Trauma-Informed Evidenced Based Practice and Overview of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

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Child Welfare Training
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http://www.kempe.org/traumaclinic

Activities

- Clinical Services for abused and neglected children and families
- Training clinicians and professionals in evidence-based practices
- Research
- Cultural competence and partnering with the community, including youth and families
- Public policy consultation
### Mission of the NCTSN (www.nctsn.org)

| To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States. |

- Spread Evidence-Based Treatments for abused and traumatized children and their families
- Promote effective approaches to:  
  - Dissemination and awareness building of EBTs  
  - Adoption of EBTs by MH service delivery systems  
  - Training in EBTs to thresholds of clinical competency  
  - Systematic implementation of EBTs in MH service delivery systems  
  - Sustained use of EBTs over time by MH service delivery systems
Acknowledgments

- Judith Cohen, M.D. & Tony Mannarino, Ph.D., Center for Traumatic Stress in Children & Adolescents, Allegheny General Hospital
- Esther Deblinger, Ph.D., New Jersey CARES Institute, UMDNJ - School of Osteopathic Medicine

- Project BEST in South Carolina (www.musc.edu/projectbest)
  - Benjamin Saunders, Ph.D., MUSC – National Crime Victims Research and Treatment Center
  - Libby Ralston, Ph.D., Dee Norton Low Country Children’s Center
- Project FOCUS
  - Shannon Dorsey, Ph.D. University of Washington
Training Objectives

• Role and Impact of trauma
  – Safety, Stabilization/Permanency, Well-being

• Prioritizing Treatment needs (focus on treating the trauma experience or not?)

• Role and importance of trauma screening and assessment on treatment planning and case management
  – When do we need a full diagnostic battery
  – When is specialized trauma-focused treatment needed?
Child Welfare Trauma Training Toolkit: Creating Trauma-Informed Child Welfare Practice

• Educate child welfare professionals about the impact of trauma on the development and behavior of children.
• Educate child welfare professionals about when and how to intervene directly in a trauma-sensitive manner and through strategic referrals.
• Assure that all children in the child welfare system will have access to timely, quality, and effective trauma-focused interventions and a case planning process that supports resilience in long-term healing and recovery.
Child Welfare Priorities-U.S.

• Assist child welfare workers in achieving the Child and Family Services Review (CFSR) goals of ensuring that all children involved in the nation’s child welfare system achieve a sense of:
  – Safety
  – Permanency
  – Well-being
The trauma-informed child welfare worker:

- Understands the impact of trauma on a child’s behavior, development, relationships, and survival strategies
- Can integrate that understanding into planning for the child and family
- Understands his or her role in responding to child traumatic stress
Essential Elements of Trauma-Informed Child Welfare Practice

1. Maximize the child’s sense of safety.
3. Help children make new meaning of their trauma history and current experiences.
4. Address the impact of trauma and subsequent changes in the child’s behavior, development, and relationships.
5. Coordinate services with other agencies.
Essential Elements of Trauma-Informed Child Welfare Practice

6. Utilize comprehensive assessment of the child’s trauma experiences and their impact on the child’s development and behavior to guide services.
7. Support and promote positive and stable relationships in the life of the child.
8. Provide support and guidance to child’s family and caregivers.
9. Manage professional and personal stress.
Types of Childhood Trauma

- Child abuse
  - Physical
  - Sexual
  - Emotional
  - Neglect
- Victim/Witness of Violence
  - Domestic
  - Community
  - School
- Accidents (e.g., motor vehicle)
- Disasters
- War/Terrorism and Refugee
- Medical (e.g., diagnosis, invasive medical procedures)
- Traumatic Grief
Rates of Trauma Exposure

- 9-16 years olds in Western North Carolina
  - 25% at least one potentially traumatic event; 6% within past 3 months
    \[(Costello, Erkanli, Fairbank, & Angold, 2008)\]

- Lifetime prevalence in 12- to 17-year-olds
  - 8% sexual assault
  - 17% physical assault
  - 39% witness violence
    \[(Kilpatrick, Saunders, & Resnick, 1998)\]

- Lifetime victimization in 2-17 year olds
  - 80% reported at least 1 lifetime victimization (69.3% in last yr)
  - Multiple types of victimization is common
  - Mean number of victimizations = 3.7
    \[(Finkelhor, Ormrod, & Turner, 2009)\]

