Trauma-Focused Cognitive Behavioral Therapy

Cindy Rollo, LCSW-C (Trainer)
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Developers of TF-CBT
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Training Agenda

- Review of Child Trauma
- Overview of TF-CBT
- Assessment of Trauma
- Training on TF-CBT components
  - Practice in each component

What is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)?

- An *evidence-based* treatment model developed by **Esther Deblinger, Judith Cohen** and **Tony Mannarino** designed to treat children who have experienced trauma. It integrates trauma sensitive interventions with cognitive-behavioral strategies.

What is Trauma?

- Trauma occurs when a child experiences an intense event that threatens or causes harm to his or her emotional and physical well-being.
- When a child is experiencing child traumatic stress, these reactions interfere with his or her daily life and ability to function and interact with others.

Types of Childhood Trauma

- Child abuse
  - Physical
  - Sexual
  - Emotional
- Victim/Witness of Violence
  - Domestic
  - Community
  - School
- Accidents (e.g., motor vehicle)
- Disasters
- War/Terrorism and Refugee
- Medical (e.g., transplant)
- Traumatic Grief
- Traumatic Separation

Trauma Impact

- Acute distress almost universal
- Impact *can* be long lasting
- Childhood trauma is a risk factor for numerous adult psychiatric and medical problems
- Impact varies; most recover over time without treatment but a significant minority will develop moderate to severe PTS symptoms and will require treatment

The Effects of Trauma on the Brain

- Adverse brain development influences:
  - Emotion regulation
    - Especially the ability to manage anxiety
  - Short-term memory
  - Physical health
  - Cognitive functioning
  - Social skills

Risk Factors for Negative Effects of Trauma

Pre-Event	During Event	Post Event
•	•	•

Protective Factors

Psychological resources	Physical Resources	Environmental Resources
•	•	•

Trauma Symptoms

Cognitive

Behavioral

Affective

Common Diagnoses

- PTSD
- Depressive disorders
- Other anxiety disorders
- Enuresis or encopresis
- Specific phobias
- Disruptive Behavior Disorders
- **Comorbidity is common**

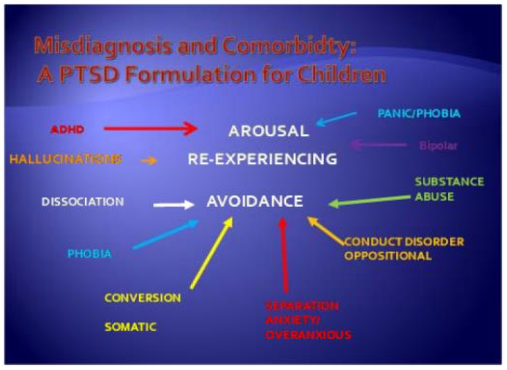
Post-traumatic Stress Disorder (PTSD) DSM-5

- Trauma and Stressor Related Disorders
  - Specifies how the individual experienced the trauma
    - Directly
    - Witnessed
    - Experienced Indirectly
  - Four symptom clusters
    - Intrusion
    - Avoidance
    - Negative alterations in cognitions and mood
    - Alterations in arousal and reactivity
  - Separate diagnostic criteria for children ages 6 or younger (Avoidance <u>or</u> Negative alterations)

Trauma Exposure in Young Children

- Broader definition to include:
- Long term separation from attachment figure
- Forced removal (eviction, parental arrest, foster care)
- High conflict with threats of injury to parent

36% of mothers identified attachment disruptions as traumatic to their children (Weiss, 2001)



Trauma and Co-morbidities

- Prioritize the child's needs
- Trauma vs. severe co-morbidity
- Issues to be mindful of
  - What components do you use to stabilize
  - How would you modify for stabilization
  - Identify if other interventions are also indicated for stabilization
- Research documents success in 12 sessions with multiple trauma and co-morbidities

What is Complex Trauma?

Combination of childhood exposure to repeated traumatic events and the impact of that exposure on current and long-term functioning over time.

What is Complex Trauma?

- Trauma sequelae are often broader than one diagnosis and may include:
  - Severe affective dysregulation
  - Interpersonal difficulties
  - Adversely affected belief systems
  - Somatic distress or disorganization
  - Serious self-esteem issues
- Typically results in significant functional impairment

What helps the child survive?

- Assumption of danger and self protective stance
- Rapid mobilization in the face of perceived threat (Fight, Flight, Freeze)
- Development of alternative strategies to meet developmental needs

Curriculum - Blaustein

Long-term consequences

- Children who have experienced trauma:
  - May not be able to solve problems as well as others
  - May not be able to concentrate and do poorly in school
  - Have lower levels of empathy, ability to relate to others, and self esteem
  - Are at risk of committing crimes or being victimized later in life

Evidence Based Practice

"the integration of best research evidence with clinical expertise and patient values"

Institute of Medicine (2001)

- Based on **reliable** and **valid** empirical findings demonstrating effectiveness
- **Systematically compared** to other treatments

Clients for TF-CBT

- Children, **age 3-18**, from any racial or ethnic group, living in urban, suburban, or rural areas.
- Children with a **history of at least one significant potentially traumatic event**
- Children experiencing symptoms related to trauma experience. They do not have to meet full diagnostic criteria for PTSD.
- Children with other problems such as depression, anxiety, shame, mistrust, behavior problems, or traumatic grief can benefit from TF-CBT.
- Parent/caregiver involvement is highly desirable and is likely to improve treatment outcome, but it is not essential.

Clients for TF-CBT

TF-CBT is effective for children who have experienced single or multiple traumas in their lives

Clients for TF-CBT

- Treatment settings: clinic, school, residential, home
- Children in foster care
- Children with exposure to chronic trauma
- Children with PTSD or other trauma symptoms
- Children with ID/ASD who function at higher level or with supports
- Children of various cultural groups, including Latino, African-American, and Native-American

Exclusion Criteria

- Child does not have a trauma history
- Child does not have symptoms related to a traumatic event

When is TF-CBT not the first line of treatment?

- TF-CBT may not be the first or best suited treatment for children referred to therapy predominantly for
  - Help with severe, disruptive behavior problems (aggression, defiance, rule or law breaking)
  - Severe mental health problems such as major depression, active psychosis, suicidal/homicidal ideation, and self-harm behaviors
  - Active substance use
  - Immediate safety concerns - child continues to be at high risk of revictimization

Is TF-CBT the Right Treatment?

- What is the diagnosis?
- Is the Is the diagnosis and/or symptomatology related to the trauma?
- Can TF-CBT interventions be integrated with other treatment strategies which address non-trauma problems?

Theoretical Underpinnings of TF-CBT

- A hybrid model that integrates:
  - Trauma sensitive interventions
  - Cognitive-behavioral principles
  - Attachment theory
  - Developmental Neurobiology
  - Family Therapy
  - Humanistic Therapy

Goals of TF-CBT

- Resolve PTSD, depression, anxiety and other trauma related symptoms
- Optimize adaptive functioning
- Enhance safety, family communication and future developmental trajectory

Empirical Support for TF-CBT

TF-CBT is the **most researched** and **most supported** of all current treatments for childhood Posttraumatic Stress Disorder (PTSD) and child trauma

TF-CBT support includes:

- 20 Randomized Controlled Trials (RCT)
- 8 RCTs have been completed by the Cohen, Deblinger, and Mannarino team
- RTC with foster families, Dorsey and group
- Two RCTs in the Democratic Republic of Congo for sex trafficked girls and child soldiers
- RCTs in Norway, Sweden, Germany, and the Netherlands
- Two Canadian studies

Empirical Support for TF-CBT

Studies have been conducted with children exposed to:

- Sexual Abuse
- Intimate Partner Violence
- Natural Disasters
- Traumatic Grief
- Foster Care
- Violence and traumatic loss in low-resource countries
- Multiple and Complex Trauma

Lessons Learned

- Improved PTSD, depression, anxiety, shame and behavior problems compared to client-centered or nondirective therapy
- PTSD improved more with direct child treatment
- Improved parental distress, parental PTSD, parental support, and parental depression compared to client-centered or nondirective treatment

"Yeah, it was probably like 3 or 4 weeks ago, I was going out with this boy for like 4 months. And he was cheating on me with this girl that I used to call my friend. It wasn't shocking but it was surprising…But I used my coping skill. I didn't beat her up. I just let it go. I breathed in and out and said, 'Okay.'"

