The Oklahoma TF-CBT Daily News

March 6, 2024

# TF-CBT News You Can Use

## Recent research and resources that can help your TF-CBT work

Amanda Mitten, LPC
Susan Schmidt, PhD


# CONTENTS

01 TF-CBT Applications

02 Caregivers and TF-CBT

03 Professional Wellness

# Telehealth TF-CBT

Psychological Services


ISSN: 1541-1559

2023, Vol. 20, No. 1, 107–121
https://doi.org/10.1037/ser0000605

## Patient Perceptions of Trauma-Focused Telemental Health Services Using the Telehealth Satisfaction Questionnaire (TSQ)

Bianca T. Villalobos[1], Aubrey R. Dueweke[2], Rosaura Orengo-Aguayo[3], and Regan W. Stewart[4]

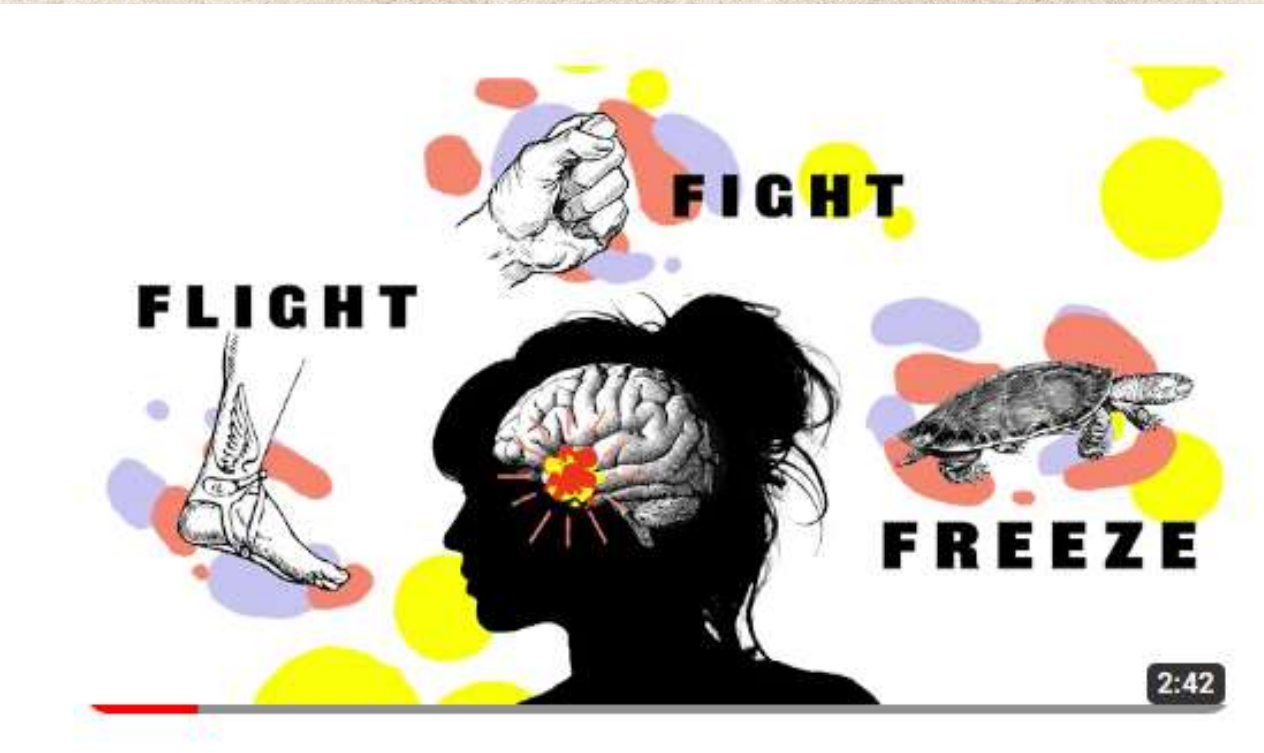
[1] Department of Psychological Science, The University of Texas Rio Grande Valley
[2] Department of Psychology, East Tennessee State University
[3] National Crime Victims Research & Treatment Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina
[4] Mental Health Disparities & Diversity Program, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina

in TF-CBT (Lange et al., 2021). Results of the present study demonstrated high satisfaction ratings from children and caregivers receiving trauma-focused telemental health services. Consistent

Furthermore, families indicated they were still able to build rapport with clinicians and felt comfortable interacting with them via videoconferencing. The ability to maintain a strong therapeutic alliance is especially important when conducting trauma-focused treatment given the need to help families process and discuss oftentimes sensitive, violent, and extremely stressful events during

therapy sessions. In addition, clinicians facilitate gradual exposure over the course of TF-CBT and rely on patient verbal and nonverbal cues of distress to proceed with increasingly trauma-specific content. It appears the clinicians were successful at navigating these challenging tasks via telehealth. In addition, all children and caregivers reported feeling as connected to their clinicians as if they were seeing them in-person and agreed that their information was kept private during sessions. Ultimately, it appears rapport was not significantly hindered by the use of telehealth from the perspective

# Telehealth TF-CBT



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# Youth with Intellectual and Developmental Disabilities

1 Research

2 Readings

3 Resources

Journal of Child & Adolescent Trauma (2021) 14:415–424
https://doi.org/10.1007/s40653-021-00354-0

TREATMENT APPROACH

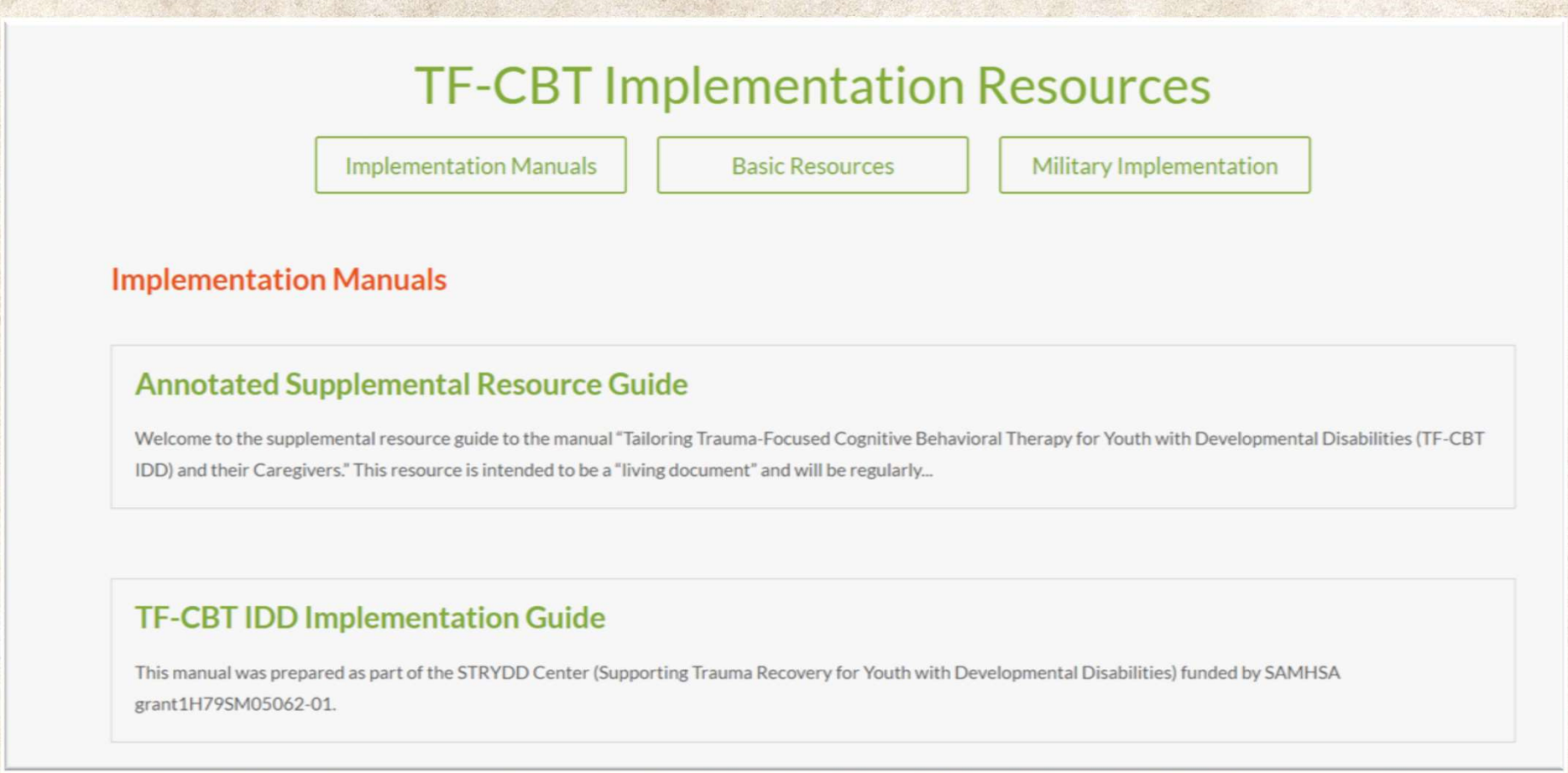
# TF-CBT Informed Teletherapy for Children with Autism and their Families

