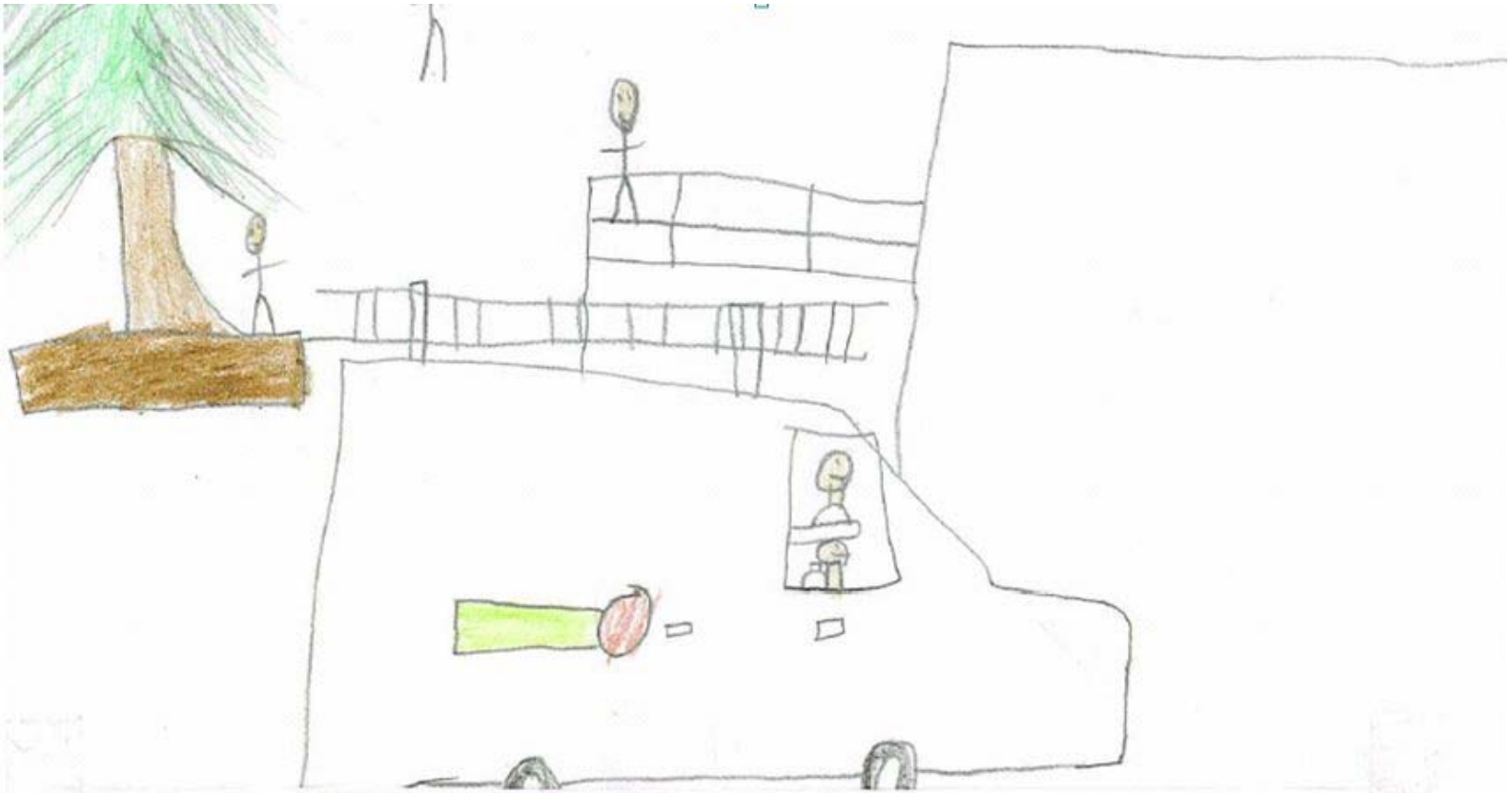
- Identify helpful vs. hurtful thoughts
- Examine contradictory evidence/facts
- Test the accuracy of thoughts
- Use the Socratic method
- Use role plays (e.g. best friend)

