Beyond Foreshortened Future: TF-CBT and High Risk Behaviors

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Overview

- At the end of this presentation participants will have learned
  - General strategies for addressing high risk behaviors in the TF-CBT model
  - How Complex Trauma concepts help you to address these behaviors
  - Nuts and bolts applications for caregivers and children who present with high risk behaviors

Gotta start somewhere

- Casey Kasem's top 5 high risk behaviors
  1. Suicidality
  2. ANY self injurious behaviors
  3. Sexually acting out
  4. Drug use
  5. Kid went inpatient (usually for any or all of the above)

What we're talking about is Complex Trauma right?

- Complex Trauma (Ask Dr. Risch ☺)

- Key points
  - Model shifts slightly: "Enhancing Safety" comes to the front
  - Always remember: SAFETY IS IMBUED THROUGHOUT THE MODEL
  - This is not only for Complex Trauma but for ANY TF-CBT case

Keys to Complex Trauma Tx. Success

- Therapeutic relationship even MORE essential than ever
- Relationships / closeness can be a trauma reminder
- Essential: develop/ monitor trust with client and caregiver
- May provide "gradual exposure" on relationships
- Understand chaos may have been, still be, ubiquitous
- Gradual exposure still occurs in each component
- Important to assure, promote, and safeguard
  - Safety
  - Trust
  - Power/Control
  - Esteem
  - Intimacy

} THE CPT BIG 5

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Safety is IMBUED throughout the model

E N H A N C I N G S A F E T Y

Phase I: Coping Skills (Stablization and getting the kid/family "Stably Unstable")

E: Enhancing Safety

P: Psycho-education

P: Parenting Skills

R: Relaxation Skills

A: Affect Modulation Skills

C: Cognitive Coping Skills

Phase II: Trauma Narration and Processing

Phase III: Consolidation and Closure

E: ENHANCING SAFETY

Safety Strategies

- Assess & build on the client and caregiver safety skills
- Develop a specific safety plan (phys/emotion, OYC ex.)
- Empower client they can make positive choices, get support
- Identify and process external resources (look hard!)
- Help ID trustworthy adults (esp. authority figures)
- Coach helpers with specific behavioral responses to help client feel safe and secure that meet client's needs
- Engage broader supports e.g. after school, spiritual, community groups, other safe activities
- More resource supports reduces burn-out of any one -increases possible successes

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Enhancing Safety – Nuts and Bolts

- That safety plan is your FIRST session
- Sometimes your 2nd and 3rd
- And it gets reviewed periodically
- You have a tornado safety plan, right?
- Your caregivers and child should be at least as fluid with the safety plan as they are with their tornado safety plan in May

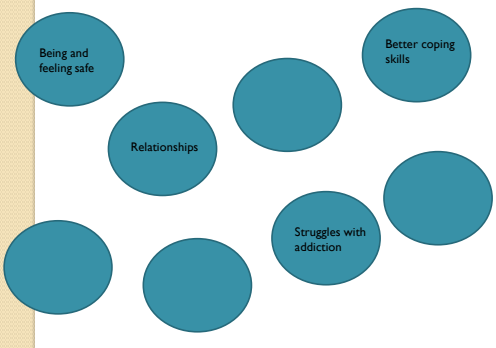
REMEMBER YOU ARE GRADING ON A CURVE!!!

Enhancing Safety – Nuts and Bolts

- Safety Check at EVERY session
  - Ex: Cut Check
  - Session starts at 4:00pm, at 4:02pm, "So how many times did you cut this week and where did you cut?"
  - Same for substances: "How much alcohol did you use this week?"
  - Remember you're grading on a curve for this
  - Suicidality, if one of the presenting problems, gets checked at each session

Enhancing Safety – COWs

- VERY easy to get derailed with this
- 1st Step: Always see if a PRAC component can help with the COW
  - "I'm glad you brought up that fight with your best friend Mary. What were you thinking when she said that?" [Cog Coping]
- For kids (or parents) who do this repeatedly
  - Consider incorporating "Agenda Mapping" into your session