Justin S. Romney[1] · Miranda Garcia[1]

Accepted: 13 April 2021 / Published online: 20 April 2021


## Abstract

A diagnosis of autism spectrum disorder (ASD) often puts a child in a vulnerable position. While the research of the effects of trauma on children diagnosed with ASD is limited, we know children diagnosed with ASD presenting with a comorbid diagnosis of post-traumatic stress disorder (PTSD) have an increased risk of suicidal thoughts and behaviors. TF-CBT is an empirically validated treatment for trauma; in this paper, we provide adaptions for using this treatment with children diagnosed with ASD and using this method for teletherapy. These adaptions include recognizing trauma behaviors and ASD behaviors, the use of repetition and the need for flexibility from the therapist, and addressing safety with ASD behaviors while working from a teletherapy platform.




https://tfcbt.org/resources/implementation/


NCTSN RESOURCE

## Choosing Trauma-Informed Care for Children with Intellectual and Developmental Disabilities: A...

Type: Fact Sheet

Provides information for caregivers on choosing trauma-informed care for children with IDD.


NCTSN RESOURCE

## Trauma and Children with Intellectual and Developmental Disabilities: Taking Care of Yourself and...

Type: Fact Sheet

Offers guidance on the importance of taking care of oneself while parenting children with IDD.


NCTSN RESOURCE

## Understanding Trauma Responses in Children with Intellectual and Developmental Disabilities and...

Type: Fact Sheet

Outlines what responses to trauma could look like in children with IDD.

https://www.nctsn.org/resources/all-nctsn-resources?page=2

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# Adolescents / Transitional Age Youth

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| Research | Readings | Resources |

Contents lists available at ScienceDirect

Neuroscience and Biobehavioral Reviews

journal homepage: www.elsevier.com/locate/neubiorev

Review article

# The body keeps the score: The neurobiological profile of traumatized adolescents

Daniela Laricchiuta [a,*], Anna Panuccio [b,c], Eleonora Picerni [b,d], Daniele Biondo [e], Benedetto Genovesi [e], Laura Petrosini [b]

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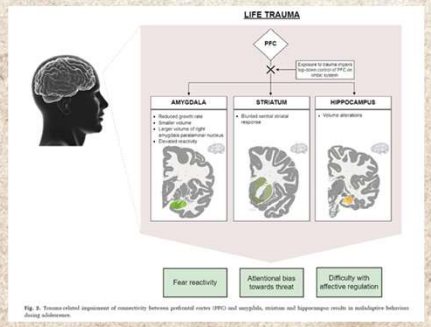
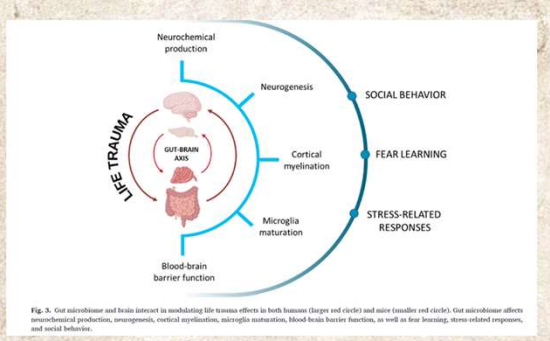
[c] Department of Psychology, University Sapienza of Rome, Rome, Italy
[d] Department of Neuroscience Imaging and Clinical Sciences, University "G. d'Annunzio" of Chieti-Pescara, Chieti, Italy
[e] Italian Psychoanalytic Society, Rome, Italy




## ABSTRACT

Trauma-related disorders are debilitating psychiatric conditions that affect people who have directly or indirectly witnessed adversities. Experiencing multiple types of traumas appears to be common during childhood, and even more so during adolescence. Dramatic brain/body transformations occurring during adolescence may provide a highly responsive substrate to external stimuli and lead to trauma-related vulnerability conditions, such as internalizing (anxiety, depression, anhedonia, withdrawal) and externalizing (aggression, delinquency, conduct disorders) problems. Analyzing relations among neuronal, endocrine, immune, and biochemical signatures of trauma and internalizing and externalizing behaviors, including the role of personality traits in shaping these conducts, this review highlights that the marked effects of traumatic experience on the brain/body involve changes at nearly every level of analysis, from brain structure, function and connectivity to endocrine and immune systems, from gene expression (including in the gut) to the development of personality.

AMERICAN PSYCHOLOGICAL ASSOCIATION
TRAUMA PSYCHOLOGY
AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychological Trauma:
Theory, Research, Practice, and Policy


ISSN: 1942-9681

2021, Vol. 13, No. 3, 313–321
https://doi.org/10.1037/tra0001016

# Trauma-Focused Cognitive–Behavioral Therapy (TF-CBT) for Interpersonal Trauma in Transitional-Aged Youth

Wilma Peters[1, 2], Simon Rice[1, 2], Judith Cohen[3], Laura Murray[4], Carsten Schley[5], Mario Alvarez-Jimenez[1, 2], and Sarah Bendall[1, 2]

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[2] Centre for Youth Mental Health, University of Melbourne
[3] Department of Psychiatry, Allegheny General Hospital, Pittsburgh, Pennsylvania, United States
[4] Department of International Health, John Hopkins University
[5] headspace Sunshine, Melbourne, Australia

***Objective:*** Posttraumatic stress disorder (PTSD) following interpersonal trauma in transitional-aged youth (TAY), aged 15 to 25, is highly prevalent; however, evidence-based interventions have rarely been studied. ***Method:*** A single-group pre-/posttest study was conducted at headspace Sunshine, Melbourne, Australia, evaluating the feasibility, acceptability, safety, tolerability, and potential clinical effectiveness of trauma-focused cognitive–behavioral therapy (TF-CBT). ***Results:*** An intent-to-treat analysis was conducted for $N = 20$ participants (65% female, $n = 13$) who attended a mean of 15 TF-CBT sessions over 25 weeks. At the end of treatment, only 1 of the 16 participants with a baseline PTSD diagnosis still met diagnostic criteria. Significant improvements were also noted for self-report measures of PTSD ($d = -.83$), anxiety ($d = -.74$), and depression ($d = -.76$). A minority of participants reported a brief exacerbation in symptoms of PTSD ($n = 8$) and anxiety and depression ($n = 5$) during stabilization and directly before and/or after the trauma-narration phase. However, all symptoms resolved at the end of treatment. The majority of participants (85%, $n = 17$) rated the intervention as helpful. ***Conclusion:*** Regardless of the expected temporary symptom exacerbation, the results indicated that TF-CBT was safe, tolerable, and acceptable. Transitional-aged youth is an emerging area of research. With limited research available on this age group to inform evidence-based practice, it is recommended that a randomized controlled trial is conducted to determine if TF-CBT (Cohen et al., 2017) can be effectively translated to this underresearched age group.

***Clinical Impact Statement***

The present study suggests that trauma-focused cognitive–behavioral therapy is feasible, acceptable, and potentially clinically effective for youth (aged 15–25) attending primary mental health services who have been exposed to interpersonal trauma (i.e., child physical or sexual abuse, maltreatment, or neglect). Although a minority of young people reported a slight exacerbation in trauma-related symptoms during treatment, most were willing to recommend the intervention to a peer who was experiencing mental ill health following interpersonal trauma. Evaluation of this model in a randomized trial is now indicated.