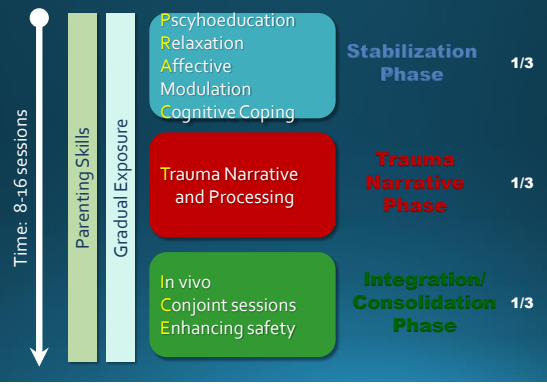
--17 year old CSEC client 1 year after treatment completion

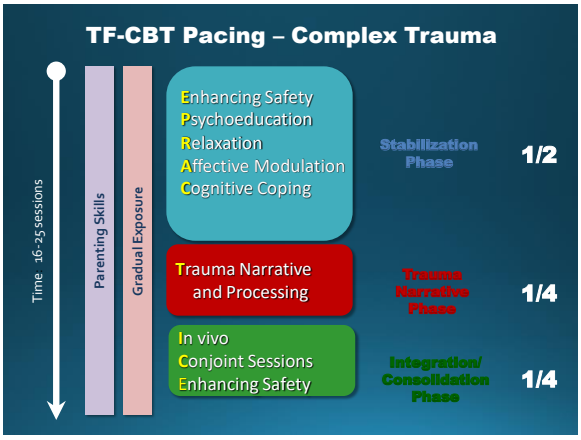
Kelly Kinnish Ph.D. & Laura Murray, Ph.D, 2016

TF-CBT Components

- PRACTICE
  - Psychoeducation and Parenting Skills
  - Relaxation
  - Affective Modulation
  - Cognitive Processing
  - Trauma Narrative
  - In Vivo Desensitization
  - Conjoint parent-child sessions
  - Enhancing safety and social skills

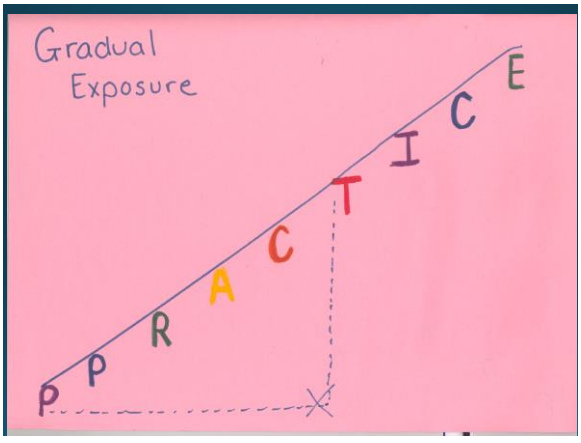
TF-CBT Pacing





Child and Caregiver Components

- Individual sessions for both child and parent
- Parent sessions - generally parallel child sessions
- Same therapist for both child and parent
- **Child and parent receive about the same amount of time at each session**
- **Treatment length: 8-25 sessions**



TF-CBT is Based on Art and Science

- **A**daptable and flexible (to address developmental, gender, initial presentation)
- **R**espectful of cultural, family values
- **T**herapeutic relationship is central

Guidelines for Cultural Modifications to EBTS

- Flexibility administering EBTS by therapist
- Enhancing meaning of therapies within the cultural context
- Increasing assessment of client's needs (before administering treatments)
- Openness to understanding and exploring client variables specific to therapy
- Avoiding outright dismissal of traditional therapies, and incorporating these therapies as appropriate
- Demonstrating client-focused empathy in a manner appropriate to the cultural context
- Avoiding categorizing cultural differences as weaknesses

(Draguns, 2008)

Role of the TF-CBT Therapist

- Develop trusting therapeutic relationship
- Collaborate with client and family
- Use clinical judgment, skill and creativity
- **Empathic and directly addresses trauma**
- Use knowledge of child development
- Incorporates a wide range of treatment approaches with children and their families
- **Incorporates gradual exposure throughout**

Promoting Resilience

- Foster attitudes of acceptance
- Take a strength based approach
- Honor cultural and family values, beliefs and differences
- Collaborate with others
- Help reduce stigmatization
- Acknowledge and expand support network
- Identify growth from adversity

Encourage Humor and Fun!

- In laughter there is always a kind of joyousness that is incompatible with contempt and indignation (Voltaire)
- A good time to smile is any time you can (Breast cancer survivor)
- If you're not laughing, you're not doing it right (Barbara Bonner, TF-CBT Traimer2008)

Applying Proven Treatments in "Real Life"

- First things first
- Provide crisis response
- Know what your setting can do
- Triage for priority first
  - Basic needs (e.g. place to live)
  - Response to system activities (e.g. placement, legal processes)
  - Psychiatric emergencies/active substance abuse
  - Sexual behavior problems

Assessments

What are some purposes of assessments?

- Answer referral questions
- Develop individualized treatment
  - Examine symptom clusters
- Finding strengths
- Understanding the environment
- Use to measure progress
  - For clinicians
  - For families
  - For agencies
- Initial connection with families; setting up "teamwork" (us listening to them)

Areas to Assess

- Standardized trauma exposure and trauma impact measures
  - E.g., UCLA PTSD Index for DSM-5 (Steinberg & Pynoos, 2014)
- The caregiver **and** the child should complete standardized trauma measures
- Parental adjustment and ability to support their child in the treatment process
- Narration capacity

Sample Introduction

"Parents know their children's behavior better than anyone. In evaluating the difficulties ___ has been having, I need your help in many ways. One way is to have information from you about his/her behavior as you see it. Please read the instructions on these forms and respond to all the items, even if some are difficult to answer or do not seem to apply. If you have any questions or come across anything you don't understand, please don't hesitate to ask for my help."

Tailoring Assessment

- Tailor assessment to best capture trauma-exposure and trauma-related problems for that cultural group
- Use culture to generate hypotheses
- Assess (do not assume) cultural beliefs and practices
- Based on assessment, integrate tailoring throughout treatment

Michael A. de Arellano, Ph.D. & Susana Rivera, Ph.D., 2016

Assessment Issues

- Clinical considerations
  - Client age, cognitive ability, developmental level
- Behaviorally-specific assessment
- Potentially traumatic events
    - Natural disasters, discrimination/racism, terrorism, trauma in country of origin, immigration-related trauma
  - Other trauma-related outcomes
    - e.g., Somatic complaints

de Arellano & Danielson, 2009

Challenges in Assessing Young Children

- Symptomotology may be transient
- Symptoms may change as developmental functions emerge
- Behavioral manifestations difficult to observe and immature verbal skills and ability to express complex emotions
- Caregiver disagreement on descriptions of behaviors/symptoms
- Current diagnostic criteria may not be appropriate for young children
- **Children may benefit from intervention even if they do not meet specific diagnostic criteria (Ippen,2002)**

Potential Cultural Constructs

- Family focus; collectivistic vs. individualistic
- Interpersonal relationships and communication
- Spirituality / religion
- Alternative or complementary medicine
- Child rearing practices
- Sex and sexual development
- Gender roles
- Language
- Views of mental health and mental health tx
- Acculturative gaps

Michael A. de Arellano, Ph.D. & Susana Rivera, Ph.D., 2016

Integrate Throughout Treatment: Spirituality/Religion Example

P: Frame tx as congruent with spiritual beliefs
R: Use of prayer as relaxation strategy
A: Positive self-statements from religion
C: Identify thinking patterns (e.g., just world)
T: Assess for unhelpful thoughts re: spirituality
I: Use to approach rather than avoid
C: ID and process caregiver unhelpful thoughts
E: Barriers or resources (e.g., views on marriage)

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Assessment Measures

- Examples of measures that have been used :
  - Child PTSD Symptom Scale and Trauma Screen (CPSS)
  - Young Child PTSD Checklist (YCPC)
  - Traumatic Events Screening Inventory for Children – Brief Form (TESI-C-Brief)
  - Trauma Symptom Checklist for Children
  - Child Depression Inventory
  - Revised Child Manifest Anxiety Scale
  - Reynolds Child Depression Scale
  - Reynolds Adolescent Depression Scale
  - Multidimensional Anxiety Scale for Children
  - Parent Emotional Reaction Questionnaire

Assessing Narration Capacity

- Baseline narration
  - Can you tell me why your adult brought you here today
- Benign narrative
  - Share a positive or neutral event. "I wasn't there so tell me all about it."
  - What were you thinking
  - What were you saying to yourself
  - What happened next
  - Tell me more about

Engagement in Treatment

What are we learning from clients?

