

Trauma-Focused Cognitive-Behavioral Therapy

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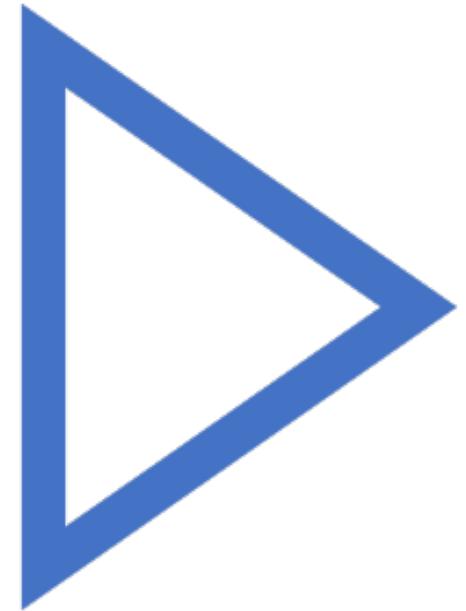
Department of Counseling & Instructional Sciences

Core Faculty – Clinical & Counseling Psychology Ph.D.
Program

University of South Alabama

Goals

1. Participants will learn about the basics of what research has to say about the nature of traumatic exposure and traumatic stress symptoms in children.
2. Participants will learn principles for the specific phases of TF-CBT
3. Participants will learn specific tactics used within each phase to promote recovery
4. Participants will learn about the scientific basis for the efficacy of TF-CBT



Disclaimers

- This workshop is not meant to contribute to formal certification in TF-CBT
- If that is of interest please see the following web pages
 - <https://tfcbt.org/tf-cbt-certification-criteria/>
- Rather, this is meant to promote understanding of evidence-based trauma intervention in general and TF-CBT in particular
- TF-CBT is an intervention designed for children and adolescents, today I will focus primarily on adolescents and particularly on court-involved teens presenting with substance abuse as part of their clinical profile.

Who am I?

- Someone with two members of my nuclear family with serious addictions problems
- Special education teacher for 3 years in a self-contained classroom with 12 children all with chronic trauma and abuse histories, most of whom have gone on to have long-term addictions difficulties
- 4,000 hours of experience in emergency medical departments, county jails as a psychiatric evaluator
- Counselor/psychotherapist, advocate and evaluator for juvenile offenders since 2000.
 - Continuous private practice with adolescents and parents since 2005



Who am I?

- Supervised over 20,000 of clinical services, mostly to juvenile offenders and their families
- Expertise – adolescent mental health, adolescent criminal & forensic psychology, psychological trauma, program evaluation and organizational/systems issues in mental health.
- Guided development and accreditation of the Clinical Mental Health Counseling and Clinical/Counseling Psychology graduate programs at USA.
- Teaching
 - Addictions Counseling
 - Program Development for At-Risk Adolescents
 - Clinical Supervision





“South”







UNIVERSITY OF SOUTH ALABAMA
GULF COAST BEHAVIORIAL
HEALTH AND RESILIENCY CENTER



Juvenile Court of Mobile County
JAMES T. STRICKLAND YOUTH CENTER



Lifelines Counseling Services
Take the First Step.



Trauma Exposure

Types of Trauma

➤ Broad Types

- Interpersonal vs. Impersonal
- Objectively Life Threatening vs. Subjectively Life Threatening
- Acute vs. Chronic
- Direct vs. Vicarious

Specific Examples

- Child Abuse
- Mass Interpersonal Violence
- Natural Disasters
- Large-Scale Transportation Accidents
- Fire & Burns
- Motor Vehicle Accidents
- Rape & Sexual Assault
- Stranger Physical Assault
- Intimate Partner Violence
- Sex Trafficking
- Torture
- War
- Vicarious experience of homicide or suicide
- Life-Threatening Medical Conditions
- Emergency Worker Exposure to Trauma

Risk for Trauma Exposure

- Those at higher risk...
 - Girls
 - Those living below the poverty line or homeless
 - LGBTQ youth
 - Intellectual disabled youth
 - Some evidence that trauma exposure risk varies by ethnic group with African Americans having the highest lifetime exposure (Roberta et al., 2011)
 - Experiencing one trauma exposure puts children at statistical risk for additional exposures
 - Youth in any secure detention or residential placement at much higher risk

Epidemiology of Child Abuse

U.S.

- **3 million** child welfare reports made each year in the U.S.
- **1500** children die each year in the U.S. from abuse or neglect
- Estimated that **< 5%** of child abuse is reported
- **80%** of child abuse is perpetrated by caregivers and parents

International

- Estimated that **4-6%** of children in industrialized countries are physically abused
- **10%** experience neglect or emotional abuse,
- **30-40%** of all girls and **10-15%** of all boys experience sexual abuse/assault by 18.

Costello, 2002

- Sample of 1420 children from general population in North Carolina
- **25%** experienced a serious, high-impact abuse event by age 16 (large epidemiological study)
- **33%** had experienced a low magnitude abuse event within the last 3
- Exposure likelihood multiplied as vulnerability risk factors increased





Trauma Symptoms



Trauma Symptoms

- Only minority of those exposed to trauma will develop traumatic stress symptoms
 - 20-30% of those exposed to trauma develop PTSD
- Developing trauma symptoms – What predicts who will develop trauma symptoms after exposure?
 - Tendency towards dissociation, e.g. detachment, in the face of trauma
 - Experiencing emotional distress in physical terms – somatization
 - Tendency to have emotional dysregulation
 - Shame and self-blame
 - Premorbid functioning deficits of any kind

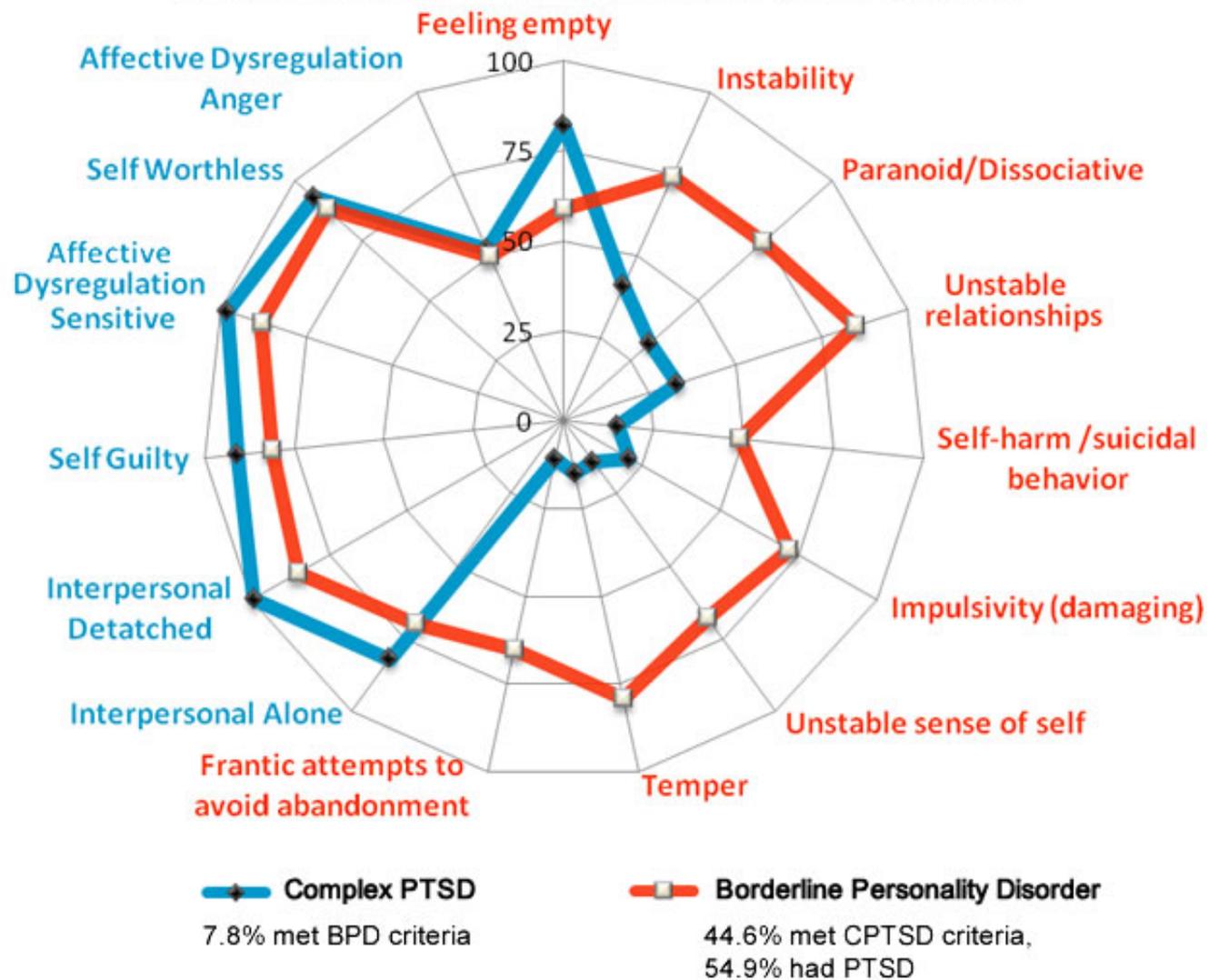
PTSD Symptoms

Intrusion	Avoidance	Cognition & Mood Changes	Arousal & Reactivity Changes
<ul style="list-style-type: none">• Involuntary & recurrent memories• Traumatic nightmares• Flashbacks• Intense or prolonged distress after exposure to reminders	<p>Avoiding trauma-related</p> <ul style="list-style-type: none">• Thoughts• Feelings• People• Places• Conversations• Activities• Objects• Situations	<ul style="list-style-type: none">• Can't recall key features of event• Negative beliefs about self or world• Distorted blame• Persistent fear, horror, anger, guilt or shame• Diminished interest in activities• Feeling alienated• Inability to feel positive emotions	<ul style="list-style-type: none">• Irritable or aggressive• Self-destructive• Hypervigilance• Exaggerated startle response• Problems with concentration• Sleep problems

