WELCOME
2011 MIDDLE
TENNESSEE TF-CBT
BASIC TRAINING

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History, despite its wrenching pain,
cannot be unlived.
But, if faced with courage,
need not be lived again.

Maya Angelou
“On the Pulse of Morning”
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Patti van Eys, Ph.D., & Jenni Thigpen, Ph.D.

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Acknowledgement

• Some slides were adapted from a presentation by Esther Deblinger, Felicia Neubauer, and Kelly Wilson (August, 2006) and provided by Kelly Wilson

• Other materials were made available as part of a TN TF-CBT state wide learning collaborative from:
  – National Child Traumatic Stress Network (www.nctsn.org)
  – UMDNJ-SOM Cares Institute
  – Center for Child and Family Health-NC
TF-CBT

• Goals: resolve trauma-related symptoms in youngsters; optimize adaptive functioning; enhance safety, family communication and future developmental trajectory

• Evidenced based; used for all types of traumas; use of gradual exposure as key component

• Used for ages 3-18, with and without parental participation, in various settings but is most commonly provided individually to child and parent in clinical settings

• Some children may first need treatment to address extreme acting out issues that threaten emotional or physical safety.

TF-CBT - Why?

• Reasons to directly discuss traumatic events:
  • Desensitization
  • Resolve avoidance symptoms
  • Correction of distorted cognitions
  • Model adaptive coping
  • Identify and prepare for trauma/loss reminders

• Reasons we avoid this with children:
  • Child discomfort
  • Caregiver discomfort
  • Therapist discomfort
  • Legal issues
Recommended Treatment Manuals


Learning Resource: TF-CBT Web

[www.musc.edu/tfcbt](http://www.musc.edu/tfcbt)

Each module has:
- Concise explanations
- Video demonstrations
- Clinical scripts
- Cultural considerations
- Clinical Challenges
Childhood Traumatic Grief
http://ctg.musc.edu/

Information about:
• Grief and Childhood Traumatic Grief (CTG)
• How to address CTG in the context of doing TF-CBT

Includes:
• Video demonstrations
• Clinical scripts
• Cultural considerations
• Clinical challenges

Evidence That TF-CBT Works

• Six randomized controlled trials have been conducted for sexually abused/multiply traumatized children comparing TF-CBT to other active treatments
• In all six studies children receiving TF-CBT experienced significantly greater improvements in a variety of symptoms, both at immediate post-treatment and up to 2 years post-treatment.
• PTSD symptoms consistently improved significantly more in the TF-CBT groups across race, ethnicity, and geography
A Multisite Randomized Controlled Trial For Sexually Abused Children With PTSD Symptoms (2004)

Esther Deblinger, Ph.D., Judith A. Cohen, M.D.¹
Anthony P. Mannarino, Ph.D.¹
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Participants

• 229 gender and racially diverse sexually abused 8-14 year old children and parents
• Most had additional trauma (average 3.6)
  – 70% received traumatic news (e.g., sudden death of family member)
  – 58% domestic violence
  – 37% serious accident
  – 26% physical abuse
  – 17% community violence
  – 13% fire/natural disaster
  – 25% other PTSD-level traumas
Lessons learned…….

• Percent no longer meeting PTSD criteria at post-treatment: 54% CCT, 79% TF-CBT

• TF-CBT > CCT in helping parents overcome depression and abuse specific distress and improve parenting practices (Cohen et al., 2004)

• TF-CBT > CCT in helping children overcome feelings of shame and dysfunctional attributions (Cohen et al., 2004)

• TF-CBT preferable over CCT for children with higher levels of depression and multiple traumas (Deblinger et al., 2005)

• TF-CBT is effective with children who have suffered other forms of trauma including traumatic grief (Cohen et al.) and children exposed to domestic violence (randomized trial underway)

PTSD: Criterion A

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

2. The person’s response involved intense fear, helplessness, or horror. NOTE: In children, this may be expressed instead by disorganized or agitated behavior

PTSD Symptoms (3 clusters)

B. **Re-experiencing Symptoms** (nightmares; intrusive thoughts/play; flashbacks; trauma-related, stimulus-evoked distress and physiological reactions)

C. **Avoidant/Numbing Symptoms** (efforts to avoid trauma-related thoughts, feelings, places, activities, people; psychogenic amnesia for trauma-related memories; diminished interest; detachment; restricted range of affect; sense of foreshortened future)

D. **Hyperarousal Symptoms** (insomnia, irritability, poor concentration, hypervigilance, exaggerated startle response)


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Beyond PTSD: Maltreatment and the Developing Brain
Child maltreatment reports
1989-2004

