Treating Trauma in Children and Adolescents Using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

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Trauma-Focused Cognitive Behavioral Therapy

- Developed, researched, and empirically tested for over 20 years by Dr. Judith Cohen, Dr. Anthony Mannarino, and Dr. Esther Deblinger

- TF-CBT is an evidence-based approach to treating children and adolescents who have experienced or witnessed a traumatic event.

- Originally designed for children who had been sexually abused, but successfully adapted for other traumas.
Why TF-CBT?

- Works for children who have experienced any trauma, including multiple traumas
- Is effective with children from diverse backgrounds
- Works in as few as 12 sessions
  - 8 – 24 sessions (up to 24 for multiple, complex traumas)
- Has been used successfully in clinics, schools, homes, residential treatment facilities, and inpatient settings
- Works even if there is no parent or caregiver participation
- Works for children in foster care
- Has been used effectively in a variety of languages and countries

How to Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
Trauma-Focused CBT is the most rigorously tested treatment for traumatized children
- 19 randomized trials

Improved PTSD symptoms, depression, anxiety, behavior problems, sexualized behaviors, trauma-related shame, interpersonal trust, and social competence compared to supportive treatments

PTSD improved more with direct child treatment

Improved parental distress, parental support, and parental depression compared to supportive treatment
Culturally-Modified Trauma-Focused CBT

• CM-TF-CBT developed by Dr. Michael de Arellano
• Modeled after TF-CBT
• Designed to address the unique cultural needs of Hispanic children who have experienced or witnessed a traumatic event.
• Based on clinical work with recently immigrated Mexican and Mexican-American families, research, and theoretical literature
• Fully maintains fidelity to TF-CBT
CM-TF-CBT Clinical Evaluations and Pilot Work Thus Far

- Pilots at 6 sites
- Very positive clinical evaluation results
  - Reductions in PTSD Symptoms (UCLA PTSD-RI)
  - High patient satisfaction
  - Less patient drop-out
  - Higher engagement
- Positive systemic results
  - Increased referrals from previous families
  - Increased referrals from service agencies
This study was a pilot feasibility trial to evaluate improvement of trauma-exposed Hispanic children receiving CM-TF-CBT.

- Hispanic children between the ages of 7 and 17.
- 32 consecutive admissions meeting criteria
- History of sexual abuse, exposure to domestic violence, or traumatic grief due to loss (kidnappings, homicides).
- Children meeting admission criteria received CM-TF-CBT for 20-24 weeks post-intake.

(Rivera & de Arellano, 2008)
Pilot Feasibility Trial in Laredo, TX

- UCLA-PTSD-RI scores significantly decreased pre to post treatment (none above the clinical cut-off).
- At intake, 100% of the participants met DSM-IV-TR diagnostic criteria for posttraumatic stress disorder.
- At discharge, only 3 participants (9.4%) still met diagnostic criteria for posttraumatic stress disorder.
- Treatment Completion Rate: 100%
- These results support the hypothesis that CM-TF-CBT would decrease PTSD symptoms.
- Acculturation level was not found to predict a greater decrease in posttraumatic stress disorder symptoms.

(Rivera & de Arellano, 2008)
Why address the Hispanic culture in treatment?

- Limited research on adapting evidence-based interventions for diverse populations.
- Hispanic is the largest ethnic minority group in the U.S.
- Understand how others interpret and function within their cultural environment.
- Identify and address personal stereotypes and biases that can interfere with provision of treatment.
Trauma and Hispanic Families

- Standard treatment interventions may not address traumas sufficient to the culture.
- More likely to experience traumatic events
  - Including events not traditionally assessed
- More likely to exhibit greater mental health problems
- Less likely to access mental health treatment
  - More likely to prematurely terminate treatment
  - Half of Hispanic clients that seek treatment will not return after the initial session (La Roche, 2002)

(de Arellano, 2006)
• Differences in views of stress and coping
• Differences in manifestation of trauma symptoms
  – Somatic symptoms
  – *Ataque de nervios*

(de Arellano, 2006)
Types of Trauma

- Child Abuse (physical, sexual, emotional, neglect)
- Victim/Witness of Violence
  - Domestic Violence
  - School Violence
  - Community Violence
- Medical (e.g., transplant, cancer)
- Accidents (e.g., motor vehicle)
- Natural or Man-made Disasters
- War/Terrorism and Refugee
- Impaired Caregiver
- Forced Displacement
- Traumatic Grief/Bereavement
- Immigration Related Trauma
- Kidnapping
- Multiple/Complex Trauma
Unconfirmed Death

• *Unconfirmed death* refers to a situation in which the family does not know for sure whether the person has died and has no guarantee that the person will return.

• Situations of unconfirmed death can occur as a result of kidnapping or war, or in the context of natural disasters such as floods, wildfires, or earthquakes. In cases such as these, the lack of certainty can be confusing, and can mean that traditional rituals such as a funeral are delayed or never occur.
• Acute distress almost universal
• Impact can be long-lasting
• Childhood trauma is risk factor for adult problems
• Impact varies; most recover over time with/without treatment.

