

Trauma-Focused Cognitive Therapy in Residential Treatment Facilities: An Implementation Manual

Judith A. Cohen, M.D.

Anthony P. Mannarino, Ph.D.

**Allegheny General Hospital
Center for Traumatic Stress in Children and
Adolescents**

September, 2013

© 2013 JA Cohen & AP Mannarino, all rights reserved. This implementation manual was prepared through funding from grant number 5U79 SM 054319-11, Child Abuse and Traumatic Loss Treatment Services Development Center from the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of the National Child Traumatic Stress Network to Allegheny Singer Research Institute. We gratefully acknowledge the assistance, support and valuable contributions of the following individuals in developing this manual: Esther Deblinger, Ph.D., Malcolm Gordon, Ph.D., Janet Chassman, NY Office of Mental Health, Scott Talley, PA Department of Mental Health, David Chambers, Ph.D., National Institute of Mental Health (NIMH), Daniela Navarro, MA, LPC, LCDC; and all of the therapists and supervisors who participated in TF-CBT RTF implementation consultation calls.

TABLE OF CONTENTS

Table of Contents.....	2
Introduction.....	3
Principles of Implementing TF-CBT in RTF.....	5
RTF TF-CBT Implementation for Therapists.....	9
Conclusion.....	24
References.....	25
APPENDIX 1: TF-CBT Integrated Curriculum for RTF Direct Care Staff.....	27
APPENDIX 2: TF-CBT for Youth with Complex Trauma.....	61
APPENDIX 3: TF-CBT Psychoeducation for RTF Direct Care Staff.....	75
APPENDIX 4: TF-CBT Relaxation Skills for RTF Direct Care Staff.....	79
APPENDIX 5: TF-CBT Affect Regulation Skills for RTF Direct Care Staff.....	82
APPENDIX 6: TF-CBT Cognitive Coping Skills for RTF Direct Care Staff.....	86

Introduction

In 2009 the Substance Abuse and Mental Health Services Administration (SAMHSA) provided grant funding to the Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents to continue to serve as a Treatment Services and Development (Category II) Center in the National Child Traumatic Stress Network (www.nctsn.org). Among the goals of this project were to consult to Community Treatment (Category III) Centers in the NCTSN in order to develop appropriate applications of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT, Cohen, Mannarino & Deblinger, 2006; www.musc.edu/tfcbt) for implementation in Residential Treatment Facilities (RTF). During the three years of the original grant funding (October 2009-September 2012), the following NCTSN programs participated in the project:

- 1) SCAN-Inc., Laredo, TX
- 2) Jewish Board of Family and Children Services, New York, NY
- 3) Dartmouth College, Lebanon, NH
- 4) Ambit Center, Minneapolis, MN
- 5) University of Kentucky, Lexington, KY

Additionally, we greatly benefitted from three concurrent projects that focused on implementing TF-CBT in RTF settings. These were sponsored by the:

- 1) New York State Office of Mental Health
- 2) Pennsylvania Department of Mental Health
- 3) National Institute of Mental Health, funded project R01MH95209, TF-CBT for Adjudicated Youth in Residential Treatment

We gratefully thank everyone who participated in these projects for all of their valuable contributions to this manual. An earlier version of the information

contained in this manual was published previously (Cohen, Mannarino & Navarro, 2012).

PRINCIPLES OF IMPLEMENTING TF-CBT IN RTF

Unique Features of Residential Treatment Facilities

More than one hundred thousand children in the U.S. currently receive mental health treatment in residential settings. These children (“residents”) typically spend from 4 months to 2 years in residential treatment facilities (RTF). This manual focuses on implementing TF-CBT in RTF but these applications may also apply to children receiving treatment in group homes, or long term inpatient treatment programs.

Two distinguishing features of RTF require that TF-CBT is implemented somewhat differently in RTF settings:

- 1) The primary reason that children are placed in RTF settings is to address severe problems that cannot be stabilized in less restrictive environment; and
- 2) RTF direct care milieu staff members rather than parents are responsible for managing children’s problems in the RTF milieu setting.

Residential treatment facilities exist for children with serious externalizing and/or internalizing problems that have not responded to interventions in less restrictive settings. Although RTF programs are increasingly recognizing that trauma contributes to these problems, trauma-focused treatment will likely only be viewed positively in RTF to the extent that it contributes to observable improvement in the serious problems for which the child was admitted (e.g., improvement in externalizing behaviors), shorter length of stay, or other RTF-relevant outcomes. Thus, in order to be successfully accepted and implemented in RTF settings, TF-CBT treatment must not only resolve trauma symptoms but first and foremost, *contribute to resolution of the behavioral or other observable problems for which the child was sent to RTF*. Therapists must therefore make clear to RTF staff, administrators, residents and parents how TF-CBT treatment

will contribute to residents' behavioral or emotional regulation in addition to how it will address the resident's other trauma problems.

Parental involvement is highly variable for children in RTF. Some have intact, supportive families and their parents participate regularly in RTF treatment. More often chaotic family living situations, maladaptive or abusive parenting contributed to the child's reasons for needing RTF care. Family disruptions also occur during RTF stays, including termination of parental rights; parents relocating out of state; caregiver relationships ending with the child losing a longstanding relationship with the parent's significant other; or foster parents terminating fostering during RTF treatment. Any of these events may escalate residents' behavioral or emotional regulation problems in the milieu. Since direct milieu staff members' task is to manage residents' problems in the RTF milieu, these staff members must understand how trauma impacts children in RTF settings, how to minimize trauma reenactment in the milieu, and how to optimally support TF-CBT implementation. This implementation manual focuses specifically on direct milieu staff, but similar considerations apply to other RTF staff members (e.g., teachers) who have regular interactions with residents in the RTF milieu.

Trauma reenactment frequently occurs in RTF settings. Trauma informed care and TF-CBT aim to prevent trauma reenactment. Trauma reminders or triggers (cues that remind a child of one or more past traumatic experience and then recreate negative aspects of the child's emotional, behavioral or physical responses to the original trauma) are numerous in the RTF milieu. For example, other residents fighting or crying, a parent calling or failing to call, or a staff member redirecting a resident in a loud voice may serve as trauma reminders. Since many residents in the RTF milieu have trauma histories, multiple residents may be "triggered" simultaneously and lead to one or more traumatized resident losing behavioral and/or emotional control. When staff members acknowledge and validate how upset a child is and encourage the child to use TF-CBT coping skills

the child is more likely to gain affective and behavioral regulation. However, when staff members intervene in a manner that the child perceives as a further trauma reminder (e.g., if a staff member uses a loud tone of voice or an intrusive or forceful physical manner) this will likely escalate rather than deescalate the child's trauma-related behavior. This response from staff members may trigger other residents in the milieu, potentially leading to poor affective and/or behavioral regulation among several residents or an out-of-control situation in the milieu. The following clinical example illustrates a scenario in which direct milieu staff members failed to recognize trauma reenactment with negative consequences for the milieu. Information sheets for direct milieu staff about how to support implementation of TF-CBT skills in the RTF milieu are included at the end of this implementation manual.

Clinical example Joe's mother didn't call when she promised she would. Joe got increasingly angry as it became clear that she would not call. He kicked over a chair, yelling, "I hate my f---ing mother". A staff member yelled, "Joe! No swearing here! Now pick up that chair!" Two residents said, "Hey, he can be pissed off" and "You don't know what it's like", respectively. The staff member who had yelled and one other staff member approached the boys and the staff member who had yelled at Joe said in a loud, threatening manner, "You all just lost your levels." Joe picked up the chair and threw it at the staff member. The two staff members then put Joe into a therapeutic hold. Two other residents who were watching the scene became angry and tried to pull the staff members off of Joe, leading to them also being restrained. Three additional residents then tried to defend those who were being restrained. Five residents and Joe were restrained during this incident. The staff members present recalled this incident as "bad kids acting badly" while all of the residents said that the staff members "disrespected us" and "didn't care how we felt". Joe later told his therapist that when the incident started he was thinking about all the times his parents had abused him and let him down. Not calling was "just one more time she disappointed me". Recognizing

trauma impact and how to implement TF-CBT coping skills may have prevented this scenario from getting out of control.

Direct care milieu staff members are often young, have had little or no professional education about child psychopathology, and have little prior experience working with troubled children. These individuals receive annual mandated training in techniques for conflict resolution and management of problem behaviors but since they are often spat on, called names, kicked and/or punched by residents, they may take this personally, viewing themselves as victims of abuse by the children in the RTF rather than seeing these children as reenacting trauma that they themselves have experienced. In the absence of a trauma-informed understanding of trauma triggers, traumatic reenactment and specific, behavioral training and practice in how to intervene early in these situations, direct milieu staff members often experience negative emotions towards residents in the milieu. To their credit, RTF programs are increasingly seeking trauma-informed care training for staff. One example is the Sanctuary® Model (www.sanctuaryweb.com), an *organizational approach* to providing care for traumatized individuals. Using a trauma informed care model such as Sanctuary in conjunction with TF-CBT likely provides an ideal approach for traumatized children in RTF settings.

Since many RTF programs cannot afford comprehensive trauma-informed training in a model such as Sanctuary®, we developed a one-day integrated curriculum to train RTF direct care staff in both trauma-informed care and how to support the implementation of TF-CBT skills. This curriculum is included as Appendix 1 to this implementation manual. The training described in this curriculum is to be provided only by approved TF-CBT trainers or supervisors. (Note: since the original production this manual, the National Child Traumatic Stress Network (NCTSN) has developed a similar curriculum, Think Trauma (available at <https://www.nctsn.org/resources/think-trauma-training-staff-juvenile-justice-residential-settings>).

RTF TF-CBT IMPLEMENTATION FOR THERAPISTS

Unique TF-CBT Assessment Strategies in RTF

Many RTF programs now include questions about trauma exposure and trauma symptoms as part of their formal initial evaluation. However, this is not universally the case. RTF programs are required to conduct and document intake assessments in order to receive reimbursement and to meet a variety of regulations (e.g., state, county, Child Welfare, Juvenile Justice, etc.). In some cases the assessment may be conducted by a psychiatrist or psychologist instead of the therapist, and for a variety of reasons the RTF assessment protocol may not include a formal assessment of trauma exposure or symptoms. In this case, the first challenge may be how to incorporate information about trauma exposure and symptoms into the assessment and treatment plan. In our experience most RTF programs want to consider this information but do not have a mechanism for how to incorporate it into the formal assessment protocol due to lack of time, manpower, assessment instruments, and/or other resources. In these situations the therapist can clinically interview the child and if feasible, the parent or caregiver, and administer the Child PTSD Symptom Scale (CPSS), a freely available instrument, with regard to the resident's trauma symptoms to determine whether this is a relevant focus of treatment. This information can then be incorporated with the initial evaluation at subsequent team meetings in order to update the diagnosis and treatment plan. A therapist who can conduct a trauma-informed assessment and provide TF-CBT integrated with other appropriate treatment as agreed upon by the treatment team will be a valuable addition to any RTF program.

Clinical example: Mary was a 13 year old admitted to RTF for participating in gang-related violence. She denied drug or alcohol use and urine toxicology screens were negative. Soon after admission Mary was seen by staff apparently responding to auditory hallucinations. She initially refused to divulge the content of these voices, but eventually Mary stated that the voices were coming from around the unit and the TV, and the voices kept saying that she was bad and should

kill herself. She was isolative on the milieu and talked to herself. Mary often slept less than 2 hours each night and when peers approached her she became violent. Her initial diagnosis was schizophrenia, R/O atypical bipolar disorder and Mary was started on antipsychotic medication. When conducting a thorough assessment for PTSD, her therapist found that Mary had a long history of domestic and community violence, had been sexually abused by her stepfather from ages 3-10 , and had more recently experienced a series of gang-related rapes. As the therapist spoke more with Mary about these experiences it became clear that Mary was frightened by the older males on the unit who reminded her of the perpetrators of the recent gang rapes. Mary said that she couldn't sleep because she had recurrent fears of being raped in the RTF. The therapist asked whether the voices started before or after these rapes. Mary said, "The voices are they all who did this to me telling me I'm no good. It's me saying I deserved what they all did to me (i.e. to be raped) so I should just kill myself and leave this life." After more questioning the therapist clarified that the "voices" were dissociative and reexperiencing phenomena rather than psychotic symptoms. The therapist explained these symptoms to Mary and changed the diagnosis to PTSD and Major Depression. TF-CBT was started, focusing on safety on the milieu. The antipsychotic medication was discontinued over a period of time.

The most significant challenge in assessing trauma impact in RTF settings is often determining whether or not a resident's severe emotional and behavior problems are related to past traumatic experiences. Individuals with PTSD may have aggressive behaviors with little or no provocation (APA, 2013, p 275) and residents' aggression may be part of a PTSD picture. Often residents have experienced long histories of multiple traumas and losses such as placements in and out of multiple foster homes, chronic experiences of physical, sexual or emotional abuse and/or domestic violence, and when a thorough trauma assessment is performed, residents and/or their caregivers endorse multiple trauma symptoms. The therapist is often able to discern connections between the child's

behavioral problems and the past trauma(s) the child experienced (e.g., sexual offending in a youth who experienced sexual abuse; physical assaultive behavior in a youth who experienced physical abuse or witnessed domestic violence, etc.), or that the behaviors are sometimes prompted by traumatic reminders (e.g., the youth started a fight when called the same name that his abusive father used to call him). These connections might be formulated as trauma reenactment), and justify the use of TF-CBT for the youth's severe behavioral problems.

Clinical example: CJ was a 14 year old admitted to RTF for gang activity. His gang behavior included violence in school and toward multiple foster parents, bullying at school, and property destruction. CJ had a long history of witnessing extreme domestic violence including the murder of his mother by father, and having been bullied by his father and older brothers and at school. Father regularly and severely beat CJ's mother and was rumored to have killed a man. CJ's older brothers were extremely emotionally and possibly physically abusive to CJ; father encouraged this behavior calling CJ a "sissy" and "mamma's boy". When CJ was 9 years old mother and he ran away from father. Father came after them and shot mother dead in front of CJ. Father was jailed but because CJ's oldest brother was an adult, he was given custody of CJ and the abuse of CJ continued. When he was 11 years old CJ joined a gang "to protect me from my brothers". He ran away again at 12 years old and was placed in a series of foster homes but was forced to visit with his brother. During the trauma assessment CJ scored 10 (low) on the CPSS but the therapist observed that CJ was extremely avoidant about talking about trauma experiences or symptoms during the clinical interview and she believed that CJ was minimizing these symptoms. The therapist began TF-CBT and after 3 sessions she repeated the CPSS. At that time his score on the CPSS was 35 and he acknowledged severe physical abuse by brothers.

While recognition of the central role of trauma reenactment in severely traumatized youth is crucial, it is also important that therapists not automatically attribute all behavior problems to trauma. Some youth only experienced trauma in

the distant past, do not have any apparent trauma symptoms other than severe behavior problems, and there is no apparent connection between the current behavior problems and the past trauma. Unless more information becomes available to suggest trauma etiology the therapist should not assume that the current behavior problems are related to or will be resolved by engaging in trauma narrative and processing work.

Clinical example: Tom was a 16 year old living with a single mother and two younger brothers, who was admitted to RTF specializing in sexual offending after he raped his neighbor. He had also raped several other girls (acquaintances) but due to his gang activity they had been afraid to disclose this. Tom was also displaying threatening behavior towards his mother. He had a history of being in a car accident as a young child and having witnessed community violence. His score on the RI was 13 but his primary trauma symptoms were irritability, gang-related hypervigilance and angry outbursts. The therapist did not believe TF-CBT was appropriate.

TF-CBT Engagement Strategies in RTF

Engaging families in TF-CBT while their children are in RTF may require unique strategies for several reasons. The child's severe emotional and/or behavioral problems may have exhausted parents leading the parents to feel both relieved and guilty about agreeing to residential placement for the child. The family may not understand why trauma should be a treatment focus for severe behaviors; if the family is chaotic or a parent experienced and/or perpetrated multiple generational trauma the parent may feel blamed or defensive about the idea of trauma-focused treatment (e.g., the parent may say, "I went through this when I was a kid and I never acted up like this."). The RTF may be far from the child's home, making it difficult for the family to participate in therapy in person. Engagement strategies for these situations are described below.

Experiencing a child's severe behavior problems or having to place a child in a residential setting brings parents heartache and the feeling that they have failed as parents. Therapists must first communicate that they do not negatively judge the parents based on the child's negative behaviors or the family's history. Providing TF-CBT is based on the premise that past traumatic experiences provide at least a partial explanation for the child's problematic behaviors. This "no shame and no blame" approach can be helpful for parents who feel that they have been ineffective or "bad" parents in not being able to control the child's problematic behaviors.

It is important to validate and acknowledge that the child's behavior has caused the parents significant distress. By relieving the parent's immediate burden of managing these behaviors, RTF admission may contribute to parental engagement over time. Psychoeducation about trauma impact may diminish child blame. Using the analogy of members of the military with violent outbursts after returning from the wars in Iraq and Afghanistan may be helpful to explain the behavioral impact of PTSD to parents who have never heard of this trauma manifestation. Pointing out that PTSD is both a response to trauma and a brain

disorder (i.e., trauma causes biological changes that maintains behavioral and emotional changes) may help parents to better understand their child's behaviors. For parents with a personal trauma history who say "I didn't act up this way", it may be helpful to first validate the parent's resilience, drawing the parallel to the fact that most members of the military have not developed PTSD. Then point out ways in which children respond differently to benign experiences such as starting kindergarten (i.e., some do well, others have problems).

TF-CBT has been provided via phone or Skype to families that lived too far to attend sessions regularly. Newer technology is making it easier for RTF programs to engage parents who live far away from the RTF program. For example, Skype and similar freely downloadable programs allow any family with a home computer to access the RTF therapist via computer at the appointed therapy hour. Therapists can now schedule sessions remotely via computer with parents and conduct TF-CBT parent sessions in which the therapist can "see" the parent and during conjoint sessions, the parent and child can "see" each other. Although not exactly the same experience as face-to-face therapy, for families who wish to participate in their children's TF-CBT treatment, this is a feasible alternative, and many families are happy to have choices through which to learn parenting and other skills during the therapy hour.

Engaging youth in trauma-focused treatment requires addressing issues of trust. Many youth in RTF have complex trauma and as such have experienced injury, loss and betrayal of trust by caregivers or other important attachment figures. The concept of gradual exposure to trauma triggers is relevant in that the therapeutic relationship itself may serve as a trauma reminder. In this context the therapist may be tested by the youth, often repeatedly, because the youth has come to expect betrayal in close relationships. Strategies for engaging youth and implementing TF-CBT for these youth are described in detail in Appendix 2.

Unique TF-CBT Applications in RTF

Unique considerations for applying TF-CBT in RTF settings include when to begin TF-CBT; how to combine TF-CBT with other RTF treatment modalities; how to include RTF direct milieu staff in TF-CBT; and how to optimally apply TF-CBT for children and youth in RTF settings.

