1 **Helping Families Heal:**
A TF-CBT Approach

IT'S HARD WORK BUT IT'S WORTH IT!

BAILEY EVANS, ME.D, LPC

2 **My Interest in Trauma: A Little Bit About Me**

1 Owen

2 Myron

3 **Child Sexual Abuse Statistics**

- Statistics indicate 1 in 4 girls and 1 in 6 boys are sexually abused before their 18th birthday. www.D2L.org reports 1 in 10 children.

- Only 38% of child victims disclose abuse

- The rate of sexual assault on youths ages 12-17 is 2.3 times higher than for adults.

4 **Who are the Perpetrators?**

2 • 90% of child victims know their perpetrators
• 30% of sexually abused children are abused by a family member
• The other 60% are abused by people trusted by their families
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4 • 40% of children who are sexually abused are abused by older children
• The younger the child the more likely the perpetrator is a juvenile

5 **Prevalence of Trauma History for Youth in Residential Treatment Settings**

1 • Research suggests rates of trauma exposure among youth in RTC ranges from 50% to over 70%. (Bettmann, et al. 2011; Jaycox et al. 2004; Warner and Pottlick 2003)

- *Remember that 10% of children in the regular population have a reported history of abuse

2 • 92% of traumatized youth in residential care reported experiencing multiple traumatic events; mean number was 5.8 exposures. (Briggs and colleagues 2012)
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• 69% experienced neglect; 63% physical abuse; 47% sexual abuse (Baker et al. 2006)

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6 **Prevalence of Trauma History Con't**

1 • 68% experienced emotional abuse; 62% traumatic loss/bereavement; 60% impaired caregiver; 58% domestic violence; 54.5% physical abuse; 40% sexual abuse; 31% community violence; and 20% school violence (Briggs and colleagues 2012).

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2 • Girls were more likely to have been physically abused (60%) and sexually abused (64%) than boys (43%) and (27%) respectively (Connor and colleagues 201).

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• 60% of youth in RTC had a caregiver with substance abuse problems; 15% had a caregiver with history of psychiatric problems; and 20% had an incarcerated caregiver (Baker et al 2005; Griffith et al 2009).

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7 **What is Trauma?**

NOT ALL KIDS WHO HAVE EXPERIENCED VERY BAD, DANGEROUS OR SCARY EVENTS DEVELOP SIGNS AND SYMPTOMS OF PTSD

CATEGORIES OF SYMPTOMOLOGY

*AVOIDANCE
*HYPER-AROUSAL
*RE-EXPERIENCING

8 **Typical Signs and Symptoms of PTSD**

- Intrusive and upsetting memories, thoughts, or dreams about the trauma.
- Avoidance of things, situations, or people which are trauma reminders.
- Emotional numbing.
- Physical reactions of hyper arousal, trouble concentrating, or irritability.

9 **We Learn By Experience**

*What we expect
*Positive versus negative experiences and the foundations that they lay for our worldview
*Patterning occurs over time
*A little story about a snake and stick

10 **The Impact of Trauma on the Brain**

1 • When faced with a threat the brain triggers a release of adrenaline, cortisol, and other stress hormones which activate the systems you need to immediately respond to the threat – either by fighting back, getting away, or freezing.

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• For most people the body's emergency response shuts down after the danger passes.

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- But for a child exposed to severe or chronic trauma the emergency response system can get stuck in the "on" mode and healthy neural development is derailed.
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- Their brains become "wired" for survival.
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- They may develop a variety of psychiatric symptoms.
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11 **What is a Traumatic Experience?**

- It is different from run-of-the mill stressful or upsetting events.
- It threatens the life or physical integrity of the child or someone critically important to the child.
- Causes an overwhelming sense of terror, helplessness, or horror.
- The body reacts to the threat automatically with an increased heart rate, shaking, dizziness or fainting, rapid breathing, release of stress hormones like adrenaline and cortisol, and a loss of control of the bowel or bladder.
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12 **Some Types of Trauma**

1 Acute

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- OCar accident
- ODog bite
- OWitnessing (or being a victim of) a school shooting
- OGoing through a natural disaster like a tornado
- OSeeing a loved one die
- OA physical or sexual assault
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3 Chronic

4
- ORepeated physical or sexual assaults on the child
- OWitnessing recurrent domestic violence
- ONeglect
- OEmotional abuse
- OImpaired caregiver
- OHospitalization with multiple medical procedures

13 **Complications of Chronic Trauma**

The effect of multiple traumas may build on each other.