• 2 – 3 weeks post-trauma – psychoeducation and “watchful waiting” in case it is triggering past trauma
• 2 – 3 months post-trauma – possible spontaneous recovery
Trauma Symptoms

- Affective
- Behavioral
- Cognitive
- Somatic/Physical
Affective Trauma Symptoms

- Fear
- Sadness
- Anger
- Anxiety
- Affective Dysregulation
  - Could be underlying physiological arousal
Examples of Self-Regulation

• Establishing sleep-wake patterns
• Increasing attention span
• Focusing on a goal
• Managing emotions appropriately and in context
• Expressing feelings constructively
Trauma, Self-Regulation, and Coping Skills

- Biology of trauma impacts ability to regulate
- Trauma impacts the caregiver-child relationship
- To heal, children must feel safe in their bodies and they must have supportive relationships with loving caregivers who they can trust
- If coping skills are more developed, a child is much better equipped to handle stress
Behavioral Trauma Symptoms

- Avoidance
- Modeling Maladaptive Behaviors
  - Sexualized behaviors
  - Violent behaviors
  - Bullying
- Traumatic Bonding
- Angry Outbursts/Temper Tantrums
- Substance Abuse
- Self-Injury
Cognitive Trauma Symptoms

- Irrational Beliefs
  - Why did it happen?
  - Who is to blame?
- Distrust
  - Causation of trauma
- Distorted Self-Image
- Loss/Betrayal of Social Contract
- Accurate, but unhelpful, cognitions
- How does child perceive trauma?
- How has trauma changed the child?
Physical/Somatic

- Short-term
  - Headaches
  - Aches and pains
  - GI problems
  - Increased illness/absences

- Long-term
  - Has been linked to many adult chronic diseases
Biological Trauma Impact

- Changes in brain and body functioning
- Amygdala and other brain fear response
- Broca’s area: speech is cut off during acute trauma reminders → “use your words” doesn’t work
- Increased headaches, stomachaches, missed school
- Increased anger, irritability, trouble sleeping
- Memory: incoherent, chaotic, unstructured
Skills specific to each developmental stage build on learning from previous stages.

Children exposed to trauma invest energy into survival instead of developmental mastery.

Development in adulthood may continue to be impacted.
School and Social Trauma Impacts

- Academic: problems learning, poor attention, difficulty following directions
- Decreased attendance, lower grades
- Changes in peer groups —“friends don’t understand”
- May associate with deviant peers; isolate
- Withdraw from/fight with siblings
- Multiple foster placements
Common Diagnoses

• Each of these capture an aspect of the traumatic experience, but do not represent the whole picture. As a result of this, treatment often focuses on a particular identified behavior rather than on the underlying trauma.

• Comorbidity is common. It is the norm, not the exception.
  – PTSD (often used, although it rarely captures the extent of the developmental impact of multiple and chronic trauma exposure)
  – Depression
  – ADHD
  – Oppositional Defiant Disorder
  – Conduct Disorder
  – Generalized Anxiety Disorder
Assessment

- Clinical Interview
- Information from both children and caregivers
- Standardized assessment measures
- Full PTSD Diagnosis vs. symptoms + impairment
  - DO NOT NEED PTSD DIAGNOSIS — only need trauma-related symptoms and impairment
- Determine appropriateness for TF-CBT through assessment
- Assess trauma exposure
- Assess trauma symptoms
- Provide feedback to child and caregiver
- Develop treatment plan
Assess for Appropriateness for TF-CBT

- When is TF-CBT not the appropriate model despite trauma exposure?
  - Referral for disruptive behavioral problems (address and stabilize behavior before providing TF-CBT)
  - Suicidal ideation (TN may worsen this)
  - Substance use disorders (TN may worsen this)
  - Psychosis
  - Psychiatric disorders (distinguish between psychotic delusions and PTSD-related intrusive thoughts)
Assessment of Trauma Exposure

- Specific inquiry regarding traumatic history in routine assessment is important since trauma is typically under-reported.
- Standardized measure that identifies and rates the severity of traumatic events.
- The index trauma used for rating trauma-related symptoms is the one identified by the child as the most upsetting.
Assessment of Trauma Symptoms

• What is the clinical presentation?
  – Presence of trauma symptoms
• What is the connection between the trauma exposure and current symptoms?
• PTSD Symptoms are present in four clusters:
  – Intrusion
  – Avoidance
  – Negative alterations in cognitions and mood
  – Alterations in arousal and reactivity
• UCLA PTSD Reaction Index for DSM-5
  – Most widely used child self-report measure for PTSD
While being culturally sensitive, do not become individually insensitive. Do not stereotype.

Don’t assume that all Hispanics adhere to the same values and belief system (heterogeneity).

Don’t assume that the child and parents have similar beliefs.

Use both formal and informal assessment.

Integrate throughout treatment.

Maintain treatment fidelity.

Language

Level of acculturation (for all family members)
  - Acculturation Rating Scale for Mexican Americans – II (ARSMA-II)

Ask about traumas not traditionally assessed.
  - Immigration related traumas (before, during and after immigration).
  - Trauma experienced in the country of origin.
Culturally Modified Assessment: Supplemental Assessment

- Immigration History
- Migration History
- Preferred Language
- Acculturation – for all family members
- Beliefs about mental health and mental health treatment
- Include all those with input into child rearing

- Cultural Constructs
  - Machismo
  - Marianismo
  - Familismo
  - Personalismo
  - Fatalismo
  - Espiritualismo
  - Respeto & Simpatia
  - Dichos & Cuentos
  - Folk Beliefs
Integrating Cultural Constructs

- Child Rearing Practices
- Family focus
- Religious beliefs and practices / Spirituality
- Beliefs about sex
- Gender Roles (Machismo, Marianismo)
- Views of Mental Health and Mental Health Treatment
- Complementary Medicine / Folk Healers / Home Remedies
- Interpersonal variables
  - Interpersonal style / Personalismo
  - Respect / Respeto
- Language
Providing Assessment Feedback to Caregivers

- Present assessment findings and treatment conceptualization to parents and children (as appropriate)
- Straightforward explanations are less stigmatizing
- Emphasize influence of parental support
- Incorporate child’s strengths into findings
- Explain treatment plan in terms of how it will help the child overcome difficulties identified in the assessment
- Ongoing informal assessment should continue throughout treatment
- Inspire confidence that this will work
Engagement in TF-CBT

