CBT for PTSD

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Disclosures

My spouse/partner and I have the following relevant financial relationship with a commercial interest to disclose:

I receive royalties from Oxford University Press for co-authoring a book.

Definition of Traumatic Event (DSM-V)

- Exposure to traumatic event:
  - An event that involved death of threatened death, actual or threated serious injury or threated sexual violation
  - Experienced in one of following ways:
    - Experienced directly by the person
    - Event witnessed by the person as it occurred to someone else
    - Person learned about an event where a close relative or friend experienced an actual or threatened violent or accidental death
    - Person experienced repeated exposure to distressing details of an event

PTSD Symptoms: Intrusion (at least one of the following)

- Recurring, intrusive, upsetting memories
- Recurring, upsetting dreams related to event
- Dissociation in which person feels the traumatic event is happening again
- Distress upon exposure to event-related cues
- Strong bodily reactions to reminders of event

Avoidance of Reminders of Event (at least one of the following)

- Avoidance of thoughts, feelings or sensations related to memories of event
- Avoidance of people, places, etc that bring up memories of event

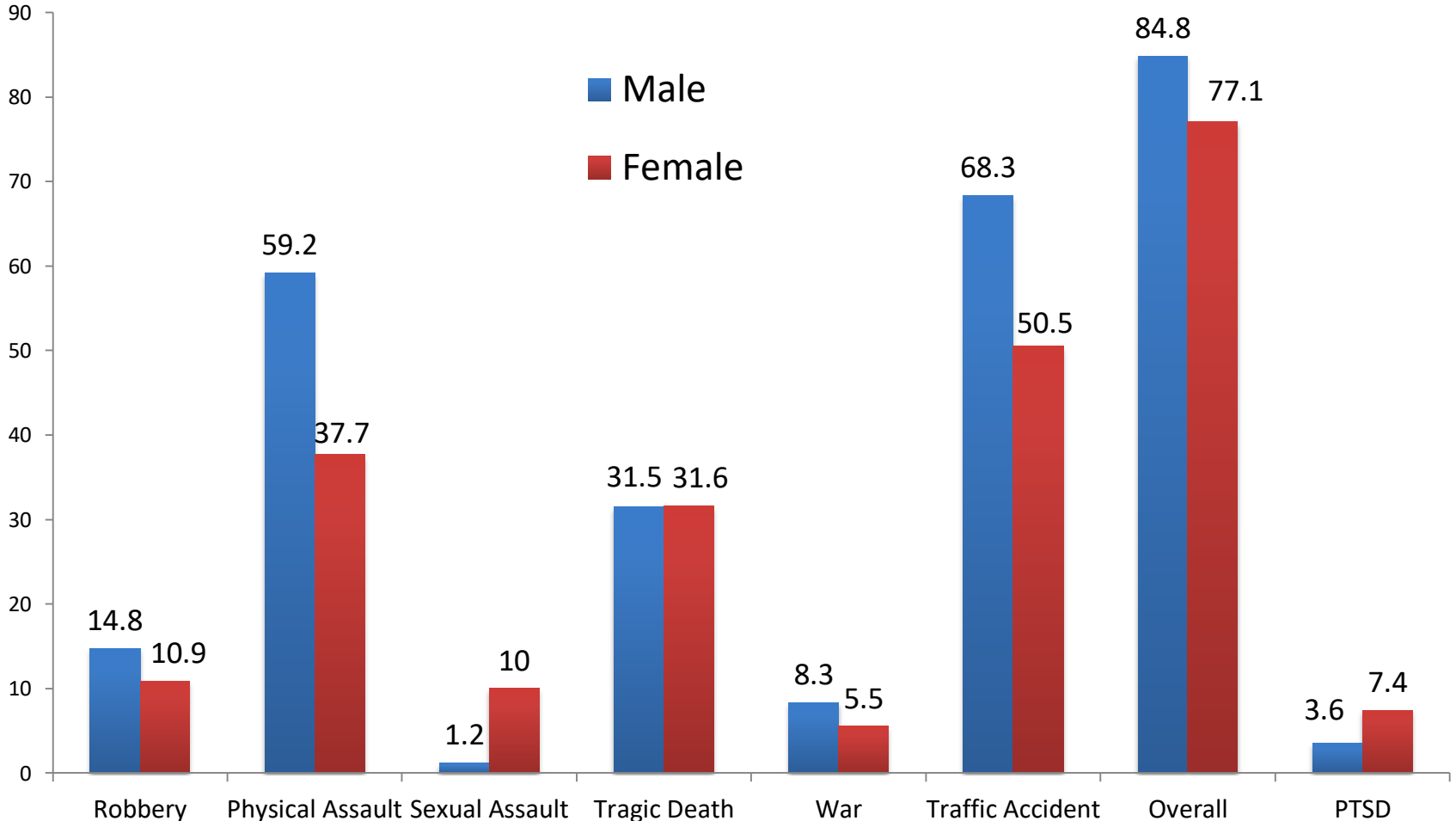
Negative Changes in Thoughts and Mood (at least two of the following):