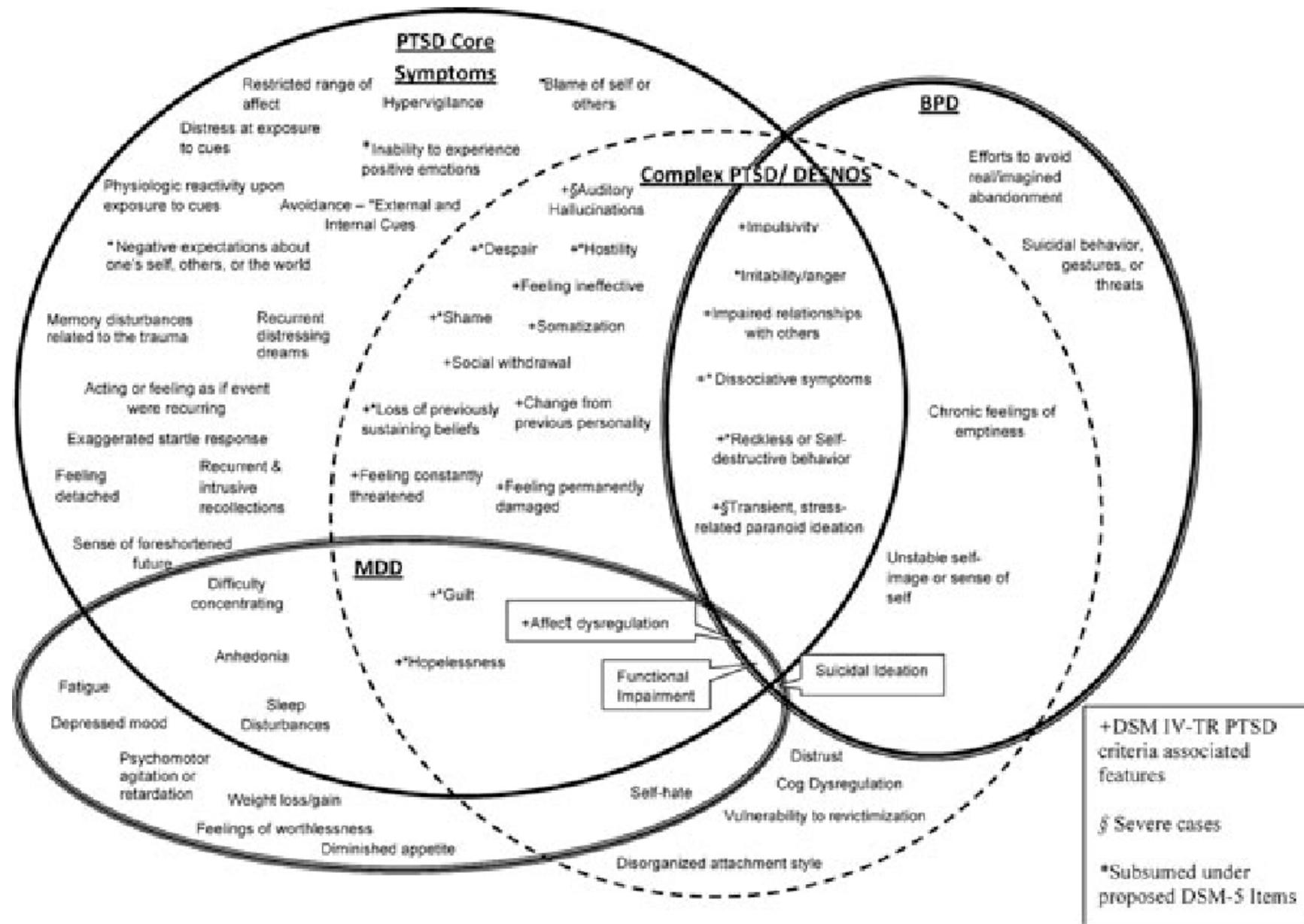
Complex PTSD

- **Complex PTSD**
 - Usual in cases of repeated and chronic interpersonal traumas such as child abuse and neglect
 - All of the normal PTSD symptoms +
 - Chronic problems with regulating emotions – highly reactive, irritable and
 - Chronic problems with interpersonal distrust, inability to attach to others
 - Disruptions in core identity formation
 - Difficult to distinguish from Borderline Personality Disorder

Distinguishing between Complex PTSD and Borderline Personality Disorder in 280 female child abuse survivors seeking PTSD treatment



Four BPD symptoms greatly increased the odds of being in the BPD compared to the Complex PTSD class: frantic efforts to avoid abandonment, unstable sense of self, unstable and intense interpersonal relationships, and impulsiveness. *European Journal of Psychotraumatology* 2014, 5: 25097. doi: 10.3402/ejpt.v5.2509



PTSD Comorbidity





Neurobiology of Trauma

Neurobiology of Trauma



- Bruce Perry, M.D., Ph.D.
 - What do children need from their environment for healthy brain development?
 - Healthy attachment to primary stable consistent caregiver
 - Synchronous, interactive and attuned relationship with caregiver
 - Safe, nurturing and enriching environment
 - These inputs create calm, well-regulated stress responses

Healthy Brain

This PET scan of the brain of a young child shows regions of high (red) and low (blue and black) activity. At birth, only primitive structures such as the brain stem (center) are fully functional; in regions like the temporal lobes (top), early childhood experiences wire the circuits.

Neurobiology of trauma

- Childhood experiences devoid of these positive caregiver interactions and characterized by abusive interactions gives rise to...
 - Child's brain remains in a prolonged chronic stress states
 - This shapes neural connections to be primed for and maldaptively reactive to future stressors
 - Renders developing child less able to benefit from nurturing supports

Front

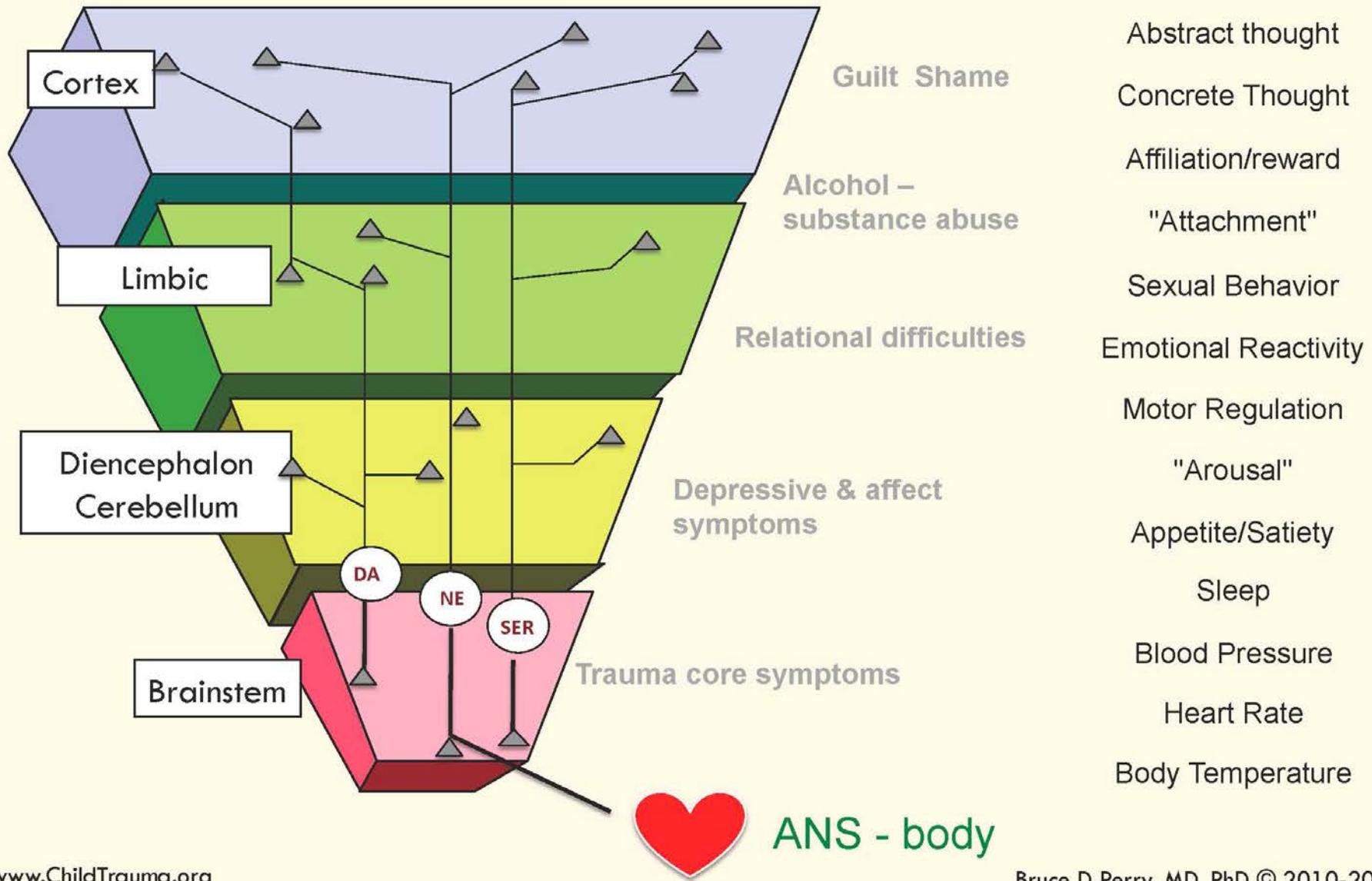
An Abused Brain

This PET scan of the brain of a Romanian Orphan, who was institutionalized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (top), which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.

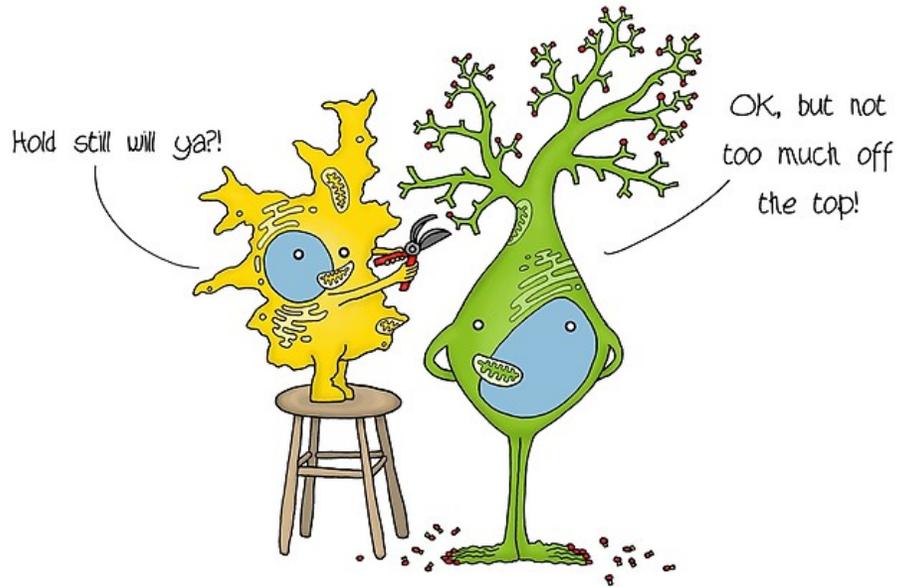
Back

MOST ACTIVE LEAST ACTIVE





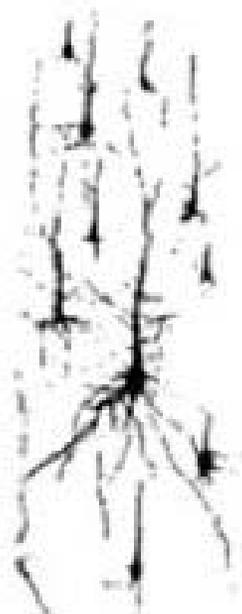
How Child's Brain Develops



Synaptic pruning...