What would you tell therapists?

"Don't give up on your client. When I first started therapy, I wouldn't talk, some therapists would have given up."

—15 year-old CSEC Client

Kelly Kinnish Ph.D. & Laura Murray, Ph.D, 2016

Engagement in TF-CBT

- Factors impacting engagement
  - Concrete and perceptual
- Turning obstacles into opportunities

Engaging Children in TF-CBT

- Positive working relationship is critical for ANY treatment to be effective.
- Goals:
  - Place where child feels safe, supported and comfortable
  - A child feels they have some choices
  - Clear ground rules (e.g., boundary issues)
  - Predictable, stable and consistent is best

Engaging Caregivers in TF-CBT

- Key to effective treatments with children.
- Goals:
  - Supportive environment
  - Empathetic response to their reactions
  - Emphasize their expertise in their child!
  - Therapy based on teamwork with caregiver if possible

Engaging Families in TF-CBT

- Establish common ground/form an alliance
- Emphasize importance/primacy of parental role
- Reduce parental distress
- Include parents as part of child's treatment
- Be flexible about scheduling
- Other ideas?

Problem Solving

- What do you think about coming?
- What could stand in the way of getting here?
- How are you going to get here?
- Who are you going to bring?
- How will these people feel about coming?
- What time is best for you?
- Will this interfere with anything else?
- How comfortable do you feel talking about your child's needs?
- How hopeful do you feel that this will help?

Mary McKay, PhD

Engaging Youth with Complex Trauma

- May view others as unpredictable, uncontrollable, and/or hostile
- May initially present as highly guarded or avoidant
- May view the therapeutic relationship as a threat
- **Gradual Exposure** to the therapist. The therapeutic relationship may be a trauma cue.
- Provide client appropriate control over the environment
- May spend longer building engagement
  - Stabilization
  - Building connections with other systems
  - Addressing safety

Kliethermes & Wamser, 2013

Trauma Exposure and Mental Health Treatment among Latino Youth

- Latino youth are at greater risk for trauma exposure and PTSD
- Latino youth are at greater risk for mental health problems
- Latino youth are less likely to access mental health services and are at greater risk for premature drop-out

Michael A. de Arellano, Ph.D. & Susana Rivera, Ph.D., 2016

Latino Cultural Values

- Familismo
- Personalismo
- Respeto
- Religion & Spirituality
- Machismo & Marianismo
- Fatalismo

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

Trauma Exposure and Mental Health Treatment among LGBTQ Youth?

- Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) youth: significantly higher trauma exposure than straight peers
- Higher rates of bullying, physical/sexual abuse, domestic/community violence, traumatic loss, do not feel safe at school
- Many do not seek professional services and/or do not disclose their LGBTQ identity to professionals due to not feeling safe or welcome

LGBTQ Youth Concerns

- Lack of safe arenas to discuss sexual orientation
- Fear that disclosing abuse will "out" them may delay disclosure of abuse
- Shame or fear that sexual orientation caused the abuse
- Fear of being labeled gay if disclose abuse by a same-sex perpetrator

Engagement Considerations

- Use gender neutral terms when asking about relationships ("Are you dating anyone?")
- Avoid labeling and stereotypes
- Ask what pronoun transgender individuals prefer
- Maintain confidentiality with regard to sexual orientation or gender identity

Engagement: Cultural Considerations

- Explore the cultural beliefs of the family
- Ask about culture specific responses for traumatic events
- Integrate and ask both parent and child about their spirituality,
  - Where do you get your strength?
  - What are their religious practices?
  - What relief do they feel when they use this?
- Explore how the model fits with their beliefs and values
- Connect with families in a culturally engaging way

Critical for First Meeting

- **Bring up what is hard to talk about**: do they want to come back? Do they think this will be any help?
  - Do you think you'd want to come back next week?
  - For everyone, some things sound good, some don't or don't make sense. What sounds good, what isn't making sense?
  - "Is there anything about this that is different from what you expected?"
  - "Is there anything we've talked about here that' s not sounding like it will work for you?"
- Will they give it a 3 week try, and check back in?

Shannon Dorsey, Melissa Runyon, Ph.D. And Esther Deblinger, Ph.D., 2016

What might a 1st TF-CBT session entail?

- ASSUMING that assessment is already done.
- Engagement
- Brief discussion of what TF-CBT is and why you think it will help them.
  - Focus on symptoms THEY are invested in changing
  - Lay out the components of TF-CBT
  - Link components and program to what client wants to change/improve
- Lay out the time-line
  - Engage the client in the timeline

Engagement: The Ongoing Process

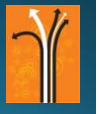
- *Each session* - continue to evaluate both the child and caregiver's engagement
- Motivate for each session! Both the child and caregiver must understand- what's in it for them

TF-CBT Components

- **PRACTICE**
  - **Psychoeducation and Parenting Skills**
  - **Relaxation**
  - **Affective Modulation**
  - **Cognitive Processing**
  - **Trauma Narrative**
  - **In Vivo Desensitization**
  - **Conjoint parent-child sessions**
  - **Enhancing safety and social skills**

Fidelity to TF-CBT

- **All TF-CBT components are provided** during treatment unless justification exists to not provide a component
- PRACTICE components are provided **in sequence**
- Progression from one component to the next is achieved at a **pace** that is appropriate for the clinical circumstances
- **GE** is included in all treatment components



Maintaining Fidelity

While sessions are not rigid with regard to this structure, each TF-CBT session should include the following:

1) Review of the past week and Pt's current symptoms (reinforces self-monitoring)
2) Review of PRACTICE assignment for past week (identifies problems in implementing past components)
3) Collaboratively set agenda for session (ask Pt first, then connect that issue to PRACTICE component therapist will address this session).
4) Address agenda items (includes both PRACTICE component to be covered this session and Pt's concerns)
5) Agree on new practice assignment for the coming week
6) Summarize, seek feedback for session

Focusing Questions for Components

In each session, ask yourself:

1. What am I doing?
2. Why am I doing it?
3. Where is the gradual exposure?

Flexibility with Fidelity

"breathing life into a manual"

– Kendall et al (1999, p.177)

- Cardemil (2010) refers to "surface level changes"- i.e., Using culturally relevant examples in treatment vignettes, linguistic adjustments.
- "Core" components are not modified nor are the underlying mechanisms of change altered.

