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

Susana Rivera, Ph.D., LPC

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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.
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.
- Model pilot-tested at 6 sites.
• Trauma-Focused CBT is the most rigorously tested treatment for traumatized children
  – 18 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
CM-TF-CBT Clinical Evaluations and Pilot Work Thus Far

• 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-TFT.

At intake, 100% of the participants met DSM-IV-TR diagnostic criteria for posttraumatic stress disorder.

At discharge, only 9.4% still met diagnostic criteria for posttraumatic stress disorder.

These results support the hypothesis that CM-TFT would decrease PTSD symptoms.

Acculturation level was not found to predict a greater decrease in posttraumatic stress disorder symptoms.

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

• Limited research on adapting evidence-based interventions for diverse populations.
• Hispanic is 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)
Trauma and Hispanic Families

- 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)
- Domestic Violence
- School Violence
- Community Violence
- Medical (illness or accident)
- Natural or Man-made Disasters
- War/Terrorism
- Impaired Caregiver
- Forced Displacement
- Traumatic Grief/Bereavement
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
Affective Trauma Symptoms

- Fear
- Sadness
- Anger
- Anxiety
- Affective Dysregulation
  - Could be underlying physiological arousal
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?
Common Diagnosis

• 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 (ODD)
  – Conduct Disorder
  – Generalized Anxiety Disorder
Assessment

- Clinical Interview
- Information from both children and caregivers
- Standardized assessment measures
- Full PTSD Diagnosis vs. symptoms + 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 three clusters:
  – Reexperiencing
  – Avoidance
  – hyperarousal
• UCLA PTSD Reaction Index for DSM-IV
  – Most widely used child self-report measure for PTSD
Cultural Modifications to Assessment

• 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.
• Don’t assume that the child and parents have similar beliefs.
• 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
  - Dichos & Cuentos
  - Spirituality
  - 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
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.
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
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.
Misconceptions About TF-CBT

- Cannot be used with children when there is no parent/caregiver available.
- Cannot be used with children in foster care. Cannot be used with children with complex trauma or multiple traumas.
- Cannot be used with children younger than 5 or older than 14.
- Cannot be used with children with special needs or developmental delays.
- Cannot be used with children from a variety of cultural backgrounds
  - Adaptation for Hispanic children and families
  - Adaptation for Native American children and families
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

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<tr>
<th>Sessions</th>
<th>1-4</th>
<th>5-8</th>
<th>9-12</th>
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<tbody>
<tr>
<td><strong>Psychoeducation</strong></td>
<td><strong>Trauma Narrative</strong></td>
<td><strong>Conjoint Parent Child Sessions</strong></td>
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<tr>
<td>Parenting Skills</td>
<td>Development and Processing</td>
<td>Enhancing Safety and Future Development</td>
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<tr>
<td><strong>Relaxation</strong></td>
<td><strong>In-vivo Gradual Exposure</strong></td>
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<tr>
<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

Baseline Assessment
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
- 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
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
Parenting Skills

- 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.”
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
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)
Praise

• Focus on actively praising the child
  ▪ Praise a specific behavior
  ▪ Provide praise ASAP after behavior occurs
  ▪ Be consistent
  ▪ 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

• 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)
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)
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)
Behavior Management

- Reasonable developmental expectations
- Limit-setting
- Behavioral interventions for
  - Anxieties
  - Sleep problems
  - Aggressive behaviors
  - Sexually inappropriate behaviors
Relaxation and Stress Management

Goal: Reduce physiologic 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
- Aerobic activity is known to decrease physical manifestations of stress as well as depression and anxiety
Cultural Modifications to Relaxation

- Breathing
  - Relevant use of imagery, such as scenes from 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
Positive Self-Talk

- 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.