- Inability to remember an important aspect of event
- Persistent and elevated negative evaluations of self, others, or the world
- Elevated blame of self or others about the event
- Pervasive negative emotional state
- Loss of interest in activities
- Detachment from others
- Inability to experience positive emotions

Changes in Arousal (at least two of the following)

- Irritability or aggressive behavior
- Impulsive or self-destructive behavior
- Feeling constantly on guard
- Heightened startle response
- Difficulty concentrating
- Difficulty sleeping

Lifetime Prevalence of Traumatic Events and PTSD



Frans et al. Acta Psychiatr Scand 2005: 111: 291-99

Traumatic Exposure Among Children and Adolescents

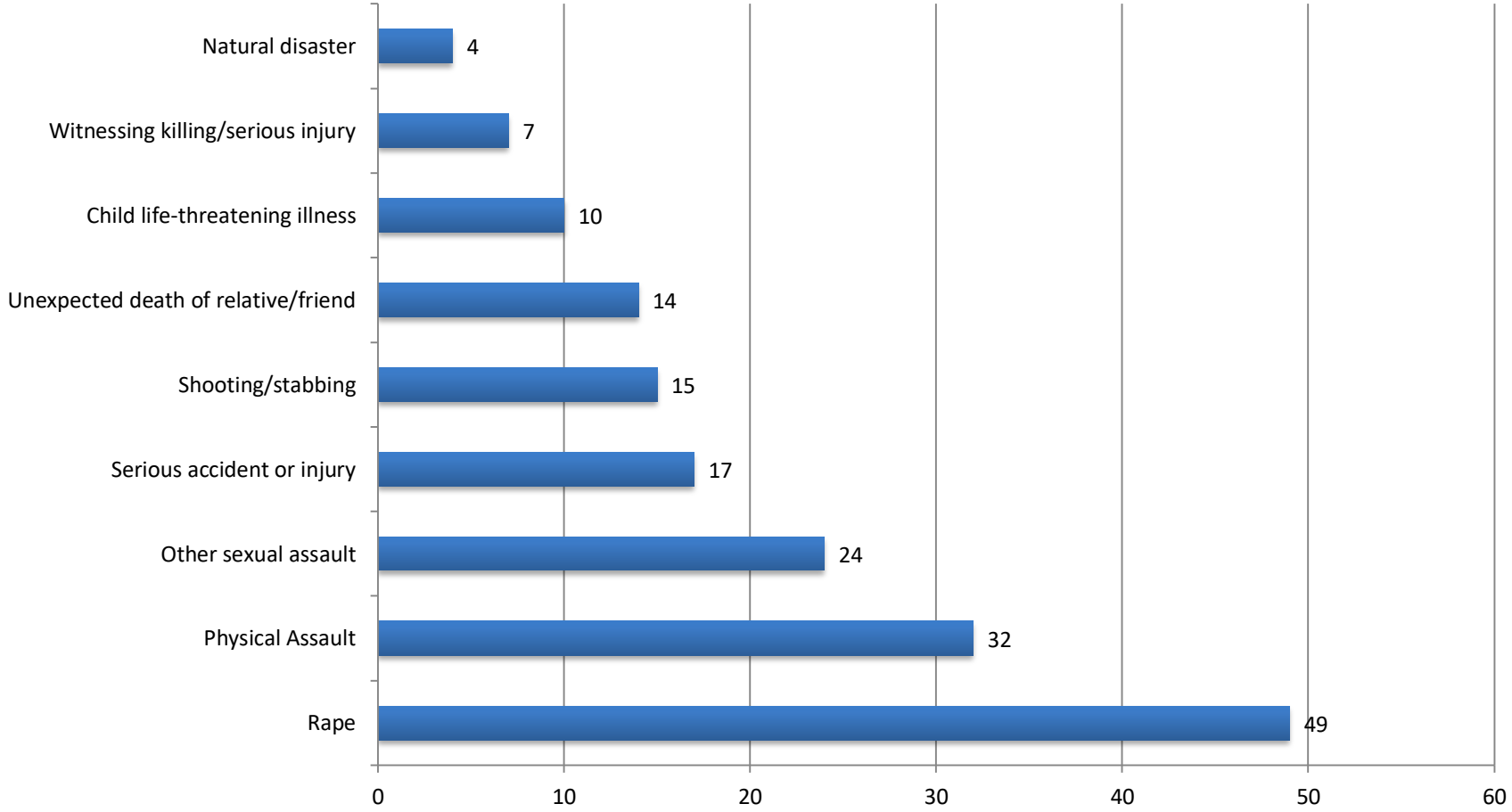
- 25% of girls and 10-12% of boys experience sexual abuse/assault by the age of 18

