Evidence-based Treatment models in trauma work with children, adolescents and families

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Presentation Outline

- Overview of evidence-based practices for youth/families who have experienced trauma
- Overview of Trauma-focused CBT
- Look at a process of choice of treatment
- Training and supervision structures
- Cultural and other adaptations

Direction of Mental Health: Brief History

- Healthcare reform in US and Britain spurs growth of evidence-based practice movement (1996-present).
- Meta-analyses of psychotherapies document effect sizes (Weisz et al, 1995, 1998, 2003; Kazdin et al., 1998, 2003).
- Surgeon General's Reports (1999; 2000; 2001) and President's New Freedom Commission highlight disparities between research and practice.
- Calls for Effectiveness Research - Dissemination, Implementation, and Transportability.

Evidence-Based Treatments

- Conditions set by APA, 1996
  1. Manual-based
  2. Sample characteristics detailed
  3. Tested in a randomized clinical trial
  4. At least two different investigatory teams must demonstrate intervention effects

- Defined in child abuse services as:
  - "…competent and high-fidelity implementation of practices that have been demonstrated safe and effective, usually in randomized controlled trials (RCTs)…" (Chaffin & Friedrich, 2004)

Review of EBPs for Child Trauma

- Movement towards identifying EBPs for maltreated/traumatized children and families
  - U.S. Office for Victims of Crime (OVC, 2001)
    - Reviewed 24 treatment protocols
    - One treatment was “well-supported and efficacious”
  - Kauffman Foundation of St. Louis
    - Identified small number of under-disseminated EBPs for abused children and their families

Evidence-Based Child/Adolescent Trauma Treatments

Authors	Pop	Design	Components
Cohen, Mannarino Deblinger	Sexual Abuse, traumas (Indiv.)	Clinical trials; completed dismantle study	Psychoed, feeling identification, relaxation, thought stopping, cognitive coping, safety training, Cognitive triangle, Gradual Exposure
Layne, Saltzman, & Pynoos	War, Comm. Violence (Groups)	Pre/Post Non-randomized	Psychoeducation, Cognitive pyramind, Cognitive restructuring, Coping skills, Trauma Narrative, Problem-solving

Evidence-Based Child/Adolescent Trauma Treatments

Authors	Pop	Design	Components
Jaycox, L.	School trauma (Group)	clinical trials	Education, Relaxation Training, Cognitive Therapy, Real-life exposure, Stress/Trauma exposure, Social problem-solving
Kolko, et al.,	Physical abuse	Manualized, in book; Clinical trial	Psychoeduction, Emotions, Parent training, Externalizing symptom focus, Coping skills, cognitive component, Self-evaluation, Relapse prevention strategies

Overview of Treatment Research for TF-CBT

- Trauma-Focused CBT is the most rigorously tested treatment for abused children
  - 10 randomized trials
- Improved PTSD, depression, anxiety, shame and behavior problems compared to supportive treatments
- PTSD improved more with direct child treatment
- Improved parental distress, parental support, and parental depression compared to supportive treatment

Treatment Research for TF-CBT

- Deblinger et al., (1996, 1999): sexually abused children, 4 conditions
  - Standard Community care
  - TF-CBT, child only
  - TF-CBT, non-offending parent only
  - TF-CBT, both child and adult
- Children experienced significant improvement in PTSD symptoms with or without parent
- Maintained at 2-year follow-up
- Deblinger et al. (2001): children aged 2-8 years, group format
  - Superior to supportive group counseling with respect to maternal abuse-specific distress and children's body safety skills

TF-CBT Treatment Research

- Cohen & Mannarino (1996, 1997):
  - Sexually abused preschool children
  - TF-CBT superior to NST in PTSD symptoms, sexualized behaviors, internalizing and total behavior problems
  - Maintained at 1 year follow-up
- Cohen & Mannarino (1998)
  - Sexually abused 8-15 years
  - Significant improvements in PTSD, depression, social competence and dissociative symptoms
  - Maintained at 1 year follow-up
- King et al (2000)
  - Individual, family or wait-list control
  - Active treatment conditions improved significantly

