Welcome to ISPIC’s Trauma Intervention Showcase 2017

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Regional Office of Education #17

Graduate Association of School Psychology

Illinois State University

Central Illinois AHEC network
School Readiness to Meet Trauma Needs Within Tiered Service Delivery: Two Self-Assessment Tools

“It’s not a program, it’s a process”

DANIEL PHILIPPE & JEFF GAROFANO
Seminal Study: Adverse Child Experience Study

- Landmark epidemiological study
- ACEs = physical and sexual abuse, neglect, domestic violence, household substance use, household mental illness, divorce, incarceration
- 28% physical abuse towards child
- 26% substance abuse in home
- 22% sexual abuse
- 19% mental illness in home
- 13% domestic violence towards mother in home
- ACES linked to a range of outcomes
Seminal Study:
Adverse Child Experience Study


https://www.cdc.gov/violenceprevention/acestudy/
Seminal Study: 
Adverse Child Experience Study

- Adverse Childhood Experiences have been linked to
  - risky health behaviors,
  - chronic health conditions,
  - low life potential, and
  - early death.
- As the number of ACEs increases, so does the risk for these outcomes.
- The wide-ranging health and social consequences of ACEs underscore the importance of preventing them before they happen.
Seminal Study: Adverse Child Experience Study

- 2 questions facing many educators:
  - Is my school trauma-informed?
  - What should a trauma-informed school actually look like? How do we know if the environment we have created is actually trauma-informed?
Tiered Intervention

- Thinking about Tiered intervention
  - Tier I not only as set of strategies/techniques (e.g. SEL curricula)
  - A culture in which awareness/sensitivity to trauma permeates the entire school environment

- 2 questions facing many educators:
  - What should a trauma-informed school actually look like?
  - How do we know if the environment we have created is actually trauma-informed?
Compassionate Schools Initiative

- School-wide initiative to help schools:
  - Establish compassionate school environments
  - Foster compassionate attitudes of school staff
  - Create and support healthy climate and culture within the school so all students can learn
  - Although the focus is on students chronically exposed to stress and trauma in their lives, this initiative is designed to benefit all students
  - The Compassionate School model is about building resiliency in the face of adverse, traumatic experiences.
Compassionate Schools Initiative

1. Focus on culture and climate in the school and community.
2. Train and support all staff regarding trauma and learning.
3. Encourage and sustain open and regular communication for all.
4. Develop a strengths based approach in working with students and peers.
5. Ensure discipline policies are both compassionate and effective (Restorative Practices).
6. Weave compassionate strategies into school improvement planning.
7. Provide tiered support for all students based on what they need.
8. Create flexible accommodations for diverse learners.
9. Provide access, voice, and ownership for staff, students and community.
10. Use data to:
    - Identify vulnerable students, and
    - Determine outcomes and strategies for continuous quality improvement.
Compassionate Schools Initiative

- A wonderful **FREE** resource: *The Heart of Learning and Teaching: Compassion, Resilience, and Academic Success*

  - Provides current information about trauma and learning, self care, classroom strategies, and building parent and community partnerships that work. Includes a range of classroom strategies, case studies/vignettes, and resources

- Access a free downloadable copy at this link: [http://www.k12.wa.us/CompassionateSchools/default.aspx](http://www.k12.wa.us/CompassionateSchools/default.aspx)

- For more information on the book and about the Compassionate Schools Initiative in Washington, contact Ron Hertel, 360-725-6042, [ron.hertel@k12.wa.us](mailto:ron.hertel@k12.wa.us).
Compassionate Learning Environment Assessment Rubric

- Accessible through the Delaware Department of Education trauma-informed practices and compassionate schools initiative: [http://www.doe.k12.de.us/Page/1814](http://www.doe.k12.de.us/Page/1814)
  - Click on the link with the rubric’s title
  - Provides a word document. Says DRAFT on it
  - Adapted from Puget Sound Educational Service District

**Strengths**
- Formative tool meant to facilitate vision statement and goals as well as evaluate needs/progress
- Free

**Weakness**
- Lengthy: addresses 10 sections
- Unclear how it was developed or if it is effective/useful
Trauma-Sensitive School Checklist

- Inception - Trauma Sensitive Schools Initiative
  https://traumasensitiveschools.org/
- Tool - http://www.doe.k12.de.us/Page/1814
- A tool to assess the level of trauma-sensitive elements in place in schools
  - Brief, efficient, actionable
- 5 domains
  - School-wide policies and practices (x8)
  - Classroom strategies and techniques (x8)
  - Collaborations and linkages with mental health (x5)
  - Family Partnerships (x3)
  - Community linkages (x2)
Trauma Sensitive Schools Checklist

Lesley University
Center for Special Education

Trauma and Learning Policy Initiative
of Massachusetts Advocates for Children
and the Legal Services Center of Harvard Law School

This checklist is organized by five components involved in creating a trauma-sensitive school. Each component consists of several elements. Please assess your school on each element according to the following scale:

1. Element is not at all in place
2. Element is partially in place
3. Element is mostly in place
4. Element is fully in place

School ___________________________ Date _________

Team Members (name and position)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
A trauma-sensitive school is a safe and respectful environment that enables students to build caring relationships with adults and peers, self-regulate their emotions and behaviors, and succeed academically, while supporting their physical health and well-being.

School-wide Policies and Practices

- School contains predictable and safe environments (including classrooms, hallways, playgrounds, and school bus) that are attentive to transitions and sensory needs.
- Leadership (including principal and/or superintendent) develops and implements a trauma-sensitive action plan, identifies barriers to progress, and evaluates success.
- General and special educators consider the role that trauma may be playing in learning difficulties at school.
- Discipline policies balance accountability with an understanding of trauma.
- Support for staff is available on a regular basis, including supervision and/or consultation with a trauma expert, classroom observations, and opportunities for team work.
- Opportunities exist for confidential discussion about students.
- School participates in safety planning, including enforcement of court orders, transferring records safely, restricting access to student-record information, and sensitive handling of reports of suspected incidents of abuse or neglect.
- On-going professional development opportunities occur as determined by staff needs assessments.
Trauma-Informed Organizational Self-Assessment

- Trauma-Informed Organizational Toolkit—access at following link: http://www.air.org/resource/trauma-informed-organizational-toolkit
- Produced by AIR’s National Center on Family Homelessness
- Organizational Self-Assessment
  - Tool designed to evaluate trauma-informed elements in homeless organizations
  - 5 domains: supporting staff development, creating safe/supportive environments, assessing/planning services, involving consumers, adapting policies
- Pros: free access within public domain; clear about how it has been developed and used
- Cons: relatively intense self-assessment, specifically targeting organizations serving homeless families (different population than schools, though considerable overlap)
Trauma-Informed Approach to Positive Behavioral Interventions and Supports

Jill S. Brink
jbrink@illinois.edu
What is Trauma? Adverse Childhood Experiences (ACEs)

- Abuse
- Abandonment
- Accidents/injuries
- Alcoholic or drug abuser in home
- Bullying
- Community violence

- Living with a family member with mental illness
- Loss of a loved one
- Exposure to violence or abuse
- Homelessness
- Natural Disasters
- Neglect
Prevalance of Trauma and Violence on U.S. Children

- Over 60% were victims or witness of violence
  - 10% saw one family member assault another
- 46% were assaulted in the past year at least one time
- 25% were victims of robbery or vandalism
- 10% were victims of maltreatment (e.g. physical or emotional abuse, neglect, or family abduction)
- 6% were victims of sexual abuse
Effects of Trauma

Symptoms
- Hyperactivity
- Distraction
- Aggression
- Anger
- Moodiness
- Fearfulness
- Sadness

More likely to have:
- Behavior problems
- Poor school performance
- Opposition to authority
- Difficulty following directions
- Somatic complaints
- Poor sleep
- Depression
- More school absences
What Can We Do?