- Establish common ground/form an alliance
- Emphasize importance of parental role in child’s recovery (maximize investment and efficacy)
- Acknowledge, validate and address parental concerns (address attitudes about mental health care)
- Address what parents need and want from treatment
- Predict course of treatment including time frames and potential setbacks
- Recognize concrete barriers to participating in treatment
- Be flexible about scheduling
Engagement in TF-CBT

- Review assessment and treatment plan (clarify mental health care need)
- Provide psychoeducation about treatment (what to expect; recovery occurs over time and not all at once; things may worsen before they improve; etc.)
- Address such issues as treatment stigma, cultural concerns, previous treatment experiences, etc.
- Encourage collaboration and optimism
- Praise and reinforce parents/caregivers for bringing child for treatment
- NO SHAME and NO BLAME
Mental Health Engagement for Hispanic Families

• Treatment adherence, completion, and satisfaction have been linked to cultural issues in treatments
  – Premature termination more likely when:
    • Therapist is viewed as cold and distant by a Hispanic client (Paniagua, 1994)
    • Cultural constructs not integrated in treatment (Sonkin, 1995)
  
• Goal: To increase engagement by increasing treatment relevance to the child and family.
Caregiver Buy-In

- Therapist needs to be convinced of the need for trauma treatment if the family is going to get on board.
- Emphasize these points to caregivers:
  - TF-CBT has been proven to work
  - Can be successful in as few as 8 sessions
  - Although talking about the trauma may be hard, it is important to the success of treatment. This will be done gradually and in collaboration with the family. Children will not be forced to talk about the trauma.
  - During the early phases of treatment, children may seem more upset than before beginning treatment. Over time, remembering and talking about the trauma will become easier and they will feel better.
Applying TF-CBT in Real Life

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

- Components-Based
- Respectful of Cultural Values
- Adaptable and Flexible
- Family Focused
- Therapeutic Relationship is Central
- Self-Efficacy is Emphasized
TF-CBT Problem Domains

- **Cognitive Problems:** maladaptive thinking patterns, including inaccurate and unhelpful thoughts
- **Relationship Problems:** difficulties getting along with peers, poor social skills, maladaptive strategies for making friends
- **Affective Problems:** sadness, anxiety, fear, inability to self-soothe, inability to regulate negative affective states
- **Family Problems:** parenting skill deficits, poor communication, disturbance in bonding or family function due to abuse/violence
- **Traumatic Behavior Problems:** avoidance of trauma reminders, unsafe behaviors, aggressive or oppositional behaviors
- **Somatic Problems:** sleep difficulties, physical tension, aches
TF-CBT Components

- Psychoeducation and Parenting Skills
- Relaxation
- Affective Modulation
- Cognitive Coping and Processing
- Trauma Narrative
- In-vivo desensitization
- Conjoint Parent-Child Sessions
- Enhancing Safety
TF-CBT Treatment Themes

• Order of PRACTICE components
• Incorporating gradual exposure into the skills-based components
• Importance of behavioral interventions with parents/caregivers
• Emphasis on proportion and balance of components
• Fidelity vs. flexibility
• Implement TF-CBT based on therapist’s knowledge of child’s skills, talents and interests
Child and Parent Components

- Individual sessions for both child and parent
- Parent sessions - generally parallel child sessions
- Child and parent receive about the same amount of time at each session
- Same therapist for both child and parent
Why is it Critical to Involve Parents in TF-CBT?

• Most children do not present at mental health treatment settings because of trauma exposure
• Children have behavior problems
• Parent/caregiver involvement is essential to address behavioral difficulties
# TF-CBT Sessions Flow

**Baseline Assessment**

<table>
<thead>
<tr>
<th>Sessions</th>
<th>1-4</th>
<th>5-8</th>
<th>9-12</th>
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<tr>
<td><strong>Psychoeducation</strong></td>
<td><strong>Trauma Narrative Development and Processing</strong></td>
<td><strong>Conjoint Parent Child Sessions</strong></td>
<td></td>
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<td><strong>Parenting Skills</strong></td>
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<tr>
<td><strong>Relaxation</strong></td>
<td><strong>In-vivo Gradual Exposure</strong></td>
<td><strong>Enhancing Safety and Future Development</strong></td>
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<td><strong>Affective Expression and Regulation</strong></td>
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<tr>
<td><strong>Cognitive Coping</strong></td>
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Entire Process is Gradual Exposure
Gradual Exposure: Not Just for Narrative!

Gradual Exposure is a part of each PRACTICE component.

- Prep for Trauma Narrative: Trauma/PTSD education, trauma-related feelings/thoughts/coping responses
- Trauma Narrative, Processing, Parent-Child TN Review

Gradual exposure develops throughout the PRACTICE components.
Components-Based Treatment: PRACTICE Phase-Based Treatment

- Psychoeducation
- Parenting Component
- Relaxation Skills

STABILIZATION PHASE
- Affective Regulation Skills
- Cognitive Processing Skills

TN PHASE
- Trauma Narration and Processing
- In Vivo Mastery of Trauma Reminders
- Conjoint Child-Parent Sessions

INTEGRATION/CONSOLIDATION PHASE
- Enhancing Safety
**TF-CBT Pacing**

- **Stabilization Phase**: 1/3
  - Psychoeuction
  - Relaxation
  - Affective Modulation
  - Cognitive Coping

- **Trauma Narrative Phase**: 1/3
  - Parenting Skills
  - Gradual Exposure
  - Gradual Exposure
  - Trauma Narrative and Processing

- **Integration/Consolidation Phase**: 1/3
  - In Vivo
  - Conjoint Sessions Enhancing Safety

