Introduction to Child & Adolescent Trauma-Informed Care (TIC) – "Why Should We Care?"

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October 21, 2010

MUSC
National Crime Victims
Research & Treatment Center

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National Crime Victims Research and Treatment Center

- Division of the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina in Charleston, South Carolina.
- Activities
  - Research
  - Training
  - Clinical Service
  - Public policy consultation
- NCTSN member
- Learning collaboratives
- **Project BEST**

Learning Objectives

- To increase understanding of:
  - the prevalence, characteristics, and impact of trauma on child victims and their families
  - the research literature related to evidence-based, trauma-focused interventions in children and adolescents
- To identify strategies and treatment approaches to address trauma-related symptoms among children and adolescents.
- To increase awareness of :
  - Trauma-Focused Cognitive Behavior Therapy, an evidence- based, trauma-specific intervention for children and their families.
  - cultural issues that may impact the therapeutic relationship and treatment components of trauma focused work.
- To increase understanding of secondary/vicarious trauma and its impact

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Module 1:

Overview of Trauma and its Effects

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Types of Childhood Trauma

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

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What is Child Traumatic Stress?

When exposure to trauma overwhelms a
child's ability to cope with
what they have experienced

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Child Traumatic Stress

- Can significantly disrupt development
- May have longterm consequences
- Can affect child's brain and nervous system
- May result in low academic performance, high risk behaviors, long-term difficulties in relationships
- Increased involvement with child welfare, juvenile justice systems

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Trauma Impact

- 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

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Bad News!

Childhood Trauma Can Have a Serious Mental Health Impact

- Behavior Problems
- Suicide Risk
- Risky Sexual Behaviors, STDs, & HIV
- Substance use/abuse
- Delinquency and criminal behavior
- Violent behavior
- Revictimization
- Guilt, shame, low self-esteem
- Academic and relationship difficulties
- Posttraumatic Stress Disorder (PTSD)
- Depression

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Bad News!
Childhood Victimization Can Have a Serious Mental Health Impact

✳ **Affective Symptoms**:

> Fear, sadness, anger

✳ **Behavioral Symptoms**:

> avoidance, sexualized behaviors, aggression, substance use, self-injury

✳ **Cognitive Symptoms:**

> Irrational beliefs, distrust, distorted self-image, unhelpful cognitions

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DSM-IV Definition of Trauma

- 'the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others'

- The person's response involved ***intense fear, helplessness or horror***

- Note: in young children, this may be expressed as disorganized or agitated behavior

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Common Diagnoses

- PTSD
- Depressive disorders
- Other Anxiety disorders
- Comorbidity is common
  - ADHD
  - Oppositional Defiant Disorder
  - Substance Use Disorders

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Posttraumatic Stress Disorder (DSM-IV)

A. Exposure to a traumatic event
- Experienced, witnessed, or confronted with actual or threatened death or injury to self or others
- Response involved intense fear, helplessness or horror

B. Re-experiencing (=> 1)
C. Avoidance of stimuli associated with trauma (=>3)
D. Persistent **increased arousal** (=> 2)

Duration of symptoms is **more than 1 month** and causes **clinically significant distress or impairment**

- <20% with history of exposure have a psychiatric disorder

- Resiliency is normative

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Prevalence and Course of PTSD

- Community lifetime rates: 1-14%
  - Higher rates for at-risk individuals: 3-58% (combat veterans, victims of crime)
- Symptoms usually appear in the 1st 3 months following trauma, but there can be delayed onset
- Duration of symptoms varies, complete recovery occurring within 3 months for ½ cases

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What does PTSD/Traumatic Stress look like in children and adolescents?

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Young Children

- Research suggests that traumatic experiences affect brain, minds, behavior of very young children – can cause similar reactions as those seen in older children
- More likely to become passive, quiet, easily alarmed, less secure
- More generally fearful, particularly around separations from a caregiver or in new situations
- May regress (e.g., start wetting the bed; sucking their thumb)

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Traumatic Stress in School-Age Children

- Wider range of intrusive images and thoughts
- Wonder what they could have done to stop the trauma or make things turn out differently
- May engage in traumatic play
- Respond to concrete reminders
- May develop intense specific fears tied to the original trauma
- May vacillate between shy/withdrawn and extremely aggressive behaviors
- Sleep disturbances (restless sleep; waking up tired)

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Traumatic Stress in Adolescents

- May fear they're 'going crazy' or that they are weak/different from everyone else
- Feel isolated – no-one understands what they went through
- May overly focus or seem fascinated by 'dark' topics
- May engage in extreme reckless/dangerous behaviors OR become extremely avoidant
  - Examples –alcohol/drug use; cutting
- May have thoughts of revenge because of belief that others failed to protect them or to prevent what happened

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Severity and Duration

- *Objective* Details of the Event
  - More severe the trauma – the more severe the response
    - Examples: repeated, violent abuse by a caregiver
      - Witness severe DV and having to 'care' for the caregiver's injuries
      - Witnessing a loved one being shot and killed
- Child's *Subjective* Experience
  - Sense of helplessness, terror, horror
  - Fear of being seriously hurt or killed
  - Fear that loved one would be seriously hurt or killed
  - Feeling that he/she could've/should've done something to prevent the trauma

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Assessment

- Evaluation for environmental risk and safety
- Assess parent's perception of youth's trauma experiences and symptoms
  - Helps to identify potential barriers to engagement

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Module 2:
Myths and Facts about Child Abuse

Dee Norton Lowcountry Children's
Center (2004)

NCTSN   The National Child
Traumatic Stress Network

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Myth or Fact? Children do not tell about abuse because they are not hurt by it or because they enjoy it.

