YOUTH PTSD CBT TREATMENT

(YPT)

A Cognitive-Behavioral Therapy Manual for Posttraumatic Stress Disorder

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Michael S. Scheeringa, MD, MPH
Remigio Gonzalez, MD Professor of Child Psychiatry
Department of Psychiatry and Behavioral Sciences
Section of Child and Adolescent Psychiatry
Tulane University Health Sciences Center
New Orleans, LA

This manual, YPT, was modified from the Preschool PTSD Treatment (PPT) manual (Michael Scheeringa, Lisa Amaya-Jackson, and Judith Cohen, 2002), which is available for free at www.infantinstitute.org.

Address correspondence to Dr. Scheeringa, 1440 Canal St., TB52, New Orleans, LA 70112. mscheer@tulane.edu

INTRODUCTION

Youth PTSD Treatment (YPT) is a theory-driven, 12-session manualized cognitive-behavioral therapy protocol for individual treatment for 7-18 year-old children and adolescents that involves their caregivers (when possible) in every session.

YPT has been used in a randomized controlled trial and shown to be effective (Scheeringa & Weems, in press). Fifty-seven 7-18 year-old youth who were recruited from the New Orleans region were randomized to receive either YPT+adjunctinve D-cycloserine or YPT+placebo. There were minimal differences between groups, but the important thing regarding the effectiveness of YPT is that both groups that received YPT significantly improved with large effect sizes.

A counterpart of YPT for very young children is the Preschool PTSD Treatment (PPT) manual (Scheeringa, Amaya-Jackson, and Cohen, 2002), which is available for free at the Tulane Institute of Infant and Early Childhood Mental Health website at http://www.infantinstitute.com/. Click on the Measures and Manuals link on the home page. PPT has been shown effective for 3-6 year-old children with PTSD in a randomized controlled trial (Scheeringa et al., 2011).

i. Cognitive-Behavioral Treatment for PTSD in General

CBT is an effective treatment modality for PTSD because of the focus on learning theories and cognitive distortions. While it is not known what causes PTSD at the neurocircuitry level, it is evident that these are new behaviors, thoughts, and feelings that were not present prior to a traumatic event that seem to be driven by magnified and automatic cognitive processes. **Behavior therapy** rests on a primary assumption that most behavior develops and is sustained through the principles of learning (Rimm & Masters, 1979). One type of learning, operant conditioning (Skinner, 1953), is particularly useful for treatment because it works by voluntary behaviors (operants) being reinforced by consequences (response). In theory, change in behavior is linked to the strength and frequency of the responses. These characteristics can be manipulated in treatment protocols. **Cognitive therapy** rests on the primary assumption that individuals interpret the world through cognitive structures (schemas) that have secondary impacts on altered feelings and behaviors (Beck, 1967). Cognitions and behaviors are, of course, not independent, and theorists have sought a more realistic amalgam of the two, such as in social learning theory (Bandura, 1969). **Cognitive-behavioral therapy** (CBT) is the rational blending of both modalities, which over the past 30 years has evolved into a diverse group of interventions (Thase & Wright, 1997). The empirically-driven theory and practice of CBT lend it well to systematic and structured treatment protocols.

CBT techniques can be simplified into two components: behavioral exposures (systematic desensitization, and prolonged/imaginal exposure) and anxiety management training (relaxation, cognitive restructuring, and biofeedback). Empirical support exists for both categories, plus for combined treatment packages (reviewed in Rothbaum & Foa, 1996). A review of studies identified three factors that were involved in successful treatments: **emotional engagement with the trauma memory, organization and articulation of a trauma narrative, and modification of basic core beliefs about the world and about oneself** (Zoellner, Fitzgibbons, & Foa, 2001). We will address all three of these in this manual.

ii. Overview of YPT

Session 1: Psychoeducation, overview
Session 2: Behavior management for defiance module
Session 3: Learn CBT tools – identify feelings.
Session 4: Learn CBT tools – relaxation exercises.
Session 5: Tell the story
Session 6: Easy narrative exposure
Session 7: Medium narrative exposure
Session 8: Medium narrative exposure
Session 9: Worst moment narrative exposure
Session 10: Worst moment narrative exposure
Session 11: Relapse prevention
Session 12: Review/Graduation

The YPT manual was created from empirical experience of the author, based on emerging research findings, and has elements in common with other CBT treatments for youth (Cohen et al., 2004; Cohen and Mannarino, 1996; March and Amaya-Jackson, 1998).

YPT also has unique elements and a relative emphasis on certain elements not found in other CBT manuals. The following is a summary of these elements that we believe makes YPT distinct:

1. **Exposures in office**: YPT uses **drawing** as the first option (as opposed to straight narrative) to **mediate** the discussion between youth and therapist. We also use the drawing to help overcome the natural avoidance by slowing down the process, stop the youth from rushing through, and help focus in on details.
2. Stimulus hierarchy/graded exposures: YPT attempts to build vertical (or horizontal) **stimulus hierarchies** and walks through **graded exposure** (systematic desensitization) from low anxiety-provoking reminders to high-anxiety provoking reminders in a graded fashion.
3. Imaginal exposure: YPT uses **imaginal exposure**.
4. SUDS ratings: YPT methodically asks for **SUDS ratings** throughout exposures to both (1) determine whether the patient is going up in anxiety or not and (2) help educate the patient about whether anxiety is going up or not.
5. Homework: YPT assigns **homework** after sessions 2-11. This includes **in vivo exposures** after sessions 6-11.
6. Psychodynamic and interpretative links: YPT does not prescribe explicitly to explore abstract meaning behind the patients' feelings. For salient thoughts or memories that patients verbalize, we do not make it a priority to ask questions like "How does that make you feel?" or "Why do you think he did that?" We are relatively less concerned with making abstract connections to past events that are not explicitly linked to the trauma. We have found this difficult for many youth to perform, particularly pre-adolescent youth, and a difficult skill to teach therapists. There is however flexibility to add these discussions by interested clinicians; they are just not prescribed explicitly in the manual.
7. **Roadway Book**: In YPT, drawings, worksheets, and homework sheets are collected in a binder and systematically reviewed in sessions 10-12 in YPT. Youth are allowed to take the book home at the end.
8. **Relaxation exercises:** In YPT (a) three different ones (breathing, muscle relaxation, and happy place imagery) are **always** taught, and (b) patients are always made to use them in sessions and during homework.

9. **Discipline plans**: In YPT session 2 is devoted to oppositional behavior and creating discipline plans for homework in YPT. There are usually 2-3 sessions of follow-up homework on discipline plans; this can be skipped if oppositional behavior is not an issue but it is rarely skipped.
10. Discuss **guilt and leniency with discipline** for all caregivers in session 2 in YPT.
11. Discuss **reluctance to return** to sessions in every session in YPT.
12. **Safety plans** created for all youth starting in session 6 in YPT. Plans are systematically rehearsed in the office and at home over sessions 6-9.
13. **Psychoeducation with pictorial aids** for all ages in YPT in session 1.
14. **Candy and snacks** for all ages is encouraged. Attending therapy sessions for trauma can be inherently unpleasant. Anything to make the sessions more enjoyable can be useful.
15. **Parents watch on TV** in YPT if OK with the children.
16. Discuss **boundary issue** with all caregivers respecting youths' confidentiality with other family members in YPT.
17. YPT uses the caregiver to help the therapist understand the layout of the trauma scene prior to session 5 by asking the caregiver to describe or draw a bird's-eye-view of the scene in session 4.
18. Session 11 is a **relapse prevention** session to anticipate future trauma reminders.

Some of these elements are expanded upon in the next section.

Drawing. The developer of this manual had prior experience developing and testing a CBT manual for young children in which drawing the traumatic memories for in-session exposure exercises worked very well. This manual retains an emphasis on drawing targets for in-office exposure work. Drawing is a common technique to assist children with recall of past memories, to help express internalized thoughts and feelings (Gross & Haynes, 1998), and in particular to facilitate the expression of painful traumatic memories (Malchiodi, 1997; Steele, 2001). The decision to retain drawing was made for several reasons. Drawing is useful for all ages to help them overcome the avoidance that is part of PTSD and force them to slow down and focus on details of their traumatic memories. In addition, younger children certainly benefit from using drawing to mediate the conversational aspect of the task with an adult therapist. But even with many adolescents, face-to-face verbal conversation with an adult is not a well-developed skill, so drawing gives a vehicle between the youth and therapist to facilitate discussion. If a teen is resistant to drawing, brief narrative writing and/or enhanced use of imaginal exposure can be used instead. Also, having all the age groups draw standardizes the protocol as much as possible across the age range.

The manual is quite flexible though. Verbal re-telling or writing out the events can be used instead of drawing if that is preferred by the children or teens.

Psychoeducation about PTSD. Pictorial aids of PTSD symptoms will be used in the psychoeducation session to help children identify their symptoms. This is another technique that was added for the preschool adaptation and we opted to retain for older children because it has proven so useful to help children grasp the rather abstract and complex symptoms of PTSD. The DARRYL, a cartoon-based, measure was originally created to elicit PTSD symptoms in 7- to 9-year-old children in an empirical study (Neugebauer et al., 1999). We used it differently with preschool children to educate them about (not elicit from them) symptoms of PTSD. We found that the pictures worked best if they depicted the type of trauma relevant to each child (i.e., scenes of domestic violence for children who witnessed that, scenes of auto accidents for children

who experienced that, and so on). The DARRYL shows only scenes of community violence. We have developed our own pictures for domestic violence, auto accidents, hurricane disasters, and physical abuse.

Oppositional defiant symptoms addressed. Another technique that was worked well in the preschool trial was to spend an entire session to create a discipline plan and follow this up with homework for several sessions. This was added based on our pilot data with children that showed this to be a common chief complaint for parents. Our early experience with older youth is that this is still relevant and parents find this useful. If this is skipped because the youth is not oppositional, the manual becomes an 11 session manual. In practice, caregivers rarely opt to skip this component.