**Time**: 8-16 sessions

**NCTSN**
The National Child Traumatic Stress Network
TF-CBT Pacing – Complex Trauma

Time: 16-25 sessions

Parenting Skills

Gradual Exposure

Psychoeducation
Relaxation
Affective Modulation
Cognitive Coping

Stabilization Phase 1/2

Trauma Narrative and Processing

Trauma Narrative Phase 1/4

Integration/Consolidation Phase 1/4

In Vivo Conjoint Sessions Enhancing Safety

NCTSN
The National Child Traumatic Stress Network
Psychoeducation

- Begins at intake and continues throughout treatment
- Provide general information about the event
  - Frequency
  - Who experiences it
  - What causes it
- Provide information about common emotional and behavioral responses to the event
  - Empirical information if available
  - Clinician’s experience with other children
  - Written literature by victims
- Provide information about the child’s symptoms/diagnosis
  - Emphasize positive coping
- Clarify myths and misinformation
- Use the proper names for child’s traumatic experiences (name the trauma)
- Do not model avoidance, e.g., lowering voice, looking away, closed body language
- Instill hope for child and family recovery
- Educate family about the benefits and need for early treatment
- Orient the family to the TF-CBT model
- [www.youtube.com/watch?v=z8vZxDa2KPM](http://www.youtube.com/watch?v=z8vZxDa2KPM)
Cultural Modifications to Psychoeducation

- 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 expectations for the treatment process and outcome
- Predict course of treatment including time frames and potential setbacks
- Personalismo
Cultural Modifications to Psychoeducation

• 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. For example:
  – PTSD
  – Susto
• TF-CBT views parents as central therapeutic agent for change
• Establish parent as the person the child turns to for help in times of trouble
• Explain the rationale for parent inclusion in treatment
  – Not because parent is part of the problem but because parent can be the child’s strongest source of healing
• Education about children’s abilities at different developmental stages in order for parents to have reasonable expectations of children.
• Importance of consistency, predictability and follow-through
• Emphasize positive parenting skills, enhance enjoyable child-parent interactions, maximize perception/reality effective parenting
Cultural Modifications to Parenting Skills

- Hispanic parents report a greater preference for more active parenting strategies.
  - Parenting skills can be reframed to be more active.
- Cultural beliefs can pose a potential barrier (e.g., respect for parents)
  - Reframe to be more acceptable
  - e.g., Strategies to increase “respect” rather than “compliance.”
Developmental Considerations

- Natural developmental processes may be disrupted and/or altered by traumatic experiences.
- Consider the impact a child’s developmental stage might have on his/her narrative and efforts to make sense of traumatic experiences.
- Provide education throughout to help parent develop age appropriate expectations.
- Establish that all problem behaviors are not necessarily linked to traumatic experiences.
- Help parent assess the norms through observation and inquiring with other parents/teachers.
- Help parent understand their changing roles in relation to their child (e.g., director, manager, consultant).
Common Parental Issues in Child Traumatization

- Inappropriate self-blame and guilt
- Inappropriate child blame
- Overprotectiveness
- Overpermissiveness
- PTSD symptoms
Treatment of Parents Research

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
Praise and Other Positive Attention

• Focus on actively praising the child
  ▪ Praise a specific behavior
  ▪ Provide praise ASAP after behavior occurs
  ▪ Be consistent
  ▪ Be present and attentive to the child
  ▪ Do not qualify your praise
  ▪ Provide praise with same level of intensity as criticism
• “Catch your child being good!”
Cultural Modifications to Parenting Skills

Reframing to be more acceptable:

- **Praise:** Parents should be provided with a thorough rationale; address concerns about reinforcing the child for doing things she/he is already supposed to be doing.
- Rather than “praising”, the therapist can describe it as “Tell the child what she or he is doing that you like and provide reasons why”.

(Adapted from McCabe, 2004)
Selective Attention

- Pick your battles
- No reaction to certain negative behaviors
  - Defiant or angry verbalizations to parent
  - Nasty faces, rolling eyes, smirking
  - Mocking, mimicking
- Walk away, busy oneself with an activity
- Remain calm, dispassionate
- Expect a reaction of more provocative behavior
- Respond with positive attention (praise) as soon as the child behaves well.
Cultural Modifications to Parenting Skills

Reframing to be more acceptable:

- **Active ignoring:** the therapist can emphasize that this is an active parenting skill (which is why it is referred to as “active ignoring”) and then demonstrate how the parent can actively apply it.
- For example, when the child engages in a problematic behavior, the parent can actively turn away or leave the room.
- Also, ignoring can be reframed as a punishment: ley de hielo (silent treatment).

(Adapted from McCabe, 2004)
Time Out

• Purpose: Interrupt child’s negative behaviors and allow him/her to regain control
• Explain to child
• Location: quiet, least stimulating
• Duration: 1 minute per year of age
• Timer starts when child stops screaming
• Once in time out, parent should refrain from comments, and maintain calm demeanor.
• Be consistent!
Cultural Modifications to Parenting Skills

Reframing to be more acceptable:

- **Time-out:** The time-out chair can be re-named the “isolation” chair, and the therapist can describe how this is a method that allows the parent to be in control.
- If parents report a preference to spanking, the therapist can state that “isolation” lasts longer than spanking and the child has to be quiet.
- Further, it can be named as a punishment: “castigo de la esquina” or “castigo de la pared” or “castigo de aburrimiento”.