Courtesy of Esther Deblinger

Disputing Dysfunctional Thoughts

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

We will do a breakout after this*



We were driving home from school and my dad was in a real happy mood. A couple days before he had been in a bad mood. I didn't tell him about [redacted] before because I didn't want him to be in a worse mood. I thought if he was happy he would take it more easily. I told him that [redacted] sexually abused me the night he let me sleep over at [redacted]'s house. I told him that [redacted] sucked on my penis and that he put his penis in my butthole. My dad seemed kind of mad. I had no clue what he was thinking. He was a little upset that I didn't tell him right away. My dad said don't let him ever do it again and that he'd make sure that [redacted] doesn't come near me ever again. I felt happy that I told my dad and my dad was happy that I told him what happened. Then we went home and told my mom.

2

Esther Deblinger

Let's Practice:

Dear Dad,

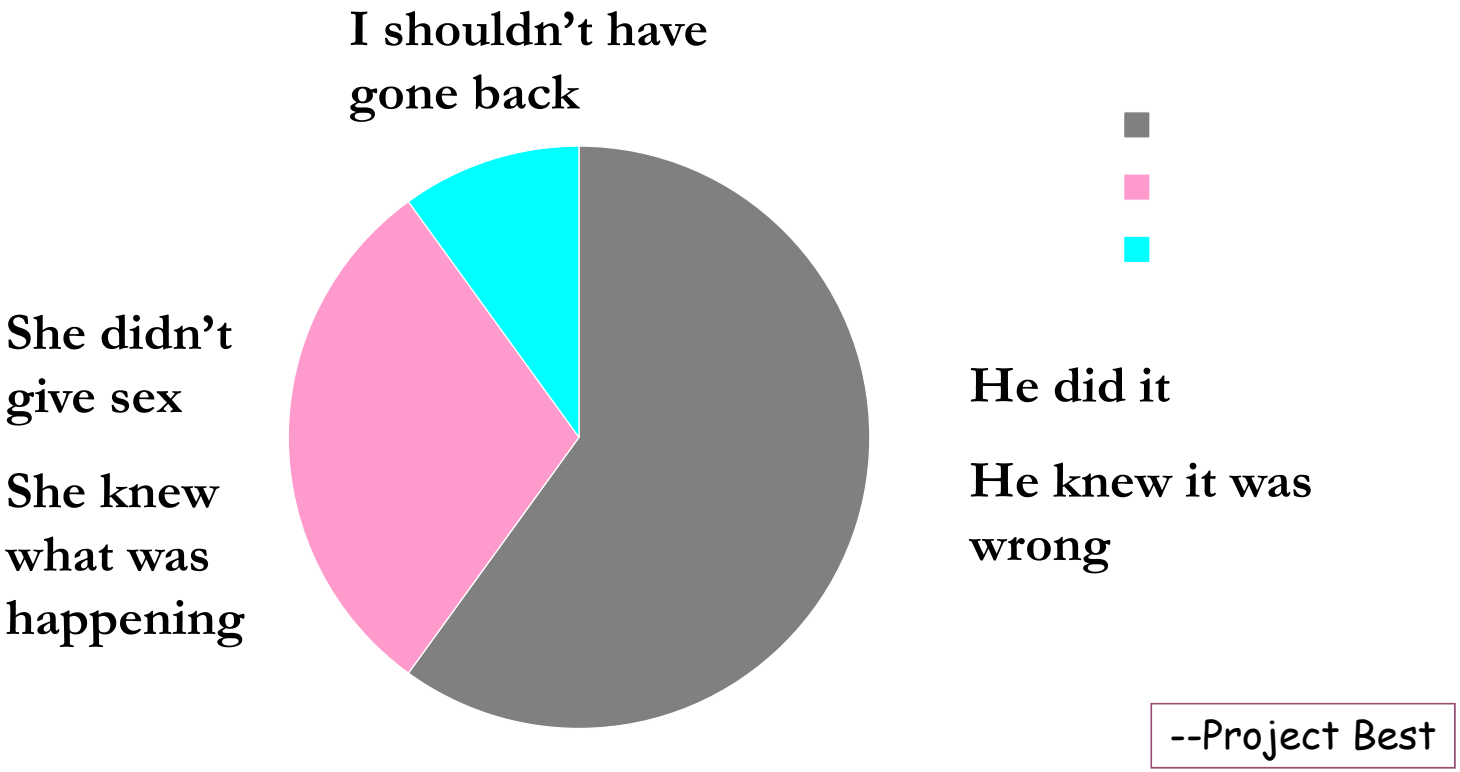
I am writing because I have some things to tell you. I'm glad you are in jail now. Now you can't hurt me or other kids anymore. Everyone knows what you did to me. Some people think it was wrong, and some people think it was OK. I think you ruined my life. I keep asking why did I do that? I should have told you to stop. I'm really mad that I told 2 years too late.

