Assessment and Trauma Focused Treatment for Children

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March 28, 2012

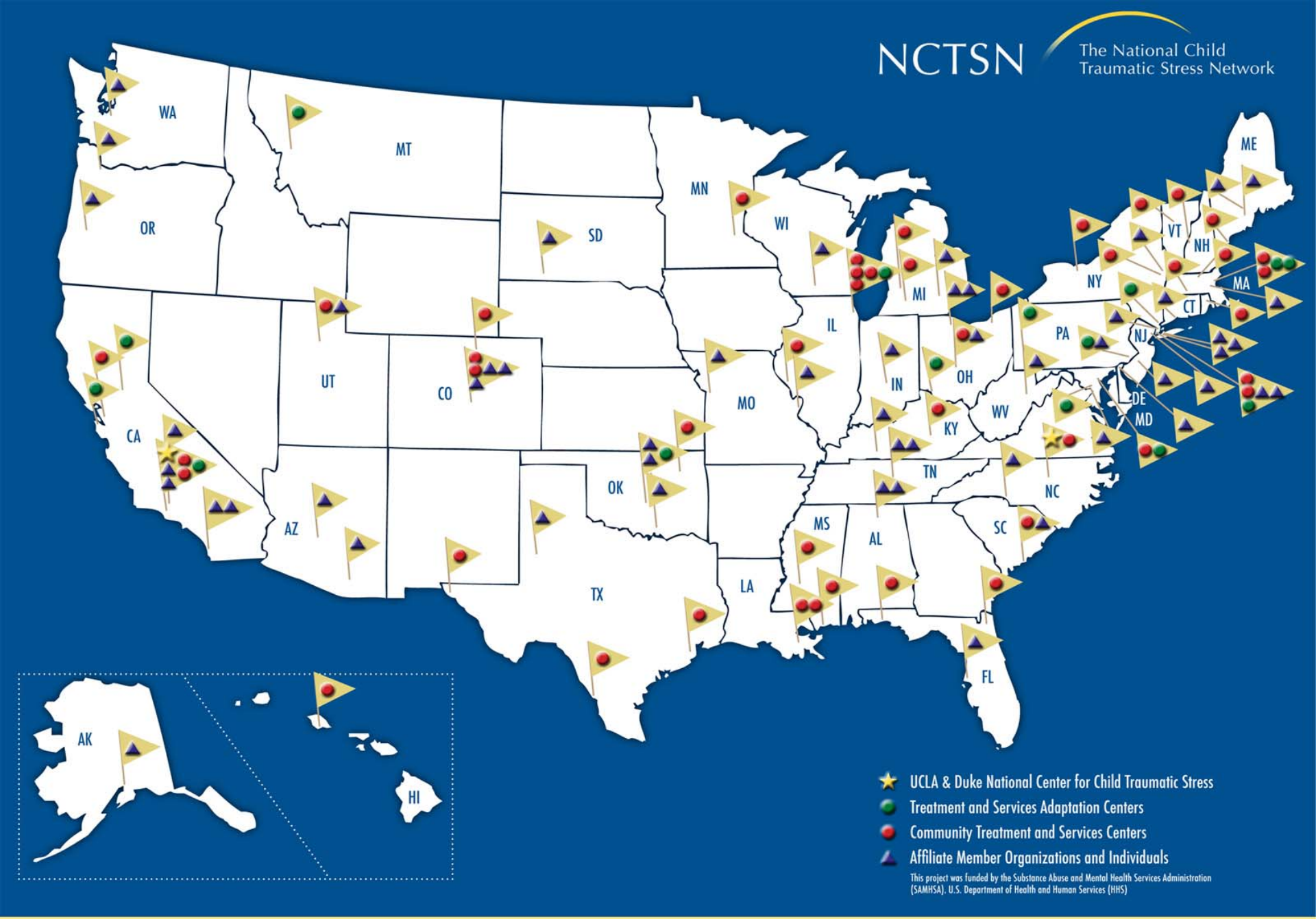
NCTSN The National Child Traumatic Stress Network

The National Child Traumatic Stress Network

The National Child Traumatic Stress Network is supported through funding from the Donald J. Cohen National Child Traumatic Stress Initiative, administered by the Department of Health and Human Services (DHHS), Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA).

National Child Traumatic Stress Network Mission Statement

The mission of the National Child Traumatic Stress Network (NCTSN) is to *raise the standard of care* and *improve access* to services for traumatized children, their families, and communities throughout the United States.



National Child Traumatic Stress Network Centers

An Overview of Child Traumatic Stress and PTSD

Range of Traumatic Events

- Trauma embedded in the fabric of daily life
  - Child abuse and maltreatment
  - Domestic violence
  - Community violence and criminal victimization
  - Sexual assault
  - Medical trauma
  - Traumatic loss
  - Accidents/fires
  - Natural disasters
  - War/Terrorism/Political Violence
  - Forced Displacement

What We Know.....

- Violence exposure through families, schools, neighborhoods, communities, and media are at epidemic levels
- Young children are particularly at risk
- Maltreatment of children and violence against women often go hand in hand
- Children suffer severe emotional and developmental consequences from exposure to violence
- The effects of trauma are further complicated by poverty and adversity

What is traumatic stress?

- Exposure to events that involve threats of injury, death, or danger where intense terror, anxiety, and helplessness is experienced
- Common causes: physical/sexual abuse, DV, war, community violence, natural disasters, displacement
- Can occur via direct experience or witnessing event, or hearing about an event
- Reactions vary with age, but even very young children experience intense reactions

Children: Signs & Symptoms of Trauma Exposure

- ✓ Sleep disturbances
- ✓ Fear/Worry
- ✓ Separation anxiety
- ✓ Hyper-vigilance
- ✓ Physical complaints
- ✓ Irritability
- ✓ Emotional upset
- ✓ Learning /School difficulties
- ✓ Regressive behaviors
- ✓ Withdrawal
- ✓ Blunted emotions
- ✓ Distractibility
- ✓ Changes in play
- ✓ Changes in social functioning
- ✓ Impulsivity
- ✓ Aggression

Symptoms of PTSD

- Re-experiencing
- Avoidance/Numbing
- Hyperarousal

Diagnostic and Statistical Manual of Mental Disorders, 4th ed. 1994.

DSM-IV Posttraumatic Stress Disorder

(American Psychiatric Association, 1994)

- A) A traumatic event
  - experienced, witnessed or confronted an event, involving actual or threatened death, serious injury
  - Trauma response involved fear, hopelessness, horror
- B) Reexperiencing: intrusive recollections, dreams, flashbacks, (traumatic play) ,distress w/ exposure to cues, physiological reactivity to trauma cues
- C) Avoidance: thoughts, feelings, activities, amnesia

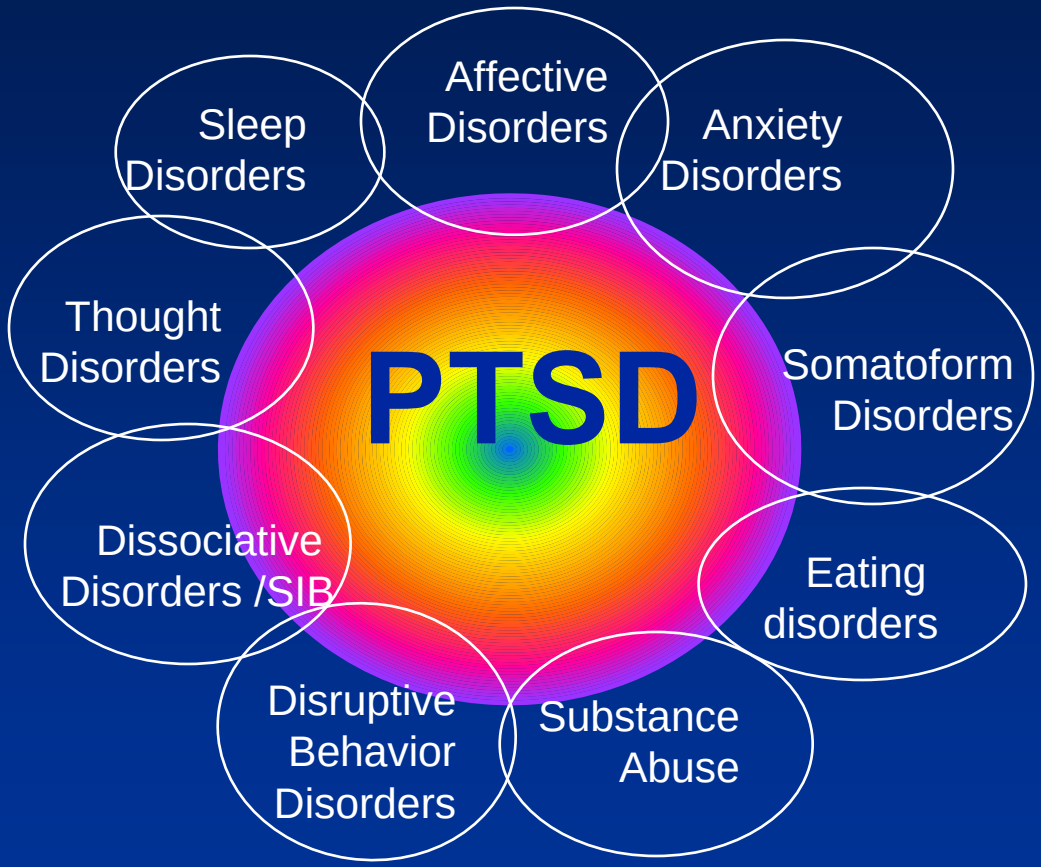
  Numbing: restricted affect, foreshortened sense of future
- D) Hyperarousal: insomnia, irritability, anger outbursts, trouble concentrating, hypervigilance, increased startle, *somatization
  - Duration > 1 month
  - Related impairment

Young Children

- Be aware of developmental differences in manifestation of symptoms
- Often present with generalized anxiety symptoms
- Fears of separation, stranger anxiety
- Re-enactment in play or drawings
- Loss of recently acquired developmental skills
  - Regress in areas like feeding, toileting
- Uncharacteristic aggression, irritability

**Young children are strongly affected by parental reactions

Comorbidity



-March & Amaya-Jackson '98

Which children & adolescents develop acute and posttraumatic symptoms?