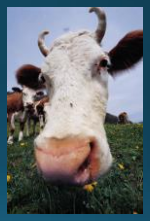
Honoring Children, Mending the Circle: Physical Aspects of Healing (Dee Bigfoot)

TF-CBT Methods
- Progressive Muscle Relaxation
- Controlled Breathing
- Visualization
- Identifying Enjoyable Activities

HC-MC Methods
- Sweatlodge
- Drumming
- Meditation
- Singing/Chanting
- Prayer
- Smudging
- Active Outdoor Games & Sports
- Healing Ceremonies

Managing COWs (Crisis of the Week/ Clinical Opportunity of the Week)

- Anticipate and address COWS
- Acknowledge the COW
  - Validate the issue
  - Look for positive aspects to praise and reinforce
  - Rate it
  - Where are the safety concerns
  - What would we address NOW?
  - Look for ways to work on the component using the COW
- Consider "Clinical Opportunity of the Week"



Other Methods of Herding a COW

- Recognize that COW may be an important clinical issue
- Remind families how the skills can help with outside issues
- Facilitate a referral
- Collaborate with the client
- Help meet immediate needs
- Apply general clinical skills

Goals of Psychoeducation

- **Normalize exposure to trauma**: *"You're not alone/not the only one".*
- **Explain and normalize PTS symptoms/PTSD and avoidance:** *"You're not crazy".*
- **Describe TF-CBT** (components, structure, and homework expectation): *"There's hope, we've got a treatment that works".*
- **Explain how treatment works** (e.g., learn skills to feel better when scared/worried; learn how thoughts drive feelings and behavior; talking about what happened lowers the emotions when remembering or being reminded; putting the trauma into perspective helps put it into the past).

Cultural Considerations

- Tailor psychoeducation to make it culturally relevant
- Acknowledge, validate and address parental concerns
- Address views of mental health treatment and the role of the clinician
- Address the role of the family and expectations for participation
- Address what the family believes causes mental health problems (e.g. fate, weakness)
- Address who the family typically seeks treatment from (e.g. *curandero*, priest)
- May seek medical help instead since somatic complaints are more culturally acceptable
- Sometimes, symptoms may overlap, and families may expect the mental health professional to treat the culturally acceptable issue instead of the mental health issue.
- While being culturally sensitive, be careful not be individually insensitive.

(De Arellano, Danielson, & Felton, 2016)

Psychoeducation: Gradual Exposure

- Using the names of trauma experiences during the component and educating parents and children about trauma triggers and their connection to children's trauma symptoms.
- Starts at the point of the first contact with the family and continues through treatment

Psychoeducation

- Focused on providing information about:
  - The model/treatment structure
    - Treatment plan, theoretical rationale, focus on positive coping, parental role
  - Benefits of early, effective treatment
  - Expectations and questions from the family
  - The child's trauma
    - Prevalence
    - Who/what/why
  - Traumatic reactions/symptoms
    - Common emotional and behavioral responses
    - Child's symptoms/diagnosis
  - Child development and norms

Psychoeducation in Practice

- ASK what they already know!
- ASK what additional information might be helpful
  - Make a list of things and tackle one a week?
  - Don't feel they ALL need to be done in the 1st session(s)
- Provide information about common emotional and behavioral responses to the event
  - Include multiple placements

Psychoeducation

This component does **not** include psychoeducation about safety skill training *unless* there is a current safety risk that must be addressed.

Foster Families

- Add Questions to What Do You Know Card Game
- Information about the prevalence of foster care placements, common reactions to placements, and reasons children are placed in care
- Acknowledge and normalize the distrust that may be present toward all authority figures
- Review of the distinct responsibilities of child protection workers, the courts, the foster caregiver as well as the therapist and the therapist's lack of or highly limited influence over decisions regarding placement

Multiple Traumas and Complex Trauma

- Educate about the impact of stress and trauma on current functioning and trauma triggers
- Information about chronic, interpersonal trauma
- Acknowledge that previous attempts were best effort to self-regulate
- View dysregulation as response to stress instead of willful misbehavior

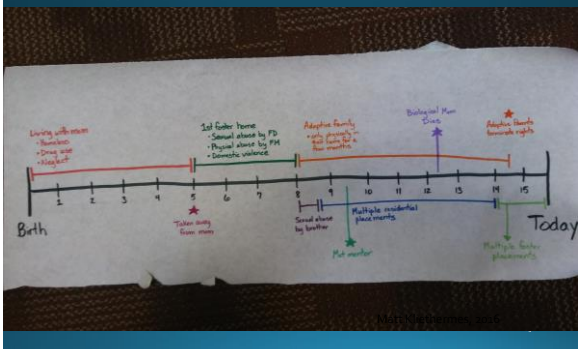
Kliethermes & Wamser, 2013

Multiple Traumas and Complex Trauma

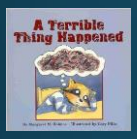
- Themes
  - Help the youth find the unifying "theme"
  - Making meaning of multiple trauma experiences that often share common threads
  - Focus on relationship oriented themes
  - Begin to identify trauma themes during initial assessment
  - Understand how they relate to current functioning
  - Connect trauma reminders to these themes

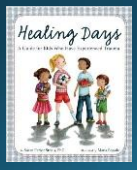
Kliethermes & Wamser, 2013

Sample Timeline



Psychoeducation Resources





Let's Practice: Psychoeducation

- **Remember the goals of psycheducation during the role-play!**
  - Engage the family
  - Normalize: You're not alone, You're not crazy
  - Instill hope for recovery: There is hope!
  - Correct misinformation
  - Start gradual exposure

Parenting Skills

- Goals:
  - Increase use of positive, effective, and safe discipline strategies for child behavior problems
  - Increase the use of trauma informed parenting strategies
  - Decrease unhealthy, ineffective, or unsafe discipline techniques
  - Improve the parent-child relationship

Parenting Skills: Gradual Exposure

- Connect the child's behavioral and emotional problems to the child's trauma experiences.
  - Trauma memories or cues and the child's behavior and emotions symptoms.
  - Parenting-related emotions and behaviors to the child's/parent's traumatic experience

Lessons Learned

- **Evidence of the benefit of parent involvement:**
  - 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
  - Cohen et al. (2004) TF-CBT more effective than CCT in helping parents overcome depression and abuse specific distress

Caregiver Considerations

- Common parent reactions to child trauma
  - Self-blame and guilt
  - Inappropriate child blame
  - Powerlessness
  - Change in parental supervision (Protectiveness vs. permissiveness)
  - PTSD Symptoms
  - Vicarious trauma symptoms
  - Concern that child will never be the same

"I'd like to trade my 15 minutes of fame for 15 minutes of peace in the bathroom without any kids pounding on the door."

Connecting Parenting to Trauma Reminders/Triggers

- Triggers
  - Internal or external stimuli that remind children and adults of past traumatic experience
  - May or may not be consciously recognized
  - May lead to externalizing and/or internalizing behaviors

Parenting Skills

- Validate the challenges of the behavior problems
- Model the skills you want them to use
  - Praise the caregiver
  - Highlight what they are already doing well
- Follow-up on homework
- Identify how to develop more positive interactions with their child
- Avoid debating/persuading

Parenting Skills: Praise

- Praise a **specific** behavior
- Provide praise ASAP after behavior occurs
- Do not qualify your praise
- Praise with higher level of intensity than criticism
- "Catch your child being good" (look for positive behaviors)

In sessions:

- Praising parents/caretakers models helpful interactions with their children
- End the session with something positive

Selective Attention

- No reaction to certain negative behaviors, including:
  - Defiant or angry verbalizations
  - Nasty faces, rolling eyes, smirking
  - Mocking, mimicking
- Walk away, busy oneself with an activity
- Remain calm, dispassionate
- Expect increase of provocative behavior

Understanding Challenging Behaviors

Understanding Challenging Behaviors

Behavior occurs for a reason!

- Conduct functional behavioral analysis (FBA)
  - Identify the problem behavior
  - Is it related to the trauma?
    - Did it start before or after the trauma?
  - Evaluate setting and context for behavior
    - When does it occur?
  - Gather information from multiple sources
- Identify the ***function*** of the problem behavior (ACES)
  - What is motivating and sustaining the behavior?
  - Is it a response to the environment?
  - Is safety a factor?

ACES

People often wonder why their children do the things they do. The answer is **ACES**:

- **Attention:** Children need attention as much as they need food and water. Are you paying attention to the good things they do?
- **Control:** Children, like you, need to have a sense of control. Can you find a way to help them feel in control in a way that is appropriate for their age?
- **Escape:** Children need to escape from threatening or dangerous situations. What can you do to help them feel safe?
- **Soothing:** Children need to be soothed. What can you do to help them feel comfortable and secure?