- Urban students
  - High rates of exposure to community violence
    \[(Bell & Jenkins, 1993; Schwab-Stone et al., 1995; Singer et al., 1995)\]
Childhood Trauma Exposure in Prevalent and has a Serious Mental Health Impact

Abuse and trauma exposure in childhood is associated with:

- **Anxiety disorders** (PTSD, social phobia, generalized anxiety disorder)
- **Affective disorders** (major depression)
- **Sexual disorders** (dysparunia, vaginismus, inhibited sexual desire)
- **Substance use/abuse/dependence** (drug, alcohol, tobacco)
- **Delinquency and criminal behavior**
- **Violent behavior** (peer aggression, dating violence, spouse/partner violence)
- **Other problems** (future victimization, self-esteem, guilt, shame, self-blame, relationship difficulties, academic performance, occupational achievement)
- **Comorbid problems**

Adapted from Saunders, 2008
Trauma Impact

- Acute distress almost universal
- Impact can be long lasting
  - Affective trauma symptoms
  - Behavioral trauma symptoms
  - Cognitive trauma symptoms
- Childhood trauma is risk factor for adult problems
- Impact varies; most recover over time with/without treatment

**Continuum**

Resilience ← Complex Trauma
Common Diagnoses

- PTSD
- Depressive disorders
- Other Anxiety disorders
- Comorbidity is common
  - ADHD
  - Oppositional Defiant Disorder
  - Substance Use Disorders
Post Traumatic Stress disorder (DSM-IV)

**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

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

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

- Community lifetime rates: 1-14%
  - Higher rates for at-risk individuals (combat veterans, victims of crime; up to 58%)
- Symptoms usually appear in the 1st 3 months following trauma; can be delayed onset
- Duration of symptoms varies, complete recovery occurs within 3 months for ½ cases
- <20% with exposure have a psychiatric disorder
- Resiliency is normative

PTSD: All traumatic events are not created equal...
Some individuals are at greater risk than others...
Complex PTSD

- Defining features:
  - Affective dysregulation
  - Interpersonal difficulties
  - Self-esteem issues
  - Self-injurious behaviors

- Our TX studies have included some youth with complex PTSD; many have had at least one defining feature
PTSD in Infants and Young Children

- **Infants**
  - Physiological symptoms, high levels of distress

- **Toddlers/Preschoolers**
  - Loss of previously acquired developmental skills, such as toileting/language
  - New onset of aggression or separation anxiety
  - New onset of fears that are not obviously related to the traumatic event (e.g., going to the bathroom alone, the dark)
  - Parental reactions may inadvertently reinforce children’s trauma-related fears

Scheeringa, 2008
• Inattention
• Dysregulation and irritability
• Behavior problems
• Physiological symptoms

These symptoms can be PTSD....or almost any other childhood disorder....
• 75% of youth in foster care: some form of abuse and/or neglect
• Approximately 90% have witnessed violence
• Often multiply traumatized, even when compared to other child-welfare involved youth

Stein et al., 2001; U.S. Department of Health and Human Services, 1998
Data are from the National Center for Child Traumatic Stress Core Data Set (2006)
What services do kids and families need?

- Good screening to identify problems, strengths, and needs
- Interventions for victimization-related mental health problems.
  - PTSD, fear, anxiety
  - Depression
  - Behavioral difficulties
  - Aggression
  - Guilt, shame, stigmatization, difficulty with trust
- Effective treatments to prevent the development of future problems.
  - Substance use/abuse/dependence
  - Physically or sexually aggressive behavior
  - Delinquency, criminal behavior
  - Sexual disorders
  - Relationship difficulties
Good News! 20 years of Research
Effective Treatments Have Been Developed, Tested, and Are Ready for Implementation

- **Trauma-Focused Cognitive-Behavioral Therapy** – TF-CBT
- Parent Child Interaction Therapy – PCIT
- Alternatives for Families Cognitive Behavioral Therapy – AF-CBT
- Cognitive Processing Therapy – CPT
- Child-Parent Psychotherapy – CPP
- Project SafeCare
- The Incredible Years (TIY) series
- Other Parent Management Training (PMT) models
- CBT for Children with Sexual Behavior Problems
- Functional Family Therapy
- Dialectic Behavior Therapy (DBT)
- Multi-Dimensional Treatment Foster Care
- Multisystemic Therapy (MST)

Adapted from Saunders, 2008
Evidence Based Practice/Products

How has an EBT affected your life today?
- Brush teeth?
- Take Medication?
- Wear seatbelt? Use child car seat?
- Take a vitamin?
- Exercise? Wear helmet biking?
What is EBP?

