

Adapted
TF-CBT

*Trauma-Focused
Cognitive Behavioral Therapy*

**Step-by-Step
Overview and Checklists**

Adapted from & Based on TF-CBT
by Dr.s Cohen, Manarino & Deblinger

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ACKNOWLEDGEMENTS & BACKGROUND

THANK YOU to the developers of TF-CBT who have provided clinicians with a useful, practical, helpful, understandable, and needed trauma therapy model. But, more importantly, thank you for providing a roadmap to recovery for victims.

THANK YOU Anthony Mannarino, PhD., Judith Cohen, MD and Esther Deblinger, PhD for all the research studies, dissemination of information, training, resources,... Thank you for the tireless and ongoing work you have done to further the study and implementation of how to help those needing assistance on their journey of recovery from trauma. You have helped clinicians, victims, caregivers, families, and institutions. Your work stands out. Thank you!

Background

In searching for a counseling modality appropriate to individuals with multiple trauma experiences, TF-CBT stood out as a promising approach.

I'd been asked to help develop and oversee the counseling program at a home for young girls rescued from sex trafficking in Southeast Asia. Even though I had almost 20 years of experience working with sexual abuse survivors, I wanted to do additional research. So, I read comparative studies on therapeutic methods indicating TF-CBT to be preferred or "best practices" for working with sexual abuse and PTSD victims, as well as other related conditions.

As I began studying this counseling modality, it made sense to me. I was pleased to realize that much of what I had been doing the past 20 years lined up well with the components of TF-CBT. While I had been providing counseling services that included much of what is in TF-CBT, it added a few 'steps' and put them in an important sequential order.

The next issues to address were:

Would I be able to adapt this method for those of other cultures?

Would I be able to make it accessible to "counselors" (staff members with little or no actual counseling or psychology training) – without losing the integrity of the model?

Would I be able to make it "user friendly" enough to be able to explain the overall concept and the initial steps to the caregivers?

In order to utilize the model overseas I felt a need to re-name the steps, in order to make it more "user friendly". This did not change the model but made it more understandable. A year after the initial training and implementation, the rescue home director shared that the counseling program (using the TF-CBT approach) was going very well. During that year, we continued to make a few small adaptations considering the young girls (sex trafficking/multiple trauma victims), the staff (and their level of knowledge and training), and cultural concerns.

Another organization, overseeing victim Aftercare in various locations around the world, observed the use of this "adapted" TF-CBT and now incorporates it's use in their victims' services.

Many have shared their relief and thankfulness at having a well-researched model, a road map of sorts, of how to help those suffering from trauma. TF-CBT provides this model and thereby brings hope and help to helpers and victims alike.

TF-CBT OVERVIEW

For a thorough understanding of TF-CBT, one should read *Treating Trauma and Traumatic Grief in Children and Adolescents*, Guilford Press, 2006 by Cohen, Mannarino & Deblinger. It provides specific information on the development, components and implementation of the TF-CBT model. Additional training is provided online (<http://fcbt.musc.edu/>) and professional training workshops are offered in various locations in the USA.

The following summary, prepared by Cohen and Deblinger, provides a brief description of the model: "Trauma-focused cognitive behavioral therapy, an intervention based on learning and cognitive theories, is designed to reduce negative emotional and behavioral responses and correct maladaptive beliefs and attributions related to the abusive experiences. It also aims to provide support and skills to help caregivers (and/or nonoffending parents cope effectively with their own emotional distress and optimally respond to their children)."

The acronym **CRAFTS** is used to summarize the **core values** of TF-CBT:

- C Components based
- R Respectful of cultural values
- A Adaptable and flexible
- F Family (caregiver) focused
- T Therapeutic relationship is key
- S Self-efficacy is emphasized

The acronym **PRACTICE** is used to present the **components** of this treatment model:

- P Psychoeducation and parenting skills,
- R Relaxation skills,
- A Affect expression and regulation skills,
- C Cognitive coping skills and processing,
- T Trauma narrative,
- I In vivo exposure (when needed),
- C Conjoint parent-child sessions, and
- E Enhancing safety and future development.

Trauma-focused CBT has been proven effective for children exposed to a variety of traumatic events and has received the strongest empirical support from studies with abused children (American Academy of Child and Adolescent Psychiatry, 1998). It has been used in individual, family, and group therapy and in office-based and school-based settings."

In a National Child Traumatic Stress Network trauma fact sheets, we read, "TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication. A series of randomized controlled trials have demonstrated the superiority of TF-CBT over nondirective play therapy and supportive therapies in children (ages 3 to 14) who have experienced multiple traumas, and those positive results were maintained over time. TF-CBT has proven to be effective in improving PTSD, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. The parental component of TF-CBT increases the positive effects of TF-CBT for children by improving parents' own levels of depression, emotional distress about their children's abuse, support of the child, and parenting practices." *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Trauma Treatment Fact Sheets vers.1.0, 2004, National Child Traumatic Stress Network www.NCTSN.org*

A comparative study, the Kauffman Best Practices Project, was conducted to evaluate various counseling modalities with minor victims of sexual abuse. Here is a brief summary:

“Through this process (of evaluating various counseling modalities), three intervention protocols emerged as clear, consensus choices as “Best Practices” in the field of child abuse treatment:

1. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
2. Abuse Focused-Cognitive Behavioral Therapy (AF-CBT)
3. Parent Child Interaction Therapy (PCIT)

It is important to note that these three Evidence Based Treatments (EBTs) are not the only protocols that could have been described as “best practices.” Indeed, there is evidence emerging with each passing month of other solid well-supported practices. However, these three protocols enjoyed the greatest level of theoretical, clinical, and empirical support, and the most agreement among the participants in the consensus-building process.”

Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices -- The Findings of the Kauffman Best Practices Project to Help Children Heal From Child Abuse.

ADAPTATIONS

The first adaptation simply changed the labels for the various steps, in order to facilitate ease of understanding (and to provide some name consistency), *while not compromising the integrity of the model.*

TF-CBT Comparison Chart

Original TF-CBT¹ “Trauma Focused Components”	Adapted TF-CBT₂
<i>(Intake & establish therapeutic alliance)</i>	1 Gathering
1 Psychoeducation	2 Learning
2 Parenting Skills	3 Helping
3 Relaxation	4 Relaxing
4 Affective Expression & Modulation	5 Feeling
5 Cognitive Coping & Processing I	6 Thinking
6 Trauma Narrative	7 Sharing 1a & 1b
7 Cognitive Coping & Processing II	8 Evaluating
8 In Vivo Mastery	<i>(incorporated under Living)</i>
9 Conjoint Child-Parent Session	9 Sharing 2
10 Enhancing Future Safety	10 Living: Free, Safe & Well
<i>(added)</i>	Reintegration-Reunification

1 original step names - see *Treating Trauma and Traumatic Grief in Children and Adolescents*, Cohen, Mannarino, Deblinger, 2006, Guilford Press

2 components renamed (to be more user friendly and to facilitate understanding) by Becca C. Johnson, Ph.D., Licensed Psychologist, USA

Perhaps a good way to present the adaptations is to include the letter written to the developers:

“...I’ve summarized the adaptations below:

1. *The steps were renamed so as to be 'user-friendly' for those of other languages and cultures as well as for non-professionals:*

Psychoeducation = Learning

Parenting Skills = Helping

Relaxation = Relaxing

Affective Expression & Modulation = Feeling

Cognitive Coping & Proccession = Thinking

Trauma Narrative = Sharing

Processing the Traumatic Experience = Evaluating

In Vivo Mastery AND Enhancing Future Safety = Living Free, Living Safe & Living Well

2. *In the Trauma Narrative (Component 6) and Processing the Traumatic Experience (Component 7), we found it helpful to delineate two different sub-steps (specifically for victims of sex trafficking):*

1-Trauma narrative based on what was done TO the victim/person

2-Trauma narrative based on what the victim did TO other victims/persons

In human trafficking, especially in the sex trade, many victims are coerced, manipulated, brainwashed,... into engaging others in sexual acts. Or, out of habit, control &/or anger, are abusive to others. One survivor shared how she had to hold another girl down while the girl was being raped for the first time. Another shared of having to recruit other girls and to force them into sexual activities. While the trauma narrative focuses on what has happened or been done TO the victim, we found it necessary to also encourage the girls (at some point in the therapy, often later) to bravely share what they did, either by force or choice, TO others.

“Examples might include:

- + having to hold someone down while others did something (sexual, ‘bad’, degrading) to her*
- + having to watch someone be tortured (&/or killed)*
- + being forced/threatened to do sexual or other ‘abusive’ acts on other people*
- + doing ‘abusive’ acts on others (not by force, but habit, choice &/or anger)*
- + enjoying & participating in the ‘abusive’ activities”*

3. *Since many of the programs and agencies providing Aftercare with victims of human trafficking around the world are residential, the Parental role & skills were incorporated into staff training for all personnel, with special attention on the House Parents (House Moms).*

As you know, in many cases it is not possible to use the parents as they are often the offenders or perpetrators of the abuse/trauma. This is especially true in Southeast Asia where it is often the parents who willingly sell their daughters, not necessarily for food, but often for material possessions and comfort. (In other countries, the young girls have been ‘disowned’ or ‘thrown out’ by her family.)