Let's Practice: Parenting Skills

Using your vignette, role-play in pairs an interaction between the caregiver and the therapist.

The therapist's goal is to help the parent:

1. Make a connection between the trauma and the behavior

2. Introduce the idea that the behavior serves a purpose for the child (ACES)

3. Develop a plan with the caregiver to help improve their response to the behavior

Relaxation

Goals:

- Reduce physiologic manifestations of stress and PTSD
- Enable the child and caregiver to use specific skills to help cope with anxiety and trauma-related symptoms

Relaxation Steps

- Increase understanding of normal body responses to stress
- Increase awareness of body cues and identification of trauma triggers
- Reduce distress related to trauma reminders
  - Lowers the body's alarm reactions
  - Develop more than one skill to use
  - Supports Gradual Exposure

Relaxation: Gradual Exposure

- Identify relaxation strategies that work when the child has trauma memories or experiences trauma cues
- Encourage parents to use relaxation
  - When they are upset or overwhelmed by vicarious trauma symptoms
  - To reinforce children to use and practice the strategies that are helpful with trauma memories or cues

Relaxation Skills Training

- Develop individualized relaxation strategies for manifestations of stress (headache, stomach ache, dizzy, racing heart, etc.)
  - Focused breathing/mindfulness/meditation
  - Progressive muscle relaxation
  - Physical activity
  - Yoga, singing, dance, blowing bubbles
- **Relaxation strategies for trauma reminders**
- Relaxation vs. avoidance

Relaxation

- Inquire about ways that caregiver and client currently relax
- Explore relevant spiritual/religious beliefs and practices
- Make sure examples and strategies are practical and feasible

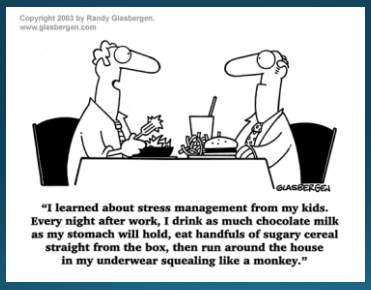
Relaxation: Work with Caregivers

- Role of their own trauma history
- Their own use of the skills
- Supporting their child's use of the skills

Relaxation: Conjoint Work

- Have child teach their parent relaxation skills
- Encourage the family to practice skills between sessions. Make it fun!
- "If it's not fun, you're not doing it right"

Relaxation: Remember Home Practice!



Let's Practice: Relaxation

Identify:

- What symptoms should be targeted during this component.
- What relaxation strategies might address those symptoms.
- Select one strategy to practice

Once identified, practice in pairs

- Providing psychoeducation about relaxation
- Link relaxation to trauma symptoms
- Conducting the activity

Affective Expression and Regulation

Affective Expression and Regulation

Goals:

- Help the child and caregiver to accurately **identify, differentiate, express, and modulate emotions**, particularly negative emotions.
- Help the child and caregivers understand healthy versus unhealthy forms of emotional expression.
- Gradual Exposure

Affect Expression Skills Training

- Identifying feelings in self and others – *look, listen, and ask*
- Accepting feelings
- Expressing feelings – *show and tell*
- Coping with the wide array of feelings associated with trauma

Affect Expression: Gradual Exposure

- Recognize the connection between feelings and the child's trauma reminders and help them identify common trauma triggers that lead to distressing emotions.
- Incorporate affective modulation strategies for trauma reminders.

Affect Expression Skills Training

- Awareness of cultural expressions of emotions.
  - A child may be more familiar with words that describe emotion in his native tongue.
  - Traumatic experiences may be associated with the language in which they were experienced.
  - When working with a bilingual family, a therapist must be conscious to conduct the sessions in the language of the client's choice.
  - Inquire about different ways that family members express their feelings
  - Get *their* vocabulary
  - Another way to talk about feelings (e.g., colors, objects…etc.)
  - Physical/Concrete manifestation (body, facial expressions)
    - Situations that correspond
    - Strength

Affective Expression/Modulation: Differentiation

- Use of Emotions Thermometer
- Use of Likert Scale
- Use of Body Pictures
- Use of Empty/Full Containers
- Pebble, Rock, Boulder
- Others?

Affective Regulation: Remember Home Practice!

Let's Practice: Affect Regulation

Identify possible intervention ideas to help this client recognize and identify emotions in themselves and others.

A 12 year old male has an extensive trauma history including exposure to domestic violence, community violence and physical abuse. He has lived in several placements and is currently living in a pre-adoptive home. He enjoys football and hanging out on the street with peers. He reports "I don't feel anything".

Cognitive Coping

Goals:
For the child and caregiver

- to identify their thoughts
- understand how to replace unhelpful and inaccurate thoughts with helpful/adaptive thoughts.

Cognitive Coping

- Help children and parents understand the cognitive triad: connections between thoughts, feelings and behaviors, as they relate to everyday events
- Help children distinguish between thoughts, feelings, and behaviors
- Help children and parents view events in more accurate and helpful ways
- Encourage parents to assist children in cognitive processing of upsetting situations, and to use this in their own everyday lives

Cognitive Coping

This component does **not** include cognitive processing of trauma memories *unless* there is a current safety risk that must be addressed.

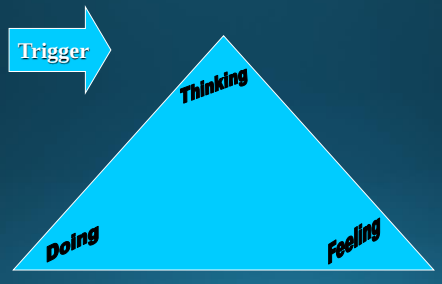
Otherwise, this occurs after the development of the trauma narrative.

Cognitive Work w/ Kids- Identifying thoughts

How do I get kids to talk about their thoughts?

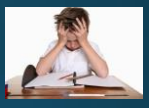
- Use KID LANGUAGE!
- ADJUST TO THEIR DEVELOPMENTAL LEVEL, BE CREATIVE!
  - What do you think about when you're feeling _____?
  - Are there any thoughts or pictures that go through your mind?
  - What popped into your head? What did you say to yourself?
  - Use a cartoon bubble and fill it in
  - We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

Cognitive Triangle: Thoughts, Feelings, and Behaviors



Examples to Illustrate Cognitive Triad

- 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?
- 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?



Types of Thoughts

Types of Inaccurate Thoughts

- Personal, Pervasive, Permanent
  - All or Nothing Alan
  - Again and Again Agnes
  - Catastrophic Cassie
  - Negative Ned

What this looks like with kids

Monica Fitzgerald, TF-CBT Trainer

Cognitive Coping

Connecting feelings with thoughts & behaviors

What you felt, what you thought, and what you did!

Thought

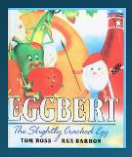
Monica Fitzgerald, TF-CBT Trainer

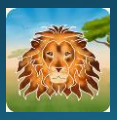
WORRY BRAIN:
5 year old male

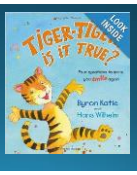
Monica Fitzgerald, TF-CBT Trainer

Cognitive Coping Resources

You can download the free *TF-CBT Triangle of Life* app from iTunes and Google Play stores







Cognitive Coping Exercise

Role-Plays

- Break into dyads – one plays therapist, one is child
- Practice introducing the cognitive triangle and using it to address a current conflict for the child
- Use a non-trauma child example (e.g., last time the child had a fight; got mad about something; felt sad about something)
- FEEDBACK SANDWICH!

Cognitive Coping: Caregivers

- Can start working on caregivers' trauma related unhelpful and inaccurate thinking at this point.
  - Parents' feelings and thoughts about the trauma impact their children's response
  - Can assist parents in coping with their own distress and help them to respond more effectively to their children
- Identify and explore spiritual/religious beliefs and thoughts connected to them to help them cope

Parental Factors

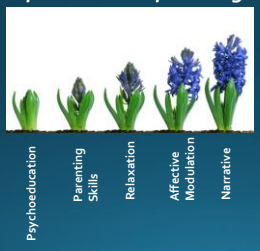
- Strength from spirituality
- Multigenerational abuse
- Minimizing/ ambivalence
- Parental emotional distress
- Self-blame/shame
- Meaning making

TF-CBT Case Example

What Have We Learned So Far?