- Not all children develop symptoms following exposure to a traumatic event
- Studies show that approximately 20% of children who are exposed to trauma develop PTSD symptoms
- Development of symptoms seems to be mediated by a variety of factors

Continuum

Resilience ⟷ Severe Distress

Varies by:

- Type of trauma
- Severity
- Chronicity
- Cultural beliefs
- Other experiences
- Timing
- Cumulative risk

Reactions: Refugee Children & Families

- Physical and psychological problems
- Idioms of distress
- Often multiple and complex trauma histories
- May appear asymptomatic
- Many problems are treatable & some problems are preventable

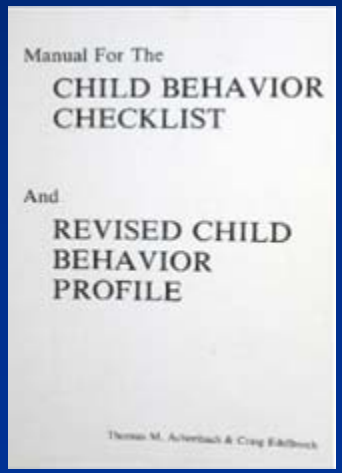
Assessment of Children

- Developmentally informed
- Culturally sensitive/relevant
- Include multiple informants
- Abuse/Trauma-specific outcomes
- Abuse/Trauma-informed cognitions & symptoms
- Other behavioral and emotional problems that may not be the result of the abuse/traumatic experience
- Functional impairments in multiple domains
  - Home, school, community

The Importance of Early Identification

- Difficulties resulting from exposure to trauma can persist (beyond a normal reaction to an abnormal event) and result in PTSD & other impairments
- PTSD affects children in every area of development (e.g., peer relationships, learning)
- PTSD can lead to increased risk of substance abuse & delinquent behavior
- Chronic trauma affects brain development and therefore may be particularly harmful for young children

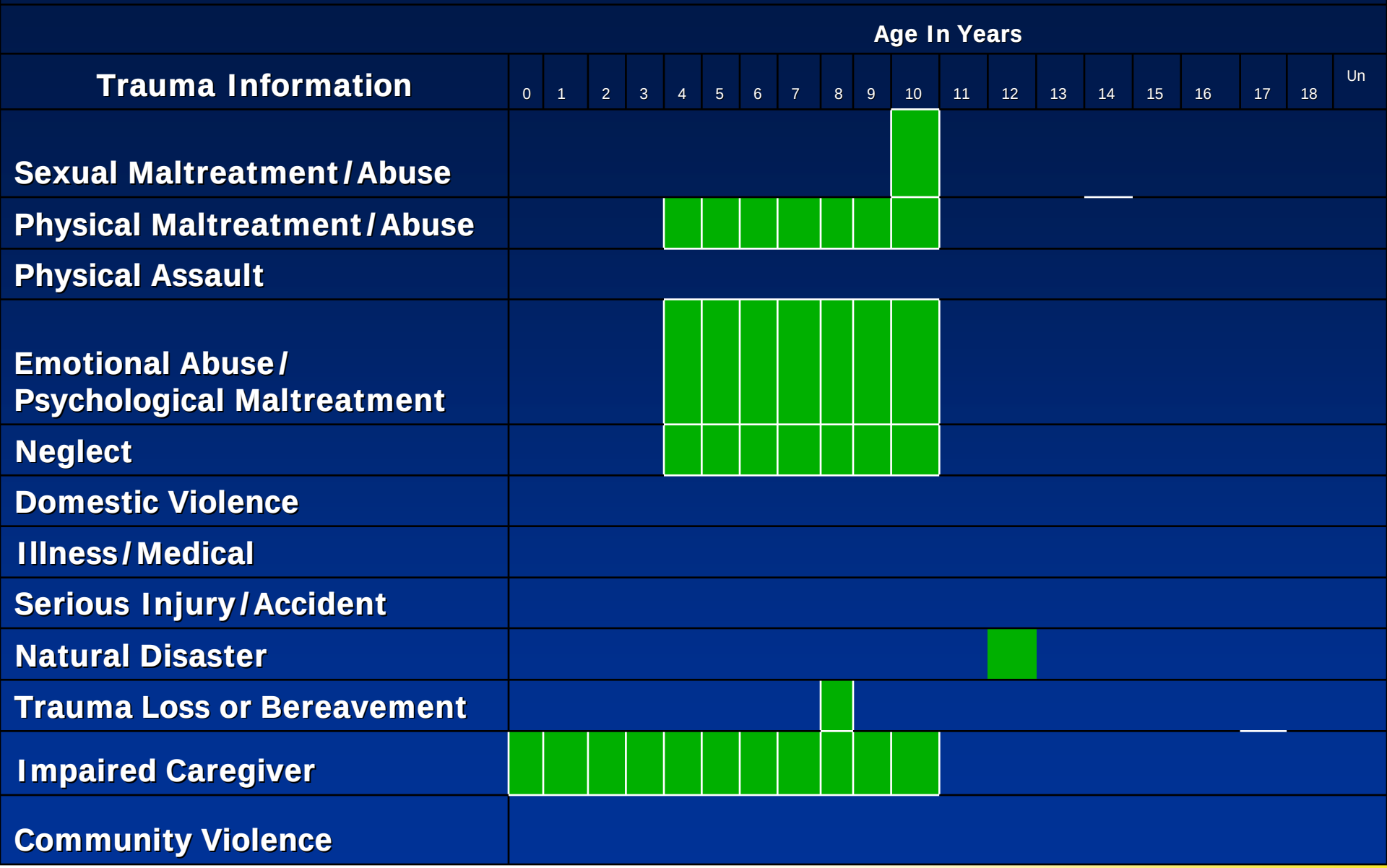
Screening and Assessment



Concerns About Assessments

- Time to administer
- Time to score/interpret
- Time involved to get scores back
- Providing Feedback
- Engagement/ Cultural Relevance
- ‘Fit’ with Clinical interview
- All those questions!!!!
- Access to measures, interpreters, other resources

Trauma History Timeline: Male Age 12

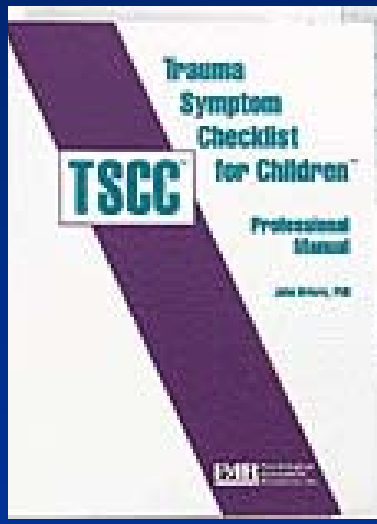


Standardized Measures (Child)

- Trauma Exposure & Symptoms
  - Exposure to Violence (Amaya-Jackson, 1995 adapted from Richters & Martinez)*
  - Child PTSD Checklist (Amaya-Jackson & March, 1995)*
  - Trauma Symptom Checklist for Children (Briere, 1996)*
  - UCLA PTSD Reaction Index (Child & Adolescent, Steinberg, Pynoos, et al)
- Depression
  - Children's Depression Inventory (Kovacs, 1992)*
- Broad-band
  - Youth Self Report Form (Achenbach, 1991)*
  - Strengths and Difficulties Questionnaire (Goodman et al., 1997)

Assessments – TSCC-A

- Trauma Symptom Checklist for Children – Alternate (TSCC-A)
  - 44 items (does NOT include items on sexual behaviors/problems)
  - Subscales = Anxiety, Depression, Anger, PTS, Dissociation
  - Critical items
  - Scores reported as T-scores (standardized)
    - T-Score of 65 or higher indicates serious problem(s) in that domain
    - T-Score of 60-64 suggests difficulty/sub-clinical
  - Also includes validity scales
    - Underresponse (Und)
      - >70 = invalid
    - Hyperresponse (Hyp)
      - >90 = invalid



Available at PAR http://www4.parinc.com/Products/Product.aspx?ProductID=TSCC

Assessments – UCLA PTSD-Index for DSM-IV

- UCLA PTSD – Index for DSM-IV
  - Assesses for DSM-IV PTSD symptoms (5 point-likert)
  - Indicates whether the child meets each of three criteria (B -Re-experiencing, C - Avoidance, D - Hyperarousal) required for a diagnosis
  - Can also be used as a continuous measure (cut-point of 38 associated with increased likelihood of having PTSD)
  - Measure also assesses exposure to more than 20 different traumatic events (CDS uses general trauma and detail forms to assess exposure)

Pynoos, R., Rodriguez, N., Steinberg, A., Stuber, M., & Frederick, C. (1998). *UCLA PTSD Index for DSM-IV*.

Available at : UCLA Trauma Psychiatry Service
Email: HFinley@mednet.ucla.edu

Assessing Lifetime Trauma History with the UCLA PTSD-RI (Items 1-14)

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**

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

Trauma History Profile

Chronic/Repeated Trauma

TRAUMA TYPE	Trauma Features		Primary	AGE(S) EXPERIENCED
Chronic/ Repeated			☐	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Neglect/ Maltreatment	☐ Physical ☐ Emotional	☐ Victim ☐ Witness	☐	☐ ☐
Sexual Abuse	☐ Penetration ☐ Non- Family ☐ Intra-familial ☐ CPS Report	☐ Victim ☐ Witness	☐	☐ ☐
Physical Abuse	☐ Serious Injury ☐ Weapon Used ☐ CPS Report	☐ Victim ☐ Witness	☐	☐ ☐
Emotional Abuse	☐ Caregiver Substance Abuse	☐ Victim ☐ Witness	☐	☐ ☐
Domestic Violence	☐ Weapon Used ☐ Reported ☐ Serious Injury ☐ Report Filed	☐ Victim ☐ Witness	☐	☐ ☐
Community Violence	☐ Gang-Related ☐ High Crime ☐ Drug Traffic		☐	☐ ☐
War/Political Violence	☐_____		☐	☐ ☐
Medical Illness	☐_____		☐	☐ ☐