In my presentations, I quote from your book,

“Although several group treatment approaches have not included a parental treatment, we believe that including parents is optimally helpful for most traumatized children... Parents have an important impact on whether, to what degree, and how quickly children recover from trauma-related problems...” (pg 37)

“While we strongly advocate that parents or other caretaking adults participate in this treatment, we also acknowledge that children may benefit even in the absence of parental involvement.” (pg 40)

Residential programs are generally well-suited to provide the consistency in behavioral management and in offering the unconditional love and acceptance so needed in establishing safety and emotional healing. That is, of course, when all staff are well-trained and compliant with the therapeutic goals.

4. *I illustrate the model as the construction of a house. Initial components being the foundation while latter components represent the building itself (walls and roof). Also, I share that when finances &/or personnel are unavailable or limited, several components can be conducted in group settings (such as psychoeducation, relaxation, thinking, feeling).*

5. *Psychoeducation, along with topics suggested in your book, also includes information on human trafficking and the sex trade (sexual exploitation).*

(the letter continues...)

I was glad to read in the information “How to Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)” (2008 updated version):

“...real-life cases may require temporary deviations from ideal TF-CBT protocols or that other issues in treatment may take temporary precedence.” (pg 17)

“Creativity and flexibility are necessary when adapting the TF-CBT model to best serve the needs of each individual child and family while maintain fidelity to the core TF-CBT components.” (pg 33)

I have sought to maintain fidelity to the model, while at the same time making necessary cultural adaptations and making it more accessible to those with limited resources as well as lesser degrees of education and training.

Several NGOs (non-governmental organizations) have shared of positive results in the implementation AND results with victims of human trafficking.

I appreciated the statement in the implementation manual, “Many therapists are already using and including many TF-CBT components and activities but may not have labeled or conceptualized them as such.” That summarizes well how I felt when first studying TF-CBT. It made sense to what I’d already been doing BUT added important missing components and put them all in a ‘best practices’ sequence. THANK YOU!

Again, let me express my gratitude for all the years (and tears) you have given to making this practical and useful model.

*With gratitude,
Becca*

*Becca Johnson, Ph.D.
Licensed Psychologist*

*Helping Victims of Sex Trafficking
Serving Sexually Abused Children & Adolescents”*

November, 2010

GUIDE to this BOOKLET

The presentation of each TF-CBT step includes:

1. The adapted NAME and Step Number, with the original name in parentheses
2. The overall GOAL of the Step
3. An OVERVIEW of the Step
4. A Checklist of TO Dos for that step

Throughout this book, the term 'girl' is often used to refer to the victims, in addition to the terms client, woman or victim. Although victims are both male and female, the term 'girl' represents the majority - which are women and girls.

TF-CBT Resources & Activities

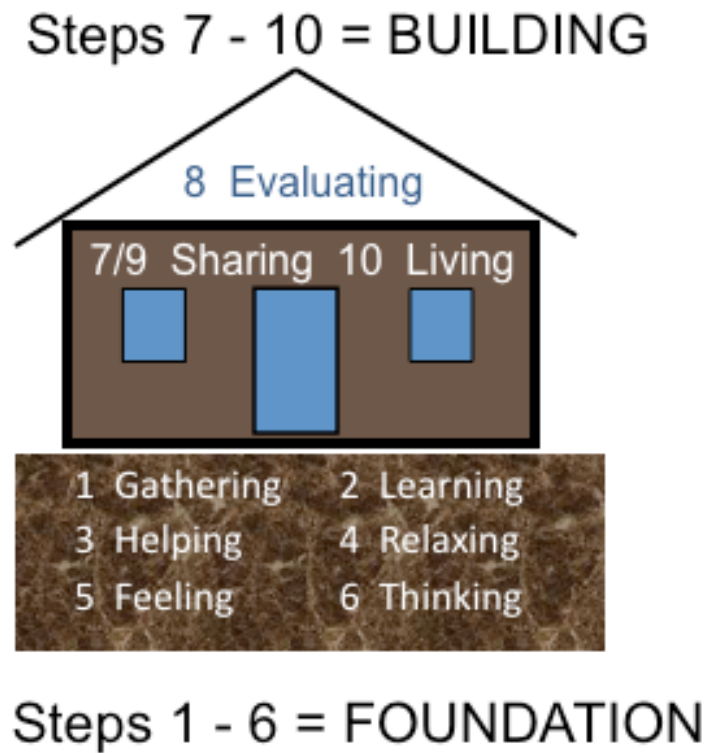
This booklet provides only the therapeutic framework for those utilizing the TF-CBT. Implementation requires the use of various activities and resources in order to implement this trauma model. Many therapists are already providing many useful therapeutic tools which can be incorporated into the TF-CBT framework.

Another document, developed to accompany this *Step-by-Step Overview and Checklists* provides a compilation of various resources (not exhaustive) that could be utilized in the implementation of each step: *TF-CBT Resources & Activities*.

Many other activities can be identified and utilized to help clients in their healing journey. Those provided in the *TF-CBT Resources & Activities* booklet represent just a few of the many possible therapeutic interventions available.

Many of these step activities come from resources I have developed over the years; from other clinicians and also from the Harborview Center for Sexual Assault and Traumatic Stress website (<http://depts.washington.edu/hcsats/resources.html>).

Conceptualization of the Adapted TF-CBT



Becca C. Johnson, Ph.D. Licensed Psychologist

Steps 1 – 6 can be considered to be the Foundation of the healing process, while the latter steps, 7-10, are the Building of the personal healing.

Foundation

- 1 - Gathering
- 2 – Learning (Psychoeducation)
- 3 - Helping (Parenting Skills)
- 4 – Relaxing (Relaxation)
- 5 - Feeling (Affective Expression & Modulation)
- 6 – Thinking (Cognitive Coping & Processing)

Building

- 7 - Sharing I (Trauma Narrative)
- 8 - Evaluation (Cognitive Coping & Processing II)
- 9 - Sharing II (Conjoint Child-Parent Session)
- 10 - Living (In Vivo Mastery, Enhancing Future Safety)

FREQUENTLY ASKED QUESTIONS

Should counseling be done in Individual &/or Group Sessions?

When resources, time, staff and energy are limited, it might be desired or necessary to conduct sessions in a group setting. The following Steps (the majority of the Foundation) can be completed in either an individual or group format:

- | | |
|-------------------------------|--|
| 2. Learning (Psychoeducation) | 5. Feeling (Affective Expression & Modulation) |
| 3. Helping (Parenting Skills) | 6. Thinking (Cognitive Coping & Processing) |
| 4. Relaxing (Relaxation) | |

How many sessions are needed in EACH Step?

The number of sessions at each Step varies greatly and depends on agency, funding, resources, staff, setting (residential, outpatient),...

It also depends on the victim's:

- Age
- Personality
- Trauma (type, duration, singular or multiple/complex,...)
- Ability to understand (developmental/mental comprehension)
- Situation/circumstances (legal proceedings, immigration status,...)
- Support systems (family, friends, faith,...)
- Housing situation (whether in a trauma-sensitive residential program, with family or other caregivers (foster family care, group home) or institutionalized (juvenile detention, incarceration,...))

... anywhere from 2 - 12 sessions per Step.

How many sessions are needed to complete ALL Steps?

It depends on:

- the individual and his/her situation
- the format: group &/or individual counseling
- whether there are restrictions and/or limitations (i.e. insurance reimbursements; staffing; funds,...)

The time needed might be anywhere from 4 months to 2 years. For those with limitations, it may be as little as 10 sessions. In fact, one organization provides the Foundational Steps separately (in individual or group settings and by less qualified staff) much like an educational group, while the latter steps are conducted in ten more individualized, therapy sessions with counseling professionals. Residential centers with in-house counseling staff generally have more flexibility and less restrictions on the number of sessions needed to complete the therapy program.

Step 1

GATHERING

The key to a positive therapeutic outcome is a positive therapeutic relationship, and, a well-developed and executed treatment plan. BCJohnson

Step 1 Gathering

OVERALL GOAL

To develop a positive, safe, therapeutic relationship and to gather needed and helpful information.
That is, to *Gather Together and Gather Helpful Information*

OVERVIEW

During this initial step, we seek to:

DEVELOP a therapeutic relationship of safety, rapport and trust
(Utilize a variety of activities, games and questions.)

PROVIDE client with information regarding the counseling process

- * Explain what counseling is/isn't
- * Clarify expectations
- * Inform about consent/client rights
- * Provide a brief overview of TF-CBT
- * Emphasize the importance of communicating if uncomfortable, confused, angry,...

GATHER information

Conduct a thorough Intake Assessment (including a Mental Status Exam and a comprehensive Psychosocial History) and administer any desired assessment measures for treatment planning, progress, treatment and program effectiveness, evaluation and research (if needed).

Information to gather should include:

- * Mental Status Exam - assessing current mental/emotional/behavioral status
- * Psychosocial history Intake, gathering information on family, health, prior counseling, education, substance use, job history, relationships,...
- * Assessment measures (depression, anxiety, trauma, psychopathology/clinical concerns)
- * Projective Drawings

Have person make several drawings during this initial step (and/or incorporate into the "Book About Me" (explained below).

Highly Desired: Self -- Family -- House-Tree-Person

Optional: "Happiness" -- "Safety" -- "Sadness" -- "Peace"

Girl/Boy - Man/Woman -- School -- Home/Center -- Temple/Church

DOCUMENT a Treatment Plan

- * Develop client *Problems List*, Identify client *Strengths and Concerns* (cultural, religious, ethnic), Identify *Potential Barriers to Treatment*; *Needed Interventions*, *Resources* and/or supplemental treatments; *Diagnoses*
- * Write an individualized *Treatment Plan*

ENCOURAGE the person to TELL a STORY in detail

(from a positive or neutral memory, NOT a negative one). This will serve as a baseline narrative (practice) for later, when asked to tell her own trauma narrative.