Gradual Exposure: Not just for the narrative!

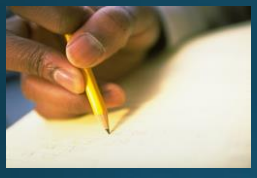
Gradual exposure develops throughout treatment



Direct Discussion of Trauma

- Reasons avoidance may occur:
  - Child discomfort
  - Caregiver discomfort
  - Therapist discomfort
  - Legal concerns
- Reasons to directly discuss traumatic events:
  - Desensitization
  - Resolve avoidance symptoms
  - Correction of distorted cognitions
  - Model adaptive coping
  - Identify and prepare for trauma/loss reminders
  - Meaning making

Trauma Narrative Development



Trauma Narrative Goals

- The child learns how to talk about the traumatic event without feeling overwhelmed or overly distressed.
- Provide Exposure
  - Gives children a sense of mastery and control over the trauma.
  - Helps children reduce the intensity of overwhelming negative emotions related to the trauma such as fear, anxiety, helplessness, guilt, and shame.
- To help the caregiver to process the child's trauma and be able to discuss it with the child without overwhelming negative emotions.

What are we learning from clients?

- "What was the most helpful? "That little trauma thing [TN]…that was like the main thing."
- "[Talking about their trauma experiences] will help them overcome what they're gong through…it can relieve stress and get stuff off their mind. Some people keep things in for so long and nobody never asked them about it"
- "Therapy was helpful. It helps people get their feeling out…It cleared some things out just talking about it."
- "Talking about it [trauma] will help them over come what they are going through."

Kelly Kinnish Ph.D. & Laura Murray, Ph.D, 2016

NCTSN The National Child Traumatic Stress Network

Trauma Narrative

- The client will include and be able to process their thoughts, feelings and actions related to the traumatic event.
- After all of these elements have been identified and the narrative has been completed you will work on restructuring cognitive distortions.

Narration is a process not a product

Preparation for the Trauma Narrative- Child

- Review baseline narrative
- Reassess narration capacity
- Review reason for the narrative
- Show confidence in child's ability to talk about the trauma and the therapist's ability to hear the details.
- Confirm who in their life they will share with (non-perpetrator supportive adult)
- Let them know the work will occur and be kept in session
- Consider language

Preparation for the Trauma Narrative- Caregiver

- Meet separately
- Review reason for the narrative
- Explore what parent knows about the traumatic event
  - Encourage caregiver to express their thoughts and feelings
  - Encourage caregiver's use of coping skills
  - Parent may not know details of what happened
    - Avoidance
    - Legal issues
- Share with parent what child has said in therapy
  - Confidentiality
  - Developmental issues
- Role-play caregiver – child interaction

Considerations for the Trauma Narrative- Caregiver

- Use child's artwork, stories, drawing (with child's permission)
- This is the next step in gradual exposure. Material should have been reviewed along the way.
- Sharing TN may not be appropriate, especially in complex trauma cases when trust is a major theme
- Sometimes another supportive adult may be sought to be involved in process
- Potential responses
  - May have difficulty expressing appropriate emotional support at first
  - May be supportive at some times but unable at other times
  - May be able to hear only part of narrative
  - See it as "fact finding"

Trauma Narrative Format Ideas

- The narrative is often put into the form of a book that the child may dictate to the therapist
- Allow alternative ways of doing the narrative: a song, poem, collage, mobile, diorama, play therapy reenactment, pretend radio talk show, stand up comedy routine, drawings, etc.
- You can be creative in making the setting comfortable: music, sounds, lighting, spiritual comfort items

Development of the Trauma Narrative

- Assess feeling state
- Decide on the media/format to be used
- Identify what things are important to include
- Create a hierarchy of anxiety provoking elements
- Start with a first chapter about innocuous information about child (name, age, school, hobbies, etc.)
- If there are multiple trauma episodes, let the child choose most significant (example: first time, last time, one best remembered)
- May include a chapter about the relationship with the person before the trauma started (if interpersonal trauma)
- Remember to include disclosure, legal procedures, medical exams, etc.
- Be matter of fact about the details to show that you can tolerate hearing it

Sample Gradual Exposure Hierarchy: Sexual Abuse Focus

1. Basic information about the child and family
2. Nonabusive interactions with the offender
3. The first episode of abuse or "grooming" incidents
4. Other abusive episodes (associated with events such as holidays, birthdays, etc.)
5. The most recent abusive or traumatic experience
6. The disclosure and resulting investigation and/or medical exam
7. The most disturbing or embarrassing abusive episodes
8. Final summary chapter: the counseling experience, what has been learned, who helped and future expectations

(Deblinger, Mannarino and Cohen, 2015)

Trauma Narrative

- Review the narrative at subsequent sessions
  - Help the child to describe more details
  - Encourage child to describe thoughts and feelings related to trauma
    - Desensitizes child to talking about the event
    - Desensitizes child to event
- Ask the child to report on what they experienced through each of the five senses and their emotions and thoughts
- Identify "hot spots" or "worst moments". Suggest "now I want you to include something you thought you would never tell anyone"
- **Once completed**, address cognitive distortions
- Prepare for conjoint session

Narration Example

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

Expanding the Narrative

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

Facilitating Detailed Narratives

- Ask broad, open-ended questions
  - What were you thinking?
  - What were you saying to yourself?
  - What were you feeling?
  - What happened next?
- Make clarifying and reflective statements
  - Tell me more about it…
  - I wasn't there, so tell me…
  - I want to know all about…
  - Repeat the part about…
  - So, your uncle began touching your vagina…
- Praise!

"Of course I'm doing something about the problem — I'm avoiding it!"

Eliciting the Narrative

Let's Practice

Review narrative example "Jeffy"

Narration Considerations:
Multiple Traumas and Complex Trauma

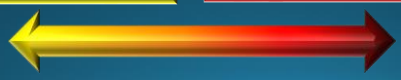
- Focus on the identified trauma themes
- Limit the number of sessions for the TN
- Provide rationale for processing trauma that includes meaning making
- Consider possible utility of life narrative or timeline
- Encourage clients to utilize PRAC skills during processing
- Trauma processing may be necessary to obtain an optimal level of self-regulation (Deblinger, et al., 2011)

Identify, Organize, and Process Complex Trauma Themes

Events	Themes
• Desensitization • behavioral/Emotional • Trees • Who, what, when, where, how?	• Meaning Making • Cognitive/Emotional • Forest • Why?

Desensitization

Meaning Making



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Narration Considerations: Foster Care

- Timing – placement?
- Greater range of experienced traumas
  - Positive interactions with past caregivers or with parents/siblings
  - Going into foster care
  - Changes in foster care placements (e.g. timeline)
- Consideration of appropriate adult

Narration Considerations: Young Children

- Consider language:
  - Younger children, "story" they may think you mean fiction
  - Accept their language but encourage details
- Be creative and meet them where they are!
  - Assess their developmental level
  - Use of play
  - Caregiver collaboration
- May not understand cognitive
- distortions

Eliciting the Narrative

Let's Practice

Cognitive Processing of the Trauma

- Goals:
  - Identify distorted, inaccurate, and unhelpful thoughts/beliefs
  - Help child see that thoughts about their trauma can be changed
  - Identify more accurate and helpful ways of thinking about the trauma and their self
  - Identify underlying global assumptions
  - Develop optimal understanding of the trauma within the context of the child's life

Cognitive Processing of the Trauma

Explore inaccurate or unhelpful cognitions about the trauma and the feelings that they lead to