P: PSYCHOEDUCATION

Psychoeducation

- Yes, do your traditional psychoeducation
- But . . .
  - How many of the kids you have who have been inpatient 10 times could teach YOU about the psychoed component?
  - So . . . Psychoed focuses on what is RELEVANT to the kid
  - Use your Motivational Interviewing style here for Psychoed
    - E – P – E
    - Elicit – Provide – Elicit

Complex Trauma Psychoed

- Often a question of which trauma to focus on first?
- Conceptualize themes rather than specific traumas
- ID themes, integrate experiences & meaning e.g. "Don't get close to people, they'll leave or hurt you"
- Work with client to co-identify themes starting early in assessment and psycho-ed, may be revealed in history, especially if multiple placements
- Help to ID via Socratic questioning, assess. tools, client statements, observations/interactions

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Complex Trauma Psychoed

- "Stably Unstable"
  - "C" student with PRAC and a
  - "GEC" (Good Enough Caregiver)
- Reason this is important is because you may have to "shape" . . .
  - The caregiver's expectations (e.g., not realistic to expect the kid who has cut for their whole life to stop 100% in a week)
  - The child's expectations (e.g., you absolutely deserve a mom who is not on cocaine but . . .That may not be realistic given mom's impairment with her addiction)
  - Both
- Keep in mind that Psychoed, in and of itself, can be a powerful cognitive processing tool

P: PARENTING SKILLS

You're not gonna like this slide

- Here's what we're gonna ask you as your first line of attack . . .
- "What have you done with the caregiver?"
- Let's brainstorm some common caregiver barriers that may be exacerbating or even supporting the Top 5

Casey Kasem's Top 5 Caregiver Barriers

1. "Checked out"
   - Variation 1: "My daddy did drugs and I turned out just fine."
   - Variation 2: "I'm just exhausted with this girl."
2. "She has bipolar, it doesn't matter what I do!"
3. "Why do I gotta come to therapy, he's the sex offender?"
4. "Why should I reward her for stuff she's supposed to do?"
5. "If they don't get better in the next month they're gonna blow this placement."

I'm gonna start backwards with #5

- #5: If they don't get better in the next month they're gonna blow this placement.
  - So . . .You're feeling zero pressure right?
- Remember: YOU are not the person who decides placement. If something happens, it's not YOUR fault. Cool?

Parenting Skills

- Need caregivers to build or "re-build" relationships
- All TF-CBT components to caregivers in parallel process
- Create a lens of not
  - "What's wrong with him?"
  - But "What's happened to him?"
- ID unhelpful/inaccurate caregiver cognitions
- Teach how negative caregiver attitudes lead to neg. behaviors and reduce trust and safety
- If family chaotic, ID if possible a stable adult to participate
- If no adult comes into sessions, try to locate a safe supportive "extended parent" and build the coping skills with that as your base

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Parenting – Nuts and Bolts

- Energy Conservation
  - In real time how long did "trying to reason" with your child take?
  - Did it work at all?
- "You're talking to an intoxicated person"
  - Our DBT brothers and sisters help us out a lot here (concept of "Triangulation" can be helpful here)
  - Ever try to "reason" with an intoxicated person?

Parenting – Nuts and Bolts

- Trust, but Verify
  - Ex: This is the second (out of three) random room checks for drugs for the week.
  - BUT I'M NOT USING!!!!
  - Great. I'm coming in.
- Anticipate "relapse"
  - This is NOT setting the kid up for failure
  - It is planning for a potential tornado
  - It is very possible there will be zero tornados this year . . . But may not be probable

R: RELAXATION SKILLS

Relaxation: Nuts and Bolts

- How many of your kids with these behaviors (especially inpatient) could teach YOU about Relaxation?
- So, first move: Go back to Elicit – Provide – Elicit MI tactic
  - "Billy, you were in Cedar Ridge a few weeks ago and I know you told me you have been in hospitals before. What ways did they show you for relaxing or calming down?"