- One epidemiologic study (Smoky Mountain Study; Costello, 2002) found that:
  - 25% of youth had experienced a traumatic event by age 16
  - 6% had experienced at least one in the previous six months

Risk Factors for PTSD

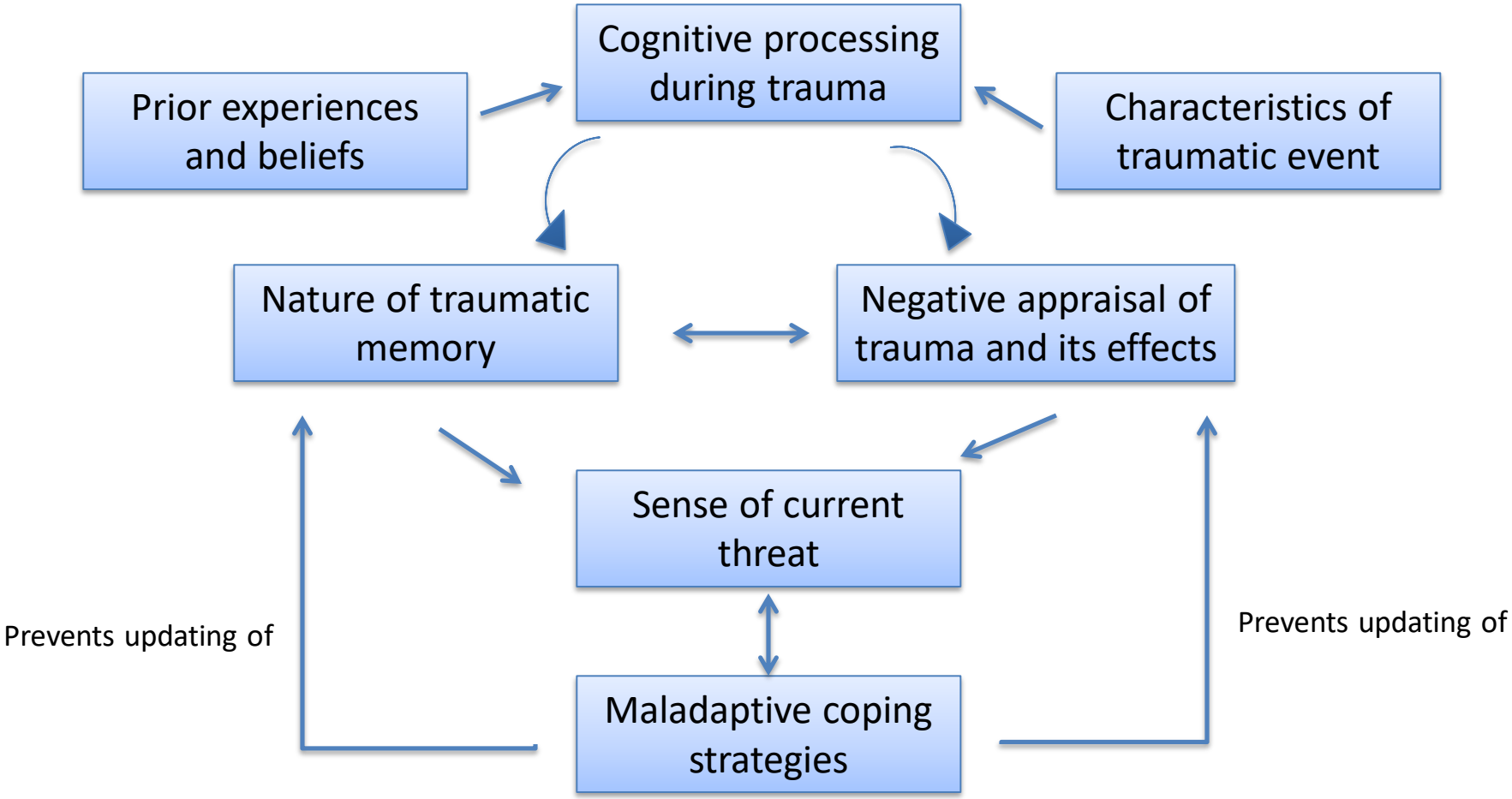
- Individual Factors:
  - Prior hx of trauma or chronic stress (especially at young ages)
  - History of family instability
  - Female gender
  - Genetic factors; family history
  - History of psychiatric disorder (presence rather than specific type)
  - Psychological factors (poor self-esteem, pessimism, neurotocism)
  - Socioeconomic disadvantage
  - Cognitive difficulties and neurological soft signs
- Peri-trauma Factors:
  - Type of trauma
  - Severity of trauma
- Post-trauma Factors:
  - Victim blaming/secondary victimization
  - Lack of social support
  - Delay in treatment