- You might already have an option set up in your school:
- PBIS – Positive Behavioral Interventions and Supports
  - School-wide, Tier 1/RiT approach
  - Aims to prevent undesired behaviors
  - Sets clear expectations for social behaviors
  - Rewards and acknowledges positive behaviors over punishing negative ones
The Key

- Emphasis on fostering positive behaviors and positive interactions with adults
- Less emphasis on punishing negative behaviors and adult interactions centered on punishment
- Many negative behaviors seen in children exposed to frequent traumas are the result of being prepared to react in self-defence to such traumatic events
- We have to make the shift from thinking, “What is wrong with this child?” to, “What has happened to this child to make them act this way? How can we help?”
Trauma-Informed PBIS

- Acknowledge that childhood trauma is common
- PBIS as a Tier 1 intervention assumes 80% of students can behave if:
  - Clear expectations are made
  - Children are taught to behave
- Behavior is often used by children to communicate an emotional need
  - Therefore, emotional need should become part of the focus
- Using a Tier 1 strategy to address these behavior and emotional needs to reduce the need for more intense interventions for most students
Emphasis on Stability and Compassion

- Reward desired behaviors, including emotional regulation progress and healthy forms of emotional expression

- Punishments should be:
  - Consistent and predictable
  - Mindful of why the student misbehaved the first place
  - Minimize exposure to additional trauma
  - Seek to teach alternative behavior
Tier 1/PBIS Suggestions

- Setting school culture and policies that foster physically and emotionally safe environment
- Provide education to all adults in the building on the impact of trauma on children and how it manifests
- Behavior management strategies that minimizes exclusion, and are clear and consistent across settings in the building
- Provide flexible and multiple avenues for success
- Provide activity and sensory breaks, calming areas, and other stress management opportunities
Thinking about your own school...

- How might you foster a trauma-sensitive environment?
- How might you add or change your existing PBIS model to be more trauma-informed?
Selected Sources


Factors associated with toxic stress include:

- Poverty, family chaos, physical or emotional abuse, chronic neglect, maternal depression, substance abuse, exposure to community or domestic violence.

The essential feature of chronic stress is the absence of any consistent supportive relationships to help the child cope and thereby return the physiological responses to baseline levels.

Research indicates that supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response.
Creating Trauma Informed Schools

Once schools understand the educational impacts of trauma, they can become safe, supportive environments where students make the positive connections with adults and peers they might otherwise push away, calm their emotions so they can focus and behave appropriately, and feel confident enough to advance their learning.

1. The school supports all children to feel safe.
2. The school addresses students needs in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional well-being.
3. The school explicitly connects students to the school community and provides multiple opportunities to practice newly developing skills.

Trauma and Learning Policy Initiative; https://traumasensitiveschools.org/
“Discipline is not something you do to children. It is something you develop within them.” — Becky A. Bailey, Ph.D.

Typically we focus our discipline on:
- Compliance training through public humiliation. Fosters obedience.
- Gain/loss of affection through “please me” discipline. Fosters approval-seeking.
- External manipulation through tangible rewards and punishments. Fosters “win at all cost” mentality, apathy or rebellion.

Conscious Discipline focuses on:
- Self-regulation
- Wise decision-making
- Goal setting and achievement
Framework

Provides adults with the discipline skills needed to transform any problem into a life lesson.

Creates a positive school climate by eliminating rewards and punishments in favor of self-regulation.

Perceptual shift: discipline encounter as opportunity to teach new skills.

Address internal state first, behavior second.
<table>
<thead>
<tr>
<th>Discipline Skill</th>
<th>Life Skill</th>
<th>Key Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>Emotion regulation; Perspective taking</td>
<td>“You seem __.” “Something __ must have happened.” “It’s hard when __ happens.”</td>
</tr>
<tr>
<td>Composure</td>
<td>Anger management; Gratification delay</td>
<td>S.T.A.R. “Breathe with me, you can handle this.”</td>
</tr>
<tr>
<td>Positive Intent</td>
<td>Cooperation; Problem solving</td>
<td>“You wanted __, so you __. You didn’t know what else to do.”</td>
</tr>
<tr>
<td>Assertiveness</td>
<td>Healthy boundaries; Bullying prevention</td>
<td>Tell children what to do. “You may not __. When you want __, say (or do) __.”</td>
</tr>
<tr>
<td>Choices</td>
<td>Impulse control; Goal achievement</td>
<td>“You may __ or __. Which do you choose?”</td>
</tr>
<tr>
<td>Encouragement</td>
<td>Prosocial skills (caring, helpfulness)</td>
<td>“You did it!” “That was helpful!”</td>
</tr>
<tr>
<td>Consequences</td>
<td>Cause and effect; Learn from mistakes</td>
<td>“If you choose __, then you will __.”</td>
</tr>
</tbody>
</table>
Situation 1

Child pushes another child when lining up.

"You wanted more space and didn't know how to get it. You may not push. Pushing hurts. You may stand in your own space with your arms at your sides or you can say, 'Move please, I need more space.'"

Child practices.

Adult provides encouragement.
Situation 2

Child grabs a toy truck away from another child.

“You really wanted to play with the truck and Johnny was playing with it. It’s hard when someone else has something we want. So you grabbed the truck away from Johnny because you didn’t know what else to do. You may not grab toys away from someone else. Next time you want a turn with the truck, tap Johnny gently on the shoulder, look him in the eye, and say, ‘Can I have a turn?’”

Child practices.

