TF-CBT: Implementation Across Time, Population, and Clinician

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Objectives

- To identify how time can affect the implementation of evidence based practices, and list ways to prevent baseline drift
- To identify modifications for special populations without affecting fidelity to the evidence based practice
- To identify warning signs of vicarious trauma or compassion fatigue in clinician using evidence based practices for trauma treatment

Implementing EBP's

- Attend to Fidelity- get it right from the start
- Understand and recognize baseline drift
  - The model is taking much longer than designed
  - What you are doing in a session is not one of the components
- Set up mechanism for preventing baseline drift
  - Provide new trainees good supervision
  - Continue to dedicate time to the models you use
  - Continue to celebrate success
  - When adapting a component, ask yourself if you are staying true to the model.

Modifications for Special Populations

- Does the modification enhance the ability to complete the model with the population?
- Does the modification enhance the ability to complete a component?
- Without the modification, TF-CBT could not be completed effectively

Modifications for Special Populations

- Children in Foster Care
- Children with Developmental Disabilities
- Adolescents with Complex Trauma

Special Population: Foster Care

- Unique Features:
  - Multiple chronic trauma exposure histories
  - Significant behavior problems
  - Higher levels of emotional dysregulation
  - Multiple presenting problems and diagnoses
  - Difficulty engaging the primary caregiver (foster parent)
  - Complexities regarding biological parent

Research in Attachment in Foster Children

- In a review of more than 70 studies, the effective interventions had the following characteristics in common:
  - Shorter term
  - Goal oriented
  - Focused, versus more extensive and broad

Adaptations for Children in Foster Care

- Collaborate with child welfare workers
- Provide regular brief updates on treatment
- Work with the case worker to decide whether or not to involve biological parents and in what capacity

Adaptations for Children in Foster Care (cont.)

- Enhance foster parent involvement
  - Address past experiences with children in mental health
  - Understand expectations of treatment
  - Address barriers from the start
  - Educate the parent in how the child's symptoms are tied to their traumas and how treatment will address the symptoms (Include how treatment works, the research behind TF_CBT, etc.)
  - Is this kinship care or non-relative caregiver?

Adaptations for Children in Foster Care (cont.)

- Engaging Children
  - May be more guarded- be transparent
  - Set structure- provide structure in beginning and ending sessions; have session rules
  - Provide incentives in the office
  - Foster parents may provide incentives as well

Adaptations for Children in Foster Care (cont.)

- Psycho-education: may include a segment on being in foster care or substance abuse. May need to enhance this component with foster parents to understand symptoms and tie to traumas that the child has experienced
- Parent Skills- May have a much bigger role

Adaptations for Children in Foster Care (cont.)

- Relaxation- may be foster care specific needs- preparing for visits, court dates, placement decisions
- Affective Identification and Modulation- in "numb" children, may need more time
- Cognitive Coping- useful for many foster care specific situations, ie. Missed visits, court decisions

Adaptations for Children in Foster Care (cont.)

- Trauma Narrative- assisting the child in identifying what to include, help to provide structure (a coherent trauma narrative), deciding on whether to include the foster care placements and their impact
- Cognitive Processing- be on the look-out for thoughts related to self worth, the ability to be loved, and perspective on the future

Adaptations for Children in Foster Care (cont.)

- Conjoint TN Session- is the foster parent the support person for the child; how much does the child share
- Enhancing Safety- frequently moved up in treatment and then enhanced again at the end

Adaptations for Children with Developmental Difficulties

- Often have difficulties in cognition, communication, and affect regulation
- Developmental difficulties may include mild mental retardation, learning disabilities, receptive and expressive language disorders, and autism spectrum disorders, including PDD and Aspbergers.

Adaptations for Children with Developmental Difficulties

- Provide structure and create routines
- Shorten sessions
- Slow down
- Use visual arts
- Use play
- Provide repetition
- Use interests and fixations

Adaptations for Children with Developmental Difficulties

- Recognition and assessment- may go unnoticed because the traumas have not been reported. May also need cognitive scales to determine the degree of cognitive impairment. May take longer to assess; may need to use visuals to aid in communication (i.e. the Rain Cloud Likert Scale, Grosso, 2011)

Adaptations for Children with Developmental Difficulties

- Psycho-education: use visual tools; normalize the reactions; use favorite characters to create stories and metaphors
- Parenting Skills: May be more than one caregiver due to the increased needs of a child with developmental disabilities; share parent toolkit with all caregivers involved

Adaptations for Children with Developmental Disabilities

- Relaxation- May play a more prominent role due to a higher baseline of anxiety and agitation. May use visuals to identify where stress is being felt; may need more than one session for reinforcement; may also need a grounding technique due to issues with sensory integration and sensitivity

Adaptations for Children with Developmental Disabilities

- Affective Expression and Modulation- use visuals; create stories using favorite characters; may consider using a camera to take pictures of you and the child expressing emotions
- Cognitive Coping- use simple terminology, i.e. “talking to ourselves.” Act out scenarios.

Adaptations for Children with Developmental Disabilities

- Trauma Narrative- requires pacing structure and visual storytelling. May need to go slower and have shorter sessions. Story may be fragmented- use index cards and don’t worry about sequence first. Assess for ability to identify detail before starting the narrative, so you know what may be expected.