Telling a Story

During the relationship building sessions, the girl should be asked to **tell a detailed story** (from a neutral or positive memory, NOT a negative one) about something (last placement, family, cultural festival/holiday,...). Ask her to tell it in as much detail as possible and to describe it as if you were blind and couldn't see, encourage her to tell you about smells, sounds, people, clothes, weather,... Keep prompting her for as many details as she can remember. This is an important practice for later in the steps when she will be asked to tell her own personal trauma story in detail.

BEGIN (optional but recommended)

a). the personalized “Book About Me”

This booklet helps reinforce learning, explore identity, encourage self-efficacy, clarify beliefs and values, identify feelings, thoughts and maladaptive responses; trauma triggers; future goals and more (depending on what pages the therapist/program decides to include and/or encourage). It is incorporated into the ongoing counseling process (not completed all at once).

Possible Content Pages (and possible # of pages)

- + Title Page with girl's NAME (1)
- + Identifying Information: name, age, date of birth, names and ages of parents & siblings, birthplace,... (1-2)
- + Drawings (intermingled): Family, Self, House-Tree-Person, others (3+)
- + Interesting information about the girl: self descriptors, strengths, personality traits, favorites, hobbies, experiences,.. (1-3)
- + Sentence completions and Questions (clarifies values, interests,...) (2-5+)
- + Life Before (the Trauma): drawing, collage, information completion, poem,... (1+)
- + What Happened (Trauma Narrative): drawing, collage, information completion, poem,... (1+):
- + What Happened Afterwards (running away, police, detention, placement,...): drawing, collage, information completion, poem,... (1+)
- + Life Now (“how I feel & think, what I've learned, how I am different, what advice would I give to others,...”): drawing, collage, information completion, poem,... (1+)
- + Future Goals and Hopes: drawing, collage, information completion, poem,... (1+)

b). Personal Journaling, and/or

c). Responsive Journaling between client and counselor

A back-and-forth journal where each person writes comments, thoughts, feelings &/or questions and the other responds.

STEP 1: GATHERING

Objective: To build a relationship with the client while gathering important information.

NAME: _____ **PROGRAM LOCATION:** _____

Tasks	Date Completed	Notes
Establish rapport* (i.e. Identify client likes/dislikes, motivations, interests,...)		
Explain the purpose of counseling, confidentiality, client rights, TF-CBT		
Complete thorough Intake Assessment including Psychosocial History and Mental Status Exam		
Complete initial symptom & clinical assessments: trauma, depression, anxiety, self-esteem, drawings, clinical issues, psychopathology,...		
Develop client <i>Problems List</i> , Identify client <i>Strengths and Concerns</i> (cultural, religious, ethnic), Identify <i>Potential Barriers to Treatment; Needed Interventions, Resources</i> and/or supplemental treatments; <i>Diagnoses</i>		
Write/document an individualized Treatment Plan		
Practice storytelling/recalling a positive or neutral memory		
Begin "Book about Me," (including drawings of self, family, and a House-a Tree-a Person)		
Optional: Begin Personal Journaling (or Responsive Journal between client & counselor)		
Other:		

**Utilize a variety of activities, resources &/or games to develop and establish the therapeutic relationship. Building trust and feeling emotionally and physically safe are our goals for the client.*

Step 2

LEARNING

(Psychoeducation)

“Psychoeducation... normalizes the child’s responses, which results in emotional validation, a sense of increased acceptance, and a greater likelihood of cooperation during the treatment process.”

(Treating Trauma and Traumatic Grief in Children and Adolescents, Cohen, Mannarino, Deblinger, 2006, page 62)

Step 2 Learning

OVERALL GOAL

To educate victims about abuse and trauma
(and other important related topics).

OVERVIEW

Providing information about abuse and trauma normalizes the experience and validate one's reactions, helping the victim realize that she is "not alone nor crazy". Providing information on other pertinent topics (such as of sex, exploitation, assault, healthy relationships, self-esteem) gives victims a needed, foundational understanding. The information is provided in an educational, rather than personal, way (not requiring personal disclosure, emotional vulnerability and possible re-traumatization).

During this step, we:

TEACH about Abuse and Trauma (and related topics)

(Exploitation, Trafficking, Sexual Assault, Coercion,..)

- Definitions, Terms and Types (what is abuse/trauma, sexual coercion, assault and harassment; types of abuse; causes,...)
- Who are the Abused/Abusers-Perpetrators
- Statistics and Facts; Prevalence and the Who, When, Where & Why?
- How it affects people: Emotional, Physical, Mental, Social & Behavioral Responses (symptoms, reactions, possible behavioral outcomes, coping strategies,...)
- Typical Healthy/Unhealthy Coping Responses

PRESENT information on Sex Education

- body parts and functions
- birth control, abortion
- sexually transmitted diseases and AIDS
- other helpful, related information

DISCUSS additional Possible Topics

- Healthy/Unhealthy Relationships: Love and Affection versus Lust and Attraction
- Self-esteem
- General knowledge about victim's rights (consent, laws) and the legal system (*if not already presented in Step 1 or if better to wait until Step 10*)

PRESENT Creatively

Be creative and age appropriate. Utilize books on trauma/abuse/sex education, as well as information sheets, movies, activities, games, puppets, dolls, role plays, skits, dramatic readings, poems, music, collages, drawing, sand play, toys,... The goal is for the information to be helpful, appropriate and personally appropriated.

Note:

- ⇒ The girl may feel uncomfortable and/or be non-compliant when talking about her situation, life and/or trauma/abuse. It is less potentially re-traumatizing to present the information in a more general or impersonal way rather than asking “Did you experience (know, do, feel,...) this?”

STEP 2: LEARNING

Objective: To provide accurate information to the client about abuse and trauma (and other pertinent topics) that will normalize and validate feelings and reactions and provide a helpful foundational understanding.

NAME: _____ **PROGRAM LOCATION:** _____

Tasks	Date Completed	Notes
Provide psychoeducation about abuse*		
Provide psychoeducation about trauma*		
Provide psychoeducation about exploitation & human trafficking* (<i>if applicable</i>)		
Provide developmentally appropriate sexual education (including anatomy, terms, AIDS, STDs, birth control, ...)		
Provide psychoeducation on self-esteem and relationships (healthy friendships, romantic & coercive relationships, domestic violence, sexual assault, Love & Affection vs Lust & Attraction, boundaries,...)		
Provide information on one's human Rights, value & worth (<i>if not already done or wait until Step 10</i>)		
Other Beneficial Topics (<i>based on individual/group needs</i>) i.e. <i>Self Esteem, Anger Management, Communication,</i>		

* Terms & definitions, statistics, symptoms (emotional, behavioral, physiological, social, mental), feelings, beliefs, reactions, coping mechanisms,...

Step 3

HELPING

(Parenting Skills)

“The parenting (*caregiver*) skills included in TF-CBT, although basic and easy to learn, have been found to have a great impact on *caregiver* abilities in *caregivers* of children experiencing behavioral problems in response to trauma such as sexual abuse.”

(Treating Trauma and Traumatic Grief in Children and Adolescents, Cohen, Mannarino, Deblinger, 2006, page 67)

Caregivers with good coping skills increase the child’s coping skills.

We generally parent the way we were parented and, unfortunately, many of us were parented in unhealthy, abusive ways.

Step 3 Helping

OVERALL GOAL

To help caregivers deal effectively with trauma victims.

OVERVIEW

In this step we want to help the caregivers respond to the victims' trauma symptoms, reactions and behaviors in ways that are helpful, by providing psychoeducation, affect attunement, behavioral management and positive reinforcement skills.

During this step, we provide training to:

HELP Caregivers understand child development as well as the effects of abuse and trauma on the victims. (Refer to Step 2)

PROVIDE an overview of the TF-CBT counseling model and explain the key role Caregivers play in the process of emotional healing.

INSTILL in Caregivers the importance of clear, consistent boundaries & discipline in the victim's emotional healing.

GIVE Caregivers behavioral management (discipline) tools and skills:

1). PRAISE

- Be specific
- Be consistent
- Do it as soon as possible
- Do it without "But..." (correction or criticism)
- Be enthusiastic
- Give it OFTEN

2). 'Selective' IGNORING

- Don't react (verbally or non-verbally)
- Wait until later to respond
- Never ignore dangerous behaviors or verbal assaults
- Ignore negative behaviors directed at caregiver

WHAT TO IGNORE (pg. 70)

Temper tantrums or angry verbalizations
Making nasty faces, rolling eyes, smirking
Mocking, taunting, mimicking
Annoying comments

3). TIME OUT

The purpose is:

To interrupt negative behavior, allowing child to regain emotional and behavioral self control

To remove child from an attention-seeking opportunity

Using Time Outs

Use time out AFTER first clearly requesting child's change of behavior -- and use if child doesn't obey

If needed, calmly escort the child, without discussion

Send girl to be alone for specified amount of time (usually 1 minute/year-age)

Location should be 'boring' and void of activity

Give a loss of privilege if girl doesn't do time out

4). BEHAVIORAL CHARTS

Select behaviors needing change

Develop a plan (reward chart)

Discuss plan with child

Give rewards regularly (daily, weekly)

Give rewards consistently

CLARIFY to the Victims expected behavior and consequences (so they know desired behaviors and the consequences of misbehavior).