Rate of PTSD Based on Type of Traumatic Event



Perkonigg et al., 2000; Kessler et al., 1995; Ballenger et al., 2000, from www1/appstate.edu

Cognitive Model of PTSD



Ehlers & Clark. Behav Res & Therapy, 2000; 38(4): 319-45

Trauma-focused CBT (TF-CBT)
(Cohen, Mannarino & Deblinger, 2006)

Evidence-based treatment for children and adolescents impacted by trauma, as well as their caregivers

Can be provided across multiple settings

Appropriate for a broad range of kids, but less so for those with behavioral problems

Hybrid treatment model that integrates:

- Trauma sensitive interventions
- Cognitive-behavioral principles
- Attachment theory
- Developmental Neurobiology
- Family Therapy

TF-CBT Components

- **PRACTICE**
  - **P**sychoeducation/Parenting Skills
  - **R**elaxation
  - **A**ffective Modulation
  - **C**ognitive Processing
  - **T**rauma Narrative
  - **I**n Vivo Desensitization
  - **C**onjoint parent-child sessions
  - **E**nhancing safety and social skills

Stabilization Phase
(4-12 sessions)

Trauma Processing Phase
(2-6 sessions)

Integration and
Consolidation Phase
(2-8 sessions)

Psychoeducation

- Normalize child's and parent's reactions to traumatic events
- Provide information about psychological and physiological reactions to stress (e.g., reactions to trauma reminders)
- Instill hope for recovery
- Begin to identify trauma "themes"

Parenting Skills

- Caregivers are a central therapeutic agent for change
- Goal is to build (or rebuild) a trusting, mutually respectful relationship between child and caregiver
- Optimizing parenting skills is important; emphasize positive parenting skills (praise), enhance enjoyable child-parent interactions
- Foster accurate understanding of trauma impact and negative behaviors
- Consider engaging other adults to help provide a safe, supportive, predictable “extended parenting” environment