Circumscribed Trauma

Circumscribed				AGE(S) EXPERIENCED 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Serious Accident	☐ Motor Vehicle ☐ Hospitalized ☐ Dog Bite ☐ _____	☐ Victim ☐ Witness	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
School Violence	☐ Shooting ☐ Bullying ☐ Suicide ☐ Assault	☐ Victim ☐ Witness	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Disaster	☐ Earthquake ☐ Fire ☐ Flood ☐ Hurricane ☐ Tornado ☐ _____	☐ Lost home ☐ Injured	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Terrorism	☐ Conventional ☐ Biological ☐ Chemical ☐ Radiological		☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Kidnapping		☐ Victim ☐ Witness	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Sexual Assault/Rape	☐ Weapon Used ☐ Stranger ☐ Date Rape ☐ Prosecution	☐ Victim ☐ Witness	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Interpersonal Violence	☐ Robbery ☐ Assault ☐ Homicide ☐ Suicide ☐ Suicide Attempt ☐ Bullying/Discrimination	☐ Victim ☐ Witness	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Loss/Separations

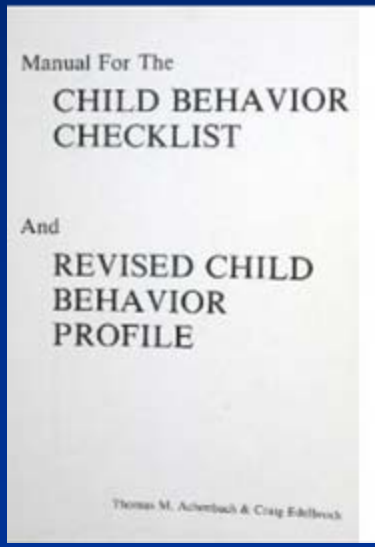
Loss/Separations				AGE(S) EXPERIENCED 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Traumatic Bereavement	□ Parent □ Sibling □ Friend □ Primary Caregiver □ Other Relative	□ Violence □ Accident □ Illness □ Disaster □ Terrorism	□	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □
Divorce			□	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □
Extended Separation and Displacement	□ Foster Care □ Refugee □ Parent in Prison □ Parent Hospitalized		□	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □

Assessments -- CBCL

- Child Behavior Checklist (CBCL)
  - Completed by parent/caregiver
  - Can be self-administered (or read to parent)
  - Caregiver uses their own judgment on scoring each item
  - Competence scales plus list of problem behaviors

- Scoring based on extensive research in clinical and non-clinical populations
  - Clinical = "in the clinical range" – definitely a problem
  - Borderline = "in the borderline range" – subclinical, but potential problem
  - Not Applicable = not a problem for this child/not developmentally Appropriate

  Available at ASEBA http://www.aseba.org/



Standardized Measures (Parent)

- Parental Distress
  - Brief Symptom Inventory-18 (Derogatis)
  - Symptom Checklist-90-Revised (Derogatis, 1983)*
  - Beck Depression Inventory (Beck, 1996)*
  - Trauma Symptom Inventory (Briere, 1995)
- Parental Stress
  - Parenting Stress Index/Short Form (Albidin)
- Parental Reports of Child Functioning
  - Child Behavior Checklist (Achenbach, 1991)*
  - Child Sexual Abuse Inventory (Friedrich, 1998)*
  - Trauma Symptom Checklist for Young Children (Briere, 2004)

Assessment of Parents

- Parental Distress/Stress
- Parent Trauma History
- Level of belief & support about the abuse/trauma
- Attitudes towards violence
- Behavior management skills/deficits
- Degree of responsibility taken for abuse/trauma
- Empathy
- Cultural beliefs & values

Summary

- Screening and assessing for trauma is beneficial to clients, clinicians and administrators
- Targeted assessments improve the quality of clinical practice and outcomes
- Assessment can be a potent evaluation tool when tied to other implementation and outcome measures
- Results from assessments can be used to promote program development and sustainability
- Requires organizational readiness and support to sustain this clinical practice

Quality Improvement Initiative: Core Data Set

What is in the CDS?

- Demographic and living situation information
- Trauma history and detail
- Indicators of severity
- Clinical evaluation
- Treatment
- N=14,088

- Standardized Assessment Measures

  PTS Symptoms
  - UCLA PTSD Reaction Index
  - Trauma Symptom Checklist for Children-Alternate (also taps associated difficulties: depressive symptoms, anxiety)

  Behavioral and Emotional Difficulties
  - Child Behavior Checklist

CDS measures: administered at treatment entry, end of treatment (if short term) or every 3 months

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Demographics

		Refugee (N=62)	*NCTSN (N=12,567)*
Age at Baseline (in yrs)	0 to 5	4.8%	17.8%
	6 to 12	35.5%	48.1%
	13 to 18	59.7%	33.8%
	19 to 21	0.0%	0.3%
Race	Caucasian	50.0%	51.0%
	African American	30.6%	29.3%
Ethnicity	Hispanic/Latino	35.5%	25.0%
Sex	Female	46.8%	51.8%
	Male	53.2%	48.2%
Living Situation	Parent(s)	72.6%	51.7%
	Other Relatives	9.7%	12.9%
	Foster Care	4.8%	12.0%
Insurance Coverage	Public	37.1%	60.6%
	Private	21.0%	9.6%

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Baseline Use of Services

	Refugee (N=62)	*NCTSN (N=12,567)*
Educational Sector		
Special Class/School*	41.8%	18.2%
School Counselor/Psych/SW	30.6%	26.2%
Mental Health/Other		
Detention Center	1.8%	3.0%
Case Management*	44.6%	27.7%
Outpatient Therapy	30.9%	28.6%
Psychiatrist	9.1%	12.3%
Residential Treatment Center	5.4%	5.5%
General Medical		
Primary Care MD/Pediatrician	22.2%	17.8%
Child Welfare		
Social Services*	17.3%	38.2%
Foster Care*	7.1%	21.7%
Treatment Foster Care	1.8%	5.6%

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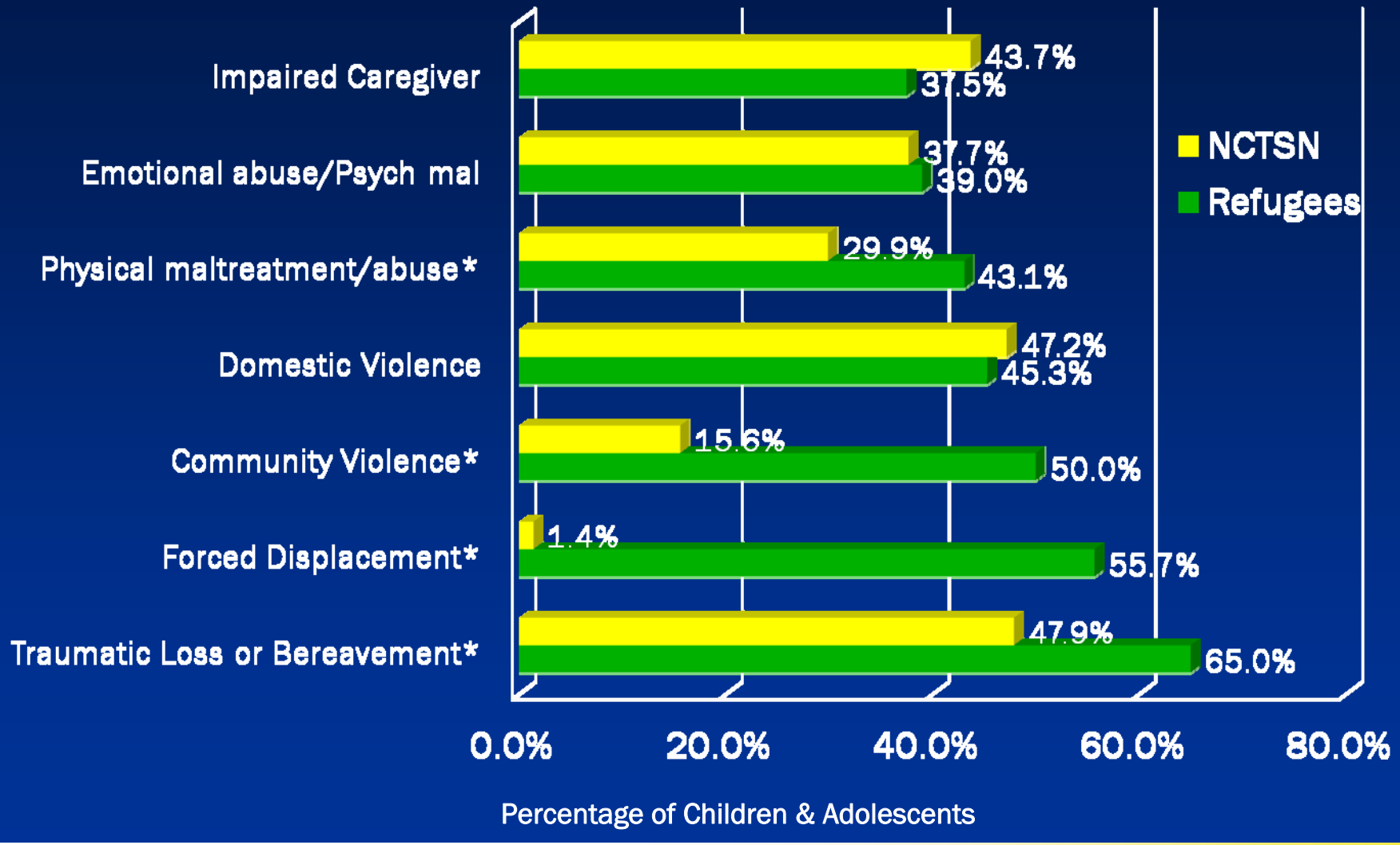
*p <.05 for all comparisons