• **Evidence Based Practice (EBP)** is the use of systematic decision-making processes or provision of services which have been shown, through available scientific evidence, to consistently improve measurable client outcomes. Instead of tradition, gut reaction or single observations as the basis for making decisions, EBP relies on data collected through experimental research and accounts for individual client characteristics and clinician expertise.

http://depts.washington.edu/ebpi/

• **Mental Health Field**
  - EBPs = treatments or interventions which are effective—aka, they have scientific findings to demonstrate their effectiveness or efficacy in improving client outcomes.
What is Evidence-Based Treatment?

- Sound theoretical basis
- Clinical literature regarding efficacy
- Accepted in clinical practice
- No evidence of substantial harm or risk
- Manual sufficiently detailed to allow replication
- Efficacy based on at least 2 randomized, controlled trials (TF-CBT has 6)
- Majority of outcome studies support efficacy
Large Gap Between Scientific Knowledge and Front-line Practice

Knowledge ➔ Practice

Goal… reduce this gap.

17 years
Why Have These EST’s Not Spread Widely in the U.S.?

- **Tradition in the field and acculturation of practitioners**
  - View of mental health treatment as primarily an *art* vs. a *science*.
  - “Eclectic” approach—pick & choose treatment techniques based upon interest.
  - Prior graduate school training—lack of EST.
  - Empirical support has not traditionally been a criteria practitioners use in treatment selection.
  - Primary reliance on previous training and clinical experience rather than new scientific breakthroughs for treatment selection.
  - Resistance to the notion of structured treatment protocols or standardized procedures.
  - Lack of accountability for outcomes. Payment for time spent talking rather than outcomes achieved.

- **Poor connection between research and practice**

- **Lack of demand for EST’s by consumers and payors...until now**
Current Situation in Iceland?

• How many children receive services?
  • _____ of maltreated youth who need mental health services actually receive services?
  • How many receive EBTs?

• Do mental health service agencies and providers
  – know about and use proven treatment approaches?
  – Implement evidence-based treatment planning and monitoring by brokers of mental health services?

• Increasing demand for use of effective treatments by consumers, payers, policymakers, and professionals.
Mental Health Needs of Youth in Foster Care-U.S.

- 1 in 2 youth in foster care have serious mental health problems
- Majority of youth placed in foster care are not receiving the mental health services they need
  - Not receiving services or...
  - Not receiving effective services
- Untreated difficulties may result in disrupted placements
## NCTSN Data on Primary Treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>% All Youth (N = 863)</th>
<th>% Foster Care (N = 104)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TF-CBT</td>
<td>38.5</td>
<td>21.2*</td>
</tr>
<tr>
<td>PCIT</td>
<td>5.3</td>
<td>6.7</td>
</tr>
<tr>
<td>CBT (other than TF)</td>
<td>11.4</td>
<td>12.5</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>4.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Play Therapy</td>
<td>2.1</td>
<td>6.7*</td>
</tr>
<tr>
<td>Other</td>
<td>6.4</td>
<td>20.2*</td>
</tr>
</tbody>
</table>
What do These Findings Tell Us?

• One of the best interventions for youth with behavioral difficulties and trauma is TF-CBT
  – Youth in FC may be receiving at a lower rate
• Receiving other treatments at a similar rate, even ones that include the caregiver (PCIT, Family Therapy)
• Therapists indicated ‘other’ at 4 times the rate of that for youth not in foster care
  – Often unclear how to best proceed with youth in foster care
    • Multiply traumatized
    • Multiple presenting problems
How do trauma-exposed children in your system get identified and connected with effective mental health treatment services, when needed?
Your Community System

**Point A**

Child Enters your agency

**Point Z**

Child Recovers
Family satisfied

How do you get from Point A to Z?
How do you get from Point A to Z?