- Born with a surplus of neurons
 - Brain maturation is not so much growing new neurons but connecting up the neurons we have. It's the connections that matter.
 - What gets connected to what is determined by what experiences the child is having – use it or lose it
- Synaptic Pruning
 - Neuron connections that are not stimulated/used are left to die

36 weeks
gestation



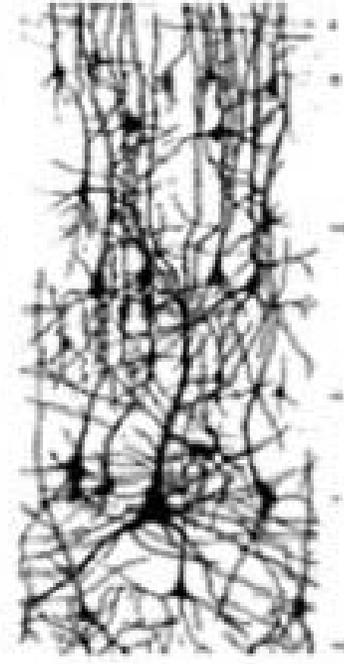
Newborn



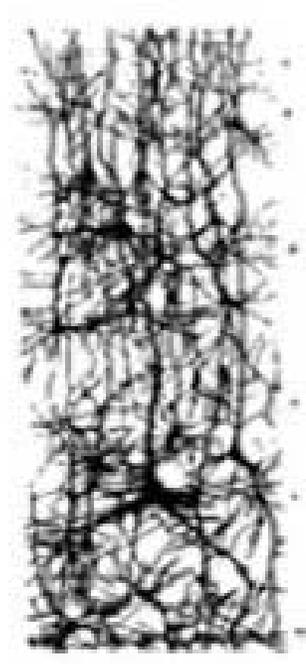
3 months



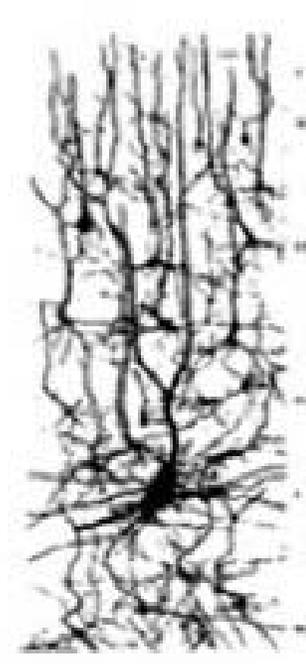
6 months



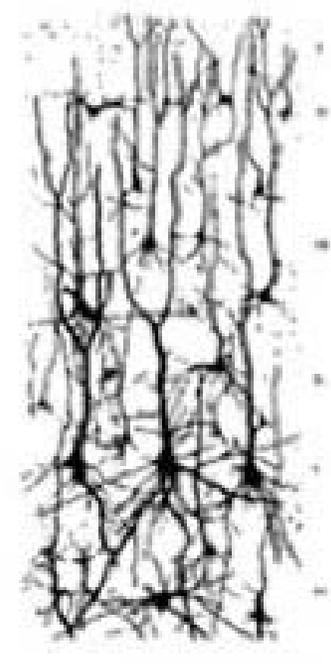
2 years



4 years



6 years



Synapse Formation

Synaptic Pruning

3 Year Old Children



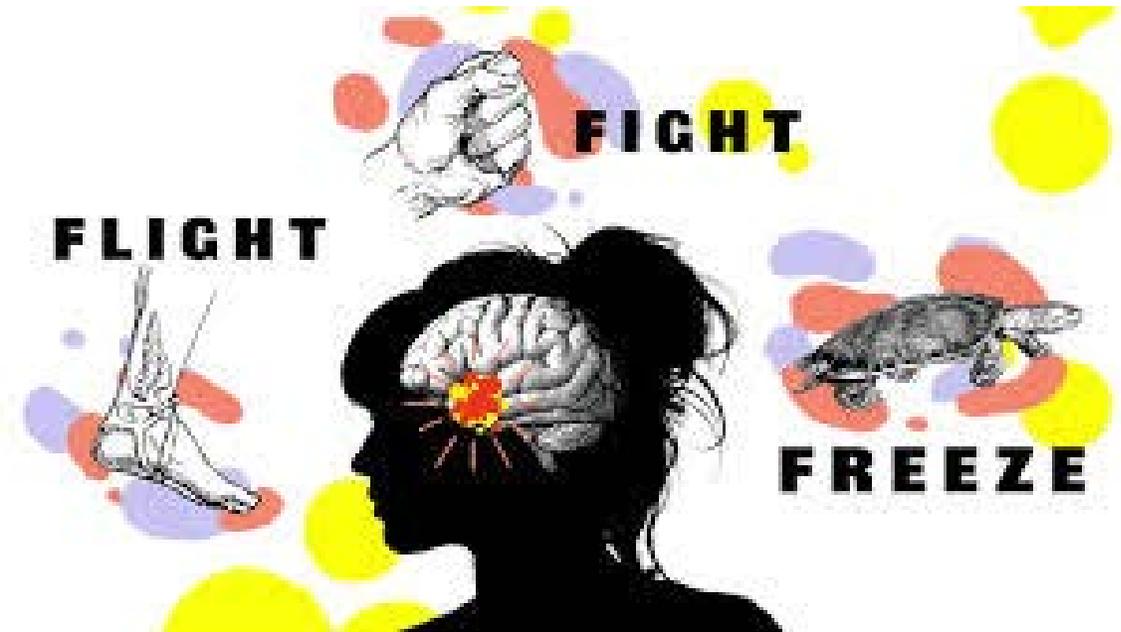
Normal

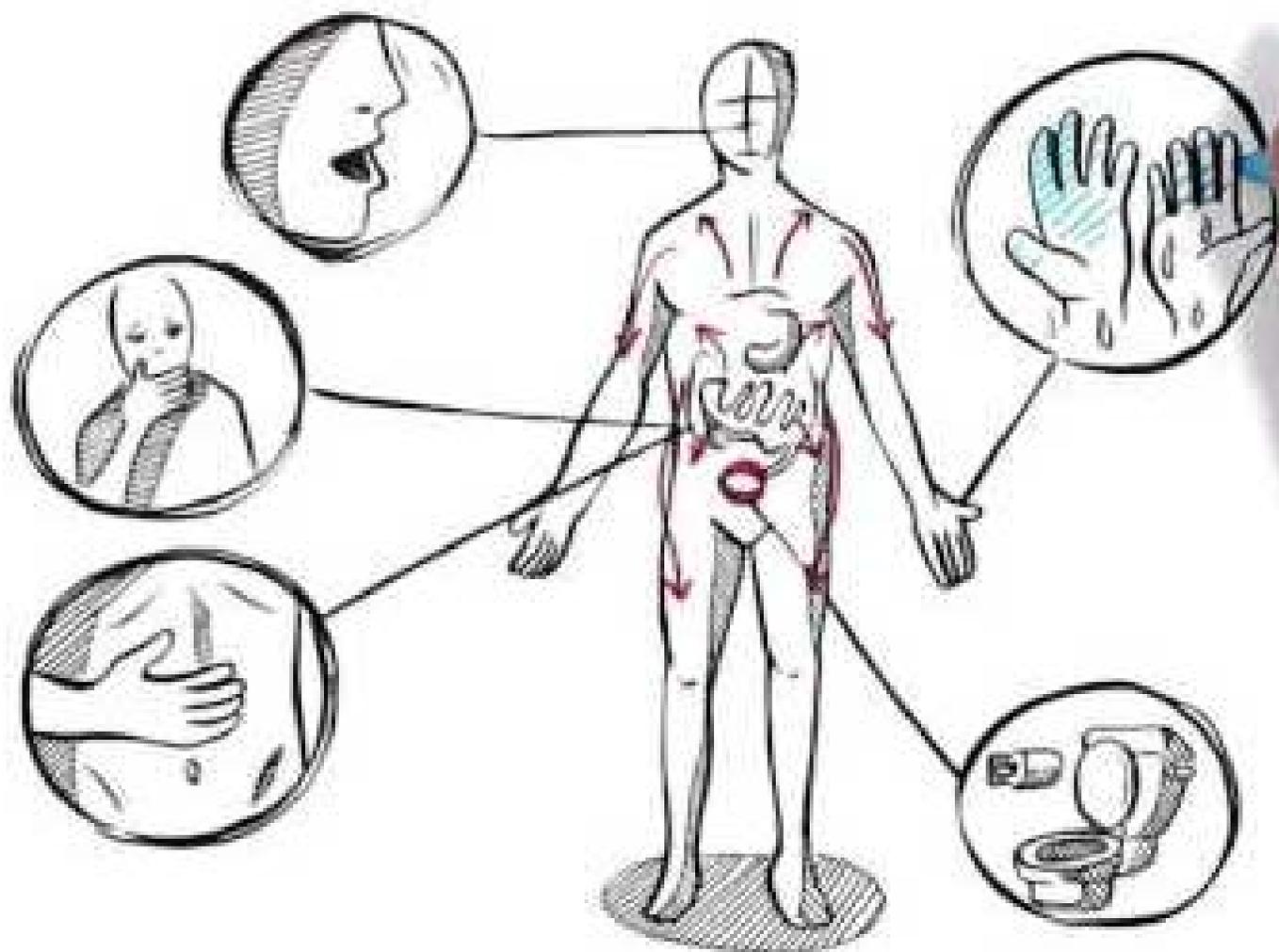


Extreme Neglect

Brain Development & Trauma

- With traumatic exposure the neural connections that remain most functional are primarily those that are involved in the **fight-flight-freeze** neural circuit
 - Old part of the brain involves in basic survival behaviors in a dangerous environment
- This leads to an increase in behaviors that are highly reactive to perceived threats and which are maladaptive attempts to soothe fear and anxiety





5 TRAUMA RESPONSES

PHYSIOLOGICAL REACTIONS:
THE 5 F'S

THE 5 F'S

AUTONOMIC NERVOUS SYSTEM

Hyperarousal, alarmed / startled.

Increases heart rate, blood pressure, breathing.

FIGHT

Physical aggression: attacker may be smaller / weaker.

Verbal aggression, e.g., saying "no".

traumadissociation.com

FLIGHT

Running, bawking away or hiding.

If there is somewhere to escape to or hide.

PARASYMPATHETIC NERVOUS SYSTEM

Hypoarousal, dissociation.

Metabolic shutdown, numbing. Hiding behaviors.

FREEZE

Tonic immobility. Involuntary response.

Less chance of injury.

FLOP / FAWN

Collapse and play dead.

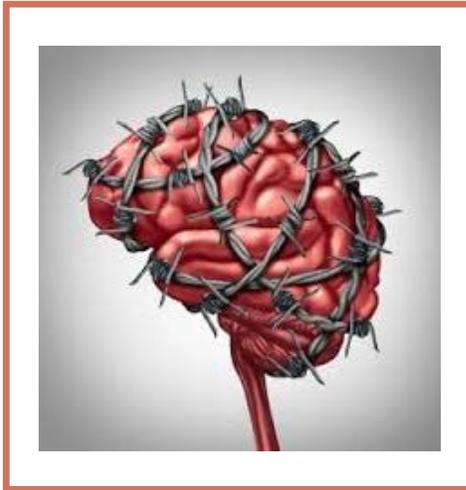
After freeze fails, conserves energy, wounds heal.