Treatment of Parents/Caregivers Research

Evidence that treating parent is important:

- Deblinger et al. (1996): Treating parents resulted in decreased behavioral and depressive symptoms in child
- Cohen and Mannarino (1996): Parents' emotional reaction to trauma was the strongest predictor of treatment outcome (other than treatment type)
- Cohen and Mannarino (1997): At the 12 month follow-up, parental support was significantly related to decreased symptoms in child

TF-CBT Treatment Research

- Cohen, Deblinger, Mannarino, & Steer, 2004
  - Two-site, Randomized controlled trial
  - 229, 8-14 year old, Sexually Abused
  - TF-CBT versus Child-Centered Therapy
  - TF-CBT superior on measures of PTSD, depression and total behavior problems
- RCT with Domestic Violence population (Cohen and Mannarino, in press)

TF-CBT Components

- **PRACTICE**
  - **Psychoeducation and Parenting Skills**
  - **Relaxation**
  - **Affective Modulation**
  - **Cognitive Processing**
  - **Trauma Narrative**
  - **In Vivo Desensitization**
  - **Conjoint parent-child sessions**
  - **Enhancing safety and social skills**

Engaging Families in Treatment

- Establish common ground/form an alliance
- Emphasize importance/primacy of parental role
- Emphasize TEAMWORK
- Highlight the short-term nature of this
- Instill hope of recovery

Psychoeducation

- Goals:
  - Normalize child's and parent's reactions to severe stress
  - Provide information about psychological and physiological reactions to stress
  - Instill hope for child and family recovery
  - Educate family about the benefits and need for early treatment

Psychoeducation in practice

- Provide general information about the event
  - Prevalence
  - Who/What/Why
- Provide information about common emotional and behavioral responses to the event
  - Empirical information if available
  - Clinician's experience with other children
  - Written literature by victims
- Provide information about the child's symptoms/diagnosis
  - Emphasize positive coping

Parenting Skills

- TF-CBT views parents/caregivers as central therapeutic agent for change
- Establish caregiver(s) as the person the child turns to for help in times of trouble
- Explain the rationale for caregiver(s) inclusion in treatment
  - Not because they are part of the problem but because they can be the child's strongest source of healing
- Emphasize positive parenting skills,
  enhance enjoyable child-parent interactions,
  maximize perception/reality effective parenting

How to fit these techniques into TF-CBT…

- Praise
- Selective Attention
- Time Out
- Contingency Reinforcement Programs
- General Behavior Management
  - Sleep problems
  - Aggressive behaviors
  - Chores

Relaxation

- Goal: Reduce physiologic manifestations of stress and PTSD
- Techniques:
  - Explain body responses to stress
  - Focused breathing/ mindfulness/meditation
  - Progressive Muscle Relaxation
  - Physical Activity
  - Music/Singing

Affective Modulation

- Feeling Identification Goals
- Accurately identify and express a range of different feelings
- Get *their* vocabulary
- Another way to talk about feelings (e.g., colors, objects)
- Physical/Concrete (body, facial expressions)
- Situations that correspond
- Strength