PREPARE Caregivers by discussing (preparing for) times that might be more emotionally hard for the victims.

More Emotionally Difficult Times (by BCJohnson, Ph.D., 2007)

Why it is helpful to know WHEN it might be more emotionally difficult for the girls?

- helps the to be prepared for the possibility of misbehavior and/or various emotions
- helps to prepare the girls by talking about it ahead of time
- helps to prepare the caregivers and all staff having contact with the victim
- can be the focus of counseling/group sessions

More Emotionally Difficult Times Include:

- counseling sessions (a time to focus on and talk about painful things)
- bedtime (missing their family, sharing a bed, 'down time' to think)
- when new girls arrive to the program
- on her birthday (if she knows it)
- special holidays and festivals: New Years, Religious
- when the girl is going to have contact with family (phone call, letter, visit)

- when another girl (friend) is going to have or has recently had contact with family (phone call, letter, visit)
- anniversary of an event (happy or sad – for example: of a parent’s death, of being sold/raped,...)
- legal proceedings (court date)
- during menstruation (especially for those who experience pre-menstrual syndrome)

ENCOURAGE Caregivers to deal with their own abuse/trauma experiences and any dysfunctional parenting concerns (past &/or present).

PRACTICE affect attunement skills with the Caregivers. (Encourage and help caregivers understand and develop emotional awareness skills.)

TEACH other pertinent information to Caregivers as needed.

Topics may include those presented to victims in Step 2 plus

- Communication Skills
- Anger Management – Conflict Resolution
- Building Self-Esteem in children/youth
- Stress, Burn-out and Vicarious Trauma
- Strengths-Based approach to working with trauma victims
- Other: _____

STEP 3: HELPING*

Objective: To give caregivers knowledge and skills in how to interact with clients in a helpful way.

**NOTE: This step may be presented throughout the course of treatment as it is focused on the caregiver, not the client. Or, in a residential setting, this occurs during staff training and ongoing in-service training.*

NAME: _____ **PROGRAM LOCATION:** _____

Tasks	Date Completed	Notes
Educate about child development (<i>if applicable</i>)		
Educate about abuse/trauma survivors: common victim symptoms and behaviors (refer to Step 2)		
Explain TF-CBT and Caregiver's key role in emotional healing.		
Encourage Caregivers to: deal with their own trauma; identify any unhealthy parenting styles (past or present)		
Discuss caregiver reactions to the victim's experience(s)		
Educate about discipline (behavioral management): consistency, consequences,... (If residential setting, include agency guidelines, governmental concerns,...)		
Teach affect attunement and regulation (skills in recognizing & responding to emotional reactions & behaviors)		
Teach Behavioral Management techniques: Active Ignoring, Time-out ("Cool Down"), and use of Reward or Behavior charts		
Help Caregivers anticipate client's emotionally difficult times		
Teach use of constructive Praise (strength-based approach; active encouragement)		
Role play real life behavioral management scenarios		
Educate about sex education topics if caregiver has insufficient knowledge (refer to Step 2)		

Encourage caregiver to model healthy relationships (refer to what client was taught in Step 2)			
Provide a referral if caregiver is needing assistance to deal with personal trauma experiences &/or parenting concerns			
Educate about stress and vicarious trauma			
Other Beneficial Topics (as needed)			

Step 4

RELAXING

(Relaxation)

“Mastering these techniques before creating the trauma narrative
(having the person tell his/her story)
can help some children feel confident that
if they start to feel overwhelmed
while talking directly about the traumatic event,
they will be able to interrupt or control these reactions.”

Treating Trauma and Traumatic Grief in Children and Adolescents,
Cohen, Mannarino, Deblinger, 2006, page 92

Step 4 Relaxing

OVERALL GOAL

To teach tools to help the individual calm and control unwanted emotion and thoughts.

OVERVIEW

In this step we desire to teach the person various ways to identify distress, to relax or calm herself and to deal with intrusive thoughts in ways that are personally useful, helpful and self-sustaining. We encourage the use of these skills when feeling overwhelmed by traumatic memories.

During this step, we:

TEACH why relaxation skills are needed and helpful –

The how, what and why of relaxation

Teach about the body's reactions to stress and how our bodies respond differently

These stress reactions can include:

- | | | |
|-----------------------|----------------------|------------------------|
| *Increased heart rate | *Shortness of breath | *Sweating |
| *Weakness/dizziness | *Headaches | *Skin rashes |
| *Upset stomach | *Tense muscles | *Fight, Flee or Freeze |

Teach the need for skills and techniques to use when feeling overwhelmed, anxious, scared or angry

PRACTICE various relaxation techniques

Learning and practicing various relaxation techniques assists the individual in identifying those best suited for personal use when anxious, worried, fearful or overwhelmed.

1). BREATHING

Helps when feeling overwhelmed

Helps person calm down

Helps re-focus thoughts

Method: watch stomach go up, count, then let air out

Encourage practicing

2). MUSCLE RELAXATION

This relaxation technique incorporates a progressive tensing then relaxing of the muscles while lying down or in comfortable position. The counselor provides an opportunity for the practice of this activity and may incorporate creative ways to present it, using the idea of being uncooked and cooked pasta, a rag doll, or facing a herd of wild elephants (refer to resource materials).

3). **MEDITATION** (mindfulness)

When using this calming technique, the individual is encouraged to focus on the present, being “mindful of the moment”. Some choose also to focus on a chosen phrase or word or to keep one’s eyes on a specific focal point.

4). **Other RELAXATION Ideas:**

Encourage the person to identify (make a list) of those activities and exercises that he/she finds personally beneficial.

- Creative activities: dancing, art (creative, expressive)
- Music: listening, playing, movement
- Aesthetic appreciation (visual, tactile, smells... ex. feel something soft)
- Create &/or imagine a ‘safe’, peaceful person, place or thing
- Guided imagery – being ‘guided’ to a peaceful place (i.e. beach, meadow)
- Putting Undesirable or overwhelming emotions in a container (guided imagery)

5). **EXERCISE & ACTIVITY**

Physical activity and exercise are always recommended for those experiencing stress and depression because it activates positive chemicals in the brain. Such activities may include walking, running, swimming, bicycling, yoga, dance, sports, gardening, among others.

IMPLEMENT Thought-Stopping techniques

Thought-Stopping techniques may include using words such as “No!” “Stop!” “Go away!” when one realizes the presence of intrusive thoughts. Some use rubber bands on the wrist, snapping it when thinking ‘bad’ thoughts as an attempt to draw attention to and stop one’s focus of thought.

Thought-Replacement encourages redirecting one’s thoughts from unwanted, negative, intrusive ones to a happy memory or safe person, place or thing (real or imagined).

Paradoxical Intention (Frankl, 1985)

In this technique, the individual is encouraged to focus attention ON the upsetting thought for specified time (for example, every top of the hour for 5 minutes). It is a “giving of permission’ TO think directly about the disturbing content. It should only be used if other techniques (cognitive restructuring) have been unsuccessful. The idea behind this method is: “trying one’s hardest to think about something makes it easier to stop thinking about it”.

EQUIP with ideas for dealing with Nightmares and Flashbacks

Help the client identify helpful ideas for dealing with nightmares, flashbacks and sleep problems. (Refer to resource on *Dealing with Flashbacks* by BCJohnson in *TF-CBT Activities and Resources*).

Example: Ideas for Dealing with Nightmares (BCJohnson)

1. Get up and do something (don’t just lie there thinking about the nightmare)
2. Turn the pillow over (like changing a channel on a television)
3. Share it with someone
4. Write it down
5. Write/make YOUR own (positive or neutral) ending
5. Play or do a distracting game or activity

STEP 4: RELAXING

Objective: To teach the client self-skills in relaxation and managing negative thoughts; and, to assist the client in identifying personally helpful calming skills and activities.

NAME: _____ **PROGRAM LOCATION:** _____

Tasks	Date Completed	Notes
Provide information (psychoeducation) about the body's response to stress and how relaxation skills can help to lessen stress, anxiety and fear reactions to abuse and trauma reminders		
Identify and discuss both negative and positive coping strategies (substance use, risk-taking,...)		
Discuss client's personal triggers and coping mechanisms (<i>IF applicable AND not uncomfortable or invasive</i>)		
Teach Relaxation and Thought-Stopping strategies, as appropriate: <ul style="list-style-type: none"> • Deep Breathing • Progressive Muscle relaxation • Exercise & Physical Activity • Mindfulness, Guided Imagery, "Safe Place" • Thought-stopping ideas • Thought-Replacement ideas • Personal anxiety-stress reduction activities (music, reading, bath, exercise, poetry,...) 		
Practice relaxation strategies		
Teach anger management/conflict resolution (if needed/appropriate)		
Help client identify & list personally helpful activities for calming herself and minimizing intrusive thoughts, feelings and memories (from techniques taught & from personal activity preferences)		
Identify helpful ideas for dealing with nightmares, flashbacks and sleep problems.		
Other:		

Step 5

FEELING

(Affective Expression and Modulation)

Those who “have experienced significant trauma may have a predominance of painful, difficult feelings as well as dysregulation of affect.” Here we desire to “help children express and manage their feelings more effectively.”

*Treating Trauma and Traumatic Grief in Children and Adolescents,
Cohen, Mannarino, Deblinger, 2006, page 87*

Step 5 Feeling

OVERALL GOAL

To empower the victim to identify and demonstrate a variety of emotions, when they are experienced and at what intensity (affect regulation and attunement skills) and to be aware of personal emotional triggers.

