Treating Traumatized Children and Trauma Focused Cognitive Behavioral Therapy  
Part I

Connie Black-Pond MA, LMSW, LPC  
Southwest Michigan Children’s Trauma Assessment Center  
October 19, 2010
Objectives of Part I

- Overview of the impact of trauma and complex trauma
- Overview and rational for the proposed Developmental Trauma Disorder
- To provide a detailed description of the core elements in trauma informed therapy.
Objectives of Part II

• To understand the benefit of psychoeducation with children and their caregivers.

• Identification of specific strategies for affect regulation skill building for children ages 6-16.

• Recognition of the importance of trauma narrative or life story in trauma processing for children.

• The importance of recognition and management of trauma triggers in trauma therapy.
How Prevalence is Trauma?
Child Mental Health/Youth Detention Population - U.S.

- Canadian study of 187 adolescents reported 42% had PTSD
- American study of 100 adolescent inpatients; 93% had trauma histories and 32% had PTSD
- 70-90% incarcerated girls – sexual, physical, emotional abuse

(DOC, 1998, Chesney & Sheldon, 1991)
Substance Abuse Population – U.S.

- Up to two-thirds of men and women in SA treatment report childhood abuse & neglect
  (SAMSHA CSAT, 2000)

- Study of male veterans in SA inpatient unit
  – 77% exposed to severe childhood trauma
  – 58% history of lifetime PTSD (Triffleman et al., 1995)

- 50% of women in SA treatment have history of rape or incest
  (Governor's Commission on Sexual and Domestic Violence, Commonwealth of MA, 2006)
The Relationship of Childhood Trauma to Adult Health

• Adverse Childhood Events (ACEs) have serious health consequences
• Adoption of health risk behaviors as coping mechanisms
  – eating disorders, smoking, substance abuse, self harm, sexual promiscuity
• Severe medical conditions: heart disease, pulmonary disease, liver disease, STDs, GYN cancer
• Early Death

(Felitti et al., 1998)
Adverse Childhood Experiences

- Recurrent and severe physical abuse
- Recurrent and severe emotional abuse
- Sexual abuse

• Growing up in household with:
  - Alcohol or drug user
  - Member being imprisoned
  - Mentally ill, chronically depressed, or institutionalized member
  - Mother being treated violently
  - Both biological parents absent
  - Emotional or physical abuse

(Felliti, et al, 1998)
“Male child with an ACE score of 6 has a 4600% increase in likelihood of later becoming an IV drug user when compared to a male child with an ACE score of 0. Might heroin be used for the relief of profound anguish dating back to childhood experiences? Might it be the best coping device that an individual can find?”

(Felitti, et al, 1998)
Total Number of Students = 687
Total Number of Students = 687
Meet Meg

Meg is 14 years old. The presenting problem includes that Meg has “meltdowns”, including hysterical crying, name calling and often goes to sleep, plays loud music or “turns people off”. Mood swings and temper tantrums are described. She often believes that men are coming on to her and dresses provocatively. Meg demonstrates highly controlling behavior with caregivers and peers, and often attempts to evoke sympathy to get attention. She takes things that do not belong to her and demonstrates minimal remorse when caught.
What is Trauma?

A. Overwhelming event or events that render a child helpless, powerless, creating a threat of harm and/or loss.

B. Internalization of the experience that continues to impact perception of self, others, world, and development.
What is complex trauma?


- Traumatic exposure: experiences of multiple traumatic events that occur within relational system
  - Sequential occurrences of child maltreatment
  - Often chronic and early in childhood
Remembering The Invisible Suitcase

Handout from the Resource Parent Training for Caregivers

Available at www.nctsn.org
Meg’s History

Meg lived with her biological mother and 5 year old half brother prior to her placement in foster care four months ago. Her mother and father separated when she was about 6 and her mom became involved with her brother’s father soon after. She was removed from her mother’s care following an incident where her mother was physically assaultive, leaving multiple injuries to Meg’s face and body. Her mother is also a long term drug user and Meg has been sexually abused by three separate relatives. A 24 year old friend of the family also sexually abused her, although her mother reports that Meg consented.
Meg’s diagnosis

Meg has been treated for depression. An earlier diagnosis of ADHD was made in first grade. She was prescribed a stimulant medication when first diagnosed, but she lost her appetite and was taken off. When first placed in care, she was taking Abilify and Lexapro each, but her dosages were doubled following an evaluation three months ago. Her current diagnosis includes Mood Disorder NOS and Post Traumatic Stress Disorder – chronic.
Common Diagnosis When Children Experience Trauma

- ADHD
- Post Traumatic Stress Disorder
- Oppositional Defiant Disorder/Conduct Disorder
- Depression and Anxiety Disorders
- Bipolar Disorder
- Mood Disorders
# Symptoms of Post-traumatic Stress Disorder

1. **Re-experiencing**
   - Imagery
   - Nightmares
   - Body memories
   - Misperceiving danger
   - Distress when cued