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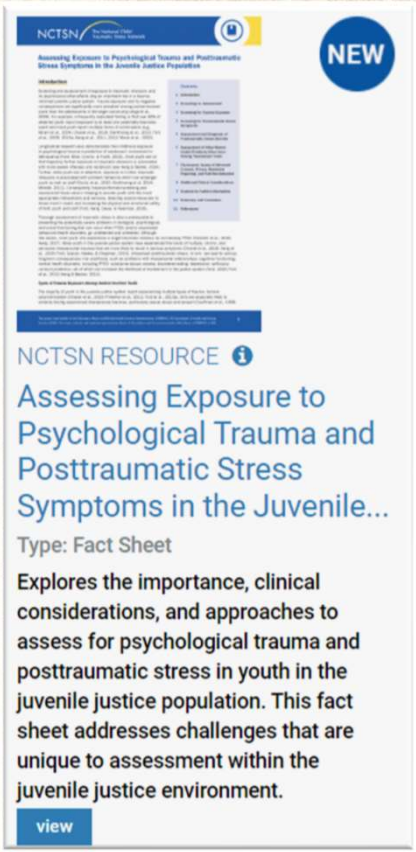


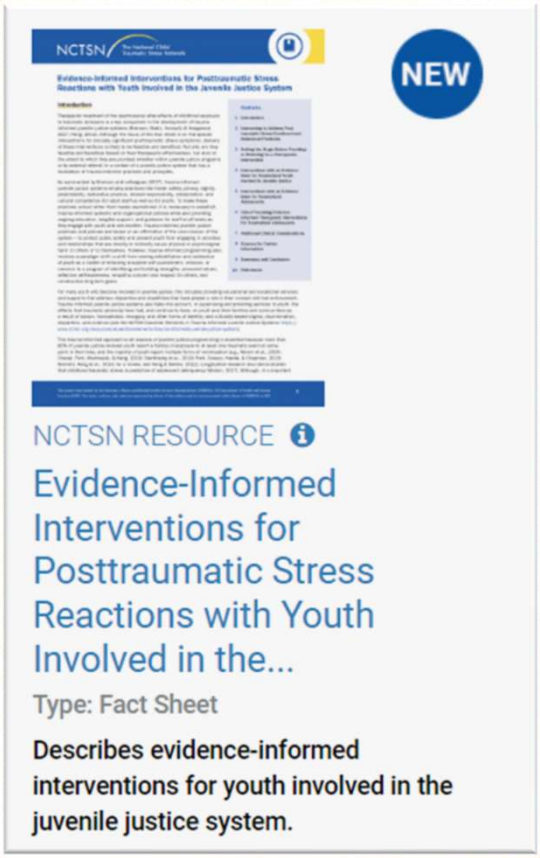


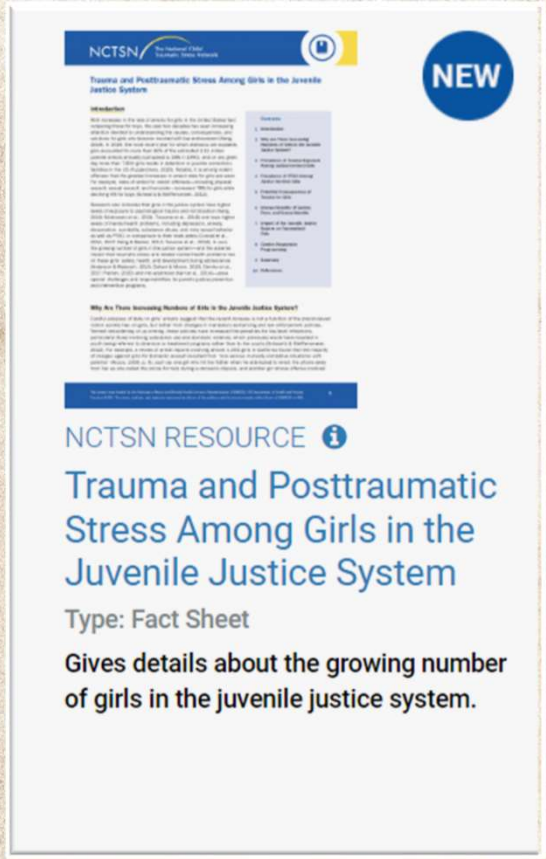


https://www.nctsn.org/resources/all-nctsn-resources?page=1

The OK TF-CBT Daily News

# Youth with Commercial Sexual Exploitation Histories

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| Research | Readings | Resources |

ELSEVIER

Available online at www.sciencedirect.com

ScienceDirect

Cognitive and Behavioral Practice 27 (2020) 253-269

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

# The Value of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in Addressing the Therapeutic Needs of Trafficked Youth: A Case Study

Yahaira I. Márquez, Ph.D., Esther Deblinger, Ph.D., *CARES Institute, Rowan University School of Osteopathic Medicine*
Allison T. Dovi, Ph.D., *Division of Behavioral Health at Nemours/Alfred I. DuPont Hospital for Children*

*Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is currently the leading intervention for childhood trauma as it has accumulated the most empirical support in treating sexual abuse in youth. However, this treatment, widely recognized as the gold-standard for the treatment of childhood trauma, has been applied only in recent years to address the unique needs of children and adolescents with histories of human trafficking and sexual exploitation. This paper strives to expand this limited literature base by examining the clinical value in individualizing TF-CBT to effectively treat an adolescent experiencing posttraumatic stress related to the experience of familial sex trafficking while also maintaining treatment fidelity. This case study emphasizes the value of the TF-CBT components in addressing a variety of factors that impact this population, including psychological coercion, psychological manipulation, the threat of legal action (in this case deportation), lack of community involvement, running away behaviors, and pregnancy by sexual assault. Multisource measures completed at the beginning and end of treatment document a significant decrease in symptoms of posttraumatic stress disorder and a depressive disorder after 20 treatment sessions that comprised individual sessions for the youth, individual sessions for the nonoffending caregiver, and conjoint caregiver-youth sessions.*

Table 1
Key Aspects of the Cultural Application and Individualization of TF-CBT to Effectively Treat Carmen

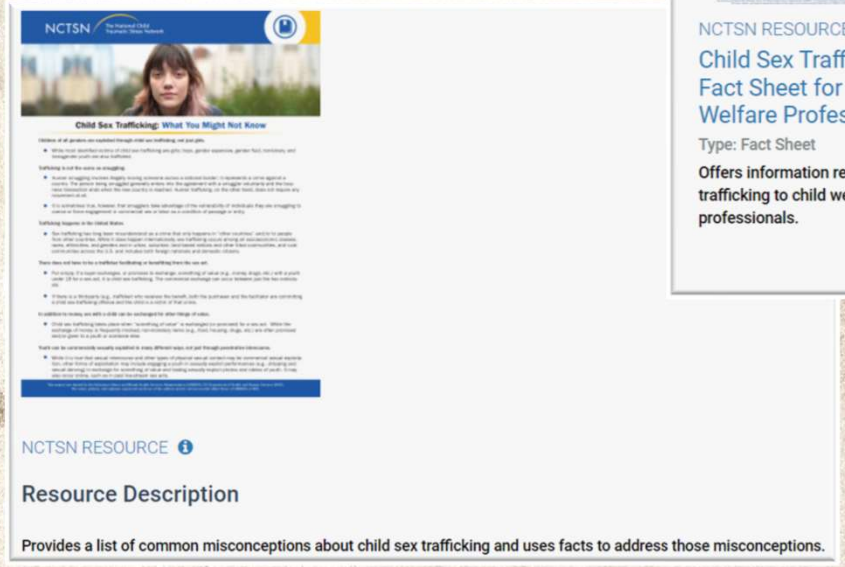
*Other important issues addressed in treatment*