Parental Involvement. When parents are not in the session physically with the youth, it is ideal if they can view the session on a television monitor in an adjacent room. Three sessions - session 1 (psychoeducation), session 2 (oppositional defiant behavior), and session 12 (review) – are joint parent-child sessions. For the other nine sessions, parents will join the therapist and children at the beginning briefly (less than 5 minutes), and then watch the children's sessions on a monitor.

This is flexible and can be opted out of if the youth desires more privacy or the therapist believes the parent has boundary issues and would not respect the privacy of the youth. Having caregivers view the youth's sessions is a substantial difference from other protocols, and it is used in this model because it was found to be useful empirically in the preschool study in that (a) parents statistically significantly improved on their own depression scores and they attributed it to seeing their children improve, and (b) a subset of caregivers who changed parenting practices with their children did so because of their experiences of watching on the monitors how the therapists handled their children during sessions, and (c) parents were very helpful to the therapists for interpreting their children's non-verbal behavior and clarifying stories for the therapists after watching sessions on monitors.

With older youth however it becomes more challenging to weigh the pros and cons of involving parents so heavily. The cons include that many children value privacy with increasing age, and may be more self-conscious and feel more discomfort with personal disclosures. With sexual abuse in particular, youth will feel embarrassment and shame about disclosure. Talking about domestic violence is another type of trauma in which youth are likely to talk differently if they know a parent is watching.

For clinics that do not have cameras, this ought not to be viewed as a high-tech, insurmountable, or expensive accessory. Camcorders, DVD recorders, and small TV monitors are fairly inexpensive. The connecting cables can usually be strung over the top of the wall adjoining the rooms and under ceiling tiles without having to drill any holes. An inexpensive option that some have used that captures the audio but not the video is a baby monitor.

Why involve parents so heavily? We reviewed all of the studies that tested the concordance of parental factors and children's symptoms following traumas that included the children (Scheeringa & Zeanah, 2001). Seventeen studies met our inclusion criteria that (a) the children had suffered DSM-IV-level life-threatening events, (b) the measures had to be standardized and replicable, and (c) the children and parents were assessed concurrently. A wide variety of constructs were measured and cannot all be reviewed in this space. In summary, all but one study found a significant association between worse parent outcome and worse child outcome. Many of the studies focused on PTSD symptoms. They found that children with more symptoms of PTSD or higher

rates of PTSD diagnosis had parents with more symptoms of PTSD or higher rates of PTSD diagnosis. How does this inform how we should treat children?

There are at least four ways to attempt to interpret this association. First, the shared genetic content of parents and children may equally predispose them to developing symptoms following traumatic events. Moderate associations between specific genes and PTSD are gradually emerging. It has been shown repeatedly in adult studies that the pre-trauma personality trait of neuroticism is a predisposing factor for PTSD (e.g., Fauerbauch, Lawrence, Schmidt, Munster, & Costa, 2000), which implicates the notion that genetically-driven characteristics are important for determining who is at risk for PTSD.

Second, it may be that the parents and children who are the most symptomatic suffered relatively more severe traumas; and the less symptomatic dyads suffered less severe traumas. However, when the traumatic event is basically the same for all subjects, the association of more symptomatic parents with more symptomatic children is still found (Cornely & Bromet, 1986; Laor et al., 1996). In addition, some studies have shown that individual factors tend to be more important predictors than degree of exposure (e.g., McFarlane, 1989), and even when the severity of exposure is a significant predictor it does not predict the majority of the variance in PTSD symptoms.

Third, more disturbed parents may be less able to help their children adapt. This suggests a relational effect. That is, parent symptomatology impacts adversely on the parent-child relationship, which has a causal, moderating, or mediating relationship on children's symptoms, at least for a subset of children. In addition, several case studies have implicated parent-child relationship dynamics that hindered the successful adaptation of the children (e.g., MacLean, 1977, 1980).

Fourth, instead of thinking that children are impacted by their parenting, the opposite may be true, partially or completely, in the sense that parents are impacted by their children. It makes rational sense that caring, protective parents may become intensely distressed by their children's distress.

These are not mutually exclusive interpretations. All four interpretations may be true for one case, or each interpretation may be true for different subsets of dyads. The main point is to recognize the different possibilities, to not automatically blame the parent in a knee-jerk response, and evaluate each patient on a case-by-case basis. Therapists who can strike this balance may find opportunities to address salient issues or, more likely, prevent themselves from pursuing inappropriate actions based on incorrect assumptions.

In practice, the more common scenario may be when children are progressing relatively slower than others in treatment and therapists scramble to find an "obstacle." This view would be supported by studies such as Cohen et al., (1996) who found that children who had mothers with higher depression scores improved relatively less than children with mothers with lower depression scores (Cohen et al., 1996). For depressed mothers to have a causal influence on children though there has to be an observable mechanism for transmitting this effect somewhere in their parenting. However, attempts to change parenting practices to this end have been few. In practice, it appears that parenting beliefs and behaviors are fairly resistant to change, and attempts to change general aspects of parenting tend to be counter-therapeutic by disrupting the focus on CBT. It tends to be more fruitful to keep the focus on the CBT tasks, and if there is potential for parenting behaviors to change, the change flows more naturally from the children improving first. Preliminary evidence at one site at least (Scheeringa, 2007), suggests that after children improve during therapy, mothers feel relieved and their depression subsequently improves. Any changes in their parenting appear to follow naturally and voluntarily as they settle back into their pre-trauma state of existence.

Parental Reluctance. Based on the research data that show caregivers have enormous burdens of their own symptoms and on the clinical experience that caregivers are often reluctant to recollect their children's traumatic experiences, we built in motivation and compliance sections for the parents in almost every session. The therapist is directed to preemptively anticipate with the parent that s/he will feel reluctant to come to subsequent sessions. This feeling is validated, systematically rated on weekly basis, and addressed in more depth when needed.

iii. Trauma Population Considerations. Caregivers may have their own resistance to treatment because talking about the trauma may arouse memories of abusive or traumatic experiences from their own past. These issues can be addressed in separate time with caregivers in the second half of most sessions.

There has been speculation that children with "complex trauma" or poly-victimization involving interpersonal trauma have "complex PTSD" or more severe problems that require different intervention. This is an emerging area of interest that so far lacks data from well-controlled studies. There is little consensus about constitutes complex trauma or complex PTSD and no controlled data that they require different treatment. Until such data exist, this manual may be considered applicable to all types of traumatic experiences.

iv. Therapist Prerequisites

This manual provides a highly structured session-by-session protocol for how to conduct CBT for licensed clinicians (or masters level clinicians on their way to licensure). The most important quality that therapists can bring is a personality that is flexible to adapt to different children and friendly so that children like spending time with them. Therapists ought to have prior didactic knowledge about:

- Cognitive-behavioral treatment in children.
- PTSD in children.
- PTSD in adults.

v. Practical Matters

Each session will last approximately 45-60 minutes. Parents are involved jointly the entire sessions for sessions 1, 2, and 12. In sessions 3 through 11 they will participant briefly at the beginning and again at the end.

Candy and snacks are offered to children every session. This practice is meant to help make the office an enjoyable place, since many children are wary of doctors' offices and avoidant of PTSD topics. Food helps break the ice and make children feel more comfortable. These are offered unconditionally according to the ground rules. They are never to be used as rewards or withheld as enticements to influence participation in therapy sessions. Soft candy (e.g., tootsie rolls, Starbursts, caramel chewies, Hershey kisses) is offered at the beginning because it can be quickly consumed and leave the child's hands free. Chips and juice are offered as a snack after most of the child's work is done. If parents spontaneously attempt to use the food for contingent purposes, the therapist must gently correct the parent. Offering snacks and drinks to parents must be a more flexible option. Routinely offering a cold drink or snack to the parent for every session is not recommended. However, if this becomes an issue for needy parents, it is not expected that offering minimal snacks would pose a serious threat to the integrity of the treatment protocol.

Take notes while you converse with the children. You will frequently not understand what the children are talking about. Rather than "interrogate" them too much, which tends to be irritating because the children don't know how to express themselves more clearly, it is sometimes best to act as if you understand. Refer to your notes later in sessions with mothers or with mothers alone on a telephone and have the mothers interpret what the children were saying.

How Closely Should You Follow the Manual?

Very closely. Minor issues can be easily handled such as when parents ask for advice or information on other topics. These should be handled professionally within the limits of your expertise and comfort. You are always encouraged to use your clinical skills to engage the family, build the therapeutic alliance, and expertise in any way that the caregivers or children appear to need, as long as it is not counterproductive to the treatment strategies of this manual.

More problematic are issues that prevent the completion of the treatment tasks. For children who won't cooperate in sessions, more time needs to be devoted to managing behavior, but it is not advised to add extra sessions completely devoted to defiance while the CBT tasks are put on hold.

For children who do not appear to understand the identification of feelings in session 3, or the relaxation exercises in session 4, or are avoidant about telling their stories in session 5, do not repeat those sessions to the exclusion of progressing to the subsequent sessions. Children will perform these tasks later with the repetition that is built into the manual across sessions.

For parents who are too anxious to help their children perform the in vivo homework exposures, it might be acceptable for a different parent, uncle, aunt or grandparent to step in and assist with the homework exposures.

You should generally not jump forward over topics, but you can move backward. Suppose a child was slow to develop an alliance with you and did not participate well when learning the relaxation exercises of session 3. Somehow, by session 5 you observe that the child has warmed up more and is now more animated and talking more. Feel free to backtrack to session 3 and go over the relaxation exercises again in the hope of the child learning them better.

Lastly, when parents are perceived to be insensitive, punitive, or poor disciplinarians, it is tempting to intervene to try to change their parenting practices. Our experience, at least in this format, is that parenting practices are robustly resistant to change, and injudicious attempts to change parenting practices are counterproductive.