(Adapted from McCabe, 2004)
• Optimize the quality of shared time between child and parent
• Increase child’s and parent’s incentives to spend quality time together
• Increase positive attention and activities; decrease negative interactions
Contingency Reinforcement Programs

- Purpose: Decrease unwanted behaviors and increase desired behaviors
- Select only one behavior to target
- Explain process to child
- Involve child in decisions about rewards
- Add stars and give rewards weekly (be consistent)
Sample Behavior Management Plan

1. Parent identifies a single behavior to target (e.g., hitting sibling).
2. Parent monitors the behavior without intervention for a week to determine frequency and circumstances in which the behavior occurs (antecedents).
3. Parent and therapist devise a specific behavioral plan to respond to hitting (e.g., praising the child when he interacts without violence, setting consequences for hitting).
4. Therapist practices with the parent how they will respond to hitting (e.g., putting the child in time out or taking away TV time).
5. Therapist follows up with the parent about how well the plan worked, praises success and modifies plan as needed (e.g., time out didn’t work because the child played with the computer in the time out room).
6. New plan is set in place and the behavior is monitored (time out is held in a room without games or toys; parent reports success with this plan).
7. Once success has been achieved with a single behavior, the other behaviors are reviewed to see if there has been change.
8. New plan is put in place for another problem behavior.
Relaxation and Stress Management

- Reduce physiological manifestations of stress
- Normalize child’s and parent’s reactions to severe stress
- Provide information about psychological and physiological reactions to stress
- Explain how the body responds to stress
  - Shallow breathing, muscle tension, headaches, nausea, skin irritations
- Develop individualized relaxation strategies for manifestations of stress
  - Deep breathing
  - Mindfulness/meditation/yoga
  - Progressive muscle relaxation
  - Blowing bubbles
- Pair these with trauma triggers/reminders
- http://youtu.be/_mZbzDOlylA
Cultural Modifications to Relaxation

• Breathing
  – Relevant use of imagery, such as scenes form Country of origin
• Progressive Muscle Relaxation
  – *Fideo* or *tortillas* instead of spaghetti
• Religion or Spirituality if it is important to the family
Affective Modulation

- Learning to correctly identify and label a range of positive and negative emotions
- Learning to accept all feelings as a normal part of life
- Understanding the causes and consequences of emotion
- Understanding how a range of negative feelings often get expressed as anger
- Learning and practicing appropriate ways to express a range of feelings
- Identifying trauma-related feelings and learning strategies to manage these feelings
- Learning self-soothing techniques
- Learning how to stop inappropriate behavior as a way of expressing negative emotion
- Learning how to increase the experience of positive emotions
- Using positive self-talk, thought stopping, positive imagery
- Enhancing social skills and problem solving
- Traumatized children may have restricted range of affect expression
- Activities: Color Your Life, Emotional Bingo, Charades
Cultural Modifications to Affective Modulation

• **Language**
  - 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.

• **Gender roles**
  - Not culturally acceptable for male children to express emotion
  - *Machismo*
Thought Interruption and Positive Imagery

• Use when overwhelmed with trauma reminders
• Temporary measure 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
• Visualize a safe place
Affective Coping Strategies

• Focus on child’s strengths
• Remind child to verbalize these
• Improving social skills: interpreting other’s affective expressions accurately
• Enhancing sense of safety
• Ask about child’s sense of safety right now
• Develop a safety plan
Cognitive Coping and Processing

- Help children understand the cognitive triad: the connection between thoughts, feelings, and behaviors.
- Help children distinguish between thoughts, feelings, and behaviors.
- Children learn how to identify thoughts associated with abuse or traumatic events and understand their connections to negative feelings and problem behaviors.
- Children learn how to identify “thinking mistakes.” These are inaccurate, maladaptive, and unhelpful thoughts that lead to negative feelings and inappropriate behaviors.
- Children learn to challenge the thinking mistakes and replace them with accurate, helpful, and adaptive thoughts that lead to appropriate feelings and behaviors.
- Encourage parents to assist children in cognitive processing of upsetting situations, and to use this in their own everyday lives for affective modulation.
Cultural Modifications to Cognitive Processing

- Explore possible culturally-related beliefs/distortions
- Focus on healthy and helpful aspects of cultural values vs. unhealthy/unhelpful aspects
- Use progressive logical questioning and reframing
- Use of spirituality in Positive Self-Talk
  - “Dios aprieta pero no ahoga” (“God squeezes but does not choke”)
  - “Dios ayuda a los que se ayudan” (God helps those who help themselves)
- Use of Guatemalan Worry Dolls
  - Prescribed worry time
  - Give each one of the dolls one of your worries and let her carry it for you.
Cultural Modifications to Cognitive Coping and Processing

• Use *dichos* for reframing
  – “No hay mal que por bien no venga” (“Every cloud has a silver lining”)
  – “Después de la lluvia, sale el sol.” (“After a rain storm, the sun will shine”)

• Use *cuentos* for cognitive restructuring
  – The Little Red Ant and The Great Big Crumb
Cultural Modifications to Cognitive Coping and Processing

• Be respectful of cultural beliefs when identifying unhealthy thoughts

• Cultural beliefs can be harmful if taken to an extreme
  – Suffering or tolerating so much adversity can interfere with the value of the importance of caring for your children/family
  – Fatalismo and marianismo

• Reframe unhealthy thoughts to be more culturally congruent
  – Teach skills for tolerating adversity
The process starts with feelings identification. Then children learn that they can change how they act and feel by thinking differently.
Helping children to identify their thoughts

- Use appropriate child language
- Adjust to their developmental level
  - 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?
  - Use a cartoon bubble and fill it in.
Cognitive Triad Examples

• You’re in the cafeteria and are walking to the table where your friends 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?
• A child does poorly on an exam at school. What are some reasons for this?
  – “I’m stupid” (thought) – How does that 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?
Direct Discussion of Traumatic Events

- Reasons we avoid this with children:
  - Child discomfort
  - Parent discomfort
  - Therapist discomfort
  - Legal issues
- Reasons to directly discuss traumatic events:
  - Gain mastery over trauma reminders
  - Resolve avoidance symptoms
  - Correction of distorted cognitions
  - Model adaptive coping
  - Identify and prepare for trauma/loss reminders
  - Contextualize traumatic experiences into life
  - Make the unspeakable speakable
Trauma Narrative