Affective Modulation

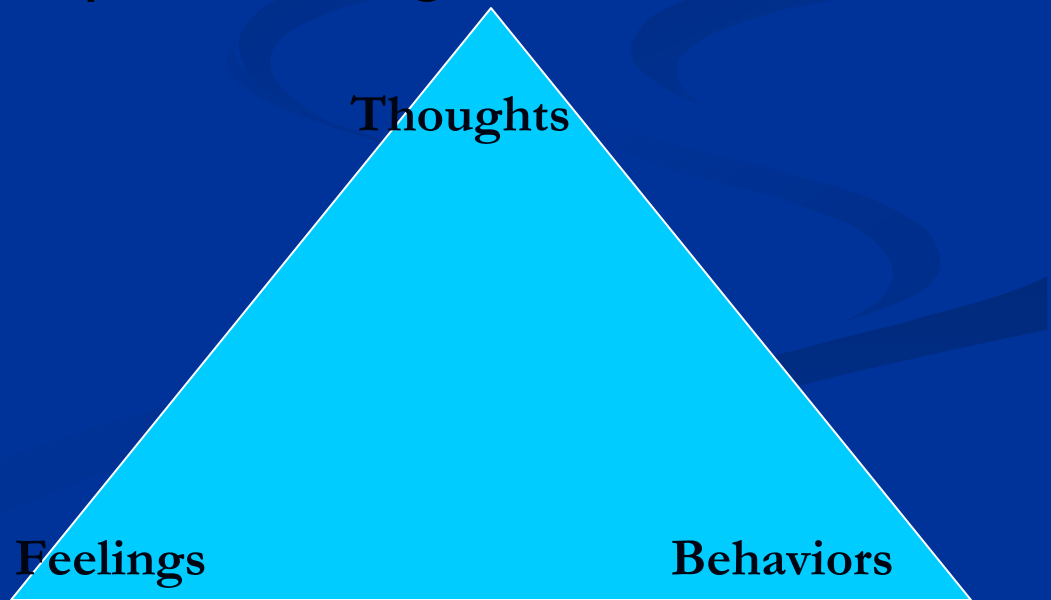
- Possible Techniques
  - Draw a person/Draw a circle
  - Feeling Brainstorm
  - Inside/Outside Feelings (Masks)
  - Cup activity (Zambia)
  - Singing (Zambia)

Cognitive Coping

- Traumatized youth/families often have inaccurate or "unhelpful" thoughts. These can take the form of:
  - Maladaptive assumptions: "If I were a better friend/parent, then I would have known this was going to happen to her"
  - Maladaptive rules: "I must always be able to protect the people I care about"
  - Maladaptive attitudes: "It's dangerous to trust or depend on anyone"
- Negative thoughts can directly exacerbate symptoms and/or make recovery more difficult.

Cognitive Coping

- **Goals**
  - Distinguish between thoughts, feelings, and behaviors.
  - Educate about the connection between T-F-B
  - Identify inaccurate or unhelpful thoughts.
  - Stop or replace maladaptive thoughts with “helpful thoughts.”



THINKING MISTAKES

1. Black - and - White Thinking - You tend to think of things in extremes - either you're perfect or you're a total failure. Example: A teenage girl on a diet eats a spoonful of ice cream and says to herself, "I've blown my diet completely!" She gets so distressed over 1 spoonful of ice cream that she ends up eating a whole quart.

2. "Yes But" Thinking - You tend to ignore the positives in your life and focus only on the negatives. Example: A friend tells you that you look nice in your new outfit and you say to yourself, "He's just saying that to be nice. He's nice to everybody."

3. Mind Reading - You act as if you are able to tell what other people are thinking without checking with them first. Example: A friend doesn't return your call and you say to yourself, "He doesn't like me anymore. He thinks I'm weird."

4. Telling the Future - You act as if you can predict the future and know that something will turn out badly. Example: A teenager wants to try out for the track team but says to himself, "I'll never make the team. I'll be so nervous that my running will be lousy." As a result, he doesn't even give it a try.

5. Emotional Reasoning - You decide how things "really" are on the basis of how you feel. Example: You feel worried about giving a report in front of your English class and say to yourself, "I feel so nervous. Everyone will see my nervousness, and something awful is going to happen during my report."

6. Labeling - You attach negative labels to yourself and call yourself names. Example: You miss an appointment with your doctor by accident. Instead of thinking, "I made a mistake", you say to yourself, "I'm so untrustworthy. I'm stupid!"

7. Should Statements - You try to motivate yourself by thinking "I <u>should</u> do this" and "I <u>shouldn't</u> do that." Example: After working all day on a drawing, a talented young artist says to herself, "I shouldn't make so many mistakes. I ought to do better after all those art classes!" Note: Beware of "must", "ought," and "have to" as well.

8. Overgeneralizing - You make a conclusion about something on the basis of 1 or 2 things. Example: You find out that a girl in your History class doesn't like you, so you conclude that everybody in the class hates you.