Adult provides encouragement.
Self-Regulation

I Feel

I Choose
Classroom Implementation
Behavior Plan

Environment Setting → Triggers → Hurtful Behaviors (Problems) → Motivate and teach new skills

Helpful Behaviors (Solutions) → Notice, encourage and celebrate
Selected Research

Rain & Brehm Consulting Group (Independent study, 2013)
- Compared CD classrooms with non-CD classrooms across 66 teachers, 1386 students and 868 parents
- Teachers using CD reported more positive emotional climates, better social skills behavior among students, and increased academic readiness
- These results were confirmed by parent report and classroom observations

Hoffman, Hutchinson, & Reiss (2009)
- Examined impact of CD training on early childhood teachers
- Teachers completed surveys about their school climate and classroom management methods
- Sig. improvement in the teachers’ perceptions of school climate and in their knowledge and use of new classroom management techniques

Hoffman, Hutchinson, & Reiss (2005)
- Examined impact of CD training on elementary school teachers
- Training focused on changing teachers’ perceptions and responses to conflict
- Children in class of CD-trained teacher showed statistically sig. improvement in behavior when compared to control group

https://consciousdiscipline.com/research/research_papers.asp
Overall Research Results Across Studies

Research shows that Conscious Discipline:

 Giulimproves the social and emotional skills of students and teachers Giulimproves the social and emotional skills of students and teachers
 Giulimproves student academic readiness and achievement
 Giulimproves the quality of student-teacher interactions
 Giulimproves school climate
 Giul decreases aggression in preschool children
 Giul decreases impulsivity and hyperactivity in “difficult” students
 Giul school-wide implementation promotes learning
 Giul district-wide implementation reduces at-risk status (e.g., increased protective factors and decreased levels of behavioral concerns)

(https://consciousdiscipline.com/research/statistical_data.asp)
Attachment, Self-Regulation and Competency (ARC) Treatment Framework

By: Stephanie Borjas, MS
University of Wisconsin-Madison
Outline

- ARC Overview
- Who is ARC for?
- Core Components
  - Flexibility
  - 3 Core Domains
  - 10 Building Blocks
  - Systems Integrations
- Duration
- Implementation
- Training
- Research Base
- Strengths/Challenges of ARC
ARC Overview

- Flexible, clinical, and organizational framework for intervention with youth and families who have been exposed to chronic traumatic stress
- Created by the Trauma Center at the Justice Resource Institute (JRI) (Boston Area)
- First developed in 2004
- Goal to support children, adolescents, caregivers, and systems by empowering and being future-orientated
Video with Founder

https://www.youtube.com/watch?v=eFwNWi9F6tA
Who Is ARC for?

- Children from age 2-21
- Exposure to chronic/complex trauma
- Multi-System Approach
- Individual level
  - Child
  - “Caregiver”- Parents, foster parents, residential group home, teachers, youth program providers
- Systems level
  - System Delivery that supports trauma-informed care
- Not only for children with PTSD, but also behavior disorders, depression, and/or anxiety related to trauma
Core Components

- 3 Core Domains
- 10 “building blocks” (Key Treatment Targets)
- Flexibility
- Systems Consideration
3 Core Domains

Attachment

Self-Regulation

Competency
10 Building Blocks

- Competency
  - Trauma Experience Integration
  - Executive Functioning
  - Self Development and Identity

- Self-Regulation
  - Affect Identification
  - Modulation
  - Affect Expression

- Attachment
  - Caregiver Affect Management
  - Attunement
  - Consistent Response
  - Routines and Rituals
Breaking Down Building Blocks

- Key Concepts
- Therapist Toolbox
  - Treatment considerations, intervention strategies, examples of implementation tools
- Developmental Considerations
- Teach-To-Caregivers
- Beyond the Therapy Room
  - Systems Considerations
- Real-World Therapy
  - Other factors to keep in mind
Flexible

- No manualized/scripted protocol
- Identifies core concepts of intervention that can be adapted across service setting
- Concepts further broken down into skills and targets
- Provide examples of approaches
- Encourages clinician’s creativity and use of their clinical judgment
Systems Considerations

- Addresses needs at the individual, familial, and systems level

- System Levels
  - Building trauma-informed system-wide practices
  - Increase staff capacity to work with children exposed to trauma
  - Psychoeducation, skill development
  - System considerations built into each component
A.R.C.: A Framework For Intervention with Youth Impacted by Complex Trauma

- **ATTACHMENT**
  - Caregiver affect management
  - Attunement
  - Consistent response
  - Routines and Rituals

- **SELF-REGULATION**
  - Affect Identification
  - Modulation
  - Expression

- **COMPETENCY**
  - Primary Components
    - Executive functions
    - Self development

- **TRAUMA EXPERIENCE INTEGRATION**

Kinniburgh & Blaustein (2005); Blaustein & Kinniburgh (2010)
Duration

- Duration can vary depending on modality and system-level being addressed
- Ranges from 12 to over 52 sessions
- Implementation at the system level
  - Workshops
  - Professional Development
  - Long-Term
Implementation

- Can be adapted to be implemented in different settings
  - School
  - Clinic
  - Residential Treatment Centers
  - Shelters
  - Day Programs
  - Domestic Violence Programs
  - Foster Care
  - Juvenile Justice Program
Implementation Cont.

- Can be integrated in various ways
  - Individual therapy
  - Group therapy
  - Family therapy
  - Caregiver education and support
  - Staff training
Training

- 2-Day Mandatory ARC Training
  - Needs Assessment/Strategic Planning
    - Implementation that is tailored to agency
    - Take into account size, population, type of service, background of trainees
  - Clinical and systems implementation
- 1 year continuous training and consultation
- Cost starts at $8000/agency
- Opportunities for advanced training
- Opportunities for workshops in Boston area
Treating Traumatic Stress in Children and Adolescents
How to Foster Resilience through Attachment, Self-Regulation, and Competency

Margaret E. Blaustein, Kristine M. Kinniburgh
Research Base

- Recognized by the National Child Traumatic Stress Network as being evidence-based

- Research has found
  - Reduction in child PTSD symptoms
  - Reduction in child mental health symptoms
  - Increase adaptive skills
  - Increase social skills
  - Reduced distress for caregivers
  - More positive views of child from caregiver
Evidence-Base Continued

- Systems Results
  - Less use of restraint
  - Improved permanency rates in foster care
- Research currently being conducted
  - Randomized Control Trial comparing ARC to a “treatment as usual” control
# Strengths/Challenges of ARC

## Strengths
- Addresses a continuum of trauma exposure
- Is flexible in its implementation
- Addresses individual, familial, and systems needs and strengths
  - Takes into account the ecological framework of a child

## Challenges
- Long-term treatment framework
- Many different facets
- Cost
References

- Trauma Center. http://www.traumacenter.org/
- Video: https://www.youtube.com/watch?v=eFwNWi9F6tA
IT'S LUNCHTIME!
Support For Students Exposed to Trauma (SSET)

Leah Marks & Erin Yosai
Overview

- Support for Students Exposed to Trauma (SSET)
  - school-based group intervention for students who have been exposed to traumatic events and are suffering from symptoms of post-traumatic stress disorder (PTSD).