When to start TF-CBT: TF-CBT is typically started in RTF once 1) the child has undergone an initial adjustment to and understands the milieu's level system and other basic rules; 2) the therapist or another clinician has completed the assessment and ascertained that trauma is relevant to treatment; and 3) stabilization of *acute* psychosis, suicidality, self-injury or other acute conditions has occurred. In a very short-term RTF program (e.g., 4 months) there may be insufficient time to completely stabilize the child before starting TF-CBT. In this situation, the pacing of integration, assessment, and stabilization occurs much faster than in longer term RTF settings. Such programs can be extremely successful at providing TF-CBT if trauma treatment is well integrated into the structure of the program and if a concerted effort is made to involve family members in treatment. For example, a four month RTF program for severely multiply traumatized Latino teens with comorbid substance abuse disorders in Laredo, TX has successfully implemented TF-CBT with more than 50 youth with significant improvement in trauma and substance abuse problems among these youth. This suggests that youth can tolerate trauma-focused treatment quite early in treatment and increasingly in RTF programs where therapists initiate TF-CBT soon after admission, youth are responding well to this approach.

Integrating TF-CBT with other RTF treatment modalities: Multiple mental health interventions are provided in RTF. Optimal methods and timing for integrating TF-CBT with existing RTF interventions are now being examined and developed. For example, one method for integrating TF-CBT into the RTF milieu or level program (developed and pilot tested in collaboration with RTF milieu staff and therapists) is through the use of TF-CBT Coping Cards (Figure 1).

Direct care staff members receive training and education about TF-CBT skills and how to support their implementation prior to using these cards. This ideally occurs through participation in trauma-informed curricula such as Sanctuary® or the full day integrated curriculum training in trauma-informed care and TF-CBT implementation. This training includes providing direct care staff with handouts about how to support the implementation of the TF-CBT trauma psychoeducation (Appendix 3) and TF-CBT relaxation, affect modulation and cognitive coping (Appendices 4-6).

The therapist fills in the Coping Card with children as they learn and practice new TF-CBT skills in treatment, and instructs children to carry the card with them whenever they are on the milieu. When a child shows signs of regulation problems any staff member asks the child for their Coping Card, identifies a TF-CBT coping skill the child is currently using, and encourages the child to use one or more skill. The child then earns points in the milieu system for successfully implementing any skill on the card to regain regulation. (The child loses points for not having the card with them.) This is also a good method through which to emphasize in an ongoing manner to residents, staff, parents, and other stakeholders **the connection between implementing TF-CBT and improving children’s behavioral problems.**

Figure 1: TF-CBT Coping Card

My Name: _____
Coping Skills I’m using:
Relaxing:
Managing feelings:
Managing behaviors:
Managing thoughts:

Many RTF programs that are implementing TF-CBT already use a group trauma format. A typical approach is to delay starting TF-CBT until youth complete the trauma group. This decision is based on the premise that providing both individual and group trauma-focused treatment concurrently is likely to be

redundant; and also on concerns that youth may become overwhelmed by talking so much about trauma issues. These RTF programs do not provide evidence-based group trauma treatments, but rather a variety of different untested approaches, and in our experience youth often continue to have high levels of trauma symptoms after the end of trauma groups, suggesting that starting with individual TF-CBT may be a more effective approach

In contrast, many other RTF interventions are optimally provided concurrently with TF-CBT. For example, many programs provide targeted treatment for juvenile sexual offenders who also have significant trauma symptoms, and some are implementing TF-CBT concurrently with treatment for offending behaviors. Therapists in these programs report that providing TF-CBT in conjunction with treatment that addresses the sexual offending behavior is optimal for these youth because it helps them to understand and feel understood regarding the connection between their personal traumatic experiences and their subsequent offending.

Clinical example: John was a 14 year-old adjudicated to RTF due to sexual assault of a 13 year-old cousin during a weekend visit with his aunt and uncle. This was his first sexual offense. During the initial assessment John acknowledged domestic violence and “other” traumas but would not disclose what this was. His CPSS score was 38, in the very severe range. He eventually disclosed severe chronic sexual abuse by father and older brothers. This was witnessed by mother on many occasions, but mother never intervened. John received TF-CBT in conjunction with treatment for sexual offending. During the trauma narrative he said, “The worst part of all was that my mother let my dad and brothers do that to me and she never lifted a finger to help me. That made me into nothing. I don’t know why no one ever loved me in that house.” Through this concurrent treatment John was able to understand his own abuse, feel compassion from his therapist and other staff for these painful experiences, and also understand the process through which he abused his cousin and take responsibility for this abuse. This allowed

him to make the connection between his own pain as a victim and what his cousin must have felt. He wrote a letter to his aunt, uncle and cousin telling them about his previous abuse and asking them if they could ever understand and if there was a way he could somehow make amends.

Including direct care staff in TF-CBT when parents are not involved: Although TF-CBT significantly improves children's symptoms when provided only to the child (Deblinger et al, 1996; Weiner et al, 2009) children derive additional benefits from a caring adult participating in TF-CBT with them. For example, including parents in TF-CBT treatment significantly improves child depression and behavior problems (Deblinger et al, 1996); and increased parental support is a strong predictor of improvement in children's trauma-related symptoms (Cohen & Mannarino, 1998; 2000). Despite ongoing efforts to engage parents, about half of the children in RTF do not have ongoing parental involvement in treatment. For these children including direct care milieu staff in TF-CBT treatment may be beneficial if the child and direct care staff member are both agreeable. In situations in which there is no parent participating in treatment, the therapist can ask the child whether s/he would like to select a specific milieu staff member to participate in treatment with him/her. Usually but not always in RTF programs in which a primary milieu staff member is assigned to each child, the child will select his or her primary staff member to participate in treatment. The therapist should explain the guidelines for participation to the staff member and the child. Specifically, the child and milieu worker must agree that the milieu staff member will not break confidences shared during therapy; and will still enforce the rules on the milieu fairly and impartially. During treatment sessions with the milieu staff member the therapist works in a somewhat parallel manner as with a parent, i.e., they identify the child's trauma triggers and plan how the staff worker might implement TF-CBT skills on the milieu. Milieu staff may need extra preparation and support for hearing children's trauma narratives before participating in conjoint sessions since they may not have previously heard these in such detail. However, many direct

milieu staff report a new level of understanding and compassion for RTF patients after participating in TF-CBT treatment.

Clinical example: Michael was an 11 year old admitted due to violent acts (bullying, property damage, theft) at school. His foster parents gave notice that they were terminating foster care shortly after he came to RTF. He had experienced early exposure to domestic violence, severe neglect, physical abuse and parental substance abuse prior to going to live with his great-grandmother when he was 6 years old. She became his legal guardian and adopted him the following year but became too ill to care for him when he was 9 years-old. Michael entered a series of foster homes where he experienced violence and school bullying. His great grandmother died two months ago, prompting serious behavior problems. During the trauma assessment, he identified this death as his worst trauma. He scored in the moderate range (20) on the CPSS but his therapist believed that he was minimizing some symptoms. Since no caregivers were available to participate and loss was a significant issue for Michael, the therapist asked him if he would like one of the milieu staff members to participate in treatment with him. Michael chose his primary milieu staff member, Joanne, a woman who like him was African American, to participate in TF-CBT with him. Joanne was a little nervous but very pleased that Michael wanted her to do this. During the first session with the therapist she expressed the concern that Michael had asked her to participate so that he could “play” her on the milieu unit. As Joanne gained increasing insight about Michael’s trauma history and triggers and how to use the TF-CBT skills to help him manage these she looked back on that comment ruefully, saying, “I can’t believe how little I understood him.” Over time Joanne came up with her own ideas about how to help Michael on the milieu. For example, she became particularly adept at recognizing early signs that he was being triggered by other kids or situations on the milieu and developing inventive techniques to distract him before he lost control. For example, she would sing his favorite rap songs to get his attention, then change the words (e.g., to “use your

skills, baby, start to breathe.”) This usually made Michael laugh. Joanne was shocked at hearing Michael’s early experiences when the therapist read the trauma narrative to her. At first she didn’t think she could do a conjoint session because she was “too angry at his parents to even be civil”. She also told the therapist that it triggered her own issues of loss (her aunt had cancer and was dying). However, she insisted that “if that little boy lived through all this, I can listen to it.” Joanne also talked to other staff members about how to recognize when Michael was having trauma reminders and how to help him settle himself down. This in turn helped Michael feel more supported and safe on the milieu. At the end of therapy, Michael thanked Joanne for being there for him, telling her she reminded him of his grandma (great-grandmother) because he knew “you’re always here for me”. Joanne said that doing TF-CBT with Michael “helped me understand what these kids have been through, and how to help them better”.

TF-CBT for youth with extreme family trauma: Many children in RTF have experienced long histories of extreme family trauma which contributes to serious impairments in establishing trust, safety, and/or attachments. RTF staff members frequently express the belief that due to long experience with betrayal from adults such children will not be ready to directly address traumatic experiences until they have spent considerable time establishing trust with the RTF staff. However, there is no evidence to suggest that talking about traumatic experiences impedes the development of trust. To the contrary, Sanctuary’s research (www.sanctuaryweb.com) documents that a trauma-informed RTF environment where discussion about trauma is actively encouraged *enhances* the development of trust and a sense of safety among children and staff. It stands to reason that children whose traumas have included extreme invalidation would benefit from direct acknowledgement that their experiences occurred and that their thoughts and feelings have a reality basis. This suggests that introducing TF-CBT early in RTF treatment for such children may be helpful. Since these children are also extremely reactive to trauma reminders, and even talking about what these reminders are may

trigger extreme responses, therapists may find it very helpful to decrease these children's hyperarousal by changing the order in which they introduce TF-CBT components for these children. For example, introducing and helping children master relaxation (without gradual exposure at first) before introducing psychoeducation may be very helpful for some of these children. Once children have mastered relaxation and possibly affective regulation skills without gradual exposure and are able to "turn down the volume" of their anxiety, they may be better able to tolerate discussion of trauma topics. Therapists can then revisit these skills components with the addition of GE.

Clinical example: Jane's mother locked her in an attic closet for the first 5 years of her life. When mother was out her boyfriend would come to the closet with a knife and sexually abuse Jane, telling her that if she made a sound he would kill her. When she cried mother would burn Jane with a hot iron. When discovered at 5 years old Jane weighed 20 pounds and was covered in feces. She was placed in foster care where she had severe aggression but was relatively stable for 2 years until foster mother died of a heart attack. In her next foster placement Jane was extremely aggressive and was physically abused by the foster mother in an attempt to get her to listen. Jane was placed in a series of foster homes where sexual and physical abuse occurred. At 11 years-old her behavior was out of control leading to RTF placement. On admission Jane endorsed physical abuse and said the worst thing that happened was her mother dying. She scored 54 on the CPSS (in the very severe range). The therapist and many staff members doubted that TF-CBT was appropriate since "her whole life has been trauma". Jane was aggressive and isolative on the milieu. After a month of non-directive therapy the therapist found that Jane liked coming to therapy and decided to try some relaxation to address Jane's agitation and aggression. Jane was able to use relaxation during the therapy sessions, but she would not look at the therapist for more than several seconds before lowering her gaze. The therapist worked with Jane's primary milieu staff, Carlos, who also tried hard to engage Jane in milieu activities and encouraged her

to use relaxation strategies on the milieu. Carlos was a muscular man whom all the residents looked up to. He dedicated himself to engaging Jane. Despite her aggression and persistent isolation Carlos believed Jane was trying to use the relaxation strategies. The therapist noticed after 2-3 sessions of using relaxation Jane seemed to be a bit more engaged in therapy. She decided to start TF-CBT at that point but to do so slowly. The therapist asked Jane whether she would like to include one of the direct milieu staff in therapy, and Jane chose Carlos. The therapist, Jane and Carlos agreed that Carlos would participate in Jane's therapy in this way: Jane would decide what she wanted to share with Carlos and the therapist and Jane would then meet with Carlos. If Jane gave permission, the therapist could also meet alone with Carlos to talk about what Jane was doing in therapy. The therapist started psychoeducation by introducing the What Do You Know Game using only some of the safety cards and providing Jane with a piece of candy whenever she answered a question. Jane and the therapist talked about safety and Jane said that she did not feel safe before coming to RTF. The therapist said, "It's hard to feel safe when the grownups who are supposed to take care of you don't keep you safe or even hurt you. But you are safe here." Jane became very anxious at this point but with the therapist's guidance was able to soothe herself using her relaxation skills. Jane then picked up one of the safety cards about "not okay" touches. Jane said, "I know all about that." The therapist asked Jane what she meant and Jane said "first Leroy (mother's boyfriend) hurt me then my mom burned me. They took turns." Jane briefly described the sexual abuse by mother's boyfriend and mother's physical abuse. The therapist told Jane how brave she was to talk about this and reassured her that she was safe in the RTF. The therapist was ready to end the session when Jane asked, "Aren't we going to tell Carlos?" The therapist asked Jane what she wanted to tell Carlos, and Jane said that she wanted to tell Carlos about the abuse she had just disclosed to the therapist. Carlos told Jane how brave she was and that he was really proud of her for sharing this. He also told her that he and the other staff would keep her safe in the RTF. Jane

continued to make slow but steady progress in TF-CBT and on the milieu. However, Jane was not able to tolerate placement in a foster home (presumably due to her early extreme traumatic experiences in nuclear family settings) and was eventually placed in a long-term group home setting where she did very well.

Unpredictable discharges: In RTF discharges may occur unpredictably based on child protection, family, and/or insurance decisions, leading to poor or no discharge planning. Specific to TF-CBT, the therapist may have no opportunity to end treatment in an optimal fashion or to arrange for treatment transfer. If the child is in the middle of the trauma narrative this would be the least optimal circumstance for ending treatment and in such cases the therapist should try to have 1-2 final sessions in order to bring TF-CBT treatment to some sort of closure before the child leaves the RTF program. If this is not feasible, the therapist might be able to arrange for these meetings via phone or Skype after discharge.

Conclusion

Youth in RTF settings have very high rates of trauma exposure, but RTF therapists have only recently recognized the potential influence of trauma on the development and escalation of behavioral, emotional and substance difficulties among these residents. Surprisingly, many youngsters who have had numerous outpatient and inpatient experiences report TF-CBT as the first therapy experience during which childhood traumas were acknowledged and directly and openly discussed. Despite their seeming fragility, many youth in RTF respond positively to addressing traumatic childhood experiences with the objective of helping them understand the relationship of these experiences to current difficulties, processing distressing trauma-related thoughts and feelings and developing coping skills to manage everyday stressors as well as trauma reminders. Ideally TF-CBT would be offered not only in the RTF setting but would continue at least briefly after discharge to outpatient care. This would be particularly important if caregivers had not been able or willing to actively participate in TF-CBT treatment with the youth during the RTF stay. This implementation manual has attempted to address the challenges and benefits of implementing TF-CBT in RTF settings, and to provide resources for mental health professionals hoping to implement TF-CBT in these settings.

References

APA (2013): Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5): Arlington, VA: American Psychiatric Publishing.

Cohen, JA, Berliner, L & Mannarino, AP (2010). Trauma-focused CBT for children with co-occurring trauma and behavior problems. *Child Abuse and Neglect*, 34, 215-224.

Cohen, JA, Mannarino, AP, & Deblinger, E (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.

Cohen, JA, Mannarino, AP, Kliethermes, M & Murray, LA (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect*, 36, 528-541.

Cohen, JA, Mannarino, AP & Navarro, D (2012) Residential treatment. In Cohen, JA, Mannarino, AP & Deblinger, E (Editors) *Trauma-focused CBT for children and adolescents: Treatment applications*. New York: Guilford Press, pp73-104.

Copeland, WE, Keeler, G, Angold, A & Costello, EJ (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, 64, 577-584.

Debellis, MD, Baum, AS, Birmaher, B, Keshavan, MS, Eccard, CH, Boring, AM, Jenkins, FJ & Ryan, ND (1999). Developmental traumatology, Part I: Biological stress systems. *Biological Psychiatry*, 45, 1259-1270.

DeBellis, MD, Keshevan, MS, Clark, DB, Casey, BJ, Giedd, JN, Frustaci, K, & Ryan, ND (1999). Developmental traumatology, Part II: Brain development. *Biological Psychiatry*, 45, 1271-1284.

Deblinger, E, Lippman, J & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, 1, 310-321.

Steiner, H, Garcia, IG, Matthews, Z (1997). PTSD in incarcerated juvenile delinquents. *JAACAP*, 36, 357-365.

Weiner, DA, Schneider, A & Lyons, JS (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review*, 31, 1199-1205.

**APPENDIX 1: INTEGRATED TRAUMA
TRAINING CURRICULUM TO SUPPORT
TF-CBT IMPLEMENTATION**

Integrated Trauma Training Curriculum to Support TF-CBT

Implementation

Judith A. Cohen, M.D.

Anthony P. Mannarino, Ph.D.

© Copyright 2013. All rights reserved. Not for duplication or distribution without the expressed written permission of the authors.

Introduction

Purpose of the curriculum

This integrated trauma training curriculum is designed to quickly and efficiently prepare direct care staff, administrators, teachers, and other non-mental health therapists who interact directly with child and youth residents in residential treatment facilities (RTF), schools, group homes or other settings to support the implementation of an evidence-based treatment for traumatized youth and their parents, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in these settings.

Under ideal circumstances staff members at programs that are ready to implement TF-CBT will already understand the impact of trauma and have received training about providing trauma-informed care. However due to high cost or other reasons many programs will not have received such training when they begin to provide TF-CBT. The Integrated Trauma Training Curriculum is designed to provide abbreviated trauma informed training to staff members who have not previously received such training in a way that is directly applicable to supporting TF-CBT skills in these settings. Programs that have received trauma informed care training have not learned how to apply it specifically in support of the TF-CBT treatment model. This curriculum can also be used to apply previous trauma informed training to support TF-CBT implementation. In both cases the curriculum will prepare staff to better understand and support TF-CBT implementation.

Curriculum Logistical Considerations

The Integrated Trauma Training Curriculum is provided during a full (eight hours) day to accommodate the challenging schedules of RTF or other direct care settings. Training in this curriculum requires detailed knowledge about trauma-informed care and about the TF-CBT treatment model as well as how it is implemented in specific settings. For these reasons training should be provided by an individual with expertise in the TF-CBT model (e.g., a TF-CBT developer, TF-CBT trainer or supervisor). If questions arise in this regard please contact the authors of this curriculum manual.

Curriculum Format

The Curriculum consists of six modules, each of which includes learning goals as well as knowledge, skills and attitude objectives for participants to gain upon completion of that module. Each module consists of several parts such as didactic information, role plays, group problem solving exercises, and/or other interactive activities. The six modules are interrelated and progressive (i.e. each builds on information and skills gained in previous modules) and are based on adult active learning principles. They build mastery in three areas: trauma informed care; supporting TF-CBT implementation; and self-care (awareness of and prevention of secondary traumatic stress or vicarious trauma).

Active Learning Components of the Curriculum

Active engagement is especially critical in a brief curriculum. Each of the six modules includes a didactic component, in which the trainer provides information through slides, lecture and handouts. However most of each module involves active learning during which staff members engage in problem solving exercises, role plays and/or other interactive activities to transform the material from theory to “real life”. Specific examples for these activities are included in this curriculum; however depending on the needs of individual program, the details of these

activities (e.g., the types of client problems or staff vicarious trauma issues that are addressed in role plays or problem solving scenarios) may be modified during a particular training.

A critical component of actively engaging staff is *modeling* the use of trauma informed care principles and TF-CBT skills during the training. When the trainer respectfully listens, thoughtfully understands and tolerates different views from his or her own without interrupting to help attendees to feel valued, respected and heard, this demonstrates how to create a more trauma informed program. The trainer can often take advantage of natural opportunities during the training to illustrate how he or she is personally using TF-CBT coping skills (e.g., positive self-talk, correcting maladaptive cognitions, relaxation strategies, etc.) to maintain self-regulation and connection with others. Through these strategies, attendees actively experience how trauma informed strategies and the TF-CBT coping skills can make an immediate difference for each of them in their working environment.