Trauma Exposure Comparisons: Refugees vs. NCTSN



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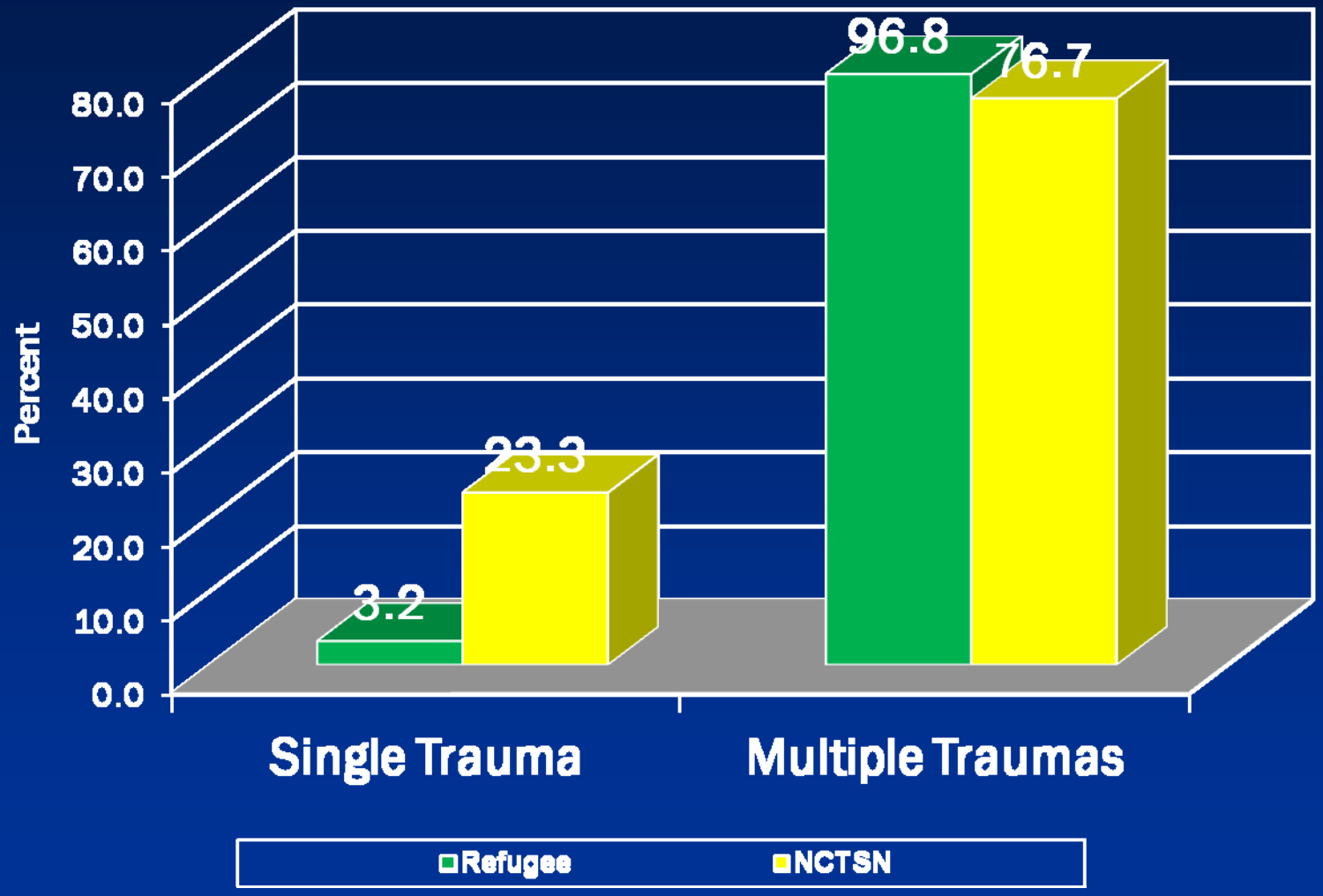
*p <.05 for all comparisons

Single vs. Multiple Trauma Types



Ref-M=6.0; SD=2.7; Range 1-14

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Most Common Clinical Problems

	Refugee (N=62)	*NCTSN (N=12,567)*
Post Traumatic Stress Disorder	65.5%	54.7%
Generalized Anxiety*	60.3%	38.5%
Dissociation*	50.0%	14.6%
Depression	50.0%	50.4%
Traumatic Complicated Grief*	48.3%	32.3%
Attachment Problems	43.1%	34.4%
Somatization*	41.4%	15.6%
General Behavioral Problems	39.7%	51.9%

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Functional Impairments

	Refugee (N=62)	*NCTSN (N=12,567)*
Problems in the Home/Community		
Behavior problems at home*	44.8%	59.2%
Attachment problems	41.1%	44.2%
Criminal activity	3.5%	7.3%
Social and School Functioning		
Academic problems	55.2%	51.5%
Behavior problems in school	49.1%	46.9%
Problems skipping school	16.1%	11.9%
Risk Taking Behaviors		
Self injury	7.0%	12.6%
Suicidality	12.1%	13.9%
Inappropriate sexual behaviors	14.0%	15.9%
Substance abuse	5.3%	7.3%
Alcohol use	3.5%	5.8%

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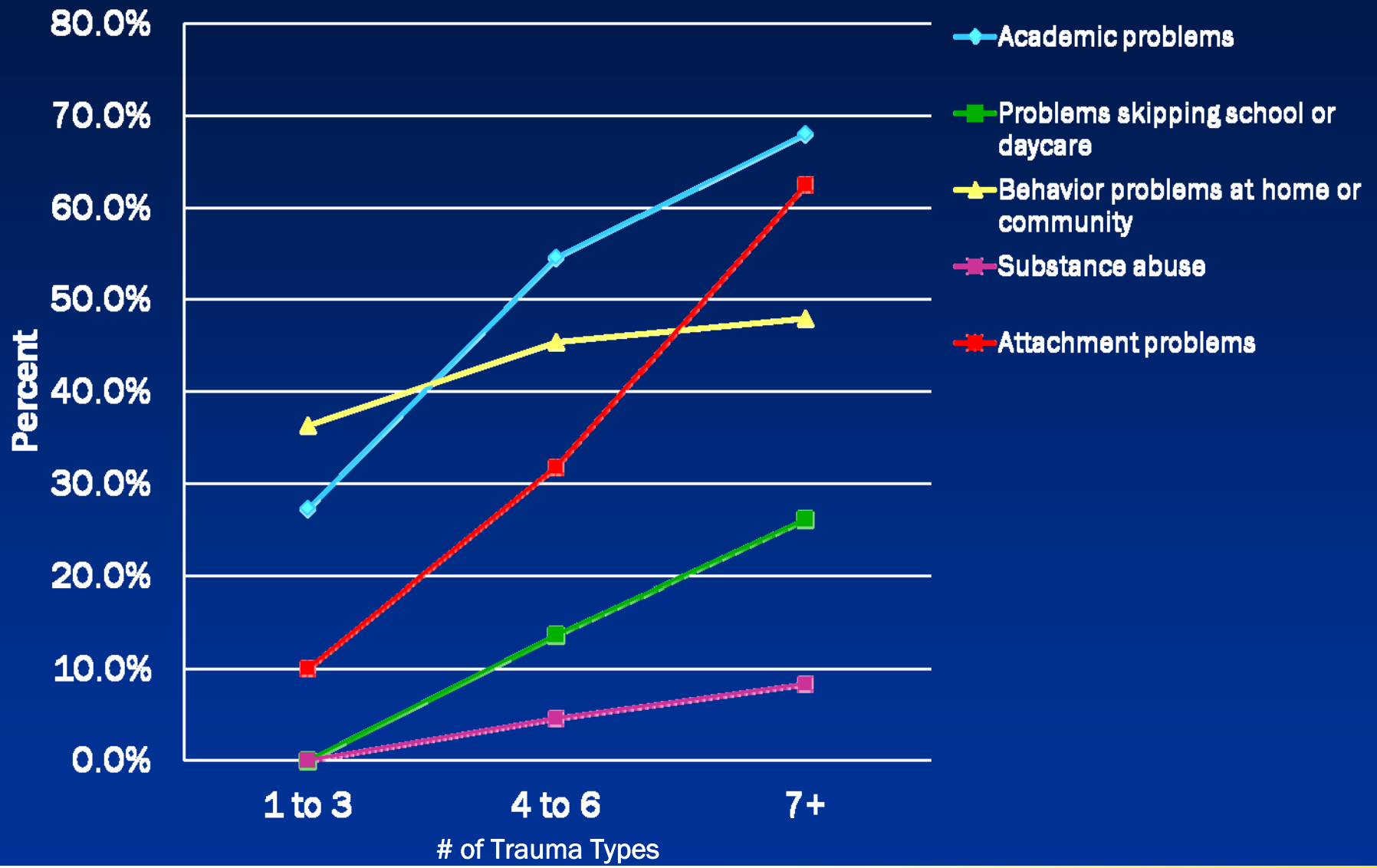
*p <.05

Adverse Childhood Experiences Study (ACES)*

Felitti et al. 1998;

Multiple Traumas & Functional Impairments



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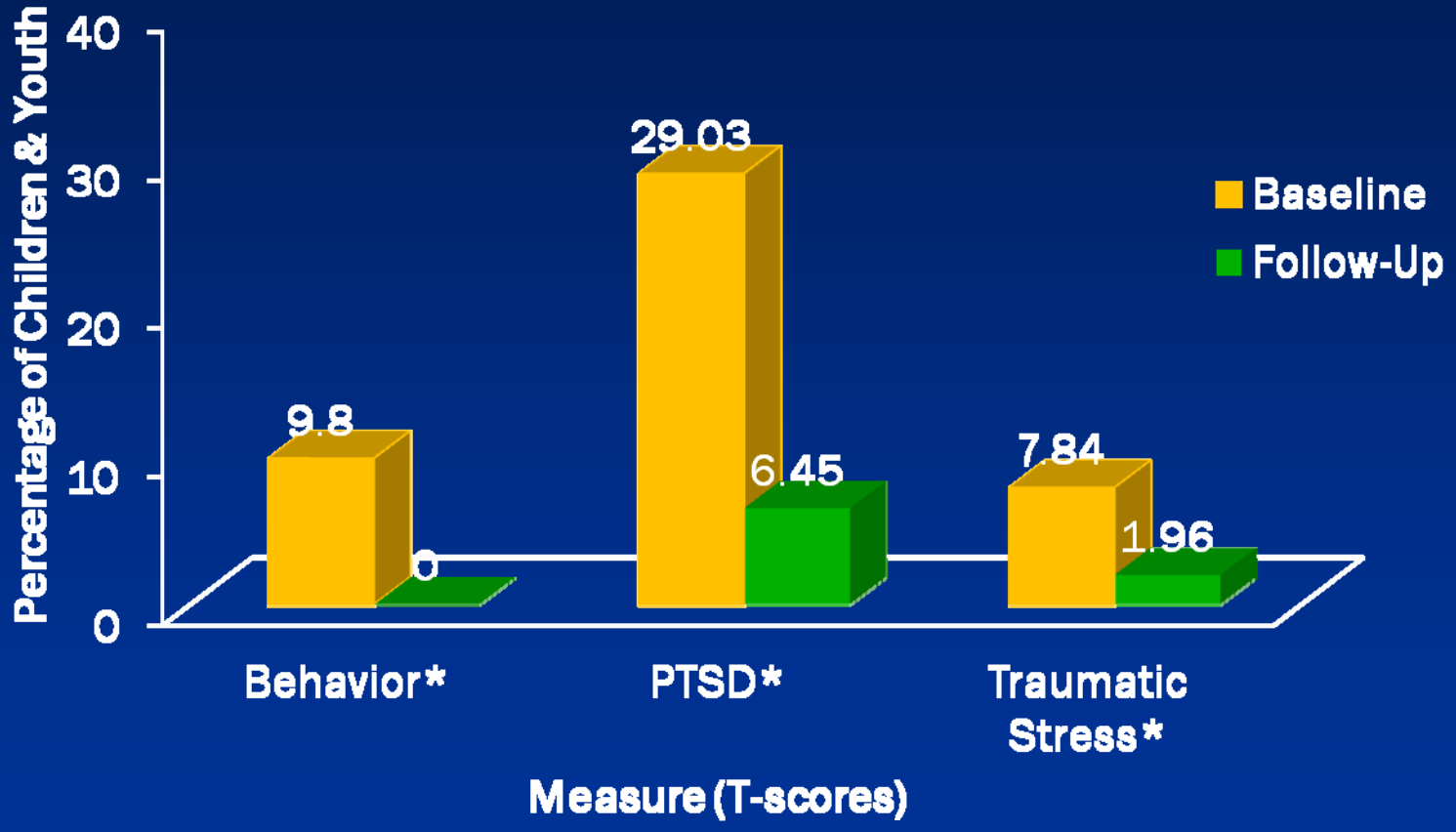
Refugee Children in the Clinical Range: Baseline and Last Follow up