| *Problem* | *Background* | *Component used to address it* |
|---|---|---|
| ***Running Away***<br>See pages 22, 23, 26, and 28 for more information. | Carmen reported running away from home in the past. She was found by her family and severely physically punished for it. She later reported having the urge to run away from the Rodriguez family home in the beginning of treatment as she didn't know what was going to happen to her and to her baby. | *Parenting Skills:* functional behavior assessment to understand function of runaway behavior. Foster mom created predictable routines and praised Carmen's efforts to share her fears before running.<br>*Relaxation and Affective Expression and Modulation:* Carmen was encouraged to express her fears and use her coping skills to manage them.<br>*Cognitive Processing:* To deal with dysfunctional thoughts and fears.<br>*Enhancing Safety:* safety planning and contract for safety. |
| ***Pregnancy and Abortion***<br>See pages 23, 28, and 29 for additional information. | Carmen experienced two pregnancies as a result of the sexual violence. The first pregnancy was terminated (age 11). The second pregnancy resulted in a child with medical needs. | *Psychoeducation:* provide general information about pregnancies in general and as a result of violence.<br>*Parenting Skills:* Carmen chose to raise her baby and she and her foster mother learned skills to enhance their joint parenting efforts. *Cognitive Processing:* To process inaccurate and dysfunctional thoughts about her abusive experiences and about parenting. *Enhancing Safety:* To explore the difference between sexual abuse and sex. To reclaim her body. To learn more about power and control in human relationships. To discuss reproductive health as an important decision for self-care. |
| ***Threats of Deportation***<br>For more information, please review pages 14 and 23. | Carmen was threatened by deportation. With the help of the system Mrs. Rodriguez and her family decided to adopt both Carmen and her daughter. | *Psychoeducation:* learned about the legal process and adoption.<br>*Cognitive Processing:* to process thoughts related to life changing decisions.<br>*Enhancing Safety:* Self-advocacy skills to be able to express wants and needs as assertively as possible. |
| ***Psychological Coercion/Manipulation/Bondage***<br>See pages 22 and 23 for more information. | Carmen was convinced that she was destined to die because of her "fatal blood illness." She was distressed by this thought often because she worried about the care of her daughter in the future and the possibility of passing this illness to her daughter. | ***Team approach:*** *Medical evaluation:* Medical evaluation and blood testing revealed that Carmen was healthy.<br>*Psychoeducation:* to learn about psychological coercion and manipulation, bondage, power/control relationship, and grooming to help process adoptive parents' behaviors.<br>*Cognitive Processing:* to process dysfunctional and inaccurate thoughts about Carmen's health. |
| ***Recovering Personal Assets: Community Involvement***<br>See page 33 for additional information. | Carmen reported enjoying playing kickball and other sports in her country of origin. | *Psychoeducation:* Explored the benefits of physical activity and the recovery of personal assets (the idea of using something that the person is good at to aid in their recovery and integration into the community).<br>*Parenting Skills:* Mrs. Rodriguez was encouraged to find avenues for Carmen to utilize her considerable athletic skills and she praised these skills and encouraged them by attending after school games whenever possible. Began volunteer work. |

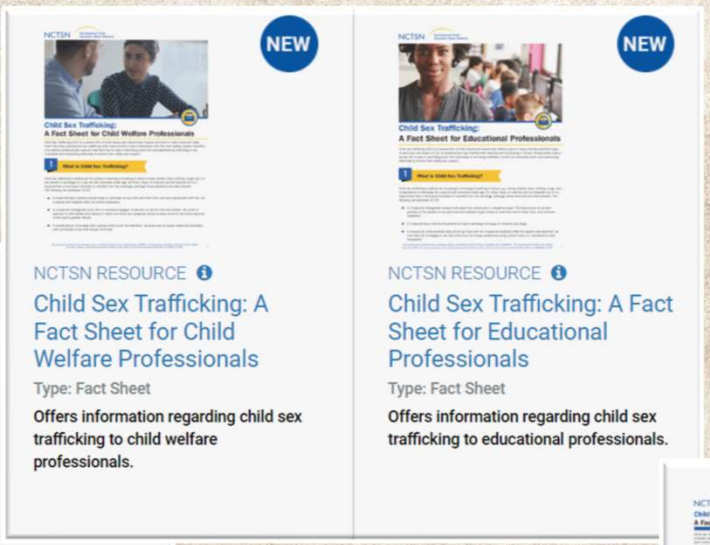
## TF-CBT For CSEC Implementation Manual

The TF-CBT for the Commercial Sexual Exploitation of Children (CSEC) Implementation Manual is now available! We are extremely grateful all of the youth, caregivers and therapists who contributed to its development.

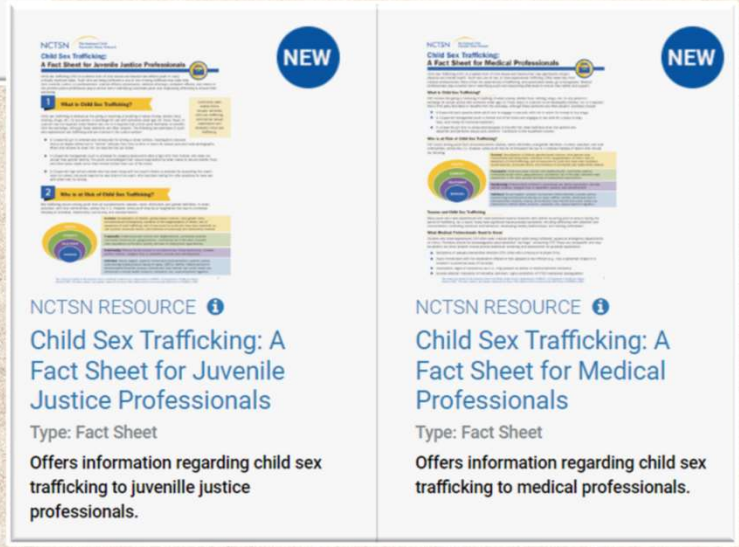
https://tfcbt.org/resources/implementation/




https://www.nctsn.org/resources/child-sex-trafficking-what-you-might-not-know




https://www.nctsn.org/resources/all-nctsn-resources



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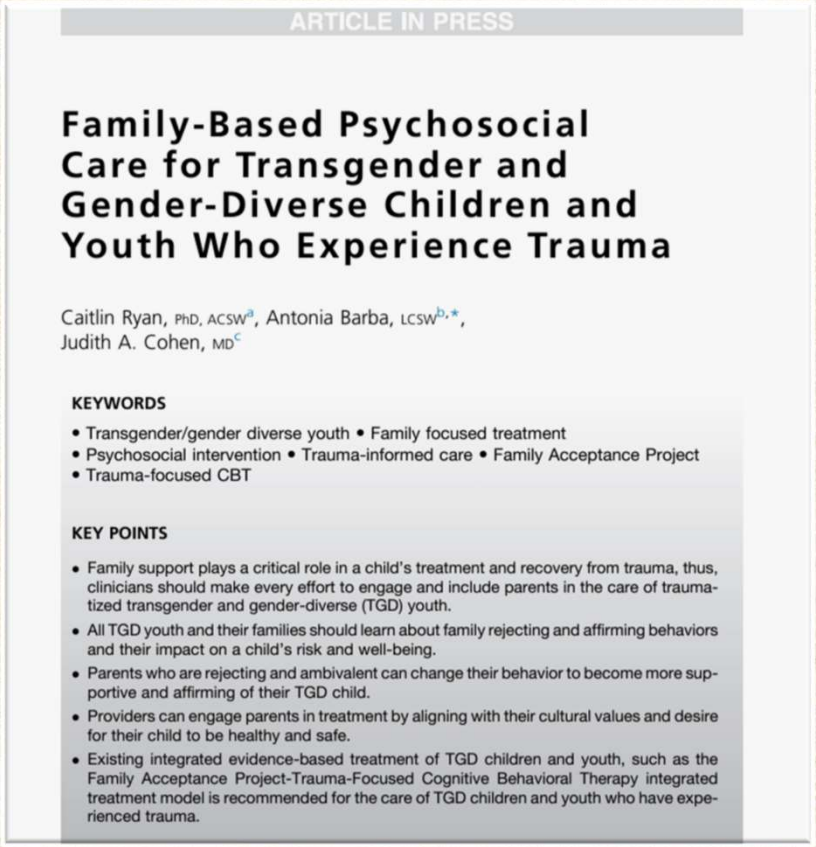
# Youth who Identify as 2SLGBTQIA+

1 Research

2 Readings

3 Resources



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# Family-Based Psychosocial Care for Transgender and Gender-Diverse Children and Youth Who Experience Trauma

Caitlin Ryan, PhD, ACSW[a], Antonia Barba, LCSW[b,*], Judith A. Cohen, MD[c]