Relaxation

- Reduce physiologic manifestations of stress and PTSD
- Reduce dysregulation in session to exposure to trauma information
- Awareness of physiologic responses as cues to implement relaxation/coping skills
- Develop individualized relaxation strategies for specific stress-related symptoms (e.g., headache, stomachache)
- Focused breathing/mindfulness/meditation
- Progressive, other muscle relaxation

Affective Modulation

- Traumatized children may have blunted affect and restricted emotional understanding

  Accurately identify different feelings

  Develop an affective vocabulary

  Model, validate, and support appropriate emotional expression

  - Develop practical skills to manage distress
  - Distraction OK initially
  - Physical activity
  - Mindfulness skills

Cognitive Processing

- Perceptual bias modification
  - Targets attention/interpretation bias towards negative affective states in others
- Self-awareness skill training
- Traditional cognitive restructuring techniques
- Encourage parents to assist children in cognitive processing of upsetting situations, and to use this themselves for affective modulation

Trauma Narrative

- Critical, albeit challenging part of treatment
- Allows the child to:
    - Gain mastery over trauma reminders
    - Resolve avoidance symptoms
    - Correction of distorted cognitions
    - Model adaptive coping
    - Identify and prepare for trauma/loss reminders
    - Contextualize traumatic experiences into life
- Child shares increasingly difficult detials about trauma experiences (including thoughts, feelings, and body sensations)
- Allows the child to “Speak the unspeakable”

Cognitive Processing of Trauma

- Identify trauma-related cognitive distortions, from trauma narrative or otherwise (e.g.,“ I deserve to be abused”)
- Use cognitive processing techniques to replace these with more accurate and/or helpful thoughts about the trauma
- Therapist shares the trauma narrative with caregiver, allowing them to prepare emotionally to help their child
- Encourage parents to identify their own maladaptive cognitions (e.g., “Why didn’t he tell me sooner?”) and reinforce children’s more accurate/helpful cognitions

In Vivo Mastery of Trauma Reminders

- Mastery of trauma reminders is critical for resuming normal developmental trajectory
- Also key to permit new learning and decrease reinforcement of avoidance and PTSD sx.
- Progressive exposure to innocuous reminders which have been paired with the traumatic experience
- Parents and other adults support the child's mastery of these situations; consistent, patient practice is key

Conjoint Parent-Child Sessions

- Fosters gradual transfer of communication and primary trust relationship from therapist to caregiver.
- Child shares narrative with caregiver; caregiver learns how to respond supportively
- Correct cognitive distortions (child and parent)
- Encourage optimal parent-child communication
- Prepare for future traumatic reminders
- Plan for trial and error and help child learn to tolerate disappointments/setbacks