- Child Enters your agency
- Trauma Screening
- Prioritize Treatment Needs
- Eligible for EBP?
- Referral to EBP?
- Engagement in EBP?
- Symptom Remission?
- Child Recovers
- Family satisfied
Community Mission-Universal

To ensure that all abused and traumatized children and their families in every community receive appropriate, evidence supported mental health assessment and treatment services.
How do we know what treatments work?

How can we sort out the good from the poor or even harmful interventions?
Questions to ask of any treatment

- **Is it based on a solid conceptual and theoretical framework?**
  - Is the theory upon which it is based widely accepted?
  - Does it make sense?

- **How well is it supported by practice experience?**

- **Does it have an acceptable benefit vs. risk for harm ratio?**

- **Can it be used effectively by community clinicians?**
  - Are books, practice manuals, and procedure descriptions available?
  - Is training, supervision, and consultation available?
  - Is there any reason the practice cannot be used with your clients?

- **How well is it supported by scientific research?**
  - How many evaluations have been conducted?
  - How rigorous were the research designs?
  - How strong are the results?

Saunders
Bridging the Gap
YOU are the necessary “cog” in the wheel

You
Effective Services
Youth
Responsibilities of Mental Health Practitioners

- Mental health practitioners have a duty to:
  - be reasonably familiar with available interventions and their supporting literature.
  - be trained, knowledgeable, and skilled in the use of proven interventions.
  - use proven interventions with appropriate clients as their first-line practice.
What is a Broker?

- Professionals, agencies and community leaders who refer abused children and their families to mental health service and monitor and track that they receive appropriate services

- Child protective services
- Foster care agencies
- Guardian ad litems
- Law enforcement
- Schools
- Judicial system
- Victim advocates
- Mentors
Responsibilities of Brokers of Mental Health Services

1. Identify children and family needs and decide if their clients need to be referred for mental health services.
2. Select mental health treatment providers to refer their clients to.
4. Take action concerning their clients based on the outcomes of treatment.
Responsibilities of Brokers

Because they take actions based upon treatment progress and outcome, brokers have a responsibility to:

• Be reasonably familiar with the evidence-based mental health interventions that are appropriate for the problems their clients often have.

• Be reasonably familiar with commonly used interventions that have little or no evidence for their effectiveness 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.
Responsibilities of Brokers

Because they take actions based upon treatment progress and outcome, brokers have a responsibility to:

- Know what types of treatment their clients are getting and to monitor client progress on treatment goals.
- Question mental health practitioners about the nature of the treatment they are providing.
- Know how outcomes are being measured by the practitioners they refer to.
Challenges Often Faced in Community and Child Welfare System
Community Treatment Plan

Project BEST [www.musc.edu/Project best]

- NOP Therapist
- Offender Therapist
- Physician
- DSS
- School IEP
- GAL
- Child Therapist
- DJJ
- MDT
- CAC

EBTP
Competing Treatment Plans

Project BEST [www.musc.edu/Project best]

- NOP Therapist
- Offender Therapist
- Physician/Nurse
- School IEP
- Child Victim
- Child Therapist
- DSS
- GAL
- DJJ
<table>
<thead>
<tr>
<th>Steps in Evidence-Based Treatment Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess</strong></td>
</tr>
<tr>
<td><strong>Integrate</strong></td>
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<tr>
<td><strong>S-N-P</strong></td>
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<tr>
<td><strong>Goals</strong></td>
</tr>
<tr>
<td><strong>Match</strong></td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
</tr>
<tr>
<td><strong>Monitor</strong></td>
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</tbody>
</table>
Assessment of a Child’s Trauma Experiences

Child Welfare Trauma Training Toolkit

www.nctsn.org


Artwork courtesy of the International Child Art Foundation (www.icaf.org)
The Importance of Trauma Assessment

- Not all children who have experienced trauma need trauma-specific intervention.
- Some children have amazing natural resilience and are able to use their natural support systems to integrate their traumatic experience.
- Ideally, children should be in a stable placement when receiving trauma-informed treatment. However, children should *always* be referred for necessary treatment regardless of their placement status.
• Unfortunately, many children in the child welfare system lack natural support systems and need the help of trauma-informed care. Some may meet the clinical criteria for a diagnosis of PTSD.