Child is more overwhelmed by each event and more convinced the world is not a safe place.

14 **Children Who Have Experienced Trauma Often Find It Difficult To:**

- Trust other people
- Feel safe
- Understand and manage their emotions
- Adjust and respond to life's changes
- Physically and emotionally adapt to stress
- Manage social interactions and relationships
- Do school their work
- They also may abuse substances and engage in reckless behavior or victimize others.
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15 **Trauma Symptoms at School**

- 1:4 children attending school has been exposed to a traumatic event that can affect learning and/or behavior
- Trauma can impact school performance
  - Lower GPA, absences, drop out, suspension, expulsion, lower reading ability
- Trauma can impair learning
  - Single vs. acute exposure
- Traumatized children may experience physical and emotional distress

16 **Clinical Symptomology**

- Re-experiencing (Criterion B)
- Avoidance (Criterion C)
- Hyper arousal (Criterion D)
- Negative moods
- Withdrawal
- Dissociation
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17 **Founders of TF-CBT**

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- Esther Deblinger, Ph.D – Center for Children's Support, University of Medicine and Dentistry of New Jersey
- Judith Cohen, M.D., and Anthony Mannarino, Ph.D. – Center for Traumatic Stress in Children and Adolescents, Allegheny General Hospital
- Originally developed for treating sexually abused children.
- They viewed working with parents as an integral part of treatment.
- Found it can be used with a range of traumas (traumatic loss/grief, physical abuse,

domestic and community violence, etc.)

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18 **Training in TF-CBT**

19 **TF-CBT**

- Evidence-based model of psychotherapy that addresses the unique needs of children with PTSD symptoms, depression, behavioral problems, and other difficulties related to traumatic life experiences.
- Individual sessions for the child and for the parents or caregivers, as well as joint parent-child sessions, are part of the treatment.
- Clinician's relationship with the child and parent or caregiver is essential ingredient of TF-CB; highly collaborative approach.
- Specific components of TF-CBT are summarized by the acronym PRACTICE but can be delivered in a flexible manner and sequence.
- Structured approach avoids chasing COWs.
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20 **A Child is Referred and Admitted to Bridges**

NOW WHAT?

21 **Assessments and Measures**

UCLA – PTSD Index
Moods and Feelings Questionnaire
Strengths and Difficulties Questionnaire

22 **Ongoing Assessment**

1 • Track most bothersome symptoms each session (run chart).
- Check subjective units of distress (SUDS) before and after intense work.
- Use feelings thermometer.
- Give lots of praise for the "hard work" completing assessments and for talking about their trauma experience.
- Pre and post testing helps answer – "are we finished with treatment?"
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23 **Preparing Families**

- Untreated trauma is like a wound that is left untreated and ends up festering up later.
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- You would not put a bandage on a cut without first cleaning out the dirt.
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- Putting your toes in the water and gradually going deeper.

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24 **TF-CBT Components**

- Psychoeducation & Parenting Skills
- Relaxation Skills
- Affect Regulation
- Cognitive Coping
- Trauma Narrative
- In Vivo Mastery
- Conjoint Child-Parent Sessions
- Enhancing Future Safety & Development

25 **Psychoeducation & Parenting Skills**

1 What to Expect:

2 • Provided to both the child and their caregivers about the impact of trauma and common childhood reactions.

- Intended to reduce parental distress and address common issues of self blame, over-protectiveness, or over permissiveness.
- Parenting skills are taught to optimize children's emotional and behavioral adjustment.

3 Skills taught to parents include:

4 • specific praise, active ignoring, behavior management, coping skill rehearsal, managing emotional regulation, identifying and understanding trauma triggers

26 **Relaxation Skills**

http://www.youtube.com/watch?v= mZbzDOpylA

Relaxation and stress management skills are individualized for each child and parent.