2. **Avoidance**
   - Numbing out
   - Dissociation
   - Detachment
   - Diminished interest
   - Self isolation

3. **Increased arousal**
   - Anxiety
   - Hypervigilance
   - Startle response
   - Sleep disturbances
   - Irritability or quick to anger
   - Physical complaints
Limitations of PTSD Diagnosis

- Conceptualized from an adult perspective
- Identified as diagnosis via Vietnam vets and adult rape victims
- Focuses on single event traumas
Limitations of PTSD Diagnosis

- Fails to recognize chronic/multiple/on-going traumas
- Is not developmentally sensitive and does not reflect the impact of trauma on brain development
- Most traumatized children do not meet full diagnostic criteria
Development Trauma Disorder

Based on Complex Trauma
(Cook et al. 2003)

White Paper available online
www.nctsn.org
Developmental Trauma Disorder

- Developmentally adverse interpersonal trauma for over one year, and exposure was before the age of 18.

- Subjective experiencing of:
  - Rage
  - Betrayal
  - Shame
  - Humiliation
Affective or Physiological Dysregulation

- Impaired developmental achievement related to arousal regulation:
  - Mood
  - Bodily Functions
  - Diminished awareness of emotional and behavioral states
  - Difficulty describing emotional or bodily states
• Meg is triggered by:
  – Potential rejection and/or loss (activities, interactions)
  – Authority

• Her attempts to regulate intense emotion are evident in her:
  • Need for control in her interactions with peers and caregivers (hyperarousal)
  • Defiance and aggression
  • Somatic tendencies
  • Withdrawal, napping and dissociative tendencies (hypoarousal)
- Attentional and Behavioral Dysregulation confused for ADHD
- Self and Relational Dysregulation attachment
- Some PTSD Symptoms
Triggered pattern of dysregulation in response to trauma cues
Antoine
Fight/Flight/Freeze

- Overdevelopment of regions of the brain involved in anxiety and fear responses

And

- Underdevelopment of regions of the brain involved in complex thought and those necessary for learning.
“When neither resistance [fight] nor escape [flight] is possible, the human system of self-defense becomes overwhelmed and disorganized. Each component of the ordinary response to danger, having lost its utility tends to persists in altered and exaggerated ways long after the actual danger is over.

Judith Herman, 1992

“The Body Keeps the Score”

Bessel van der Kolk (19..)
Treating Traumatized Children and Trauma Focused Cognitive Behavioral Therapy Part II

Connie Black-Pond MA, LMSW, LPC
Southwest Michigan Children’s Trauma Assessment Center
October 19, 2010

www.wmich.edu/traumacenter
What Helps Children Heal from Trauma and Traumatic Stress?
Definition of Trauma
Informed Care

• Mental Health Treatment that incorporates:
  – An appreciation for the high prevalence of traumatic experiences in persons who receive mental health services

  – A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual

  (Jennings, 2004)
Allan Schore (2008): “The focus of treatment is not on reconstruction of the trauma but on the effects of the trauma on right brain regulatory processes.”
Overview of Core Elements

Intended to increase practitioners’ ability to provide traumatized children and their families with effective, individually-tailored mental health services that reflect the client’s unique needs and strengths, cultural background, developmental level, and life circumstances.
Core Components (Elements) of Trauma Treatment

- Psychoeducation about trauma for caregiver and child
- Affect regulation skill building
- Trauma processing through trauma narrative or life story (not fact finding, but memory of the experience)
- Recognition and management of trauma triggers
TF-CBT

“Treating Trauma and Traumatic Grief in Children and Adolescents” (2006)
J. Cohen, A. Mannarino & E. Deblinger

Web Based Training:
http://tfcbt.musc.edu/
Most rigorously tested treatment for traumatized children:

• Improved PTSD, depression, anxiety, shame and behavioral problems compared to supportive treatments.
  85-90% of children made marked improvement

• Improved parental distress, parental support and parental depression compared to supportive treatments.
Common Parental Issues in Child Traumatization

- Inappropriate self-blame and guilt
- Inappropriate child blame
- Overprotectiveness
- Overpermissiveness
- PTSD Symptoms
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.
Problems addressed in TF-CBT

• Affective (mood)
• Relationship and Attachment
• Internalizing and Externalizing
• Distorted Beliefs about self and world
• Family Problems
Core Values of TF-CBT

C - Component Based
R – Respectful of Cultural Values
A – Adaptable and Flexible
F - Family Focused
T - Therapeutic Relationship is Crucial
S - Self Efficacy is emphasized
• TF-CBT is:
  – Sequenced: Stress inoculation precedes trauma exposure (narrative)
  – Time Limited (beginning, middle and end)
  – Attachment based
  – Specialty Treatment
  – Fun (need to have fun!)
TF-CBT and Complex Trauma

✓ TF-CBT is an effective treatment for Complex Trauma
✓ Stress inoculation components often need more practice, take more time
✓ Add mindfulness and sensorimotor considerations (in the body!)
Treatment Components
“PRACTICE”

- Psychoeducation
- Parenting
- Relaxation
- Affect Regulation
- Cognitive Coping
- Trauma Narrative
- In vivo Desensitization
- Conjoint Sessions
- Enhancing Safety
Psychoeducation

Goal...