Fact:

- There are a number of reasons why children do not tell or delay their telling about sexual abuse.
- Children are often threatened not to tell, and are afraid of being harmed by the person who abused them if they tell.
- When children are bribed or coerced, they may feel responsible for the abuse and be afraid that they will be blamed or in trouble if they tell.
- Some sexual abuse programs instruct children to say no and tell which may cause them to feel guilty if they were too scared to tell when it happened.
- Some children are told by trusted adults that what is happening is okay or are too young to understand that what has happened is abuse.

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Myth or Fact?: A child who has been abused would be frightened of any future contact with the person who abused them.

Facts:

- Offenders may be very nice to the child and present the abuse in a loving way. They "groom" the child with special attention .
- They may define the relationship as "special" and "our secret."
- Parents who abuse their child may have been positive in other areas of the child's life.
- Some touching is pleasurable and my have felt good to the child.
- Some children respond positively to offenders to protect themselves.
- Children are most often abused by members of the family.
- When physical abuse is common within a family, the child may not know that it is wrong or is afraid of the physical consequence of telling.

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Myth or Fact? Children seldom lie about something as important as abuse

Facts

- Young children tend to lie to protect themselves. Older children may lie to "survive" their family or the "system."
- Lies are most often related to denying abuse or minimizing the abusive experience vs. falsely reporting abuse.
- It is very rare for a child to make a false report of abuse.

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Myth or Fact? Young children can easily be misled to falsely claim abuse

Facts:
- Seldom are non-abused children coached or misled to falsely claim child abuse. It is more likely that accurate reports from a child may be misinterpreted as abuse and then reported as abuse.
- One purpose of objective, neutral forensic interviewing is to rule out abuse when it did not happen.
- Very young children are more suggestible than older children and adults. This fact needs to be considered in any assessment of abuse.
- Children ≥5 do not appear to be any more suggestible than older children or adults.

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Myth or Fact? When a child discloses abuse and then recants that disclosure, the original disclosure was a lie.

Facts:
- When disclosure results in the child being blamed, shamed, punished, or not believed, the child may recant in an effort to control the reaction to their disclosure.
- Child victims may also recant to take care of others or to try to undo any negative consequences of their telling (e.g., offender in jail; removal from home)

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Myth or Fact? Children who have *really* been abused will present with significant emotion when disclosing their abuse.

Facts
- There are many factors that may impact the emotion or lack of affect exhibited by child victims. Children who have had to repeat their report multiple times may present as if they have memorized the story.
- Children who have dissociated themselves from the event in order to protect themselves emotionally may report as an observer.
- Children who are too young to understand that what has happened to them is abuse may report as if they are telling about an every day event.

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Myth or Fact? Disclosure of abuse during a separation, divorce or custody battle is most often the result of coaching by a parent.

Facts:

- Disclosures of child abuse during marital or custody conflict must be carefully evaluated, just as with all reports of abuse.
- Failure to assess abuse allegations objectively puts children at risk.
- There are a number of factors that contribute to children's reports as their parents are separating or fighting for custody.
  - The child may believe that if a parent is able to leave a marriage or seek custody, that the parent would be able and willing to protect the child from abuse.
  - They may tell because of fear that they'll live alone or visit with an abusive parent.

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Myth or Fact? If the child does not *resist* the sexual advances of the offender, he/she shares responsibility for the sexual abuse.

Facts:

- Attributing any responsibility to the child is inappropriate. We teach our children to obey adults and to do what they are told. In sexual abuse cases, the child usually knows the offender and trusts him or her. Offenders easily convince children that the sexual abuse is okay.
- If the abuse begins at an early age, the child may not know that it is wrong. The closeness and special attention given to the child is some cases may be desirable.
- Adolescents may be flattered by the adult attention. It is the adult's responsibility to set the standards of behavior for their children.

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Myth or Fact? Children who have been abused will exhibit behavioral and/or emotional problems that will last a lifetime.

Facts:

- Not all children will exhibit significant longterm problems as a result of abuse
- Children are resilient
- With a supportive response, protection and treatment (if indicated), the child can do well.

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Myth or Fact? It is better to not talk about the abuse and just let the child forget what happened.

Facts:
- Not talking about abuse may be more comfortable for the adults, but may leave children feeling ashamed or believing that they have to keep all of their feelings inside.
- As with any problem, it is helpful to talk about what happened. Talk is also the most important tool in helping the children understand what has happened and to feel okay about themselves.

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Myth or Fact? The most important factor in how child victims manage their experiences is the quality of the treatment they receive.

Fact:
- The most important factor in how child victims manage their experiences is the presence of a believing, supportive and protective adult caregiver.

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Myth or Fact? Children who have been sexually abused by an adult of the same sex are significantly at risk for homosexual behaviors

Facts:
- Children who are sexually abused may act out what they have experienced, but such abuse does not automatically lead to a homosexual orientation.
- However, boys who are abused by older males are often more reluctant to tell as they may believe that such abuse means that they are homosexual. They may also be afraid that, if they tell, others will believe that they are homosexual.

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Module 3:

Overview of Trauma-focused, Evidence Supported Interventions for Youth – Part 1

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What is Trauma-Informed Care?

- Recognition that many of our clients/consumers have histories of trauma and that this often leads to mental health and other co-occurring disorders (e.g., health problems, substance abuse, eating disorders, contact with the criminal justice system)

- To become 'trauma-informed', must assess/modify every part of the agency's organization, management and service delivery to ensure that all involved have a basic understanding of how trauma impacts a person's life

- Modifying the environment to be supportive of trauma victims, be aware of triggers and avoid re-traumatization

SAMHSA – National Mental Health Information Center

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Trauma-Specific Interventions

- Designed specifically to address consequences of trauma and facilitate healing
- These programs recognize...
  - survivor's need to be <u>respected</u>, <u>informed</u>, <u>connected</u>, and <u>hopeful</u> regarding their own recovery;
  - the interrelation between trauma and symptoms of trauma (e.g. substance abuse, eating disorders, depression, anxiety, etc.);
  - the need to work in a <u>collaborative</u> way with survivors (and also with family and friends of the survivor) and with other human services agencies to empower survivors and consumers.