OVERVIEW

Because traumatized individuals experience various and overwhelming feelings, they often have difficulty identifying, understanding, regulating, controlling and expressing emotions. This step helps the victim progress toward affective regulation as they learn to identify and express emotions in healthy ways and also to identify people, places and things that trigger upsetting emotions.

Note:

- ⇒ The girl may feel uncomfortable and/or be non-compliant when talking about her emotions. It may be more effective (less vulnerable and/or potentially re-traumatizing) to discuss feelings in a more general or impersonal way, such as “What might A girl feel who has experienced...?”
- ⇒ In this step it is important that the counselor identify spoken and unspoken family &/or cultural ‘rules’ regarding what is/isn’t appropriate emotional expression.

During this step, we help the individual:

IDENTIFY a variety of emotions (to expand her ‘feelings’ vocabulary). Use photo or picture cards, Feelings poster, and/or magazine photos and ask “What might this person be feeling? Why?”

EXPRESS a variety of emotions, using activities which incorporate awareness of facial expressions and body language. Activities can include playing charades (acting without words) various emotions and/or asking “What are _____ (eyes, mouth, arms, body) like when someone feels _____ (emotion)?”

APPROPRIATELY EXPRESS a variety of emotions, with focus on when, where, why, what, how much and how best to communicate them.

Helpful questions could include: “What emotion might you feel WHEN _____ (event) happens?” or “WHEN would you feel _____ (an emotion)?” When should/shouldn’t we express our emotions? To what degree (intensity) should we express our feelings? “How intense/strong of an emotion would you feel if _____ happens?” “HOW _____ (emotion) would you feel if _____ (event) happens?” “On a scale of 1 to 10 (1 being no emotion and 10 being intense emotion) how much _____ (emotion) would you feel if _____ (event) happened?”

RECOGNIZE triggers of upsetting emotions.

Identify what people, places, things, or events trigger unpleasant memories and emotions and develop a plan in managing, facing or avoiding them.

- HOW?
1. Recognize distress signals
 2. Implement stress reduction (relaxation) activities & techniques
 3. Implement Thought-Stopping &/or Thought-Replacement strategies (Step 4)

TF-CBT STEP 5: FEELING

Objective: To empower the client to identify and appropriately express emotion and be aware of emotional triggers.

NAME: _____ **PROGRAM LOCATION:** _____

Tasks	Date Completed	Notes
Practice identifying and labeling emotions		
Present psychoeducation regarding emotional expression including: What, How, When, Why and How much (intensity).		
Practice recognizing and expressing various emotions and when they are generally experienced and to what degree.		
Discuss the role of body language and facial expressions in the communication of various emotions.		
Explore emotional distress signals and triggers (<i>if not done previously</i>)		
Practice applying relaxation and stress reduction techniques to emotional distress signals and triggers (<i>if not done previously</i>)		
Other:		

Step 6

THINKING

(Cognitive Coping and Processing I)

“Given children’s limited experiential and knowledge base, they may be particularly prone to inaccurate or dysfunctional thoughts about traumatic experiences and these thoughts can negatively influence their developing views and belief systems.”

*Treating Trauma and Traumatic Grief in Children and Adolescents,
Cohen, Mannarino, Deblinger, 2006, page 107*

Step 6 Thinking

OVERALL GOAL

Help victim identify the difference between thoughts and feelings as well as the relationship between them and behavior.

OVERVIEW

Understanding the difference and relationship between thoughts, feelings and behaviors helps the individual in the process of overcoming trauma's negative effects. Recognizing one's negative inner dialog and combating the inaccurate &/or unhealthy thinking, provides needed insight and help in overcoming these intrusive thoughts.

During this step, we want the person to:

DISTINGUISH between feelings and thoughts, identifying and clarifying the difference between them.

“What would you THINK if _____ (event) happened?”

“What would you FEEL if _____ (event) happened?”

Match the Thought with a Feeling

(game with scrambled list of thoughts and matching list of accompanying feelings)

“What kind of THOUGHTS make people feel _____? (feeling; ex. “sad”)

UNDERSTAND the relationship between Thoughts – Feelings – Behavior (the Cognitive Triangle). *Demonstrate with role play.*

RECOGNIZE the existence of the “internal dialog” (our negative inner messages)

Use “thought bubbles” (like those used with cartoon characters)

IDENTIFY their wrong, inaccurate, unhelpful thoughts.

From Treating Trauma and Traumatic Grief in Children and Adolescents)

TYPES of INACCURATE and UNHELPFUL THOUGHTS (page 112)

People who attribute negative events to:

Personal (*internalized*)

Pervasive (*global/generalized*)

Permanent (*“always”, eternalized*)

Causes are more likely to become depressed (*Seligman, 1998*)

All or Nothing (“yes” or “no”; all good or all bad, no in-between)
Always (“bad things will now always happen”)
Awful (focuses on worst case scenario)
Always Awful (always thinking negatively/pessimistic) (*page 112-113*)

CORRECT ‘wrong’ thinking, generating alternative thoughts that are more helpful &/or accurate.

STEP 6: THINKING

Objective: To help client understand the difference and relationship between thoughts, feelings and behaviors as well as the thinking process and inner dialogs.

NAME: _____ **PROGRAM LOCATION:** _____

Tasks	Date Completed	Notes
Explain the difference between “thoughts” and “feelings”		
Increase awareness by asking: What might a person be Thinking When ____ happens? or What might people be Thinking if they are feeling ____? (refer to various Step 5 activities but now ask about “thoughts” rather than “feelings”)		
Present the existence of “inner dialog” – our internal conversations with ourselves		
Present the thinking process, including: <ul style="list-style-type: none"> • That we think (internal dialog) • What we think: positive vs negative thoughts • Why we think what we do (influences, experiences) 		
Teach the Cognitive Triangle: How our Thoughts affect our Feelings, which lead to our Behavior (<i>role play examples</i>)		
Review common inaccurate, unhelpful thoughts		
Identify ways to respond to negative internal messages with accurate, helpful thoughts		
Practice scenarios from the client’s everyday life		
Other:		

Step 7

SHARING I

(Trauma Narrative)

“Creating the trauma narrative, or telling the story of what happened, is like cleaning out the wound. It might be a little painful at first, but it hurts less and less as we go on, and then the wound can heal.”
The trauma narrative serves in... “desensitizing the child to traumatic reminders and decreasing avoidance and hyperarousal.

This process also enables the child to integrate the traumatic experience into the totality of his/her life.”

Treating Trauma and Traumatic Grief in Children and Adolescents,
Cohen, Mannarino, Deblinger, 2006 (page 121, 120)

Step 7 Sharing 1

OVERALL GOAL

The person shares her trauma/abuse story – helping to lessen the pain and shame and its effect.

OVERVIEW

Sharing is possible when there is a safe therapeutic environment to share about one's abuse/trauma experience(s). As the individual shares his/her personal trauma story it loses its sting and healing progresses more quickly. "The point (of the trauma narrative) is... to help the child describe, and gain mastery over his/her most upsetting, intrusive memories and images of the trauma." (pg 132) We help the client integrate her trauma as part of and not the totality of her life's story.

Note: While individuals may 'tell' their story earlier, it may be less therapeutically beneficial due to the fact that it may be shared incompletely, for shock value, to make the person appear better/worse, or to see how much the listener can handle. It is viewed as less therapeutically helpful when shared before the foundational steps are completed. Therefore, we do not encourage the sharing of one's story until the foundational steps (1-6) are completed.

That is, BEFORE she shares her story, we want the person to feel safe and comfortable with the counselor (step 1); to understand the effects of trauma and abuse on people (the normalization and validation of step 2); to know how to calm herself when anxious (step 4); to be able to understand and have the words to describe her feelings and thoughts and to recognize unhelpful thinking patterns (step 5 and 6). We believe that the telling of one's story AFTER these steps are presented, provides for greater healing from the trauma. Any story shared before this point might be helpful but more likely to be incomplete, tainted, or contrived.

WHICH Trauma Story to Tell When there are Multiple?

Some victims prefer to share a smaller, less vulnerable trauma story first as an attempt to gain mastery (feel more in control). From there, the individual may decide to share an event considered to be more or the most traumatic. This is a progressive sharing of trauma. The person may share several trauma stories before skipping to the "worst" one - - may share one or more "smaller, less vulnerable" events before sharing the most difficult.

For others, if ready, willing and able, they prefer to tell the biggest or most horrible trauma first to "get it over with". For many, telling the worst negates the need to tell all of the 'lesser' traumatic events experienced. For others, there may be a desire to share

several of their different traumatic events – perhaps related to such areas as the initial abuse; the first assault/rape; prostitution/exploitation; violence &/or torture; having to recruit/abuse someone else,...).

The individual (not the therapist) identifies and chooses the trauma story (-ies) to share. Often the most “traumatic” event is not what the counselor would be assumed to be the biggest. That is, a one-time initial betrayal and abuse as a child may be considered the “worst” trauma even in comparison to sexual exploitation (with its ongoing rape, exploitation, assault and violence).

NOTE:

The TF-CBT developers address the question, “What do we do if the child is reluctant, anxious &/or avoidant and doesn’t want to tell his/her story?” on pages 133-134.

SHARING 1 – Part A

During this step, we want to:

PREPARE the person by explaining the importance and benefits of “getting it out” -- sharing one’s story. (It may be helpful to first read another person’s trauma story as an example).