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The Role of Intervention

How does intervention help children?

- Provides safety and stability
- Counselors can assist the family in getting legal help, advocacy, or access to other services
- Counseling provides an opportunity for children to talk about their worries and fears
- Counseling can also provide parents with information about how to talk to the child about the violence

Barriers to Services & Treatment

- Cultural and linguistic barriers
  - Norms and mores: violence, relationships, children, health
  - Use of an interpreter
  - Definitions of disease/illness; stigma
  - Expectations about health & wellness (cure vs. treatment)
- Gender related barriers
  - Exploitation/mutilation/rape
- Financial constraints
- Poor awareness of available services (consumers)/poor awareness of complex health needs (providers)
- Social and geographic isolation
- Distrust (government, social service providers)
- Fear of deportation

Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical & Sexual Abuse

(www.musc.edu/ncvc)

National Crime Victims Research & Treatment Center
Medical University of South Carolina

Ben Saunders, PhD

Center for Sexual Assault &Traumatic Stress
Harborview Medical Center

Lucy Berliner, MSW

Office of Victims of Crime
U.S. Dept.of Justice

Treatment Guidelines: Children and Adolescents with PTSD

- AACAP (1998). Practice parameters for assessment & treatment of children/adolescents with posttraumatic stress disorder. J. Cohen et al., *J Am Acad Child Adolesc Psychiatry*, 37(10), (1998 suppl) 4S-26S.

- Cohen J, Berliner L, & March J. (2000). Treatment of children & adolescents. In Foa, Keane, & Friedman (Eds). *Effective treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*, NY: Guilford Press.

- www.aacap.org
- www.istss.org

Trauma Specific Evidence-Based Practices

Available at NCTSNet.org

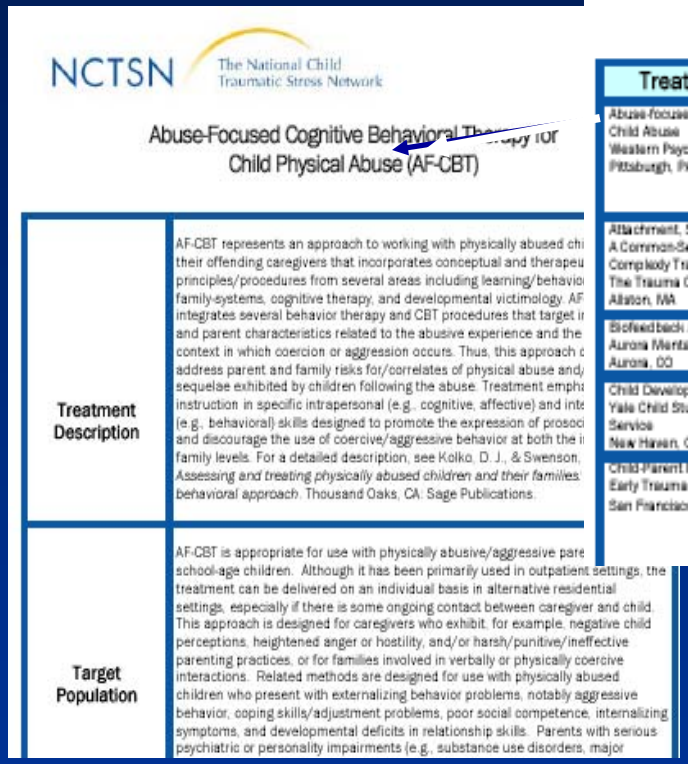
Summary Table

NCTSN The National Child Traumatic Stress Network

NCTSN Empirically Supported Treatments and Promising Practices

(Listed Alphabetically, with Level of Evidence*)

Treatment and Developer Site	Level of Evidence*	Description
Abuse-focused Cognitive Behavioral Therapy for Child Abuse Western Psychiatric Institute and Clinic Pittsburgh, PA	Supported and Probably Efficacious	↓ Parent to child aggression, abuse risk ↓child to parent aggression & externalizing behaviors, less family conflict & greater cohesion Clinic or alternative residential setting Age: school age
Attachment, Self-Regulation, and Competence (ARC): A Common-Sense Framework for Intervention with Complexly Traumatized Youth The Trauma Center Allston, MA	Promising and Acceptab	↓Trauma symptoms ↑ attachment(s), regulatory capacity, competency, and systems of care implemented in school, community, or clinic settings All ages
Biofeedback Assisted Reduction of PTSD Symptoms Aurora Mental Health Center Aurora, CO		
Child Development-Community Policing Program (CDCP) Yale Child Study Center, New Haven Department of Police Service New Haven, CT		
Child-Parent Psychotherapy for Family Violence Early Trauma Treatment Network San Francisco, CA		

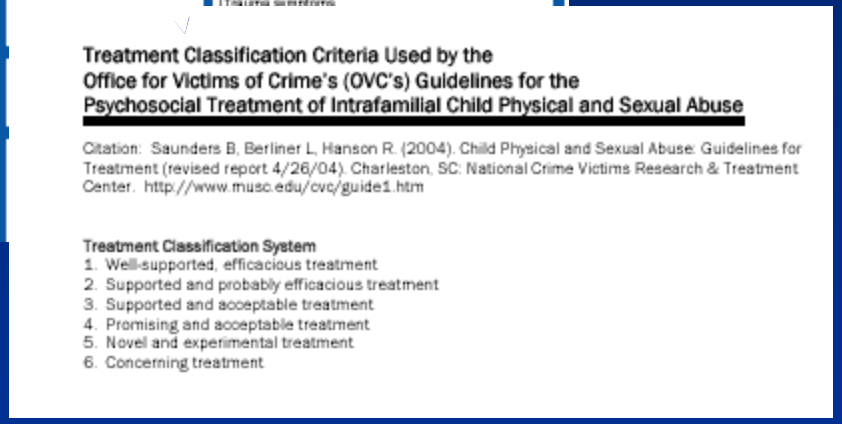


NCTSN The National Child Traumatic Stress Network

Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)

Treatment Description	AF-CBT represents an approach to working with physically abused chi their offending caregivers that incorporates conceptual and therapeu principles/procedures from several areas including learning/behavio family-systems, cognitive therapy, and developmental victimology. AF integrates several behavior therapy and CBT procedures that target i and parent characteristics related to the abusive experience and the context in which coercion or aggression occurs. Thus, this approach address parent and family risks for/correlates of physical abuse and/ sequelae exhibited by children following the abuse. Treatment emph instruction in specific intrapersonal (e.g., cognitive, affective) and int (e.g., behavioral) skills designed to promote the expression of prosoc and discourage the use of coercive/aggressive behavior at both the i family levels. For a detailed description, see Kolko, D. J., & Swenson, *Assessing and treating physically abused children and their families: behavioral approach*. Thousand Oaks, CA: Sage Publications.
Target Population	AF-CBT is appropriate for use with physically abusive/aggressive pare school-age children. Although it has been primarily used in outpatient settings, the treatment can be delivered on an individual basis in alternative residential settings, especially if there is some ongoing contact between caregiver and child. This approach is designed for caregivers who exhibit, for example, negative child perceptions, heightened anger or hostility, and/or harsh/punitive/ineffective parenting practices, or for families involved in verbally or physically coercive interactions. Related methods are designed for use with physically abused children who present with externalizing behavior problems, notably aggressive behavior, coping skills/adjustment problems, poor social competence, internalizing symptoms, and developmental deficits in relationship skills. Parents with serious psychiatric or personality impairments (e.g., substance use disorders, major

Intervention Fact Sheets



Treatment Classification Criteria Used by the Office for Victims of Crime's (OVC's) Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse