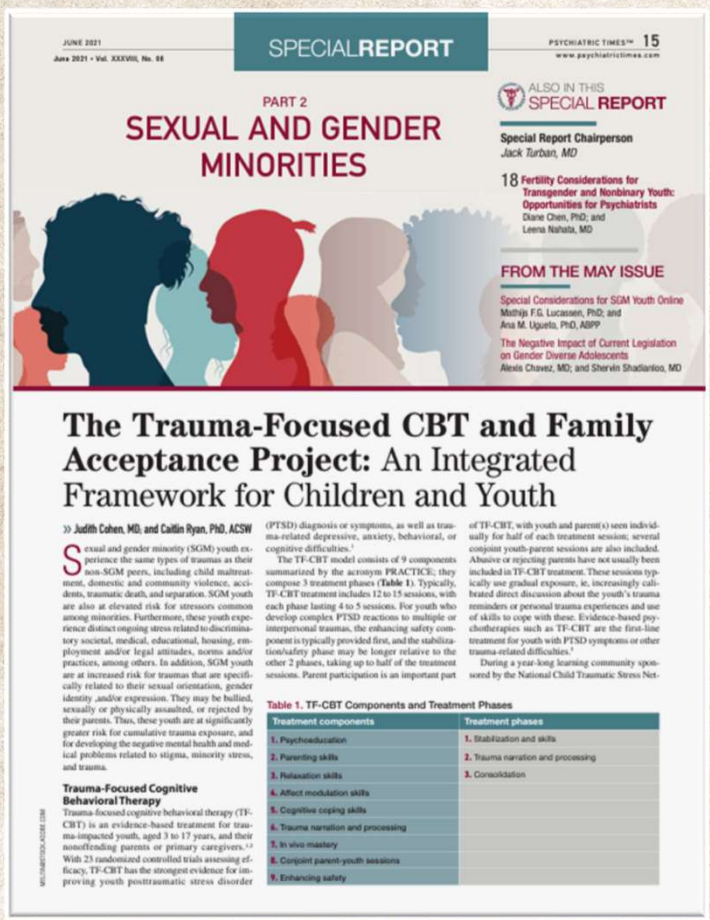
**KEYWORDS**

- Transgender/gender diverse youth • Family focused treatment
- Psychosocial intervention • Trauma-informed care • Family Acceptance Project
- Trauma-focused CBT

**KEY POINTS**

- Family support plays a critical role in a child's treatment and recovery from trauma, thus, clinicians should make every effort to engage and include parents in the care of traumatized transgender and gender-diverse (TGD) youth.
- All TGD youth and their families should learn about family rejecting and affirming behaviors and their impact on a child's risk and well-being.
- Parents who are rejecting and ambivalent can change their behavior to become more supportive and affirming of their TGD child.
- Providers can engage parents in treatment by aligning with their cultural values and desire for their child to be healthy and safe.
- Existing integrated evidence-based treatment of TGD children and youth, such as the Family Acceptance Project-Trauma-Focused Cognitive Behavioral Therapy integrated treatment model is recommended for the care of TGD children and youth who have experienced trauma.

https://tfcbt.org/wp-content/uploads/2023/06/Family-Based-Psychosocial-Care-for-Transgender-and-Gender-Diverse-Children-and-Youth-Who-Experience-Trauma.pdf



JUNE 2021
June 2021 • Vol. XXXVIII, No. 06

SPECIALREPORT

PSYCHIATRIC TIMES™ 15
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PART 2
SEXUAL AND GENDER MINORITIES

ALSO IN THIS SPECIAL REPORT

Special Report Chairperson
*Jack Turban, MD*

18 Fertility Considerations for Transgender and Nonbinary Youth: Opportunities for Psychiatrists
Diane Chen, PhD; and
Leena Nahata, MD

FROM THE MAY ISSUE

Special Considerations for SGM Youth Online
Mathijs F.G. Lucassen, PhD; and
Ana M. Ugueto, PhD, ABPP

The Negative Impact of Current Legislation on Gender Diverse Adolescents
Alexis Chavez, MD; and Shervin Shadianloo, MD

# The Trauma-Focused CBT and Family Acceptance Project: An Integrated Framework for Children and Youth

» Judith Cohen, MD, and Caitlin Ryan, PhD, ACSW

Sexual and gender minority (SGM) youth experience the same types of traumas as their non-SGM peers, including child maltreatment, domestic and community violence, accidents, traumatic death, and separation. SGM youth are also at elevated risk for stressors common among minorities. Furthermore, these youth experience distinct ongoing stress related to discriminatory societal, medical, educational, housing, employment and/or legal attitudes, norms and/or practices, among others. In addition, SGM youth are at increased risk for traumas that are specifically related to their sexual orientation, gender identity ,and/or expression. They may be bullied, sexually or physically assaulted, or rejected by their parents. Thus, these youth are at significantly greater risk for cumulative trauma exposure, and for developing the negative mental health and medical problems related to stigma, minority stress, and trauma.

## Trauma-Focused Cognitive Behavioral Therapy

Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based treatment for trauma-impacted youth, aged 3 to 17 years, and their nonoffending parents or primary caregivers.[1,2] With 23 randomized controlled trials assessing efficacy, TF-CBT has the strongest evidence for improving youth posttraumatic stress disorder (PTSD) diagnosis or symptoms, as well as trauma-related depressive, anxiety, behavioral, or cognitive difficulties.[1]

The TF-CBT model consists of 9 components summarized by the acronym PRACTICE; they compose 3 treatment phases (**Table 1**). Typically, TF-CBT treatment includes 12 to 15 sessions, with each phase lasting 4 to 5 sessions. For youth who develop complex PTSD reactions to multiple or interpersonal traumas, the enhancing safety component is typically provided first, and the stabilization/safety phase may be longer relative to the other 2 phases, taking up to half of the treatment sessions. Parent participation is an important part of TF-CBT, with youth and parent(s) seen individually for half of each treatment session; several conjoint youth-parent sessions are also included. Abusive or rejecting parents have not usually been included in TF-CBT treatment. These sessions typically use gradual exposure, ie, increasingly calibrated direct discussion about the youth's trauma reminders or personal trauma experiences and use of skills to cope with these. Evidence-based psychotherapies such as TF-CBT are the first-line treatment for youth with PTSD symptoms or other trauma-related difficulties.[1]

During a year-long learning community sponsored by the National Child Traumatic Stress Net-

**Table 1.** TF-CBT Components and Treatment Phases

| Treatment components | Treatment phases |
|---|---|
| 1. Psychoeducation | 1. Stabilization and skills |
| 2. Parenting skills | 2. Trauma narration and processing |
| 3. Relaxation skills | 3. Consolidation |
| 4. Affect modulation skills | |
| 5. Cognitive coping skills | |
| 6. Trauma narration and processing | |
| 7. In vivo mastery | |
| 8. Conjoint parent-youth sessions | |
| 9. Enhancing safety | |

https://tfcbt.org/wp-content/uploads/2023/06/The-Trauma-Focused-CBT-and-Family-Acceptance-Project.pdf

## TF-CBT LGBTQ Implementation Manual

This manual provides therapists with up-to-date information about how to implement TF-CBT for trauma-impacted LGBTQ youth, and also includes valuable resources from the Family Acceptance Project (FAP) ™ . We are extremely grateful to Dr. Caitlin Ryan of the FAP for...

https://tfcbt.org/resources/implementation/

# Youth with Problematic Sexual Behavior

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| Research | Readings | Resources |


https://www.nctsn.org/sites/default/files/resources/special-resource/ajs_story_about_not_ok_touches.pdf

## AJ's Story about Not OK Touches

Is designed to be read by a supportive adult (parent/caregiver, therapist) to a child (ages 5-10, or as developmentally appropriate) who has engaged in a Not OK touch or problematic sexual behaviors with another child. This children's book contains conversation boxes throughout its pages that assist children in expressing their thoughts and feelings about what is going on in the story.

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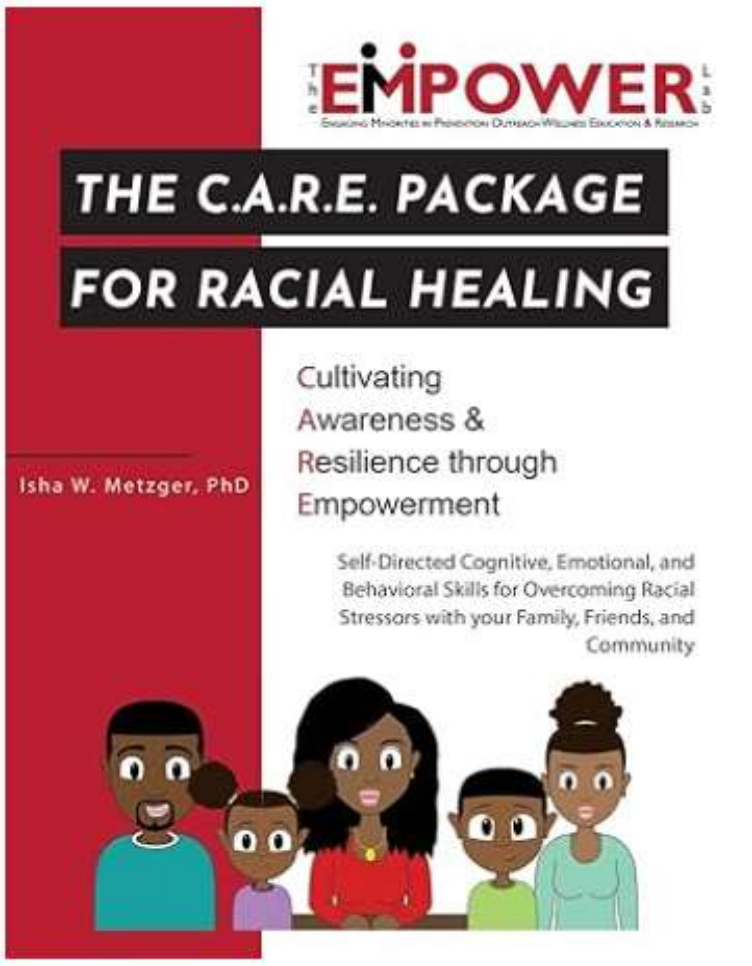
# Youth Who Have Experienced Racial Traumatization