• Many children who do not meet the full criteria for PTSD still suffer significant posttraumatic symptoms that can have a dramatic adverse impact on behavior, judgment, educational performance, and ability to connect with caregivers.

• These children need a comprehensive trauma assessment to determine which intervention will be most beneficial.
The Importance of Trauma Assessment, cont'd

• Trauma assessment typically involves conducting a thorough trauma history.
  – Identify all forms of traumatic events experienced directly or witnessed by the child to determine the best type of treatment for that specific child.

• Supplement trauma history with trauma-specific standardized clinical measures to assist in identifying the types and severity of symptoms the child is experiencing.
What Does Trauma-Informed Assessment and Treatment Look Like?

- There are ESTs that are appropriate for many children and that share many core components of trauma-informed treatments.

- Unfortunately, many therapists who treat traumatized children lack any specialized knowledge or training on trauma and its treatment.

- When a child welfare worker has a choice of providers, he or she should select the therapist who is most familiar with the available evidence and has the best training to evaluate and treat the child’s symptoms.
Examples of Trauma Assessment Measures

- UCLA PTSD Index for DSM-IV
- Trauma Symptom Checklist for Children (TSCC)
- Trauma Symptom Checklist for Young Children (TSCYC)
- Child Sexual Behavior Inventory
• Information about *trauma exposure* and *PTSD symptoms*
• Youth (ages 7-18) and Parent versions
• Yes/no response for 13 trauma exposure questions
• 5 point scale (‘none’ to ‘most’) – child reports how much time he/she has experienced problem in past month
  – Re-experiencing, Avoidance, Increased Arousal
• Answering a specified # of items at a level of 2 or higher indicates whether child meets PTSD symptom criteria
• **Score of > 38 is associated with ↑ likelihood of having PTSD**
## UCLA PTSD Index for DSM IV (Child Version, Revision 1)

Below is a list of VERY SCARY, DANGEROUS OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences, some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

### FOR EACH QUESTION:
- Check "Yes" if this scary thing HAPPENED TO YOU
- Check "No" if it DID NOT HAPPEN TO YOU

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Being in a big earthquake that badly damaged the building you were in.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Being in another kind of disaster, like a fire, tornado, flood or hurricane.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3) Being in a bad accident, like a very serious car accident.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>4) Being in place where a war was going on around you.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>5) Being hit, punched, or kicked very hard at home. (DO NOT INCLUDE ordinary fights between brothers &amp; sisters).</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>6) Seeing a family member being hit, punched or kicked very hard at home. (DO NOT INCLUDE ordinary fights between brothers &amp; sisters).</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>7) Being beaten up, shot at or threatened to be hurt badly in your town.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>8) Seeing someone in your town being beaten up, shot at or killed.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9) Seeing a dead body in your town (do not include funerals).</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>10) Having an adult or someone much older touch your private sexual body parts when you did not want them to.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>11) Hearing about the violent death or serious injury of a loved one.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>12) Having painful and scary medical treatment in a hospital when you were very sick or badly injured.</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
Assessing Lifetime Trauma History with the UCLA PTSD-RI (Items 13,14)

13) **OTHER** than the situations described above, has ANYTHING ELSE ever happened to you that was **REALLY SCARY, DANGEROUS OR VIOLENT**?  
Yes [ ]  No [☑]  

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank. # ____________  

b) If you answered "YES" to **MORE THAN ONE THING**, place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank. # ____________  

   3  

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? **4 Months Ago**  
d) Please write what happened: **Bad Car Accident**  