FRIEND

Trauma bonding (attach) / Stockholm Syndrome

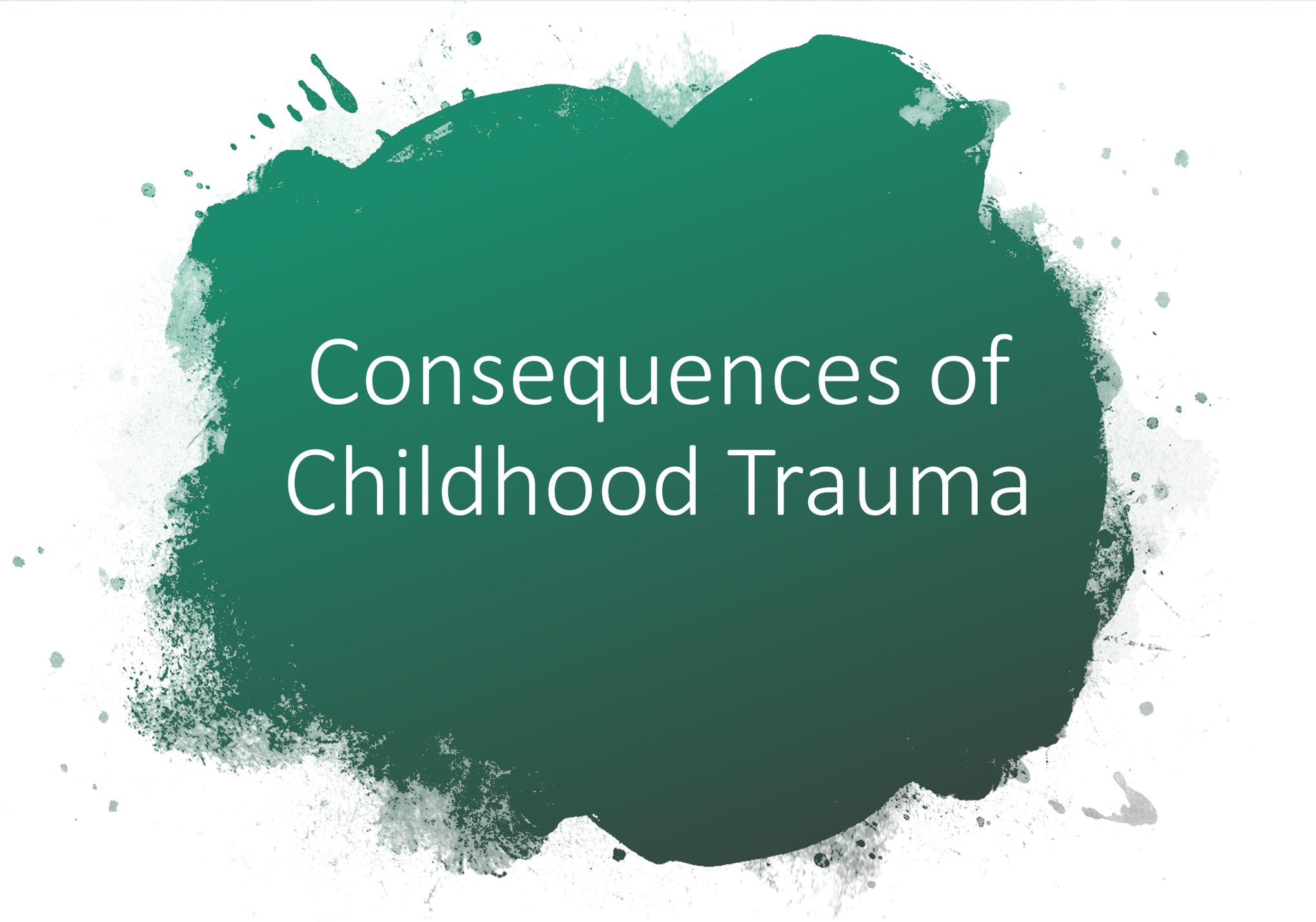
Social engagement. Prolonged or infant trauma.

Schore, 2009;
Lodrick, 2007

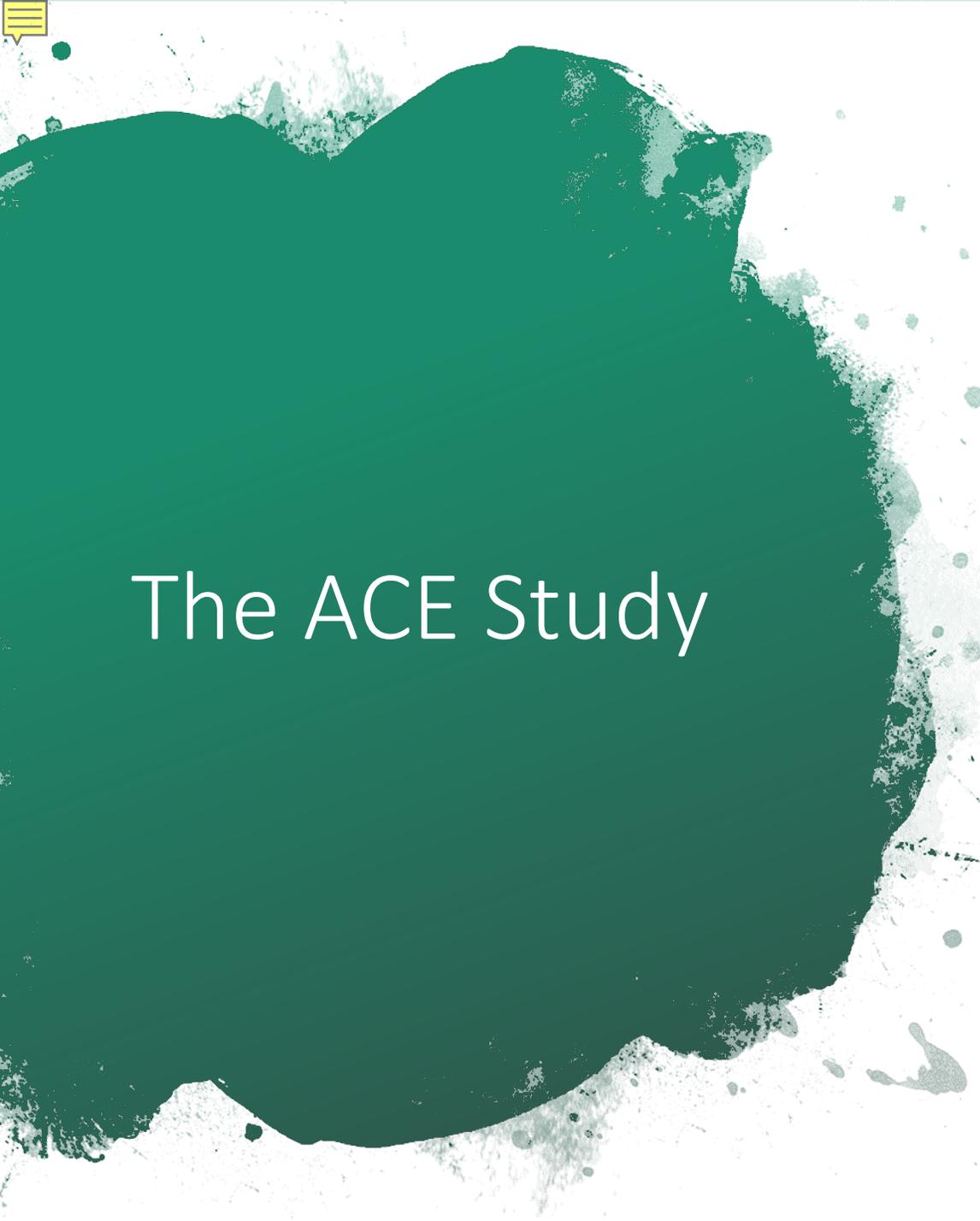


Your Brain on Trauma

- A brain shaped for reactivity and to protect oneself.
- Pathways related to F-F-F circuitry are primed and potentiated
- Increase in behaviors meant to serve the purpose of reducing emotional arousal – addictive and compulsive behaviors
- Interpersonal patterns of avoidance and reactivity cycle
- Behavioral pattern more likely to include aggression as a means of coping and protection.



Consequences of Childhood Trauma



The ACE Study

- The Adverse Childhood Experiences Study (ACE)
- Led by Robert F. Anda, MD, MS & Vincent J. Felitti, MD, Center for Disease Control, and Kaiser Permanente
- The largest scientific research of its kind (N = 17,000), analyzing the relationship between multiple categories of childhood trauma and adversity (ACEs) and behavioral and health outcomes in later life