Prior to each training, the trainer should obtain information about the type of program (e.g., size, ages, gender and nature of problems of children served as well as types of traumas typically experienced by children in this setting and average length of stay) as well as whether the facility has received prior trauma-informed training. This will help the trainer to best match the training to the facility. At the start of the training, the trainer should ask participants to introduce themselves with 1-2 sentences about previous training or knowledge about trauma informed care or TF-CBT. This will help to engage participants and also to further match the training to participants' current experience levels.

Module 1: Trauma Impact and Reminders

Goals: At the conclusion of this module participants will be able to:

- 1) Identify common types of traumas youth have experienced, including complex traumas
- 2) Describe and recognize the “ABCS” domains of trauma impact in youth in this setting
- 3) Understand trauma reminders that can “trigger” these types of trauma responses among youth in this setting

Knowledge Objective:

- 1) Increase participants’ knowledge about trauma impact and trauma reminders

Skills Objectives:

- 1) Increase participants’ skills in recognizing trauma impacts among children in this setting
- 2) Increase participants’ skills in identifying trauma reminders in this setting

Attitude Objective:

- 1) Increase participants’ understanding and compassion toward traumatized youth

Didactic Presentation

The didactic portion of Module 1 describes different types of trauma experiences children and youth have commonly experienced; the “ABCS” domains of trauma impact; and the concept of trauma reminders. In order to help participants connect this information to children they work with, clinical examples of youth typically seen in the specific setting should be woven into each domain when describing these domains during the presentation.

Affective (“A”), or emotional, responses to trauma may include sadness or anxiety, but the types of affective responses typically seen that are important for staff to

understand in relation to trauma are irritability, anger, flat affect, and emotional dysregulation (“going from zero to sixty”—when kids seem calm then are suddenly enraged by seemingly minor things and cannot calm themselves again).

Behavioral (“B”) responses to trauma may include trauma avoidance (not talking about, saying they don’t remember anything about, or otherwise avoiding things that remind them about traumatic experiences or things that remind them of these experiences); as well as behaviors that resemble the original trauma the youth experienced (e.g., a youth who experienced bullying may bully others; a youth who was sexually abused can exhibit sexually aggressive behaviors; a youth who experienced domestic violence can exhibit controlling or violent behavior towards others, etc). Other trauma-related behaviors may include aggression and other behavioral dysregulation, using drugs or alcohol or other dangerous behaviors (e.g., unprotected sex or having multiple sexual partners) or self injury.

Biological (“B”) responses to trauma may include headaches, stomachaches, dizziness, menstrual cramps, aches and pains in different body parts, appetite and sleep problems and other somatic symptoms.

Cognitive (“C”) responses to trauma may include changes in how youth see themselves (e.g., damaged, unlovable, undeserving of good treatment or good things happening); others (e.g., expecting that others will hurt them, betray or cheat them, or will never care about them); and/or the world in general (e.g., I will not live a long life; justice will never be done; no one can be trusted; everyone hates black/Latino/ white people; the world is a terrible place; children are better off dead).

Social (“S”) responses to trauma may include changes in youths’ attachments or connections to others (e.g., diminished or loss of trust in family or peers; feeling that no one can understand them; sense of isolation) leading to shifting affiliation (e.g., affiliate with more deviant peers; reject relationships with siblings or parents, etc)

School (“S”) responses to trauma may include decreased concentration, decline in grades, poor school attendance, school drop out, and responding to trauma reminders in school settings.

A trauma reminder is anything such as a person, place, thing, situation or condition (e.g., an internal physiological state) that reminds the youth of a previous trauma they experienced. Understanding and recognizing potential trauma reminders are critical to understanding child behaviors in the setting because many of the above trauma responses may be easily confused with common child behavior problems. Trauma responses may seem to occur suddenly, unpredictably or in ways that are frightening or feel threatening to staff, but in fact are occurring in response to unrecognized trauma reminders. This module begins the process of connecting trauma-related responses to trauma reminders.

Role Plays

The purpose of these role plays is to demonstrate three different scenarios in which children have what appear to be “typical” behavior problems (i.e., an “unpredictable” episode of aggression, angry outburst, or withdrawal, respectively in each of the three role plays). In each role play, the trainer plays the role of the youth and a participant plays the role of a staff member. Before the role play the trainer privately asks each respective staff member playing in the role play to not make any effort to react differently in the setting than he or she believes his or her peers normally would react in such a scenario. The goal in these early role plays is NOT to encourage staff to act in trauma informed manners, but to recognize that youth who are having “typical” behavior or emotional problems seen, may in fact be responding to trauma reminders that no one is recognizing.

NOTE: Throughout the curriculum, the trainer makes adjustments to role plays as appropriate to optimally illustrate the types of behavioral and emotional problems seen in the setting.

Role Play #1:

Trainer takes the role of a 15 year old male. The trainer enlists a participant to play the role of a staff member and instructs the individual to sit in a chair in the hall. The role play proceeds as follows: The staff member is sitting in a chair in the hall. The trainer unexpectedly punches wall and says, "I hate that bitch!" If the staff member does anything but validate the trainer's anger, the trainer gets increasingly verbally aggressive.

Role Play #2

The trainer takes the role of a 12 year old male and asks another participant to take the role of a staff member who is supervising at mealtime. The trainer explains to participants that at the start of the role play he is eating breakfast with other kids, nothing special going on. At the beginning of the role play, the trainer suddenly gets angry, jumps up from table, and starts to run from the breakfast room. If the staff member does anything but validate the boy's anger, the trainer tells her to "shut up".

Role Play #2

The trainer takes the role of a 14 year old girl and asks another participant to take the role of a staff member on the milieu. The trainer sits on floor withdrawn, and won't talk to the staff member no matter what, remaining sullen and non-verbal. If the staff member tries to do anything but validate the girl's feelings, she becomes more withdrawn, sullen, non-responsive, even scared.

Interactive Activity

The trainer initiates the interactive activity by explaining that the above role plays are all from traumatized youth who shared their experiences about being “triggered” by trauma reminders while in the setting. Encourage participants to think about and discuss what kinds of trauma reminders might have occurred to prompt these scenes. The interactive discussion is more important than coming to the “right” answers. The trainer leads the activity encouraging the participants to consider the following:

- 1) What are typical kinds of traumas the youth in your setting have experienced (e.g., encourage participants to consider the impact of complex/chronic trauma, emotional abuse, neglect)?
- 2) What are some typical types of reminders of these trauma experiences that might occur while they are in your setting? For example, if a youth experienced sexual abuse, what might be a reminder? Encourage participants to consider trauma reminders for complex trauma (parental neglect or emotional abuse, betrayal by parents, multiple losses, etc)
- 3) How might these reminders be manifested in your setting?

Resources

Cohen, JA & Mannarino, AP (2010). Implementing TF-CBT in RTF: General information for RTF milieu staff. Available at <http://www.learn.nctsn.org>

Picone, F (2008). Creating safe and respectful environments. University of Medicine and Dentistry of New Jersey University Behavioral HealthCare-Violence Institute of New Jersey. Available at http://vinst.umdnj.edu/csre2/cd/fin20%jjc%20video_files/Default.htm

Lieberman, A, Deblinger, E & Pelcovitz, D (2006). Trauma's impact on development across childhood. Available at <http://learn.nctsn.org/mod/resource/view.php?id=760>

DeArellano, M (2006). Trauma among Hispanic and Latino populations. Available at <http://learn.nctsn.org/mod/resource/vie.php?id=768>

Module 2: Preventing Trauma Reenactment

Goals: At the conclusion of this module participants will be able to:

- 1) Describe trauma reenactment and how it occurs in this setting
- 2) Recognize common trauma reminders and two common interactions between children and staff that prompt trauma reenactment in this setting
- 3) Describe three steps that staff can take to prevent trauma reenactment from occurring in this setting

Knowledge Objectives:

- 1) Increase participants' knowledge about how trauma reminders and staff-child interactions contribute to trauma reenactment in this setting.

Skill Objectives:

- 1) Improve participants' ability to recognize when trauma reenactment is occurring in this setting
- 2) Improve participants' ability to minimize trauma reenactment in this setting by recognizing trauma reminders, recognizing behavioral manifestations of trauma, and avoiding behavioral interactions that repeat previous traumatic patterns

Attitude Objectives:

- 1) Increase participants' desire to minimize trauma reenactment in this setting
- 2) Increase participants' acceptance that when trauma reenactment occurs in this setting, this is often due to staff-child interactions

Didactic Presentation

The didactic presentation during Module 2 provides participants with more experiential understanding into the connection between children's trauma

experiences, trauma reminders and behavioral problems that commonly occur in this setting. The trainer provides several case descriptions of children and youth who experienced chronic, severe, and/or multiple traumas prior to coming to this setting (e.g., ongoing sexual and physical abuse by a parent's paramour while the other parent did not protect; severe parental neglect while the parent was abusing substances; domestic violence leading to eventual murder of one parent by the other and placement in a series of foster homes; removal at an early age and placement in serial foster homes due to abuse, neglect or death) and asks participants to consider possible trauma reminders or "triggers" when these youth come to the setting. The trainer helps participants understand that patterns of interacting (e.g., being called names, being spoken to harshly, being "disrespected", etc) often serve as trauma reminders for children and youth who have long histories of abuse, neglect, domestic violence and other traumas during which these interactional patterns served as trauma cues or triggers. Helping participants to recognize when these interactional patterns are contributing to trauma reenactment in their settings is critical to preventing such reenactment from occurring.

In order to allow trainers to use their own experiences and to match the needs of each program only one case vignette is included here. As a guideline, each vignette should include information that will emotionally engage participants as well as information about:

- 1) Types of trauma the child experienced and under what circumstances (set the stage for participants to understand the child's trauma reminders)
- 2) How the child responded to the trauma when it was happening (how the child felt, thought, physical responses at the time—help participants understand the child's inner experiences)
- 3) How adults responded or didn't respond to the child and how this shaped the child's expectations and trauma triggers

- 4) Subsequent trauma experiences and how these reinforced the initial trauma reminders

Sample Case Vignette

Marquee is a 9 year old girl who was severely sexually and physically abused by her mother's boyfriend from ages 2-6 years old. Mother was addicted to drugs and was often present when Marquee was being abused. When Marquee cried or asked the perpetrator to stop he would tell her to "shut up" or punch her. Marquee was scared that he would kill her; in fact she remembers one time he held his hand over her mouth and nose until she thought she would die. He told her "if you don't shut the hell up I'll shut you up for good." After that Marquee was always silent during the sexual abuse episodes but inside she was thinking that she was going to die and why didn't her mother help her? When she started school her teacher thought Marquee was having "anger management" problems due to "unpredictable" outbursts of anger (Marquee later reported that boys in class would yell or bump into her and that made her mad). The teacher called the home and told mother's boyfriend Marquee was having angry outbursts. He beat Marquee with a belt and his fist and burned her with his cigarette. When the teacher saw the burns on Marquee's arm child protection was notified. Marquee has been in a series of foster homes since then. In the first of these foster placements she was sexually abused by an older teen male who was babysitting for Marquee and a younger foster child in the home; this led to Marquee's removal from that home. Marquee has been increasingly out of control, leading to removal from several subsequent foster homes. Foster parents report that her behavioral outbursts occur when other children yell or play boisterously around Marquee. The foster parents respond to her outbursts by trying to set limits. When these don't work they become stern, and then punish her to force her to comply with the house rules. They admit that they have increasingly become frustrated and have used some corporal punishment,

including hitting her on the butt and arm. Foster mother also tries “shaming” Marquee, telling her she will end up like her mother if she continues this behavior.

Discussion points for Sample Case Vignette:

- 1) What interactional patterns serve as a trauma reminder for Marquee? (e.g., loud fighting, severe discipline, yelling, boisterous interactions)
- 2) What are adults doing in her current setting to contribute to trauma reenactment? (e.g., foster parents using stern voices or using corporal punishment)
- 3) How could adults interact with Marquee differently to minimize or prevent trauma reenactment? (e.g., validate that they understand what triggers her fears; problem solve with her how to reduce her reenactment; develop a mutual plan about how to help her use skills without retriggering her)

Role Plays

During the following role plays, the trainer plays the role of the youth and a staff member volunteers to play the role of a staff member. The goal is for the staff member to recognize trauma reminders and the beginning signs of the child’s or youth’s trauma reenactment. Instead of interacting with the child or youth in a manner that contributes to trauma reenactment, the staff member tries to interact with the child or youth in a manner that prevents trauma reenactment from occurring. The trainer encourages other staff members to offer suggestions for ways to prevent trauma reenactment while the role play is occurring. The staff member in the role play tries these suggestions during the role play.

NOTE: The following scenarios can be used as examples of situations that led up to the Role Plays described in Module 1 above

Role Play #1:

One hour prior to the episode, youth's mother was supposed to attend a family therapy session. She did not arrive at the expected time, or call to explain why she was not coming. The boy punches the wall. Mother was involved with a man, Mr. Paul, who physically abused the youth and the youth suspects that mother is still seeing him.

Role Play #2

While eating breakfast another child said, "Give me the cereal. What's wrong with you, retard?" When the boy heard the word "retard" and staff didn't do anything he became enraged, starts swearing, throwing things and hitting the child who called him a retard. This boy was severely abused and neglected by his parents and often called a "retard" and "stupid" by both parents. He was then in a number of foster homes where he was called "stupid" and "retard" because he has a learning disability.

Role Play # 3

During a group activity a girl is instructed to uncross her legs to participate in a relaxation exercise. She uncrosses her legs but keeps her ankles crossed. A female staff member says harshly, "Do as you're told and do it now or you'll lose your levels." The girl jumps up and calls the staff member "f—king ho". This girl had a long history of severe physical and emotional abuse and neglect by mother and mother's paramours.

Interactive Activity

The trainer encourages the participants to discuss how these role plays impacted them and how a trauma-informed lens may start to shift some of their assumptions about children's behavioral problems. The trainer encourages interactive discussion around topics such as:

- 1) Are you starting to recognize interactional patterns that contribute to trauma reenactment?
- 2) Did the challenges of responding to these children remind you of problems you have faced in your setting?
- 3) Did the problem solving strategies suggested here help you come up with ideas for how to avoid trauma reenactment in your setting?

Resources and Handouts

Cohen, JA & Mannarino, AP (2010) TF-CBT trauma psychoeducation for RTF milieu staff. Pittsburgh, PA: Allegheny General Hospital. Unpublished information sheet available at <http://learn.nctsn.org/mod/forum/view.php?id=3199>

Bigfoot, D.(2007). American Indian youth: current and historical trauma. Available at <http://learn.nctsn.org/mod/resource/view.php?id=443>

Flores, L (2007). The traumatic experiences of border and immigrant youth. Available at <http://learn.nctns.org/mod/resource/view.php?id=442>

Schneir, A & Ballin, D (2007). Working with homeless and runaway youth. Available at <http://learn.nctsn.org/mod/resource/view.php?id=441>

Stern-Ellis, H & Killen-Harvey, A (2007). Trauma among gay, lesbian, bisexual and transgendered youth. Available at <http://learn.nctsn.org/mod/resource/view.php?id=439>

Module 3: Vicarious Trauma

Goals: At the conclusion of this module participants will be able to:

- 1) Describe common difficulties associated with vicarious trauma or secondary traumatic stress
- 2) Identify four ways that vicarious trauma may be manifested at work in this setting
- 3) Identify three ways that positive TF-CBT parenting skills may be helpful in preventing and responding to vicarious trauma

Knowledge Objectives:

- 1) Increase participants' knowledge about vicarious trauma
- 2) Increase participants' knowledge about how vicarious trauma may impact work performance
- 3) Increase participants' knowledge about resources for assistance in their settings if vicarious trauma occurs
- 4) Increase participants' knowledge about TF-CBT positive parenting skills

Skills Objectives:

- 1) Increase participants' ability to recognize the presence of vicarious trauma in themselves or colleagues
- 2) Increase participants' ability to use TF-CBT positive parenting skills with each other and youth

Attitude Objectives:

- 1) Increase participants' recognition that they can personally experience vicarious trauma
- 2) Increase participants' compassion for those who experience vicarious trauma

Didactic Presentation

The didactic presentation in Module 3 introduces participants to vicarious trauma (also sometimes variously referred to as “secondary traumatic stress” or “burn-out”). The trainer provides information about different ways this can occur to individuals who work with traumatized children including: 1) the individual having a personal history of trauma as a child or adult, which is then re-triggered by hearing about the child’s trauma experiences or through trauma reenactment such as has been described in the previous module; 2) the individual is spit on, kicked, called names, threatened, beaten, has one’s family threatened, is badly frightened, or is otherwise hurt by a child or adolescent in the facility, and is traumatized by this violent or threatening experience; 3) the individual is constantly exposed to a high volume and/or a high intensity of extremely emotional and/or physically demanding work in the setting which leads to burn-out.

Common signs and symptoms of vicarious trauma include the following:

- 1) Somatic symptoms: unexplained headache, stomachache, dizziness, aches and pains, fatigue, worsening of chronic condition (e.g., asthma, diabetes), sleep problems, appetite problems, and/or missed days of work
- 2) Avoidance: not wanting to think or talk about past trauma (if applicable) or of the incident in the workplace; avoiding friends, family, and/or work peers; avoiding situations, places or people that remind the individual of the trauma (e.g., if sexual abuse, may avoid intimacy with partner/spouse; if a fight in the workplace, may avoid any confrontations at work)
- 3) Intrusive thoughts: cannot get thoughts about the incident/trauma out of one’s head; nightmares, obsessive thoughts about what might have done or should have done; these thoughts may be accompanied by somatic symptoms
- 4) Extreme affect: anger, irritability, outbursts, may lead to relationship problems or excessive drug or alcohol use

- 5) At work: inappropriate humor, avoid peers, inappropriate anger at children, avoiding reminders/triggers at work, shunning certain types of work (leaving for others to do), missing work

Positive parenting skills used in TF-CBT include looking for, recognizing and praising when youth are engaging in positive behaviors (“praise”); overlooking minor negative behaviors (e.g., mocking, mimicking, rolling eyes, “disrespectful” attitudes, not complying immediately with requests), in favor of praising positive ones (“selective attention”); and using active listening and validation to show compassion and understanding (e.g., “I know you’re having a really tough day, I’m here if you want to talk about anything”). Using these strategies with co-workers as well as with youth in the setting can be very effective at preventing vicarious trauma. The trainer provides examples of each of these strategies and encourages participants to discuss how these might be helpful in stressful situations they encounter in their setting.

The trainer adapts this presentation for the specific setting and presents one or more case illustrations of situations in which a staff member inappropriately manifests vicarious trauma.

Role Play

During this role play the goals are for participants to recognize that vicarious trauma negatively impacts not only the person who is suffering from this condition, but also coworkers, supervisors, youth and ultimately the entire program.

Role Play #1

The trainer takes the role of a staff member and asks for two volunteers from among the participants. One participant will take the role of a youth on the unit and the other will take the role of another staff member. The trainer will

instruct the two as follows: The “staff member” will act as he or she usually acts on the unit with staff and youth. The “youth” will come up to the “staff members” while they are talking and intrude on their conversation, demanding attention in a typical way that residents do. The “staff member” will respond to the youth in an appropriate way but trainer will do something different. The rest of the participants will observe and comment on what is occurring.