- Designed specifically for use by teachers and school counselors
  - SSET is a non-clinical adaptation of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Program.
  - SSET teaches many of the same cognitive and behavioral skills as CBITS, such as social problem solving, psychoeducation, and relaxation.
SSET

- delivered in an easy-to-use lesson plan format
  - ideal for educators.
- 10 support group sessions, students who participate in SSET learn a wide variety of skill-building techniques:
  - common reactions to trauma
  - relaxation
  - identify maladaptive thinking and learn ways to challenge those thoughts
  - learn problem solving skills
  - build social support
  - process the traumatic event.
- between sessions, children practice the skills they have learned.
SSET

- **Population**
  - evaluated for use with middle school students ages 10-14
  - will likely work well with students in late elementary through early high school.
  - Students who have experienced/witnessed community, family, or school violence, or who have been involved in natural disasters, accidents, physical abuse, or neglect.
  - developed and tested in middle schools serving diverse, multicultural, and multilingual students
    - predominantly Latino, African American, Caucasian, and Asian.
    - designed to be used in schools with children from a variety of ethnic and socioeconomic backgrounds and acculturation levels.
Implementing SSET Throughout School Systems

- Emphasized for Tier 1 or Tier 2
- Screening Tools provided!
  - (Tier 1)
  - General class periods
- Tier 2 – Students identified at risk or who have been exposed to trauma
- Tier 3 – In tandem with individual treatment
Limitations?

- Not all students are permitted by parents to participate in screening or intervention in schools.
  
- Some students missed

- Some students will need additional treatment above and beyond this early intervention group treatment

- SSET implementers need to work with a clinician to make appropriate referrals after or in parallel to SSET.
Trauma-Focused Coping in Schools (TFC)

Also known as Multimodality Trauma Treatment (MMTT)
Created by: Dr. John March and Dr. Lisa Amaya-Jackson
Duke University
Dr. Edna B. Foa University of Pennsylvania

Presented By: Caicina Jones M.A. and Geovanna Rodriguez M.A.
Commonly Used Trauma Treatments

- Variations of CBT-like treatments used to treat PTSD
- School-based CBT programs most successful in reducing trauma symptoms (Rolfsnes & Idsoe, 2011)
  - CBT programs yielded medium to large effect size
- **Trauma Focused-CBT**
  - For use with children and adolescents (ages 3-18)
  - **PRACTICE** framework (psychoeducation, relaxation skills, affective expression, cognitive coping, trauma narration, in vivo exposure, conjoint therapy, and enhance safety)
- **Multimodal Trauma Treatment (MMTT)**
  - Developmental approach
  - Psychoeducation, narrative, exposure to memories, relaxation skills, and cognitive restructuring
What is TFC?

• Skills-oriented CBT treatment
• School-based peer-mediation group intervention

Target Population
• School-age (6-18 year olds)
• Anxiety and disruptive behavior concerns
• Single incident trauma and posttraumatic stress disorder (PTSD)

Goals
• Decrease symptom presentation of PTSD, depression, and anxiety
• Anger management
• Improve sense of internal locus of control
Structure and Materials

- Individual assessment sessions
- 14 group sessions w/ one individual pull-out session midway
- 6-8 members per group
- Materials needed
  - Manuals (include a fidelity checklist)
  - Trained Personnel
  - Dry Erase Boards
  - Flip Charts
  - Homework=skills practice
Key Components

• **Session 1**: Psychoeducation
• **Session 2**: Anxiety Management
• **Session 3**: Anxiety Management and Cognitive Training (Thinking, Feeling, Doing, and Stress Thermometer)
• **Session 4**: Cognitive Training (Traumatic Reminders)
• **Session 5a**: Anger Coping
• **Session 5b**: Grief Management
• **Session 6**: Individual Pull-out Session (Narrative Exposure)
Key Components Cont’d

- **Session 7**: Setting up the Stimulus Hierarchy (group)
- **Session 8**: Group Narrative Exposure
- **Session 9**: Group Narrative Exposure (Cognitive and Affective Processing)
- **Session 10**: Group Narrative Exposure (Worst Moment)
- **Session 11**: Worst Moment Cognitive and Affective Processing
- **Session 12-13**: Relapse Prevention and Generalization
- **Session 14**: Graduation Ceremony
Session Breakdown

- Individual structured clinical interviews
- Duration: 50-60 minute group sessions
- General structure:
  - Homework check and review
  - Present goals for current session
  - Session activities
  - Help group choose the next homework, review strategies
  - End with social reward
Outcomes: Suggested Assessment Measures

- Screening Tool: Child and Adolescent Trauma Survey CATS (March & Amaya-Jackson, 1997)
- PTSD scale: Clinician-Administered PTSD Scale-CAPS-C
- Depression Scale: Children’s Depression Inventory-CDI (Kovacs, 1985)
- Anxiety Scale: Multidimensional Anxiety Scale for Children- MASC (March et al., 1997)
- Violence Exposure measure also recommended
Research Outcomes

  - Significant decreases in anxiety, stress, and trauma
  - 8 of 14 no longer met criteria for PTSD → 12 of 14 at 6 month follow-up

- Additional studies using a shortened (14 session), developmentally enhanced protocol in two elementary schools, one high school, and a community based clinic revealed similar (published) findings.
  - Amaya-Jackson, Reynolds, Murray, McCarthy, Nelson, Cherney, et al., 2003
  - March, Amaya-Jackson, Murray & Schulte, 1998
  - Berthiaume & et Turgeon, 2004
Cultural Considerations

- Not tailored toward a specific group
- Used in multiple states (e.g., CT, LA, ME, NC) and countries (e.g., Australia, France, India)
- Manual has been translated to French and Spanish
- Specific cultural adaptations are not included, but reportedly easy to adapt and modify
- CBT has demonstrated robust results across various racial/ethnic groups
Considerations for Implementation

- School climate and response to trauma
  - Parent and school administrator buy-in
- Time, feasibility, access to curriculum
- Staff with appropriate training and background as well as commitment to facilitate (e.g., school’s crisis team)
- Space for individual and group sessions
- Limitation→ commonly used to treat single-incident traumatic experiences
Evaluation

- SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP) - Scale of 1-4 rating
  - Readiness for Dissemination rating (3.7)
  - Implementation Material (3.8)
  - Training and Support Resources (4.0)
  - Quality Assurance Procedures (3.4)

- California Evidence-Based Clearinghouse for Child Welfare
  - Scientific Rating (1-5) = (3) Promising Research

- Clearinghouse for Military Family Readiness
  - Unclear
Recognition

- Awards
  - 1996 American Academy of Child & Adolescent Psychiatry Norbert and Charlotte Reiger Excellence in Service Award
  - 1998 American Academy of Child & Adolescent Psychiatry Scientific Achievement

- TFC has been used as a model and prototype for several other empirically supported school and clinical setting trauma-focused cognitive-behavioral treatments, such as
  - “Cognitive-Behavioral Treatment in Schools” (Jaycox, 2004)
  - “Preschool PTSD Treatment” (Scheeringa, Amaya-Jackson & Cohen, 2002).
Cost and Resources

- Two required treatment manuals
  - How to Implement Trauma Focused Coping: A Trauma Focused Cognitive Behavior Treatment for Youth (manual)
  - Trauma Focused Coping Manual: Treatment of Pediatric Post Traumatic Stress Disorder After Single-Incident Trauma
  - Free by contacting Dr. Amaya-Jackson
    amaya001@mc.duke.edu