• Introduce rationale for the TN
• TN: What occurs between the child and therapist in sessions, not what ends up in written form

• Chapter 1: General information about the child
  – name, age, school hobbies, favorites, etc.
• Chapter 2: Before the trauma
  – what life was like before the traumatic event occurred
  – what the relationship was like with the person before the trauma started (if interpersonal trauma)
Trauma Narrative

• Chapter 3: The traumatic event. Encourage the child to “tell what happened” during the trauma using expressive arts techniques.
  – If multiple episodes, let the child choose one (example: first time, last time, one best remembered, most distressing)
  – Typically children proceed from first to last episode, but not always.
  – Include disclosure, legal procedures, medical exams, counseling, etc
  – Multiple traumas: focus on overarching trauma theme

• Chapter 4 – After the trauma
  – What have you learned?
  – What would you tell other kids who have experienced this?
  – How are you different now from when it happened/when you started treatment?
Trauma Narrative – Identifying Trauma Themes

• Multiple, chronic, repeated trauma – “What trauma should I focus on in TF-CBT”?
• We used to ask the youth to identify the “worst” trauma.
• Misses opportunity to integrate and make meaning of multiple trauma experiences that often share common threads.
• Help the youth find the unifying “theme”.

NCTSN
The National Child Traumatic Stress Network
Trauma Narrative – Some Complex Trauma “Themes”

• “People who should keep me safe hurt me”.
• “It’s hard to trust people when the people I was close to always left”.
• “How can I feel safe when people in my own family hurt each other”?
• “No one will ever love me if my own parents didn’t”.

TYPICALLY RELATIONSHIP-FOCUSED
Trauma Narrative – Creation and Processing

- Focus on theme, weave specific traumatic experiences into theme.
- Complicated trauma memories often more fragmented, non-linear.
- Find a workable way to create the TN. Be flexible and creative.
- Carefully assess sharing the TN if youth adamantly refuses (e.g., foster parent).
Unconfirmed Death: Modifications to the Trauma Narrative

• Explore the child’s relationship with the missing person.
• Help the child to understand that:
  – The trauma is not his or her responsibility
  – Whatever the relationship with the missing person, it was unrelated to what happened
  – The “unfinished business” of the relationship, whether or not this gets to be resolved when and if the missing person returns, should not be confused with the child’s feelings about the trauma.
Unconfirmed Death: Modifications to the Trauma Narrative

• Address the relationship: tell me about the missing person and what your relationship has been like; help me to know how you interacted up to the time this happened. Write this as part of the TN in the “before” chapter.

• Include in the “when it happened” chapter what the child’s perspective is about what happened the day of the trauma (each child may have different memories or knowledge about this – they are at different developmental levels, etc.)
Unconfirmed Death: Modifications to the Trauma Narrative

• The most difficult part of treatment may be the subsequent chapter: “since it happened”. Include:
  – What I hope will happen
  – What I will do if what I hope for happens
  – What I fear/the worst will happen
  – What I can do to cope if the worst happens
  – How to deal with waiting
  – What if we never find out what happened (a possible outcome)
Unconfirmed Death: Modifications to the Trauma Narrative

• All of our futures are an unwritten book and we don’t know what will happen to any of us in the future.

• Wherever the missing person is (alive somewhere, or dead and in heaven – or wherever they believe people go after death) what do they want to write in their own book for the missing person to read?

• The TN is not just the story of what happened to the missing person, but what will happen in their own lives in the future that is part of this story.

• They don’t have control over what happened to the missing person, but they have control over the future of their own stories and what is written in their own books.
Unconfirmed Death: Modifications to the Trauma Narrative

• What story would they like the missing person to read about them, wherever the person is, if he could read their story?
• Would he be proud of them?
• Would he be happy about how they are going forward in their lives?
• If the missing person were to come back some day, at some point, what would they want him to find them doing, being, becoming?
• If the missing person doesn’t come back, but can look down from heaven, same questions.
• This is also part of the TN and perhaps the most important or meaning-making one for them.
Trauma Narrative

• Let the child title the TN and each chapter
• As many chapters as necessary
• Throughout the development of the TN, use the Subjective Units of Distress Scale (SUDS) to help children quantify their degree of distress within each session
• Identify “hot spots” or worst moments
• Help the child to describe more details
• Review, identify and correct cognitive distortions as the TN is being developed
• Desensitize child to talking about the event.
Reviewing the Trauma Narrative

Review the child’s description in each segment/session

- Help the child to describe more details
- Encourage child to describe thoughts, feelings and body sensations related to the trauma
- Child progressively gains mastery over memories and fears
Cultural Modifications to Trauma Narrative

- Tendency to not air dirty laundry outside the family
- Identify unhealthy thoughts that may be culturally relevant
  - Conservative beliefs about sex – Sexually abused girl is no longer a virgin and may be considered used or dirty
  - Responsible for disrupting the family
  - Trauma as punishment for past sins (*fatalismo*)
Cultural Modifications to Trauma Narrative - Child

• Help identify unhelpful thoughts that may be culture related:
  - No longer a virgin.
  - Gender roles
  - Responsible for negative impact on the family
  - This happened to me as a punishment.
Cultural Modifications to Trauma Narrative - Caregivers

• Help identify caregivers’ unhelpful thoughts:
  – I have brought shame to my family be letting this happen to my child.
  – I should suffer because of what I allowed to happen to my child.
  – My daughter is damaged because she is no longer a virgin.