Forbidden Actions

When using this protocol in research to test effectiveness, theoretically different interventions need to be avoided to preserve the integrity of the intervention. The following is a list of prohibited interventions:

- Treatments for other disorders, such as depression or obsessive compulsive disorder, that are beyond the scope of this manual.
- Psychodynamic interpretations of thoughts, feelings, or behavior patterns.
- Personal involvement with the children or parents outside the structure of the study.
- The child or parent involved with another mental health clinician simultaneously during the study.

What if New Traumas Occur During Treatment?

Children who have suffered traumatic events often live in families that disproportionately experience trauma and adversity. We've developed the following guidelines to follow when a new trauma occurs in the middle of treatment. All of these may or may not be salient.

Mainly, step outside of the manual and spend a separate session (or more) on the new trauma to cover the following suggested topics:

- Get the details of what happened
- Find out what the child actually saw, heard, or understands about it
- Is there ongoing exposure or has the incident truly passed?
- Does the child have an unrealistic sense of not being safe versus is the child truly not safe in the current environment? In other words, do you need to develop immediate safety and/or coping plans for real ongoing threats?
- Is the child repeatedly exposed to family or neighbors talking about it?
- Is it an event that has generated local news coverage and the child is re-exposed to it daily from the television?
- Ask the mother what she has already been doing to help the child cope.
- If someone died, is a funeral planned?
- Is survival of the family an issue? That is, does the parent realistically need to be primarily concerned about shelter, food, and safety? If so, the daily nuances of parental sensitivity with children may be lost.
- Does a caregiver have PTSD symptomatology from the newest event?

The DSM-5 has a requirement that symptoms from an event be present for one month before making a diagnosis and there are substantial data to support this timeline. Most people following a trauma have some PTSD-like symptoms in the first month but only about 30% have enduring symptoms after the first month. The National Institute for Clinical Excellence (NICE) recommended watchful waiting for mild symptoms within the first month, while treatment within the first month ought to be considered only for severe PTSD symptoms (National Institute for Clinical Excellence, 2005). In general, new events should be treated like old events, i.e., sessions used to tell the narrative, and conduct office and homework exposures, but only after watchful waiting for about one month to see if symptoms are going to persist from the new event.

SESSION 1: PSYCHOEDUCATION

CHILD GOALS: **1. Get acquainted**
2. Education about PTSD
3. Overview of 12 sessions

PARENT GOALS: **Same as child, plus**
4. Motivation/compliance preparation

THERAPIST PREPARATION

Materials

- Candy and snacks. The ground rules about candy and snacks will need to be covered. Small, soft candy will be offered once at the beginning. Snacks (chips and juice) will be offered after most or all of the child's work is completed. For some children, giving the snack during their session actually helps "keep them at the table" literally and increases their compliance. Snacks are not to be used as a reward or withheld as an enticement.
- Two 3-prong binders for the child's book and homework.
- Stickers for the book cover and for homework sheets.
- Markers.
- Handout sheets for the Roadway Book (Appendix).
- Outline of the 12 sessions (Appendix).
- 2 copies of handout of PTSD symptoms from trauma (Appendix).
- Pictorial aids of PTSD symptoms. The pictures need to about the type of the trauma the youth suffered in order to be salient. They also need to depict the type of symptoms the youth suffers. For example, for a youth who has distress at reminders after sexual abuse, the pictorial aid needs to depict a youth suffering distress at reminders from a trigger reminder related to sexual abuse. Three to four pictorial aids will be needed.

Roadway Books

This book will be one of several methods used to help the child develop a coherent narrative of the trauma absent cognitive and memory distortions. Over the course of the treatment, this book will be filled with projects and homework. It will be organized (session by session) in chronological order. Children will be asked to individualize their books by decorating the cover and naming it.

The book can also serve an important function of containing the distressing memories for the child. While exposure is a fundamental component of CBT, overwhelming exposure is not fruitful. The book can be used symbolically to contain memories until the child is ready to deal with them. The books, and symbolically the memories, stay in the office. At the end of treatment, the child is given the option of taking the book home.

Compliance/Motivation/Therapeutic Alliance

A warm therapeutic alliance makes therapy more pleasurable. However, treatment can be just as successful with more aloof alliances, and an aloof alliance should not slow down therapy. When this does not come so easily, the therapist must

be able to adapt her/his interaction style to the temperament and personality level of each individual.

It is important to adopt a "matter of fact" attitude about discussing the trauma that is perhaps more important with younger children than older children. If the child is avoidant to discuss the trauma, the therapist may feel uncomfortable "pressing the issue" because the power differential of age, size, and verbal abilities are magnified relative to older children and adults. If a caregiver has made clear that they have avoided talking about the trauma with the child, the therapist now has two patients to worry about upsetting. Humor can be used to lighten the mood. Despite these potential challenges, the success of treatment depends on the child, and perhaps the caregiver, ultimately being able to confront these memories without disabling fears and anxiety.

An extra, novel emphasis is placed on the therapist telling the parent that it is likely that the parent will not want to come back for subsequent sessions. This can be for several reasons. The parent doesn't want to confront painful memories. The parent doesn't want to put the child through painful memories. The child improved a bit and the parent has an excuse to stop coming. The parent has started to dredge up traumatic memories from her own past. If one of these reasons stops a family from coming back for treatment, it is already too late to address it. In this protocol, the reluctance to return is anticipated and discussed in the first session and every session thereafter. This preemptively validates the parent's experience. This intervention has the added benefit of showing competence in the therapist to the parent and helps build trust in the therapist. It shows that the therapist has been through this before and knows what's coming down the road. Parents are given directive advice to ignore their reluctance and come back anyway.

Child Cooperation

Many children are relatively unfocused, uncooperative, and energetic in the office for the first 2-3 sessions. They often settle down quickly as they learn the routine. They also settle down in session #3 and beyond because that's when the caregiver starts going into the next room and the child is alone with the therapist. In most cases, no special plan is needed to manage this behavior if it can be waited out. Have patience.

TREATMENT PROTOCOL

Introduction and Rules

With both mother and child in the room, explain that this is the beginning of therapy and that there are some ground rules to cover: a typical sequence of events that will happen in every session: candy, meet together briefly, work with child alone, meet with caregiver alone, and then meet together again to plan homework.

Offer the candy to the child now. If the child is not interested, do not make it an issue. Make it clear that the candy will be put away (out of sight) and cannot come back out this session. For children who try to take more than one piece of candy, don't use a dish full of candy; offer two choices, or just offer one piece.

Describe the purpose of the sessions

Next, make it clear at the start that both the child and the caregiver are here to deal with the trauma and the symptoms of PTSD. Tell them they will learn tools to help

them feel better. Tell them we will meet 12 times. Give the caregiver the outline of the 12 sessions (appendix: OVERVIEW OF THE 12 TREATMENT SESSIONS).

Describe Posttraumatic Stress Disorder

Briefly describe how we know that traumas can cause symptoms in people. Define a life-threatening trauma. Use examples that are relevant for adults and different ones for youth to give them perspective.

Next, introduce the terms "posttraumatic stress disorder" and "PTSD". For the younger children, re-frame it as "your scary feelings" or "your scary thoughts." We've found that the acronym "PTSD" is too abstract for younger children.

Next, describe the different kinds of symptoms. Give the parent the handout of common trauma-related symptoms (appendix page 55: POSTTRAUMATIC STRESS DISORDER). Avoid going through all 17 PTSD symptoms verbally as this is too much information to process. The handout has this detail for the parent to read later. Focus instead on the three types of symptom clusters. Use a made-up example that is different from their real trauma to illustrate.

Next, use the pictorial aids of some of the PTSD symptoms (available from the author) and the handout of the 17 PTSD symptoms (appendix) to help illustrate these concepts with the youth. Typically, three pictures are enough to try with the youth. We've found that three of the re-experiencing items work well:

- psychological distress from reminders
- intrusive recollections of the event
- nightmares

But remember that the pictures need to be of symptoms that the youth actually have so that they can identify with the symptom. Have the youth seated with you a table with the pictures (and the caregiver separated on a couch).

"So, I just explained the definition of PTSD to you and your mom. For the rest of the counseling we're going to use this definition a lot. I need to make sure you understand it. I'm going to ask you to explain to me how each of these pictures is like a PTSD symptom. For this first one, how is this girl/boy experiencing distress from being exposed to a reminder of her/his trauma event?"

Older youth ought to be able to converse about this more easily than younger youth. You will have to walk younger youth through this task in a more guided fashion, and perhaps even tell them everything that is going on in the picture. For example:

"This boy had been crossing the street one day and got hit by a car. Now, every time he plays by the street and a car whizzes by fast, this reminds him of when he got hit and he gets scared and thinks about the time he got hit …"

If youth claim that the pictures don't look anything like their symptoms, or that they don't have these symptoms, then simply ask them to explain the symptom in the hypothetical realm.

The overall purpose of this psychoeducation task is that they make the connection that there is such a thing as PTSD (or "scary feelings" or "scary thoughts") and that they have "it". We don't want this to become a discussion about the child, because we don't want this to be a full exposure session. A simple affirmation from the child is sufficient to confirm that connection.

For children who have experienced more than one type of traumatic event, it appears OK to lump these as you talk about the pictorial aids, e.g., "That may be like what happened to you when you were in the flood or saw that shooting."

If the child is not responding much, encourage the mother to use her "influence" to encourage the child to talk. Due to the nature of some traumatic events and the parent-child relationship dynamics that have developed, some children may feel that they need permission from their mother to discuss the event(s). If this is truly salient, this will probably be obvious. You could say to the mother, "Hmm. I wonder if s/he needs a little permission from you that it's OK to talk about this stuff. What do you think?"

Rarely, the explanation of PTSD symptoms with the pictorial aids works better with the child if the mother is out of the room. For example, if the mother of a child who witnessed domestic violence starts crying and the child becomes disengaged from the task, consider excusing the mom to the next room and try again alone with the child.

End the pictorial aid story with a happy ending: Show the picture of the child smiling. This also serves the purpose of educating the child that symptoms do get better, counseling is effective, and about why they're coming here.