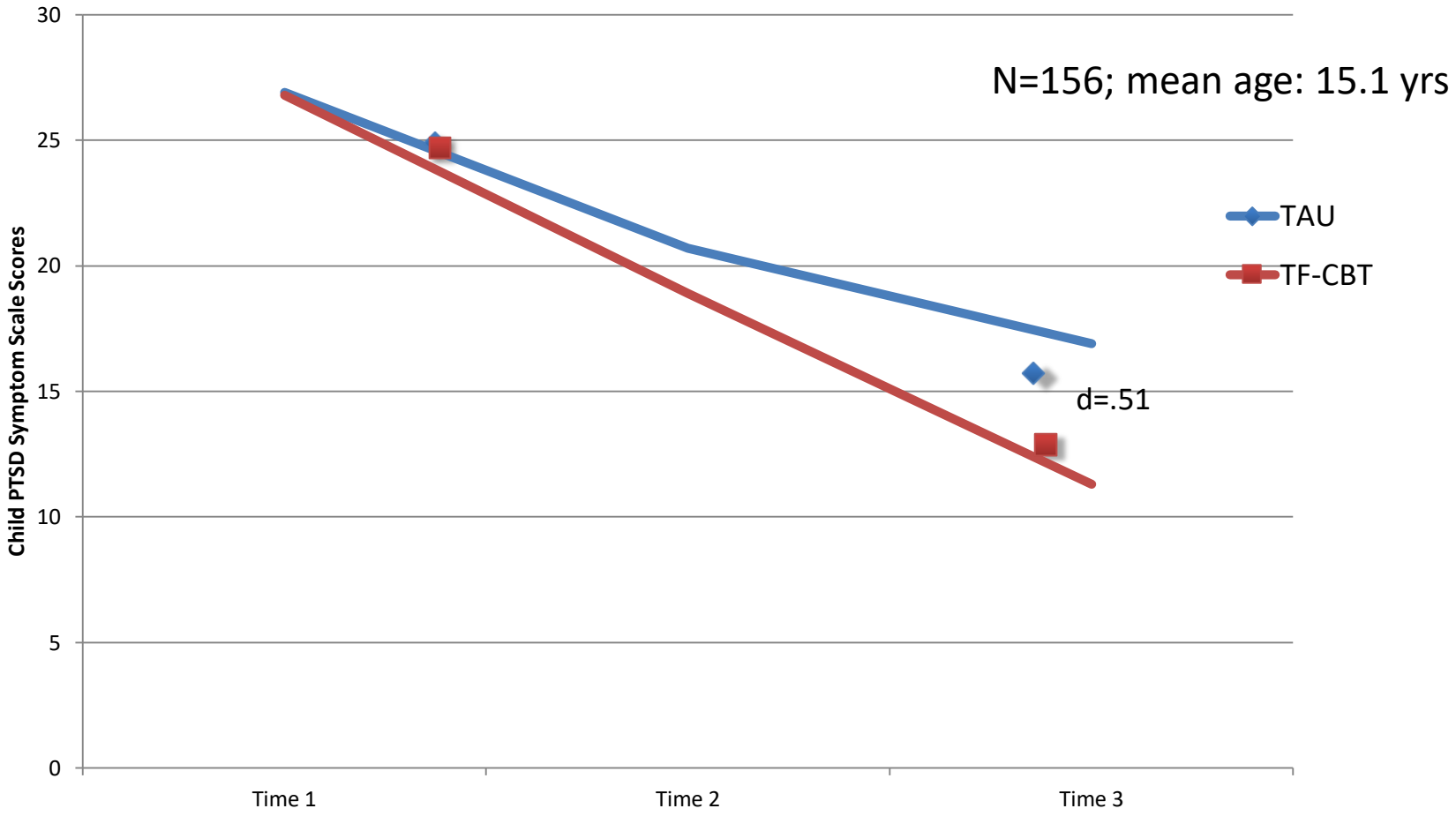
Enhancing Safety Skills

- Enhance child's sense of safety (may be first priority for some)
- Establishing trusting therapeutic relationship is essential (secure attachment)
- Therapist advocates to other adults (caregivers, teachers)
- Develop children's body/personal safety skills
- De yvelop a safety plan including identifying safe adults, additional external resources, may involve engaging other services
- Practice these skills outside of therapy
- For sexually abused children, include education about healthy sexuality
- For children exposed to DV, PA, CV, may include education about bullying, conflict resolution, etc.