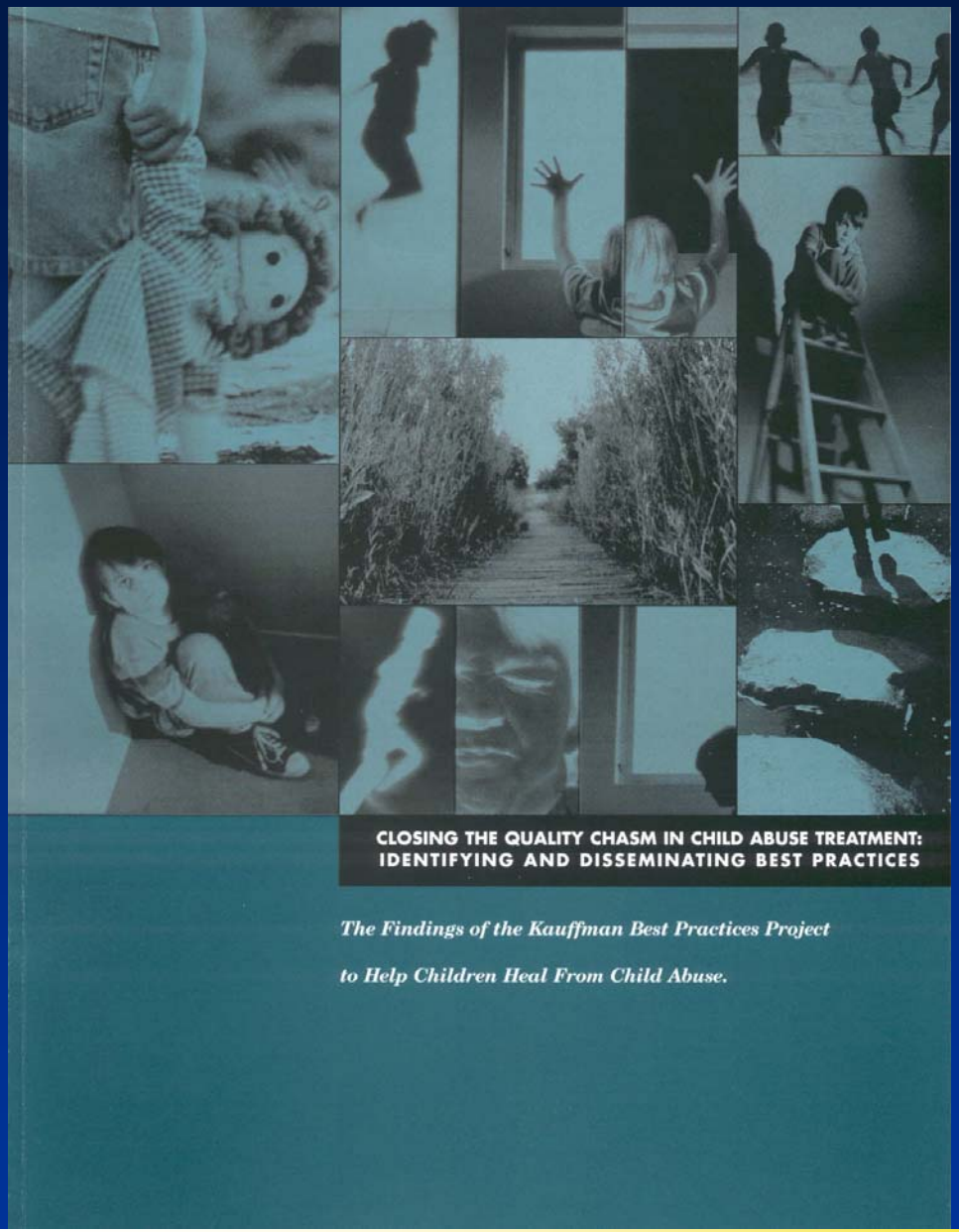
Citation: Saunders B, Berliner L, Hanson R. (2004). Child Physical and Sexual Abuse: Guidelines for Treatment (revised report 4/26/04). Charleston, SC: National Crime Victims Research & Treatment Center. http://www.musc.edu/cvc/guide1.htm

Treatment Classification System

1. Well-supported, efficacious treatment
2. Supported and probably efficacious treatment
3. Supported and acceptable treatment
4. Promising and acceptable treatment
5. Novel and experimental treatment
6. Concerning treatment

Level-of-Evidence Criteria

Kauffman Best Practices Project Final Report



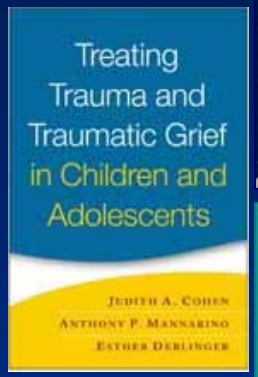
Download at www.chadwickcenter.org

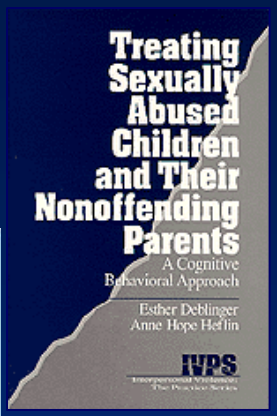
--Wilson & Saunders, 2005

Treatment Best Practice (Kaufman Report)

- Trauma-Focused Cognitive Behavioral Therapy

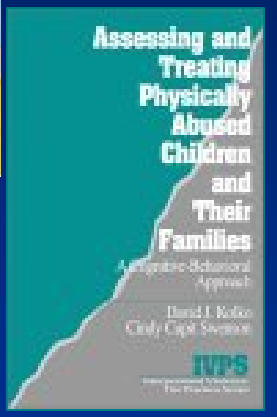
  (TF-CBT) for child sexual abuse





- Abuse-Focused Cognitive Behavioral Therapy/Alternatives for Families Cognitive Behavioral Therapy

  (AF-CBT) for child physical abuse



--Wilson et al, 2005

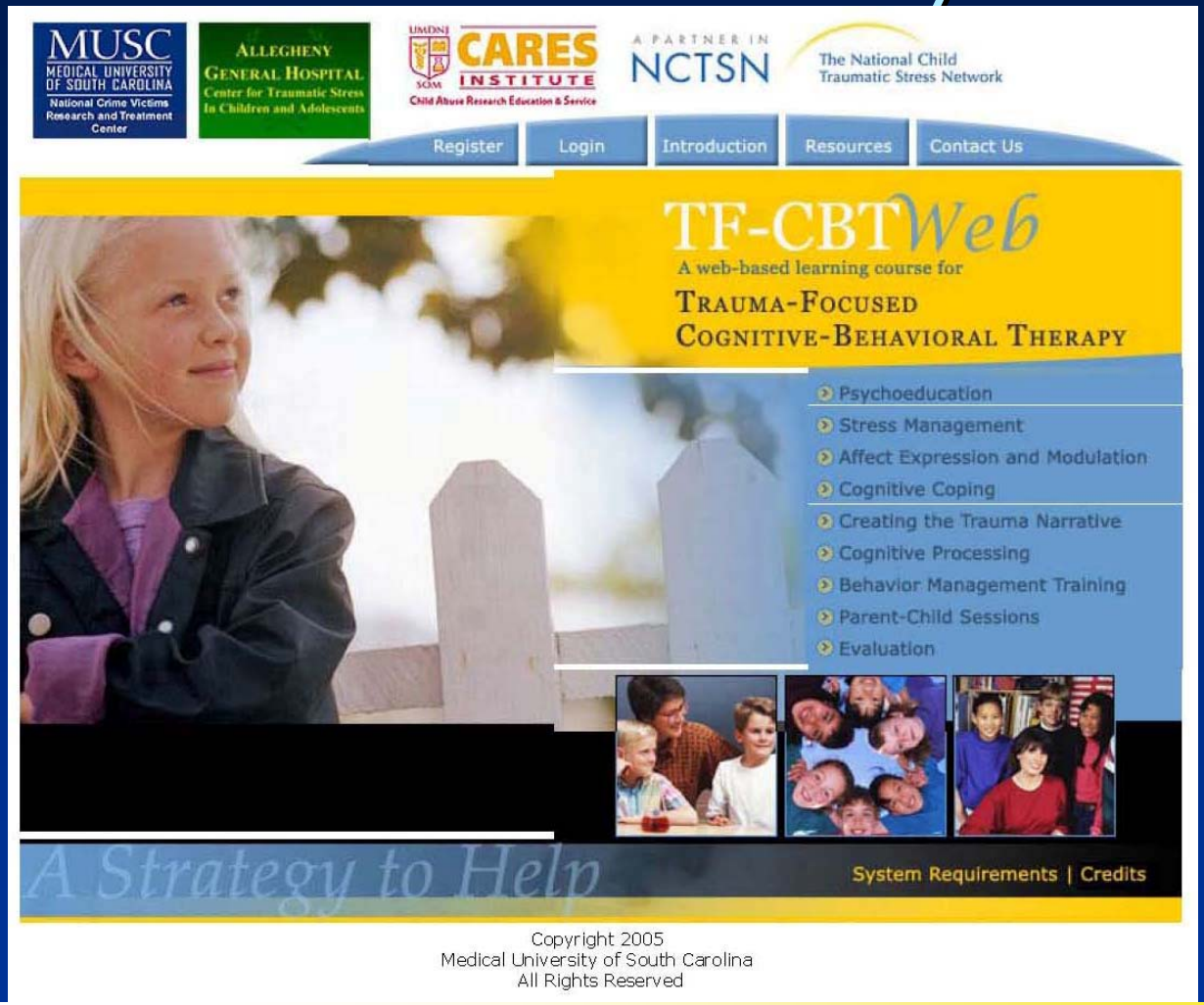
- Parent Child Interaction Therapy (PCIT)

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).

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



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Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Esther Deblinger, Ph.D.

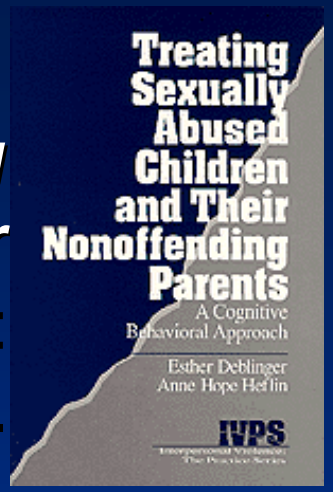
Center for Children's Support University of Medicine and Dentistry of New Jersey

Judith Cohen, M.D., and Anthony Mannarino, Ph.D.

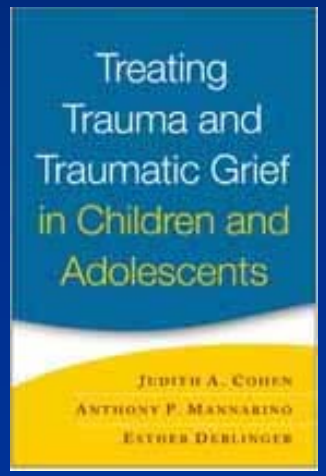
Center for Traumatic Stress in Children and Adolescents Alleghany General Hospital

Recommended Treatment Manuals

Deblinger, E. & Heflin, A.H. (1996). ***Treating sexually abused children and their nonoffending parents***. Sage Publications: Thousand Oaks, CA.