Relaxation: Nuts and Bolts

- I find that a lot of times my PRAC skills have been "contaminated" by a previous provider
  - "Mr. Jones showed me that deep breathing stuff but it didn't work at all on the unit."
- So . . . We have a few choices
  - Same tactic – different implementation or language
  - Different tactic

Relaxation: Nuts and Bolts

- CT youth have more neurobiological dysregulation
- Past maladaptive strategies: likely "best attempt" to cope w/ stress or circumstances, met w/ punishment, criticism?
- Use old strategies /skills if safe helpful
- Explore what works, expect use/mastery to take more time than typical clients
- Teach their body's "overactive" alarm system for danger
- Relaxation w/out GE is probably best to start out
- Physical-based activities may initially be better than cognitive, e.g. PMR, exercise, vs. guided imagery
- Allow distraction but monitor for overuse

Relaxation: Nuts and Bolts

- I add a LOT of mindfulness here
- Our DBT brothers and sisters have a LOT of good tricks here for this
- Mindfulness ranges from
  - Very simple (e.g., I Spy)
  - To the VERY sophisticated (e.g., Zazen)
- One homework assignment is for the kid (with the caregiver) to research which one will work
  - There are literally thousands

A: AFFECT MODULATION SKILLS

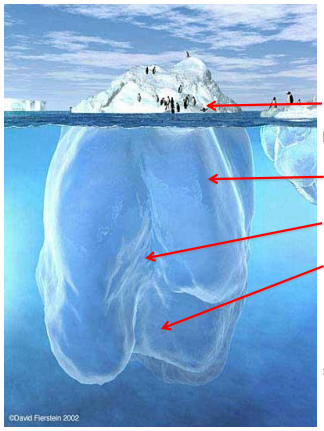
Affect Regulation

- Start with therapists own attunement and relationship
- Model expression, mirror client
- Teach the role of emotions in daily life
- Negative affective states are temporary, tolerable
- Expressing and communicating emotions can modulate their intensity and invite support from others

The Invisible Suitcase is Packed

Trauma shapes children's beliefs and expectations:

- About themselves
- About the adults who care for them
- About the world in general



External "baffling" Behaviors

Invisible Suitcase / beliefs

Developmental Impacts

Safety [physical & emotional]

Slide courtesy of Chris Foreman CISW

Affect Regulation

- CT clients have a high rate of numbing & dissociation, the latter may appear as anger, boredom, indifference, what else?
- These likely were adapted as protective responses
- Emotional detection & vocabulary likely very stunted
- Are you feeling "SUD-ZY"?

C: COGNITIVE COPING SKILLS

Cognitive Coping

- Initially increasing awareness of thoughts in general then thoughts during stressful experiences
- Mindfulness, modify negative emotional biases
- Use Cognitive Triangle as a tool to test multiple experiences stressful or not
- Consider a little "trigger hunting" when distress occurs via CBT
- Introduces gradual exposure into stabilization phase (we usually don't do this)

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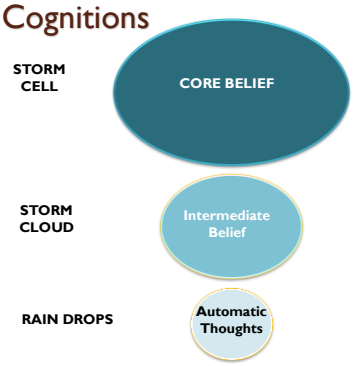
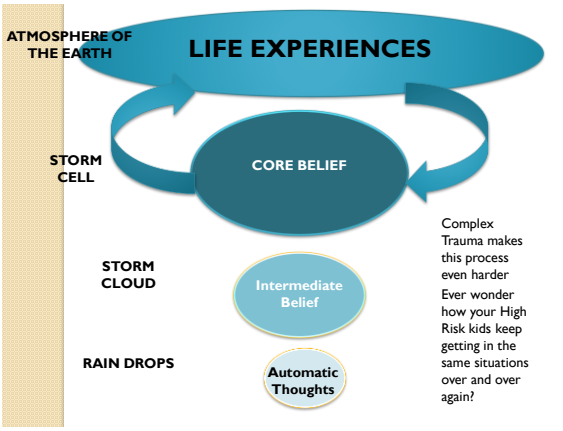
Our standard CBT model of Cognitions