- Diaphragmatic breathing
- Progressive muscle relaxation
- Guided imagery

27 **Affect Regulation**

- Affective expression and modulation are taught to help children and parents identify and cope with a range of emotions.
  - Identifying general feelings in themselves and others.
  - Expanding child's emotions vocabulary.
  - Identification of physiological responses.
  - Recognizing cues, triggers, physiological signs.
  - Gauging intensity of feelings.

OGrounding
OMindfulness skills
OThought stopping, replacement, and redirection.

28 **Cognitive Coping**

2 • Cognitive coping and processing are enhanced by illustrating the relationships among thoughts, feelings, and behaviors.
• This helps children and parents to identify inaccurate or unhelpful thoughts about the trauma.
• Enhances use of positive self-statements.
• Restructures/replaces maladaptive thoughts and cognitive distortions.

29 **Trauma Narrative**

• Trauma grows if you keep it in your head.
• Repeated exposure to upsetting memories gradually decreases negative emotional responses and maladaptive avoidance coping.
• Therapist and child talk about the child's traumatic experiences in a different way in each session, with gradually increasing intensity allowing for gradual desensitization.
• In creating a trauma narrative the child is encouraged to talk about the details of their trauma experience and then to share that experience with a trusted individual in a safe supporting environment.
• Goal is to get the child to he point where they can think about the memory without all negative effects.
• Should not be used in a situation where a child remains in a dangerous environment.

30 **Therapist Role in Development of The Narrative**

Secretary and facilitator
Ask broad open ended questions:
What were you thinking or saying to yourself?
What was happening in your body?
How were you feeling?
Make clarifying and reflective statements:
Tell me more about it...
I was not there, so tell me...
So your uncle was touching your penis...

31 **In Vivo Mastery**

• In vivo mastery of trauma reminders is used to help children overcome their avoidance of situations that are no longer dangerous, but which remind them of the

original trauma.

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- Challenge inaccurate and unhelpful cognitions.
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- Identify and reinforce mastery moments.
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32 **Conjoint Child-Parent Sessions**

Conjoint child-parent sessions help the child and parent talk to each other about the child's trauma.

Parents are taught to provide praise and support for bravery and hard work.

33 **Enhancing Future Safety & Development**

- The final phase of treatment is enhancing future safety and development.
- Addresses safety, helps the child to regain developmental momentum, and covers any other skills the child needs to end treatment.
- Provides age appropriate information about healthy sexuality.
- Contextualizes events and work on making meaning.
- Identify competence in responding to the abuse.
- Traumatic growth – How have I changed; What have I learned; What would I tell other kids who have experienced this.

34 **Safety Goals**

2 • https://www.youtube.com/watch?v=a-5mdt9YN6I

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4 • Differentiate "ok" from "not ok" and confusing touches.
- Enhance communication between child and caregiver.
- Enhance caregiver's protective response.
- Help child tune into physiologic cues of pending danger.
- Increase assertiveness.
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35 **Benefits to Children & Parents**

- Overcoming general feelings of depression
- Reduction of PTSD symptoms
- Reduce emotional distress about the child's trauma
- Improve parenting practices
- Enhance their ability to support their children
- Effectiveness compared to other therapies, has been documented in multiple studies across a variety of client populations who have experienced sexual abuse, physical abuse, multiple traumas, traumatic loss, and PTSD.

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1 • Parent does not acknowledge the trauma occurred.
• Parent acknowledges the trauma occurred but does not believe it has affected the child significantly.
• Parent is overwhelmed or highly distressed by his or her own emotional reaction.
• Parent is suspicious, distrustful, or does not believe in the value of therapy.
• Parent is facing many concrete problems such as housing, finances, or legal concerns and does not have the energy to invest in treatment.
• Parent is not willing to change parenting practices that may be important for treatment to succeed.
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2 Potential Barriers to Parent Participation

37 **Overcoming Barriers**

2 • Emphasizing the importance of parents role in the child's recovery.
• Parent session to address their distress and instill empowerment.
• Delayed presentation of some content in joint sessions until the parent can offer the necessary support.
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4 • Arrange assistance with meeting concrete needs.
• Psycho-education about how the therapy works and the therapeutic process.
• Instilling optimism in the parent about the child's potential for recovery with successful therapy.
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38 **Legal Concerns**