- Optional Training Opportunities
  - 2-day on- or off-site training $2400 per training plus travel expenses if necessary
  - 2-day on- or off-site advanced training $2400 per training plus travel expenses if necessary
  - Consultation (by phone) $150 per call
Selected References


http://www.cebc4cw.org/program/trauma-focused-coping/detailed
http://mha.ohio.gov/Portals/0/assets/Initiatives/TIC/SAMHSAEvidenceBasedProgramsandPractices/Trauma%20Focused%20Coping.pdf
http://www.militaryfamilies.psu.edu/programs/trauma-focused-coping-tfc
Trauma-Focused Cognitive Behavioral Therapy

Developed by Drs. Judy Cohen, Esther Deblinger, and Anthony Mannarino

Presented by: Paula Smith and Mia Bonitto
Trauma-Focused Cognitive Behavior Therapy

- **Purpose:** Short-term, evidence-based trauma treatment for children and their families
- **Accessibility:** FREE web-based training
- **Structure**
  - **Client:** Experienced or witnessed a traumatic event and is experiencing related internalizing symptoms, characterized as full or partial PTSD and/or misconceptions about the traumatic event
    - Suitable for children of ages 3-18
    - Involvement of nonoffending parent is highly encouraged, but not required
  - **Treatment logistics:** 12-20 sessions individually with the child, the parent, and joint sessions
TF-CBT Content and Sequence

Psychoeducation

Parenting Skills

Relaxation Skills

Affective Modulation

Cognitive Coping

Trauma Narrative and Cognitive Processing

In Vivo Mastery of Trauma Reminders

Conjoint Child/Parent Sessions

Enhancing Safety and Future Developmental Trajectory
Techniques

- Psychoeducation: Normalization, modeling of nonavoidance, setting expectations
- Parenting skills: Identification and impact of parental distress, positive parenting practices
- Relaxation skills: Skills reverse physiological dysregulation and distract from traumatic reminders
- Affective modulation: Encourage expression of feeling and self-regulation of emotion
- Cognitive coping: Examine connection of thoughts, feelings, and behaviors; identify patterns of negative thinking and methods to modify
Techniques

- Trauma narrative and cognitive processing: Employ nonavoidance and corrects inaccurate and unhelpful cognitions
- In vivo mastery of trauma reminders: Utilize in vivo desensitization to correct maladaptive emotional responses, increase tolerance of fears and identify trauma cues
- Conjoint sessions: Transfer agency of change from therapist to parent, safety planning is completed
- Enhancing safety: Practice body safety skills
- Gradual exposure: Range from references of traumatic event to in vivo trauma reminders
TF-CBT in a School Setting

Benefits, challenges, and additional considerations
Benefits of School Implementation

- Many components of TF-CBT are commonly done in schools and can easily be a part of the school psychologist’s practice
  - Psychoeducation
  - Relaxation
  - Affect Modulation
  - Cognitive Coping

- School psychologists commonly work closely with teachers to implement behavioral modification plans or positive coping reinforcement plans, which can be a part of TF-CBT

(Fitzgerald & Cohen, 2012)
Challenges for School Implementation

- Inconsistent Caregiver Participation
  - Minimal caregiver involvement is better than none
  - Consider preparing the parent for conjoint sharing over the phone
  - Incorporate periodic in-home visits

- Disruption of services and scheduling problems due to truancy, school transfers, school holidays, testing periods, etc.
  - Be creative with scheduling sessions
  - Ideally, work with the whole school team to build a trauma informed staff that places value on care for mental health so that there will be understanding and flexibility with rescheduling sessions

(Fitzgerald & Cohen, 2012)
Challenges for School Implementation

- Development of a trauma narrative is very emotional, difficult for school setting
  - Ideally, therapy sessions should be conducted at end of day to prevent difficulty transitioning back into academic rigor
  - If they must transition back to class, ensure there is a buffer time where the demands of the classroom are as limited as possible
  - End the session with a positive, calm activity to ease transition
  - Develop a plan with the teacher and the child to cope with increased distress immediately following a session
  - Consider checking in with the child and teacher later in the day, after the session to assess functioning and any concerns or difficulties with reintegration

(Fitzgerald & Cohen, 2012)
Additional Considerations for School Implementation

- The skills taught in the parenting component also largely apply to the educators
  - School staff balance many roles and demands in the classroom environment, which sometimes makes it difficult to provide direct support to an individual child
  - Like parents, teachers will have concerns and fears about trauma therapy. Therefore, it is important to explain the treatment process, enlist the teacher’s buy-in, and maintain an ongoing supportive relationship with the teacher
  - Like parents, teachers benefit from learning about child trauma, its effect, and the symptoms with which the child is struggling

(Fitzgerald & Cohen, 2012)
TF-CBT In Practice
A look into clinical adaptations
Adaptations: Cycle of Victimization

- Setting: Community Agency – Child Advocacy Center
- Client: “Michael,” 11 y.o., African American male
  - Presenting problem: Sexual abuse victim (of 14 y.o. male neighbor) and subsequent perpetrator (to 5 y.o. male cousin)

- Adaptation to Techniques
  - Psychoeducation: Adjusted to include cycle of victimization
  - Trauma narrative: Projective activity with 3 dinosaur characters engaging in a cycle of victimization, characters were adjusted to broaden scenarios
    - Attention to trauma experienced as a victim and trauma related to outcry when perpetrator
  - Safety rules: Adapted and enhanced differentiation of safe and unsafe behaviors
Adaptations: Group Format

- Setting: Community Agency – Child Advocacy Center
- Client: Group of four, 8th grade females, 2 African American, 2 Hispanic (1 undocumented)
  - 2 sisters – both victims of physical abuse, 2 other unrelated females – both older sisters of sexual abuse victims

Adaptations to Techniques
- Processing switched from coping with abuse to “failing” as a protector
- Creation of a shared projected narrative

Benefits of Group Format
- Excellent opportunities for skill practice
- Diverse experiences and perspectives

Hindrances of Group Format
- Confidentiality
- No parent involvement
Evaluation of TF-CBT

Strengths
- Strong scientific evidence of positive effects for children and parents
- Treatment training is free and continuously available
- Detailed online training, including sample scripts
- Plethora of related handouts/workbooks available online
- Flexible adaptation is encouraged

Limitations
- Treatment is often lengthy
- No suggested assessments for monitoring progress
- Less ideal for use in school setting given nature of activities
- Prefers involvement of parent

Cohen et al. (2004)
Deblinger et al. (1996, 2001)
Questions? Interested?

Web-based training on TF-CBT: https://tfcbt.musc.edu
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Kristy Warmbold-Brann & Emily Morrow
ISPIC Showcase 2017
CBITS Discussion

Experiences with CBITS?

What would you like to learn?
Overview

- **What is CBITS?**
  - Skills-based, group intervention
  - Relieves symptoms of PTSD, depression, anxiety among children exposed to trauma

- **Who should facilitate CBITS groups?**
  - Social workers, psychologists, school counselors
  - Individuals with training in CBT with trauma survivors

- **Target Population**
  - Children in 6th-9th grade (ages 10-15)
  - Experienced significant trauma

- **Intensity**
  - 1 hour session per week for 10 weeks
  - 1 to 3 individual sessions
  - 1 teacher and 2 parent education sessions
Why CBITS?