- Inaccurate thoughts (ex: "the sexual abuse was my fault")
- Unhelpful thoughts (ex: "this may be the day of the next terrorist attack")
- Inaccurate AND unhelpful thoughts (ex: "it's my fault my mother was killed in the hurricane. I should have made her evacuate sooner.")
- Replace distorted cognitions with more accurate, realistic, or helpful ones
- Responsibility vs. regret

Ways to Identify Cognitive Distortions

- Trauma Narrative
- Assessment measures
  - Children's Attributions and Perceptions Scale
  - Child Post-Traumatic Cognitions Inventory
- Attending to child's comments throughout PRAC
- Parent's observations
- Supervision

Cultural Considerations

- Explore possible culturally-related beliefs/distortions
- Focus on healthy and helpful aspects of cultural values
- Explore ideas about forgiveness and revenge
- Be mindful that what you identify as cognitive distortions may come from long held family beliefs
- Be aware of how trauma gets talked about in the family

Cultural Considerations for Cognitive Processing

- Use *dichos* for reframing - *"No hay mal que por bien no venga"* ("Every cloud has a silver lining")
- Use *cuentos* for cognitive restructuring
- Use spirituality for positive self-talk - *"Dios ayuda a los que se ayudan"* ("God helps those who help themselves")
- When identifying cognitive distortions such as viewing the trauma as a punishment from God, it is important to remain respectful of the child's cultural values and beliefs.
- Cultural beliefs can be harmful if taken to an extreme
  - Excessive suffering can make a mother unable to care for her children
  - *Fatalismo* and *marianismo*

(De Arellano, Danielson, & Felton, 2016)

Addressing Caregiver Cognitive Distortions

- Help the child's parent identify his/her own cognitive distortions and related feelings
  - "I should have known this would happen"
  - "My child will never be happy/can never recover from this"
  - "My child's childhood is ruined"
  - "Our family is destroyed"
  - "I can't handle anything anymore"
  - "The world is dangerous"
- Help their parent challenge his/her own distortions and replace them with more accurate and helpful cognitions
- Help their parent identify and practice effectively challenging their child's cognitive distortions

Cognitive and Affective Processing for Caregivers

- 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." "The world is not a safe place."
  - Personalized: "I'm a terrible parent because my child was hurt."
- *"If my best friend had a child who experienced a similar traumatic experience, what would I say to him or her?"*
- *"Would I want my child to overhear me making this statement out loud?"*

The Role of Validation

- Complex trauma survivors are often highly sensitive to perceived invalidation/disrespect
- Done poorly, cognitive processing can easily be perceived as invalidating

Socratic Questioning

- The purpose is to help uncover the assumptions and evidence that underpin thoughts in respect to the trauma.
- Implemented in a positive, fun manner
- Each question is a step on the bridge
- May take more than one session

Socratic Method

- Revealing the issue:
  - What evidence supports this idea?
  - What evidence is against its being true?
- Finding reasonable alternatives/exceptions:
  - What might be another reason for the situation?
  - Why else did it happen?
- Examining various potential consequences:
  - What are worst, best, bearable and most realistic outcomes?
- Evaluate those consequences:
  - What's the effect of thinking or believing this?
  - What could be the effect of thinking differently?

Socratic Method

- Does thinking {_____} lead to positive or negative feelings?
- Does thinking {_____} help you in your relationships with friends and family?
- Is this thought always true? What evidence supports this idea? Any times it is not true?
- How would your Mom/Dad feel if they heard you say this?

Socratic Questioning: Helping caregivers and kids do the work

Keeping in mind

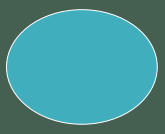
- What is your endpoint/possible endpoint?
- Planning what questions do you ask to get them there?
- Eventually you may have to provide some information/alternatives, but use questioning technique as much as possible

Shannon Dorsey, 2009

Responsibility Pie

The client is a ten year old boy. His teacher noticed a mark on his arm and asked about it. He told his teacher that his mother and grandmother had beat him after he had been suspended from school for fighting. He and his younger siblings were removed and placed in foster care.

Client thought: It's my fault we're in foster care. I never should have told.



How to Re-train Yourself…

Old Thought: It's my fault we're in foster care. I never should have told.

Possible Endpoint: When I told, I kept my siblings safe.

What I want to tell her	Turn into eliciting questions
• Telling doesn't put you in FC, abuse does	
• Your parents knew it was against the law, that's why they said don't tell	
• Your parents were hitting the other kids too, Something really serious could have happened	

Shannon Dorsey, 2009

The Importance of Balance

- Most of us develop positive and negative schemas about self, others, and the world
- These schemas are differentially activated depending on such factors as:
  - Mood
  - Circumstance
  - Recent life events
  - Biology
- It is helpful for us to be able to access both
- Trauma tends to "push schemas off balance"

Matt Kliethermes, 2014

The Importance of Balance

Safety

I'm never safe ---------- I'm always safe

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

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

Trust

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

I can't trust anyone ---------- I trust everybody

Matt Kliethermes, 2014

The Importance of Balance

Intimacy

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

Power/Control

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

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

Esteem

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

Matt Kliethermes, 2014

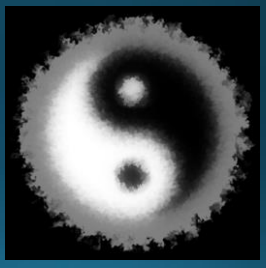
Working with Shades of Gray

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

Matt Kliethermes, 2014

What is "Gray" Thinking?

- Few (if any) absolutes
- Flexible
- Takes a broader perspective
- Summarizes all available information
- Based on facts not assumptions or generalizations
- Quantitative vs. qualitative
- Tends to be emotionally neutral (but **not** emotionless)
- Focuses on what **is**, not what **could** be or **should** be



Matt Kliethermes, 2014

Steps for Cognitive Processing with Complex Trauma

- Make the process explicit (a parallel process!!)
  - Identify the problematic belief
  - Identify what you want to say, but DON'T say it
  - Validate the belief
  - Develop understanding of the belief
  - Help the youth/caregiver become aware of how the belief might be a problem
  - Identify a potential balanced belief
  - Identify the information they are not paying attention to
  - Help them attend to this information (Socratic process)
  - Make the process explicit

Matt Kliethermes, 2016

WHO WANTS TO BE A COGNITIVE PROCESSOR?

- Game Play:
  - Each team selects a "therapist."
  - Teams develop a cognitive processing plan for the "therapist" to implement with the "client."
  - "Therapists" help the "client" balance their distorted belief using any cognitive processing technique.
  - "Therapist" gets mandatory "ask your team" lifeline.
  - Report out/group discussion.

Scenario 1: Crystal

Crystal is 12-years-old. She came into treatment after being sexually abused by her 16-year-old brother. While working on the trauma narrative, overnight visits with her family were initiated. Crystal's parents chose to not turn on the door alarms. During the first overnight visit, Crystal's older brother convinced Crystal to engage in sexual intercourse. Crystal subsequently disclosed this new abuse to her grandmother. During her next therapy session, Crystal stated the following: "It's my fault, I should have known better."

Scenario 2: Derrick

Derrick is 10-years-old. He came into treatment after witnessing the murder of his grandmother and uncle by two unknown assailants who were never identified or arrested. The murders occurred six months ago. Derrick is very scared about the fact that the murderers are still at large and recently stated: "I'm not safe; they are going to come and get me."

Ending Narration with Integrated Understanding

- Final Chapter: include the following:
- What have you learned?
- What would you tell other kids who experienced this?
- How are you different now from when it happened/when you started treatment?
- Personal strengths
- Expectations for the future

Narrative Example: What I Learned in Counseling

I came here because I was sexually abused by my uncle. I used to feel scared and dirty. Now I know my body is OK. I don't know why he did that, but he has a problem and it wasn't my fault.

I didn't know what to say or do about the sexual abuse. I felt like I didn't do anything, but I did. I told my Mom and a wrote a book about it. That makes me feel proud.

If this ever happens to you, you could say, "No!", get away and tell. If it's hard to say no or get away – just tell - that is the most important thing anyway! Tell someone you trust.