The trainer portrays a staff member who is angry about youth on the unit “acting up.” This staff member does not believe that the youths’ behavioral problems are trauma related because he was abused as a child and he never got in trouble like this when he was their age. He thinks all this trauma stuff is an excuse for “letting kids get off easy, and not having to follow the rules. The role play starts with the trainer complaining about this to the other participant playing a staff member. When the youth intrudes on their conversation, the trainer says something inappropriate to the youth (e.g., “Quit blaming everyone else and shape up. Thank God I have normal kids to go home to.”)

Interactive Activity

The trainer encourages the participants to discuss the above role play. How would the staff member who was suffering from vicarious trauma feel during this scenario? How would the other staff member in this role play feel? How would the youth in this role play feel? What actions might each of these individuals have subsequently taken (e.g., would the other staff member report to a supervisor; would the youth be more likely to become dysregulated?)

The trainer then encourages each participant to write on a piece of paper “what is the hardest thing about working in this setting” Each person silently goes around the circle and shares what they have written with each other person. When

the exercise is done, the group discusses what they have learned. What positive parenting strategies might be helpful in these situations?

Resources

Cohen, J Rivera, S &. Ross, L, Secondary traumatic stress in professionals treating child sexual abuse. Available at <http://learn.nctsn.org/course/view.php?id=29&topic=3>

Whitham, C (1991). Winning the whining wars and other skirmishes: A family peace plan; Los Angeles: Perspective Publishing

Module 4: TF-CBT Coping Skills

Goals: At the conclusion of this module participants will be able to:

- 1) Describe core TF-CBT coping skills summarized by the PRACE acronym (Psychoeducation; Relaxation; Affect modulation; Cognitive coping; and Enhancing Safety)
- 2) Explain how each of these skills helps children with self-regulation in this setting

Knowledge Objectives:

- 1) Increase participants' knowledge about the TF-CBT coping skills
- 2) Increase participants' knowledge about how each of these skills increases children's ability to self-regulate behavioral or emotional problems

Skills Objectives:

- 1) Increase participants' ability to recognize each of the TF-CBT coping skills when children are using these in this setting
- 2) Begin to develop participants' ability to support children's use of these skills in this setting

Attitude Objectives:

- 1) Increase participants' appreciation of the value of using TF-CBT skills to decrease behavioral and emotional regulation problems in this setting

Didactic Presentation:

The didactic presentation in Module 4 provides participants with information about the TF-CBT coping skills summarized by the PRACE acronym. The trainer provides brief information about the TF-CBT coping skills with appropriate

examples that relate to the specific setting. The trainer should emphasize that therapists in the setting are providing these skills to youth during individual treatment sessions; other staff are supporting youth in implementing these skills. Thus therapists and other staff will ideally communicate about how each youth is learning these skills and work together closely to best support each youth's use of the skills in the setting outside of therapy.

The trainer should not assume that staff members have any level of familiarity with these skills, how therapists provide them, or how to support them. The trainer should provide very simple, clear and concrete examples of how therapists provide each skill to youth in this setting and how youth might be expected to implement each skill in the setting.

Psychoeducation provides youth with better understanding about the impact of trauma on their functioning; helps youth to make connections between their current behavioral and emotional problems and past traumatic experiences; validates that they are not alone in experiencing these traumatic experiences; and provides hope for recovery and living healthy and positive lives in the future. Psychoeducation also helps youth identify trauma reminders and understand how these are affecting them in the present. Therapists ideally communicate with other staff in the setting about these trauma reminders so that the other staff are aware of these.

The trainer can provide as an example that Marquee's therapist in the above example might help her to recognize that a central theme of her past trauma experiences was that adults who were supposed to support and protect her had not protected her, and sometimes had even been the ones to hurt her. As a result, for Marquee, trauma reminders might include both situations such as fighting or harsh discipline that reminds her of these adults; but also situations in which she perceives that people may abandon her such as when peers do not listen to her.

The next step after youth recognize the impact of trauma on youth's current functioning is developing specific coping skills for how to deal with these impacts. When all staff members are aware of each youth's trauma cues, they can best support the use of the youth's coping skills. The trainer then provides information about the following specific TF-CBT coping skills.

Relaxation skills provide youth with individualized strategies to “turn down the volume” of their biological responses to trauma. Youth often say that they “see red”, “explode”, or have somatic symptoms such as not being able to sleep, having headaches or stomachaches, etc. Each youth develops individualized relaxation strategies with his or her therapist to use when trauma cues or reminders occur. Some examples of these strategies include focused breathing; visualization exercises (e.g., imagining a “safe place”, the beach, a cloud or other pleasant visual or mental image); progressive muscle relaxation; exercise; crafts or journaling, or other activities that are relaxing to the individual youth.

The trainer can provide as an example that the therapist might introduce present focus activities to Marquee when peers' loud voices in the milieu gets her agitated.

Affective modulation skills include a variety of activities that youth can engage in to modulate upsetting affective states (e.g., anger, sadness, loneliness, “feeling nothing”, etc.) Therapists help youth to identify a range of emotional states, acknowledge these feelings rather than running from them (e.g., many youth with serious behavioral problems only acknowledge feeling angry because other negative emotions cause too much vulnerability), and then help them develop several strategies for coping with these uncomfortable states. These strategies may include seeking social support from staff members; engaging in distraction activities (e.g., reading, watching TV; doing something physically strenuous);

writing about their feelings; or actively trying to change the feeling to a better one through humor, faith, or cognitive coping (described below).

The trainer might use as an example that Marquee's therapist might help her to seek social support from staff when she felt angry that peers on the unit were abandoning her by ignoring her.

Cognitive coping skills include recognizing and exploring alternative ways of looking at maladaptive thoughts. Maladaptive thoughts may include thoughts that are inaccurate (e.g., "my father abusing me was my fault"), or thoughts that may be accurate but are unhelpful (i.e., they do not help the youth to feel or to function better, e.g., "You can never tell whether a man will become violent in a relationship"). Therapists help youth to become more aware of their automatic thoughts, recognize when these thoughts are contributing to upsetting feelings or negative behaviors, and to explore alternative ways of looking at their assumptions about the world, other people, and themselves. Therapists may focus on a time in the past week when the youth was upset and ask the youth to "track back" to what they were thinking then. In this way the therapist helps the youth to identify possible maladaptive cognitions that were contributing to the negative feelings, and to address these.

The trainer might use the example that Marquee's therapist might help her to explore the thought, "no one likes me", by first thinking about whether this thought makes her happy (no) and whether there is any other possible way of looking at the fact that a girl in the milieu did not respond when Marquee spoke to her. Talking with the therapist allowed Marquee to consider that possibly the girl was preoccupied with upsetting circumstances of her own and that what happened did not have to do with not liking Marquee.

Enhancing safety skills include recognizing unsafe situations (e.g., violent and abusive situations that the youth can avoid or escape; drug use; unsafe sex; and unhealthy romantic relationships) and enhancing the youth's ability to avoid or escape these situations.

The trainer might use the example that Marquee's therapist might help her to develop a plan for feeling safe when confronted with trauma reminders such as asking for help from a staff member or going to a quiet corner when loud or violent episodes occur in the milieu and using her relaxation skills.

Role Plays

During these role plays the goal is for participants to accurately identify "real life" situations in the setting in which the above TF-CBT coping skills would be helpful for youth to implement. The trainer should focus during this module on simply encouraging participants to accurately identify which coping skill would be helpful to use in which situation (multiple coping skills might be appropriate in a given scenario). More specific strategies about how staff members can support youth in implementing these skills will be provided during the next module.

Role Plays/ Interactive Activity

The trainer encourages participants to develop 2-3 Role Plays in which they enact youth who have typical difficulties on the milieu that the participants believe may be related to trauma. The trainer explains that he will stop the role plays as the participants are enacting them to encourage discussion about what TF-CBT coping skill might be useful to use in a given situation.

The trainer encourages the participants to discuss their ideas during these role plays about what TF-CBT coping skills might be helpful for youth to use in the different situations that the participants have chosen to depict in the role plays. Presumably these are scenarios that commonly arise in the setting. Through these activities the trainer encourages the participants to use each of the TF-CBT coping skills as a natural way to respond to typical behavioral and emotional problems that youth display in the setting.

Resources

Cohen, JA & Mannarino, AP (2010). TF-CBT Psychoeducation for RTF Direct Care Staff. Available at www.nctsn.org

Cohen, JA & Mannarino, AP (2010). TF-CBT Relaxation Skills for RTF Direct Care Staff. Available at www.nctsn.org

Cohen, JA & Mannarino, AP (2010). TF-CBT Affective Modulation Skills for RTF Direct Care Staff. Available at www.nctsn.org

Cohen, JA & Mannarino, AP (2010). TF-CBT Cognitive Coping Skills for RTF Direct Care Staff. Available at www.nctsn.org

Deblinger, E (2006). The cognitive processing component. Available at <http://learn.nctsn.org/mod/resource/view.php?id=762>

Module 5: Supporting TF-CBT Coping Skills

Goals: At the conclusion of this module participants will be able to:

- 1) Demonstrate one or more way to support a child's use of relaxation in this setting
- 2) Demonstrate one or more way to support a child's use of affective modulation in this setting
- 3) Demonstrate one or more way to support a child's use of cognitive coping in this setting

Knowledge Objectives:

- 1) Increase participants' knowledge about how to use TF-CBT Coping Cards in this setting

Skills Objectives

- 1) Increase participants' skills in supporting children's use of relaxation skills in this setting
- 2) Increase participants' skills in supporting children's use of affective modulation skills in this setting
- 3) Increase participants' skills in supporting children's use of cognitive coping in this setting

Attitude Objective

- 1) Increase participants' enthusiasm about supporting TF-CBT skills in this setting
- 2) Increase participants' understanding of the value of supporting TF-CBT skills in this setting

Didactic Presentation

Module 5 builds on the information provided in Module 4 by helping participants develop practical strategies through which to support youth in implementing the TF-CBT coping skills learned during that module. In place of a didactic presentation, the trainer encourages participants to develop strategies that will work in their setting.

Role Plays /Interactive Activities

The trainer encourages participants to discuss how they might encourage youth to implement the TF-CBT coping skills in a variety of scenarios in their setting. The trainer has several choices about how to do this, including but not limited to group discussion; assigning one skill to each of 5 small groups to come up with demonstrations; or through role plays that the entire group discusses together, or all three. By the end of the module the goal is for all participants to have actively contributed to ways to support the implementation of these skills. The following descriptions outline each of these approaches:

- 1) Group discussion: the trainer asks the entire group to brainstorm in order to create several scenarios in which a youth becomes dysregulated and each of the TF-CBT coping skills would be useful in helping the youth regain regulation. The group may discuss challenges to using these skills in their setting and brainstorm about how to address these challenges; or situations in which they do not know how to implement a particular skill. The trainer facilitates problem-solving by the group encouraging everyone in the group to take an active role in discovering solutions.
- 2) Small group demonstrations: the trainer divides the group into 5 small groups (these may consist of as few as 2 participants/group), and assigns one TF-CBT coping skill to each group. The groups get 15 minutes to

develop a scenario in which a youth is becoming emotionally or behaviorally dysregulated in the milieu and a staff member recognizes that if the youth implemented their assigned coping skill, this might help the youth to regain affective or behavioral regulation. The group demonstrates the scenario and how the staff member supports the youth in using the assigned coping skill, and through this how the youth regains regulation. The group may also choose to demonstrate both how a staff member might fail to recognize how using their assigned coping skill would be useful and what would happen if the youth failed to use the coping skill; and what would happen when the staff member DOES recognize that this would be helpful and encourages the youth to implement the assigned coping skill.

- 3) Role plays: the group may continue the process begun in Module 4, by presenting challenging scenarios that arise in the setting and asking the trainer to demonstrate how to implement the TF-CBT skills. The trainer may demonstrate this several times but the goal is to encourage the participants to begin to use these skills in an active way during the training rather than to continue to observe.

Resources:

TF-CBT*Consult*: www.musc.edu/tfcbtconsult includes many questions about managing difficult behaviors using TF-CBT skills in residential settings.

Module 6: TF-CBT Skills and Self-Care

Goals: At the conclusion of this module participants will be able to:

- 1) Recognize situations in which TF-CBT coping skills are appropriate for personal use
- 2) Use TF-CBT coping skills to enhance self-care
- 3) Use TF-CBT to prevent vicarious trauma
- 4) Apply personal understanding about the benefits of using TF-CBT coping skills to support children in using these skills in their setting

Knowledge Objectives:

- 1) Increase participants' knowledge about the connection between stress and common medical and emotional problems
- 2) Increase participants' recognition of the overlap between TF-CBT coping skills and common stress-reduction techniques

Skills Objectives:

- 1) Improve participants' ability to use TF-CBT coping skills for personal stress management
- 2) Improve participants' ability to use TF-CBT coping skills to prevent vicarious trauma
- 3) Improve participants' ability to support children's use of TF-CBT coping skills

This module continues the process begun in Module 3 in which participants began to discuss stress associated with working in their setting. In this module the trainer describes that the TF-CBT coping skills are life skills that are beneficial to any individuals who experience stress in their daily lives. The trainer is most effective in this regard if he or she can provide personal examples in which these skills successfully relieved work- or personal stress. The trainer provides other

examples that are pertinent to the setting of how skills can be used to minimize vicarious trauma.

Role Plays

The role plays in this module are intended to help participants recognize how to use TF-CBT coping skills to reduce their own vicarious stress and to continue to encourage youth to use these skills.

Role Play #1

In this role play the trainer takes the role of a staff member who is interacting with a noncompliant youth. The trainer asks a volunteer participant to take the role of the youth, and instructs this volunteer to be a bit disrespectful when the trainer tells him or her to do something. When the “youth” does so during the role play, the trainer says, “How dare this kid treat me so disrespectfully?! Damn it, I’m older than him, I deserve to be treated with some respect!” Then the trainer stops the role play and asks the participants to consider which coping skill might be helpful in this situation (e.g., cognitive coping, what thought might be more helpful or accurate in this situation—what about the youth might be contributing to his irritability, why is the staff member making it all about himself, etc?) Help them come up with a more helpful and accurate thought.

Role Play #2

In this role play the trainer takes the role of a staff member who is overwhelmed with paperwork and someone else has called off. The trainer asks a volunteer to take the role of a youth who comes up to her to ask her to play a game and she snaps at him, “Not now, I’m busy!” The trainer stops the role play and asks what coping skill might be helpful (e.g., relaxation, seeking support, asking for help, etc).

Role Play #3

In this role play the trainer asks a volunteer to play the role of a youth who will spit on him and call him a name. The trainer is dealing with a dying parent and is just stressed out; when this happens he storms off the unit and says, “That’s it, I’m sick of these friggin kids!” What coping skill might be helpful?

Interactive Activity

The group discusses what they have learned about using TF-CBT coping skills to prevent or address vicarious trauma and to support traumatized youth in their setting. The trainer asks and answers any questions. After this discussion the trainer asks each person to write on a piece of paper, “What is the best thing about working in this setting?” Each person silently goes around the circle and shares what they have written with each other person. The group then discusses what they have learned.

The training concludes with slides that share testimonial quotations from youth in similar settings who have received TF-CBT treatment. The trainer explains, “These are quotations from youth who have received help from people like you. You may be asked to participate in TF-CBT treatment someday, not only to support TF-CBT skills, but to actually be part of a child’s treatment if their parent is not available or not supportive— you may participate with them during some of their sessions to hear about their personal trauma experiences to and provide support and validation. These kids wanted thank the people who helped them get better and to tell you what TF-CBT was like and to. This is what they had to say.”

Resources:

Srdanovic, M. Vicarious Traumatization: An occupational hazard for helping professionals. Available at <http://heretohelp.bc.ca/publications/visions//trauma-victimization/bck/9>

Acknowledgements: Funding for the development of this curriculum was provided by the Substance Abuse and Mental Health Services Administration (Grant No SM54319). We gratefully acknowledge the contributions of our colleague and TF-CBT co-developer, Esther Deblinger, Ph.D. and the SAMHSA-funded TF-CBT RTF learning community that included the following organizations (listed alphabetically): Dartmouth University Trauma Treatment Interventions Center, DePelchin Children’s Center (Houston), Jewish Board of Family and Children’s Services (New York City), SCAN-Inc (Laredo, TX), and the University of Minnesota Ambit Center. We offer our sincerest thanks to the fifteen Pennsylvania residential treatment centers that are implementing TF-CBT through funding from the Pennsylvania Department of Mental Health, and gratefully acknowledge Scott Talley and Jessica Bradley for making this project possible. We also thank the four residential programs in New York State that are implementing TF-CBT through funding from the New York Office of Mental Health and gratefully acknowledge the ongoing support of Janet Chassman of the New York Office of Mental Health Evidence Based Treatment Dissemination Center. Finally and most importantly, we thank all of the youth and parents who have so graciously agreed to share their experiences about TF-CBT treatment in order to help others. We are inspired by their courage and generosity.

**APPENDIX 2:TF-CBT FOR YOUTH WITH
COMPLEX TRAUMA**



Contents lists available at SciVerse ScienceDirect

Child Abuse & Neglect



Practical Strategies

Trauma-focused CBT for youth with complex trauma[☆]

Judith A. Cohen^{a,*}, Anthony P. Mannarino^a, Matthew Kliethermes^b, Laura A. Murray^c

^a Drexel University College of Medicine, Allegheny General Hospital, Department of Psychiatry, 4 Allegheny Center, 8th Floor, Pittsburgh, PA 15212, USA

^b University of Missouri-St. Louis, Children's Advocacy Center West Pine, St. Louis, MO, USA

^c Johns Hopkins School of Public Health, Baltimore, MD, USA

ARTICLE INFO

Article history:
Received 30 January 2012
Received in revised form 20 February 2012
Accepted 1 March 2012
Available online xxx

Keywords:
Trauma-focused CBT
Complex trauma
Children
Adolescents
Evidence-based practice

ABSTRACT

Objectives: Many youth develop complex trauma, which includes regulation problems in the domains of affect, attachment, behavior, biology, cognition, and perception. Therapists often request strategies for using evidence-based treatments (EBTs) for this population. This article describes practical strategies for applying Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for youth with complex trauma.

Methods: TF-CBT treatment phases are described and modifications of timing, proportionality and application are described for youth with complex trauma. Practical applications include (a) dedicating proportionally more of the model to the TF-CBT coping skills phase; (b) implementing the TF-CBT Safety component early and often as needed throughout treatment; (c) titrating gradual exposure more slowly as needed by individual youth; (d) incorporating unifying trauma themes throughout treatment; and (e) when indicated, extending the TF-CBT treatment consolidation and closure phase to include traumatic grief components and to generalize ongoing safety and trust.

Results: Recent data from youth with complex trauma support the use of the above TF-CBT strategies to successfully treat these youth.

Conclusion: The above practical strategies can be incorporated into TF-CBT to effectively treat youth with complex trauma.

Practice implications: Practical strategies include providing a longer coping skills phase which incorporates safety and appropriate gradual exposure; including relevant unifying themes; and allowing for an adequate treatment closure phase to enhance ongoing trust and safety. Through these strategies therapists can successfully apply TF-CBT for youth with complex trauma.

© 2012 Elsevier Ltd. All rights reserved.