Give the child a snack if they desire one.

Roadway Book

Show the child the 3-prong binder. Explain that over the course of your meetings, this book will be filled with projects. Explain that it will eventually be like a story of the child's life with a beginning, middle, and an end. Write their first name on the cover. They will be allowed to decorate the cover with stickers and/or markers. Obviously, younger children may like doing this more than the older youth. Do not have more stickers out than you are willing to allow the child to stick on the cover. A control battle over stickers on the first day is not a good start. Each child is asked to name their book. Inappropriate name choices ought to be vetoed or investigated further, as appropriate. If a child cannot think of a name, call it the Roadway Book. You or the child writes the new name on the cover.

Complete the first assignment for the book (appendix: SESSION 1: *ABOUT YOU*). Help the child fill in the blanks. When asked what "the event that happened to me was," some children will hesitate because they either don't want to talk about their trauma yet or really don't know what you're talking about. Go ahead and answer quickly for the child if the child hesitates. The point of this is to very briefly make it clear to the child why they are here, not to make it a quiz or a re-exposure episode.
In other words, you don't want to spend a lot of time talking about the traumatic event yet. That is saved for Session 5 after the child has learned relaxation exercises.

What if you've got an oppositional child who won't cooperate with the exercise? Try these techniques:

- Don't ask them to do the exercise. Tell them (politely).
- Act indifferent about his/her participation, make no eye contact, and start doing the exercise alone and act like you're having fun. Have two identical sheets ready for this purpose – one for the therapist and one for the child. Provide a running commentary of what you're doing. Sometimes if you act like you don't want the child to cooperate, this will pull defiant children in.

- Act indifferent about his/her participation, make no eye contact, and make it a competition. Oppositional children are typically competitive. Make gently indifferent comments such as, "Oh, I don't think you'll like this. You probably don't have a favorite color. Well, my favorite color is orange."

Place the completed sheet in the book.

Preview next week

Compliment the child's work. Tell the child that next time they will learn some new tools to make "PTSD go away" or make "scary thoughts go away".

Homework

None

For Parent: Motivation/Compliance

In addition to the above work, introduce the topic of resistance to come back for subsequent sessions. Explain that you know from experience that parents are often reluctant to come back. Sometimes it's because parents don't want to think about the trauma anymore. Sometimes it's because parents don't want to expose their children to the trauma memories anymore. Sometimes it's because old memories get stirred up from the parent's past. Explain that this is very likely to happen as the time approaches to come for the next visit. This is natural and happens to almost every parent. This explanation validates the parent's experience as normal. Explain that unfortunately the success of therapy depends on being able to tolerate this short-term discomfort. Finally, explain that this reluctance will become less as therapy proceeds and you will be asking about this at every session.

"We know from experience that some mothers are reluctant to come back for future sessions. This is normal. . .When you're getting in the car for next session and feel like not coming, just come anyway. Remember what you tell yourself to make you go, and we'll talk about it."

In addition, briefly note that the child also may become resistant to return to therapy as the work gets harder, and that you will address that more later.

Wrap up with the two of them together to say goodbye and schedule for next week.

SESSION 2: Oppositional defiance module

CHILD GOALS: **1. Identify coping patterns: a. Child's defiance pattern**
b. Parent's leniency due to guilt
2. Make discipline plan for home
3. Make plans for grieving, if appropriate

PARENT GOALS: **Same as child, plus**
4. Address reluctance

THERAPIST PREPARATION

Oppositional defiance is common in youth following trauma. This has been demonstrated in research and, in our experience, is the most common reason parents bring children for treatment (as opposed to PTSD symptoms). Therefore, a special session is devoted to this problem and followed up in subsequent sessions. Grieving can also be a problem that parents need help with for youth. The appropriate parts of this session can be "pulled out" and tailored to each child. If neither defiance nor grief are problematic issues for a child, skip this session and go on to Session 3.

Oppositional defiant disorder has no single, clear etiology and is probably the common result of multiple different pathways. That is, it may result from children with extremely difficult temperaments regardless of how their parents manage them. It may result from extreme stress within families. Or, it may result from a combination of these factors. However, in our clinical experience, defiance following trauma often has a clear thread. The parent feels guilty that the child has been through enough already and is reluctant to upset the child further by imposing discipline. Parents are quite cognizant of this dynamic and readily admit it. Fortunately, this type of defiance is remedied with a discipline plan.

When a loved one has been lost in a trauma, grief can be an important issue. Grief can also be tricky for parents to deal with because they are not sure whether children should be encouraged to grieve or not. Sometimes the issue is that the parents don't want to think about the loss, and so, by proxy, they discourage the child from talking about the person and evolving through the normal grieving process.

The therapist spends the entire time with the child and parent together.

TREATMENT PROTOCOL

Child and Parent Together

Welcome.

As usual, offer the candy to the child.

Review.

Begin the usual protocol of reviewing what has been learned so far. Last week they learned about PTSD (or "scary thoughts") and started the Roadway Book.

Defiance.

Explain defiance. Review from the initial assessment on how much of a problem the parent thought this was. Re-evaluate briefly the situation now. Re-confirm the time course that defiance is a problem that either started completely new or became markedly worse after the trauma.

Rather than ask for the parents' best guesses about why this developed or what to do about it, explain the theory about parental guilt and leniency with discipline. This is such a common scenario that jumping ahead like this saves time (and makes the therapist appear wise). If this theory is wrong, the parent will tell you. (Don't forget to ask about Dad, grandparents, or any other daily caregiver).

TIP: Therapists often find this awkward at first if they place too much emphasis on the importance of this question and psychodynamics. The trick is to understand in your mind that in the lifetime of a parent thousands of important events have occurred, and you're asking about just one of those. This script may be helpful:

"As we're talking about oppositional behavior today, there's something in our protocol we've found helpful to ask about. We've found in our experience that after children go through traumas, parents often become lenient in their discipline because they feel guilty about what their children went through. Do you think you did that?"

If confirmed, move on to the intervention.

The key is to negotiate an agreement with the mother that she will work towards ignoring her guilt or empathy towards the child, and enforce discipline. Explain that this is a well-known cognitive therapy technique of recognizing maladaptive thoughts and replacing them with more appropriate thoughts. Instead of thinking, "Poor thing. He's been through too much already", replace it with, "Poor thing. But he still has to follow the rules. Following the rules isn't going to kill him".

If parental guilt leading to leniency is not the issue, ask more questions to explore for other etiologies. Sometimes the problematic issue is the other parent or a grandparent who undermines the mother. Ask systematically how other caregivers handle discipline with the children. Remain open to all possible etiologies of defiant behavior. Some parents need coaching to use rewards for positive behavior before considering punishments for negative behavior. If no clear cause can be found, the parent management techniques reviewed in this session may still be helpful.

TIP: There will be awkward and tense dynamics for some of these discussions. In those cases, one will probably question whether it was wise to try to do this session with the child and parent together or whether it would work better to work with each individually to avoid the tension. It is encouraged not to split them up individually for several reasons. First, the discipline plan needs to be a joint plan that both of them agree upon. Second, tense discussions are part and parcel of family dynamics and are unavoidable. A therapy office ought to be a place where difficult topics can be professionally discussed. Third, in this session the focus is on a practical "fix it" strategy with solutions. If the discussion is tense that probably means too much time is being spent discussing blame or personal issues, and not enough time on a practical "fix it"

plan. There will be plenty of time in later sessions for both the child and caregiver to discuss more personal issues with the therapist if desired.

Next, make a list of defiant behaviors on the worksheet for the Roadway Book (appendix: SESSION 2: BEHAVIORS TO CHANGE). There are usually one or two recurring situations that caregivers would most like to see changed. Pick one behavior as the target behavior for the discipline plan.

Narrow this behavior down to a measurable, clear behavior that you (and the caregiver) can tell when it has been accomplished. For example, if the caregiver said that "He's mean" is her target behavior, this is not measurable and clear. Other unacceptable targets include, "He's aggressive", "He hits" and "He doesn't listen."

Clear and measurable target behaviors include:

"He chokes his sister."

"He throws objects at the walls and/or people."

"He doesn't pick up his clothes after I tell him three times."

Review the parents' history of discipline techniques, including use of time-out. Go over the rewards that will be used.

Write out the plan clearly and neatly on the worksheet for the parent to take home (appendix: SESSION 2: DISCIPLINE PLAN FOR DEFIANT BEHAVIORS). It is extremely important that they leave the session with the plan written on paper. Do not leave this part of the task up to them to do at home.

NOTE ON TIME-OUT: Misunderstandings about time-out are so common that it is worth a special mention. We do not use time-out to extinguish bad behavior or instill morality. It may extinguish bad behavior in your average child who has no clinical-level disturbances, but that is not our clinical population. If a parent says, "I tried time-out and it doesn't work," then re-educate them on the true usefulness of time-out. Time-out is a last resort measure to temporarily interrupt disobedience or to stop children from harming themselves, others, or property. "Temporarily interrupt" is the key phrase. When time-out temporarily stops a child from doing the unsuitable thing that they were doing, it, by definition, has worked. We generally do not use time-out in discipline homework, but you may want to address it because it is so commonly misused.

The child is in the room during this time and may spontaneously interject comments or can be pulled in for suggestions. Older youth ought to be more involved than younger youth. Most importantly, children can often be helpful to suggest salient rewards or consequences. Sometimes the child can offer helpful information about why they act up. They can also, surprisingly, sometimes admit quite openly that they know mom won't punish them anymore. In addition, it is revelatory for the child to hear that the therapist is backing up the caregiver to crack down. This implicit "show of force" helps the child understand that the old situation is changing.

One ought to feel free to talk with the caregiver about implementing a similar discipline plan with a sibling who also shows defiant behavior.

Grief.