-- Project Best

From,
The daughter you hate

Allocating Blame/Fault: Responsibility Pie

"Whose fault was the sexual abuse?"



--Project Best

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

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

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

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

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

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

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

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

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

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

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

In Vivo Exposure: Mastering Traumatic Memories

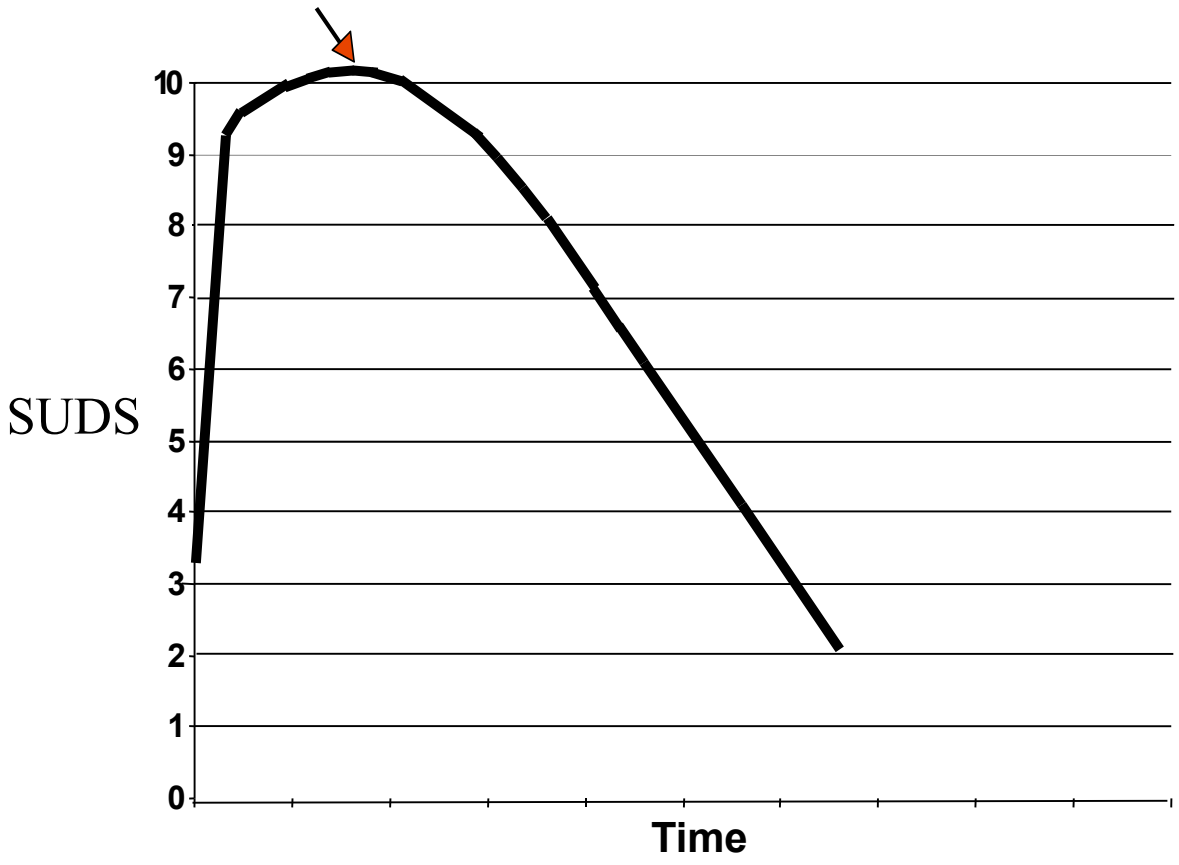
- **Two-pronged process: Trauma Narrative and In Vivo Exposure**