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



TF-CBT: Just the Facts

- For traumatized children 3-18
- Research initially conducted on sexual trauma, now looking at traumatic grief, and other forms of trauma
- 12-20 one hour sessions
- Homework
- Parent and child seen separately and together
- Research base on clinic setting but has been done in home and schools
- Applied within child developmental framework

Trauma-Focused Cognitive Behavioral Therapy

Psycho-education and Parent Treatment
Relaxation
Affect Modulation
Cognitive Processing
Trauma Narrative
In Vivo Exposure when appropriate
Conjoint Family Sessions
Enhancing Future Normal Developmental Trajectory

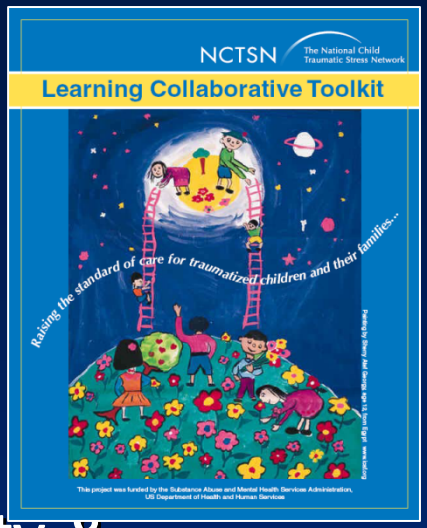
(Deblinger, Cohen, and Mannarino)

Implementation & Dissemination

NCCTS Learning Collaborative Model

NCCTS Learning Collaborative on Adoption & Implementation of EBT©

- Toolkit
- Fidelity Guidelines



12 Month intensive collaborative with faculty & practitioner teams

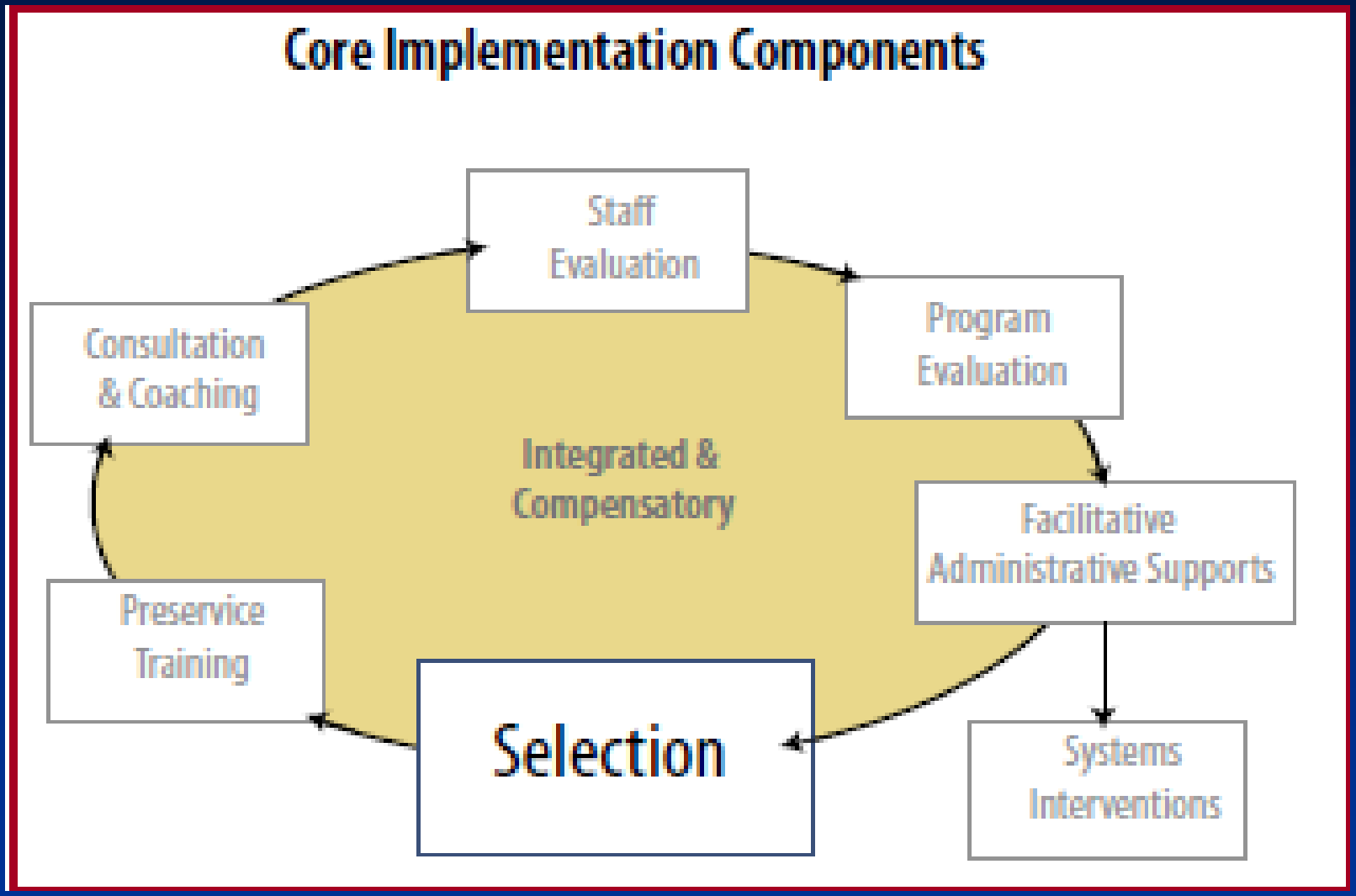
Emphasis on:

- Clinical competence
- Fidelity to the EBT model being used
- Implementation capability for providers
- Use of Improvement methods to achieve necessary change
- Sustainability strategies

Used in 50+ Learning Collaboratives across the country

NCCTS Training & Implementation Program, 2008
J Markiewicz, L Ebert ,L Amaya-Jackson, N Tise

Fixen, Naoom, Blase, Friedman & Wallace (2005)
http://nirn.fmhi.usf.edu



Fixen, Naoom, Blase, Friedman & Wallace (2005)

Implementation -"Selection and Coordinated Training"

- Selection of practitioners is a neglected area of implementation and needs to really include who will be a good fit with the practice to be implemented
  - Champions and early adopters

- "Train-and-hope" approaches (Stokes & Baer, 1977) do not work!

- Training should include presenting information (knowledge), demonstrations (live or taped) of the important aspects of the practice or program, and opportunities to practice key skills in the training setting (behavior rehearsal; Joyce & Showers, 2002)

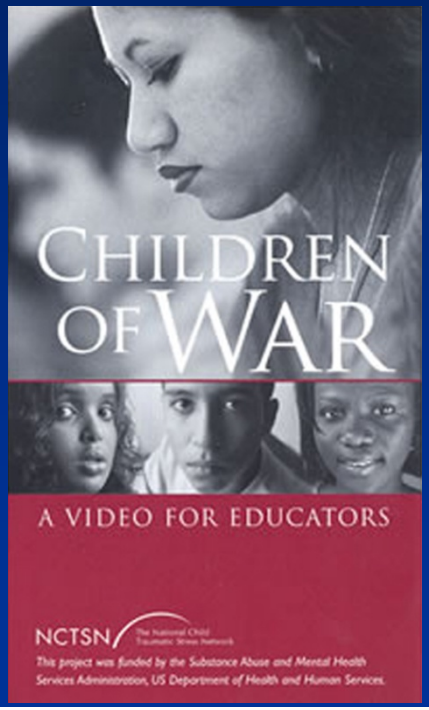
Fixen, Naoom, Blase, Friedman & Wallace (2005)

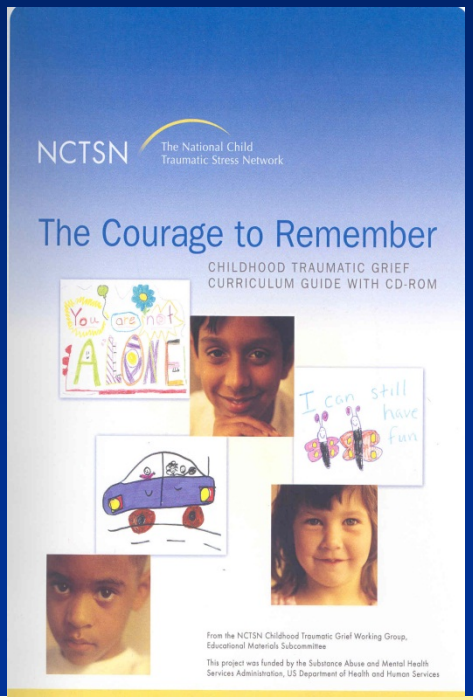
Key Objectives for Implementation and Sustainability