SAMHSA – National Mental Health Information Center   36

Good News! 20 years of Research
Effective Treatments Have Been Developed, Tested, and Implemented

- **Abuse-Focused Cognitive Behavioral Therapy – AF-CBT**
- **Child-Parent Psychotherapy – CPP**
- **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)**
- **Cognitive Processing Therapy**
- **Eye Movement Desensitization and Reprocessing (EMDR)**
- **Multisystemic Therapy (MST)**
- **Parent Child Interaction Therapy – PCIT**
- **Project SafeCare**
- **Seeking Safety**
- **The Incredible Years (TIY) series**
- **Trauma-Focused Cognitive-Behavioral Therapy – TF-CBT**
- **Triple P – Positive Parenting Program**

**Not an exhaustive list

www.nrepp.samhsa.gov

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So…how to decide?

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What is an Evidence-Supported Tx

?

- Aka:
  - Evidence-based treatment
  - Empirically supported treatment
  - Evidence-based practice
  - Best Practice
  - Promising Practice
  - EBT/EST/EBP

  YADA YADA YADA

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What is an EST (cont'd)

- Tx or intervention with scientific, empirical research evidence supporting its efficacy
- How is this determined?
  - Multiple baseline, single case designs
  - Open trials, pre-post designs
  - Controlled studies without randomization
  - RCT –'gold standard'

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A Question...

How can the average front-line practitioner locate Evidence Supported Treatments for cases of child abuse or trauma?

?

"Whoa—way too much information!"

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OVC Guidelines Project:
Classification Results

1.	Well-supported, efficacious treatment	1
2.	Supported and probably efficacious treatment	1
3.	Supported and acceptable treatment	14
4.	Promising and acceptable treatment	8
5.	Innovative or novel	0
6.	Experimental or concerning treatment	1
		25

EST's for abused children are available!

16 protocols had at least some empirical support.

Download at www.musc.edu/ncvc

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Finding Evidence Supported Treatments on the Web

- www.nctsn.org
  National Child Traumatic Stress Network
- http://nrepp.samhsa.gov/
  National Registry of Evidence-based Programs and Practices
- www.cachildwelfareclearinghouse.org/
  California Evidence-Based Clearinghouse for Child Welfare
- www.wsipp.wa.gov
  Washington State Institute for Public Policy
- www.childtrends.org/
  Child Trends
- www.ncptsd.va.gov
  National Center for PTSD
- http://ebmh.bmj.com/
  Evidence-Based Mental Health Online
- www.cochrane.org
  Cochrane Collaboration
- www.campbellcollaboration.org
  Campbell Collaboration

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Module 4:

Overview of Trauma-focused, Evidence Supported Interventions for Youth – Part 2

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What are some ESTs I should know about?

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Three Treatments Selected as "Best Practices" in Child Abuse Cases

- Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Alternatives for Families - Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)

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Parent-Child Interaction Therapy (PCIT) (Hembree-Kigin & McNeil; Urquiza & McNeil)

✹ Behavioral Parent Training
  ▪ Developed for early childhood behavior problems
  ▪ Adapted for physically abusive parents
✹ Specific goal is to change parent-child interaction, not specific child behavior.
  ▪ Increase positive parent-child interactions.
  ▪ Disrupt escalating coercive cycles.
  ▪ Reduce physically abusive behavior.

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Structure of PCIT

✹ Assessment sessions
✹ Teaching sessions
  ✹ Describing
  ✹ Modeling
  ✹ Role-playing
✹ **Live-Skill coaching sessions: Cornerstone of PCIT**
  ✹ Parent wears a Bug-in-the-Ear receiver while playing with child in playroom
  ✹ Therapist observes and codes parent and child behaviors at start of session
  ✹ Therapist coaches specific skills from observation room using microphone
  ✹ Spouses take turns being coached with child and observing spouse's coaching

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Child-Directed Interaction — CDI

Parents follow
Play therapy skills: Dos & Don'ts

Do:	Don't
Praise	Give Commands
Reflect	
Imitation	Ask Questions
Description	Criticize
Enthusiasm	

Nonverbal communication of affect

Differential attention

Parent-Directed Interaction — PDI

Parents lead

❋ Limit-setting
❋ Consistency
❋ Problem solving
❋ Reasoning

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Where can I learn more?

www.pcit.org

Clinical Child Psychology Library
Parent–Child Interaction Therapy
Toni L. Hembree-Kigin
Cheryl Bodiford McNeil

Hembree-Kigin, T. & McNeil, C.B. (1995). *Parent-Child Interaction Therapy.* New York: Plenum.
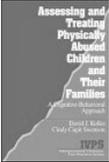
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Alternatives for Families - Cognitive Behavioral Therapy for Child Physical Abuse
(Kolko & Swenson, 2002)

- Assessment of family structural roles and interaction
- Reframing to enhance cooperation
- Identify negative effects of the use of physical force
- No violence contract
- Problem solving skills
- Communication skills
- Social skills
- Problem-solving family routines as alternatives to physical punishment
- Behavior management skills
- Affect regulation to manage abuse-specific triggers
- Combination of child, parent, and family components
- One randomized controlled trial/ongoing research

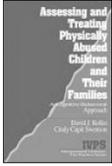Assessing and Treating Physically Abused Children and Their Families
David J. Kolko
Cindy Cupit Swenson

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Where can I learn more?