• May cue caregivers’ own victimization
  – Hispanic adults are less likely to have received mental health treatment for their own abuse experiences.
  – Provide psychoeducation and support
  – Assess caregivers’ need for their own treatment
How to Encourage Children to Tell What Happened

- Avoid asking “Do you remember...?”
- Instead encourage “telling the story”
- “I wasn’t there so tell me all about what happened”
- “What happened next?”
Alternative methods for creating a trauma narrative:
- Cartoon strip
- Poem
- Talk Show Interview
- Song
- Drawings
- Text Message
- Play (very young children)
Trauma Narrative

- When the child is anxious or avoidant
  - Ask for just one detail about the trauma
  - Agree on a certain amount of time to be spent on the TN
  - Plan a fun activity for the end of the session after working on the TN
  - Encourage positive self-talk
  - Praise small steps
  - Use creative techniques (art, music, clip art)
  - Ask what the child thinks will happen if he/she talks about the trauma
Sharing the Trauma Narrative with the Parent

- Parent may not know details of what happened
  - Avoidance
  - Legal issues
- Explore what parent knows about the traumatic event
- Share with parent what child has said in therapy
  - Confidentiality
  - Developmental issues
- May use child’s artwork, stories, drawings (with child’s permission)
- Joint parent-child sessions
Legal Issues and the Trauma Narrative

- The TN component should be deferred if there is an active CPS or law enforcement investigation until investigative interviews have been completed so that treatment does not compromise the legal process.
- The TN is not part of the client’s file. It is stored separately.
- Progress notes should not refer to the TN; rather they should refer to discussion of the traumatic event.
- Clinicians do not want the TN to fall into the hands of a defense attorney in legal cases.
Cognitive Processing of the Traumatic Experience

• Develop optimal understanding of the trauma within the context of the child’s life
• Common negative distortions
  ▪ Self-blame (i.e. “It’s my fault” or “I should have been able to keep it from happening”)
  ▪ Overestimating danger (i.e. “The world will never be safe again” or “I can’t trust anyone any more”)
  ▪ Changed world view (i.e. “My family will never be okay again” or “I will never be happy again”)
Cognitive Reframing

- Identify cognitions related to the trauma
  - As reported in trauma narrative
  - Direct inquiry
  - Indirect reports
  - Assessment measures
  - Attending to child’s attributions in session
  - Parent’s perspective
  - Child’s responses in role plays, puppet shows, etc.
  - Talk about how child/parent felt when thinking about trauma over the past week and elicit problematic thoughts
Cognitive Processing of the Trauma

• Explore inaccurate or unhelpful cognitions about the trauma and the feelings that accompany them
  ▪ Inaccurate thoughts (ex: “the sexual abuse was my fault”)
  ▪ Unhelpful thoughts (ex: “you can never tell when a drive-by shooter might hit you”)
  ▪ Inaccurate AND unhelpful thoughts (ex: “it’s my fault my mother was killed in the hurricane. I should have made her evacuate sooner.”)
  ▪ Responsibility vs. regret over actions taken or not taken
Challenging Trauma-Related Cognitive Distortions

- Replace distorted cognitions with more accurate, realistic, or helpful ones
  - Progressive logical questioning
  - Overgeneralizations
  - Examining the evidence and generating alternative cognitions
  - ”Best Friend” role play
  - News Interviews
  - Responsibility Pie
Progressive Logical (Socratic) Questions

• Evidence for and against? (hold up in court?)
• Based on logic or emotion?
• Extreme language (should, always, never)?
• Have others done the same → no death?
• Require powers beyond what normal people have (e.g., read minds, tell the future, etc.)?
• Different actions if had these powers?
Best Friend Role Play

- Has a friend ever had this happen?
- What did you tell them?
- If not, what would you tell your best friend if this happened to them?
- Do the role play, help the child be supportive to best friend
- “Be your own best friend”
Responsibility Pie

- Name all who had anything to do with the trauma
- Allocate proportion of responsibility
- Explore reallocation of responsibility using Progressive Logical Questioning
Cognitive Processing of Trauma with Parent/Caregiver

- Help 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”
  - “I can’t trust anyone anymore”
  - “The world is terribly dangerous”

- Help parent challenge his/her own distortions and replace them with more accurate and helpful cognitions

- Help parent identify and practice effectively challenging child’s cognitive distortions
Cultural Modifications to the Trauma Narrative - Caregivers

- Help identify caregivers’ unhelpful thoughts:
  - I have brought shame to my family by letting this happen to my child.
  - I should suffer because of what I allowed to happen to my child.
  - My daughter is damaged because she is no longer a virgin.

(de Arellano, 2006)
Cultural Modifications to the Trauma Narrative - Caregivers

• May cue caregivers’ own victimization
  – Hispanic adults are less likely to have received mental health treatment for their own abuse experiences.
  – Provide psychoeducation and support
  – Assess caregivers’ need for their own treatment
In-vivo Mastery of Trauma Reminders

• 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 abusive or traumatic events.
• Mastery of trauma reminders is critical for resuming normal developmental trajectory
• To be used only if the feared reminder is innocuous (not if it’s still dangerous)
• Hierarchical exposure to innocuous reminders which have been paired with the traumatic experience.
• Resolve generalized avoidant behaviors
  – Gradually help the child get used to the feared situation
• Identify trauma reminder or trigger
• Develop in-vivo desensitization plan
• Praise and reinforce in-vivo work
In-Vivo Mastery of Trauma Reminders

- Behavioral plan to overcome generalized avoidance and/or cope with trauma triggers
- Identify and assess feared situation/triggers
- Engage child and/or parent in creating specific desensitization plan to gradually approach feared situation
- Ensure parent is committed to follow through with plan; parent uses praise, selective attention, and rewards
- Therapist MUST have confidence that this will work or it won’t
- Goal: improved adaptive functioning for child and child regains sense of competence and mastery
Sample Desensitization Plan for Child Who Fears Going to Sleep in His/Her Own Bed