Introduction

Many youth experience multiple and chronic traumas (Copeland, Keeler, Angold, & Costello, 2007; Finkelhor, Ormrod, & Turner, 2007). Child maltreatment, domestic violence, and other forms of early interpersonal trauma that disrupt primary attachments increase the risk for developing a constellation of difficulties referred to as “complex trauma” (Cook et al., 2005; Ford & Cloitre, 2009; Herman, 1992). Complex trauma is characterized by significant problems with attachment security, affect regulation, biological regulation, dissociation, behavioral regulation, cognition and self-concept (Cook et al., 2005).

[☆] Support for this manuscript was provided in part from funding from Grants No. SM54319, Substance Abuse and Mental Health Services Administration; and R01MH 095208, National Institute of Mental Health.

* Corresponding author.

Evidence-based treatments (EBTs) are those that have produced positive outcomes in randomized controlled treatment trials (RCTs). Typically RCTs include youth exposed to a specified trauma type (e.g., sexual abuse or domestic violence). As a result, even though most participants in such RCTs have experienced multiple traumas and have problems in complex trauma domains (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Lieberman, van Horn, & Ippen, 2005; Stein et al., 2003), a common misconception is that EBTs are not suitable for youth with complex trauma. Therapists often ask how to implement trauma-focused EBT for youth with complex trauma. This paper describes practical strategies for applying Trauma-Focused Cognitive Behavioral Therapy (TF-CBT, Cohen, Mannarino, & Deblinger, 2006; www.musc.edu/tfcbt) for these youth. Two composite case descriptions are used to illustrate these strategies throughout the paper.

Assessing youth with complex trauma

Assessing youth with complex trauma can be challenging for a number of reasons and a detailed description is beyond the scope of this paper. Briefly, the therapist attempts to gather not only basic information about the youth's trauma experiences but also about secondary adversities that often occur related to traumas. These include removal or rejection from family, placement in foster care or a residential treatment facility (RTF), legal, medical or other procedures that in themselves may also be traumatic. Youth who have complex trauma often under-report traumatic experiences and trauma-related problems. This may be because they avoid overwhelming trauma material; attachment-related injuries cause youth to not trust the therapist; and/or because they view chronic trauma and regulation problems as the normal fabric of life. Assessment is therefore usually an ongoing process which requires obtaining information from parents or caregivers (hereafter referred to as "caregivers"), if available, and other adults who know about the youth's history and functioning.

By definition complex trauma impacts multiple domains including affect, attachment, behavior, biology, cognition and perception, self-image, and academic functioning in addition to standard Posttraumatic Stress Disorder (PTSD) symptoms. Therapists must conduct ongoing assessment of all of these domains. Therapists gather information from the youth, caregiver(s), school and other resources while also understanding the critical importance of establishing a trusting relationship with the youth who may view such information gathering with suspicion. Standardized instruments can be used to assess trauma exposure (e.g., the Traumatic Events Screening Inventory for Children, TESI-C, National Center for PTSD, 2011), PTSD (e.g., the UCLA PTSD Reaction Index, Steinberg, Brymer, Decker, & Pynoos, 2004) and complex trauma outcomes (e.g., Trauma Symptom Checklist for Children, TSCC, Briere, 1996). More information about assessment is available elsewhere (e.g., Briere & Spinazzola, 2005).

Applying TF-CBT for complex trauma: Phase-based treatment

Several authors recommend that youth with complex trauma respond best to phase-based treatment with an initial stabilization phase to provide coping skills, a trauma processing phase to understand personal trauma experiences, and a final integration phase to consolidate and generalize safety and trust (e.g., Ford & Cloitre, 2009; Ford, Cortois, Steele, van der Hart, & Mijenhuis, 2005). TF-CBT consists of several progressive components summarized by the acronym PRACTICE. As Fig. 1 illustrates, these components are divided into three distinct phases that parallel the recommended phases for youth with complex trauma: an initial coping skills-building phase (stabilization phase); a second trauma narrative and processing phase (trauma processing phase) and a final treatment consolidation and closure phase (integration phase) (Murray, Cohen, Ellis, & Mannarino, 2008).

Proportion and balance are important concepts in providing TF-CBT. Typically therapists dedicate approximately the same number of treatment sessions to each of the 3 TF-CBT treatment phases (i.e., 1/3 of sessions for coping skills; 1/3 for trauma narrative and processing; 1/3 for treatment consolidation and closure). However, youth with complex trauma have significant regulation problems in multiple domains and these are frequently compounded by challenges in establishing a consistent, trusting therapeutic relationship. Therefore the proportionality of treatment is modified to dedicate about half of the total TF-CBT treatment sessions to the coping skill building phase. The duration of TF-CBT treatment also often needs to be extended, from the typical 8–16 sessions to 25 sessions and occasionally up to 28–30 sessions assuming sessions of 50 min duration.

Developing and sustaining the therapeutic relationship is always central in TF-CBT treatment (Cohen et al., 2006, pp. 46–53) but is especially critical for youth with complex trauma and their caregivers. Due to repeated interpersonal trauma experiences youth with complex trauma view most relationships as potentially threatening. Every TF-CBT component typically includes gradual exposure to help youth gain mastery over trauma reminders. The therapeutic relationship itself often serves as a trauma reminder for youth with complex trauma. During early TF-CBT sessions the therapist gradually exposes the youth to the idea of a safe and predictable relationship. This work can also be considered part of the in vivo mastery component as described later. Often caregivers have personal chronic trauma histories as well. The therapist must carefully calibrate both the youth's and the caregiver's abilities to tolerate distress related to the relationship and decrease the intensity of the interaction when needed. Distress tolerance is defined here as the youth's ability to self-regulate when experiencing negative affective states, including those triggered by trauma reminders. Practical strategies to target affective distress are described below. Gradual exposure to traditional trauma reminders may need to be modified as described later.

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

Phase 1: Coping Skills

E: Enhancing Safety

P: Psycho-education

P: Parenting Skills

R: Relaxation Skills

A: Affective Modulation Skills

C: Cognitive Coping Skills

Phase 2: Trauma Narration & Processing

T: Trauma Narrative & Processing

I: In vivo Mastery of Trauma Reminders

Phase 3: Consolidation & Closure

C: Conjoint Youth-Parent Sessions

E: Enhancing Safety and Future Developmental Trajectory

G: Traumatic Grief Components as indicated

Fig. 1. TF-CBT practice components for complex trauma.*Phase 1: TF-CBT coping skills for complex trauma*

Overview. During the initial coping skills phase youth begin to establish a trusting relationship with the therapist and develop safer and more effective self-regulation skills. Under optimal circumstances, participating caregivers also gain understanding of and attunement to youths' complex trauma responses and needs. However, since these changes require youth to shift their longstanding responses for adapting to severe stress, they rarely occur in a linear fashion. Even if the youth's trauma responses are maladaptive or dangerous, they seem to have helped the youth to survive, so giving them up may be terrifying. As a result, youth usually need many attempts of practicing using new self-regulation skills in diverse situations before they begin to use them effectively. Youth may respond very poorly to disappointing early attempts and "give up," requiring the therapist to repeatedly reengage the youth in attempts to try new self-regulation skills. The youth may repeatedly "test" the therapist for trustworthiness during this process (e.g., a youth may not mention self-injury until the end of a session to see whether the therapist "cares" enough to extend the session). The therapist may be challenged to maintain personal regulation in these situations but doing so is critical to modeling coping skills as well as a fair, predictable, consistent relationship whose rules and boundaries the youth can come to understand and rely upon. Thus, the youth gradually gains increasing self-regulation while learning to tolerate reasonable levels of frustration within the context of an ongoing supportive relationship.

Enhancing safety. As Fig. 1 illustrates, Enhancing Safety is usually the final TF-CBT treatment component. However, for youth living with ongoing threats to safety or stability, addressing safety concerns becomes the first treatment priority and often is an ongoing process throughout TF-CBT (Cohen, Mannarino, & Murray, 2011; Ford & Cloitre, 2009). Indeed, enhancing the youth's sense of safety is the core therapeutic goal for many youth with complex trauma. Ongoing danger may include the youth's suicidality, self-injury or risk-taking behaviors including serious substance abuse; ongoing abuse or violence toward the youth; or other immediate threats such as a new HIV diagnosis or imminent placement disruption. Youth with complex trauma have a great need, yet often few skills, for developing consistent, safe, nurturing relationships. Since secure attachments are essential for youth to develop a "felt sense of security" (Cassidy & Shaver, 2008; Siegel, 1999), establishing a trusting therapeutic relationship is essential for enhancing the youth's sense of safety. Developing other safe relationships in the youth's immediate and extended environment will further enhance the youth's sense of safety. Especially at the start of TF-CBT treatment, the therapist advocates for the youth with the caregiver, educators, direct care staff and others to increase safety, build positive relationships, and thus to promote resiliency. The therapist encourages the development of safety by including the caregiver in TF-CBT; identifying safe adults in the community in order to enhance safety; providing psychoeducation to caregivers, educators and RTF direct care staff to ensure a consistent understanding of the youth's trauma-related impairments where there may be a consistent trauma theme; and nurturing the youth to express his own views and choices both in and outside of therapy. Examples of these advocacy roles are described in case examples below, and are consistent with the CDC violence prevention strategy of increasing safe, nurturing social networks for victimized

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

youth (www.CDC.gov). Safety strategies include building the youth's and caregiver's personal safety skills, as well as helping them to access available external resources. The strategy of working with the youth and caregiver to develop a specific safety plan conveys to the youth that he has the ability to make positive choices and to obtain appropriate support, rather than continuing to view himself as helplessly at the mercy of malevolent others. Often youth have lived in crisis for years and have no experience in perceiving caregivers, police, teachers or other authority figures as helpful. Systematic work is often necessary to change this state of affairs. This includes helping the youth to identify adults he is willing to turn to for help. It also involves helping the caregiver and other significant adults to learn specific behavioral responses that reliably provide the youth with optimal safety and a sense of security. The therapist also engages other services to increase safety and protectiveness in the broader environment (e.g., encouraging enrollment in after-school, spiritual, or other safe activities). An additional practical strategy therapists must address is assuring safe learning and therapeutic environments as described in the following example.

Case example: Kayla witnessed early domestic violence of her mother until mother threatened to call the police. Father absconded with Kayla when she was 6 years old and they lived "on the run" until she was 10 years old. At that time father was arrested and sent to prison for dealing drugs. Kayla's identity was discovered and she was found to have several sexually transmitted diseases. She disclosed that several of father's associates had sexually abused her. Kayla was returned to live with mother where she had severe behavior problems. Mother became physically abusive and Kayla was removed from her care. Mother's parental rights were later terminated. Kayla was placed in a series of foster homes where she experienced additional episodes of sexual abuse by males in the community. She was sent to a residential treatment facility (RTF) at 13 years old after she stabbed a male teacher. Upon admission, Kayla required therapeutic holds several times a day due to aggression towards male staff and peers. Every night she barricaded herself in her room by moving all of the furniture in the room against the door. Several staff members had to break into the room each morning to wake her up resulting in her losing points on the level system. Her therapist began the TF-CBT safety component by observing that Kayla seemed to be trying very hard to keep herself safe at nighttime. Kayla asked why the staff kept taking away levels for this. The therapist validated Kayla's need for nighttime precautions since she had not been safe at night in the past, but that the choices she was making were not safe (e.g., if there was a fire she could be trapped). She and Kayla brainstormed about alternative strategies that would make Kayla feel safe and agreed on (1) having a staff member check the room each night and sit directly outside her door all night; (2) giving Kayla a shriek alarm to hold all night; (3) leaving a night light on all night in Kayla's room; and (4) allowing Kayla to come out of her room twice each night if she was scared. The therapist encouraged direct care staff members to respond more positively and compassionately to Kayla's needs as described later and she subsequently felt more understood and supported. The therapist also suggested some relaxation strategies that Kayla could use at night when she was scared (she chose listening to favorite music). At subsequent sessions they established a fear hierarchy and made a schedule for Kayla to gradually work up to sleeping through the night in the RTF without needing a staff member outside her room (in vivo mastery plan). They agreed to start working on this plan with the understanding that it might take several weeks for Kayla to be able to sleep through the night.

Psychoeducation. This component provides the youth and caregiver with information about trauma impact, trauma reminders and hope for recovery (Cohen et al., 2006). Therapists often ask, "Which traumas should I focus on for youth with complex trauma?" Assessment instruments often ask youth to identify a single "worst" trauma experience. Doing so rarely captures the essence of the youth's complex traumatic experiences or outcomes. It is usually more helpful to conceptualize one or more underlying trauma "theme(s)" that cut across and provide an integrative meaning to the youth's trauma experiences. Thus the theme/themes rather than a specific trauma type, become the focus of TF-CBT treatment. Throughout TF-CBT, gradual exposure focuses on trauma reminders to the youth's theme. The therapist weaves specific traumas the youth experienced into this theme throughout treatment.

The therapist and youth work together to co-identify the youth's theme early in TF-CBT treatment. Often the theme emerges naturally during psychoeducation, and the therapist assists the youth in identifying it through Socratic dialogue (described in detail at www.musc.edu/tfcbt and www.musc.edu/cpt). During the assessment and early psychoeducation sessions, the therapist elucidates the youth's history and trauma experiences (understanding that more details will likely be revealed as the youth's trust in the therapist increases). The therapist may use information from an assessment instrument; statements that the youth makes during therapy; or observations from interactions with the youth to initiate an interaction about the youth's trauma theme. The therapist uses clinical judgment to determine whether to directly introduce this topic (e.g., "I would like us to talk about identifying your trauma theme") or to explore this topic more indirectly as in the case example that follows. These trauma themes are usually relational (e.g., feeling unsafe or afraid in relationships) but they may occasionally focus on self-concept (e.g., "I am worthless," etc.). Initially identifying the trauma theme generally requires relatively few sessions through the process described in the following example. Addressing this central theme is the core task of the rest of the TF-CBT treatment. As in most effective therapies, the theme may evolve or shift focus somewhat as new mastery is gained and new issues emerge (for example, from basic safety to establishing an intimate relationship).

Case example: Daniel, aged 14 years, was severely neglected by his substance-addicted mother and witnessed domestic violence of mother by several drug dealers from early childhood. At 6 years old he had still never attended school; he was found by police naked, covered with feces, and severely dehydrated; mother's whereabouts were unknown and she has never been located. Daniel was placed in a series of temporary foster homes, eventually living with maternal great-grandmother ("grandma") at 7 years old. Daniel lived with grandma until 9 years of age when he witnessed grandma's sudden death from

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

a stroke. Daniel was placed in several foster homes but each placement was terminated due to Daniel's aggressive behaviors. At 12 years old Daniel was placed in an adoptive home. Parents had decided to adopt after 18 years of unsuccessful attempts to conceive. Soon after the adoption was finalized adoptive mother unexpectedly became pregnant. When the adoptive parents told Daniel about the pregnancy he became increasingly aggressive and began abusing a variety of drugs. When the therapist approached the topic of Daniel's recent drug use, Daniel said to his therapist "They just want to get rid of me. What difference does it make if I do drugs?" The therapist asked a clarifying question, "I can hear that you feel hopeless about things. Help me understand why you think they want to get rid of you?" Daniel said, "Because they don't care about me now that they're having a baby. They're just gonna get rid of me once the baby comes." The therapist said, "It sounds like you're having a really hard time believing that your parents care about you now that they are having a baby." Daniel said, "Why should they care about me? No one else does and now they won't either. I might as well get high." The therapist said, "It's hard to believe that your parents care about you because no one else does? Help me understand what you mean about no one else caring about you?" Daniel said, "I'm sick of this." The therapist responded, "Do you mean you're sick of people not caring about you?" Daniel said, "I'm sick of thinking people will be here for me and then they aren't." The therapist said, "It's hard for you to believe that anyone will be here for you when people haven't been here for you before." Daniel said, "Why should they? They have their own kid now." The therapist said, "It's really scary to put your trust in them since you've been let down so many times before." Daniel said, "I've been through this before. It sucks. I don't want to go through it again." Through this process of Socratic dialogue the therapist was able to help Daniel identify his own trauma theme of "It's hard to believe anyone cares about me when no one's been here for me before" This became Daniel's theme during TF-CBT. The therapist worked closely with adoptive parents throughout TF-CBT treatment as described below to enhance their sensitivity, understanding and support of Daniel.

Trauma reminders for youth with complex trauma may be idiosyncratic (e.g., a color or internal feeling) or very general (e.g., adults correcting them using loud voices; hearing peers arguing). In either case they may not be easily recognized early in treatment. Identifying the youth's theme often facilitates the identification of trauma reminders since the reminders are often associated with the theme. As trauma reminders are identified, the therapist helps the youth and caregivers understand connections between these and the youth's regulation problems. Then they begin to develop stabilization skills to address them.

Case example: Daniel's therapist described typical trauma reminders for youth who have experienced traumatic loss, e.g., that they may get very upset when other people act indifferently, do not say hello, or leave without warning. Daniel said that he hated when people "disrespect me." For example, when a girl in school whom Daniel wanted to ask out did not talk to him, Daniel cut school to use drugs. Daniel did not initially connect this to his mother's neglect or grandma's death, but he agreed when the therapist said, "Some kids have been hurt in big ways. When someone hurts them now it reminds them of the big ways they were hurt before." The therapist helped Daniel's adoptive mother understand this trauma reminder. Over time, and through ongoing parenting skills used in conjunction with coping skills for Daniel, adoptive mother became much better attuned to Daniel's sensitivity to rejection and how to successfully respond to this.

Parenting skills. Ultimately, the goal of including caregivers in TF-CBT is to build (or rebuild) a relationship between the youth and caregiver based on understanding, trust and mutual respect. Therapists provide every TF-CBT component to caregivers in parallel parenting sessions. Optimizing caregivers' parenting skills is particularly important. In order to support youth with complex trauma, caregivers must understand the youth's trauma-related problems as such ("bad things happened to him"), rather than viewing these as the youth "being bad." Due to the complexity, severity and duration of these youths' problems, caregivers often have difficulties believing or accepting this explanation. This is particularly difficult in relation to persistent externalizing behavior problems that seem remote from the trauma. Negative caregiver cognitions and attitudes towards the youth (e.g., "he's just using trauma as an excuse," "I was abused as a child and I didn't act like this") are likely to be reflected in negative behaviors towards the youth, and contribute to further deterioration of the youth's trust and safety. Helping the caregiver understand the impact of trauma (psychoeducation) and adopt positive, safe interactions with the youth (positive parenting skills) are thus critical initial priorities in the parenting component of TF-CBT treatment. Daniel was fortunate to live with committed, supportive adoptive parents who recognized the challenge that having a new sibling would present in light of his trauma theme. They were dedicated to helping him through this difficult transition period. Youth with complex trauma are frequently living in chaotic or unstable situations (e.g., homeless; with a perpetrator) in which no caregiver is identified to participate in TF-CBT. In these situations the therapist adopts a multi-pronged approach to the parenting component. If at all feasible the therapist locates a stable adult in the youth's life (e.g., a grandparent; adult sibling, other relative or previous foster parent) that the youth is willing to include in TF-CBT to whatever extent is feasible and possible.

Youth who live in foster homes often hesitate to include their foster parent in therapy because they do not trust this caregiver and do not want to share details of their past life with them. These youth may also struggle with conflicting loyalties to biological parents and not want to form attachments to foster parents through engaging in therapy with them. Recent research documents that specific therapeutic efforts to include foster parents in TF-CBT often improve the foster parents' understanding of complex trauma, enhance their supportive attitudes and behaviors towards foster youth, and improve outcomes for youth with complex trauma (Dorsey, 2012).