David Kolko, Ph.D.

E-Mail: kolkodj@upmc.edu

Kolko, D. & Swenson, C.C. (2002). *Assessing and treating physically abused children and their families*. Thousand Oaks, CA: Sage Publications.

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Module 5:

Overview of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
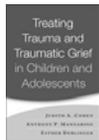
Part 1

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Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Judith Cohen, M.D.

Anthony Mannarino, Ph.D

Allegheny General Hospital
Pittsburgh, PA

Esther Deblinger, Ph.D.

University of Medicine and Dentistry of New Jersey
School of Osteopathic Medicine
Stratford, NJ

Treating Trauma and Traumatic Grief in Children and Adolescents

What is TF-CBT?

✳ Conjoint child and parent psychotherapy model
✳ Theoretical basis
  · Cognitive-behavioral therapy
  · Exposure therapy
  · Behavioral parent management
✳ Developed for children and adolescents experiencing significant emotional/behavioral difficulties related to traumatic life events.
  ▪ PTSD
  ▪ Depression
  ▪ Fear
  ▪ Anxiety
  ▪ Behavioral problems

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What is TF-CBT

- Components-based treatment protocol
- Time limited, structured approach
- Usually completed within 12-20 sessions

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Why TF-CBT?

The California Evidence-Based Clearinghouse
for Child Welfare

- Strong empirical support for its efficacy
  - 8 randomized controlled trials
  - Highest rating in the *OVC Guidelines Report*
  - Highest rating by the California Evidence-Based Clearinghouse for Child Welfare
  - Named a "Best Practice" for cases of child abuse in the *Kauffman Best Practices Report*
- Strong clinical anecdotal reports of effectiveness.
- Successfully implemented in community service agencies worldwide.
- Impact generalizes to a wide variety of problems.
- Teaches basic skills necessary in many ESTs.

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Target Criteria for TF-CBT

1. **Child is age 3-18 years.**
   Child from any racial or ethnic group, living in urban, suburban, or rural areas.

2. **Child has a trauma history.**
   Child has a history of at least one significant potentially traumatic event, such as sexual assault, physical assault, witnessing serious violence in the home or community, or unexpected, traumatic death of a loved one.

3. **Child has symptoms of PTSD.**
   Child does not have to meet full diagnostic criteria for PTSD.

4. **Child has other symptoms related to trauma.**
   Child has symptoms of depression, anxiety, shame, or traumatic grief directly related to a traumatic event.

5. **Parent/caregiver involvement is highly desirable.**
   Likely to improve treatment outcome, but it is not necessary.

TF-CBT Not Indicated

1. Child does not have a trauma history.
2. Child does not have significant mental health symptoms related to a traumatic event.
3. Child has severe cognitive disabilities or autism spectrum disorder.
4. Problems to be managed first prior to trauma-focused therapy:
   - Safety
   - Extremely poor caregiver system
   - Severe disruptive behavior problems
   - Substance abuse

Project BEST

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Inappropriate Cases for TF-CBT

- Child still with perpetrator
- No validation of abuse by an outside source
- Imminent very concerning safety issues
  - Actively suicidal
  - Basic needs not met
  - Psychosis
  - Dangerous behaviors (e.g., fire setting)
  - Active substance use to the point of impairment

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TF-CBT Approach

Child's Treatment
Education
Skill building
Exposure/Processing
Prep for Joint Session

Parent's Treatment
Education
Skill building
Exposure/Processing
Behavior Management
Prep for Joint Session

**Joint Sessions
Family Sessions**

© 1996 Deblinger & Heflin

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Parental Involvement

- Treating parents decreased behavioral and depressive symptoms in children (Deblinger et al. 1996)
- Parents' emotional reactions to trauma was the strongest predictor of treatment outcome (other than treatment type) (Cohen & Mannarino, 1996)
- At the 12 month follow-up, parental support was significantly related to decreased symptoms in child (Cohen & Mannarino,1997)
- Treatment associated with improved parenting skills and reduced parental distress (Deblinger et al., 2010)

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Parental Involvement (cont'd)

- Parents viewed as central therapeutic agents for change
- Parent is a lifetime resource for the child.
- Establish parent as the person the child turns to for help
- Explain the rationale for parent inclusion in treatment

Parental involvement continues throughout the therapy.

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Components of TF-CBT:
PRACTICE

Psychoeducation and **P**arenting skills

Relaxation

Affective modulation

Cognitive coping and processing

Trauma narrative

In vivo mastery of trauma reminders

Conjoint child-parent sessions

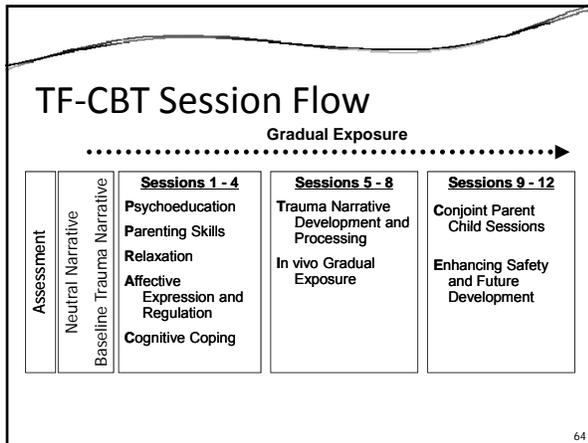**E**nhancing future safety and development