ENCOURAGE the sharing of one’s story in a personally chosen format.

Ways to Share One’s Story

- | | | |
|--------------|-------------|-------------|
| * Writing | * Sand play | * Drama |
| * Story book | * Collage | * Dance |
| * Poem | * Puppets | * Other.... |
| * Drawing | * Music | |

This sharing, of course, will need to be developmentally appropriate for the individual’s age and verbal/writing abilities

REMIND the person to use relaxation technique (from Step 4) as needed and that negative thoughts, feelings and reactions represent the past and not the present.

ASK the person to share her story by dictating it to the counselor.

Have the person repeat her story several times throughout the process of developing it, as that will lessen the extreme emotional and physiological reactions to the event.

That is, after writing part of the story, stop and say, “I’d like to read to you what I’ve written so far, to see if I’ve gotten it right and to see if there’s anything you might want to change or add” (such as thoughts, perceptions, self-blame, and/or sights, sounds, smells, colors, weather, people (ages, eye and hair color, height, weight, clothes,

appearance, facial expressions, words,...) and/or other details). It is helpful to repeat this Dictating-Stopping-Reading-Asking process numerous times during the process of telling one's story.

SHARING 1 – Part B

The focus of Step 7, Sharing I, Part A, is providing an opportunity for the person to share about the traumatic, abusive things have happened or been done ***TO her***. The emphasis is on her as the recipient of abusive &/or traumatic acts.

In working with the sexually exploited (victims of human trafficking), I have found it necessary to also encourage victims to share what he/she may have done ***TO others*** (either by coercion or 'choice').

Examples might include:

- having to hold someone down while others abused/traumatized her
- having to watch someone be tortured (&/or killed)
- being forced to do sexual or other 'abusive' acts on others
- doing 'abusive' acts on others (not by force)
- enjoying & participating in the 'abusive' activities

NOTE: Two Ways to Proceed

- 1). Complete Step 7 Sharing I, Part A, focusing on what was done TO the victim, then proceed with Steps 8 & 9 (evaluating and then re-telling one's trauma story). After completing this, return again to Step 7, Part B, focusing on what was done by the victim TO others, then, proceed with Steps 8 & 9.
- 2). Complete Step 7 Sharing 1, Part A, then do it again, with Part B, BEFORE continuing to further Steps.

During Sharing I Part B, we:

PREPARE the person by explaining the importance and benefits of "getting it out". Use the checklist of possible activities the victim may have done TO others (compiled by BCJohnson, 2011) to help normalize the experiences.

ENCOURAGE the sharing in a personally chosen format (*same as Part A*).

ASK the person to share her story (stories) by dictating to the counselor (*same as Part A*).

REMIND the person to use relaxation technique (from Step 4) as needed and that negative thoughts, feelings and reactions represent the past and not the present (*same as Part A*).

Reminder: *After completing Steps...*

7 Sharing one's story (*Part A – what was done TO her*)

8 Evaluating one's story, and

9 Sharing one's story with someone else

return and re-do these three steps, focusing on Sharing I, Part B, IF the person has not already done so and IF and WHEN the person is ready to share about what he/she may have done TO someone else.

Ask if he/she would now like to share stories of abuse/trauma in which he/she participated or initiated. If 'yes', repeat Steps 7, 8 and 9 - only if client agrees and is emotionally ready.

STEP 7: SHARING I

Objective: To provide a safe, therapeutic environment to share about one's abuse/trauma experience(s).

NAME: _____ **PROGRAM LOCATION:** _____

Task	Date Completed	Notes
Read a story about someone's experience of abuse/trauma (<i>to normalize the sharing and provide an example</i>)		
Discuss reason and importance for doing a trauma narrative (sharing one's story)		
Have the client choose which abuse/trauma story to share (i.e. the worst or the first or when...)		
Discuss options for storytelling in a personally chosen format (other than the dictating): *Writing *Drawing *Art *Music *Poem *Collage *Dance *Drama *Puppets *Sand Tray *other...		
Encourage use of relaxation techniques (stress reduction strategies) if fearful or anxious		
Affirm that negative thoughts and feelings are in the past, they are not part of the present		
Have the client tell her story using format personally chosen and age appropriate.		
Have the client tell her story in detail, dictated to and repeated by the counselor (with some prompting for additional details, thoughts, feelings,...)		
Praise the client for bravely sharing her personal story of trauma and remind her that it reflects only <i>part</i> of and not the totality of her life's story.		
If a 'lesser' abuse/trauma was chosen, ask client if she'd like to now share a worse abuse/trauma and repeat this sharing process		
IF/when the client is willing and ready, encourage her to share not just what was done or happened TO her, but what he/she may have done TO others. (This may be done now or return to it after Steps 7, 8 & 9 are completed for what happened TO her.)		
Other:		

Step 8

EVALUATING

(Cognitive Coping and Processing II)

“It was my fault, I should have known he was going to do this.”

Treating Trauma and Traumatic Grief in Children and Adolescents,

Cohen, Mannarino, Deblinger, 2006, page 137

Step 8 Evaluating

OVERALL GOAL

Use what was taught in Step 6 (identifying and correcting unhelpful, inaccurate thinking) on what was shared in Step 7.

OVERVIEW

After the person has shared his/her trauma/abuse story(-ies), we review and evaluate what was shared in order to identify any unhelpful beliefs (thinking patterns) that negatively effects how the event(s) are incorporated into one's identity and world view. The person, not the therapist, is then encouraged to recognize and 'fix' the unhelpful thoughts.

During this step, we want to:

REVIEW what was shared in Step 7, searching for and identifying any statements reflecting wrong thinking (cognitive distortions). The **counselor** develops a list of questions and also **REVIEWS** unhealthy thinking (step 6) with the person, to help the **person**...

RECOGNIZE any unhelpful, inaccurate thoughts, beliefs or perspectives, so that the **person** can...

REVISE (*Fix/Change*) the story(-ies) to represent more accurate and helpful perspectives on what happened.

Unhealthy Perspectives are often related to:

- Blame & responsibility
- Shame and stigma
- Changes in trust - generalization of mistrust
- Assumptions regarding the causes or sources about the offender or trauma events
- Negative self perceptions (body image, value, personal safety,...)

Examples of Wrong Thinking (cognitive distortions): "I'll never be normal"

- | | |
|---------------------------------------|-----------------------------|
| "I should have been able to stop it." | "My life is destroyed." |
| "I should have known better." | "I've destroyed my family." |
| "I can't trust anyone again." | "I'll never get over this." |
| "I'll never to safe again." | "The world is unsafe." |

Types of Inaccurate or Unhelpful Thoughts (pg 112-3)

People who attribute negative events to:

Personal (*internalized*)

Pervasive (*global/generalized*)

Permanent ("*always*", *eternalized*)

From Step 6: (again) *Thinking that is...*

All or Nothing (all good or all bad, no in-between)

Always ("bad things will now always happen")

Awful (focuses on worst case scenario)

Always Awful (always thinking negatively/pessimistically)

TF-CBT STEP 8: EVALUATING

Objective: To help the client evaluate and revise his/her story using the Step 6 skills of identifying and correcting unhelpful and/or inaccurate thinking.

NAME: _____ **PROGRAM LOCATION:** _____

Tasks	Date Completed	Notes
Review the client's story prior to the session(s), developing a list of questions to elicit identification of inaccurate, unhelpful thoughts in the story		
Review the story with the client, asking questions so that he/she identifies the wrong thinking.		
Assist the client in developing accurate/helpful thoughts, so that he/she 'fixes' the story, not the counselor		
Review and read the newly edited story again		
Discuss with client about what she has learned through this process		
Praise the client		
Other:		

Step 9

SHARING 2

The therapists must make sure that the support person “responds to the child in a supportive and helpful manner (that) will encourage the child to talk... about any problems that arise in the future.”

Treating Trauma and Traumatic Grief in Children and Adolescents,
Cohen, Mannarino, Deblinger, 2006, page 130

Step 9 Sharing 2

OVERALL GOAL

The person shares his/her trauma story with someone other than the counselor.

OVERVIEW

As the person re-tells his/her (now, revised and healthier) trauma/abuse story with someone other than the counselor, healing increases and the pain and shame decrease.

During this step, we want to:

ASSESS if she is emotionally ready to share her story with someone other than the counselor.

Discussing expectations, hopes and possible reactions is helpful in assessing and preparing the person to share.

CHOOSE with whom to share his/her story. It should be a safe, close, caring person.

It may be necessary to help the person select someone with whom to share, someone capable of being supportive and encouraging.

Depending on the victim's housing situation, the chosen person may be a parent, house Mom, Social Worker, foster parent, residential program manager or someone else.

PREPARE the chosen person for the "sharing" (story telling session) by 'coaching' him/her on how best to respond and what to say/not say.

Help the person understand what responses are helpful: giving praise and encouragement during and after the session, such as "Thank you for sharing with me." "You are brave to share this." "I'm so glad you're sharing this."

Help the person understand what responses are not helpful: crying uncontrollably, getting mad, focusing on self, making statements such as "Why didn't you tell me sooner?" "What were you thinking?!" "You should have told someone!"

SHARE the trauma/abuse story (the revised, corrected version from Step 8).

DEBRIEF with the client - how it went, were expectations met, and what he/she feels and thinks about the sharing time.

If needed and possible, it might also be helpful to have a Debrief session with the person chosen to hear the victim's story.