Whether or not an appropriate adult can be identified to participate in TF-CBT with the youth, the therapist should attempt to locate and engage other adults to participate in providing a supportive, safe, predictable "extended parenting"

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

Name

Relaxation Skills (date learned)

Behavior management skills (date learned)

Feeling management skills (date learned)

Thought management skills (date learned)

Fig. 2. TF-CBT Coping Card.

environment. These adults may include extended family, faith community, educators, other health or mental health professionals, or others. The therapist educates these adults about ways to enhance positive interactions while not encouraging trauma reenactment.

Case example: Criticism was difficult for Daniel, especially when it occurred publicly. Daniel's schoolwork had initially improved upon placement with his adoptive family, but after his mother became pregnant his school attitude, performance and attendance deteriorated. On one occasion his math teacher openly criticized Daniel in class for coming late. Daniel immediately stormed out of the school. After speaking with mother and obtaining Daniel's permission, the therapist called the math teacher. The teacher was initially negative about Daniel. However, once the therapist validated the teacher's right to expect regular attendance and appropriate behavior, the teacher was willing to listen. The therapist explained that due to Daniel's previous trauma history, public criticism served as a trauma reminder and interfered with his tenuous self-regulation abilities. After that call the math teacher started to "look out" for Daniel in school. He refrained from critical comments to Daniel, privately offered to help him with math homework during study hall, said hello to him when he saw him in the hallways, and generally served as a positive presence for Daniel at school. With this supportive presence and ongoing positive parenting interventions (e.g., help with homework, validation of negative feelings about the pregnancy; support about the female peer ignoring him), Daniel's feelings about school changed and he began to attend regularly.

Youth in RTF often experience more frequent disruptions of caregiver relationships. The caregiver may not visit, be uninvolved in the youth's treatment, or placement/custody may be terminated during the youth's RTF stay. RTF direct care staff members then become the youth's de facto caregivers for the duration of the RTF placement. Involving these staff members in the youth's treatment is often critical. Direct care staff members are ideally incorporated into the process from the time TF-CBT is first introduced into an RTF setting. This occurs by educating direct care staff members about trauma impact and about how to support TF-CBT coping skills. As individual youth begin TF-CBT treatment, the therapist asks the youth about sharing information about these coping skills with direct care staff members, so that the direct care staff can help the youth to use these skills successfully. Many youth will initially object, since trust is so tenuous at this stage and the youth expects betrayal. The therapist may brainstorm with the youth about how to safely provide this information. For example, the youth may choose to personally demonstrate the skill to a single chosen staff member during a treatment session with the therapist, enabling the youth to retain control of the information shared and how it is provided. This may reassure the youth that "secret" communications between the therapist and the staff member about the youth's therapy sessions will not occur without the youth's knowledge and agreement. Once youth trust the communication process, they become more willing to share coping skills with additional direct care staff members. In some instances, youth will become willing to include a chosen direct care staff member in the TF-CBT treatment itself.

Case example: Soon after starting TF-CBT, Kayla's therapist suggested that a direct care staff member participate in TF-CBT treatment. Kayla refused. Her therapist said, "It's hard to feel safe when you were unprotected for so long" (Kayla's theme). As the therapist continued to address the safety component, Kayla said, "I just need to get away from everyone. If everyone would just leave me alone I wouldn't need any more (therapeutic) holds." The therapist suggested discussing this plan with a chosen staff member. Kayla could ask this staff member to help her find a quiet place whenever she needed time alone. Kayla said, "It won't work—no one listens to me." The therapist said, "I think you've got a good idea. Let's pick one staff member, and try it out." The therapist assumed Kayla would select one several female staff members who had been remaining outside Kayla's room at nighttime. Instead, Kayla chose to discuss her plan with Chuck, a very popular staff member who was admired by other residents and staff. Chuck readily agreed to the plan. During the following weeks, Kayla tested Chuck repeatedly (e.g., constantly interrupting him to ask to go to a quiet place). Chuck responded fairly, predictably, and according to the agreed plan. After several weeks Kayla was no longer receiving therapeutic holds during Chuck's shifts. In a subsequent session when Kayla learned affective modulation skills, the therapist was ending the session when Kayla asked, "Isn't Chuck coming in to hear how to do this with me on the unit?" The therapist agreed and suggested that she complete a TF-CBT Coping Card to share with Chuck (Fig. 2). Kayla demonstrated the affective modulation strategies for Chuck and showed Chuck her Coping Card. Chuck thanked Kayla and praised her for her recent improvements in the milieu. Over time, Kayla showed the Coping Card to other direct care staff as well. As she continued to share coping skills with Chuck, the therapist suggested that she could include a staff member in her TF-CBT treatment. Kayla asked Chuck and he agreed to participate in TF-CBT with her.

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

Relaxation, affective and cognitive coping skills. Youth with complex trauma have documented dysregulation of neurobiological stress systems (e.g., DeBellis et al., 1999; Ford et al., 2005). These youth have often used maladaptive strategies (e.g., drugs or alcohol; unprotected sex; skipping school) to cope with elevated levels of stress and have likely been criticized or punished for these behaviors. The therapist validates for the youth that these strategies were the youth's best attempts at the time to cope with the neurobiological impact of trauma, although they were often problematic (e.g., they got the youth in trouble). The therapist then helps the youth to develop more effective coping strategies, understanding that he will likely need more time than other youth to consistently and effectively use these strategies to reverse longstanding hyperarousal. Early in the coping skills phase, physically-based relaxation strategies (e.g., yoga, progressive muscle relaxation, dance, etc.) may be more useful than cognitive-based ones (e.g., visualization or mindfulness) (Kliethermes & Wamsler, 2012).

Some youth become highly dysregulated if the initial coping skills sessions contain even minimal trauma information. For these youth, the therapist often starts TF-CBT using relaxation skills without gradual exposure as Kayla's therapist did initially. That is, these strategies are initially not paired with the youth's trauma reminders. Once the youth gains some ability to use one or more relaxation strategy, the therapist carefully begins to introduce gradual exposure through the safety and psychoeducation components, encouraging the youth to use the previously mastered relaxation skills as trauma information is introduced. As the youth gains increased mastery using relaxation skills, the therapist then pairs these with specific trauma reminders (further titrating the gradual exposure).

Case example: Once Kayla was successfully using music, yoga, deep breathing and visualization strategies at bedtime, her therapist worked with her to identify other situations that made her anxious (e.g., being around groups of males in the RTF; hearing laughing or loud talking) when she could also use these skills. Kayla gradually became more able to use these strategies when she became anxious or irritable. Over time she became more aware of internal responses to these reminders ("cues," e.g., fisting her hands; clenching her teeth) and used these cues as signals that she should use relaxation coping strategies.

Youth with complex trauma often have blunted affect and lack a full range of affective vocabulary. Most commonly they have learned not to express feelings because doing so was previously punished, ridiculed and/or dangerous. The therapist does not make assumptions about expressing feelings in the current home or community environment being safe since this may not be the case. The therapist personally models a range of appropriate affective expression and validates a broad range of feelings as acceptable, but youth may be understandably reluctant to accept such statements at face value. Youth will often initially "test the waters" through expressing negative emotions that leave the youth less vulnerable (e.g., anger, disdain). Therapists work with parents or caregivers to validate and support appropriate emotional expression as described below. Feeling identification work may need to start on a very basic level. For example, the therapist (and ideally the caregiver) may need to mirror the youth's facial expressions (e.g., smiling when the youth smiles) and labeling the emotion the youth appears to be experiencing in the moment (e.g., "You feel happy!"). This process is similar to interactions that occur between adults and very young children in secure attachment relationships and serves as the foundation for developing more advanced affective regulation skills.

TF-CBT includes a wide range of practical strategies for decreasing affective distress (Cohen et al., 2006). Some specific strategies used for youth with complex trauma include distraction; mindfulness; perceptual bias modification; self-awareness skills; and cognitive coping skills. Each is described briefly here.

Distraction activities are helpful when initially starting to manage affective distress since most youth with complex trauma already use some of these activities (e.g., talking to or texting peers; watching TV; playing video games). These can be used as examples of how the youth has already learned to "turn down the volume" of difficult emotional states. The therapist encourages the youth to identify and practice a variety of distraction techniques and experience how different types of distraction activities feel very different. For example, listening to music, doing a crossword puzzle, watching a comedy show, taking a walk or knitting are likely to elicit different responses. As the youth adds different distraction techniques to his "toolkit," he then uses different activities in different distressing situations to see which works best in which situations. Youth may overuse distraction strategies to their detriment (e.g., watching TV all night instead of doing homework) because they do not have an adequate range of alternative strategies for distress tolerance. Situations in which youth find they are overusing distraction can thus serve as learning opportunities for youth to apply new skills.

Mindfulness refers to the ability to be fully aware of and in touch with the present moment without taking a judgmental or evaluative approach to one's inner experiences. The therapist may use a variety of sensory activities to introduce mindfulness to the youth. For example, instructing the youth to focus on the sensation of taste as he allows different foods to melt in his mouth one by one (e.g., chocolate; ice; mint); focusing on touch as he reaches into a bag and explores different pieces of fabrics (silk; corduroy, denim). The therapist encourages the youth to fully experience the sensations associated with each and to fully describe what each was like. Through these exercises, the youth becomes increasingly aware of the present moment. The therapist instructs youth to spend specified periods of time dedicated to mindfulness each day. As the youth gains mindfulness he is increasingly able to observe his feelings without having to react to them. For youth who prefer physically-based activities, yoga can provide an entrée to developing mindfulness.

Perceptual bias modification strategies aim to correct youths' bias towards perceiving negative affective states in others (Pollack & Tolley-Schell, 2003). The therapist first asks the youth to identify a variety of feelings expressed in magazine pictures or photos of youth and adults. If the youth displays bias towards negative emotions (e.g., labels neutral faces "mad" or is unable to distinguish between different negative emotions), the therapist provides practice in accurate emotion identification. This includes in vitro (e.g., using pictures) as well as in vivo experiences (asking individuals how they are

feeling), using gradual exposure to assure that safe individuals are selected for the initial in vivo activities. Through these activities youth gain a more accurate perspective on others' emotions, which are often a source of the youth's own affective distress.

Self-awareness skill-building: Many youth with complex trauma lack self-awareness about how others perceive them in social interactions. The therapist encourages the youth to describe a recent negative social interaction and to tape record the youth's description of this interaction. After the youth describes the interaction (preferably including verbal exchanges between the youth and the other person), the therapist asks the youth to describe the feeling the youth was trying to convey to the other person. The therapist then replays the tape recording as the youth and therapist to explore whether the youth accurately conveyed the desired emotion during the youth's description of the interaction. For example, a youth who intended to express hurt feelings to a friend for not calling, instead realized upon listening to herself that she had expressed a great deal of anger and rejection towards her friend. This led to her expressing remorse because she "didn't mean to sound like that" and problem solving about how to correct mistakes that are later regretted. Through similar self-reflective activities, youth gain greater ability to modulate social interactions and thus to effectively access social support.

Cognitive coping strategies help youth and caregivers to identify alternative thoughts that may be more accurate or helpful than their current beliefs. Youth with complex trauma struggle to implement these strategies more than other youth because their maladaptive cognitions are often more deeply ingrained than those of other youth. Indeed, a thought the therapist is questioning (e.g., Daniel said, "You can't trust anyone") may be the one the youth believes is responsible for his survival. In this instance the therapist validated and acknowledged the importance of this belief in the Daniel's past (e.g., "There was a time when no one in your life was trustworthy so it was very important for you to remind yourself of this to keep yourself safe from harm"). The therapist then inquired about Daniel's current circumstances and whether there was any room to revise the belief, even slightly (e.g., "Since being adopted, has there ever been a time or a person that you thought you could trust at all, even a little?"). Daniel acknowledged that he sometimes trusted his adoptive mother, and revised his thought to "I don't trust most people but sometimes I trust my mom." He was able to recognize that this helped him feel safer and more cared about at home than thinking that he couldn't trust anyone, and that these feelings in turn helped him get along better with his parents.

Involving caregivers in skills components. As the above process occurs to develop the youth's coping skills, the therapist meets regularly in parallel sessions with the caregiver to help the caregiver learn these skills. This enables the caregiver to support skills implementation at home or in the youth's current setting, both when the youth is exposed to trauma reminders and when the youth otherwise experiences dysregulation. The caregiver must recognize the connection between trauma reminders and regulation problems (psychoeducation and parenting skills); understand how the youth is supposed to implement the above coping skills (learn relaxation, affect modulation and cognitive coping skills as they have been individualized for the youth), and effectively intervene with the youth when regulation difficulties begin. This usually requires significant caregiver commitment as well as repetition, practice, in-session role play and, often, tweaking of unsuccessful strategies. For example, in the above affective modulation description, if the caregiver responds negatively to the youth's expression of anger, the youth is likely to dismiss affective expression as a "waste of time". If this occurs, the caregiver and therapist will need to spend extra time convincing the youth that it is indeed worthwhile expressing feelings to the caregiver (and having the caregiver practice a different response if and when they youth does so in the future). However, if the caregiver praises or validates the youth for expressing anger in a relatively appropriate manner (e.g., using angry words—even swear words—instead of aggressive behavior), the youth is more likely to begin believing that affective expression is a viable strategy and continue to express other feelings.

Case example: Daniel had a pattern of responding to perceived rejection by "shutting off" emotionally, leaving the situation and using drugs. The therapist addressed this by observing when Daniel distanced himself emotionally in therapy. Over time she and Daniel were able to talk about Daniel's feelings when these situations occurred. Daniel acknowledged his belief that no one really cared about him and that talking about feelings was "useless." The therapist's validation of this within the context of Daniel's experiences helped him to feel understood and to start to trust his therapist more. Over several weeks Daniel expressed more feelings with the therapist. Concurrently the therapist was meeting weekly with adoptive parents to encourage their positive response whenever Daniel expressed any feelings. The adoptive father was especially annoyed when Daniel "shut down" and was likely to take a "to hell with him" attitude when this occurred. Daniel in turn was extremely sensitive to this rejection. He would respond to this by going to his room and using marijuana, which father was then sure to smell and punish Daniel for using. The therapist pointed out that father was "playing into Daniel's expectations" by doing this. Mother and father agreed to experiment with only positive responses to any affective expression that Daniel made during a 3-week period. Parents would not respond negatively to any episodes of Daniel shutting down. Each parent was given a "homework" assignment to observe and comment positively on Daniel's affective expression at least 3 times each day, and to record this along with Daniel's responses at the end of each day. Both parents found the idea of tracking their behaviors and Daniel's response to be helpful in "keeping us on track" and observing Daniel's improvements. Father successfully attended to Daniel when he expressed anger and annoyance. For example, when Daniel said, "This sucks so much" father responded, "Daniel, I really appreciate you sharing your disgust and annoyance with me." Daniel actually smiled and said, "Anytime, man" and did not lose his temper as he usually would in this circumstance. Using this strategy Daniel gradually began expressing more feelings with adoptive parents. Over the next several weeks, he also began to express feelings his math teacher when he felt upset at school. He found that these adults were increasingly supportive and understanding of

his feelings. Parents reported that Daniel experienced growing self-regulation abilities and he used drugs less frequently. With similar parental support he showed significant improvement in cognitions, problem-solving and reading of social cues related to peers. Rather than thinking “No one respects me” and using drugs when the chosen girl continued to not talk to him, Daniel began to date another girl.

Phase 2: Trauma narration and processing of complicated trauma

Overview. Asking youth to talk and think about their complex trauma experiences introduces new challenges to recently gained regulation abilities. However, to the extent that trauma narration and processing allows youth to understand themselves, their relationships and their past experiences in new and more positive ways, it also offers the opportunity for enhancing self-regulation mastery. For many youth, particularly those who have higher levels of anxiety or fear, trauma processing may be *necessary* to obtain an optimal level of self-regulation (Deblinger et al., 2011). Through the trauma narration and processing phase, youth gradually understand and integrate their traumatic experiences in greater depth.

Therapists are often uncertain about the level of self-regulation needed before beginning the trauma narration and processing phase of TF-CBT for youth with complex trauma. Youth gain increasing ability to use self-regulation skills during the coping skills phase, but often regulation continues to vary in some domains. Since self-regulation is relative, and often fluctuates for these youth, the concept of “stably unstable” is useful. Youth that have gained at least some ability to use coping skills and have “leveled off” in terms of improvement, can be considered stably unstable. These youth can usually begin trauma narrative and processing. In other words, it is often unrealistic to expect mastery of these skills before moving onto trauma narrative and processing.

Case example: Daniel had gained substantial self-regulation skills during 14 TF-CBT sessions. However, as mother’s pregnancy progressed, he experienced renewed difficulty in expressing feelings and began using drugs with increasing frequency related to his fears of being displaced by the coming baby. For example, when parents invited Daniel to choose the baby’s middle name, he believed this was “to remember me after they kick me out” and went on a drug binge. This angered father and he punished Daniel. Daniel pointed to father’s anger as proof that parents were about to send him away. Daniel said, “Why shouldn’t I get high? Everyone loves that baby and no one ever gave a damn about me.” The therapist agreed that what had happened to Daniel when he was young was very unfair, but suggested that telling his life story would clarify whether anything had changed for him since then. Daniel said that was a stupid idea. The therapist reflected Daniel’s irritation by saying that anything she suggested then would probably seem stupid. Having accurately validated his mood Daniel said, “Okay, let’s do the stupid f—king story,” and gradually became engaged in trauma processing.

Trauma narrative and processing. Narrative development and processing for youth with complex trauma revolves around the trauma theme rather than a chosen trauma. Specific traumatic experiences, cognitions, feelings, behaviors and other trauma-related experiences are woven into the core theme as appropriate. Many youth cannot create a fully integrated trauma narrative due to the fragmented and non-linear nature of complex trauma memories. The therapist may encourage the development of a “life narrative” which typically begins at the youth’s birth or earliest remembered point of reference (e.g., “whom do you first remember living with?”) and then proceeds sequentially, woven around the trauma theme while including specific events, experiences, sensations, thoughts, feelings, and other trauma material that the youth remembers. Using rap or other music the youth likes as a metaphor for story telling may help some youth to engage in trauma processing. Importantly, the therapist meets with the caregiver alone as the youth is creating the narrative to share the developing narrative with the caregiver and prepare the caregiver to support the youth during the upcoming conjoint sessions. Often the caregiver has not previously understood the youth’s trauma experiences and/or does not know the impact these experiences have had on the youth. Hearing the youth’s trauma narrative enhances the caregiver’s ability to more fully understand and support the youth. It is critical to carefully assess the caregiver’s ability and motivation to engage in this process. Youth with complex trauma have often experienced relationships with caregivers characterized by inconsistency, neglect, and abuse. They thus may be easily triggered by perceived negative caregiver behavior during conjoint sessions. Therefore, a motivated, well-regulated caregiver is a high priority. If the therapist is not confident the available caregiver can provide this presence it may be wise to postpone or eliminate conjoint trauma narrative sessions.