If a loved one was lost in the trauma, use this time to discuss how this loss has affected both the child and the parent. Explain the normal grieving process, and that, on

average, this takes two years. Ask the child if they cry, and if they hide it from their mother. Ask the mother if they cry, and if they hide it from their child. Ask if it is allowed in the home to talk about the deceased. Ask if they went to the funeral. Are they allowed to visit the gravesite? What does the child understand about death? Does the child persistently ask where the deceased has gone? How has the parent answered this question? Did that satisfy the child? The concept of "Heaven" is often too abstract for young children. A more concrete and satisfactory answer of where the deceased has gone is in a box, in the ground, at the cemetery.

If the child was not allowed to attend a funeral or a gravesite, or if the child simply wishes to memorialize the deceased more personally, a memorial can be created. This can be a picture for their Roadway Book, a letter, a poem, or listing that person's special characteristics.

Give the child a snack if they desire one.

For Parent: Prepare for Next Session

In Session #3, you will be covering feelings with the child. This works best if you know ahead of time what real-life non-traumatic things have made the child scared, mad, sad, and glad. Ask the mom to give a couple examples of each, including examples of different gradations. For example, you want an example of something that made the child a little mad and then something that made the child a lot mad. Even older youth can have difficulty "remembering" these things so it doesn't hurt to ask for these things ahead of time from the caregiver to use in the next session.

Motivation/Compliance

Revisit the issue of reluctance to come to sessions. Ask if that happened prior to today's session. Ask them to grade how strong the feeling was on a scale of 1 to 10. This scaling will be a concrete way to grade the reduction in this reluctance as therapy proceeds. Ask what tricks they successfully used to overcome the feeling. Remember their answer so you can prompt them in the future to use the same trick. Remind the parent that the reluctant feelings are short term and will get better.

Ask if their child seemed reluctant also. Ask them to grade their child's reluctance on a scale of 1 to 10. If either person was reluctant, ask for the reason(s) why to complete the Reluctance Checklist.

Homework

Follow the new discipline plan.

In addition, the mother's homework is to catch herself feeling guilty and try to ignore it. Fill out the worksheet and hand to the mother (appendix: SESSION 2: FOR PARENTS: CHANGING MY THOUGHTS).

Mom gets her own 3-clasp binder for homework. Place the discipline plan and stickers in her homework binder for the mother to take home.

Preview next week

Before they leave, explain that next week you will review the discipline plan and start learning new tools to make PTSD go away. Remind them that they'll start the routine of splitting up next week.

SESSION 3

CHILD GOALS: **1. Identify distressful feelings**
2. Introduce SUDS
3. Recognize internal dialogue (cognitions)
4. Introduce cognitive triad

PARENT GOALS: **Same as child, plus**
5. Address reluctance

THERAPIST PREPARATION

First, children will learn to identify their emotional and bodily (somatic) feelings in relation to different stimuli. This is the first step in being able to practice interventions to reduce distress. This is also a key step in the larger goal of producing a coherent narrative of the entire traumatic experience without distortions. Discussion and questions will be used to explore emotional feelings. Drawing on an outline of a body will be used to explore bodily feelings.

If a discipline plan was instituted last week, you will need to vigorously follow up on it. There are generally three possible outcomes at this point. First, if the plan was successful, you will either need to negotiate how it needs to be modified for the upcoming week, or just left in place unmodified. Second, if the parent followed the plan, but the child's behavior did not improve, you will need to decide whether to stick with the same plan another week, "ratchet it up a notch" with more potent rewards, or choose a different target behavior. Third, **if the parent did not follow the plan, you will need to assertively address this issue now, rather than later**. That is, put the issue of the parent's noncompliance on the table straightforwardly, as opposed to glossing over it. It is highly probable at this point that it was not an accident that the parent did not follow the plan, and it will not be followed in the future if it is not enforced. The counselor is the enforcer. You must sensitively "hold their feet to the fire" and remind them that there are consequences, i.e., their child's defiant behavior, if the parent does not follow the behavior plan.

TREATMENT PROTOCOL

Child and Parent Together

Welcome.

Offer the candy once then put it away.

Review the last session and the homework with mom and child together.

Briefly talk about last session. It is not anticipated that the child will recall much detail but this sets up the practice of reviewing when it will become more important later. If a new discipline plan was started last week, review how that went. Don't spend more than about 5 minutes together at the start of each session. You just want to get a sense of how the homework went before you start working with the child. If the adults have a long discussion about the child's misbehavior in front of the child, while the child is bored and restless, this sets a negative tone.

If needed, politely explain to the mother, "OK, I'd like to hear about that later. I want to get started with (child's name) right now. You and I can talk later about that."

Before splitting up, briefly explain to the mother what you and the child are going to do. "I'm going to ask your daughter/son how s/he feels about some things today. We're going to work on identifying different emotions, how they are connected to events, and learning to grade intensity of feelings on a scale."

Child Alone

Teach the child to identify feelings.

You need to make sure children can accurately identify different emotional states. Have a feelings chart laid out on the table. This should include faces of happy, sad, mad, and scared faces at a minimum. First, tell the child that this is a quiz about feelings. You must educate the child about what you're trying to do. In other words, don't just dive into the task without explaining what you're doing.

"Today we'll work on one of the tools that you'll need in later sessions. One of the ways that this works is that I'll need you to identify your feelings that are triggered by different stimuli and how intense those feelings are. So today we're going to practice together what we'll need for later sessions."

Then point to one of the first faces on the feelings chart, say the happy face. Ask what kind of stimuli, or situations, would could the youth to feel happy. Get two or three examples. Do this for sad, mad, and scared.

Lots of different play therapy techniques, drawings, and props can be used to help children identify feelings. If you don't want to use a feeling chart, use your creativity.

Some children will enjoy this, some will not. Nonetheless, praise them for their efforts and move forward.

Gradations of feelings.

Second, you need to determine if the child can accurately rate gradations of an emotion. For the SUDS score, children will have to identify not just feeling scared, but they will have to identify gradations of scared. This skill cannot be assumed to be present in all children like it can be assumed in older populations. You will need to test to see if the child can do this. Again, this can work best if you have discussed this with the caregiver beforehand and learned what situations make the child a little scared and a lot scared (although this is not foolproof). It also works best if you have enough real life examples. Have the SUDS score form on the table for you and the child to look at.

As usual, explain the purpose so the child understands what you're trying to accomplish. "Later in treatment, you're going to have to rate yourself on whether you feel a little versus a lot nervous. So this next part is about us developing our jargon for that."

For example, say to the child, *"When the teacher calls on you to answer a question, this makes you a little nervous, right?"* Point to a low SUDS rating. "*But when you have to stand up in front of the class to give a talk, this would make you a lot nervous."* Point to a higher SUDS rating. Make sure the child understands the difference in the different level of nervousness in those experiences.

Go through an example like this for sad and mad. Scared/nervous will not be the salient emotion for all youth in their exposure exercises so it is good to cover all of these negative emotions in this practice session.

At some point, give the child a snack if they desire one.

Somatic feelings.

Next, pull out today's worksheet for the Roadway Book (appendix: SESSION 3: FEELINGS IN MY BODY) and have the youth draw on the body where mad, scared, sad, and happy are felt. As usual, explain the purpose. "Another dimension of feelings is how we feel them in our bodies. So now I want you to think about how you feel each of these in your body and we're going to use these in the future in our work."

If children are hesitant, it's more important to make it engaging and fun, even goofy, than to have them comply with everything. If children have a hard time figuring out where to draw on the body outline, go through a list of stepwise possibilities: heart pounding, head hurts, stomach knots, lump in the throat, and fidgety. Ideally, the child will do the drawing. If reluctant, you do the drawing according to what the child tells you. You may need to make the first drawing to make the exercise clear to the child. It is OK to give suggest ions for symbols such as lightning bolts, sun-rays, squiggles, etc.

Internal dialogue and cognitive triad.

Lastly, present the concepts of an internal dialogue (cognitions) and then the cognitive triad of how thoughts, feelings, and behaviors have a circular cause and effect influence on each other. Because you've focused on feelings today, and to keep it simple at the start, give an emphasis to feelings being the first cause of thoughts and behaviors today. As usual, explain the purpose, "The last thing on the agenda today is to go over what we call the cognitive triad. It will also be important in our later work together to identify how your feelings trigger different thoughts in your head and cause different behaviors."

Therapists may have other names for this besides the cognitive triad. You can call it by different names. The main point is that the youth learns the fundamental issue that feelings, thoughts, and behaviors are all interconnected and influence each other.

The first step in the process that is often the most difficult is for youth to realize that they have an internal dialogue of cognitions. So some emphasis is placed in teaching in helping them learn to capture those cognitions. Go back to some of the examples you were using earlier to teach about identifying feelings. Say, for example, having to stand up in front of the class to give a talk. Sketch each scene out on a sheet of paper to make it concrete and to have a vehicle for discussion between you and the youth. Walk through this example with the youth slowly. Have a pictorial aid on the table in front of both of you that shows feelings, thoughts, and behaviors connected with lines. As the youth feels nervous or scared about having to talk in front of the class, this generates cognitions* in his/her mind, such as, "I'm no good at this," or "My face is going to turn red." Some of these will be accurate (face will turn red) and some of these will not be accurate (I'm no good at this). Help them see the difference in how their mind generates accurate and inaccurate cognitions. Do this with several examples. Make sure you introduce the actual phrase "inaccurate thoughts" because you will start using this phrase regularly in session 6.

The feelings and/or the thoughts also generate one or more behaviors inside the body, such as sweating, lump in the throat, dry mouth, butterflies in the stomach, bouncing legs, tapping fingers, heavy breathing, or fast and pounding heart beat. It may also create external behaviors, such nervous giggling, getting up and walking around, cracking a joke to relieve tension, or getting in trouble because you were nervous and

weren't thinking clearly. Walk through your examples and discuss the behaviors inside the body and the external behaviors that would be generates.

*(In later sessions you will be interested in detecting more generalized automatic negative cognitions such as "Bad things will always happen to me" or "I'll never be loved by anyone." But for this practice session, you don't need to detect that extreme level of automatic thought.)