**PTSD CRITERION A1/A2 (15-27)**

FOR THE NEXT QUESTIONS, please CHECK [YES] or [NO] to answer **HOW YOU FELT** during or right after the bad thing happened that you just wrote about in Question 14.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes ✓</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15) Were you scared that you would die?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>16) Were you scared that you would be hurt badly?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>17) Were you hurt badly?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>18) Were you scared that someone else would die?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>19) Were you scared that someone else would be hurt badly?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>20) Was someone else hurt badly?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>21) Did someone die?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>22) Did you feel very scared, like this was one of your most scary experiences ever?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>23) Did you feel that you could not stop what was happening or that you needed someone to help?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>24) Did you feel that what you saw was disgusting or gross?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>25) Did you run around or act like you were very upset?</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>26) Did you feel very confused?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HOW MUCH OF THE TIME DURING THE PAST MONTH</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>D4</td>
<td>I watch out for danger or things that I am afraid of.</td>
</tr>
<tr>
<td>2</td>
<td>B4</td>
<td>When something reminds me of what happened, I get very upset, afraid or sad.</td>
</tr>
<tr>
<td>3</td>
<td>B1</td>
<td>I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.</td>
</tr>
<tr>
<td>4</td>
<td>D2</td>
<td>I feel grouchy, angry or mad.</td>
</tr>
<tr>
<td>5</td>
<td>B2</td>
<td>I have dreams about what happened or other bad dreams.</td>
</tr>
<tr>
<td>6</td>
<td>B3</td>
<td>I feel like I am back at the time when the bad thing happened, living through it again.</td>
</tr>
<tr>
<td>7</td>
<td>C4</td>
<td>I feel like staying by myself and not being with my friends.</td>
</tr>
<tr>
<td>8</td>
<td>C5</td>
<td>I feel alone inside and not close to other people.</td>
</tr>
<tr>
<td>9</td>
<td>C1</td>
<td>I try not to talk about, think about, or have feelings about what happened.</td>
</tr>
<tr>
<td>10</td>
<td>C6</td>
<td>I have trouble feeling happiness or love.</td>
</tr>
<tr>
<td>11</td>
<td>C6</td>
<td>I have trouble feeling sadness or anger.</td>
</tr>
<tr>
<td>12</td>
<td>D5</td>
<td>I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.</td>
</tr>
<tr>
<td>13</td>
<td>D1</td>
<td>I have trouble going to sleep or I wake up often during the night</td>
</tr>
</tbody>
</table>
Overview: Why utilize comprehensive assessment?

- Trauma-specific standardized assessments can identify potential risk behaviors (i.e. danger to self, danger to others) and help determine interventions that will reduce risk.

- Thorough assessment can identify a child’s reactions and how his or her behaviors are connected to the traumatic experience.

- Assessment results provide valuable information for developing treatment goals with measurable objectives designed to reduce the negative effects of trauma.

- Assessment results also can be used to determine the need for referral to trauma-specific mental health care or more detailed trauma assessment.
Core Components of Trauma-Informed, Evidence-Based Treatment

- Building a strong therapeutic relationship
- Psychoeducation about normal responses to trauma
- Parent support, conjoint therapy, or parent training
- Emotional expression and regulation skills
- Anxiety management and relaxation skills
- Cognitive processing or reframing
Core Components of Trauma-Informed, Evidence-Based Treatment, cont'd

- Construction of a coherent trauma narrative
- Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child’s experience
- Personal safety training and other important empowerment activities
- Resilience and closure
Questions to Ask Therapists/ Agencies That Provide Services

• Do you provide trauma-specific or trauma-informed therapy? If so, how do you determine if the child needs a trauma-specific therapy?

• How familiar are you with evidence-based treatment models designed and tested for treatment of child trauma-related symptoms?

• How do you approach therapy with traumatized children and their families (regardless of whether they indicate or request trauma-informed treatment)?

• Describe a typical course of therapy (e.g., can you describe the core components of your treatment approach?).
Examples of Evidence-Based Treatments

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)
- Child-Parent Psychotherapy (CPP)

There are many different evidence-based trauma-focused treatments. A trauma-informed mental health professional should be able to determine which treatment is most appropriate for a given case.
How do I become “reasonably knowledgeable” about EBP/ESTs?

• Continuing Education/Training
• Use of Web-based resources
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
www.cachildwelfareclearinghouse.org

- Built upon the OVC Guidelines Project
- Revised the ranking criteria
- Examined programs related to child welfare

CEBC Scientific Rating Scale

Chadwick Center for Children and Families, Rady Children’s Hospital San Diego
Example of EBT for Child Trauma....