- **Goals of CBITS:**
  - **Symptom Reduction**
    - PTSD, anxiety, depression, low self-esteem, behavior problems, aggressive and impulsive behavior
  - **Build Resilience**
    - Build on strengths
  - **Peer and Parent Support**
    - Meet other trauma survivors
    - Increase parental understanding of responses to trauma
Preplanning Steps

1. Visit website
   - View and order materials (manual approx. $45)

2. Complete Readiness to Adopt Questionnaire

3. Complete training

4. Review online documents and FAQs

5. Plan screening and create school documents

6. Implement screening and follow-up with identified students
Pretraining Activities

This page provides resources for preparing to deliver CBITS groups, including a readiness assessment, frequently asked questions about getting started, and educational materials to help you gain support from school personnel, families, and communities.

Preparing for Implementation

- Readiness to adopt questionnaire
- Implementation prep at a glance
- Implementation guidelines: Getting started
- Implementation guidelines: Session overview
- Sample CBITS schedule
- Frequently asked questions

Educational Materials

- Child trauma basic facts
- Listen. Protect. Connect booklet
- NCTSN Child Trauma Toolkit for Educators
- Managing Threats: Safety Lessons Learned from School Shootings
- Violent Aftershocks: Children are Particularly Vulnerable to Post-Traumatic Stress Disorder
- Trauma Awareness for Schools slides
- Trauma Awareness for Schools (non-disaster) slides
Training

- Free online training with certification!
- Minimally Accepted:
  - Combined virtual/manual, and live training
  - Should have experience with cognitive-based trauma interventions
- Most Comprehensive/Highest Recommendation:
  - Face-to-face, virtual, manual, and telephone
CBITS Provider Basic Training

Courses

CBITS Provider Basic Training Course, Part 1
Part 1 of the online training course for Cognitive Behavioral Intervention for Trauma in Schools. The CBITS manual for the entire course is available for purchase from Sopris Voyager. Call customer service at 1800-547-6747, x295. Ask for the Cognitive Behavioral Intervention for Trauma in Schools, Item #62674, and be prepared to provide credit card information over the phone. (Web purchasing is not currently available.)
Presenters: Audra Langley PhD, Marleen Wong PhD, Sheryl Kataoka MD, MSHS, Joshua Kaufman LCSW, Ailieith Tom MSW, Lisa Jaycox PhD

CBITS Provider Training Course, Part 2
Part 2 of the online training course for Cognitive Behavioral Intervention for Trauma in Schools. The CBITS manual for the entire course is available for purchase from Sopris Voyager. Call customer service at 1800-547-6747, x295. Ask for the Cognitive Behavioral Intervention for Trauma in Schools, Item #62674, and be prepared to provide credit card information over the phone. (Web purchasing is not currently available.)
Presenters: Lisa Jaycox PhD, Sheryl Kataoka MD, MSHS, Joshua Kaufman LCSW, Audra Langley PhD, Ailieith Tom MSW, Marleen Wong PhD
Ongoing Support

- Consultation
- Booster training sessions for certified implementers
- Online community
Implementation
Screening and Intervention Timeline

- **Screening**
  - Group not needed
  - Group not appropriate, Refer out
- **Clinical interview**
- **Pre-Group Assessment**
- **CBITS Group (10 weeks)**
- **Self-Assessments**
- **Post-Group Assessment**

*(Kibler, Taylor, & Poland, 2014)*
Screener and Follow-Up

**Screening Measures**
- Trauma Exposure Checklist and PTSD Screener
- Child PTSD Symptom Scale (Foa et al., 2001)
- Eligible Students:
  - One or more lifetime exposures to trauma
  - AND PTSD symptoms in the clinical range related to trauma

**Outcome Measures**
- Child PTSD Symptom Scale (Foa et al., 2001)
- Children’s Depression Inventory--2nd Edition (Kovacs, 2004)
- Pediatric Symptoms Checklist
Introduce why you are meeting and review confidentiality information and mandatory reporting.

Using screener, review trauma or violence exposure endorsed. If necessary, ask questions about what the child meant when he/she endorsed a particular traumatic or violent event. When asking the child about their responses, try to identify a specific trauma they would be willing to work on in the support group. If there are several traumas, try to ascertain which one is currently the most difficult/bothersome. Some kids may be apprehensive to disclose a specific trauma right away, but try to have identified at least one event they might be able to use for exercises in the group.

Note here the event the student wants to work on:

Using screener, review symptoms endorsed. Normalize that given what they have experienced, it is normal that they are also experiencing... (fill in their symptoms as you review)

- If there was significant trauma above,
  - And child continues to endorse symptoms, then describe the group and explain that he/she will learn skills to help him/her cope better with what happened and will also be asked to share about the trauma(s) identified above.
  - And child no longer endorses symptoms, consider excluding the child from the group.
- If there was no significant trauma above,
  - And child continues to endorse symptoms, try to figure out where the symptoms are coming from, and whether a trauma-focused group would be appropriate. Consider excluding the child from the group and referring them for other services.
  - And child no longer endorses symptoms, consider excluding child from the group.

Ask child if there are any issues with other classmates that might make it hard to be in a support group, in order to gather information about possible bullying. If the student acknowledges problems, discuss the nature of those problems and ask for specific names so that you do not inadvertently convene a group that includes students who have bullied your interviewee.
Note specific issues

- Take notes on the interview. This can aid in developing support group goals later.

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<tr>
<th>Eligible for program?</th>
<th>YES</th>
<th>NO</th>
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<tr>
<td>If no, note why not, and discuss with supervisor before making a final decision.</td>
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<tr>
<th>Assents to program?</th>
<th>YES</th>
<th>NO</th>
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Essential CBT Components

- Psychoeducation About Reactions to Trauma
  - Normalize trauma reactions
  - Explain CBT model

- Relaxation Training
  - Controlled breathing
  - Progressive muscle relaxation

- Cognitive Therapy
  - Cognitive distortions
  - Cognitive restructuring

- Real Life Exposure
  - Gradual exposure to feared situations related to trauma

- Stress or Trauma Exposure
  - Gradual exposure to stress or trauma memory

- Social-Problem Solving
  - Practice responding to difficult social situations
Lessons

- **Session 1**
  - Ice breaker game
  - Intro to group and rationale
  - Group management
  - Brief statement about trauma
  - Homework: Goal worksheet

- **Session 2**
  - Psychoeducation about trauma
  - Relaxation training practiced at home/school
  - Parent handout

- **Session 3**
  - Feeling thermometer review
  - Introduce cognitive model
  - Hot seat: Practice thought-challenging in session and at home

- **Session 4**
  - Continue practicing cognitive restructuring skills
  - Hot seat: Practice thought-challenging in session and at home

- **Session 5**
  - Discuss avoidance and non-avoidance coping strategies
  - Construct fear hierarchy
  - Homework: 1st real-life exposure
The Feeling Thermometer