9. Catastrophizing - You exaggerate the likelihood that something bad will happen, or you exaggerate how bad it would be if it really did happen. Example: A teenager is nervous about a blind date he has scheduled this weekend, and says to himself, "chances are she'll hate me, which would be awful and horrible. I could never face our mutual friends again."

Direct Discussion of Traumatic Events

- Reasons we avoid this with children:
  - Child discomfort
  - Parent discomfort
  - Therapist discomfort
  - Legal issues
- Reasons to directly discuss traumatic events:
  - Gain mastery over trauma reminders
  - Resolve avoidance symptoms
  - Correction of distorted cognitions
  - Model adaptive coping
  - Identify and prepare for trauma/loss reminders

Trauma Narrative/Gradual Exposure

- Goals
  - Confront fears and prevent avoidance
  - To discuss trauma without undue distress, avoidance, numbing or detachment
  - To realize that nothing bad will happen

- Examples for Rationale
  - Monsters under the bed or in the closet
  - Watching a scary movie
  - Splinter or a cut/scrape
  - Swimming in a cold pool

Creating the Trauma Narrative

- Introduce the child to the rationale for the narrative
- Review the child's description at subsequent sessions
  - Help the child to describe more details
  - Encourage child to describe thoughts and feelings related to trauma
  - Desensitize child to talking about the event
  - Gradually desensitize child to actual event

Creating the Trauma Narrative

- Multiple episodes – multiply traumatized
  - Let the child choose one (example: first time, last time, one best remembered)
  - Typically children proceed from first to last episode, but not always
- Timeline
- Chapters
- Can choose certain ones that seem to be contributing more to the syptoms/problems

Cognitive Processing of the Trauma

- Explore inaccurate or unhelpful cognitions about the trauma and the feelings that accompany them
  - Inaccurate thoughts (ex: “the torture/abuse was my fault”)
  - Unhelpful thoughts (ex: “you can never tell when someone might pull a gun on you in my community”)

Cognitive Processing of the Trauma

- Replace distorted cognitions with more accurate, realistic, or helpful ones
  - Progressive logical questioning
  - Alternative cognitions
  - ”Best friend” role play
  - Lists, Definitions
  - Scientific Investigations
  - News Interviews
  - Responsibility Pie

Creating the Trauma Narrative

- Ending on a positive note…

- What have you learned?
- What would you tell other kids who experienced this?
- How are you different now from when it happened/when you started treatment?

Preparing for Joint Sessions

- Meet with child and prepare questions
- Meet with parent
  - Review child's questions and appropriate responses
  - Prepare their questions – Reframe if necessary

Conjoint Parent-Child Sessions

- Share information about child's experience
- Correct cognitive distortions (child and parent)
- Encourage optimal parent-child communication
- Prepare for future traumatic reminders
- Model appropriate child support/redirection

Enhancing Safety Skills

- Typically done in conjoint parent-child sessions, but may also be done individually
- Develop a safety plan which is responsive to the child's and family's circumstances and the child's realistic abilities
- Practice these skills at home
- For sexually abused children, include education about healthy sexuality
- For children exposed to DV, PA, CV, may include education about bullying, conflict resolution, etc.

Looking to the Future

- **Goals:**
  - Facilitate normal developmental progression
  - Relapse prevention
  - Build skills for upcoming developmental tasks
- **Application:**
  - Asking “What did you learn?”
  - Personal development goals
  - Timeline
  - Imagine, plan for my life in the future

Applying TF-CBT in Real Life

- First things first
- Provide crisis response
  - Integrate COWs into treatment components
- Know what your setting can do
- Triage for priority focus
  - Basic needs (e.g., place to live)
  - Response to system activities (e.g., placement, legal processes)
  - Psychiatric emergencies/active substance abuse
  - Sexual behavior problems

Choosing an EBP

- What are the needs/problems of the population?
- What are the ages addressed?
- Is there a family/caregiver piece?
- Does it consider developmental variation?
- What is the evidence behind its effectiveness?
- Adaptability?
- Flexibility?
- Trainability?