Finally, it should be noted that for many youth with complex trauma, the idea of sharing their trauma narrative with a caregiver may be a point of contention. This may be particularly true when the youth has been removed from the custody of their biological parents and placed with an alternative caregiver (e.g., foster parent) who is participating in TF-CBT. Subsequently, the youth may be reluctant for their current caregiver to know their life history. This reluctance often seems to be related to embarrassment/shame, distrust of “the system,” a sense of loyalty to their biological family, or a combination of the three. It is critical to validate the youth’s concerns about sharing the trauma narrative, to provide a clear rationale for why it would be specifically beneficial for the youth, and to be open to negotiation (i.e., giving the youth some appropriate choices with regard to when, where, and how the conjoint work occurs). Ultimately, should the youth decide that they do not want to share their trauma narrative with the caregiver this decision should be respected. The youth may perceive failure to respect this decision as a serious violation of the therapeutic relationship, which would be a significant impediment to further treatment progress.

Case example: Kayla said her “whole life was trauma.” She continued to use music as a relaxation strategy and agreed when her therapist pointed out that some of her favorite singers “told a story” in their music. The therapist suggested that

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

Kayla write a song about her own life story, focusing on her theme of not feeling safe because no one protected her. Kayla's memories of these events were recalled in bits and pieces over the course of nine sessions. Her song included the following:

From when I was only three, Dad was always hurting me.
There was never safety for me, only danger waiting for me.
He traded me for drugs and cash like I was just part of his stash.
He said I was just like crack when they had me on my back.
My mom knew all along, I don't know who did more wrong.
Why can't they see there is a me?
Will anyone ever care?

As Kayla created and discussed her narrative with the therapist, the therapist also shared the narrative with Chuck in separate sessions in preparation for upcoming conjoint sessions. It was often very difficult for Chuck to hear about Kayla's previous life (for example, the therapist noted that Chuck was often tearful and angry when hearing the narrative). He was grateful for being included in the treatment since it allowed him to better understand and support Kayla.

Alternatively the therapist may encourage youth to select several seminal "anchors" (e.g., foster homes; schools; significant life events) around which they mentally think about their life and organize the narrative accordingly. For example, TF-CBT often utilizes a timeline to mark down important and traumatic events, which can then be used to organize the narrative.

Case example: Daniel thought of his life as "before grandma," "with grandma" and "after grandma." The therapist suggested that they organize this story into these chapters. As Daniel created the following narrative the therapist shared it with the adoptive parents and prepared them for the coming conjoint sessions. Daniel developed the following information over several weeks, in a non-linear fashion. BEFORE GRANDMA: I don't remember. I was alone for a long time, like maybe a month. I drink out of the toilet and there was no water and I had to go to the bathroom. Annabelle (biological mother) always had needles in her arms. All the men beat her up. She beat me up. There was no food and it was cold. It was dark and that's it. The cops come. At foster homes there was food and I went to school. GRANDMA'S: When I went to grandma's I was happy because I had a home and grandma would keep me. I liked living with grandma because she always cooked dinner for me. She put my schoolwork on her refrigerator and said "I love you" every night before I went to sleep. I thought everything was okay, safe and happy in life until I was 9 years old. One day I came home and grandma wasn't cooking dinner. Right then I got the feeling things weren't okay. An hour later grandma fell over and I couldn't wake her up. I called 911 and the ambulance came, but grandma was dead. They called the police and I went back to foster care. I didn't even get to go to grandma's funeral. No one will ever love me like grandma. AFTER GRANDMA'S: In foster care I was mad, kids stole my nice clothes that grandma got me and they didn't even know that those things meant something to me. I was always getting punished and that made me even madder. At first when I got adopted I thought it would be okay even though it wasn't grandma's house. They were nice and got me new clothes. But then they're having a new baby. They only adopted me because they couldn't have their own. Soon it will be here and they won't want me anymore because they'll have their own. It's just like with grandma. I thought everything would be okay and then everything gets taken away again. Maybe it will be okay. I don't know. I'm tired of having to leave. For once I just want a place that lasts.

Developing the trauma narrative is an iterative process that occurs between the youth and the therapist; whatever is created on the written page (or in whatever format is selected) is less important than the actual process that occurs during the therapy sessions between the youth and the therapist. In most cases the final narrative "product" reflects only a very small portion of this process. As the term implies, trauma processing implies that the youth both describes past complex trauma experiences and comes to new understandings about the meaning of these life experiences. In order to successfully process these experiences, the youth must identify and thoughtfully examine the impact of core beliefs related to the underlying theme. Since complex trauma impacts core beliefs in multiple arenas, creating a life or trauma narrative provides many opportunities for identifying and processing deeply internalized maladaptive core beliefs.

Although these beliefs may have served a survival purpose and been functional in the youth's previous living situations, they are now preventing positive adaptations. Although the youth usually understands that their current way of thinking is hurting them and preventing positive changes, changing this requires considerable time during which the youth repeatedly tests an alternative belief to see if it can be trusted. Even after a new belief has been successfully adopted, under stressful circumstances youth are prone to returning to previous maladaptive cognitions. The therapist prepares the youth and caregiver for this occurrence and encourages the youth to re-test the new cognition, usually repeatedly. TF-CBT is believed to be effective for these youth in part because a primary goal is to provide youth and caregivers skills for thinking about things in alternative ways.

Case example: The therapist explored Kayla's beliefs about why no one protected her from the experiences she described in her narrative (sexual abuse by father; father trading her for drugs or money; mother knowing about father sexually abusing her prior to leaving and not protecting her). Kayla initially defended her parents' behaviors by attributing this to "something wrong with me." The therapist used Socratic dialogue (Cohen et al., 2006; www.musc.edu/cpt) to help Kayla explore this belief. Kayla first said that her parents' maltreatment was because she was probably a "really bad child." Specifically, she said she cried, broke things and didn't listen. The therapist asked what kind of punishment parents usually use for those kinds of behaviors. Kayla thought and said, "Time out or taking away TV... or maybe being spanked." The therapist asked,

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

“So those behaviors are not usually punished with sexual abuse. Help me understand what types of behaviors children have that parents should punish with sexual abuse or allowing the child to be sexually abused by someone else for drugs?” With further exploration, Kayla herself came to see that her parents’ behaviors were not typical punishments for children behaving badly.

Through this process, she came to realize that what her parents did was not in response to her behavior or her fault. Kayla was then able to talk about how hard it was to be angry at her parents because she still wished that her parents would care about her and come back for her. The therapist validated this wish and said, “It’s really hard to think that you can’t control how your parents feel about you or what they do. Part of thinking that what happened was your fault is wishing that you could control what happened. It’s hard to accept that you didn’t have any control over what your parents did then, or what they do now.” This led Kayla to explore alternative explanations for her parents’ abuse and neglect. She came up with several possible explanations (drugs, mental problems, bad childhood, etc.) and said, “It’s hard to not know why. And not know if—they’ll ever feel sorry, if they’ll ever want to see me again or if they’ll ever care about me.” The therapist validated how hard it was to have these unanswered questions. She also acknowledged the difficulty of knowing that she could not change her parents. Having her therapist understand and acknowledge this uncertainty and pain allowed Kayla to more clearly consider how her parents’ behaviors had impacted her. Kayla’s cognitions shifted over time from internalized responsibility for not being protected (“what was wrong with me?”), to holding her parents responsible. As she confronted the reality that her parents would likely never provide the care she needed, Kayla experienced intense sadness and loss. The therapist provided TF-CBT grief-focused components to address these issues (described below). Kayla developed greater self-acceptance and hope that she would receive what she needed from future relationships. This was facilitated by the safety and nurturance she felt in relationships with the therapist, Chuck, and RTF peers and staff. In this regard she added the following lines to complete her narrative:

“I was filled with despair, thought no one would care
But I’ve found a new way to start every day
I’m open to feeling, I know I am healing
Thank you for being here.”

In vivo mastery of trauma reminders. For youth who experience generalized avoidance of a specific trauma reminders, developing a hierarchy of feared stimuli and a schedule for gradual exposure to these situations is generally done in a similar manner for youth with complex trauma, with the caveat that these youth may require a longer period of time to achieve mastery of these situations, as in Kayla’s example described earlier. However, many trauma reminders for these youth will not be specific stimuli related to a traumatic event (e.g., the bedroom in which an episode of sexual abuse occurred). Instead, their trauma reminders are often more general situations and experiences associated with the underlying themes that developed due to trauma exposure. Relatively innocuous relationships may serve as trauma triggers for youth who expect betrayal (Saxe, Ellis, & Kaplow, 2007) as in the case of Daniel’s teacher described above. *In vivo* exposure can be used for these more general situations and experiences also. In Daniel’s case, his therapist worked with the teacher to gradually change the relationship to one in which Daniel could experience trust and support. In the RTF setting, youth are naturally exposed to ongoing relationships with the therapist and direct care staff as described earlier, as well as to other residents. Therapists should be mindful of how such exposure can serve as trauma triggers. However, these exposures also provide many opportunities for *in vivo* mastery as youth gain skills and trust.

Phase 3: Treatment consolidation and closure

Overview. Once the youth completes trauma processing the final phase of TF-CBT encourages the gradual transfer of communicating about trauma and a primary trust relationship from the therapist to the caregiver (if one is participating in TF-CBT treatment); generalizes the ability to establish positive, trusting relationships from the therapist to other important people in the youth’s environment; and generalizes the youth’s ability to maintain safety in daily life. This phase is often prolonged for youth with complex trauma as they repeatedly apply and “test out” what they have learned earlier in TF-CBT treatment while attempting to establish safety and develop appropriate relationships in real life situations. Including TF-CBT grief-focused components is also relevant for the many youth with complex trauma who have experienced traumatic grief.

Conjoint youth–parent sessions. If a caregiver has participated in TF-CBT several conjoint sessions occur during which the youth typically shares their narrative directly with the caregiver, the youth and caregiver communicate directly about the youth’s trauma experiences, and the youth gains confidence that the caregiver will respond supportively to such communications in the future. This is another step in the process of the youth and caregiver building a relationship based on understanding and trust.

Case example: Daniel shared his narrative with parents and they continued to assure him that he was a permanent part of their family. Father said that hearing Daniel’s narrative helped him to better understand why Daniel used drugs and “shut down” when father became angry or frustrated with him. During these sessions father also talked about his own father (now deceased), who had been a stern man who demanded obedience and with whom father had had difficulty sharing feelings.

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

Father wanted to be a different kind of father, but said that he knew he sometimes acted the same way his father had. He asked Daniel to be patient with him while they learned together. Daniel was surprised that father did not blame him for everything that went wrong in their relationship but agreed to keep trying.

Enhancing safety and trust. Youth with complex trauma often require additional time to apply what they have learned in TF-CBT to their current (or new) environments. Transitioning from trusting the therapist and a caregiver to trusting new people requires trial and error; as the youth engages in this process the therapist supports the youth to use skills through expected setbacks. As the youth gradually learns to tolerate these disappointments they are offset by successes and growing mastery in multiple domains

Case example: Kayla completed conjoint sessions with Chuck and was doing well in RTF after 20 TF-CBT sessions. However, several attempts to transition to foster homes were unsuccessful due to problematic interactions between Kayla and prospective foster parents (e.g., Kayla reported that 1 foster parent threatened her; she ran away from another home during a weekend visit, and got into a physical altercation with a male foster son at a third prospective foster home). Chuck suggested that Kayla was undermining these placements in order to remain in the RTF setting where she felt safe. The therapist explored this with Kayla during two additional sessions focused on enhancing safety. Kayla was able to acknowledge her desire to continue treatment with the current therapist and contact with Chuck whom she viewed as a protective adult presence and to openly say that she was afraid of going to an uncertain future since her past foster care experiences had been unsafe. The therapist explored the possibility of Kayla going to a group home which she was more comfortable with; during the next 2 months Kayla gradually transitioned to a nearby group home. The therapist continued to focus on safety, and how Kayla could use what she had learned during TF-CBT treatment to ease the transition to the new setting. Kayla met the group home therapist and had 3 joint sessions with this therapist and her RTF therapist; during the 4th joint session Kayla volunteered that she had created a trauma narrative in the RTF and that she would share this with the new therapist. Chuck took her to visit the group home, she met several residents whom she liked and after another month Kayla successfully transitioned to the group home. Since Kayla had no community supports, Chuck offered that Kayla could call him at the RTF if she needed support. Kayla called Chuck appropriately and successfully transitioned to the group home.

TF-CBT grief-focused components for youth with complex trauma. The TF-CBT model includes several grief-focused components for youth who have traumatic grief (Cohen et al., 2006; www.musc.edu/ctg). These components are provided after the trauma components described above. Many but not all youth with complex trauma have experienced inappropriate parenting (e.g., Kayla). Although Daniel had also experienced neglect by his biological mother, his most salient traumatic grief issues were related to the death of “grandma” as described below.

Case example: After the birth of Daniel’s sister, mother developed significant medical complications requiring a 6 week hospitalization. This triggered past traumatic loss reminders for Daniel, specifically, he “went back in my head to when grandma died.” Daniel was terrified that mother would die like his grandma had. He initially blamed his new sister for causing mother’s illness and he refused to go to the hospital to see sister. He initially had several problematic behaviors (aggression in school; drug use; tantrums at home). The supportive network in place was helpful in containing some of these behaviors. Daniel’s math teacher met with the school counselor and developed a plan to help Daniel in school; father became Daniel’s primary caregiver during this period and worked with the therapist to continue being supportive to Daniel. The therapist initially focused on safety, psychoeducation, and skills components that Daniel had previously mastered, helping him to apply these to the current situation. Once mother’s safety was certain, the therapist introduced the TF-CBT grief-focused components. Daniel was initially very hesitant to enter into this work, but reluctantly agreed to, telling the therapist that “I guess I don’t have much to lose.” After grief psychoeducation the therapist helped Daniel to talk about what he missed about his grandma and what he would miss in the future. Daniel talked about currently missing grandma’s cooking most; he said in the future he would most miss his grandma seeing him graduate from high school since she always told him to get an education. Preserving positive memories about grandma was somewhat challenging because Daniel had no concrete keepsakes... However, he described many positive memories which the therapist made into a “memory book.” Daniel also used each letter of grandma’s name to write one happy memory of their time together (e.g., “M: made dinner for me every night.”) The therapist then helped Daniel to draw one balloon that he was holding onto, to represent things about grandma that he still had (“memories; what she taught me; and the love we shared.”) Daniel then drew a second “helium balloon” floating into the sky, to represent things about grandma that he had to let go of (“the house we lived in, the time we shared together; being able to hear her voice; and seeing her when I came home from school every day.”) The therapist then talked with Daniel about committing to present relationships. Daniel said that no one could “take grandma’s place” but he acknowledged that he was relieved and happy that his parents had stuck by him despite the birth of his sister. After refusing to do so for several weeks, Daniel agreed to visit his baby sister in the hospital. To his surprise he enjoyed holding her and spending time with her. His behavior problems gradually stabilized over the next several weeks and when mother and sister came home he was doing somewhat better. The therapist continued to work with the family to incorporate the skills they had learned for several more sessions until Daniel fully adjusted to sister being part of the family. Treatment closure included addressing the likelihood that Daniel would experience future trauma and loss reminders and planning for how he and his family could cope with these going forward.

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

Data supporting TF-CBT for youth with complex trauma

TF-CBT studies have typically included youth with complex trauma; the following studies specifically focused on these youth. (1) Three evidence-based treatments were compared to Systems of Care treatment as usual (SOC) for youth in foster care at high risk of placement disruption due to externalizing behavior problems. In this project TF-CBT was modified as described in this paper. Outcomes were assessed using the Child and Adolescent Needs and Strengths (CANS) and the UCLA PTSD Reaction Index. Compared to SOC, TF-CBT led to significantly greater improvement in emotional and behavioral problems and PTSD symptoms and was significantly superior in preventing placement disruption and running away (Weiner, Schneider, & Lyons, 2009). (2) Using the modifications described above, TF-CBT was provided to 30 youth with complex trauma who were adjudicated to RTF. These youth experienced significant improvement in PTSD symptoms from pre- to post-treatment with mean scores on the UCLA PTSD Reaction Index decreasing from 52 to 21 ($p < .01$) (Cohen & Mannarino, 2011). (3) Two studies of youth with complex trauma from sex trafficking or having been former child soldiers or in the Democratic Republic of Congo received group TF-CBT modified as described above. These youth experienced positive improvements in multiple trauma domains (Paul O'Callaghan, personal communication, December 20, 2011).

Summary

TF-CBT implementation can be conceptualized in a phase-based fashion that is attentive to the needs of youth with complex trauma. This approach maintains the components and flow of TF-CBT, yet allows for additional time and focus on the multiple domains that are problematic in complex trauma cases. TF-CBT should be considered for these youth with the modifications that are described in detail in this paper. Practical strategies include extending the TF-CBT coping skills phase to address the needs of complex trauma; including overarching trauma themes throughout TF-CBT treatment; progressing to the trauma narrative and processing phase even when absolute stability has not yet been attained; and as indicated, allowing for a somewhat longer treatment consolidation and closure phase that includes TF-CBT traumatic grief components. Extensive clinical experience and growing empirical evidence suggests that with some modifications TF-CBT can lead to significant improvement across multiple domains that impact youth with complex trauma. Continued research is warranted in applying TF-CBT for youth with complex trauma.

References

- Briere, J. (1996). *Trauma Symptom Checklist for Children*. Professional manual. FL: Psychological Assessment Resources, Inc.
- Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress, 18*, 401–412.
- Cassidy, J., & Shaver, P. R. (2008). *Handbook of attachment: Theory, research & clinical applications*. New York: Guilford Press.
- Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A multi-site randomized controlled trial for children with sexual abuse-related PTSD. *Journal of the American Academy of Child Adolescent Psychiatry, 43*, 393–402.
- Cohen, J. A., & Mannarino, A. P. (2011). TF-CBT for youth in residential treatment facilities: Preliminary treatment outcome findings. Data reported in NIMH grant application Number R01MH95208 funded to Allegheny Singer Research Institute July 2011.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.
- Cohen, J. A., Mannarino, A. P., & Murray, L. A. (2011). Trauma-focused CBT for youth who experience ongoing trauma. *Child Abuse & Neglect, 35*, 637–646.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Lioutard, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*, 390–398.
- Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry, 64*, 577–584.
- DeBellis, M. D., Keshevan, M. S., Clark, D. B., Casey, B. J., Giedd, J. N., Frustaci, K., & Ryan, N. D. (1999). Developmental traumatology: Part II. Brain development. *Biological Psychiatry, 45*, 1271–1284.
- Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M., & Steer, R. (2011). Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and treatment length. *Depression & Anxiety, 28*, 67–75.
- Dorsey, S. (2012). Trauma-focused CBT for youth in foster care: Preliminary findings from a randomized controlled trial. In *Presented at the San Diego conference on child and family maltreatment* San Diego, January, (p. 2012).
- Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect, 31*, 7–26.
- Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy for children and adolescents. In C. A. Cortois, & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 59–81). New York: Guilford Press.
- Ford, J. D., Cortois, C. A., Steele, K., van der Hart, O., & Mijenhuis, E. R. S. (2005). Treatment of complex posttraumatic self-dysregulation. *Journal of Traumatic Stress, 18*, 437–447.
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Kliethermes, M., & Wamsler, R. (2012). Adolescents with complex trauma. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), *Trauma-Focused CBT for children and adolescents: Treatment Applications* (pp. 175–196). New York: Guilford Press.
- Lieberman, A. F., van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child–parent psychotherapy for young children exposed to marital violence. *Journal of the American Academy of Child Adolescent Psychiatry, 44*, 1241–1248.
- Murray, L. K., Cohen, J. A., Ellis, B. H., & Mannarino, A. P. (2008). Cognitive behavioral therapy for symptoms of trauma and traumatic grief in refugee youth. *Child & Adolescent Psychiatric Clinics of North America, 17*, 585–604.
- National Center for PTSD (2011). Traumatic Events Screening Inventory for Children. Available at <http://www.ptsd.va.gov/professional/pages/assessments/assessment-pdf/TESE-C.pdf> (accessed 04.12.11).
- Pollack, S. D., & Tolley-Schell, S. A. (2003). Selective attention to facial emotion in physically abused children. *Journal of Abnormal Psychology, 112*, 323–338.
- Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach*. New York: Guilford Press.
- Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York: Guilford Press.