The Future For Me

I learned that you can trust some people that did something and you have every right to be mad or sad at them. I think that my family changed in a good way by my mom being more safe (or overprotective). Advice I would give to another family would be that someone will be there for you, someone will help you get through it and guide you step by step. I feel more safe by my mother because she helps me in a positive way by making sure our family is right and put back together piece by piece like a puzzle and by watching after us. That makes me feel happy. And just know this, even if your mother or father is overprotective, they still love you. I am making it, more of a positive person, thinking new things, growing, but it takes time. I am more of a high roof sky lander now (instead of a miserable kid who felt depressed). A stormy dark cloud was over me and now it is fading to a white cloud. Even thought I may still feel in a negative way sometimes, I am going to get past it.

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In Vivo Desensitization

Goal:
To help the child reduce and master their fears and enable them to function appropriately around people, places, things, or activities that may be associated with the traumatic events.

In Vivo Desensitization

- Mastery of trauma reminders is critical for resuming normal developmental trajectory
- Hierarchical exposure to innocuous reminders that have been paired with the traumatic experience
  - To be used only if the feared reminder is not dangerous
- Resolve generalized avoidant behaviors

In Vivo - How do you do it?

- Find out as much as you can about the feared situation
- Get 'buy in' and involvement from key participants: (parents, school personnel, etc.)
- Educate their parent about how avoidance interferes with development
- Develop a client-led plan that eases them into facing the feared cues
  - Make it specific and include rewards
  - Make sure it is realistic
- Plan should progressively increase exposure
- Praise and reinforce *in vivo* work

Practice: Developing a Plan for In Vivo Exposure

Clinical example "Cedric"

- Cedric is a 13 year old male who was sexually abused by his father in the shower for four years. He is very avoidant of showering and therefore has significant problems with hygiene. His difficulties with personal hygiene have resulted in problems with his peers. He is currently safe.

Monica Fitzgerald, 2011

Conjoint Parent-Child Sessions

Conjoint Parent-Child Sessions

Goals:

- Promote positive, healthy communication between caregiver and child about the traumatic events and the child's reactions
- Enhance the child's comfort in talking directly with the caregiver about the trauma and any other issues the child may want to address
- Help their caregiver to respond appropriately and develop a relationship that can sustain gains made by the child
- Prepare for future trauma reminders

Conjoint Sessions

- Therapist models appropriate support of child
- Caregiver models skillful coping
- Facilitates open communication
  - Trauma knowledge and education
  - Sharing the trauma narrative
  - Sex education
  - Personal safety

Conjoint Sessions

FORMAT OF SESSIONS:

- Meet individually with parent and child prior to joint part of session
- Meet together after child and parent prepared for session

Assessing Readiness for Conjoint Sessions

- Child completed narrative and is 'comfortable' with sharing the TN
- Parent/Caregiver has read and **processed** what is to be shared and can emotionally tolerate it
- Parent/Caregiver can create a positive atmosphere
- Parent/Caregiver is able to answer the child's questions about the trauma and aftermath
- Session is planned in advance
  - Have sufficient time
  - Both are prepared

Conjoint Sessions

- **WHEN NOT TO HAVE JOINT SESSIONS:**
  - The parent is unable to provide appropriate support
  - The parent continues to be overly emotional in response to child's traumatic experience
  - The child is adamantly opposed (evaluate how realistic objections are)
  - Other clinical issues (e.g. trauma involves parent, instability in the relationship)

Conjoint Sessions

Other Options:

- Have joint session with parent and child but do not include review of child's TN
- Instead focus on
  - General communication
  - Conflict resolution
  - Praising each for what they have done successfully
  - Problem solving
  - Building opportunities for positive interactions

Conjoint Sessions

Let's Practice

Expanding the Narrative

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

Enhancing Safety and Future Development

Goal:

- Improve the child's and parent's ability to maintain safety in the present and future.

Enhancing Safety and Development

- Identify fears the child may have for their personal safety in the future
- Explore possible dangers in the environment
- Help the child build the skills necessary to keep safe in the future
  - Enhance the child's ability to communicate with others about scary and confusing experiences
  - Helping the child to identify safe adults
  - Identifying resources that can be accessed when encountering dangerous situations
  - Develop children's body safety skills
  - Practice these skills outside of therapy

Enhancing Safety Skills

- Contracting and planning for safety
  - Have a specific goal in mind (e.g., not running away for next 7 weeks)
  - Have the client (and caregiver if possible) help come up with solutions/barriers and a plan
  - Use the skill of TF-CBT as appropriate
    - E.g., Do a triangle with the client on the situation to help understand where client is coming from
    - Write down the agreement in very specific steps
    - Brainstorm problems with the plan
    - Assign homework to practice plan

Safety Skills

- May be done individually or in joint sessions
- Provide Education, depending on individual needs
  - Healthy sexuality
  - Bullying
  - Conflict resolution
- Practice skills related to coping with the child's trauma
- Develop a safety plan that is responsive to the child's and family's circumstances, and the child's abilities
  - Consider family socio-economic culture when making recommendations

Safety Skills- Assertiveness Training

- Establishing a "personal safety space"
- Saying "no" to invasions of personal space
- Leave, escape, report ("NO, GO, TELL")
- Assuming an assertive stance
  - Assertive communication
- Being vigilant without being hyper-vigilant
- Increasing awareness and boundaries

Plans for the Future

- Plan for what to do when triggered by future events (reminders) such as:
  - Anniversary dates
  - Locations,
  - Weather, etc.
- Know that trauma issues may reemerge at times of developmental shift including:
  - Puberty and dating,
  - Starting a first job or college
  - Becoming a parent, etc.

Ending TF-CBT

- Review skills and progress achieved
- Retest using trauma measure
- Fade out and/or plan booster sessions
- Discuss and plan for natural setbacks
  - Encourage clients' confidence in managing setbacks
- Emphasize parents' role as a continued therapeutic resource for the child
- Celebrate the clients' TF-CBT graduation

Childhood Traumatic Grief

- Childhood Traumatic Grief Web http://ctg.musc.edu/
  - Using TF-CBT with Childhood Traumatic Grief
- Identify that it is a traumatic grief response vs. uncomplicated grief response to loss
- Initially, same sequence as TF-CBT, but with adaptations
- Address the traumatic aspect of the death first
- Grief-focused work based on typical tasks of bereavement following completion of components

Vicarious Trauma

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."

Rachel Remen, 1996
Kitchen Table Wisdom

Professional Quality of Life Elements Theory and Measurement http://www.proqol.org/

-Free online assessments, research, resources

Vicarious Trauma

- Balanced caseloads
- Peer group support and consultation
- Balanced life away from work
- Acknowledge that it is normal to experience

Take Home Points

- The goal is symptom reduction and distress tolerance
- Gradual exposure should occur from the start and continue throughout treatment
- Proportionality of the components is important
- Engagement is essential and ongoing
- This model is about hope
- Your work with families is extremely valuable!

Continued Learning

This training is just the starting point…

On-going learning, consultation calls, collaboration, supervision

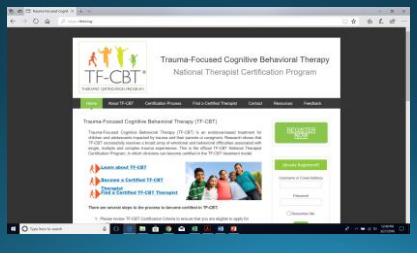
Cohen, J., Mannarino, & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents, Second Edition. New York: The Guilford Press.*

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

Deblinger, E., Mannarino, T., & Cohen, J.A. (2015). *Child Sexual Abuse: A Primer for Treating Children, Adolescents and Their Nonoffending Parents, Second Edition.* Oxford University Press.

Getting Started

TF-CBT Therapist Certification Program
https://tfcbt.org/



Continued Learning

CTG Web http://ctg.musc.edu/
A web based learning course for Childhood Traumatic Grief

TF-CBT Therapist Certification Program https://tfcbt.org/

TF-CBT Consult http://etl2.library.musc.edu/tf-cbt-consult/
A web based resource for common questions related to the use of TF-CBT

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