• Insuring child's safety is the first priority.
• This approach to treatment is predicated on confirmation that the abuse occurred either through clinical assessment or substantiation by a Child Protective Services agency or law enforcement.
• Some components of TF-CBT should be deferred until active CPS or law enforcement investigative interviews have been completed so treatment does not compromise the legal process.
• The trauma narrative is not intended to be used a as forensic document.
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39 **What can you do?**

1.CREATE A SAFE SPACE TO TALK
2.TALK ABOUT SAFETY WITH THOSE YOU LOVE
3.EDUCATE OTHERS AND SUPPORT HEALTHY CHOICES

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1 • 100 sexually abused children, 8 – 14 years old, and parents randomized to TF-CBT for child only, parent only, child plus parent, or treatment as usual (TAU).
• Children receiving TF-CBT experienced significantly greater improvement in PTSD symptoms.
• Children of parents receiving TF-CBT experienced significantly greater improvement in depression and behavioral symptoms; parents experienced significantly greater improvement in positive parenting practices.
• Differences sustained at 2-year follow-up.
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2 Deblinger, E., Lippmann, J., Steer, R (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment,* 1(4), 310 – 321.

41

1 • 86 sexually abused children, 3-6 years old, and parents randomized to TF-CBT or nondirective supportive therapy (NST), followed for one year post-treatment.
• Children receiving TF-CBT experienced significantly greater improvement in total behavior problems, internalizing, externalizing, and PTSD symptoms characteristic of young sexually abused children at one year follow-up.
• Parental support and emotional distress mediated preschool children's symptoms.
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2 Cohen, J. A., Mannarino, A. P., (1997). A treatment study for sexually abused preschool children: Outcome during one-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry, 36(9), 1228-1235.*

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1 • 82 SA children, 8 – 15 year old, representative of a community SA sample, and parents randomized to TF-CBT or NST, followed one year post-treatment.
• Study did not require minimum symptoms for entry, only elevation on at least one of the study instruments.
• Intent-to-treat analysis indicated greater improvement in TF-CBT group for depression, sexual problems, and dissociation, at 6 months post-treatment; and in PTSD and dissociation at one year post-treatment.
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2 Cohen, J. A., Mannarino, A. P., Knudsen, K. (2005). Treating sexually abused children: One year follow-up of a randomized controlled trial. *Child Abuse and Neglect,* 29(2), 135-145.

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1 • 229 SA children, 8-14 years old, and parents randomized to TF-CBT or Child Centered Therapy at two sites, followed for one year post-treatment.

- More than 90% experienced multiple traumas.
- Children receiving TF-CBT experienced significantly greater improvement in PTSD, depression, behavioral problems, shame, and abuse-related attributions.
- Parents in TF-CBT experienced significantly greater improvement in depression, abuse-specific distress, support for child, and effective parenting practices.
- At one-year follow-up, children with multiple traumas and initial high levels of depression did worse in CCT group only, suggesting that TF-CBT is more effective than CCT for these children.
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2 Cohen, J. A., Deblinger, E., Mannarino, A. P., Steer, R. A., (2004). A multi-site, randomized controlled trial for children with sexually abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43(4), 393- 402.*

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- TF-CBT and two other evidence-based practices, Child Parent Psychotherapy, and Structured Psychotherapy for Adolescents Recovering from Chronic Stress, compared to TAU for children in Systems of Care (SOC) foster care.
- TF-CBT achieved gains that were significantly greater than comparable youth in (SOC) on traumatic stress symptoms and child behavioral/emotional needs.
- Children participating in TF-CBT were one-tenth as likely as same-age children in SOC to run away from a placement and half as likely to have any placement interruption.
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2 Mental Health Services & Policy Program, Norhtwestern University (2008). Evaluation of the implementation of three evidenced-based practices to address trauma for children and youth who are ward of the State of Illinois, Final Report

45 **Case Studies**

- 11 y/o female
  - Sexual abuse
  - Adoptive Family Support
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- 15 y/o female
  - Sexual Assault
  - Biological Family Support
  -
- 13 y/o female
  - Complex Trauma
  - Staff Support

46 **Thank you!**

WHAT QUESTIONS DO YOU HAVE FOR ME?