To normalize and de-stigmatize the effects of trauma and exposure to trauma.

Resources:

“What do you Know?” card game Deblinger
Psycho education on Traumatic Stress and the Brain

- Psycho education on normal responses to danger
- Psychoeducation on individualized issues (medical, learning styles etc)
The Cliff
Parenting

• Identify concerning behavior and strategies for addressing behavior (reducing negative behavior) are successful.

• Important early on in treatment (first 2-4 sessions)

• Behavioral interventions with a “trauma lens” (understanding behaviors as “survival” rather than “willful” and “manipulative”)
Parents and Caregivers

• Assess Parents for their ability to engage in conjoint sessions

• Requirements to witness the narrative:
  
  Believes Child
  Child Focused
  Supportive to Child

  May Not Know
  Potential to witness in the beginning!
Relaxation - Skill Building

- Music
- Soothing/Calming Objects
- Belly Breathing
- Progressive muscle relaxation
- Squeezing lemons
- Blowing bubbles (float like a bubble)
- Feathers
- Robot/wet noodle
- Be creative
Relaxation includes “Focusing” Activities that anyone can model and participate in:

Goal: To decrease physiological reactivity

• Alphabet Game
• Colors in the room
• Drumming/Rhythm
• Balloons
• “Mindfulness”
Affect Regulation

Goal: To increase child’s ability to identify and express feelings

- Traumatized children often rely on avoidance of feelings to function = “emotional numbing”
- Their range of emotion may be restricted.
- Expression of emotion dependent on identification of bodily states and ability to express through language.
- Traumatized children often interpret facial expressions as hostile.
Affect Regulation

- Write down different feelings in three minutes
- Take turns picking feelings from list and describing last time felt this feeling
- Feeling games – Mad, Sad, Glad Game etc.
- Color Your Life (O’Conner, 1985)
- Feeling Wall
- Family Sculpture
- Plays and role play
- Dice Game
- Focus on body and sensory sensations
Procedural Learning – early precortical responses
Cognitive Coping

Goal:

- to stop and change inaccurate and unhelpful thoughts to accurate and helpful thoughts

- and

- to link thoughts to feelings and behaviors
Cognitive Coping

What Else Can You Think that is Accurate and helpful?

Thinking

Feelings

Behavior
Goals...

To expose child to distress of trauma memories in tolerable doses.

To desensitize child to the intensity of physiological and emotional responses related to trauma.

To correct cognitive distortions.
Another time. One time he put the phone in his pants so I couldn’t call my mom and said, “if you want it, you have to get it.” I cried because I wanted my mom. My mom is the most special mom in the world. Even more than my brothers. I felt scared and sad at
When he put the phone in his pants.
“The Experience”

When this was happening, it was like I knew what was going on but it came at me so fast, I was puzzled. My body felt shaky. It was like all the pieces of a puzzle were thrown at my face and I was trying to put them together like this piece goes here, that piece goes there. But even when I think it's put together, it's not really put together.
Cognitive Distortions – Processing with Children and Parents

Cognitive Distortions are beliefs and perceptions that are inaccurate and reflect:

Coping Strategies = denial, minimization, rationalization

The impact of Traumatic Exposure: Self Blame, shame, helplessness, negative working model etc
I was only six when I went into foster care. I remember vividly just sitting outside the courthouse . . . my birth mother crying. And then suddenly, I was living somewhere else, in some house I didn’t know. No one told me anything. For five years, no one told me anything.

Luis

Sharks
In Vivo Mastery

• **Goal:** Improved functioning for child and child experiences sense of competence and mastery

• **Use when trauma triggers interfere in child’s ability to function (sleep, go to school, go to a friends’)**
Conjoint Sessions

- Conjoint Sessions begin at the Assessment sharing phase and continue throughout each component. During Trauma Narrative, parent meets individually with therapist.

- Through PRAC skills, parent may join session each time, with child teaching parent new skills.

- In Vivo and Enhancing Safety include parent.
Enhancing Safety

Should Occur after the Trauma Processing so child will not blame self for not using skills and alter narrative to reduce shame

Focuses on Assertiveness and Self Protection

Recognition and Managing of Triggers - Safety Planning

Heroes Project (Kagen) – Personal Power Plan

“What If” Game
Thank You!
Not always what we expect:

30% of traumatized people show no change or decrease in heart rate activation during traumatic recall, indicating hypoarousal.

Lanius, 2005
• She also demonstrates compensatory behaviors such as lying and “story telling” that provide her with a sense of safety and control in her environment and serve to regulate intense anxiety. She has many fears, including significant fears of being alone. Repression and denial of her victimization allow her to experience relief from intense anxiety.