For youth dealing with grief, a Grief Triad handout is in the appendix.

Roadway Book.

Place any completed sheets in the book.

Homework.

The homework will be on the oppositional behavior again, if needed. Explain this briefly to the child.

Preview next week.

Tell them that next week they will learn more about feelings and one more tool to help with reminders.

Parent Alone

Teach about feelings.

Review the feelings and cognitive work that were covered with the child.

Obtain any feedback as needed from the mother about any information from the child wasn't clear, and may need to be interpreted for you by the mom.

Review.

If the discipline plan was not attempted last week, ask why and why it was difficult. Mothers who can't implement basic discipline at this point typically have some resistance to the idea. You should be directive but can soften it with humor. Remind them that they are the only person who can do this for their child. Their child needs them to do it for them. It may be evident that a particular mother simply can't attempt this intervention at this time. Perhaps the child has not been so oppositional that the mother is at the end of her rope. This time may come later and explain it to the mother this way. You can also "lay it out on the table" that maybe adding tougher discipline is not in the cards. If the mother can live with the child this way, then OK. Ultimately, remember that you can't force the mother to do anything. If they are unable or unwilling to work on discipline, then drop the issue and continue with the CBT work.

The mother should be bringing her homework binder with her to sessions. Ask to see it.

Motivation/Compliance.

Revisit the issue of reluctance to come to sessions. Ask if that happened prior to today's session. Ask them to grade how strong the feeling was on a scale of 1 to 10. Record their answer. Once again, remind that the reluctant feelings are very likely to pop up again, maybe even worse than before for a while, but that it is short term and will get better.

Also, ask them to rate their child's reluctance to come today on a scale of 1 to 10. If reluctant, ask for the reason(s) why to complete the Reluctance Checklist. Note to

them again that reluctance might increase as the work gets harder and that this is natural.

Homework.

The homework will be on the discipline plan again, if needed. Adjust the target behavior, reward, or overall plan as needed.

Wrap Up Together

Preview next week.

Finish up with both of them together, go over the homework assignment, and tell them that next week they will learn more about feelings and one more tool to help with reminders.

FINAL NOTE: If the child showed little cooperation with or understanding of the tasks today, the rule of thumb is not to repeat the session. Move ahead next time with Session 4. Children will get more practice with these techniques in later sessions.

SESSION 4

CHILD GOALS: **1. SUDS practice**
2. Learn relaxation exercises

PARENT GOALS: **Same as child, plus**
3. Address reluctance

THERAPIST PREPARATION

Children will learn relaxation exercises. These intervention will be practiced in sessions and be a homework assignment for practice in the "real world". It is important to learn a relaxation exercise early on so that it can be used later when more distressing memories are addressed later in treatment.

They will also get more practice learning to rate gradations of feelings on a Subjective Units of Distress Scale (SUDS) scale. This is a concrete visual aid for rating the severity of distress. This will be used in later sessions as the child gradually builds up to confronting more distressing reminders.

All of the relaxation exercises described here may not work for some children. A child may completely dislike the relaxation exercises for an idiosyncratic reason, or cannot grasp them, or it may become apparent that another exercise works much better. For example, a youth may get a better result from a yoga technique the she learned elsewhere and would prefer to use. Feel free to (a) ask caregivers for other options, and (b) substitute exercises that work.

TREATMENT PROTOCOL

Child and Parent Together

Welcome.

Offer the candy once, then put it away.

Review the last session and homework together.

Briefly review last session. If you assigned the discipline plan homework, ask them how it went. If it was not attempted, talk about why it was difficult.

Try to keep this all under 5 minutes and in a fairly light and positive mood. Escort the mom into the next room and begin working with the child alone.

If working with a developmentally delayed younger child, this can be difficult. Before splitting up, tell the mother that you are going to teach her child how to think of a calm image in his/her head today. Ask the mother what words you could use with her child to help him/her understand the concept. Does the child understand the word "imaginary" yet? How about "make believe" or "pretend?" The mother may be able to suggest a phrase for you to use that the child will understand.

Child Alone

Teach relaxation exercises.

Explain what you are trying to do before you do it. Following the "full disclosure beforehand" principle, explain that you will be teaching relaxation methods to help with the PTSD symptoms (or "scary thoughts"), then you will both practice it. Explain that

there are three parts – muscle relaxation, creating an imaginary "Happy Thought", and slow breathing.

Explain that these will be the child's tools in their toolkit to make the PTSD symptoms go away.

Show the training videotape of an "actor" child demonstrating the breathing and muscle relaxation exercises (not available at other sites unless you make your own).

Start with muscle relaxation since this one tends to be accepted more easily than the others. The exercise description in the Appendix is more appropriate for children on the younger end of the spectrum for this manual. This description uses counting by two's to make it rhythmic and concrete. We've found that it's engaging to describe it as making your muscles "tight, tight" (demonstrate by squeezing your arm muscles) and then "go loose like noodles" (shake your arms around like noodles to demonstrate). You may use your own favorite method too. The point is to try to make it fun and engaging.

For adolescents, they will be more self-conscious. Move their chair off-camera without asking with an explanation of something like, "I want you to practice these without being self-conscious." Use a bit more detailed and mature description of muscle relaxation than the one describe earlier.

Next, teach them about diaphragmatic breathing. Children typically show the most difficulty with this exercise. Try to make it engaging by putting your hand on your stomach and making it go in and out with big breaths. Have the child imitate you in a contest. Or, make it a contest about breathing in through the nose, and then out through the mouth. Younger child can be encouraged to blow hard with a prop like a pinwheel or a party favor blowout toy. Counting and tapping out beats can also make it rhythmic and easier to remember (e.g., "breathe in, one, two, breathe out, one, two, three"). Or, suggest that the child can lie down to make it more relaxing.

If the child appears embarrassed offer to let them turn their chair away from you, or you turn your chair around.

Next, explain happy place imagery. Children can learn to self-soothe by replacing scary feelings with this nice picture when they get too nervous. You can call it "happy place" or "happy thought" or you may need a different term that they understand better. A happy thought can be some event that was fun (like shopping), or someplace calm, like the beach, or someplace familiar, like home with family, or someplace isolated, like their bedroom. Young children tend not to associate thoughts of being alone as happy thoughts because they are so rarely alone. Younger children's happy thoughts will tend to be about events with other people. Be sure to take notes on the details that the child relates. Draw the image on the worksheet (appendix: SESSION 4: DRAW YOUR SAFE OR HAPPY PLACE). Have fun practicing thinking about this together for about 15-30 seconds.

If the youth has difficulty imagining a scene with his/her eyes closed, it might help to practice this skill. Tell them to look at a poster on your wall and then close their eyes but keep that picture of the poster in their head. With their eyes closed, quiz them about what's on the poster. Do this a few times until they can tell you what's on the poster with their eyes still closed.

Offer the snack to the child, if desired.

Teach the SUDS.

Review that you've already learned two tools – how to identify feelings and relaxation exercises. Explain that today you will teach tool #3.

Show the child the SUDS form (appendix: SESSION 4: SUDS) and the SUDS 10-point rating scale. Give examples of mild stressors and severe stressors. Guide the child in filling in the SUDS sheet with appropriate stressors in the blanks. The child may not be willing to include the trauma on the sheet yet but give them permission by saying, "You're trauma might be the number 10."

Practice a scary thought, the SUDS score, and a relaxation exercise with the child. You must take the lead and do it together. This can be fun and engaging.

Homework.

Show the child the homework sheet. Pick a tentative specific thing to expose themselves to that they know will make them slightly nervous (not related to the trauma). Explain that they will need to (1) expose him/herself one time to a specific thing that is known to make the child slightly nervous, (2) rate him/herself on the SUDS, and then (3) practice the relaxation exercises. This must be done at home with the parent. Confirm later in the session with the mother before writing it down.

Preview next week.

Explain that next week you'll do another part of the Roadway Book and learn some new things about how to control reminders.

Parent Alone

Review Homework.

Look over the discipline plan homework sheet. Discuss with the mother how this went. Place the completed homework sheet in the Roadway Book. If the homework was not completed, ask why, and help problem solve on how future homework can be facilitated.

Teach relaxation.

Go through the steps of explaining the relaxation exercises to the parent. Make sure she understood them. The mother will be expected to prompt the child to practice this at home so she needs to fully understand what is involved.

Some mothers may decide to use these exercises for themselves. While this manual does not prescribe that mothers use these exercises for themselves, it is acceptable to go down that path with caregivers if it seems compelling.

In addition, ask the mother what she uses at home to comfort her child. These tried and tested methods may be able to be worked into the relaxation exercises.

Teach the SUDS score.

Review the SUDS. The mother will be asked to help the child practice this at home once next week so the mother will need to completely understand how it works.

Have Caregiver Draw Bird's-Eye-View Diagram of Traumatic Scene.

Before the next session it is helpful to get details from the caregiver about the traumatic event(s) about which the child is going to narrate. Explain to the parent that you and the child are going to discuss the trauma event in this session and in the

following sessions, you will be working with these memories. It can be enormously helpful to therapists to have a map drawn of the physical layout of the scene. Either ask the mom to draw on a piece of paper a bird's-eye-view diagram of the scene, or you draw with the mother's information. This information often elicits new information and will help you guide children through their narratives because you will have accurate information to help them through their avoidance. We have also found it a practical aid for the therapists to more quickly understand the children's narratives and avoid asking repetitive and irritating questions to try to understand what happened.

Possible Boundary Issues.

Some caregivers are inappropriately intrusive beyond their children's personal boundaries for privacy and confidentiality. By now, you will probably know if a caregiver has that issue. For example, a caregiver may tell family members inappropriate things about what the child is doing in therapy. Or, the caregiver may try to get the child to do their homework and relaxation in front of other family members even though the child is embarrassed. But even if the caregiver does not appear to have a boundary issue, it is worthwhile to give all caregivers the following spiel to preempt an awkward scene in the future.