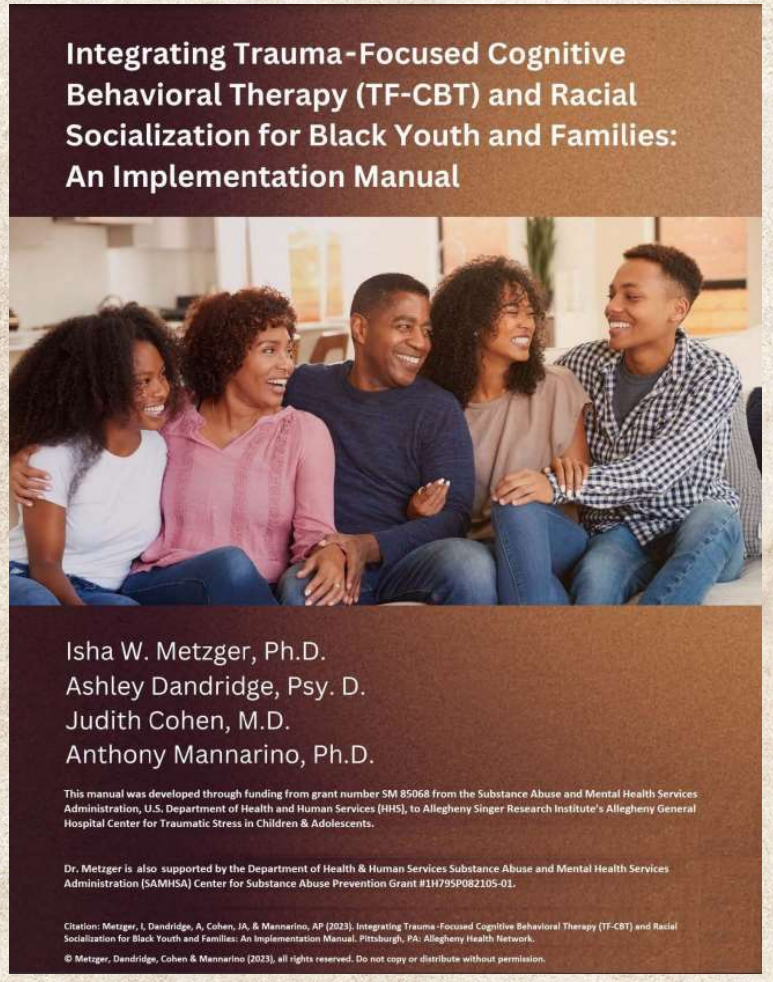
| 1 | 2 | 3 |
| --- | --- | --- |
| Research | Readings | Resources |

## TF-CBT and Racial Socialization Implementation Manual

This manual addresses strategies for implementing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT+RS, Metzger, Dandridge, Cohen, & Mannarino, 2023) and Racial Socialization for Black youth ages 3-17 years and their parents and/or other caregivers who...

https://tfcbt.org/resources/implementation/


The EMPOWER Lab
Engaging Minorities in Prevention Outreach Wellness Education & Research
THE C.A.R.E. PACKAGE
FOR RACIAL HEALING
Cultivating
Awareness &
Resilience through
Empowerment
Isha W. Metzger, PhD
Self-Directed Cognitive, Emotional, and Behavioral Skills for Overcoming Racial Stressors with your Family, Friends, and Community


Integrating Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Racial Socialization for Black Youth and Families: An Implementation Manual
Isha W. Metzger, Ph.D.
Ashley Dandridge, Psy. D.
Judith Cohen, M.D.
Anthony Mannarino, Ph.D.
This manual was developed through funding from grant number SM 85068 from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (HHS), to Allegheny Singer Research Institute's Allegheny General Hospital Center for Traumatic Stress in Children & Adolescents.
Dr. Metzger is also supported by the Department of Health & Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention Grant #1H79SP082105-01.
Citation: Metzger, I, Dandridge, A, Cohen, JA, & Mannarino, AP (2023). Integrating Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Racial Socialization for Black Youth and Families: An Implementation Manual. Pittsburgh, PA: Allegheny Health Network.
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The OK TF-CBT Daily News

# Caregivers of Traumatized Youth

# ANNOUNCEMENT

## Announcement 1

What caregivers bring to their child's TF-CBT treatment is impactful to their child's participation and treatment outcomes.

## Announcement 2

Caregivers can experience mental health gains throughout their child's TF-CBT treatment.

# The OK TF-CBT Daily News

Psychological Trauma:
Theory, Research, Practice, and Policy

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## Bidirectional Effects of Parental and Adolescent Symptom Change in Trauma-Focused Cognitive Behavioral Therapy

Carolyn A. Greene[1], D. Betsy McCoach[2], Julian D. Ford[1], Kimberly McCarthy[1], Kellie G. Randall[3], and Jason M. Lang[1, 3, 4]

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Study results demonstrated that both parents' and adolescents' symptoms improved over the course of nine months of TF-CBT. Adolescents' PTSD and depressive symptoms declined dramatically during treatment, although progress was slower for youth who started treatment with a higher level of symptoms. Parents also appeared to vicariously benefit from their children's psychotherapeutic treatment. At the outset of treatment, parents' depressive symptoms were, on average, very near the clinical range for major depression. As hypothesized, and consistent with previous studies of TF-CBT (Martin et al., 2019), parents' symptoms systematically decreased over the course of treatment.

Parental depression may make it more difficult to respond supportively to a child's symptoms. Indeed, parents who have difficulty regulating their emotions are more likely to respond negatively to their children's negative affect (Martin et al., 2018; Morris et al., 2007), which, in turn, is associated both cross-sectionally and longitudinally with youth internalizing and externalizing problems (Klimes-Dougan et al., 2007; Schwartz et al., 2014). Similarly, children's traumatic experiences may be painful reminders of parents' past experiences that could cause them to withdraw or, alternatively, could trigger their own posttraumatic reactions that might exacerbate their child's symptoms (Scheeringa & Zeenah, 2001).

Surprisingly, adolescents' PTSD and depressive symptoms at each time point contributed to *decreases* in their parents' symptoms at the subsequent time point. In other words, adolescents' PTSD and depressive symptoms accelerated their parents' response to treatment. This seems inconsistent with previous studies documenting that parents frequently experience distress, and potentially impaired mental health, as a result of their children's symptoms and experiences (Raposa et al., 2011; Sellers et al., 2016). It may be that for parents of highly symptomatic children, enrolling them in therapy provides relief from their worry, and contributes to the remittance of their depressive symptoms. Alternatively, once children are enrolled in treatment, parents' concern for their children may cause them to value the role of therapy, and lead them to be more committed to and engaged with their child's treatment (Self-Brown et al., 2016), which, in turn, produces greater vicarious benefits to themselves.

### Clinical Implications

These findings underscore the substantial impact that parents and children have on each other's response to children's treatment to address posttraumatic symptoms. Parents who are experiencing depressive symptoms may find it difficult to engage fully or effectively in their children's treatment or may engage in treatment-interfering behaviors. The reductions in depression symptoms shown by parents during their child's trauma-focused treatment suggest that participating in, and seeing their child benefit from, trauma-focused therapy may substantially ameliorate the parent's depression. Thus, for many parents, separate treatment may not be necessary in order to recover. However, child-focused treatment may not be sufficient to assist some parents who have severe depression symptoms, and thus therapists should also carefully monitor parental symptoms to detect any cases in which those symptoms are distressing for the child or sufficiently severe to require separate treatment. This may have been the case for some parents in the current study; whether the parents who were receiving TF-CBT in this cohort also were receiving individual therapy was not assessed.