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TF-CBT Session Flow

Gradual Exposure ···▶

Assessment	Neutral Narrative Baseline Trauma Narrative	Sessions 1 - 4	Sessions 5 - 8	Sessions 9 - 12
		Psychoeducation	**Trauma Narrative Development and Processing**	**Conjoint Parent Child Sessions**
		Parenting Skills		
		Relaxation	**In vivo Gradual Exposure**	**Enhancing Safety and Future Development**
		Affective Expression and Regulation		
		Cognitive Coping		

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Psychoeducation and Parenting

- Psychoeducation
  - Education about trauma and its effects
  - Rationale and overview of treatment
  - Sex education and body safety
- Parenting
  - Behavior management
  - Use of praise and positive parenting strategies

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Relaxation

- Developmentally appropriate strategies for anxiety management
- Ways to address physiological symptoms of trauma
- Examples:
  - Controlled breathing
  - Progressive muscle relaxation
  - Guided imagery
  - Yoga
  - Mindfulness

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Affective Processing – Case Example

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Cognitive Coping/Cognitive Restructuring

Trigger

Feeling

Doing   Thinking

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Thoughts

Feelings
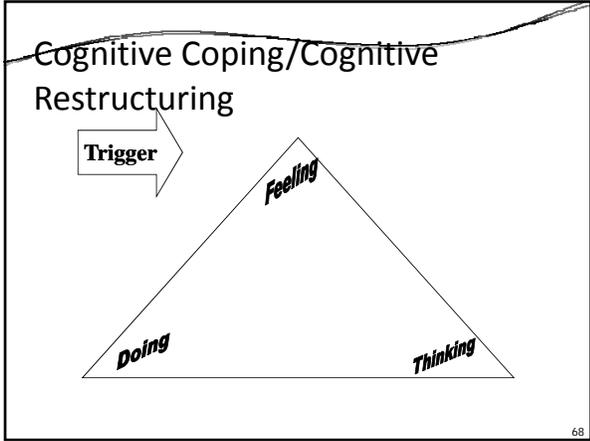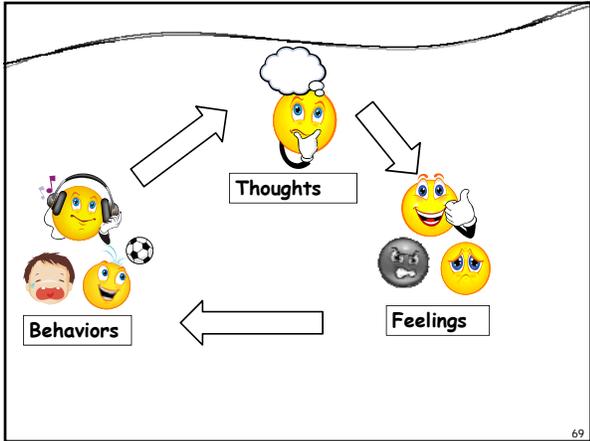
Behaviors

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Module 6:

Overview of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Part 2

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Trauma Narrative

✸ Gently encouraging the child to think about, describe, and talk about the traumatic events
✸ **Sensory recapitulation**
✸ Applying skills learned to manage trauma-associated thoughts & feelings
   ‣ Relaxation
   ‣ Cognitive processing
   ‣ Affective processing
✸ Habituation
✸ To resolve and incorporate the traumatic event into their life narrative

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Purposes of the TN

- Identify and 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

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Trauma Narrative Devices

- Writing a "Trauma book"
- Picture gallery
- Songs, raps
- Poems
- Puppet or toy play
- Cartoon strip
- Computer program
- Talk Show Interview
- Drawings
- Life timeline

Device is less important.
What is done with the device is.

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Enhancing Safety & Risk Reduction

- Reducing risk for the future
- Safety Planning
- Positive and healthy sexuality

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Resources for Adolescents
Encouraging Healthy Sexuality

Girlology:
www.girlology.com

http://www.kidshelpkids.net/

http://www.plannedparenthood.org/teen-talk/

Info on alcohol and peer pressure: http://www.thecoolspot.gov/

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TF-CBT — Impact of TN and Treatment Length

Latest study: further proof that TF-CBT works! (full story on A2)

Hot off the press!

TF-CBT Research

- 210 children (4-11) – referred for CSA and PTSD symptoms
- Randomly assigned to 1 of 4 conditions:

8 sessions		16 sessions	
No TN	TN	No TN	TN

Deblinger et al., 2010

Study Findings

- <u>8 or 16 sessions</u>: TF-CBT effective in improving symptoms, parenting skills, and children's personal safety skills
- <u>8 sessions with TN</u>: most effective in reducing parents' abuse-specific distress, children's abuse-related fear, and general anxiety
- <u>16 session no TN</u>: greater increases in effective parenting, fewer externalizing child behavior problems
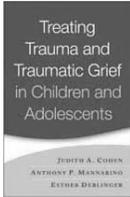
A Question...

Where can I learn more about TF-CBT

?

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Treatment Manual

Trauma and Traumatic Grief in Children and Adolescents.
Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating*
New York: Guilford Publications, Inc.

Treating
Trauma and
Traumatic Grief
in Children and
Adolescents

JUDITH A. COHEN
ANTHONY P. MANNARINO
ESTHER DEBLINGER

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Misconceptions about TF-CBT

- TF-CBT cannot be used with children:
    - in foster care
    - who've experienced complex trauma or multiple traumas
    - who have symptoms other than PTSD
    - younger than 5 or older than 14
    - who have special needs or developmental delays
    - from a variety of cultural backgrounds
    - when there is no caregiver available

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TF-CBT *Web*

www.musc.edu/tfcbt

TF-CBT*Web* is an Internet-based, distance education training course for learning Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT).