3 Domains:

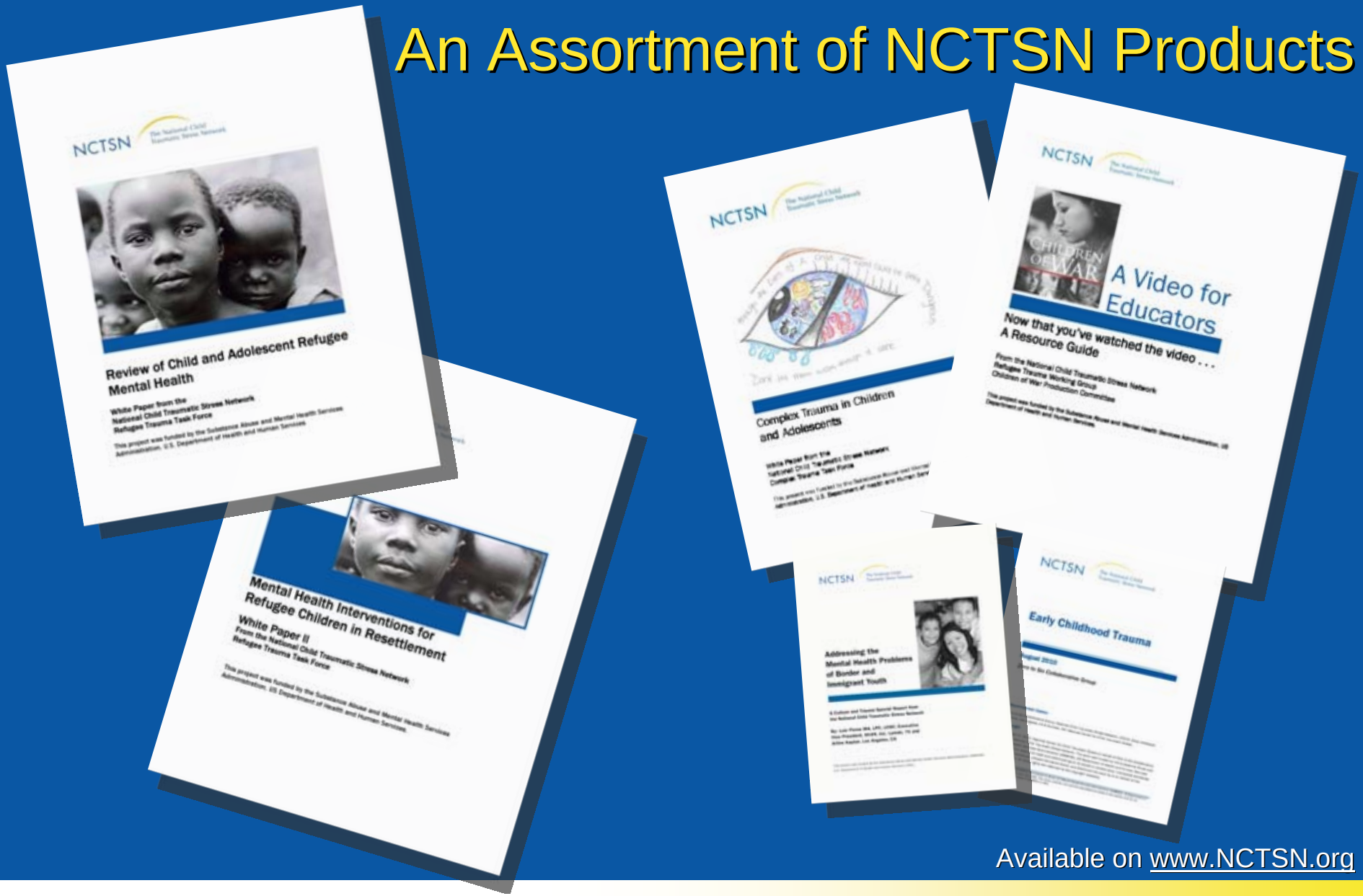
* Organizational Support and Capacity
* Family and Child Engagement
* Clinical Competence

NCTSN Products: Some Highlights





An Assortment of NCTSN Products



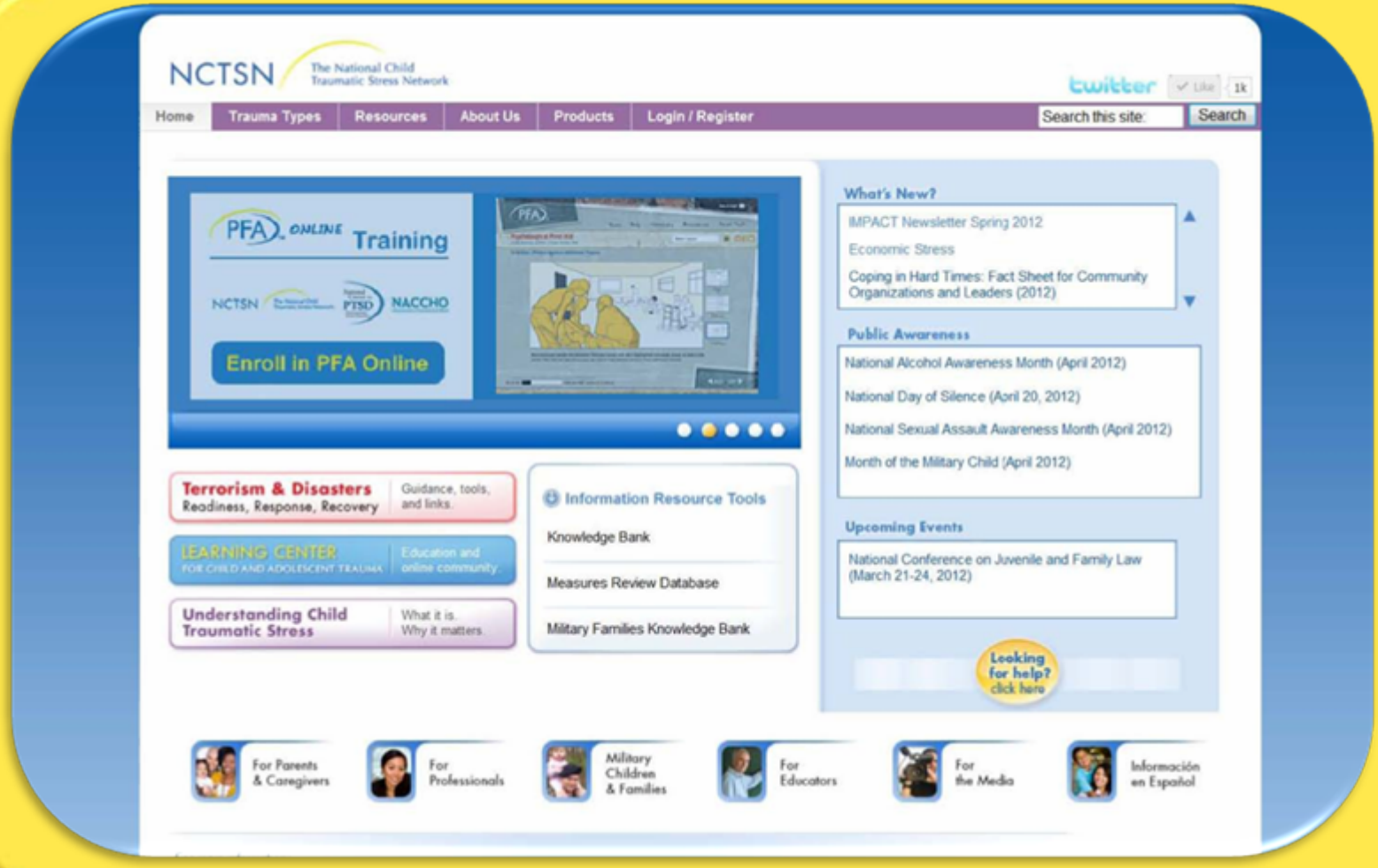
Available on www.NCTSN.org

NCTSN The National Child Traumatic Stress Network

An Assortment of NCTSN Products

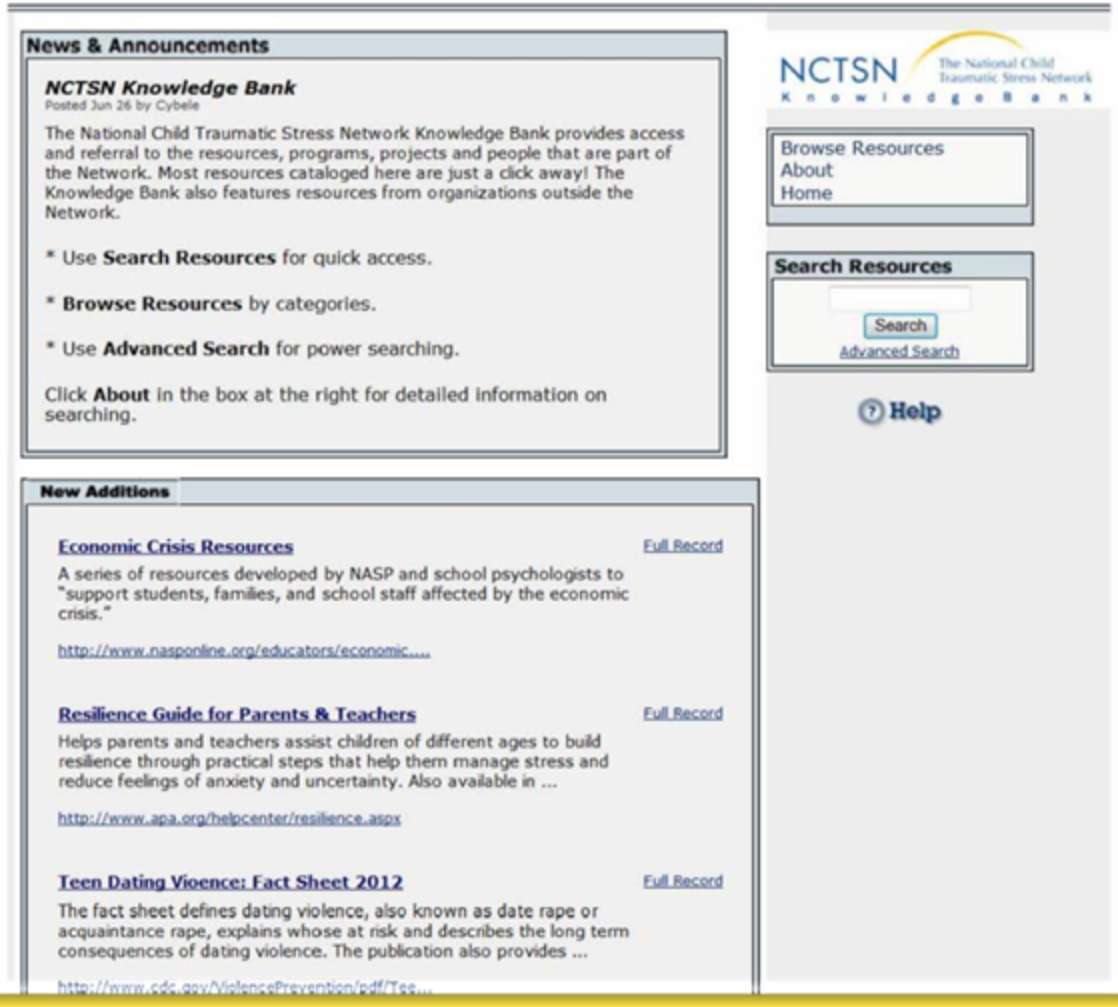
Available on www.NCTSN.org

www.NCTSN.org



http://learn.nctsn.org

http://kb.nctsn.org



Contact Information

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(919) 613-9855

THANK YOU!!!!!

For more information about the NCTSN
please visit our website:

www.nctsn.org

Questions?