Empirical Support for TF-CBT

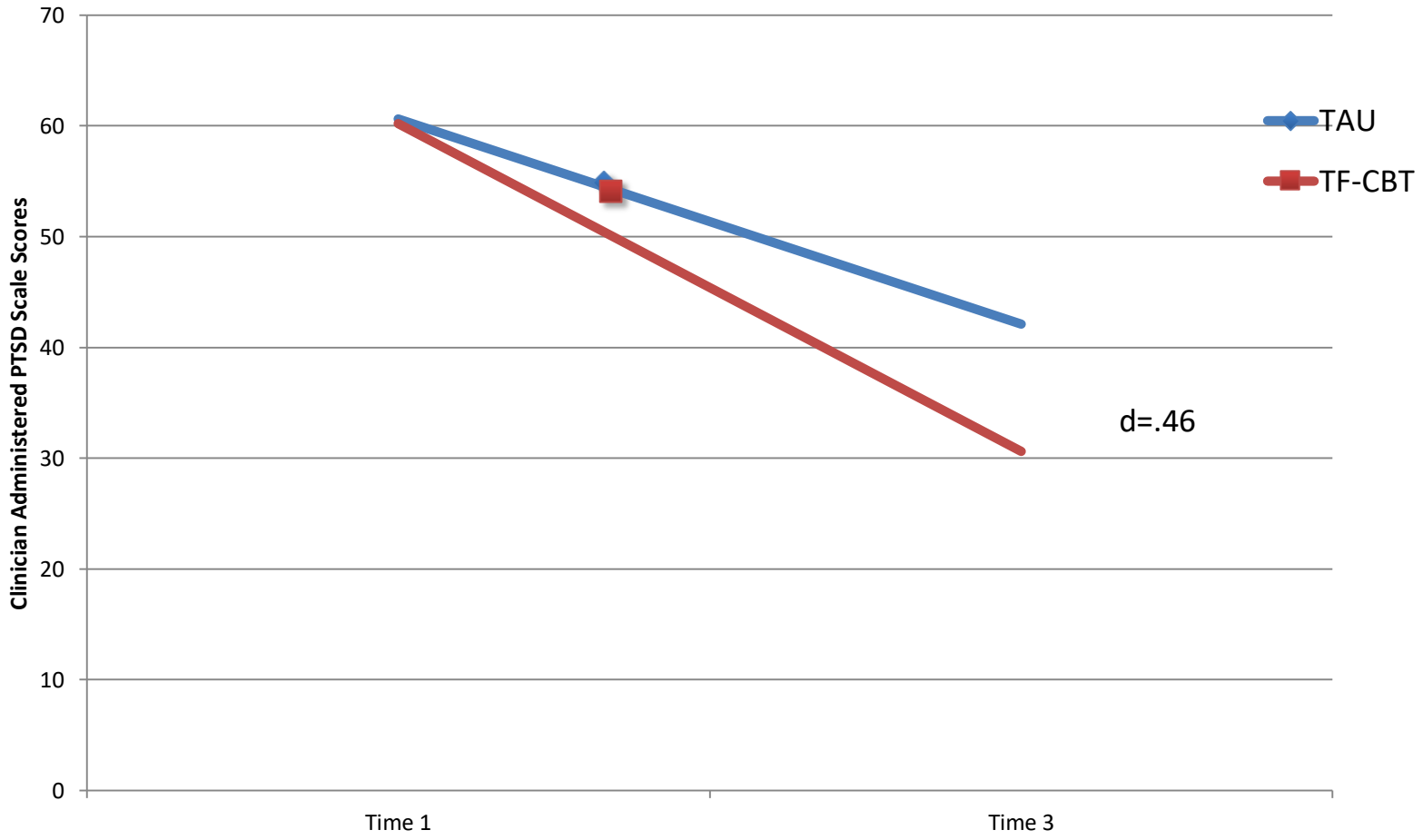
- >13 completed randomized controlled trials (RCT) using comparison treatments
- >1200 traumatized children (mostly sexual abuse), 3-18 years old
- TF-CBT meets criteria as a well-established intervention
- Demonstrated efficacy in reducing PTSD symptoms and other emotional problems in traumatized children (pre-post treatment change)
- Superior to other active treatments with regard to improvement in PTSD sx, depression, anxiety, internalizing, externalizing, sexualized behaviors, shame, abuse-related cognitions
- Treatment gains maintained over follow-up (e.g., 18 months post treatment)