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma Focused
Cognitive-Behavioral Therapy

- Evidence-based
- Evidence supported
- Conjoint child and parent psychotherapy model
- For children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events.
- Used with a range of traumatic events
- Effective with children age 3 to 18 years
- Components-based treatment protocol
- Time limited, structured approach
- Usually completed within 12-20 sessions
**Components of TF-CBT PRACTICE**

<table>
<thead>
<tr>
<th>P</th>
<th>Psychoeducation and Parenting skills</th>
</tr>
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<tbody>
<tr>
<td>R</td>
<td>Relaxation</td>
</tr>
<tr>
<td>A</td>
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<tr>
<td>C</td>
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<tr>
<td>C</td>
<td>Conjoint child-parent sessions</td>
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<tr>
<td>E</td>
<td>Enhancing future safety and development</td>
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</tbody>
</table>
TF-CBT

- Strong empirical support for efficacy.
  - Multiple randomized controlled trials supporting its efficacy
  - Systematic review supporting efficacy
  - 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.

- High demand for TF-CBT training.
Effectiveness of TF-CBT

- Randomized clinical trial (2004) comparing TF-CBT to Child Centered Therapy (CCT)

- Sample included 8 to 14 year old sexually abused children and a non-offending parent

- TF-CBT demonstrated highly effective treatment outcomes – more effective than standard of care (CCT)
  - Rate of PTSD diagnoses declined
  - Child depression, behavior problems, shame, and abuse-related attributions improved
  - Parent depression, abuse-specific distress, support for child, and parenting practices improved
Who is Involved in Treatment?

- Children, siblings, and caregivers
- Caregivers = any adult who has a significant caregiving role in the child’s life
  - Biological parents
  - Foster parents
  - Adoptive parents
  - Relatives offering Kinship Care
  - Case Workers
TF-CBT Sessions Flow

Entire process is gradual exposure

1/3

Sessions 1 - 4
- Psychoeducation /Parenting Skills
- Relaxation
- Affective Expression and Regulation
- Cognitive Coping

1/3

Sessions 5 - 8
- Trauma Narrative Development and Processing
- In vivo Gradual Exposure

1/3

Sessions 9 - 12
- Conjoint Parent Child Sessions
- Enhancing Safety and Future Development

------------------
PARENT-CHILD WORK THROUGHOUT ------------------
Child and Parent Components

**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
Therapist Role in TF-CBT

- Agenda-setting
  - Watching for and managing COWS (Crises of the Week)
  - Being responsive to families while staying on track
- Directive
- Active
- Supportive
- Fun!
Contraindications for TF-CBT

- Dangerous behaviors (suicidality; severe aggression)
- Unsafe environment (e.g., trauma is ongoing or there is high risk for reoccurrence)
- Unstable placement
- Unsure??
  - Ask colleagues
  - Use consult calls for case discussion
- “Stably unstable?”
- Ongoing DV? Address safety issues (i.e., “Enhancing Safety” component)
Components of TF-CBT PRACTICE

| P | Psychoeducation and Parenting skills |
| R | Relaxation |
| A | Affective modulation |
| C | Cognitive coping and processing |
| T | Trauma narrative |
| I | In vivio mastery of trauma reminders |
| C | Conjoint child-parent sessions |
| E | Enhancing future safety and development |
Psychoeducation

• Goal
  – Normalize response to trauma
  – Help reinforce accurate beliefs
  – Provide hope – not alone and we know how to help

• Content
  1. General education about abuse and trauma
  2. Specific information about trauma experienced
  3. Sex education (sexual abuse)
  4. Risk reduction and safety planning

• Strategies
  – Worksheets, board games, radio show, children’s books
  – Be creative!
**Parenting Skills: Behavior Management**

- **Goal:** Teach parents positive parenting strategies to manage behavior problems, fears, sleep problems, sexual behavior problems

- **Strategies include:**
  - Attending skills and praise
  - Active ignoring / Selective attention
  - Effective commands and time-out
  - Behavioral management plans

- Help to establish reasonable developmental expectations

- **Golden Rules:** Consistency, predictability and follow-through
Relaxation/Stress Management

• Goals
  – Tool kit to manage anxiety

• Content
  – Teach children about body reactions to stress and that we have control over our stress reactions

• Strategies
  1. Controlled breathing (toy, bubbles)
  2. Muscle relaxation (tense/relax, progressive, spaghetti)
  3. Meditation or visualization
  4. Other (e.g., coping box, physical activity, yoga)