Note: After completing Steps...

7 Sharing one's story (Part A – what was done TO her)

8 Evaluating one's story, and

9 Sharing one's story with someone else

return and re-do these three steps, focusing on Sharing I, Part B, IF and WHEN the person is ready to share about what he/she may have done TO someone else.

Ask if he/she would now like to share stories of abuse/trauma in which he/she participated or initiated. If 'yes', repeat Steps 7, 8 and 9 - only if client agrees and is emotionally ready.

STEP 9: SHARING 2

Objective: To decrease shame and increase healing through sharing the trauma story with another person.

NAME: _____ **PROGRAM LOCATION:** _____

Tasks	Date Completed	Notes
Assess client's readiness to share his/her story with someone other than the counselor		
Client identifies a supportive person with whom to share her personal abuse/trauma story		
Assess the support person's readiness to hear the client's trauma story and prepare ('coach') the person in how best to respond		
Prepare client to share her trauma story, discussing expectations and possible reactions of the chosen person.		
Encourage use of relaxation techniques (stress reduction strategies) as needed		
Client shares her (revised, corrected) trauma story with the support person		
Praise both parties		
Debrief experience with client		
Debrief experience with support person (if desired/possible)		
Other:		

Step 10

LIVING: Free, Safe & Well

*(In Vivo Mastery;
Enhancing Future Safety)*

“By learning that they can overcome their terrifying memories and fears, children gain self-efficacy that can have far-reaching positive consequences in their lives.”

Treating Trauma and Traumatic Grief in Children and Adolescents,
Cohen, Mannarino, Deblinger, 2006, page 150

Step 10 Living: Free, Safe & Well

OVERALL GOAL

To live free of fear, with a sense of safety and with future goals.

OVERVIEW

- ***LIVING FREE:** We identify any trauma avoidance areas (anxieties and phobias) and develop plans to minimize/eliminate them.
- ***LIVING SAFE:** We seek to increase the individual's personal sense of safety and safety skills.
- ***LIVING WELL:** We encourage the practicing of real life scenarios; choosing to help others; and the setting of future goals; and celebrating accomplishments.

During this step, we focus on:

LIVING FREE: We strive to...

“Narrative techniques alone may be insufficient to resolve generalized avoidant behaviors... Some children have developed generalized fears that interfere with their ability to function optimally due to ongoing avoidance of perceived trauma cues that are inherently innocuous... they do not serve the purpose of maintaining safety in the present, and if over-generalized, may interfere with healthy adaptation.” *Treating Trauma and Traumatic Grief in Children and Adolescents*, Cohen, Mannarino, Deblinger, 2006, page 147

IDENTIFY any avoidance areas: people, places and/or things (obvious or innocuous) that continue even after sharing (the trauma narrative).

DEVELOP a plan for dealing with the fear/avoidance areas (i.e. gradual desensitization).

IMPLEMENT and monitor the plan

LIVING SAFE: We want the person to...

LEARN personal safety skills of prevention and protection as well as problem-solving skills.

It is best to postpone the teaching of personal safety skills until after the girl has shared her trauma narrative because she may feel guilty for not having used those self-protection and/or assertiveness skills during her trauma/abuse experience(s) and/or may alter her story to incorporate the skills.

Personal safety skills should include:

1. Learning to communicate one's feelings and desires clearly
2. Paying attention to 'doubts' (uncertainties)
3. Identifying safe people/places
4. Learning to say "no" (especially regarding body)
5. Asking for help (and being persistent)
6. Distinguishing between "good & bad touches" and "good & bad secrets"
7. Understanding one's rights and legal protection

DEVELOP a Personal Safety Plan stating what to do, where to go and who to contact when/if feeling unsafe (emotionally and/or physically).

PRACTICE role playing real life situations, which allows us to:
Rehearse, practice, and be prepared when/if in a variety of difficult, unexpected, uncomfortable situations.
Explore different scenarios/outcomes for various situations
Develop problem solving skills
Clarify what we believe and value
Develop thinking, problem solving and empathy skills
Evaluate what influences our decisions

LIVING WELL: We encourage the person to...

HELP others by volunteering in some capacity and/or by sharing one's journey.

Helping others re-focuses our attention from ourselves to others and provides an opportunity to contribute to the well-being of others. Sharing one's personal journey can bring hope to others and healing for oneself.

Helping Others (*examples*)

“What advice would you give to other girls?”

“What (if anything) would you like to do to help others or to share with others?”

(Examples: volunteer at a crisis center, work with neighborhood children, teach crafts at a former brothel, do street outreach, serve at an animal shelter, volunteer at a juvenile detention center, work with a church youth group, share your story...)

SET future goals - educational, vocational, emotional,... and develop realistic plans to accomplish them. Include hobbies, activities, and other desired extracurricular pursuits. Encourage the person to dream again.

COMPLETE any post-tests or measure required or desired for the counseling process (to determine client growth, counseling and/or program effectiveness,...). Evaluate the counseling process together. Finish the “Book About Me” with pages that include one's future goals, hopes and dreams.

CELEBRATE the completion of the counseling process by having a closure event (party, give a certificate,...). Be sure to leave an “open door” regarding counseling, sharing that future set backs are ‘normal’.

STEP 10: LIVING – FREE, SAFE & WELL

Objective: To identify & minimize trauma-avoidance areas, increase personal safety, and set future goals.

NAME: _____ **PROGRAM LOCATION:** _____

Tasks	Date Completed	Notes
LIVING FREE (of fears/phobias)		
Identify avoidance areas (people, places, things- obvious or innocuous)		
Develop & implement a gradual de-sensitization plan for each avoidant area		
LIVING SAFE (protection, prevention & planning)		
Teach personal rights (<i>if not done in Step 2</i>)		
Teach personal safety skills: *Awareness & identification of safe/unsafe people & situations *Assertive communication *Self defense		
Teach problem solving skills		
Make a Personal Safety Plan: what to do if/when feeling unsafe		
Practice Role plays - utilizing various possible real life scenarios		
LIVING WELL (future planning & termination)		
Discuss potential for helping others (<i>if appropriate</i>) and implement when possible		
Set goals for the future: educational, vocational, emotional, recreational,...		
Complete any final assessments (post-test measures, evaluation,...)		
Complete "Book About Me" (including the Safety Plan, Future Goals, Hopes & Dreams)		
Celebrate completion of counseling (or, this phase of it) but keep "open door" and normalize set backs		
Other:		

Bibliography & Training

Treating Trauma and Traumatic Grief in Children and Adolescents, Guilford Press, 2006 by Cohen, Mannarino & Deblinger, provides specific information on the development, components and implementation of the TF-CBT model.

Additional training is provided online (<http://tfcbt.musc.edu/>) and professional training workshops are offered in various locations in the USA.

TF-CBT Activities & Resources

Another document, developed to accompany this *Adapted TF-CBT Step Overview and Checklists* provides a compilation of various resources (not exhaustive) that could be utilized in the implementation of each step.

Many of these step activities come from resources I have developed over the years; from other clinicians and also from the Harborview Center for Sexual Assault and Traumatic Stress website (<http://depts.washington.edu/hcsats/resources.html>).

Many other activities can be identified and utilized to help clients in their healing journey. Those provided in the *TF-CBT Resources & Activities* booklet represent just a few of the many possible therapeutic interventions available.

Adapted TF-CBT Step-by-Step Summary

1	GATHERING	<p>To develop a positive, safe, therapeutic relationship and to gather needed and helpful information.</p>	<p>DEVELOP a therapeutic relationship of safety, rapport and trust. (Utilize a variety of activities, games and questions.)</p> <p>PROVIDE client with information regarding the counseling process</p> <p>CONDUCT a thorough Intake Assessment (including a Mental Status Exam and a comprehensive Psychosocial History) and administer any desired assessment measures for treatment planning, progress, treatment and program effectiveness, evaluation and research</p> <p>DOCUMENT a Treatment Plan</p> <p>ENCOURAGE the person to TELL a STORY in detail (baseline narrative)</p> <p>BEGIN a). the personalized “Book About Me” b). Personal Journaling, and/or c). Responsive Journaling between client-counselor</p>
2	LEARNING	<p>To educate victims about abuse and trauma (and other important related topics). Providing information about abuse and trauma normalizes the experience and validate one’s reactions, helping the victim realize that she is “not alone nor crazy”.</p>	<p>TEACH about Abuse and Trauma (and related topics: Exploitation, Trafficking, Sexual Assault, Coercion,..)</p> <p>PRESENT information on Sex Education</p> <p>DISCUSS additional possible topics (such as of sex, exploitation, assault, healthy relationships, self-esteem, anger management) which gives victims a needed, foundational understanding.</p> <p>PRESENT Creatively and age appropriately. The information is provided in a general, educational, rather than personal, way (not requiring personal disclosure, emotional vulnerability and possible re-traumatization).</p>
3	HELPING	<p>To help caregivers deal effectively with trauma victims by providing psychoeducation, affect attunement, behavioral management and positive reinforcement skills.</p>	<p>HELP <u>Caregivers</u> understand child development and the effects of abuse and trauma on the victims.</p> <p>PROVIDE an overview of the TF-CBT counseling model and <u>Caregivers</u> key role in the process</p> <p>INSTILL in <u>Caregivers</u> the importance of clear, consistent boundaries & discipline in the victim’s emotional healing.</p> <p>GIVE <u>Caregivers</u> behavioral management (discipline) tools and skills (such as: Praise, ‘Selective’ Ignoring, Time Out, Behavioral charts)</p> <p>CLARIFY to the <u>Victims</u> expected behavior and consequences</p> <p>PREPARE <u>Caregivers</u> by discussing times that might be more emotionally hard for the victims.</p> <p>ENCOURAGE <u>Caregivers</u> to deal with their own abuse/trauma experiences and any dysfunctional parenting concerns (past &/or present).</p> <p>PRACTICE affect attunement skills. Encourage and help caregivers understand and develop emotional awareness skills.</p> <p>TEACH other pertinent information (vicarious trauma, child/adolescent development, conflict resolution, strengths-based approach)</p>