"In our experience, some children get embarrassed if their therapy is talked about with other family members. And if this happens, they won't do the homework or they won't talk to me anymore in therapy sessions. I just need to warn you about that ahead of time."

Motivation/Compliance.

Revisit the issue of reluctance to come to sessions. Ask if that happened prior to today's session. Ask them to grade how strong the feeling was on a scale of 1 to 10. Compare this to their rating last week. Ask what tricks they successfully used to overcome the feeling. You may need to prompt them to use the trick they used before that worked. Once again, remind them that the reluctant feelings are very likely to pop up again, maybe even worse than before for a while, but that it is short term and will get better.

Next, ask them to rate the child's reluctance to come today on a scale of 1 to 10. If reluctant, ask for the reason(s) why. Remind them that if reluctance is going to increase it typically happens around sessions 4-8 and is natural. Give them verbal support that they will need to tolerate the reluctance to get through this hard part of the treatment.

Child and Parent Together

Homework: Test drive the rating and exercises

Wrap up with caregiver and youth together. Fill out the homework worksheet (appendix: SESSION 4: HOMEWORK: HOW MUCH I'M SCARED).

This must be done one time at home with the parent. The plan must be very explicit with the VERY SPECIFIC target, date, and time written down on paper BEFORE THEY LEAVE.

Explain to the mother explicitly that another purpose of this homework is to figure out which of the three relaxation exercises the child likes the best. Tell the mother to remind the child of and do all three exercises during the homework, but the child doesn't have to do all three.

Explain that the purpose of this homework is a test to see if the child really understands how to use what has been learned about these exercises.

Make it enormously clear to the parent that this is to be a planned time for practicing. They are not to make their children use the relaxation exercises in the midst of a temper tantrum. These exercises are not for that purpose.

This has the potential to become a control battle. Explain extremely clearly to the parent that if the child does not want to do it that they should never be pressured or coerced. For younger children, they can remind the child of the reward sticker once a day, but then it should be dropped.

Place the new relaxation homework check sheet (and stickers for younger children) in the homework binder.

Keep an eye out for the subset of children who have anxiety sensitivity (Weems et al., 2007). That is, they get anxious about becoming anxious. They will get so worked up about the prospect of doing any exposures that might make them anxious that they can't ever get to the point of actually doing the exposures. If you suspect this, investigate this systematically as soon as possible by interviewing the youth and/or the mother to confirm or disconfirm it from past history. If anxiety sensitivity appears to interfere, then this can then become the actual early target for homework.

CAUTION: Do not give caregivers permission to do this homework more than one time in the next week: There is a subset of caregivers who will either misunderstand this homework or deliberately do it differently no matter how persuasively you explain it. The worst-case scenario is a caregiver who jumps the gun and decides to start breaking their child of a phobia. For example, one caregiver decided to try to cure her child of being afraid of the dark immediately by placing her child in a dark room and telling the child to use the exercises DAILY. This was inappropriate, too fast, too scary, and had the potential to sabotage the rest of treatment. Another caution is that if they do the exercises incorrectly for some reason, you don't want them doing that daily. There is absolutely no reason to assign this homework more than once per week.

Think of this homework as the test drive. You don't need to test drive daily. Once per week is all that is needed to practice this.

Preview next week

Explain that next week you'll start talking more about the child's actual symptoms and how to use the tools they've learned.

FINAL NOTE: If the child showed little cooperation with or understanding of the tasks today, the rule of thumb is not to repeat the session. Move ahead next time with Session 5. Children will get more practice with these exercises in later sessions.

SESSION 5

CHILD GOALS: **1. Tell the story**
2. Create the stimulus hierarchy

PARENT GOALS: **Same as child, plus**
3. Address reluctance

THERAPIST PREPARATION

Now that the youth has learned about PTSD and developed tools to deal with distressing reminders, the next task is to start constructing the coherent narrative. The child will be asked to tell the whole story of what happened from start to finish. The two goals of today are to use this session as narrative exposure for habituation to anxiety, and to build a stimulus hierarchy of distressing reminders. This may seem too stressful to the inexperienced clinician, but many children welcome the opportunity to talk about what happened to them.

Helpful comments from the therapist ought to be geared to helping the child understand that it is important to have an organized and accurate story of what happened, including their thoughts and feelings along the way. Include smells, sights, sounds, tastes, or touch sensations that were relevant. This will help the child think, feel, and behave in ways that are consistent with their past experience, rather than in ways that perceive the whole world to be threatening and dangerous.

You ought to take notes during the story to record details accurately. Make sure you record events in the correct timeline. The stimulus hierarchy is simply a list of reminders arranged from the least scary to the most frightening. This list will be used to pick items for office exposures and homework exposures.

What if children had more than one traumatic event in their lives? Which story do they tell? Can you mix and match events on the stimulus hierarchy? Children can only tell one story at a time so they ought to be encouraged to recall their most traumatic one. However, in order to make the most efficient use of therapy, tackling multiple traumas is a feasible goal. Evaluate which single event was most scary and caused the most symptoms, and start with that one. If time allows in this session, ask them to recall a second one. If children spontaneously start talking about additional events, allow them to do this freely. The stimulus hierarchy can include reminders from more than one event.

TREATMENT PROTOCOL

Child and Parent Together

Welcome

Offer the candy once, then put it away.

Review the last session and homework together

Briefly review last session. Discuss the homework practice, and ask about how it went. Congratulate the child on good reports.

As usual, try to keep this all under 5 minutes and in a light and positive mood. Escort the mom into the adjacent room and begin working with the child alone.

Child Alone

Rehearse the Relaxation Exercises

Briefly review the three relaxation tools – muscle relaxation, happy place imagery, and diaphragmatic breathing – for practice. Repeat what you did in Session 3, but you will be able to do it much faster this time. Ideally, the youth ought to demonstrate these with you quickly to make sure they remember how to do them.

Tell the trauma story

Explain that you're going to do something new together. Then explain why you're doing it. Explain that you will take notes on the worksheet (appendix: SESSION 5: THE WHOLE STORY ABOUT WHAT HAPPENED). The way this task is explained to the child will depend on the developmental levels each child shows for verbal and abstract capacities. Basically, you need to get a complete picture of the trauma story. Explain that you know this probably will not be fun to talk about but that it is an important job. Older children may be able to grasp that the purpose is to develop a complete story of the trauma in order to help with the child's treatment. Younger children may not find this a compelling rationale. Greater cooperation may be obtained from younger children by telling them that we need to get the whole story of the trauma for the Roadway Book. Show them the work sheet that needs to be filled in with your help. Other explanations could be that you need the child's help to make sure we're not missing any important details of what happened. You will be like detectives to look for clues. The more "competitive"/ oppositional children may find more motivation if this is made into a contest.

At the beginning obtain the initial SUDS rating and record it on the SUDS Log (appendix).

During the process, ask the child how they felt during key parts of the trauma. Help them with cues by asking about fear, helplessness, and anger.
Use these details to complete the work sheet for today.

Ask them about automatic negative thoughts. "Remember in our earlier session when we talked about how thoughts can influence feelings and behaviors? When you have memories of the story, do any automatic negative thoughts pop into your mind?" You probably won't have time to track how they influence feelings and behavior in this session, so just gather data and take notes about these thoughts.

Younger children do not have the skills yet to give lengthy, detailed narratives of past events. Without guidance, most children would tell their stories in less than a minute. After allowing each child to tell their stories uninterrupted, you will need to go back and lead each child through their stories step by step:

- What was happening before the trauma happened?
- Who was present?
- Don't forget to ask about pets.
- Where exactly was everybody and what were they doing?
- What exactly was the child doing before the trauma happened?
- What were the first signs of danger?
- What were the child's first reactions?
- What did the child wish they had done but didn't?
- Does the child remember what s/he was wearing?
- Any smells or tastes associated with the events?
- For car accidents, was the other vehicle a car, van, SUV, pickup, or truck?

What color was it?
- For domestic violence and maltreatment, what other objects or furniture in the environment were memorable?

Write down notes for yourself of a tentative stimulus hierarchy of the most distressing moments. Try to get at least five moments on the list.

After several minutes, check the anxiety level of the child on the SUDS. If 4-5 or higher, use the relaxation exercises to bring it down.

After that, check the SUDS periodically based on your judgment of the anxiousness of the child. A more anxious child may need a few more checks and relaxations than a less anxious child.

After recounting the whole story, check the anxiety level of the child on the SUDS. Practice the exercises regardless of their score. If anxiety is a 4 or 5 on the SUDS score, use the exercises again to bring down their anxiety to 3. Keep working with the child until the anxiety comes down.

Congratulate the child on bravery and a job well done.

Place the worksheet in the book.

Also, at appropriate moments during the narrative, check if child thinks the trauma was their own fault.
- Is there something the child thinks they should have done to prevent it?
- Something they wish they could do now about it?
- Something they wish they could do now just to make themselves feel better?

You don't need to have advice or a plan for these right now. You need to just gather data about what the child is thinking or wishing right now.

If distorted thoughts or feelings are detected, caution is urged again not to prematurely assume that a thought or feeling is distorted. For example, a child may say that they blame their mother for the fight that led to the battering. By waiting to concur and opting for a more careful exploration, this may lead to finding new details about the event that the mother wasn't willing to disclose at first.

Completing the stimulus hierarchy

Show the child the two options for the worksheet (appendix: SESSION 5: Vertical stimulus hierarchy and SESSION 5: Horizontal stimulus hierarchy), one of which needs to be completed today. Explain that the job today is to list the scary/anxious memories. Some people are able to rank them from the least to the most anxiety-provoking. This would be a vertical hierarchy. Some people are not able to rank them; nearly all of the events are equally scary. This would be a horizontal hierarchy. Whichever sheet is filled out will be put in the Roadway Book and used in later sessions.

For the vertical hierarchy, it's important that the reminders are listed in the correct order. The therapist uses the notes made earlier. Rank the reminders using the SUDS score. Complete the work sheet. For younger children, three to five items for the list are the most that young children can be expected to comprehend. Compliment the child on bravery again.