Adaptations for Children with Developmental Disabilities

- Cognitive Processing- may take more time due to their limited capacity for critical thinking. May use their interests to create stories to challenge unhealthy beliefs
- In Vivo- May need to use smaller increments of escalating stimuli so as not to overwhelm children. It is important to address as soon as possible. Parental involvement is often more critical.

Adaptations for Children with Developmental Disabilities

- Conjoint sessions- parental involvement is critical to encourage practice of skills. Make sure to use their expertise. A particular challenge is getting a 2 way conversation.
- Enhancing Safety- risk of re-victimization is higher. Boundaries may be poor

Adolescents with Complex Trauma

- This population represents a large segment of traumatized teens
- Dysregulation is the hallmark feature
- Particularly difficult because ideally you want to return teens to their baseline functioning or better, and sometimes there is no baseline because of how early the abuse started

Adolescents with Complex Trauma

- Frequently are very guarded due to inconsistent, negative, or unpredictable interpersonal experiences
- Often have difficulty identifying an affective state

Adolescents with Complex Trauma

- Assessment- may not have a stable caregiver and may be unable to obtain history. Must address their guardedness; must normalize their guardedness and encourage them to open up as soon as possible. May need to have a broader sense of what "trauma" is. May need a broader assessment of domains of impairment- different tools

Adolescents with Complex Trauma

- May require a phase based treatment approach: engagement, safety, and stabilization; recalling traumatic memories; enhancing daily living

Adolescents with Complex Trauma

- Phase 1: Establishing engagement, safety, and stability- must establish rapport as well as trust; **enhancing safety** must be moved forward, included establishing stability; Safety mapping is an excellent tool; in **psycho-education**, teach the concept of trauma triggers; help them understand emotional behavioral dysregulations are over-reactions to stress

Adolescents with Complex Trauma

- Phase 1 (cont.): **Parenting** component is more often conceptualized as a "systems" component; help the system relate symptoms to triggers and reactions; **relaxation**- validate the coping components already used- assess for whether or not they are healthy; physically based relaxation techniques may be beneficial

Adolescents with Complex Trauma

- Phase 1: **Affective Expression-** may need to highlight the functions of emotions; help them understand numbing as a protective adaptation, not lost forever; may need to start with recognizing affective states in others; **Cognitive coping-** may be used to increase awareness of cognitions in current experiences;

Adolescents with Complex Trauma

- Phase 1: Conjoint sessions may be used to enhance safety and stability, but depending on the relationship to the caregiver, who may themselves be a trauma trigger, conjoint sessions can be used as in vivo opportunities to gradually expose adolescents to those triggers. Use to practice decreasing signals of danger and increasing signals of care

Adolescents with Complex Trauma

- Phase 2- Recalling Traumatic Memories: Psycho-education- rationale may focus o uncovering the meanings the adolescent has made; Parenting- insure that the system givers are utilizing appropriate engagement and behavior management skills;

Adolescents with Complex Trauma

- Phase 2: **Relaxation, Affective Expression and Modulation, and Cognitive Coping-** continue to use gradual exposure throughout these components; **Trauma Narrative and Processing-** allow adolescent to guide what events or experiences should be included; desensitization may not be as vital in this component; repeated readings may not be as important as meanings

Adolescents with Complex Trauma

- Phase 2: **In Vivo-** may play a more critical role and may be needed to be moved up in the treatment, then reinforced later for self regulation; **Conjoint Session-** help adolescent identify a caregiver, but do not force for the sake of conjoint work; **Enhancing Safety-** may need to temporarily stop treatment, but do it mindfully

Adolescents with Complex Trauma

- Phase 2: Completing trauma processing- adolescent should be able to experience trauma cues without significant emotional or behavioral difficulties; PTSD symptoms should be manageable; adolescent should have healthy meanings and view traumas as a part of their life, not defining it.

Adolescents with Complex Trauma

- Phase 3- Enhancing Daily Living: **Psycho-education**- identify and normalize challenges likely experienced; discuss anticipated future triggers as normal part of recovery; provide information about healthy lifestyle choices for future development; **Parenting**- help parents identify appropriate expectations; assist in the process of "aging out" of the system

Adolescents with Complex Trauma

- Phase 3: **Relaxation, Affective Regulation, and Cognitive Coping-help** them to generalize these skills to larger range of situations; coaching for unfamiliar situations can be helpful, i.e. getting a job, dating, parenting; **Conjoint Sessions-** focus is on increasing caregiver's ability to support and coach;

Adolescents with Complex Trauma

- Phase 3: **Enhancing Safety and Future Development-** include primary prevention skills of awareness, assertiveness, problem solving, and seeking help; also include information about healthy relationships; help identify goals for future; **Ending Treatment-** very important component- take time to do it right

A Few Thoughts About Clinicians

- When first learning TF-CBT, try to have some balance in case types.
- Clinicians come with their own special strengths as well as their own personal histories- recognize these and use them to help clinicians enjoy their work
- If you have more than one trauma model, think about how to maintain variety in caseloads.

A Few Thoughts About Clinicians

- Understand and talk about compassion fatigue, vicarious trauma, and vicarious growth
- Identify and celebrate successes

Thank-you

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