Very anxious

8 – Walking home from school alone

3 – Going out on playground at recess

Not anxious at all
Lessons

- **Session 6 & 7**
  - Imaginary exposure by writing/drawing, sharing with group
  - Discuss feelings about exposure
  - Homework: Imaginary and real-life exposures

- **Session 8**
  - Review cognitive model, emphasizing action
  - Practice brainstorming solutions to problems
  - Practice choosing solutions to try
  - Homework: Practice solving problems

- **Session 9**
  - Continue practicing problem-solving
  - Hot seat: Thought-challenging and problem-solving

- **Session 10**
  - Review progress, predict challenges and problem-solve around them
  - Celebrate participants’ achievements!
  - Phone call with parent
Generalization: Parent and Teacher

Parent Sessions
Psychoeducation
Normalize trauma reactions
Explain CBITS
How to support child
Gauge emotions
Promote relaxation and cognitive restructuring
Support exposures
Help with problem solving

Teacher Education Session
Psychoeducation
Same as parent psychoeducation
How to support students
Use a “trauma lens”
Provide choices
Remain calm
Watch for triggers
Self-care
Implementation Demonstration
CBITS Evidence

Studies found that CBITS:
- Reduced trauma (PTSD) symptoms (Stein et al., 2003)
- Reduced depression symptoms (Kataoka et al., 2003)
- Reduced psychosocial dysfunction (Stein et al., 2003)

Recommended Practice:
- U.S. Dept of Justice (OJJDP)
  - Exemplary Program
- Promising Practices Network
  - Proven Program
- White House’s Helping America’s Youth
  - Highest Quality Evidence
- CDC Prevention Research Center
  - Effective Program
- SAMHSA’s National Registry
  - 3.8/4.0 Dissemination Rating
- National Child Traumatic Stress Network
- Blueprints Promising Program

Sumi & Woodbridge, 2016
Strengths and Challenges

**Strengths**
- Flexible, manualized intervention
- Easily adapted for different populations
- Specifically designed for use in schools
- Only trauma intervention found to be effective in RCT for multiply traumatized youth

**Challenges**
- Not yet adapted for early elementary students or for older adolescents/young adults
- Need whole school participation
- Can be difficult for small and rural schools
Interested?

Visit website: https://cbitsprogram.org/

Make an account

Order Manual

- Call Sopris Voyager customer service at 1800-547-6747 x295
- Ask for Cognitive Behavioral Intervention for Trauma in Schools Item #62674

"This experience was very rewarding because I know with great certainty that we made a difference in these kids' lives. We heard this straight from them as well as from their parents."
Parent-Child Interaction Therapy

Presentation by:
Victoria Doobay, M.A.
Shaun Wilkinson, Ed.S.
What is PCIT?

- 14 to 20-week manualized intervention
- Targeted towards children age 2 to 7 years old with disruptive behaviours
- Two phases:
  - Enhancing parent-child relationship (CDI, 7-10 sessions)
  - Improving child compliance (PDI, 7-10 sessions)
Theoretical Basis

- Operant Conditioning
  - Social reinforcement to modify parent-child interactions
- Attachment Theory
  - Importance of parental warmth and responsiveness
Treatment Sessions

- 1-hour of didactic training on specific communication and behaviour management skills
- Live coaching of parents in treatment sessions with their children
- Homework: practice skills at home for 5 minutes every day
Child-Directed Interaction (CDI)

- Parent’s coached to follow children’s lead during play activities and praise appropriate behaviors

- PRIDE skills:
  - Praise
  - Reflection
  - Imitation
  - Description
  - Enjoyment
Parent-Directed Interaction (PDI)

- Parents coached to give only essential, clear commands
- Continue to use PRAISE skills when appropriate
- Parents coached on strategies for dealing with noncompliance
  - Time-out
  - Removal of privileges
Therapist-Parent Interactions

- As parents gain skills, therapists do less coaching and more praising of parents’ use of PCIT skills.
- Therapists may also challenge parents’ cognitions about their children’s problem behaviors.
Empirical Evidence

- Not uncommon for maltreated children to have trauma symptoms AND problems with disruptive behaviour

  - Generalized to home, school, untreated siblings
  - Cultural and language groups

  - Parent/child dyads, children exposed to domestic violence, children with foster parents
PCIT: Why it works

- Management of Disruptive Behaviour
PCIT: Why it works

- Improved Child Relationship Security and Stability with Primary Caregiver
PCIT: Why it works

- Parents as Therapists: Supporting Parent-Child Communication
PCIT: Why it works

- Management of the Traumatized Child’s Affect
PCIT: Why it works

- Decreasing Child Behavioral Problems may Increase Parent Competence
References


References Continued


Real Life Heroes

Jared Bishop, MEd, MA
Purpose

To help children develop self-esteem and overcome difficult experiences and traumas in their lives.
Theory Behind Real Life Heroes

- Based on the ‘Essential Elements of Trauma-Informed Child Welfare’ (NCTSN, 2008)
  - Safety (Psychological, physical, & emotional) for the student and their family.
  - Strengths and relationship focused
  - Self-regulation development
  - Trauma-memory re-integration

- Incorporates elements of Trauma-Focused CBT, Eye-Movement Desensitization and Reprocessing (EMDR), Progressive Counting, and Attachment Therapy.
The Heroes Challenge

- Heroes use the tough times in their lives to grow stronger.
- Emotions and feelings are natural. Use them to grow smarter.
- Relationships matter. Heroes work together to make things better.
- Open up your options. Use the power of your brain to find new ways to solve problems with help from other people.
- Experiment. Find the courage to check out and test out new solutions to old problems.
- Stronger and stronger. Discover your skills and make them even stronger.
The Basics

- **What is it?**
  - Centered around the Real Life Heroes Life Storybook
  - Built around the metaphor of heroes.

- **Who will benefit?**
  - Designed for children ages 6 to 12 and adolescents (13-19 years old) with delays in social, emotional, or cognitive functioning.
  - Children who have experienced some kind of trauma.