Effectiveness of TF-CBT for trauma-exposed youth: Child Ratings



Jensen et al. J Clin Child Adolesc Psychol 2014; 43(3): 356-69

Effectiveness of TF-CBT for trauma-exposed youth: Clinician Ratings



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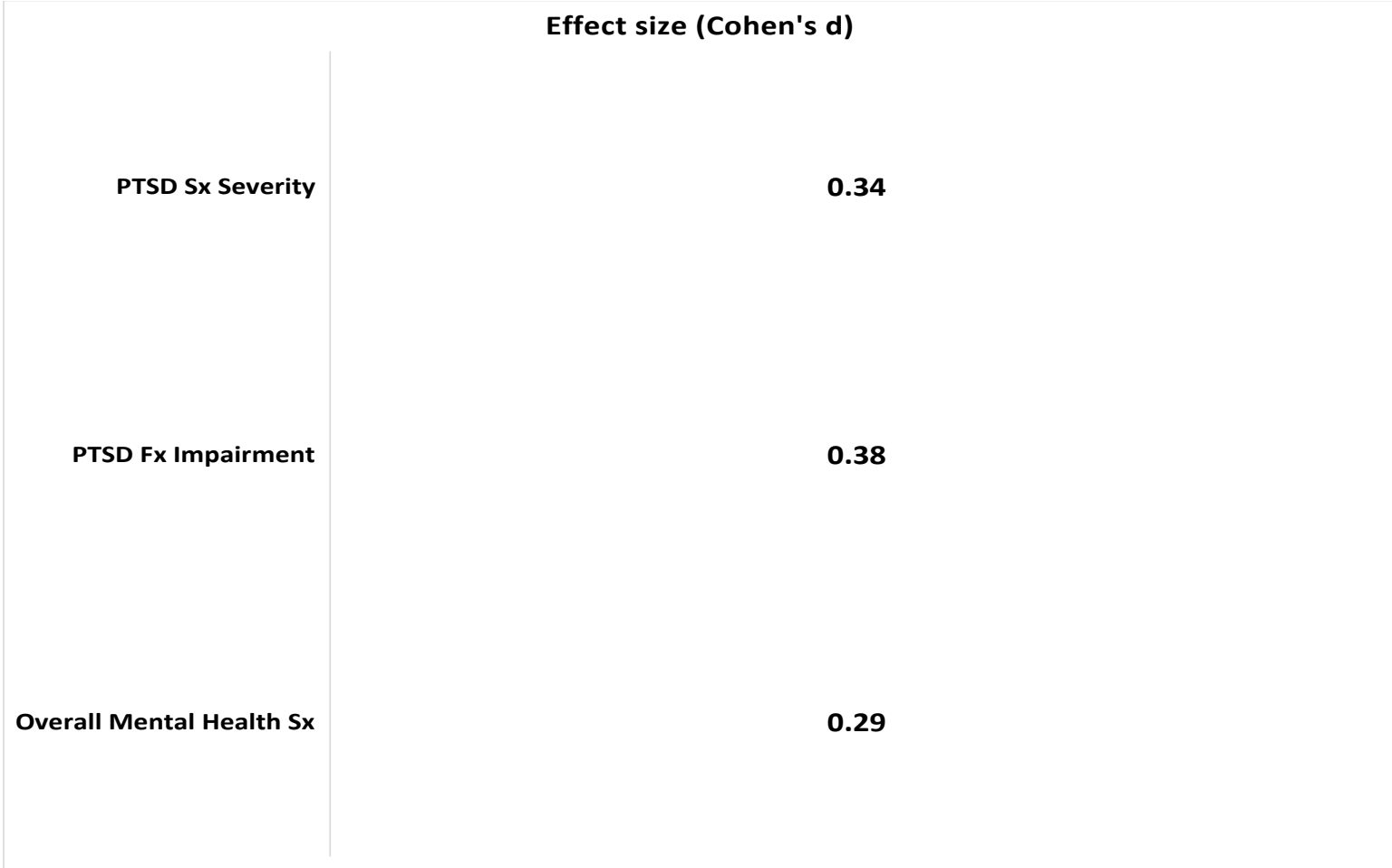
Effectiveness of TF-CBT in Community Settings



Rudd et al., 2019, Am J Community Psychol 64(3-4): 438-50.

Resources

- ptsd.va.gov
- Foa et al. (2007) Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences
- Resick & Schnicke (1996) Cognitive Processing Therapy for Rape Victims: A Treatment Manual
- Hendricks et al. (2014). Dealing with Trauma: A Workbook for Teens
- Seeking Safety (www.seekingsafety.org)
- Trauma-focused CBT (www.tfcbt.org)