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

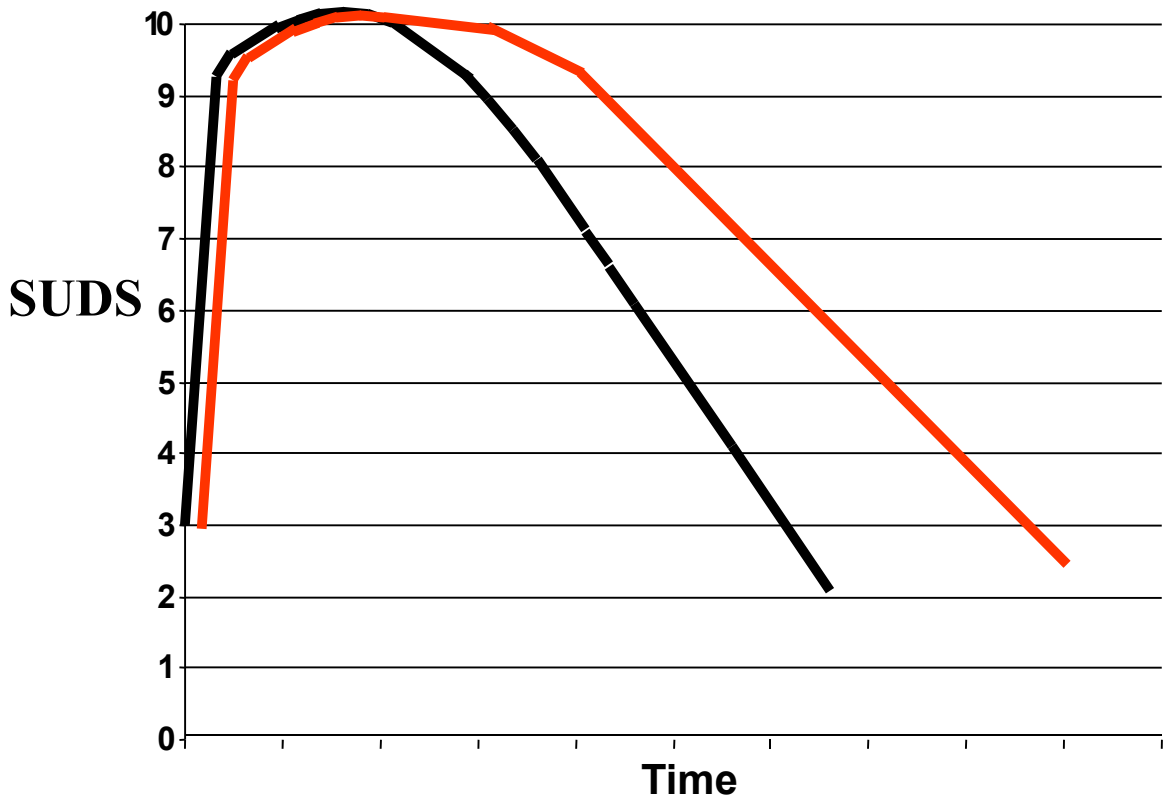
Avoidance

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

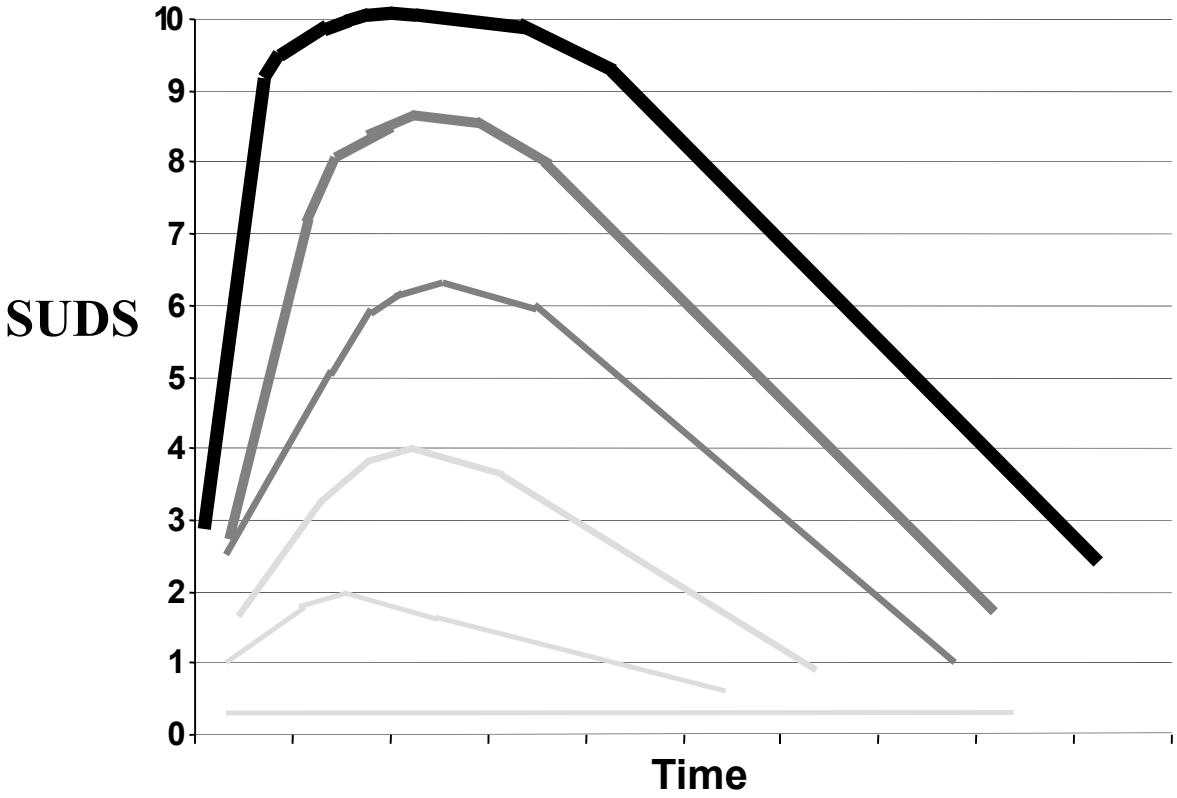
Avoidance



Exposure-Avoidance vs. Habituation



Exposure-Habituation



In Vivo Exposure

- Conducted only with avoidance of innocuous cues and <u>not</u> 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

I n vivo exposure

- Address avoidance of *innocuous* reminders
  - Assess function of avoidance and when it occurs
  - Get support of parent in advance
  - Create plan with support of parent and child
  - Predict difficulty

How do you do it?