4	RELAXING	Teach tools to help the individual calm and control unwanted emotions and thoughts. We seek to help the person to identify distress, to relax or calm herself and to deal with intrusive thoughts in ways that are personally useful, helpful and self-sustaining. We encourage the use of these skills when overwhelmed by traumatic memories.	<p>TEACH body's reaction to stress and anxiety and why relaxation skills are needed and helpful</p> <p>PRACTICE various relaxation techniques Identify those best suited for personal use when anxious, worried, fearful or overwhelmed: Breathing, Muscle Relaxation, Meditation (mindfulness), Other: art, music, dance, journaling,...., Exercise & Activity</p> <p>IMPLEMENT Thought-Stopping and Thought-Replacement techniques</p> <p>EQUIP with ideas for dealing with Nightmares and Flashbacks</p>
5	FEELING	Because traumatized individuals experience various and overwhelming feelings, they often have difficulty identifying, understanding, regulating, controlling and expressing emotions. This step helps the victim progress toward affective regulation as they learn to identify and express emotions in healthy ways and also to identify people, places and things that trigger upsetting emotions.	<p>IDENTIFY a variety of emotions (to expand her 'feelings' vocabulary).</p> <p>EXPRESS a variety of emotions</p> <p>APPROPRIATELY EXPRESS a variety of emotions, with focus on when, where, why, what, how much and how best to communicate them.</p> <p>RECOGNIZE what people, places, things, or events trigger unpleasant memories and emotions and develop a plan in managing, facing or avoiding them.</p> <p>⇒ <i>The girl may feel uncomfortable and/or be non-compliant when talking about her emotions. It may be more effective (less vulnerable and/or potentially re-traumatizing) to discuss feelings in a more general or impersonal way, such as "What might A girl feel who has experienced...?"</i></p> <p>⇒ <i>In this step it is important that the counselor identify spoken and unspoken family &/or cultural 'rules' regarding what is/isn't appropriate emotional expression.</i></p>
6	THINKING	Understanding the difference and relationship between thoughts, feelings and behaviors helps the individual overcome trauma's negative effects. Recognizing one's negative inner dialog and the inaccurate &/or unhealthy thinking, provides needed insight.	<p>DISTINGUISH between feelings and thoughts, identifying and clarifying the difference between them.</p> <p>UNDERSTAND the relationship between Thoughts – Feelings – Behavior (the Cognitive Triangle). <i>Demonstrate with role play.</i></p> <p>RECOGNIZE the existence of the "internal dialog" (our negative inner messages)</p> <p>IDENTIFY their wrong, inaccurate, unhelpful thoughts.</p> <p>CORRECT 'wrong' thinking, generating alternative thoughts that are more helpful &/or accurate.</p>
7	SHARING I	The person shares her trauma/abuse story – helping to lessen the emotional pain, shame and its effect so that healing progresses more quickly. We help the client integrate her trauma as <i>part</i> of and not the totality of her life's story.	<p>Part A Sharing what was done TO the victim</p> <p>PREPARE the person by explaining the importance and benefits of "getting it out" -- sharing one's story. (It may be helpful to first read another person's trauma story as an example).</p> <p>ENCOURAGE the sharing of one's story in a personally chosen format (poem, song, story, drawing, collage,...) This sharing, of course, will need to be developmentally appropriate for the individual's age and verbal/writing abilities.</p>

		<p>(Some choose to do Step 7 Parts A & B before proceeding to steps 8-10. Others prefer to do Step 7-9 with Part A, then return again to Steps 7-9 with Part B. This should be decided by the person & counselor to determine readiness to face the additional trauma of Part B.)</p>	<p>REMIND the person to use relaxation technique (from Step 4) as needed and that negative thoughts, feelings and reactions represent the past and not the present.</p> <p>ASK the person to share her story by dictating it to the counselor. Repeat a Dictating-Stopping-Reading-Asking-Adding process numerous times during the process of telling one's story.</p> <p>Part B Sharing what the victim did TO others</p> <p>PREPARE the person by explaining the importance and benefits of "getting it out". Use the checklist of possible activities the victim may have done TO others (compiled by BCJohnson, 2011) to help normalize the experiences.</p> <p>ENCOURAGE the sharing in a personally chosen format (<i>same as Part A</i>).</p> <p>ASK the person to share her story (stories) by dictating to the counselor (<i>same as Part A</i>).</p> <p>REMIND the person to use relaxation technique (from Step 4) as needed and that negative thoughts, feelings and reactions represent the past and not the present (<i>same as Part A</i>).</p> <p>NOTE: <i>BEFORE she shares her story, we want the person to feel safe and comfortable with the counselor (step 1); to understand the effects of trauma and abuse on people (the normalization and validation of step 2); to be in a supportive environment (step 3); to know how to calm herself when anxious (step 4); to be able to understand and have the words to describe her feelings and thoughts and to recognize unhelpful thinking patterns (step 5 and 6). We believe that the telling of one's story AFTER these steps are presented provides for greater healing from the trauma. Any story shared before this point might be helpful but more likely to be incomplete, tainted, or contrived (it may be shared incompletely, for shock value, to make the person appear better/worse, or to see how much the listener can handle).</i></p>
8	EVALUATING	<p>After the person has shared his/her trauma/abuse story(-ies), we review and evaluate what was shared in order to identify any unhelpful beliefs (thinking patterns) that negatively effects how the event(s) are incorporated into one's identity and world view. The person, not the therapist, is then encouraged to recognize and 'fix' the unhelpful thoughts.</p>	<p>REVIEW what was shared in Step 7, searching for and identifying any statements reflecting wrong thinking (cognitive distortions). The counselor develops a list of questions and also REVIEWS unhealthy thinking (step 6) with the person, to help the person...</p> <p>RECOGNIZE any unhelpful, inaccurate thoughts, beliefs or perspectives, so that the person can...</p> <p>REVISE (Fix/Change) the story(-ies) to represent more accurate and helpful perspectives on what happened.</p>

9	SHARING II	<p>The person shares his/her trauma story with someone other than the counselor. As the person re-tells his/her (now, revised and healthier) trauma/abuse story with someone else, healing increases and the pain and shame decrease.</p>	<p>ASSESS if she is emotionally ready to share her story with someone other than the counselor. Discussing expectations, hopes and possible reactions is helpful in assessing and preparing the person to share.</p> <p>CHOOSE with whom to share his/her story. It should be a safe, close, caring person. The chosen person may be a parent, house Mom, Social Worker, foster parent, residential program manager or someone else.</p> <p>PREPARE the chosen person for the “sharing” (story telling session) by ‘coaching’ him/her on how best to respond and what to say/not say.</p> <p>SHARE the trauma/abuse story (the revised, corrected version from Step 8).</p> <p>DEBRIEF with the client - how it went, were expectations met, and what he/she feels and thinks about the sharing time.</p>
10	LIVING: Free Safe Well	<p>To live free of fear, with a sense of safety and with future goals.</p> <p>*LIVING FREE: We identify any trauma avoidance areas (anxieties and phobias) and develop plans to minimize/eliminate them.</p> <p>*LIVING SAFE: We seek to increase the individual's personal sense of safety and safety skills.</p> <p>*LIVING WELL: We encourage the practicing of real life scenarios; choosing to help others; and the setting of future goals; and celebrating accomplishments.</p>	<p>LIVING FREE: We strive to...</p> <p>IDENTIFY any avoidance areas: people, places and/or things (obvious or innocuous) that continue even after sharing (the trauma narrative).</p> <p>DEVELOP a plan for dealing with the fear/avoidance areas (i.e. gradual desensitization).</p> <p>IMPLEMENT and monitor the plan</p> <p>LIVING SAFE: We want the person to...</p> <p>LEARN personal safety skills of prevention and protection as well as problem-solving skills. Postpone the teaching of personal safety skills until after the girl has shared her trauma narrative so that she does not alter her story to incorporate the skills.</p> <p>DEVELOP a Personal Safety Plan stating what to do, where to go and who to contact when/if feeling unsafe (emotionally and/or physically).</p> <p>PRACTICE role playing real life situations.</p> <p>LIVING WELL: We encourage the person to...</p> <p>HELP others by volunteering in some capacity and/or by sharing one's journey.</p> <p>SET future goals (educational, vocational, recreational, emotional,...) and develop realistic plans to accomplish them. Include hobbies, activities, and other desired extracurricular pursuits. Encourage the person to dream again.</p> <p>COMPLETE any post-tests or measure required or desired for the counseling process (to determine client growth, counseling and/or program effectiveness,...). Evaluate the counseling process together. Finish the “Book About Me” including future goals & dreams.</p> <p>CELEBRATE the completion of the counseling program by having a closure event (party, give a certificate,...). Be sure to leave an “open door” regarding future counseling, sharing that set backs are ‘normal’.</p>

Notes