Let's tag on 2 Tactics

- Positive Self-Talk
  - "Fire your cheerleaders in your head"
  - Practice & develop positive self-talk, it makes post narrative processing way easier,
  - Pop culture examples?
  - YouTube Motivational Videos
  - Key here is CATCHING the thoughts (lot like smelling the smoke and knowing the house is on fire
- Positive Life Experiences
  - Do they have ANY positive thing they do?
  - For Caregivers, have they taken away even "growth privileges"?
  - If you have a case manager this is where connecting the child to ANY prosocial activity can go
  - Looks a lot like Enhancing Safety slide doesn't it?

IMPORTANCE OF TRAUMA NARRATION AND PROCESSING

"Significant affective dysregulation is only reduced after TN"

- Sharma-Patel and Brown (2016)
  - Put to the test what we always say: If you want the emotion dysregulation to go down you HAVE TO do TN.
  - Emotion dysregulation as a moderator for reduction of PTSD symptoms AND behavior problems
  - Self-blame was a partial mediator and moderator of conduct problems

Here's what a loss looks like

- 16 y.o. Caucasian Male
- Hx of sexual abuse
- Hx and presenting problem of problematic sexual behaviors
- In foster care since 8
- Bio mom absolutely not working plan (but saying she's gonna get him back)
- GREAT foster parents
- Great placement system (when do you see that???)
- School is great
- Family invested in adopting this child but concerned about problematic sexual behaviors

Here's what a loss looks like

- One of the two incidents of rape was on the foster families biological son
  - Yet, they still wanted to give him a second chance
- My referral point: He had offended on foster brother while in outpatient treatment and they referred to me
- I conducted PSB-A and TF-CBT treatment
- For half a year

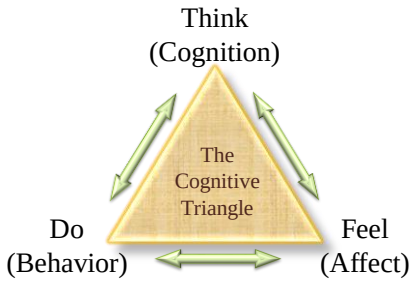
Here's what a loss looks like

- Got him stabilized (with what I showed you in the previous slides)
- Caregivers were the best you could ask for
- He had risky behaviors but technically no re-offense
  - Ex: a boy at school texted him sexually inappropriate messages and he responded (told foster mom but engaged in this behavior)
- Final incident: goes into foster brothers room and "wrestles" with him
- We have to send him to a facility

Here's what a loss looks like

- I felt I lost. Like REALLY bad. Like I let the family down.
- Also, to add to it the Child Welfare worker blew the original plan we had because he told the kid while he was at school even though we SPECIFICALLY asked him to wait.
- So . . . I was not in a good place.

So let's do my cognitive triangle



Ergo: Trauma Stewardship

CONJOINT SESSIONS

Conjoint/ Parallel Caregiver Work

- Complex trauma most often has it's roots in context of a care-giving relationship
- If there is a caregiver, this work promotes engagement and relationship stability (pull for coping practice at home)
- Expect these relationships will often be strained and dysfunctional, coach responses for dysregulation
- For kids w/disrupted attachments caregiver engagement, (warmth, closeness) more likely a trauma and or loss reminder

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Conjoint/ Parallel Caregiver Work

- Conjoint work may actually provide In Vivo GE work to improve relationships
- Replacing "signals of danger" with "signals of care"
- You can never go wrong with validation and empathy
- May be here w/out long term adult support "Accessio Mentorum!!" Find a Mentor!

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Ending Treatment

- How we end is as <u>or</u> ***more*** important than how we began
- This might be their first healthy "good-bye" experience
- Plan for and discuss this early.
- Ending may trigger past feelings of loss, abandonment, rejection
- Help to see cognitively and emotionally how this ending is different than their previous experience.
- Help client have appropriate control over process
- Celebrate this achievement
- Let's discuss some appropriate ending ideas!

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"We pitty the negative cognition!"

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