1. Find out as much as you can about the feared situation
2. Get 'buy in' and involvement from key participants: (parents, school personnel, etc.)
3. Develop a plan that eases the child into facing the feared cues
   - Make it specific and include rewards
4. Plan should progressively increase exposure

Test drive: Developing a Plan for In Vivo Exposure

Cedric, a 13 y.o. male was sexually abused by his father for 4 years, and the abuse often occurred in the shower. As a result, Cedric is very avoidant of showering and therefore has significant problems with hygiene. His difficulties with personal hygeine have resulted in problems with his peers.

- Note: Cedric is safe—his father is no longer in the home.

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

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

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

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.

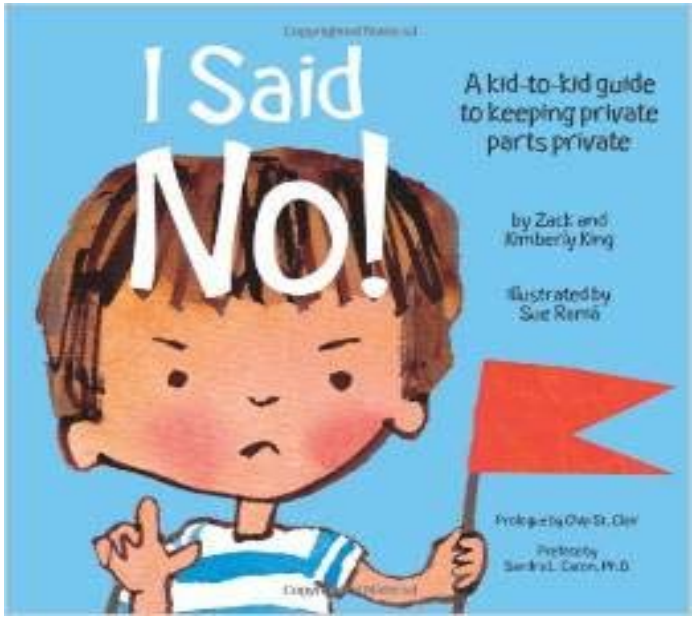
When to Introduce Personal Safety Skills in the Model

- 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."

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?"

Safety skills specific to cases involving sexual abuse



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

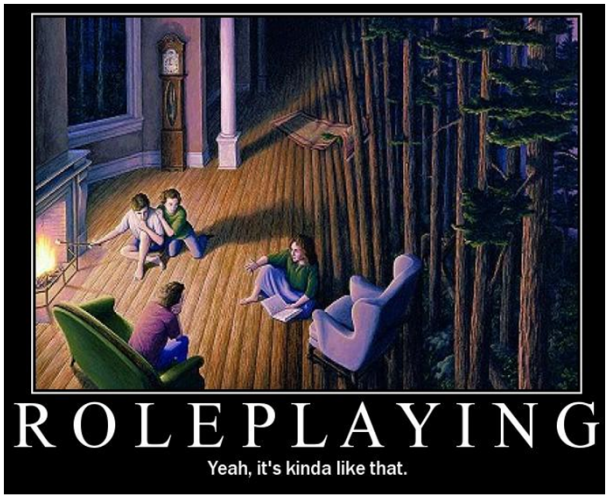
Additional Safety Skills Specific to Interpersonal Violence:

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

Deblinger and Heflin, 1996

3 strikes!

DEMONSTRATIONS!



scenarios

Confident walking

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

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

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.

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/

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/

CONSENT

IT'S SIMPLE AS TEA

Post Treatment Assessment Goals

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

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!

11 Musts of TF-CBT

1. Go into each session with an agenda
2. Get gradual exposure into every session
3. Go sequentially through the model
4. Meaningfully include caregiver in every component (parenting strategies and role plays)
5. Prepare client and caregiver separately for every conjoint
6. Keep up the pace and don’t water down sessions with COWS
7. See your client weekly if at all possible
8. Wait until trauma narrative has been completely developed before challenging trauma-specific distortions
9. Wait until trauma narrative has been completely developed and processed before having a conjoint session in this component.
10. Make sure caregiver is processing with you individually during Trauma Narration and Processing
11. Trauma Narrative is NEVER homework