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Module 7:
TF-CBT and Cases of
Child Traumatic Grief

Saunders, B.E. (2010)

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CTG *Web*

www.musc.edu/ctg

CTG*Web* is a follow-up course that teaches how to apply TF-CBT to cases of child traumatic grief

CTG*Web* is offered free of charge.

6 hours of CE

CTG*Web* was launched on September 1, 2008.

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Traumatic Death

- Most often are emotionally close to the deceased, but not always.
- Perceived by the child as sudden, unexpected, frightening, gory, or shocking.
- May not be perceived that way by the adults.
- Types of Traumatic Deaths:
  - Domestic violence
  - Community violence
  - MVA
  - House/apt/trailer fire
  - Disaster (flood, hurricane, tornado)
  - Combat

Saunders, B.E. (2010)

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Common Symptoms

- Intense distress when thinking about the deceased.
- Fear of the manner of death coupled with strong memories of the deceased.
- Avoidance of traumatic reminders of the death or the deceased.
- Intense and prolonged longing for the deceased.
- Difficulty accepting the death.
- Guilt, self-blame
- Anger, revenge
- Inability to think about positive time with the deceased.

Saunders, B.E. (2010)

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CTG Treatment

- PRACTICE sequence of treatment is the same.
- Components are adapted to CTG.
- Add the tasks of bereavement which often have not been accomplished due to avoidance.
- Cultural and religious beliefs and practices about death are central.

Saunders, B.E. (2010)

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Grief Psychoeducation

- Words for "death."
- What is "death" to a child?
- Understanding the finality of death.
- Beliefs about death.
- Feelings associated with death.
- What is typical grief.

Saunders, B.E. (2010)

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Grieving and Ambivalent Feelings

- What is missed?
  - Activities
  - Places
  - Personal characteristics
- Future
  - Difficult dates and events
- Ambivalent feelings
  - Deceased die on purpose (search for control)
  - Deceased doing something inappropriate when s/he died
  - Love and Anger towards the deceased
  - Guilt and Self-blame for the death
- Process feelings
  - Deal with negative aspects of the relationship.

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Preserving Positive Memories

- Building positive memories of the deceased.
- Anagram exercise

Joked around with me a lot
Orange juice was his favorite
Saved his money
Expected the best from me
Practiced basketball with me
Helped me with my homework

Saunders, B.E. (2010); Cohen, Mannarino, & Cohen, 2007

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Redefining the Relationship

- Encourage new relationships
  - Not disrespectful to the deceased
- Continue parts of the relationship with the deceased
  - Memories
  - Teachings, lessons learned
  - Activities you enjoyed
  - How to make deceased part of future events
  - Negative parts of the relationship are not there now

Saunders, B.E. (2010)

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Caveats about ESTs

- ESTs do not work every time for everyone
  - Not everyone gets better
  - A few get worse
  - They do not work for every problem.
- ESTs do not exist yet for all the mental health problems and needs children and families might have.
- Evidence-based algorithms are not yet established for multi-problem children and families
  - Sequencing of ESTs
  - Pros/cons of components based approaches

Saunders, B.E. (2010)

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Responsibilities of Practitioners

- ✳ Practitioners have a duty to be familiar with available interventions and their supporting literature.
- ✳ Practitioners have a duty to be trained, knowledgeable, and skilled in the use of proven interventions.
- ✳ If they are not, they have a duty to refer clients to practitioners who are.
- ✳ When they exist, practitioners should use proven interventions with appropriate clients as their first-line practice.
- ✳ A clinical decision to use an alternative, unsupported approach when a empirically supported intervention exists must be considered an ethical issue.
- ✳ Practitioners should refrain from using experimental or potentially dangerous interventions.

SAUNDERS, B.E. (2009)

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Responsibilities of Brokers of Mental Health Services

Because they take actions based upon treatment progress and outcome:

- Brokers have a responsibility to be <u>reasonably</u> familiar with the evidence-based mental health interventions that are appropriate for the problems their clients often have.

- Brokers have a duty to obtain appropriate, evidence-based treatments for their clients from providers who are trained, knowledgeable, and skilled in their use.

- Brokers have a responsibility to know what types of treatment their clients are getting and to monitor client progress on treatment goals. SAUNDERS, B.E. (2009) 94

Module 8:

Targeting Challenging Behaviors with Adolescents

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Working with Adolescents

- <u>Participant Activity</u>: Trip Down Memory Lane

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Go back to your own adolescence. Try to recall what it felt like to be 14, 15, or 16. Try to bring up the feelings and images of yourself as a teen. What images and memories readily come up for you when I say "think about your own adolescence?" Think of a time when you felt....

- a part of something great
- excluded
- like you disappointed your family
- Like your family disappointed you
- proud/accomplished something meaningful
- Alone /Depressed / Anxious /Happy

What made things especially difficult for you as a teen? (e.g., peers, school, parents, siblings?)

How does this apply to our work?

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BEHAVIORAL ANALYSIS

- Identify (trauma) triggers, behaviors and consequences

- Identify places where coping skills/behavior interventions can be used

- Opportunity for behavioral rehearsal

- Weave psychoeducation throughout

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CHAIN ANALYSIS OF PROBLEM BEHAVIOR

WHAT exactly is the PROBLEM BEHAVIOR?

What **PROMPTING EVENT** started the client on the chain to the problem behavior?

What things in the client and the environment made him/her **VULNERABLE?**

WHAT exactly were the CONSEQUENCES in the environment?