Please cite this article in press as: Cohen, J. A., et al. Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect* (2012), <http://dx.doi.org/10.1016/j.chiabu.2012.03.007>

APPENDIX 3: TF-CBT TRAUMA
PSYCHOEDUCATION FOR RFT DIRECT
CARE STAFF

**TF-CBT Trauma Psychoeducation for RTF Milieu Staff**

TF-CBT Psychoeducation helps children understand the impact that past traumatic experiences have on them in the present. You can support TF-CBT psychoeducation by recognizing when trauma reminders occur, understanding connections between trauma reminders and behavior problems, and preventing trauma reenactment.

Ramon was physically and emotionally abused by his father, witnessed domestic violence, and has a severe learning disability. He is in RTF due to physical aggression. Ramon gets into fights every day before school which he refuses to attend. One of the other kids will call him "stupid" prompting Ramon to become aggressive, requiring you to physically intervene. This enrages Ramon, and he screams, "I'll kill you, get away from me!" One time you get so frustrated that you yell, "Cut the crap, Ramon!"

When children like Ramon have experienced severe early traumas, they often reenact those traumas in new situations and relationships. These episodes are frequently spawned by children coming into contact with a **Trauma Reminder**. Trauma reminders are things, places, situations, people, words, sounds, smells or other cues that remind children of their past traumatic experiences.

Trauma reminders can be internal to the child. For example:

- the child's thoughts,
- the child's memories,
- the child's feelings,
- the child's behaviors,
- the child's own body or body parts
- physical sensations or anything else internal to the child

Trauma reminders can also be external to the child. For example:

- another person
- a place
- a situation
- a smell
- a certain type of food
- a song
- a word
- a color
- a time of day
- a physical characteristic, mannerism, or behavior of another person
- anything else external to the child that reminds the child of the traumas they experienced.

Trauma reminders provide an important link between past trauma and current behaviors problems. Understanding the impact of trauma reminders and preventing trauma reenactment will allow you to help children to learn new ways to cope and to move forward.

Children work with their TF-CBT therapist to identify their personal trauma reminders. Therapists may write a child's trauma reminders on a PRACTICE Coping Card, which the child will carry on the unit. However in the moment the children may not understand or forget that they dealing with a trauma reminder. You can help children by being familiar with their trauma reminders, helping

them appropriately manage them when they are encountered and therefore, reduce trauma reenactments in the milieu.

When Ramon was living at home he was afraid to go to school because every day after school his father would call him a "retard". When mother intervened, father beat her, then would sit on Ramon and punch him and make Ramon say "I'm a piece of crap".

Working with his therapist, Ramon identified the following as trauma reminders:

- being called names,
- being held down,
- being hit
- going to school

Now it is easier for you to understand Ramon's behavior as trauma reenactment. You thought he was being non-compliant in refusing to go to school, but the thought of going to school is really scary to Ramon. The other kids taunting him served as a second trauma reminder of his father's past emotional abuse, and triggered his past fear of being beaten up. He began to **reenact his past trauma by acting in the way most likely to prompt the abusive adult behavior he has come to expect**. You and other staff members unknowingly fulfilled these expectations by holding him down and yelling at him. You feel awful about this, but how could you know that this was trauma reenactment rather than bad behavior?

You can't always know every trauma reminder for every child. However, you can be calm, fair, and firm, to ensure that all children are treated with respect, and to implement the rules consistently. **If you are aware of each child's trauma reminders, you will be in a good position to recognize and prevent trauma reenactment.**

Here are some clues that trauma reenactment is occurring:

- Child's emotional response is extreme for the situation, e.g., a minor situation triggers extreme rage.
- Child's behavioral response is extreme for the situation, e.g., a minor disagreement prompts an immediate violent reaction.
- Child seems "out of it," unresponsive, or dissociative
- Child seems to be responding to someone other than the person present, e.g., yelling "I'll kill you" did not seem directed at you in the above example.
- Child is engaging in "strange" behavior, things that don't seem to make sense under "normal" circumstances.

Once you understand trauma reminders and can connect these to behavior problems, you are in a better position to intervene and prevent trauma reenactment.

For example, now that you and Ramon's therapist have identified his trauma reminders, how can you help him prevent trauma reenactment every morning before school?

Idea #1 -- Change the routine.

Together, his therapist, you, Ramon and the teacher need to replace his current negative routine (get ready for school, refuse to go, get teased, get into a fight, get restrained) with a positive one. The routine can include elements such as, some 1:1 time with staff he likes, acknowledgement and labeling by him of his feelings, use of his PRACTICE Coping Card strategies, and a special activity with the teacher when he arrives at school. These activities will make going to school more enjoyable or at least less upsetting, less of a trauma reminder. Changing his morning routine will

likely take some time to accomplish, and will require a team effort until it becomes established, so be persistent.

Idea #2 – Change peer interaction.

Be on the lookout for peers who tease Ramon at breakfast or anytime before school. This behavior should not be acceptable at any time, but knowing that this is a trauma reminder, it should be followed immediately by consequences so that Ramon does not feel threatened or left to deal with it alone.

Idea #3 – Reinforce positive coping strategies.

Help Ramon recognize when he copes positively with trauma reminders. For example, if he is able to restrain himself from fighting when you give consequences to a peer who teases him, use this episode as an opportunity not only to praise his control, but also to educate him that trauma reminders are likely to occur in unexpected places, and he gets to be in charge of how he responds to trauma reminders, them rather than trauma reminders controlling him.

Information about additional TF-CBT PRACTICE skills will also be helpful in supporting children to master trauma reminders and avoid traumatic reenactment.

APPENDIX4: TF-CBT RELAXIATION
SKILLS FOR RTF DIRECT CARE STAFF

**TF-CBT Relaxation Skills** for RTF Milieu Staff

TF-CBT Relaxation Skills help children “turn down the volume” of physical hyperarousal due to trauma. Common relaxation skills are listed below, but often TF-CBT therapists and children create individualized relaxation strategies for specific settings. You can support children in using these strategies in RTF settings by encouraging children to use relaxation skills before hyperarousal gets out of control.

Tracy was physically and sexually abused and neglected during early childhood. Tracy’s mother was a drug addict and often absent. At 6 years old Tracy came to school with bruises and was placed in a series of foster homes where she experienced sexual abuse by older foster siblings. Tracy is in the RTF due to aggressive and self-injurious behavior. She is extremely jumpy, irritable, can’t sleep and has angry outbursts towards males.

Chronically traumatized children like Tracy are like war veterans. Visible wounds include physical injuries and emotional or behavioral problems. **Trauma also causes less visible wounds to children’s brains and bodies.** These may include:

- Elevated heart rate and blood pressure
- Smaller brain volumes
- Impaired immune functioning and increased physical illness
- Trouble sleeping
- Increased startle response
- Increased irritability and anger
- Impaired ability to distinguish between danger and safety
- Inability of brain to extinguish learned fear responses
- Dysregulated biological response to stress and trauma

Even when they are safe, traumatized children like Tracy function as if they were still in danger. Their bodies and brains remain “on alert”.

“Every night when I got ready to go to bed, I never knew whether this was a safe night or a bad one. If it was a bad night, my father would be coming in to hurt me. If I cried he’d put his hand over my mouth and nose until I couldn’t breathe. The worst feeling was not being able to breathe when he’s tearing me up inside down there. I thought I was going to die. I couldn’t get any breath. I still feel that way. Every night when I go to sleep it comes back on me. I thought foster care would be better but I was never safe.”

Tracy’s body reacts pretty much the same whether she is scared or angry—she becomes short of breath, her heart is pounding, her gut shuts down, and her muscles tense. She is ready to fight. To you she looks aggressive, but inside she is a scared kid. How can you help her calm the storm inside her body?

Supporting TF-CBT Relaxation Skills

Some common TF-CBT relaxation skills that therapists will work with you to support children in using include the following:

- Focused (yoga) breathing
- Progressive muscle relaxation
- Visualization (“perfect day”, ocean, sky, cloud, butterfly, etc)
- Music
- Dance
- Going to room to relax or calm down
- Talking to you or another staff person
- Drawing, journaling, reading
- Going outside for a walk
- Nature
- Sports
- Blowing bubbles (younger children)

TF-CBT relaxation skills are individualized to meet the needs of each child. Therapists work with each child to identify what relaxation strategies work best in different situations. The child’s therapist will communicate with you to keep you up to date about this as strategies change during therapy. This may be through writing the child’s relaxation strategies on the child’s PRACTICE Coping Card; through regular unit meetings; or other systematic ways of communicating with you.

Ask the child, “*What relaxation skills are you using to cope with stress?*” If the child says he or she is not using any or the child doesn’t know what you are talking about, ask to see the child’s PRACTICE Coping Card. If no relaxation skills are on the card, you might suggest that the child use one of the strategies in the list above in the moment. Check-in with the child’s therapist to let them know how this strategy worked and whether other relaxation skills should be added to the child’s PRACTICE Coping Card.

If specific relaxation strategies are marked on the child’s PRACTICE card, encourage the child to use these skills. If you aren’t familiar with the particular skill on the card, ask the child to show the skill to you. This approach is a great way for the child to show you that they have special “expertise” in something, to potentially share this skill with you, and for you to praise them for remembering, demonstrating, and using it. Providing positive feedback (e.g., “*Wow, I never saw that before. That’s a great idea. I’m going to try that myself when I’m stressed out!*”) is a great way to show appreciation for the child’s special knowledge and skill and reinforce their use of effective strategies in daily life.

You also can model appropriate relaxation skills by staying calm and “keeping your cool” in the milieu setting, even when things get stressful. When you model “walking the walk”, children may ask you how you manage to stay so relaxed and easy-going under pressure. Then you can share some of your personal favorite stress reduction strategies with them.

©2010 Judith A. Cohen, Anthony P. Mannarino and Allegheny General Hospital. All rights reserved.

**APPENDIX 5: TF-CBT AFFECT
REGULATION SKILLS FOR RTF DIRECT
CARE STAFF**



TF-CBT Affect Regulation Skills for RTF Milieu Staff

TF-CBT Affect (feeling) Regulation Skills help children recognize and talk about their upsetting feelings rather than showing these feelings through problematic behaviors. Often therapists and children create individualized affect regulation skills during TF-CBT treatment. In the moment, it may be especially helpful to validate, acknowledge and inquire about the child's feelings as described below.

At 5 years old Anthony witnessed his father's death from community violence. Two older brothers died in gang-related shootings. Last year his sister was raped. Anthony was sent to the RTF after stabbing one of the brothers of his sister's rapist.

Many children in RTF settings have experienced repeated traumas like Anthony. These children often have severe difficulty with emotional and behavioral regulation. That is, they cannot appropriately manage their feelings and related behaviors. When something reminds traumatized children of their past traumatic experiences — a **trauma reminder** — they often decompensate. The process that typically occurs is that a trauma reminder causes significant negative feelings, which lead to acutely agitated, dissociative, self-injurious, disorganized, aggressive and/or destructive behaviors. However this process may occur very quickly with seemingly little warning between the reminder and the behavior. This diagram illustrates the process:

Trauma reminder → **Negative feeling** → **Negative behavior**

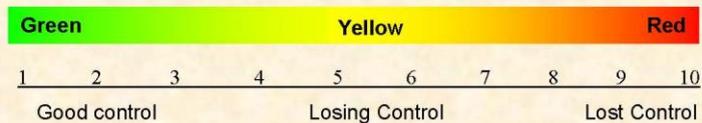
Anthony overheard two boys talking while watching TV, shouting to the TV character, "Kill him!" Anthony became enraged, and with narrowed eyes and clenched fists, stomped over and started punching the boys.

Your goal is to prevent children's negative feelings from progressing to negative behaviors, that is, to interrupt this progression **as early as possible in the process**. It is helpful to:

- Recognize and intervene when trauma reminders occur in the milieu (e.g., when Anthony's peers said "Kill him!")
- Recognize early signals of emotional distress or dysregulation (e.g. Anthony's narrowed eyes and clenched fists)
- Help children recognize their distressing feelings (e.g., Anthony's anger, grief)
- Help children use affect regulation skills to "turn down the volume" of distress before it leads to out-of-control behavior (use TF-CBT skills described below)

Recognizing early warning signals of distress

The higher a child's emotional response, the more out of control their behavior usually is and the less able they are to listen, reason, think clearly, or use coping skills. When rating behavior problems on a scale of 1-10, with 1 = perfect behavior control and 10 = behavior totally out of control, interventions are more effective when children's emotional and behavior responses are at 4-5, not at 8-9. Using the analogy of traffic signals, green (1-3) is "safe"; yellow (4-7) is "warning—slow down" and red (8-10) is "danger—STOP!". You need to put on the brakes when problems are in the yellow zone. By the time they are in the "red" zone it is too late.



Some things to look for in trying to detect **early warning signs** are:

- Trauma reminders that may set off the above process
- Changes in facial expression or body language suggesting increased distress
- Changes in verbal expression suggesting distress: increased volume, change in tone, increased irritability, escalation of arguing, etc.
- Changes in physical agitation level, e.g., increased shaking of extremities, fidgeting, pacing, tapping feet or fingers, etc.
- Angry face, clenched lips or fists, muttering, narrowed or rolling eyes
- Requests or demands for staff attention, stomping away when requests are not granted
- Increase in silent, withdrawn, moody behavior, seeming more “out of it”, talking to self, seeming more confused, dissociative or psychotic than previously

You may be thinking, “*This describes every child in RTF. What am I supposed to do, pay attention to every early warning sign in every child?*” You can’t be perfect at recognizing early warning signs of emotional or behavioral regulation problems. However waiting to intervene until *severe* problems occur is “the squeaky wheel gets the grease” model. That is, the children with the most severe problems get the most staff attention. Since staff attention, even negative attention, is often reinforcing for children, this approach will result in children developing more, not less, severe behavior problems. The RTF will become crisis-driven rather than focused on developing children’s coping skills.

The goal is to interrupt the process early, in the green or early yellow periods, when interventions will be most effective. When you instead focus on identifying problems at a lower level of intensity, children learn to use coping skills earlier in the process. The milieu will become skills-focused, not crisis-driven. Over time children will have less severe behavior problems. Everyone in the RTF milieu benefits from this approach—children, families, administration, and you, the front line milieu staff.

Interrupting escalation using TF-CBT feeling identification skills

Imagine you see the early warning signs of Anthony’s distress in the above example (i.e., his clenched fists and angry face) before he stomped over to the boys watching TV and started punching them. How could you interrupt this process? Here are some ideas:

- **Acknowledge and inquire.** Ask the child about the feelings you are observing. “*Anthony, you look really mad. What’s going on?*” Anthony will hopefully respond to your acknowledgement with a response that shows just how angry his is. This response is exactly what you hope for, a verbal response instead of angry behavior. He may say something like, “*F—king right, I’m mad. My brothers are dead. They f—ked with my family. How the f—k do you think I feel?*”

- **Validate the feeling.** Tell the child you understand why he is feeling the way he is what he believes is going on: *"Of course you're angry. You're thinking about your brothers and how they died. You're right, I'd be mad too if that had happened to my family."*
- **If the child denies the feeling, ask what he is feeling.** If instead of describing their feelings, the child denies a feeling such as, *"I'm not mad, leave me alone"*, reflect what you see, as if you were holding up a mirror: *"I only asked that because your fists are clenched and your face looked angry. I guess I'm way off base. What are you feeling?"*

Using TF-CBT affective modulation skills to "turn down the volume"

Once children have acknowledged feelings you have already started to defuse the situation. However it is still not a "done deal" that the child won't escalate to out of control behavior. At this point it is crucial to help children use affective modulation skills to "turn down the volume" to prevent further escalation. At this point you can:

- **Model affective modulation skills.** Continue to keep your voice calm. Speak slowly and softly even if the child is yelling. Raising your voice to match his volume will not help the child to calm down. Raising your voice will only make him angrier and escalate the situation. Do not reprimand him for swearing. This is the time to model affective regulation, not to establish your authority.
- **Offer options for affective modulation.** Offer the child options for affective modulation, for example, offer distraction options such as asking if he would like to play a game with you, go to a quiet place and talk with you, take a walk, or whether there is another affective modulation skill on his PRACTICE Coping Card he would like to use. Your knowledge of the particular child, his interests and mood, and your intuitive judgment of what will work best to defuse a given situation, is critical to success in the moment.
- **Offer praise for not escalating.** Once the child is able to respond to you calmly, praise him for successfully avoiding further escalation: *"Anthony, you've done a great job of keeping your cool even though you're really angry. That's hard to do and I hope you're really proud of this."*

**APPENDIX 6: TF-CBT COGNITIVE
COPING SKILLS FOR RTF DIRECT CARE
STAFF**

**TF-CBT Cognitive Coping Skills for RTF Milieu Staff**

TF-CBT Cognitive Coping Skills help children understand connections between maladaptive thoughts and negative feelings and behaviors. By helping children to examine and change unhelpful or inaccurate thinking patterns, children learn to modify their negative feelings and behaviors.

Maladaptive thoughts may be factually inaccurate. For example, Anthony from the Affective Modulation handout may think, *"I should have been able to save my father's life."* Maladaptive thoughts may also be somewhat accurate, but unhelpful. For example, Anthony may think, *"You can never tell who belongs to the gang that raped my sister."* Either one of these thoughts may contribute to negative emotions, increased physiological arousal, and to Anthony quickly going from zero to ten in behavior problems when triggered by a reminder of gang behavior.

TF-CBT therapists work with children to examine such thoughts and replace them with more accurate and helpful thoughts, and how this might affect their feelings and behaviors. The idea is that less upsetting thoughts lead to less upsetting feelings, which prevent negative behaviors. The connections between thoughts, feelings, and behaviors are usually shown as a triangle, but they can just as accurately be shown this way:

More accurate/helpful thoughts ➡ **Less negative feelings** ➡ **Less negative behaviors**

- A more accurate thought for Anthony might be, *"Even the EMT and the doctors couldn't save my father's life. I wish I could have done something to save him, but I was only 5 years old. It was really painful to see him die."*
- A more helpful thought might be, *"Most guys do not rape girls."*

Therapists will work closely with you to keep you informed of each child's cognitions and how they are addressing them in therapy. This information will help you to reinforce more adaptive cognitive coping by the child in daily life situations.

Often kids in a RTF have negative thoughts about non-trauma-related things as well. For example, they may assume that other kids are laughing at them, that their peers don't like them, or that staff is angry at them. Instead of doing a "fact check" (e.g., asking the kids why they are laughing, asking the peer if there is a problem, or asking the staff member if they have done something wrong), kids will typically get angry, isolate, explode, or withdraw without bothering to see whether their assumptions are accurate. You can help children in the milieu examine these negative cognitions by checking with children when you see this sort of situation happen and helping them to check out the facts and examine the evidence rather than jumping to conclusions.

When kids learn to have more accurate and helpful thoughts about non-trauma-related issues, this practice will help them to "turn down the volume" of their negative feelings, which in turn will decrease their negative feelings.