ACEs

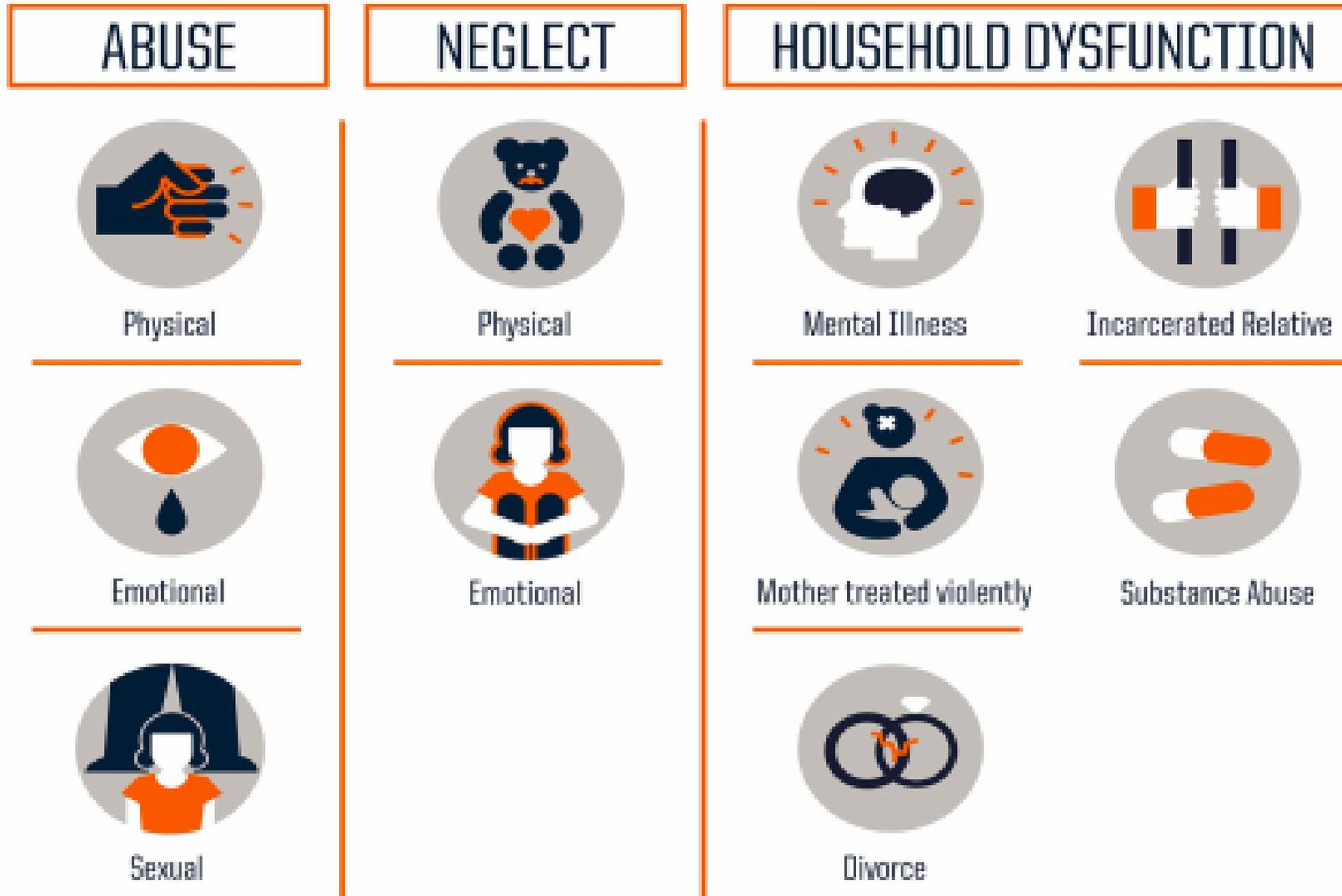


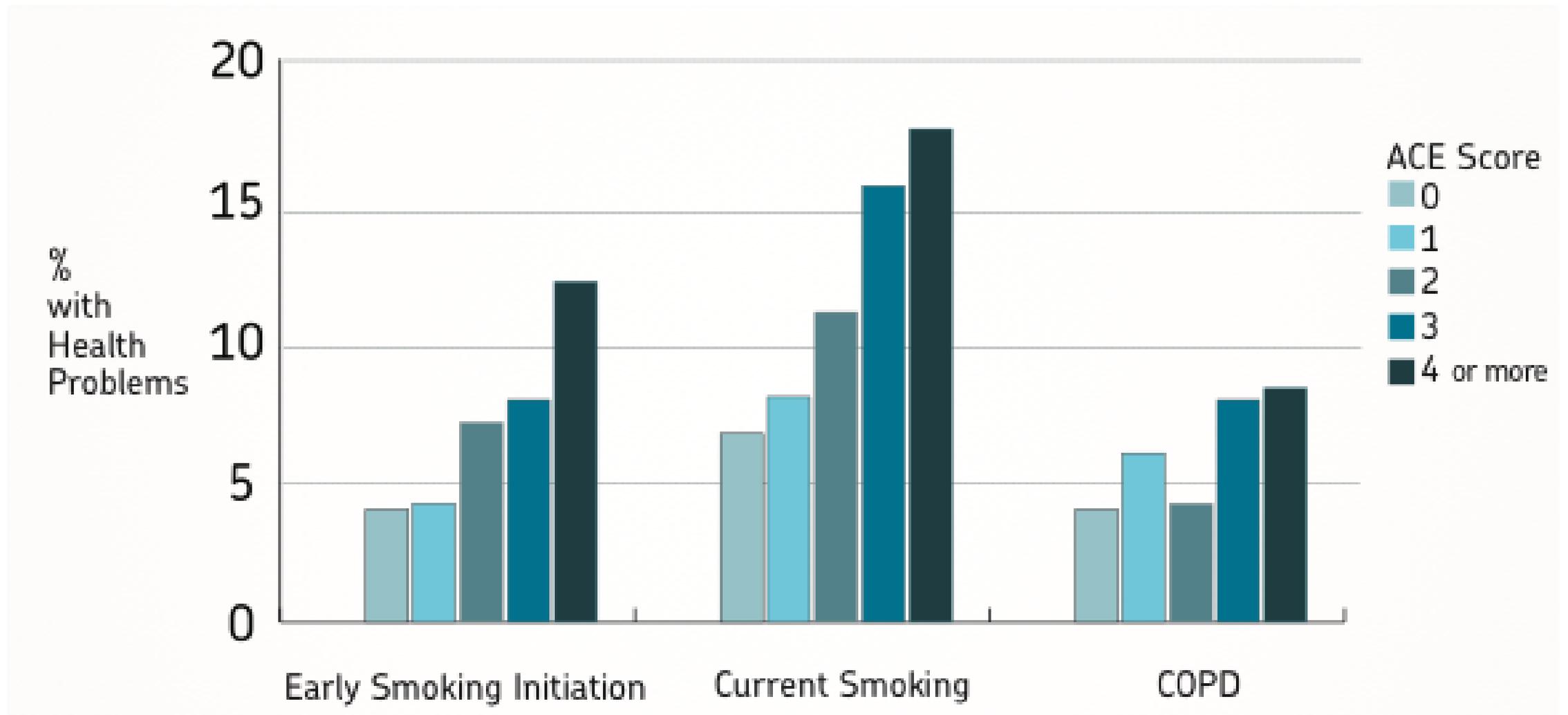
Figure 2
wff.org and cdc.gov, 2014

ACE Study Findings:

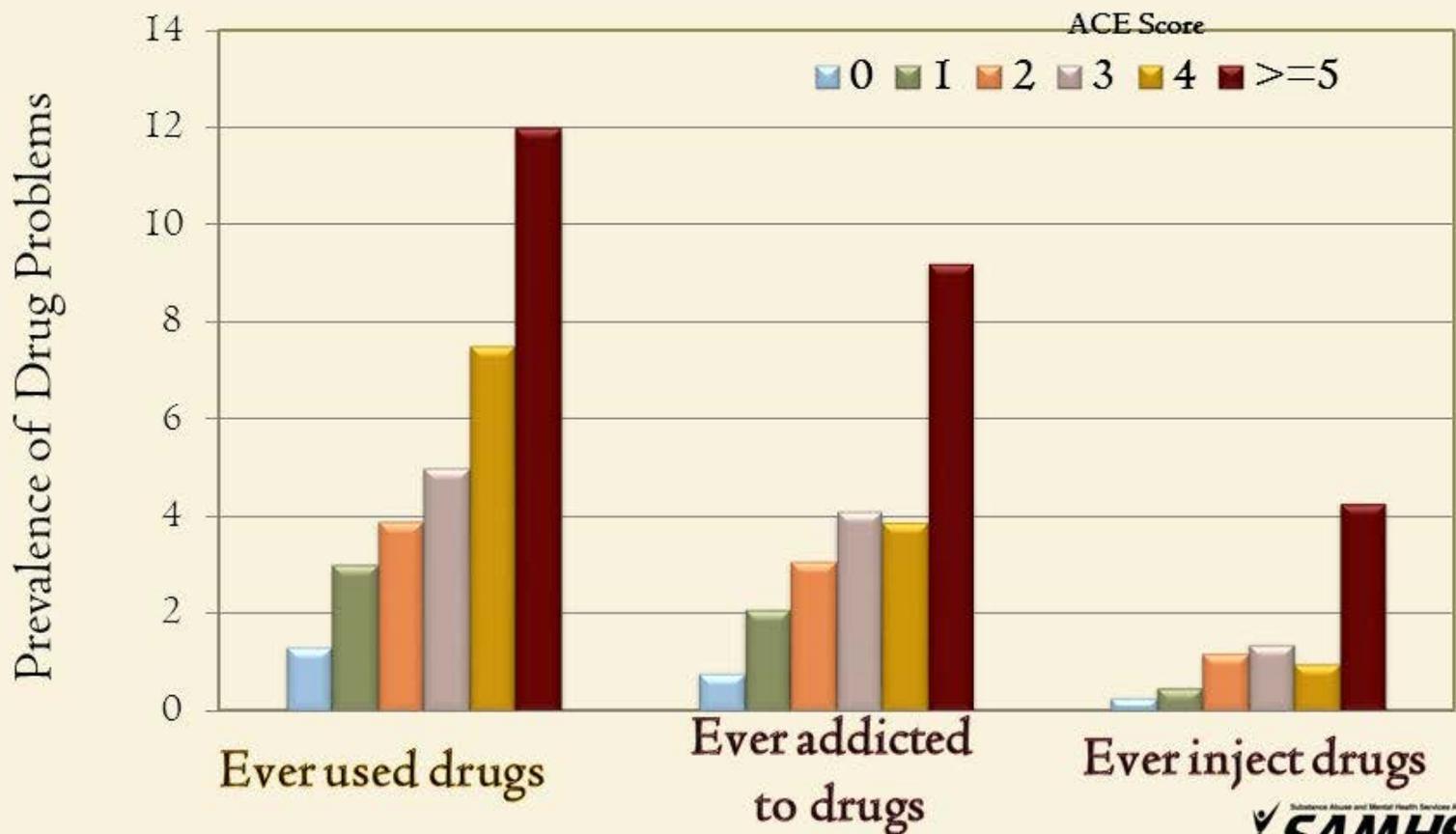
- 2/3 of adults had at least 1 ACE
- 20% were sexually abused as children
- 66% of the women experienced abuse, violence or family strife in childhood.
- If you have 1 ACE, 87% chance you have another
- Dose-response effect – the more ACES you have the worse your life outcomes including psychological, social and medical
- Doesn't matter which type of trauma
- ACE score or 4 (6% of people in the study) or more begins to robustly predict negative outcomes