⇩   ⇩

| **Immediate** | **Delayed** |

Adapted from Akron Children's Partial Hospitalization Program
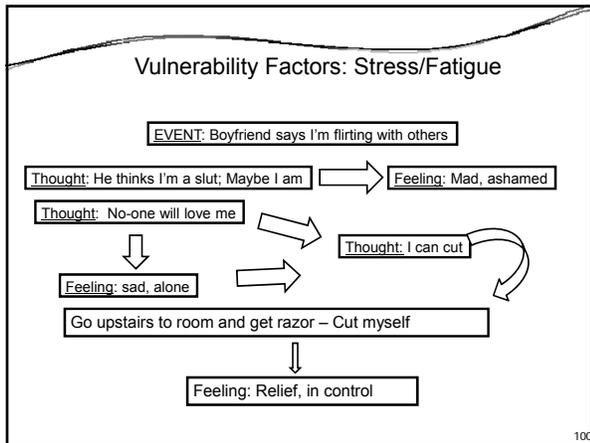
99

Vulnerability Factors: Stress/Fatigue

EVENT: Boyfriend says I'm flirting with others

Thought: He thinks I'm a slut; Maybe I am → Feeling: Mad, ashamed

Thought: No-one will love me

Feeling: sad, alone → Thought: I can cut

Go upstairs to room and get razor – Cut myself

Feeling: Relief, in control

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Vulnerability Factors

- Physical Illness
  - Chronic pain, PMS, allergies
- Drugs and Alcohol
- Sleep
  - Falling asleep, waking up, nightmares
- Nutrition
  - Caffeine, sugar, vitamins, energy
- Exercise
  - Buffers stress
- Stressful Events

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What Could You Do Next Time

- Mindfulness
- Distraction
  - Use your senses
    - Music
    - Journaling
    - Sports
    - Aromatherapy
- Assertive communication
- Cognitive coping
- Buffer stress
- Create joy
  - Build positive experiences in life
- Distress Tolerance

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Working with Adolescents (cont'd)

- Distress Tolerance
- Sense of Identity/Self-competency
  - Asking adolescent to define him/herself
  - Working with them to develop sense of themselves
  - Use this info to compare/contrast how current behaviors don't match with their described 'sense of self'
  - Worry or Anger Tree Activity

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Jimmy

- Jimmy is a 14 year old being evaluated at the juvenile detention center (he was recently arrested for striking a teacher at school). During the evaluation he describes having a fight with his mother. He says that she "choked him" and "beat him" three days ago. You do not observe any bruises on the child. What would you do, if anything:

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Jimmy

- Talk to the child to get more information   Y or N
- Inform the child's parent(s)   Y or N
- Talk to (consult with?) a colleague   Y or N
- Make a report to law enforcement
- Make a report to Child Protective Services   Y or N
- Refer the child for abuse-focused treatment   Y or N
- Encourage Jimmy to talk to his parents   Y or N

Y or N

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Robin

- Robin is a 14 year old in counseling for depression. Her mother recently read a message she had posted on Facebook talking about her new "cool" 25 year old boyfriend.
- What would you do, if anything

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Robin

- Talk to the child to get more information	Y or N
- Inform the child's parent(s)	Y or N
- Talk to (consult with?) a colleague	Y or N
- Make a report to law enforcement	
- Make a report to Child Protective Services	Y or N
- Refer the child for abuse-focused treatment	Y or N
- Encourage Robin to talk to her parents	Y or N
- Nothing – she seems happier	Y or N

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Sara

- Sara is a 15 year old student at your school. She comes to your office and asks if she can talk to you privately. She proceeds to tell you that she thinks her boyfriend is being physically abused by his father. Sara tells you that her boyfriend has told her that his dad can get 'really angry,' and that sometimes he takes his anger out on him.
- Sara admits that she's kind of scared of her boyfriend's father and that they spend most of their time at her house. Sara swore to her boyfriend she would not tell anyone. What would you do, if anything?

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Sara

- Talk to Sara's boyfriend to get more information
- Inform the boyfriend's child's parent(s)
- Talk to (consult with?) a colleague
- Make a report to law enforcement
- Make a report to Child Protective Services
- Refer the boyfriend for abuse-focused treatment
- Encourage Sara's boyfriend to talk to his parents
- Nothing – you have to keep Sara's promise

Y or N
Y or N
Y or N
Y or N
Y or N
Y or N
Y or N
Y or N
Y or N

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Module 9:

Cultural Considerations for Trauma-Focused Interventions

Michael de Arellano, Ph.D

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Trauma and Ethnic Minorities

- Research suggests ethnic minorities are:
  - More likely to experience potentially traumatic events
  - More likely to have emotional and behavioral problems related to trauma
  - Less likely to access mental health services

  - DHHS, 2001

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Cultural Sensitivity and Competence

- Essential to understand family's values related to religion, ethnicity, and culture
- Previous treatment outcome studies - successful treatment for diverse ethnic and racial populations
  - (Cohen & Mannarino; Deblinger et al.)

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Evidence-Based Treatments and Ethnic Minority Populations

- One review found evidence-based treatments to be as effective for ethnic minority participants as Caucasians (Huey & Palo, 2008)

- Another review found cultural modifications helped to enhance efficacy and engagement (Grimer, 2006)

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Flexibility of TF-CBT

- Allows for the integration of cultural beliefs and practices into treatment
- Can change rationale, exercises, examples, etc. to be more culturally relevant
- Need to keep in mind the function/purpose of the intervention

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Culturally Modified Trauma Focused Cognitive Behavior Therapy (CM-TF-CBT)

- **Developed for Latino children and families**
- **Modification of TF-CBT**
- **Based on:**
  - **Over 10 years clinical work with Mexican and Mexican American families**
  - **Research (Literature and our studies – Focus groups, HFS, COPE)**
  - **Theoretical Literature (Psychology, Sociology, Anthropology)**
- **Further developed with NCTSN sites**

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Culturally Modified Assessment and Treatment