Active teaching and practice!
Affect Expression and Modulation

• Goals
• Content
  1. Identify emotions
  2. Rate intensity of emotions
  3. Appropriate emotional expression
• Strategies
  – Feeling posters and cards
  – Feelings charades
  – Life books
  – Games with family specific questions
  – Making list of questions for caregivers
  – Fishing box
  – Thoughts and feelings sheet

Link emotion experience to trauma!
Cognitive Coping

• Goals
• Common Themes
  ▪ Self-blame
  ▪ Overestimating danger
  ▪ Changed world view
  ▪ Shame
  ▪ Abandonment, loss
• Content
  1. Accurate vs. inaccurate cognitions
  2. Helpful and unhelpful cognitions
  3. Relationship between thoughts, feeling and behaviors
Trauma Narrative

- A form of \textit{gradual exposure therapy} that allows the child to experience the negative feelings, thoughts, memories associated with the trauma in small doses in a safe, controlled environment.
- Goal is for child to be able to tolerate traumatic memories without significant emotional distress and no longer need to avoid them.
- Sense of mastery and control over trauma reminders
  - Child tells story gradually in session
  - Increasing detail about thoughts and feelings during the trauma
  - Stress management used throughout narrative
Rationale for Trauma Narrative

Why talk to kids about trauma...?

Gradual exposure... sense of mastery and control over trauma reminders
• Resolve avoidance symptoms (approach rather than avoid) and other trauma symptoms
• Correction of distorted thoughts re: self, others, the world
• Models adaptive coping
• Identify and prepare for trauma/loss reminders
• Contextualize traumatic experiences into life
• Model healthy communication skills for parents
• Reduce future risk
Books for Introducing the Trauma Narrative

- **Strong at the Heart**: How it feels to heal from sexual abuse
- **When I Was Little Like You**: A story for young children
- **Finding the Right Spot**: A book about finding a sense of belonging
- **Please Tell!**: A child's story about sexual abuse
- **A Terrible Thing Happened**: A story for children about trauma
- **A Place for Starr**: A story of hope for children experiencing family violence
Trauma Narrative: Cognitive Processing

- Identify maladaptive thoughts and beliefs about why the traumatic event occurred, why it happened to me, consequences of the event, etc.
- Promote the notion that thoughts can be changed.
- Challenge the maladaptive thoughts:
  - Is the thought true/helpful?
  - Does thinking this lead to positive/negative emotions and behavior?
  - Does thinking this help you feel good about yourself?
  - Does thinking this help you in your daily life?

Be creative… how else can you challenge thoughts?
In Vivo Mastery of Trauma Reminders

• Mastery of trauma reminders is critical for resuming normal developmental trajectory
• To be used only if the feared reminder is innocuous/harmless (not if it’s still dangerous)
• Hierarchical exposure to innocuous reminders which have been paired with the traumatic experience
Conjoint/Parent-Child Sessions

• Why bring them together...?
  – Parents demonstrate comfort hearing about trauma and mode healthy coping
  – Child’s sense of accomplishment
  – Parent-child communication enhanced
  – Groundwork for continued communication after treatment
Parent-Child Sessions

- Child Readiness
- Parent Readiness
  - Emotional readiness
  - Support of child
    - Active listening, emotion coaching, emotion support skills
  - Specific concerns
    - What if parent had role in trauma?
Enhancing Safety

• Goals

• Content
  1. Knowledge
  2. Concrete strategies and planning
  3. Rehearsal

• Strategies
  – Education/Books
  – Games
  – Role play
  – Writing plan
  – Identifying and reducing risky situations
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
  - Combining TF-CBT with other interventions
• Children (ages 3-18) with known trauma history—single or multiple, any type
• Children with prominent trauma symptoms (PTSD, depression, anxiety, with or without behavioral problems)
• Children with severe behavior problems may need additional or alternative interventions
• Parental involvement is optimal
• Treatment settings: clinic, school, residential, home, inpatient
• Group model: CBITS
A Question...

Where can I learn more about TF-CBT?
TF-CBT Web is a web-based, distance education training course for learning Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT).

TF-CBT Web is offered free of charge.

10 hours of CE
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