Study findings suggest that high levels of children's PTSD and depressive symptoms do not interfere with parents' ability to reap benefits from their children's treatment. Indeed, parents whose children are experiencing relatively high levels of symptoms may benefit more than other parents in TF-CBT. This could be due to those parents being more engaged in their children's treatment due to higher levels of distress, the parents feeling less distress when a child is able to reduce their posttraumatic symptom severity to a more manageable level as TF-CBT progresses, or to another aspect of the therapy or the parent–child interaction and relationship.

Available online at www.sciencedirect.com

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Behavior Therapy

www.elsevier.com/locate/bt

# Caregiver Behaviors and Child Distress in Trauma Narration and Processing Sessions of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

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Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an effective treatment for children impacted by trauma, and non-offending caregivers play an important role in this treatment. This study aims to identify correlates of four caregiver variables that have been identified as predictors of child outcomes in TF-CBT: support, cognitive-emotional processing, avoidance, and blame/criticism. Audio recorded sessions were coded from a community effectiveness trial of TF-CBT that included 71 child-caregiver dyads participating in the trauma narration and processing phase of treatment. Regression analyses were conducted to examine caregiver trauma history and child baseline symptoms (internalizing, externalizing, and post-traumatic stress disorder [PTSD] symptoms) as predictors of caregiver behavior during the trauma processing sessions. Caregivers who reported exposure to more trauma types exhibited more in-session avoidance and also processing during the trauma processing phase of treatment. Child symptoms at baseline did not predict caregiver in-session behaviors. Bivariate correlations were used to investigate concurrent associations between mean levels of in-session caregiver behaviors and in-session child distress (negative emotion, hopelessness, negative behaviors). More caregiver blame/criticism was associated with more in-session child distress on all three measures. Caregiver avoidance was associated with more child negative emotion and hopelessness. Findings may help identify therapeutic targets when working with caregivers to promote change and enhance TF-CBT outcomes.

*Interventions*

# Attachment security as an outcome and predictor of response to trauma-focused cognitive-behavioral therapy among maltreated children with posttraumatic stress: A pilot study

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Sage

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The obtained evidence supported the first hypothesis that attachment security would improve over the course of treatment. For those participants reporting a relatively low score for attachment security at the beginning of treatment, significant and large improvements were observed. These data provide some support for the theoretical postulation that improvement of attachment security may occur when a supportive caregiver is involved in a treatment protocol that provides some level of discomfort for a child (e.g., exposure therapy; Bosmans et al., (2016). However, it must be stressed that these data were obtained from a small sample as only 8 participants in the current trial were included in this particular analysis. Nonetheless, the very large size of the effect observed is encouraging and suggests that this may be a fruitful avenue to explore for the identification of interventions to improve attachment security among youth.

The current study does support the proposition that identifying interventions for improving attachment security among school-aged children and adolescents may benefit from exploring protocols that yield the opportunity for caregivers to support youth through challenging experiences. This may include exposure-based interventions, such as TF-CBT, or through discussions about emotionally-charged topics or memories, as suggested by Bosmans et al., (2016). In addition, this pilot study suggests that the current attention being paid to the identification of factors predictive of response to trauma-focused interventions may find little of value in exploring attachment security as a predictor of response. However, the change seen in attachment security seen in the current pilot suggests the potential of attachment security as a potential mechanism of change. In this view, those beginning treatment with attachment insecurity may see reductions in PTSD symptoms because of improved attachment security that occurs over the course of treatment. Theoretically, the argument can be made that improving attachment security better equips the youth for confronting trauma reminders in the environment and managing stress resulting from intrusive thoughts. Demonstrating such an effect requires mediational analyses and a sample size considerably larger than that of the current pilot study. Nonetheless, implementing a measure such as the Security Scale is quite feasible as it requires little time to complete and is easily scored. Integrating attachment measures into future studies of TF-CBT or other trauma-focused interventions may allow for suitable exploration of this hypothesis.

# ACTIVE LISTENING

This powerful communication tool helps you better understand and show you care about your child's view. Working together (instead of against each other) in problem solving, decreases conflict and improves your relationships.

- Listen (without interrupting) while youth is speaking.
- Fully attend to their words and body language. (Avoid getting lost in your own thoughts)
- Repeat back what you hear. Summarize their message.
- Watch youth's body language for cues on how they are feeling.
- Ask open questions to encourage youth to share more.
- Ask what youth needs from you.

**BUILDING NEW SKILLS TAKES WORK!**

HOME PRACTICE THIS WEEK:

# Parenting stress and children's trauma symptoms over the course of TF-CBT: Examining differences between relative and foster/adoptive caregivers

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ARTICLE INFO

*Keywords:*
Parenting stress
Foster Care
Adoption
TF-CBT
Trauma symptoms

ABSTRACT

*Background:* Through Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), the gold standard in children's trauma treatment, caregivers participate in sessions parallel to the child. However, much of the research examining the impact of this caregiver involvement has focused on biological or relative caregivers, despite the high prevalence of trauma and trauma symptoms among youth in foster care and high rates of parenting stress among foster/adoptive caregivers.

*Objective:* The current study examined differences among relative and foster/adoptive caregivers' levels of parenting stress throughout the course of TF-CBT and how these differences were associated with child trauma symptoms throughout treatment.

*Participants and setting:* Participants were 130 caregiver-child dyads (84 = foster/adoptive; 46 = biological/relative) who completed TF-CBT in either an academic-based clinic or an associated mental health agency. Providing clinicians were trained in TF-CBT, participated in case consultation, and received ongoing clinical supervision.

*Methods:* Children and caregivers completed baseline measures prior to beginning treatment and termination measures at the completion of treatment.

*Results:* Prior to treatment, foster/adoptive caregivers reported greater dysfunction in their parent-child interactions and relative caregivers reported greater personal stress. These differences were not seen at treatment termination, and significant reductions in child trauma symptoms and caregiver parenting stress were evidenced from pre to post treatment. Significant covariation between child trauma symptoms and relative caregiver parenting stress at termination was also found.

*Conclusions:* There were different profiles of parenting stress for relative versus foster/adoptive caregivers, but treatment completion attenuated group differences in parenting stress over the course of treatment.

# Additional New Resources for Implementing TF-CBT with Families

## TF-CBT Military Implementation Manual

View the document here: Military implementation manual

## TF-CBT Foster Care Implementation Manual (© Deblinger et al, 2016)

View the document here: FosterCareManual FINAL

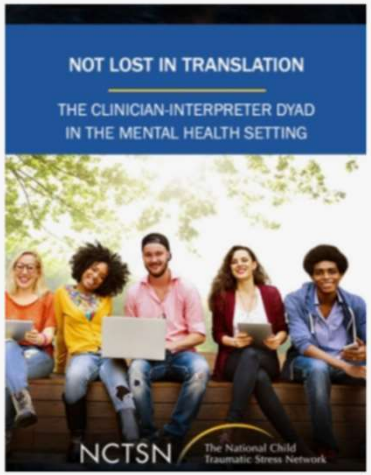
https://tfcbt.org/resources/implementation/


NCTSN RESOURCE

## Resource Description

Offers guidance to parents and caregivers on deciding whether or not a child should return to their home or neighborhood after it was damaged in a wildfire.

https://www.nctsn.org/resources/preparing-children-after-a-wildfire-damages-your-community