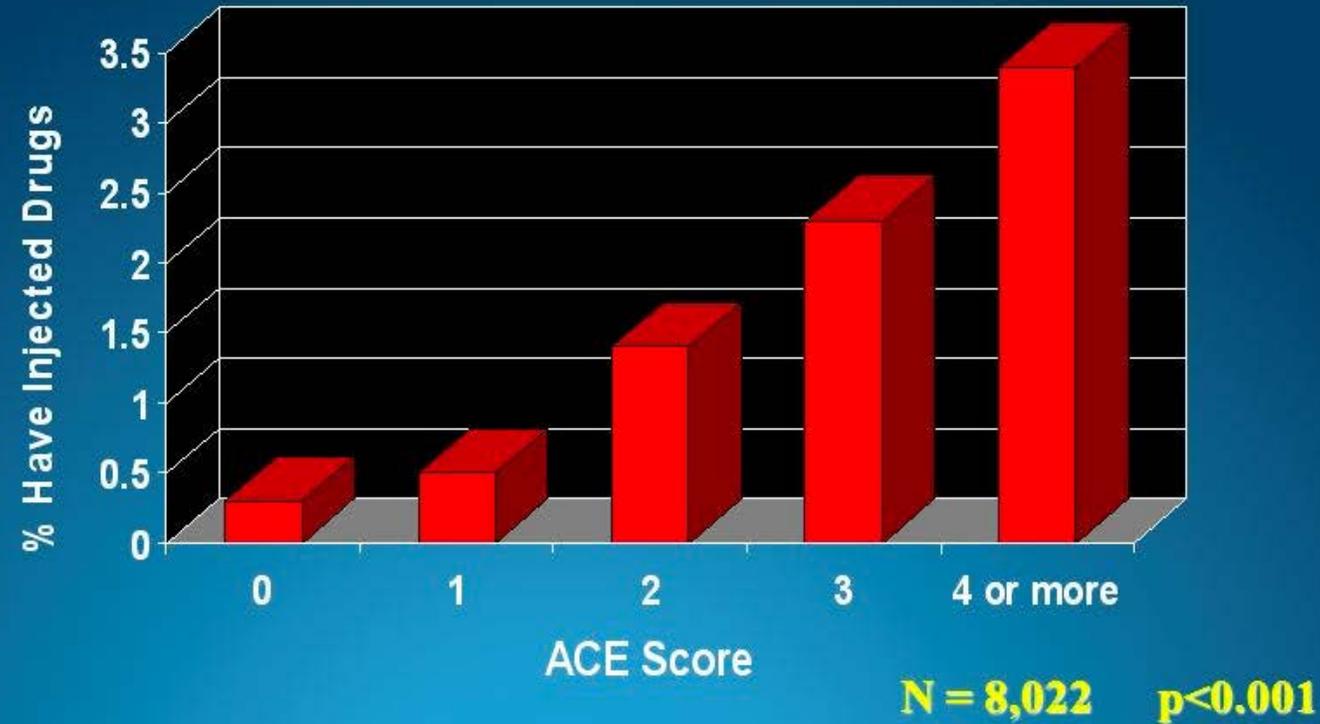
ACEs, Smoking and Lung Disease

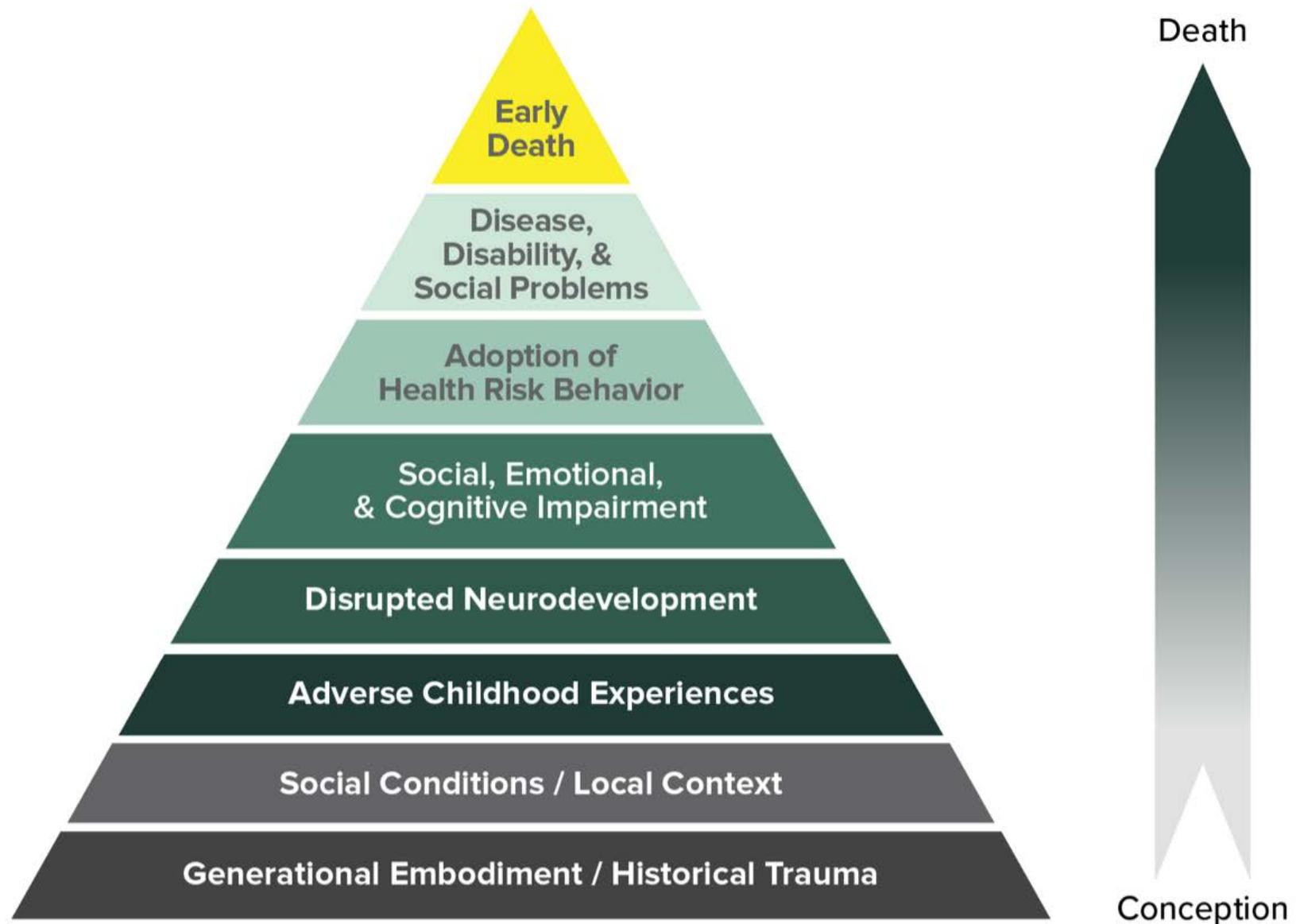


ACE Score and Drug Abuse



ACE Score and Intravenous Drug Use





Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Healing Neen

- Documentary that depicts growth and recovery after trauma and abuse, and it's FREE!
- <https://vimeo.com/15851924>

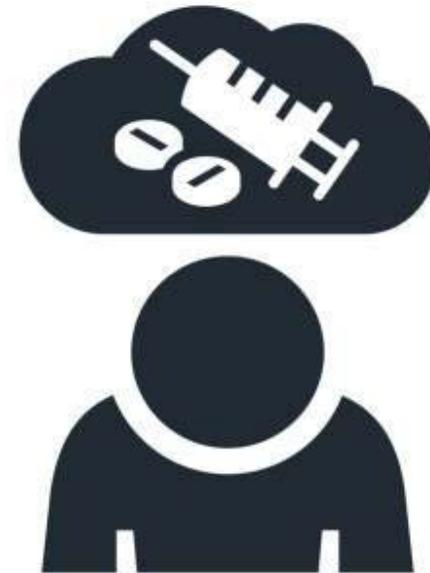




Childhood Trauma & Addiction

Trauma & Addictions

- Well-documented correlation between childhood abuse, PTSD and SUDs
- Evidence that brain dysfunction accompanies both PTSD and SUDs and these worsen the longer these disorders are active (DeBellis et al., 2000)
- Both PTSD and SUDs place children at higher risk for suicide (Brent et al., 2002).



Duncan et al. (1996)

- A national survey found an association between child physical abuse and SUD, depression and PTSD.

Silverman, Reinherz & Giaconia, 1996

- 17 year longitudinal study of a community-based sample found association between child abuse and PTSD and SUDs by 21 years of age.

Pietrzak et al., 2011

- 2010 National Epidemiologic Survey on Alcohol and Related Conditions ($N = 34,653$)
- Among individuals with PTSD, nearly half (46.4%) also met criteria for an SUD and more than one-in-five (22.3%) met criteria for substance dependence

Triffleman et al., 1995

- 38 male veterans with SUDs
- 77% had exposure to severe childhood abuse
- 58% had lifetime PTSD
- SUD symptoms strongly correlated with severity of childhood abuse

Farrugia et al., 2011

- 103 participants in an RCT testing an integrated treatment model for SUDs and PTSD
- 77% had experienced at least 1 trauma before age 16
- 55% endorsed sexual abuse
- Again childhood trauma strongly correlated with adult SUDs

Khoury et al., 2010

- 587 patients at Grady memorial Hospital in Atlanta
- Substance abuse, particularly cocaine, strongly correlated with measures of childhood abuse
- Exposure to multiple types of childhood trauma was particularly linked to substance abuse.

U.S. Studies of Trauma & Addiction

Fergusson & Lynskey 1997

- Followed birth cohort in New Zealand for 18 years
- Found that child abuse was associated with cannabis and alcohol abuse, even after controlling for social and contextual factors associated with maltreatment.

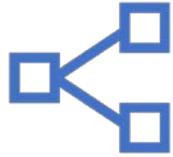
Ruchkin et al., 2002

- Studied 370 youths incarcerated in Russia found that a large proportion of these youth had been exposed to child abuse and other traumatic events and high rates of PTSD.
- The severity of their PTSD symptoms predicted both drug and alcohol abuse.

Kender et al., 2000

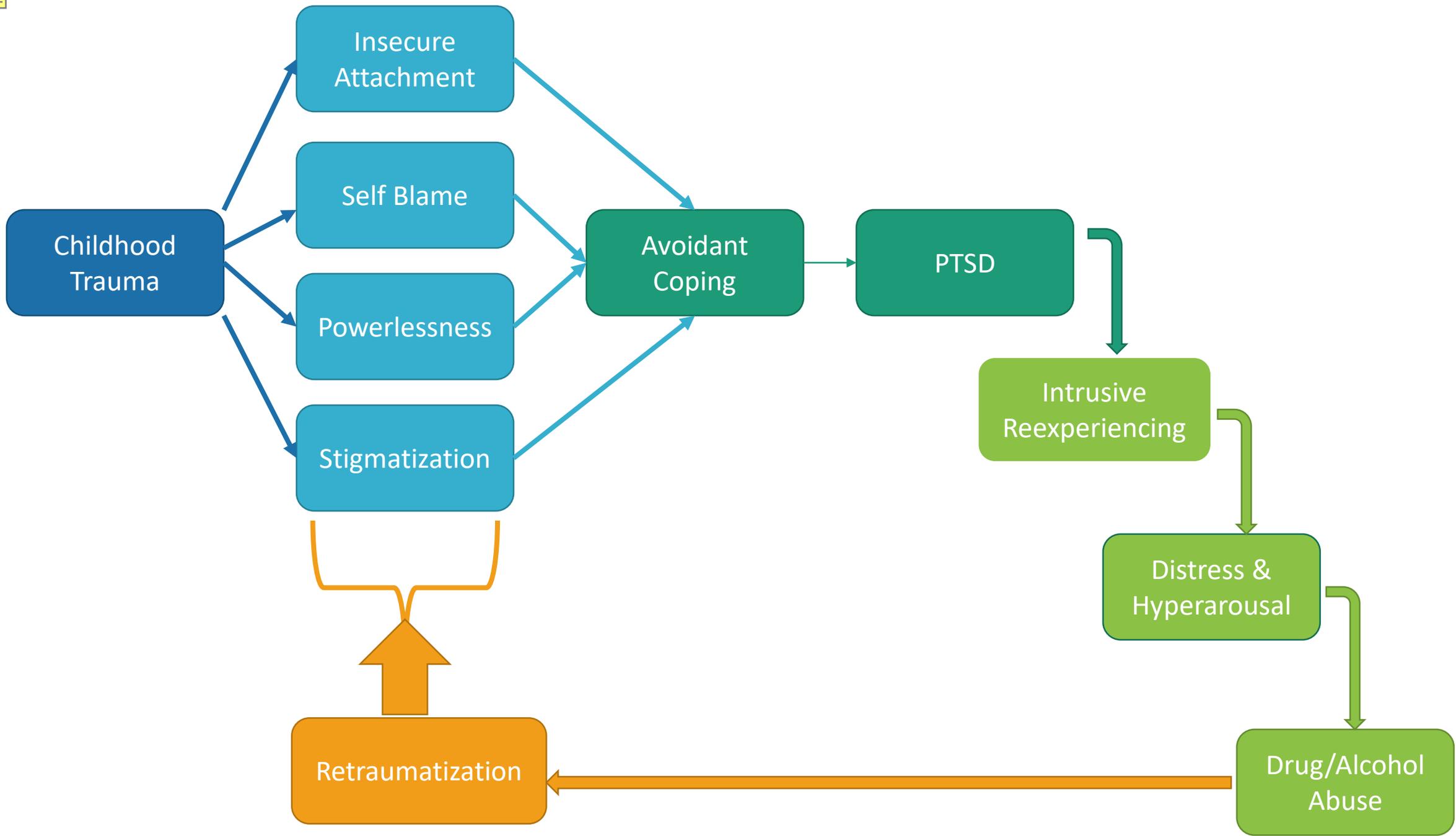
- Examined American and Australian twins
- Demonstrated that a history of child sexual abuse increased risk for substance abuse, even after controlling for family background risk factors such as family substance abuse, parental conflict, presence of a stepparent, and child physical abuse and neglect.