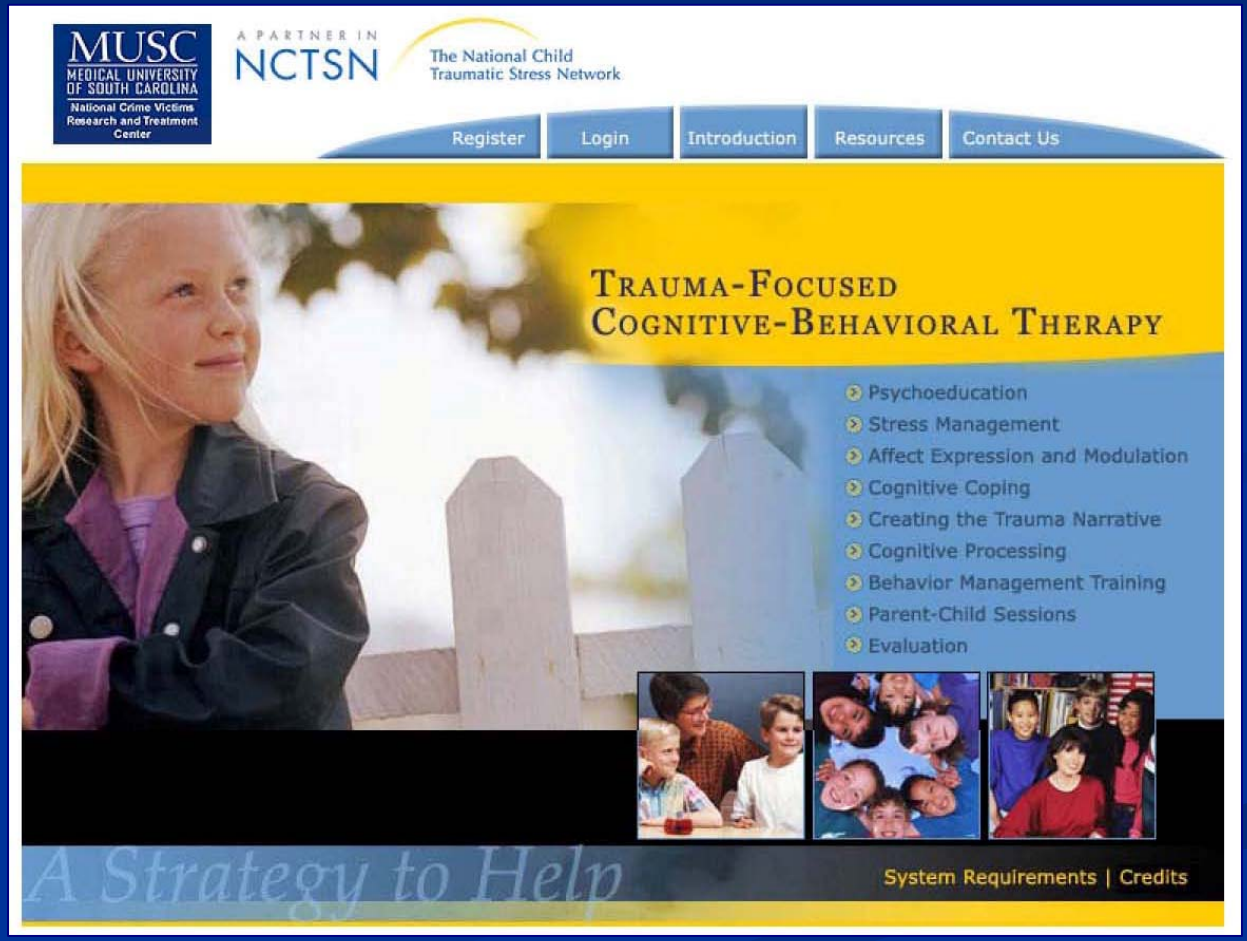
Training and Supervision

- Online
- Live training (e.g., 2 weeks, 2 5-day)
- Group practices
- Educational background: at least high school
- Identification of local leaders; train as future supervisors
- Ongoing group supervision
- Possible outside clinical supervisors