- Broader range of traumatic events
- Immigration/Migration history
- Preferred language
- Views of mental health and mental health treatment
- Child rearing practices

- Cultural constructs
  - Gender roles
  - Spirituality
  - Traditional healing
  - Views of Interpersonal Relationships
  - Views of Family
  - Acculturation & Acculturative Stress

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Tailoring Treatment to be more Culturally Relevant

- Assess, not assume, cultural beliefs and practices (heterogeneity)
- Use both formal and informal assessment
- Assess the child and family members
  - Be alert to discrepancies
- Assess child and family's views of what is important to address
- Integrate throughout treatment
- Maintain treatment fidelity

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Incorporating Spirituality/Religion

- Spirituality and psychoeducation
  - If family believes they do not need treatment because God will provide, can discuss:
    - God helps those who help themselves.
    - Perhaps coming to this clinic is how God is providing.
- Spirituality and relaxation
  - Use prayer as a relaxation exercise
  - Use rosary as prayer/meditation
- Spirituality and cognitive coping
  - Positive self-statements

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Incorporating Spirituality/Religion

- **If virginity is an issue in a CSA case**
  - Virginity is something that can not be taken, it can only be given
  - May need to bring in an expert or authority
- **Spirituality and trauma narrative**
  - Praying for strength at the beginning of the session.
  - Giving your problems up to God.
  - Assess for cognitions associated with guilt/punishment

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Extended Family and other Family Issues

- **Assess others that are involved in the child's life** (both direct and indirect influences).
- **Involve other family members in treatment** (consider extended family)
- **Be attentive to reluctance to discuss "family business" outside of the family.**
- **Emphasize the needs of the child when they seem to conflict with the needs of the family.**
- **Involve other family members in safety planning and termination.**

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Tailoring Psychoeducation

- **Information specific about group**
  - **Prevalence, consequences, treatment**
- **General mental health and therapy**
  - **Family may have limited familiarity**
  - **May need a more comprehensive description**
  - **What is a Therapist? What is therapy? How long does it last? Are parents involved?**
  - **Information about current treatment approach**
    - **Rationale, course, roles and responsibilities**
- **Be very clear about expectations**

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Tailoring Parenting – Incorporating Views on Child Rearing

- **Respect toward parents**
  - **Focus on increasing respect rather than compliance**
- **If parents are reluctant to praise children or bribe (reinforce) for wanted behaviors, then consider framing the goal of the intervention is to increase *respect*, rather than increase *compliance* (McCabe 2004)**

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Cultural Modifications to Cognitive Coping

- Use of Worry Dolls (Guatemalan)
  - Prescribed worry time
  - Give each one of the dolls one of your worries and let her carry it for you.

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Cultural Modifications to the Trauma Narrative

- **Present a culturally relevant rationale**
  - **Use appropriate examples**
  - **Stories/vignettes that children can relate to**
  - **Use of Music**
- **Address potential barriers**
  - **Conservative beliefs about sex**
  - **Not sharing "family business" outside family**

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Cultural Modifications to the Trauma Narrative - Child

- Help identify unhelpful thoughts that may be culture related:
  - No longer a virgin.
  - Gender roles
  - Responsibility for negative impact on the family
  - Belief that 'this' happened to me as a punishment.

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Cultural Modifications to the 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.

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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

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Overall Strategy

- Be creative.
- Be willing to go outside your comfort zone.
- Don't give up; takes practice

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Module 10:

Vicarious Trauma

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Vicarious Trauma - AKA

- Burnout
- Vicarious trauma
- Compassion Stress
- Compassion fatigue
- Traumatic Counter-transference

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Secondary Traumatization

- Risk factors
  - high caseload
  - poor supervision
  - negative "in session response"
    - inattention/dissociation
    - lack of empathy
    - feeling powerless
  - poor response from/frustration with others

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Activity

- Write down 3 *difficult* aspects about your work
- Silently walk around the room and exchange cards

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Large Group Report Out

- What are the most difficult aspects of working with trauma victims?
- Are there differences in working with adult vs. child clients?
- Are there differences depending on type of trauma?

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Activity Part 2

- Write down 3 *rewarding* aspects about your work
- Silently walk around the room and exchange cards

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Positive Aspects of Working With Trauma Victims

- Positive aspects:
  - observing client resilience
  - personal growth
  - collegial support
  - sense of importance of services provided

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Large Group Report Out

- What are the positive aspects of working with trauma victims?
- Do these vary with type of client or type of trauma?

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Coping Strategies

- What are some of the ways you cope with secondary trauma?
- How do you manage your work with trauma victims?
- Does this vary with type of client? Type of trauma?

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Coping Strategies

- Seeking support from others
- Seeking regular supervision and consultation
- Maintaining an appropriate balance between personal and professional lives
- Diet and exercise
- Engaging in spiritual activities
- Making a decision to seek therapy if needed

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References & Sites for Further Info

- McCann, I.L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131-149.
- Salston, M, & Figley, C.R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16(2),* 167-174.
- Schauben, L.J., & Frazier, P.A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19,* 49-64.
- Saakvitne, K.W., Pearlman, L.A., & the Staff of the Traumatic Stress Institute (1996). Transforming the pain: A workbook on vicarious traumatization. New York: W.W. Norton.

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Maya Angelou:

"The world is changed one child at a time"

Thank you for all you do for traumatized children!

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Resources

- SAMHSA's National Center for Trauma-Informed Care
  - www.samhsa.gov/nctic
- SAMHSA's National Registry of Evidence-based Programs and Practices
  - http://www.nrepp.samhsa.gov/
- Association for Behavioral and Cognitive Therapies (ABCT) – Evidence-based mental health treatment for children and families
  - http://www.abct.org/sccap/

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