NCTSN
The National Child Traumatic Stress Network
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
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”)
  – “Despues 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

• Use spirituality for positive self-talk
  • “Dios ayuda a los que se ayudan” (“God helps those who help themselves”)
  • “Dios aprieta pero no ahoga.” (“God squeezes but does not choke”)
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.
## Cognitive Processing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thought</th>
<th>Feeling</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Situation</td>
<td>New Thought</td>
<td>New Feeling</td>
<td>New Behavior</td>
</tr>
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</table>
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

- Critical procedure for helping the child cope with trauma related symptoms
- Helps control intrusive and upsetting trauma related imagery
- Helps reduce avoidance of cues, identify unhelpful cognitions about the trauma, and recognize and prepare for reminders of the trauma
- Focus on what is most distressing for the child
- Introduce the rationale for the narrative
- Can introduce the TN by reading a book
- 4-6 sessions for Trauma Narrative
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

• 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?
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.
Cultural Modifications to Trauma Narrative

- Tendency to not air dirty laundry outside the family
- Identify unhealthy thoughts that may be culturally relevant
  - 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)
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
- 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
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
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

• 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
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.
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
Treatment Closure

- Making meaning of traumatic experiences
- Creating a Public Service Announcement: what I would tell other children about my traumatic event
- 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
Anticipating/Avoiding Pitfalls – The Crisis of the Week

• Be alert to:
  – Too much time spent on providing case management and support
  – Having COWs derail treatment, preventing systematic application of components
  – Failure to follow-up on homework assignments
  – Failure to think about and plan for when treatment will end

• Communicate treatment rationales and plans clearly, label and acknowledge COWs.

• Establish session structure that allows crises to be addressed without “hijacking” session.
Long-Term Treatment

• When to provide TF-CBT over a longer time course:
  – Child has difficulty establishing a therapeutic relationship
  – Child is emotionally unstable and needs more sessions to learn to tolerate trauma-related feelings
  – Child has experienced many episodes of abuse or types of trauma, so that it takes longer to develop the trauma narrative
  – Child experiences repeated crisis situations during treatment that prolong the course of treatment

• Extend treatment by:
  – Spending more time on each component
  – Devoting more sessions to components the child is having difficulty mastering
  – Reviewing previous components at later points

How to Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
Children Who Don’t Seem Traumatized

- Less serious trauma/supportive response
- Event not experienced as traumatic
- Event severe
  - child resilient
  - avoidance coping adaptive
- Event not perceived as victimization
Strategy for Less Affected Children

- Psychoeducation
- Identification of potential areas of problems
  - Onset of new developmental periods
  - Interaction of new stresses with earlier trauma
- Review of coping strategies
- Revictimization prevention
Strategies for Children Who Do Not Perceive as Victimization

- Form an alliance that acknowledges child’s perception of relationship
- Listen and learn why child cooperated/participated
- Allow child to take responsibility for actions
- Do not approve or legitimize
- Help child see potential negative consequences
Summary of TF-CBT

- Trauma-focused treatment for children exposed to a variety of traumas and their parents/caretakers
- May be provided in as little as 8 sessions or adapted for longer term therapy
- Components-based hybrid treatment which incorporates principles of a variety of theoretical frameworks
- Supported by empirical studies involving over 500 traumatized children in 6 completed randomized controlled studies
- These studies included children experiencing multiple types of traumatic events, children in single parent and foster homes, children living in poverty, children with substance abusing parents, and children with multiple psychiatric problems.
TF-CBT Skill Acquisition

- Complete TF-CBT Web
- Read *Treating Trauma and Traumatic Grief in Children and Adolescents* (Cohen, Mannarino, & Deblinger, 2006, NY: Guilford Press)
- Attend 2 days of intensive skills-based training in TF-CBT
- Ongoing clinical consultation with an expert in TF-CBT
- Address barriers and challenges around implementation

**Remember:**
- Be creative
- Be willing to go outside your comfort zone
- Don’t give up; it takes practice
Resources

- TF-CBT Web - [www.musc.edu/tfcbt](http://www.musc.edu/tfcbt)
- CTG Web – [http://ctg.musc.edu](http://ctg.musc.edu)
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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