- **Cost**
  - Real Life Heroes Storybook (3rd Edition): $29.95
  - Real Life Heroes Toolkit (2nd Edition): $57.15

- **Training is available**
  - $5,000-$6,000 for two-day workshop (includes Storybook and Toolkit, plus monthly follow-up consultation groups)
Intervention Format

- Developed for use in outpatient therapy sessions
  - A 60-90 minute session once a week for 6-18 months, depending on number and severity of trauma.
  - Designed for one child and their caregiver(s) (if available)
- Easily adapted for short term, group interventions in school settings.
  - Depending on the needs and goals of the student.
Real Life Heroes Toolkit

Includes:

- Additional activities to reinforce RLH storybook concepts.
- Guidance on adapting the session for older or younger children.
- Tips on integrating family and cultural heritage into sessions.
- Troubleshooting guidelines for a variety of issues that may arise in sessions.
- Checklists for treatment fidelity.
The Curriculum

Creating a Future

Developing a Life Story of Overcoming

Moving through the Tough Times

Coping and Survival Skills

Strengthening Supportive Relationships

Rebuilding Security and Co-Regulation

Developing Self-Regulation and Safety Skills

Learning to Recognize, Express, and Modulate Feelings
Measuring Student Progress

My Thermometers

- Knots (Stress)
- Self-control
- Mad
- Sad
- Glad
- Feel Safe

10 HIGH

1 LOW
Rebuilding Attachments with Traumatized Children by Richard Kagan
References


Trauma and Grief Component Therapy for Adolescents (TGCT-A)

Presented by Ray Geosling
About TGCT-A

- Manualized and modularized treatment for trauma-exposed adolescents and young adults

- Intended population
  - 12-20 year old males and females
  - Youth exposed to interpersonal violence and traumatic loss (primary) and disasters, injuries, and illness (secondary)
  - Has been implemented in the United States and internationally

- Sessions
  - 10 to 24
  - About 50 minutes per session
  - Group or individual
  - Can be implemented in various treatment settings

- CBT approach
Module Overview

- Pre-Group Assessment
- Module I-Psychoeducation and skill building
- Module II-Trauma Narrative
- Module III-Grief
- Module IV-Planning for the future
Pre-Group Assessment

- Gather baseline data
  - Demographics
  - Childhood Trust Events Survey
  - UCLA PTSD Reaction Index for Children and Adolescents
  - Adolescent Dysregulation Inventory
  - Short Mood and Feelings Questionnaire
  - Adolescent Dissociative Experience Scale (optional)
- Self-Reported Delinquency Scale (optional)
- Peer Conflict Scale (optional)
Module I

- Eight sessions
  - Build group cohesion
  - Individuals develop goals for the group
  - Psychoeducation
    - Posttraumatic reactions
    - Grief reactions
    - Trauma and loss reminders
  - Develop effective coping strategies
  - Emotion regulation
  - Negative thinking/Hurtful thoughts
  - Recruiting social support
# Trauma Goal Worksheet

**By the end of this intervention:**

### I want to feel LESS: *(please circle all that apply)*

<table>
<thead>
<tr>
<th>Nervous</th>
<th>Scared</th>
<th>Angry</th>
<th>Upset</th>
<th>Sad</th>
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### I want to feel MORE: *(please circle all that apply)*

<table>
<thead>
<tr>
<th>Happy</th>
<th>Calm</th>
<th>Excited</th>
<th>Relaxed</th>
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### I want to change the way I do things and think about things: *(please check ✓ all that apply)*

- Calm myself down when I feel upset.
- Think about things that happened without feeling upset.
- Talk about things that happened without feeling upset.
- Stop avoiding things that made me nervous.
- Do more of the things that I used to do.
- Think more about things before I do them.
- Make better decisions.
- Have fewer problems with my family.
- Have fewer problems with my friends.

### I also want to change:

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Module II

- Number of sessions depends on group size
  - Teach participates how to create trauma narrative
    - What happened? What thoughts did you have? What did you feel?
  - Participants share their narrative
  - After everyone has shared, process through common themes, hurtful thoughts, thinking errors, and learning points
Module III

- Six sessions
  - Focus is on grief in loss
  - Loss reminders
  - Adaptive and maladaptive grief reactions
    - Separation Distress
    - Existential/Identity Crisis
    - Distress related to circumstances
  - Normalization of feelings
  - Plan for difficult days in the future
Module IV

- Two sessions
  - Additional skill training
  - Preparing for the future and future stressors
  - Relapse prevention
  - Celebration of growth
Goenjian et al. (1997)

- Participants: Adolescents exposed to earthquake in Armenia in 1988
- One group received TGCT-A while another did not receive psychotherapy
- Alleviation of posttraumatic stress symptoms and fewer depressive symptoms in experimental group
  - Benefits seen 18 months later
- Control group had worsening posttraumatic stress and depressive symptoms
Selected Research Support

- Layne et al. (2001)
  - Participants: War traumatized adolescents in Bosnia and Hercegovina
  - Pre-test, post-test
  - Reduction in posttraumatic stress, depression, and grief symptoms.
Training and Cost

Contact William Saltzman for information regarding trainings and cost

wsaltzman@sbcglobal.net


Integrative Treatment of Complex Trauma for Adolescents

Alyzae Karim
Background Information

- Evidence-based
  - Standardized protocol
  - Multimodel interventions:
    - Affect regulation training
    - Relational/attachment-oriented
    - Mindfulness skills development
    - Cognitive therapy
    - Family and group therapy
    - Exposure therapy
    - Trigger management
- Applied in various settings
- Addresses cultural differences through sensitivity and responsiveness
  - Social marginalization
  - Poverty
Population

- Age: 12-21 years
- Cultural/Racial groups:
  - Hispanic-Americans
  - African-Americans
  - Caucasian Americans
  - Asian Americans
- Other characteristics:
  - Homeless youth
  - Adolescents in juvenile justice system
  - Patients in residential treatment
  - Particularly adapted for economically disadvantaged
  - Unaccompanied minors from Mexico and Central America
- Region: Rural and urban
- Also tailored for Spanish-speakers
Core Components

- Approximately 16-36 sessions
  - Emphasis on safety, posttraumatic stress, depression, and anxiety
  - Complex trauma
    - Attachment disturbance
    - Identity-related issues
    - Behavioral and affect dysregulation
    - Interpersonal difficulties
    - Chronic negative relational schema
    - *Substance abuse

- Type of trauma experienced
  - Primary: Complex trauma, physical abuse, sexual abuse, emotional abuse and neglect, community violence, domestic violence, medical trauma, traumatic loss
  - Secondary: Parental substance abuse
Core Components

- Therapeutic relationship
- Interview and/or standardized trauma specific measures given every 2-3 months
  - *Trauma Symptom Checklist for Children
  - Children’s Depression Inventory
  - CBCL
- Developmental approach to interventions
Interventions

- Processing traumatic memories - John Briere, Ph.D.
- Psychoeducation
- Distress reduction
  - Grounding
  - Relaxation
  - Mindfulness & meditation
- Affect regulation skills
  - Identifying & discriminating emotions
  - Identifying and countering thoughts that underlie negative emotional states
  - Resistance to tension reduction behaviors
  - Affect regulation and tolerance
Interventions

- Cognitive processing
- Titrated exposure/Relational processing
  - Exposure
  - Activation
  - Disparity
  - Counter-conditioning
  - Desensitization and resolution
- Trigger identification and intervention (worksheet)
Resources/References

USC Adolescent Trauma Training Center

- Contact info: Cheryl Lanktree, Ph.D., John Briere, Ph.D., Karianne Chen, M.S., MFT
  - Phone number: (310) 370-9208
  - Email: attc@usc.edu Website: attc.usc.edu
- Free training, manual, worksheets (available in Spanish):
  
  http://keck.usc.edu/adolescent-trauma-training-center/about-itct-a


http://www.nctsn.org/sites/default/files/assets/pdfs/ITCT_general.pdf
Thank you!

For Attending our Presentation