We’re “neglecting the brain” at a most vulnerable developmental time…
Brain Growth

Newborn 6 Year old Newborn 6 Year old

Growth of Human Brain from birth to 20 years

7 years
Attachment Behaviors of Child

- Internal Working Model: Anticipate future responsiveness
- Relationships are safe and trustworthy
- Lower arousal: Child bolsters Affect Regulation Normal Stress Response
- Relationships are predictable

Child's Needs

TRUST

Need Met Caregiver Responsive

Express Emotion or Behavior

Healthy Attachment

- Emotion regulation
- Interpersonal Relatedness
- Self efficacy and self worth
Maltreatment Cycle

Internal Working Model
- Anticipate Future Harm
- Hypervigilant or shut down

Child's Needs

Fight Flight Freeze
- Relationships are unsafe - Traumatized
- Child feels Out of control (Affect Dysregulation)
- Chronic Stress

Caregiver unresponsive, abusive or neglect

Relationships are unresponsive, unpredictable, dangerous, and/or chaotic

Express Emotion or Behavior
- Crying
- Reaching
- Talking/Calling

Normal vs. Neglected Brain

As cited by Felitti & Anda, 2003; sou
Developmental Trauma Disorder
van der Kolk, May 2005, Psychiatric Annals 35:5

A. Exposure
B. Triggered pattern of repeated dysregulation in response to trauma cues
C. Persistently Altered Attributions and Expectancies
D. Functional Impairment

Developmental Trauma Disorder
van der Kolk, May 2005, Psychiatric Annals 35:5

- Exposure
  - Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma (e.g., abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence and death)
  - Subjective experience (e.g., rage, betrayal, fear, resignation, defeat, shame)
Developmental Trauma Disorder  
van der Kolk, May 2005, Psychiatric Annals 35:5

• Triggered pattern of repeated dysregulation in response to trauma cues  
  – Dysregulation (high or low) in presence of cues  
    • Changes persist and do not return to baseline; not reduced in intensity by conscious awareness  
  – Affective  
  – Somatic (e.g., physiological, motoric, medical)  
  – Behavioral (e.g., re-enactment, cutting)  
  – Cognitive (e.g., thinking that it is happening again, confusion, dissociation, depersonalization)  
  – Relational (e.g., clinging, oppositional, distrustful, compliant)  
  – Self-attribution (e.g., self hate, blame).

Developmental Trauma Disorder  
van der Kolk, May 2005, Psychiatric Annals 35:5

• Persistently Altered Attributions and Expectancies  
  – Negative self-attribution  
  – Distrust of protective caretaker  
  – Loss of expectancy of protection by others  
  – Loss of trust in social agencies to protect  
  – Lack of recourse to social justice/retribution  
  – Inevitability of future victimization
Developmental Trauma Disorder
van der Kolk, May 2005, Psychiatric Annals 35:5

• Functional Impairment
  – Educational
  – Familial
  – Peer
  – Legal
  – Vocational

Doing TF-CBT
Importance of Strong “Therapy” Skills

- Centrality of therapeutic relationship
- Establish a collaborative relationship with clients
- Importance of therapist judgment, skill, humor, and creativity in implementing TF-CBT
- Good understanding of basic development in order to understand trauma across childhood and to implement developmentally sensitive treatment techniques
- Understanding of family systems and attachment

PRACTICE components

- P sychoeducation and parenting skills
- R elaxation
- A ffective expression and regulation
- C ognitive coping
- T rauma narrative development & processing
- I n vivo gradual exposure
- C onjoint parent child sessions
- E nhancing safety and future development
TF-CBT Sessions Flow

Entire process is gradual exposure

~1/3 ~1/3 ~1/3

- Psychoeducation/Parenting Skills
- Relaxation
- Affective Expression and Regulation
- Cognitive Coping
- Trauma Narrative Development and Processing
- In vivo Gradual Exposure
- Conjoint Parent Child Sessions to share trauma narrative
- Enhancing Safety and Future Development

Weekly caregiver involvement is optimal

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TF-CBT

Child Sessions
- Education
- Skill building
- Exposure/Processing
- Preparation for Sharing Narrative

Caregiver/Child Sessions
- Education
- Skill Building Demonstrations
- Practicing Positive Parenting
- Narrative Sharing

Caregiver Sessions
- Education
- Skill building
- Exposure/Processing
- Positive Parenting
- Preparation for Sharing Narrative

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8/12/2011