Cross Cultural Studies of Trauma & Addiction



Theories of Trauma- Addictions Link

- Childhood abuse most often is associated with...
 - Insecure attachment
 - Self-Blame
 - Avoidant coping & dissociation
 - Stigmatization
 - Distrust
 - Lowered help-seeking, sense of powerlessness
- Of the above, avoidant coping and dissociation are strongly linked to developing PTSD
- PTSD is characterized by hyperarousal, intrusive memories/reexperiencing
- Some youth with PTSD utilizes substances to reduce or distract from or escape this arousal and intrusive experiences
 - Drugs become yet another way to engage in avoidant coping
- Stable pattern of substance abuse, in turn, increases likelihood of retraumatization



PTSD + Addiction Links

- Not proven there is a direct causal connection between child abuse and addiction
- However, copious indirect evidence and theory would suggest there is likely a causal connection
- The relationship between trauma symptoms and addiction is likely bidirectional
 - Trauma begets addiction
 - The onset of addiction increases likelihood of additional traumatic experiences





PTSD + Addiction Links

- Chicken or the egg?
 - Strong consensus that childhood trauma is one among many causal variables that precedes and drives the development of addictions in SOME people.
 - Equal set of evidence that many other people experience addictions due to genetic, personality and experiential causes (non-traumatic).
 - Trauma is not a SINGULAR cause of addiction
- Today we are primarily envisioning the adolescent whose addiction is at least partially caused by prior childhood trauma experiences, which have lead to PTSD symptoms.



Evidence-Based Treatment for Adolescent Substance Abuse Disorders

cognitive distortions
regarding self-blame
for child abuse

increase tolerance for
reminder of child
abuse

increase tolerance for
trauma-related
distress and
hyperarousal

increase active coping
strategies

increase problem-
solving, safety-related
decision-making, and
social skills

optimize parental
support that is often
offline due to avoidant
coping that has set in

Trauma & Addictions: Treatment Targets



EBP Treatments for Adolescent SUDs

- Research suggests that the key determinant of the success of adolescent SUD intervention are...
 - Treatment factors - Specific therapeutic components
 - Therapist factors
 - Training and experience of the treatment providers
 - Competence in CBT approaches
 - Not related to the treatment setting (inpatient, outpatient vs. residential)
 - Not related to therapist's own personal history of SUDs



Family therapy and CBT are most predictive of reduction in adolescent problem behavior and substance abuse

Evidence that family therapies produce more sustained reduction in externalizing behaviors and substance abuse than individual CBT

Evidence that combining individual CBT with family therapy and with Motivational Interviewing yields better outcomes

Multisystemic Therapy – effective, but unwieldy and costly

12-step programs – no evidence for their superiority to family therapy, CBT and MI in SUDs among adolescents; best practices is to integrate 12-steps programming with these other EBP approaches

EBP Treatments for Adolescent SUDs

Research in Treatments for Youth with Comorbid PTSD and SUDs

Youth with child abuse histories and SUDs appear to need more treatment services and have worse clinical outcomes than youth with SUDs without abuse histories.

Research evidence that 12-step programs for youth with SUDs and child abuse is ineffective on its own

Calls for more assessment of trauma exposure and symptoms in settings treating youth with SUDs

EBP for SUD in Adolescents



Motivational Interviewing



Family Therapy



Substance use monitoring



Adjunctive 12-step program



Cognitive Behavioral Therapy



Relapse prevention skills



Strong therapeutic alliance including collaborative empiricism, structure and flexibility/choice for the youth



Integrated Treatment of
Comorbid PTSD and
Substance Use Disorders

Integrated Treatment of Trauma & Addiction in Youth

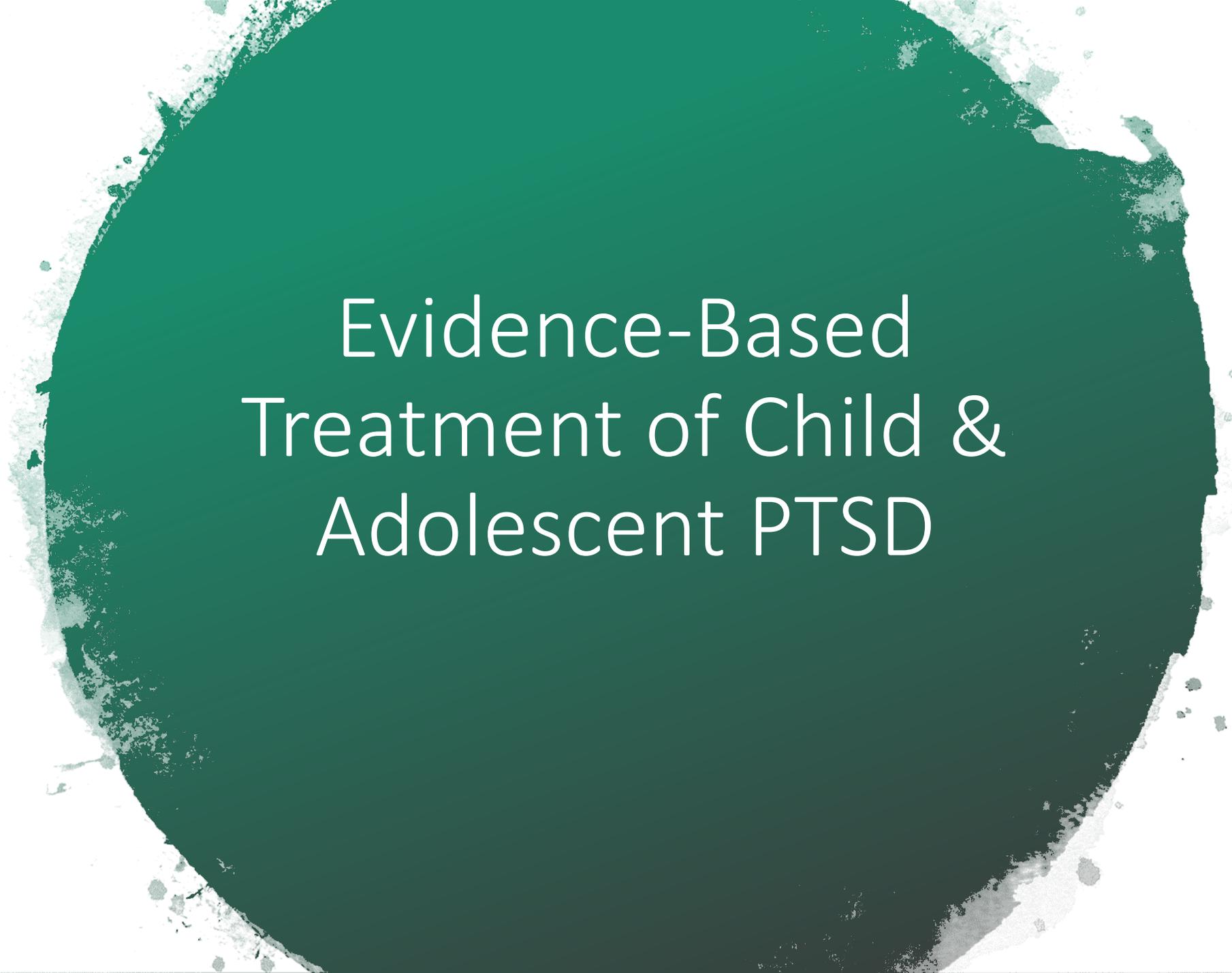
- Research of interventions using TF-CBT principles with adults with comorbid PTSD and SUD
 - Improved PTSD symptoms, social adjustment, problem-solving abilities, depression and decrease substance abuse and suicidal thoughts and behaviors
 - Seeking-Safety – group approach for adults adapted to an individual therapy model for youth

Integrated Treatment of PTSD and SUD

- Seeking Safety (Najavits, 2002)
 - Adapted for youth in adolescents from a group format to an individual format
 - 24 week program
 - Close therapeutic alliance
 - Affect regulation skills
 - Increase prosocial behaviors
 - Relapse prevention skills
 - Case management
 - Opportunity to discuss traumatic experiences

Integrated Treatment of PTSD and SUD

- Seeking Safety (Najavits, 2002)
 - RCT with 33 adolescents with PTSD and SUD
 - Seeking Safety vs. Treatment as Usual
 - Results – better outcomes for Seeking Safety in reducing SUD, dissociation and sexual concerns but not for PTSD symptoms
- Parent and family components
 - Found to improve treatments for both SUD and PTSD in adolescents
 - Yet to be explored if including parents in treatment for comorbid PTSD and SUD will lead to best outcomes



Evidence-Based
Treatment of Child &
Adolescent PTSD

A word on evidence-based treatments

- What they are....
 - Approaches to counseling that have been studied through clinical trials utilizing random assignment to treatment or true control groups.
 - Research utilizes as standardized an approach to the counseling model as possible in order to be able to generalize.
 - A manual is developed and utilized
 - Participants are standardized as much as possible in that they share a given diagnosis.

A word on evidence-based treatments

- What they are not...
 - They are not practice-based evidence - do not always reflect field-based observations in naturalistic settings.
 - They do not account for all the variability seen in people being treated
 - They are also not an approach that devalues the therapeutic relationship, therapist judgment and creativity, flexibility or attending to cultural and values
 - These are simply not as easy to observe or quantify in research, which does not mean these facets of intervention should be minimized



TF-CBT

- Most researched child/adolescent trauma intervention
- Empirical support for reducing PTSD, depressive symptoms and behavioral problems
- Most appropriate for children ages 5-14
- Evidence is available across cultures and nations
- Primary goal of TF-CBT is to reduce trauma-related symptoms and increase caregiver's ability to support the child's recovery from trauma. (Wamser-Nanney & Steinzor, 2017)

Research Evidence for TF-CBT Efficacy

- “Gold Standard” treatments for PTSD
 - Adults
 - Prolonged Exposure Therapy – 8-15 sessions
 - Cognitive Processing Therapy – 12 sessions
 - Children & Adolescents
 - TF-CBT defined as a first line treatment for childhood PTSD by the American Academy of Child and Adolescent Psychiatry and the International Society for Traumatic Stress Studies
 - Children & Adolescents
 - TF-CBT



TF-CBT Randomized Clinical Trials

- 5 RCTs have demonstrated TF-CBT is superior to
 - nondirective play therapy,
 - supportive therapy
 - child centered therapy
 - "treatment as usual"
 - and as compared to wait-list control groups and
 - Studies were among preschoolers, elementary school children and adolescents.
 - The results were not modified by gender or ethnicity.

Cohen & Mannarino, 1996; Deblinger et al., 1996; King et al., 2000



EBP for PTSD in Adolescents



Cognitive intervention targeting self-blame and stigma



Active coping skills



Affect regulation



Exposure to trauma material



Enhance parent/caregiver support



Therapy alliance embodying TiC principles of collaboration, safety and choices



Promote safety, social skills & problems solving



Cognitive Behavioral Therapy

FIRST EDITION

Treating
Trauma and
Traumatic Grief
in Children and
Adolescents

JUDITH A. COHEN

ANTHONY P. MANNARINO

ESTHER DEBLINGER

TF-CBT – P.P.R.A.C.T.I.C.E.