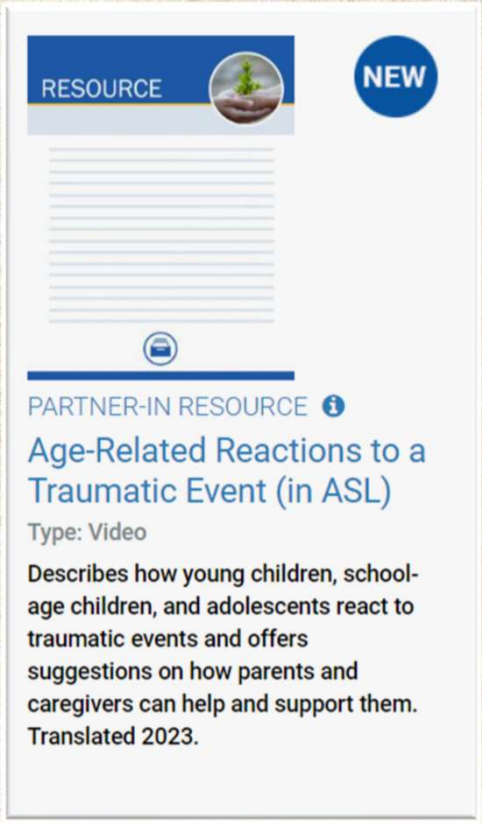

NCTSN RESOURCE

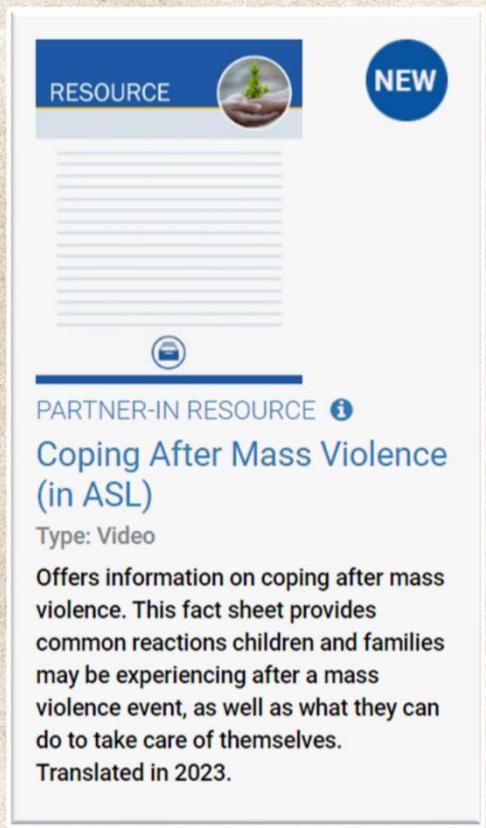
## Resource Description

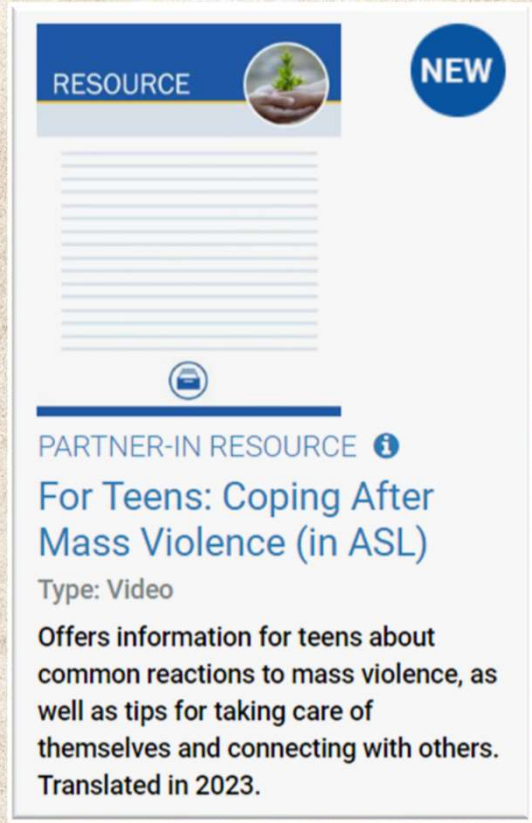
Is designed to increase the capacity and partnership of professional interpreters and mental health clinicians working together in order to improve quality and access of services for children, adolescents and families with no or limited English proficiency (LEP) and who have experienced trauma and are seeking mental health services. This course is based on the resource, *A Socio-Culturally, Linguistically-Responsive, and* Trauma-Informed *approach to Mental Health Interpretation*, and has lessons for both interpreters and clinicians to better support their work with families and children who have experienced trauma.

Published in 2022

https://www.nctsn.org/resources/not-lost-in-translation-the-clinician-interpreter-dyad-in-the-mental-health-setting




https://www.nctsn.org/resources/all-nctsn-resources?page=2

## Sesame Street Workshop Videos

These Sesame Street Workshop video links may be very helpful to therapists who are implementing TF-CBT for younger children via telehealth. You can find many additional videos, play and print resources for young children and caregivers at: https://sesamestreetincommunities.org

We are so grateful to Sesame Street for making these resources available to us!

### Psychoeducation:

Homelessness
Foster care
Community Violence (also for Enhancing Safety)
Parental Addiction (also for Trauma Narration)

### Parenting Skills:

A Child's Perspective of a Traumatic Experience
Foster care (series of videos for caregivers)

### Relaxation Skills:

Elmo's Belly Breathing
Count, Breathe, Relax
PMR: I Can Calm Myself Down

### Affect Modulation Skills:

Name That Emotion
Move It Out
Elmo Shows Big Feelings
Problem solving: Meet Maggie Cadabby

### Cognitive Coping Skills:

Janelle Monae: Power of Yet
Bruno Mars: Don't Give Up
I Can Do It

### Trauma Narration and Processing:

Foster Care: A Place for You
Homelessness: Dot to Dot
Cognitive Processing (Understanding Empathy)

### Enhancing safety:

Big Bird's Comfy -Cozy Nest
I Can Feel Safe
New Way to Walk with Destiny's Child

### Traumatic Grief:

Give Your Heart a Little Time
Bruno Mars: Don't Give Up
I Can Do It

https://tfcbt.org/telehealth-resources/

The OK TF-CBT Daily News

# BREAKING NEWS!

TF-CBT training is good for therapists, too!

Aminihajibashi et al.
BMC Health Services Research (2022) 22:1328
https://doi.org/10.1186/s12913-022-08670-3

BMC Health Services Research

RESEARCH Open Access

# Professional wellbeing and turnover intention among child therapists: a comparison between therapists trained and untrained in Trauma-Focused Cognitive Behavioral Therapy

Samira Aminihajibashi[1*], Ane-Marthe Solheim Skar[1,2] and Tine K. Jensen[1,2]

**Prevalence findings**

Results showed that over 70% of the respondents suffer from a medium (~48%) to high (~24%) level of burnout and secondary traumatic stress symptoms although they also express medium to high level of compassion satisfaction. This feeling of fulfillment may be one of the reasons that the majority of respondents (68%) reported a low level of intention to leave their job in the current or near future. Importantly, we found similar rates both among TF-CBT trained and untrained therapists. This is the first prevalence study from Norwegian CAMHS and indicates that preventive measurements are required for all therapists.

**Between group differences**

On average, TF-CBT trained therapists, compared to untrained therapists, reported a significant lower degree of burnout and turnover intention along with higher compassion satisfaction, both before and after controlling for variations in therapists' attitudes towards EBPs. TF-CBT therapists also reported numerically lower symptoms of secondary traumatic stress than the comparison group, but mean differences did not reach the significance level. The findings are consistent with both self-efficacy and job demands-resources theories and with findings from some other studies that have shown an association between the use of EBPs and higher compassion satisfaction [25] or reduced risk of burnout [25, 35, 41], and turnover intention and behavior [9, 40]. Yet, other studies did not find a positive effect of using EBPs on professional wellbeing [23], burnout [11] or team turnover rates in mental health services [13, 45], and some therapists have expressed concerns that using EBPs may reduce the level of engagement between client and therapists [82] or increase the workload, stress and staff turnover [39, 42].

# Be Well

My Feelings While at Work Brainstorm

What parts of your job do you avoid? Reflect on what feelings arise in those experiences.

Commit to a habit/practice to increase your emotional awareness during the day.

What things/times are you likely to ruminate over/during?

My Go-To Fully Engaging Activities:

My Story: Why I Choose This Work

For situations beyond my control....

About those situations/feelings I tend to avoid...

When feeling insecure in my skill-set...

Keeping it Real: Compassion for Self and Others

Call to mind someone you find yourself 'faking nice' with....

I'm feeling....

They may be thinking/feeling....

I can be genuine by....

Work friendships I will foster...

My 5-minute resets...

# Be Well, TF-CBTers

## Practical Guide to Supporting Your Own Success in Your Trauma Narrative Work

### Ask Yourself:

Are there reasons not to proceed with trauma narrative? Are these reasons about me? Or about the client/family?

### When Things Do Not Go As Planned

What structure can I return to? Have I checked that my expectations are fair? For me? For the family? For the child?

### Identifying My Own Cognitions

What am I telling myself about this process? Would other thoughts be more helpful? Consider these:

1. TN can be hard, and we know it is the most helpful part of treatment.
2. My gentle guidance of the client is not hurting them. They have learned skills for success.
3. I am a skilled clinician who is capable of supporting when distress arises.
4. I have been successfully incorporating GE, client knows what to expect.

### When Session is Over

Identify what that experience was like. What is my take away? What will I do if rumination creeps in between sessions?


Amanda Mitten, MA, LPC 02/2024

The OK TF-CBT Daily News

# THANK YOU!

Amanda Mitten, LPC
Susan Schmidt, PhD