TF-CBT*Web*

www.musc.edu/tfcbt

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



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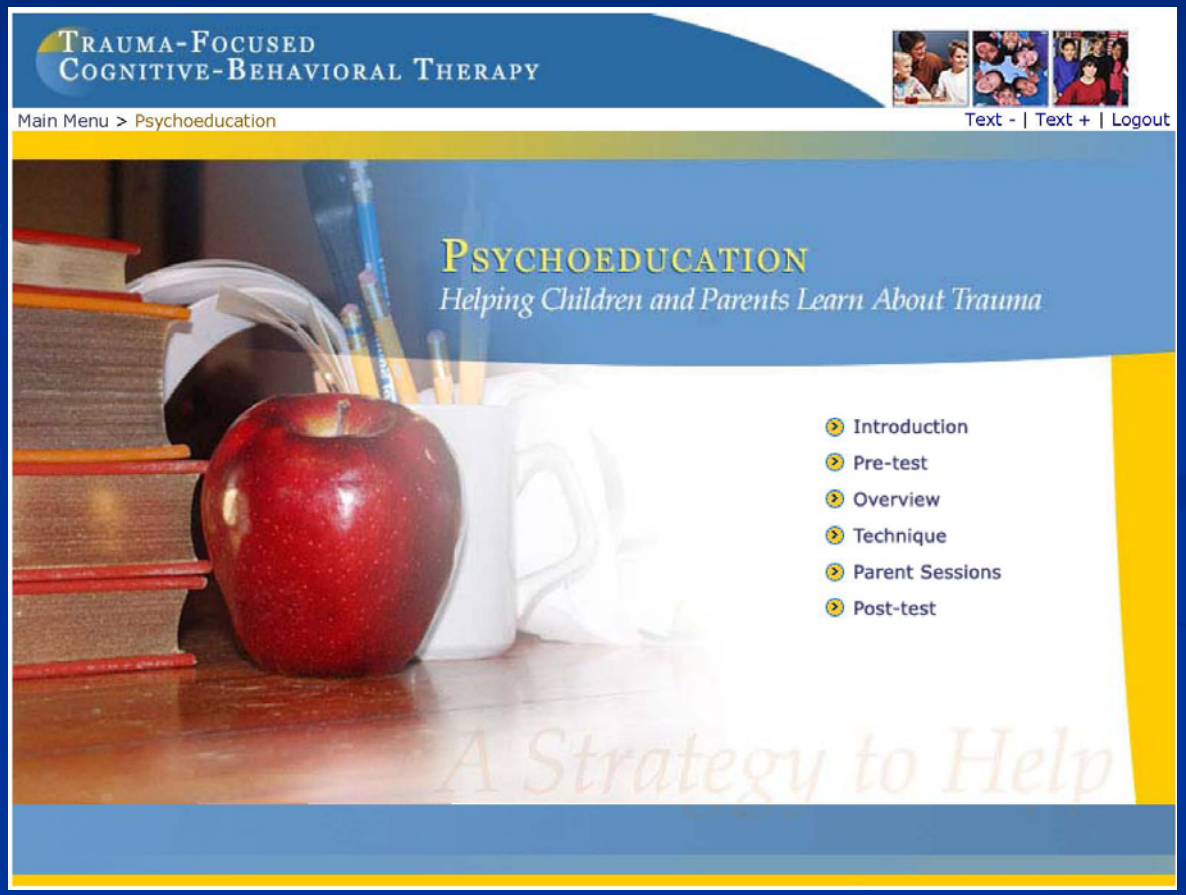

- Web-based learning
- Learn at your own pace
- Learn when you want
- Learn where you want
- **10** hours of CE credit
- Return anytime

TF-CBT*Web* is offered free of charge.

Cultural Adaptations

- Local languages: tribal languages more simple
- Trauma narratives done in pictures
- Markers/Colors become sticks/plants/rocks
- Witchcraft/Spirits and cognitive restructuring
- Bread-winning often

prioritized over safety so

extensive safety plans

were developed when

sending kids home

Summary

- Solid evidence-based treatments for abuse/neglect and trauma for youth and families.
- Increasing numbers of cross-cultural effectiveness studies.
- Studies show these treatments are trainable and can be done with fidelity and flexibility.

Thank You!

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