P.R.A.C.:

Coping Skills Phase

- P - Psychoeducation
- P - Parenting Skills
- R – Relaxation Skills
- A – Affective Modulation Skills
- C – Cognitive Coping

T.:

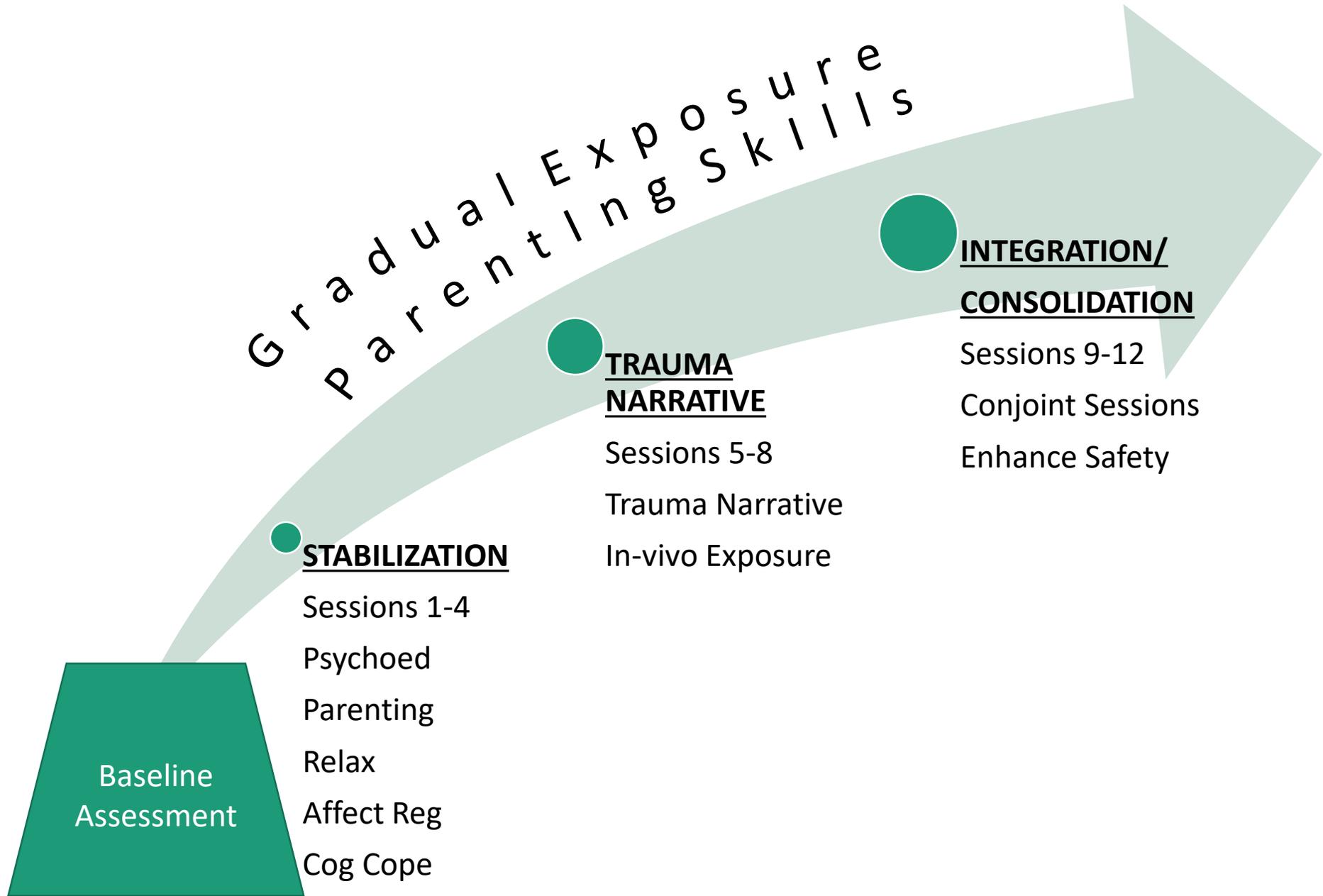
Trauma Narrative and Processing Phase

- Trauma Narrative and Processing

I.C.E.:

Treatment Consolidation and Closure Phase

- I – In vivo Mastery of Trauma Reminders
- C – conjoint Youth-Caregiver Sessions
- E – Enhancing Safety



Baseline
Assessment

Gradual Exposure
Parenting Skills

STABILIZATION
Sessions 1-4
Psychoed
Parenting
Relax
Affect Reg
Cog Cope

TRAUMA NARRATIVE
Sessions 5-8
Trauma Narrative
In-vivo Exposure

**INTEGRATION/
CONSOLIDATION**
Sessions 9-12
Conjoint Sessions
Enhance Safety

Baseline Assessment

- Appropriate instruments
 - UCLA PTSD Reaction Index
 - Steinberg, A. M., Brymer, M., Decker, K., Pynoos, R. S. (2004). The University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index. *Current Psychiatry Reports*, 6: 96-100.
 - CROPS/PROPS/LITE
 - Child Report of Posttraumatic Stress
 - Parent Report of Posttraumatic Stress
 - Greenwald, R., & Rubin, A. (1999). Brief assessment of children's post-traumatic symptoms: Development and preliminary validation of parent and child scales. *Research on Social Work Practice*, 9, 61-75.



Psychoeducation

- Normalize child's and parent's reactions to traumatic events and chronic stress
- Provide information about the nature of psychological and physiological reactions to trauma
- Education on the principles of CBT and the specific components of the TF-CBT model
- Instillation of hope
- Educate family about the potential for early intervention to change child's trajectory for the better
 - Give caregiver and child credit for seeking and sticking with help
- Psychoeducation occurs throughout treatment



Parenting Skills



- Parents are not optional in TF-CBT they are a **REQUIRED** component of treatment and a major drive of recovery
- Treatment should facilitate the child's view of parent as a figure who is safe and can handle the child's need for support during times of stress
- Communicate an invitation for parent involvement that frames this as parent is a key component of the solution, vs. inviting them because they are the cause of the child's problems.
- Promote and reinforce positive reinforcement-based parenting, particularly parental praise and creating opportunities for positive parent-child interactions

Relaxation Skills

- Reduce physiologic indicators of stress
- Teach relaxation strategies to be applied when physiological indicators occur. Important to tailor and individualized relaxation strategies.
- Examples
 - Focused breathing/mindfulness/meditation
 - Progressive, other muscle relaxation
 - Physical Activity
 - Yoga, singing, dance, blowing bubbles
- Promote strategies that are fun, rewarding and the child wants to repeat



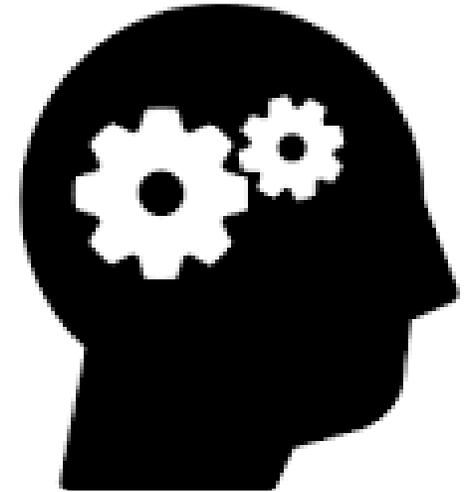


Affect Regulation Skills

- Identifying and labeling feelings
 - Expand range of feeling words
 - Use of various games to promote emotional labeling
- Typical for traumatized children to present with a restricted range of emotional expression, and to struggle to accurately label the emotional expressions of others. Bias towards hostile attribution.
- End every affect regulation training session on a positive note. Therapist praise child's successive effort to build these skills
- Reinforce the child enacting affect recognition skills and linking increasing emotional awareness as a signal to engage active coping such as relaxation.

Cognitive Coping

- Teach the cognitive triad
 - Teach skills to distinguish thoughts, feelings and behaviors
 - Reinforce connection between thoughts fueling feelings fueling behavior through review of weekly events
 - Collaborative empiricism is important aspect of this stage
- Identify and promote more positive reframes for both child and parent. Focus on helpful attributions that reduce negative emotional arousal and reduce behaviors driven by trauma reactivity.
- Enlist parents as external aids in helping child to engage in cognitive processing of aversive situation and apply principles in daily life.



Trauma Narrative & Processing

- Core feature of TF-CBT is to help child create and disseminate a trauma narrative
- Rationale for this component
 - Gain mastery over trauma reminders
 - Challenge and extinguish avoidant behavior
 - Challenge maladaptive cognitions related to original trauma exposure
 - Model adaptive coping for the child by therapist and parent
 - Identify, map and prepare for trauma triggers
 - Bring child into awareness as to what place traumatic experiences have in the full context of their life, e.g. they don't define them

Trauma Narrative & Processing



- Identify cognitive distortions linked to the traumatic experience present in both the child's and parent's thinking
- Engage in cognitive processing dialogue to identify distorted thoughts and collaborate with child and parent to select more helpful and adaptive thoughts in regards to the traumatic experiences.
- Encourage parents to reinforce children's more accurate/helpful cognitions

In vivo Mastery of Trauma Reminders

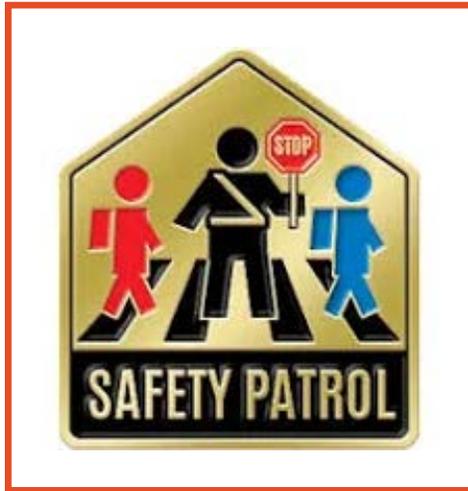
- This phase is critical to promote optimal long-term recovery
- If trauma triggers in child's life are risky or dangerous this step is not undertaken
- Gradual exposure to trauma triggers along a hierarchy established in consultation with child and parent





Conjoint Youth-Caregiver Sessions

- Provide space for child to share their experiences about the focal trauma and about their relationship with the caregiver as it relates to the trauma and otherwise
- Listen for cognitive distortions and offer more helpful thoughts
- Teach or reinforce effective communication skills in child and parent
- Use these dialogues to promote preparation for anticipated future exposure to trauma triggers in everyday life – this should end with the parent being a more effective “lifeline” for the child
- Teach and model appropriate limit-setting and redirection of the child that is not retraumatizing.



Enhancing Safety

- May be done individually or in joint sessions
- Develop children's body safety skills
- Develop a safety plan which is responsive to the child's and family's circumstances and the child's realistic abilities
- Practice these skills outside of therapy
- For sexually abused children, include education about healthy sexuality
- may include education about bullying, conflict resolution, etc.



Dropout from EBP Treatments for PTSD

- Dropout from CPT and PET – real world studies (Najavits, 2015)
 - Most patients do not stay in treatment for the prescribed amount of time
 - Watts et al. (2014) median # of sessions attended among 1924 veterans was 5
 - Only 2% attended what the data suggested was an adequate dose of 8 sessions
- Why?
 - Avoidance of traumatic memories itself is a key symptom of PTSD
 - Imel et al. (2013) – meta-analysis found that past-focused PTSD treatment has higher dropout rate than present-focused treatment
 - Evidence that dropout reliably occurs prior to the initial imaginal exposure tasks – aversion to the anxiety induced by the exposure component
 - Evidence that CPT has less aversive impact on clients than PET



Dropout and Treatment Obstacles TF-CBT

- 20-75% of children prematurely terminate TF-CBT (Wamser-Nanney & Steinzor, 2017)
 - Caregiver buy-in
 - Often referred by a third-party – law enforcement, child welfare worker, clergy etc.
 - Have their own direct or vicarious PTSD symptoms related to the child's victimization – they avoid the trauma material along with child
 - Child abuse is correlated with families facing multiple stressors which may impact treatment attendance and compliance
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