- Educate parent on importance of quality sleep for recovery and developmental importance of child being able to sleep alone
- Efforts to make child feel safer in room (i.e. night light, flashlight, checking closets, etc.)
- Bedtime rituals, transitional objects, and relaxation techniques
- Warn parents that first few nights will likely be difficult (first try over the weekend) but persistence is key
- Plan: parent initially stays in the child’s room for 15 minutes, gradually reduces time spent in room, and eventually moves to chair outside room
- Parent reassures child he/she will check in at regular intervals (not when child is crying)
- Parent praises child for complying (staying in bed quietly) for increasing intervals
- Special reward when child falls asleep and stays in own bed for the whole night
In-Vivo mastery of Trauma Reminders

- Facing Down The Fears Of The I-35W Bridge Collapse

Conjoint Parent-Child Sessions

- Share information about child’s experience
- Correct cognitive distortions (child and parent)
- Encourage optimal parent-child communication
- Prepare for future traumatic reminders
- Model appropriate child support/redirection
Conjoint Parent-Child Sessions

• Content of sessions
  ▪ Trauma knowledge and education
  ▪ Share child’s trauma narrative
  ▪ Encourage open discussion, question/answer between child and parent about trauma and other topics
  ▪ Preparation for future trauma reminders and how the child and parent can optimally cope with these
  ▪ Praise for progress made
  ▪ Personal safety
Conjoint Parent-Child 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
Conjoint Parent-Child Sessions

• When NOT to have joint sessions:
  – Parent unable to provide appropriate support
  – Parent continues to be overly emotional in response to child’s traumatic experience
  – Child adamantly opposed (evaluate how realistic objections are)
Enhancing Future Safety

• Typically done in conjoint parent-child sessions, but may also be done individually
• Develop a safety plan which is responsive to the child’s and family’s circumstances and the child’s realistic abilities
• Practice these skills outside of therapy also
• For sexually abused children, include education about healthy sexuality
• For children exposed to DV, PA, CV, may include education about bullying, conflict resolution, etc.
• Improve problem solving skills in stressful situations
• Teaching assertiveness skills and confident body language when faced with potentially unsafe situations
• http://www.youtube.com/watch?v=sNI8rODXIBk
Demonstration of Safety Skills

- Establishing a “personal safety space”
- Saying “no” to invasions of personal space
- Leave, escape, report (“NO, GO, TELL”)
- Assuming an assertive stance
- Being vigilant without being hypervigilant
Cultural Modifications to Enhancing Safety and Future Development

- Psychoeducation around sexual development
- Be sensitive to and respectful of conservative beliefs about sex
- Discuss safety strategies that were in place in country of origin.
BOSSes - Barriers and Obstacles to Safety and Stability

COWs – Crisis of the Week

- We conceptualize this as a method of avoidance that ultimately prevents exposure work and/or poorly managed trauma related behavior difficulties that need to be re-directed to the Parenting component of TF-CBT.

- Managing COW - rather than "setting aside time" to deal with COW, conceptualizing how COW are trauma manifestations and/or how TF-CBT components apply to managing COW.
Managing the COW

• If our attention is constantly diverted from trauma-focused work to the COW and the child (or parent) is avoidant of addressing the trauma, then the child (parent) who produces the COW succeeds in avoiding trauma-focused treatment.

• Important to be aware of this dynamic and not allow COW to deter from continuing to spend time each session on trauma-focused material.

• Conduct a FBA of the COW to determine why the behavior occurred and what is reinforcing it, and then make a thoughtful decision about how to handle COW in session.
Teenager comes to session very distressed and tearful because she learned that a friend was spreading rumors about her and trying to take her boyfriend away.

You might respond: “I am sorry to hear that. It must be aggravating. So how would you like to handle this today? We can just talk about it for a few minutes and then get back to our plan for today, or we can use this situation to see if there is any way you would apply what you have been learning. For example, how did you handle the feelings you had about it? How could you use the cognitive triangle to make sense of your reaction and maybe identify some ways to think about it differently? What would you like to do?”
• Parent is angry and frustrated because of an incident in which the child got into a fight with peers at school and was rude to the teacher. He may be expelled.

• You might respond: “Yes, I can understand why that would be upsetting. You are trying so hard to keep everything going and if he gets kicked out it will be a big hassle finding a new school and you might get into trouble at work. So how can I help you? Would you be interested in using the behavioral analysis we discussed and coming up with a plan? Otherwise we will get back on track with what we were working on related to the trauma impact.”
Treatment Closure Issues

- Making meaning of traumatic experiences
- Summarizes psychoeducation, exposure, cognitive processing and altruism into a final product to share with parent
- Treatment graduation: is an achievement, like other graduations
- Return to treatment is not a failure
“There is a cost to caring”. – Charles Figley

Vicarious Traumatization: A transformation of the helper’s inner experience, resulting from empathic engagement with the client’s trauma material (Saakvitne & Pearlman, 1996).

- This is hard work
- Take care yourself and your colleagues
- Ask for consultation
- Balance a life outside of work
- Get help if you need it.
TF-CBT Therapist Certification

- [https://tfcbt.org](https://tfcbt.org)
- TF-CBT Web
- 2 day face-to-face training
- 12 consultation calls implementing TF-CBT
- Complete 3 TF-CBT cases (2 with caregiver) using standardized assessment instrument
- Complete online knowledge test, pay fee → certified for 5 years


• TF-CBTWeb - [www.musc.edu/tfcbt](http://www.musc.edu/tfcbt)

• CTGWeb – [http://ctg.musc.edu](http://ctg.musc.edu)

• TF-CBT Certification: [https://tfcbt.org](https://tfcbt.org)

• The National Child Traumatic Stress Network – [www.nctsn.org](http://www.nctsn.org)
Please Note...

- Intellectual Property Rights for these training materials belong to Dr. Judy Cohen, Dr. Tony Mannarino and Dr. Esther Deblinger.

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