For a horizontal hierarchy, you may still be able to rank some memories vertically at either end of the spectrum. You can note these with handwritten notes on the sheet.

For 7-11 year-old children, if they come up with a horizontal hierarchy, you ought to double check with the caregiver and see if the caregivers can rank some of them of them. Self-reflection and ranking emotional valence on past events is still an emerging skill at these ages.

Also, when writing memories on the hierarchy, keep in mind what is practical and what can be turned into homework exposures and what might be physically impossible.

Offer the snack to the child as usual.

Homework

Show the child the worksheet for the next week of homework and that will be similar or the same as last week. The assignment is one practice.

Preview next week

Tell the child you look forward to seeing them next week.

Parent Alone

The first question to ask is an open-ended, "Well, what did you think?" The caregiver has just observed their child talk about their life-threatening traumatic event with another adult in a structured therapeutic setting, which will also probably be the first times most caregivers have ever heard their children talk about their events. So talk as little as possible for a bit and let the parent tell you what important things have been stimulated in their minds.

Common things that caregivers tend to say include, "I had no idea he remembered that much," and "I forgot that had happened." Also commonly helpful is that parents can interpret confusing chronologies, mixed up dates, and casts of characters. Sometimes real insight about children's symptoms occurs, such as "Now I see why he's afraid of the dark. It happened when the lights were out and she associates that with the dark. I just thought she was playing us or something. I guess she really is nervous about that."

A sizeable subset of youth do not readily acknowledge their nervous feelings during this narrative session and later exposure sessions, so you are often trying to infer whether or not they are nervous from their body language. However, you do not know each child's typical body language. Parents who have known their children their entire lives can easily infer when their children are nervous from the slightest of body language cues. Parents are enormously helpful to interpret body language to let you know if the child was nervous or not during the narrative.

Review Last Session

Review the old worksheet for the relaxation homework. Make sure they are filling out the SUDS correctly. Review the relaxation exercises and make sure they still understand the purposes of this.

Possible Boundary Issues

Revisit the boundary issue if you feel that your preemptive discussion in session #4 was not enough. "I mentioned this last session, and I want to remind you again of how important confidentiality is for children. It appears that your child does not like (fill in the blank of the situation that embarrasses the child, i.e., caregiver asks too many questions, caregiver tells family members the child's personal business, etc.). I'm afraid this could get in the way of him/her cooperating with me. So, I want you to try to catch yourself when you're about to (fill in the blank of what the caregiver does

inappropriately). When you catch yourself about to do this, try to stop yourself. When you come in next week, tell me how many times you caught yourself, OK?"

Motivation/Compliance

Revisit the issue of reluctance to come to sessions. Ask if that happened prior to today's session. Ask them to grade how strong the feeling was on a scale of 1 to 10. Compare this to their rating last week. Remind them that especially after today's session the reluctant feelings are very likely to pop up again, but that it is short term and will get better.

Next, ask them to rate the child's reluctance to come today on a scale of 1 to 10. If reluctant, ask for the reason(s) why. Remind them that if reluctance is going to increase it typically happens around sessions 4-8 and is natural. Give them verbal support that they will need to tolerate the reluctance to get through this hard part of the treatment.

Child and Parent Together

Homework

With both of them together, give the caregiver the homework worksheet (appendix: SESSION 5: HOMEWORK CHECK SHEET: PRACTICE ONCE, SUDS). Explain that she will need to prompt the youth to practice the SUDS score and relaxation exercise once in the next week, just like last week. (not related to the trauma). The plan must be very explicit with the VERY SPECIFIC target, date, and time written down on paper BEFORE THEY LEAVE. They will need to place a sticker in the box (if using stickers) at home when completed.

As with the previous homework, you may still be trying to determine which of the three relaxation exercises the child likes the best. Explain this again to the mother. Tell the caregiver to remind the child of and do all three exercises during the homework, but the child doesn't have to do all three.

(Note: in this and future homeworks, children may spontaneously use relaxation for innovative and/or unique purposes. For example, a child may integrate a relaxation exercise into a magical destruction of a bad object on their own. If this happens, go with it as long as it appears positive towards the child's healing.)

Preview next week

Explain that you'll start practicing narrative exposure for the next 5 sessions.

FINAL NOTE: If this session did not produce much detail in the trauma narrative or cooperation from the child, it is tempting to want to try to repeat this session, but don't. For a variety of reasons, if it didn't work smoothly in Session 5, it is unlikely to work more smoothly one week later. Keep moving ahead and stay on track with the protocol because the children will get more practice with narratives in the subsequent exposures.

SESSION 6

CHILD GOALS: **1. Easy narrative exposure**
2. Safety planning
PARENT GOALS: **Same as child, plus**
3. Address reluctance

THERAPIST PREPARATION

The main task today is to practice an easy narrative exposure. For youth with a vertical stimulus hierarchy, easy items that the child can already tolerate fairly well are picked first. You will work together over the next five sessions up the list toward the "worst moment". Do not let an over-eager child pick their worst moment for their first exposure practice. Conversely, you may need to encourage anxious children to move more quickly up the list.

For youth with a horizontal stimulus hierarchy, it is not obvious which memory to work with, so the protocol describes how to negotiate with the youth to come up with best option.

A new topic will be introduced today on safety planning (Runyon et al., 1998). Over the next four sessions, the children will learn to identify early signs of danger, how to remove themselves from dangerous situations, and how to get help. Today's session will focus on the identification of early danger signals and making the safety plan.

TREATMENT PROTOCOL

Child and Parent Together

Welcome

Offer the candy once and then put it away as usual.

Review the last session and homework together

Briefly review in under 5 minutes. Mention that you had an important session last time. The child was very brave in talking about the whole trauma story. This was enormously important for making PTSD symptoms go away. You are very proud of the child.

Ask how the homework went.
Next, split up as usual.

Child Alone

Easy exposure/Imaginal exposure

Drawing exposure

Next, explain that the child is going to start making the PTSD symptoms (scary feelings) go away. For youth with a vertical stimulus hierarchy, they will need to pick an easy item from their list, draw it and talk about it, and tolerate the anxiety until their nervousness goes down to a 2 rating. For this easy task, this may not take long.

Give some examples first, such as public speaking or moving to a new school. The first time is the most nerve-wracking, but it gets less nerve-wracking the fifth time, and is not nerve-wracking at all the tenth time. This is what will happen with the stimulus

hierarchy. Pick an example from the child's stimulus hierarchy and explain the same way that the PTSD symptoms will go away with exposure.

Some children feel relatively more anger than fear from these exposures. If you only use the words "scared", "nervous", or "anxious" with them, the task may not have salience for them, and it will look like it is not working with them. If this appears to be the case, consider using an emotion word that more accurately reflects their feelings stirred up by the reminders. If it's not fear or nervousness, it is usually anger, but it could be sadness or some other negative emotion. In fact, we have tried using SUDS scales marked "scared", "angry", or "sad" to be explicit with different children. Older children can adapt on their own if you are using the wrong emotion words, but younger children tend to follow your directions more literally.

Finally, have the child pick an easy item from the hierarchy list for the first in-office exposure. For youth with a horizontal hierarchy, negotiate with them a bit on which memory to pick from the list. "Lay it out on the table" what the purpose of the task is and what the problem is, i.e., you need a memory that is less anxiety-provoking than the others but they are all ranked the same on the list. Have the youth help you solve the problem. The youth will likely be able to reflect more in-depth about these memories and pick one that suits the purpose for today. If a youth truly cannot rank any memories and claims that all the memories are equally anxiety-provoking, then a compromise is simply to start from the beginning of an event but maybe not go through the whole event that session.

Tell them to draw a picture of this item and then build the narration around this drawing task. For the drawing introduce the purpose of it as "We know from experience that it is natural to avoid these memories and to skip over details. Drawing is a technique to slow down and focus the mind on the details."

If an adolescent puts up any challenge about doing the drawing, do not get into a debate on the merits of the protocol. Instead, challenge him/her back on whatever specific aspect s/he found wanting. For example, if s/he resists by saying s/he is not a good drawer, say, "Let's see." If the resistance is something like the vague adolescent ennui of "Do I have to?.....", challenge him/her back with, "I know that just talking would be easier. Drawing is actually more difficult because you have to slow down and focus on details that are painful."

Give the child the worksheet for the Roadway Book with empty space for drawing (appendix: SESSION 6: DRAW THE "NOT TOO ANXIOUS" REMINDER). This is labeled the "easy reminder". The purpose is to stay mentally in the situation until they are nervous and then not nervous. The child can use the relaxation exercise to help him/her stay with the scene until the scary feelings go away. This sounds simple, but it can be a rather long affair for children who have difficulty and need guidance on what and how to draw. For children who simply can't or won't do the drawing, you can do the drawing and narrate out loud as you go. Other children may take a long time because they want to spend a lot of time on the drawing. Have patience.

Ask for the SUDS rating at the beginning for a baseline rating and then every five minutes or so thereafter. "How anxious are you now?" Keep a copy of the SUDS in view on the table for the child to reference. We've found that we need to be leading with younger children. Young children do not have fully developed skills yet for the meta-cognitive task of self-monitoring their internal states and then reporting these states to

another person. They need some scaffolding to understand this exercise. It is useful to remember that in the early sessions you are probably educating the child on how to do this exercise as much as anything. We approach it in a two- or three-step ritual:

1. Before asking the child for their rating, ask the child, *"Did that make you feel more nervous? Did your SUDS score go up?"*
2. Then ask the child to point to the rating that matches how s/he feels.
3. If the child has finished the drawing and the score is still "a lot scared", or the child seems particularly anxious before the drawing is finished, say, *"Now, we're going to do one of our tools to make the PTSD symptoms go away."*

The youth needs to be become distressed (SUDS needs to be elevated) for the exposure to be effective. If the SUDS is not elevated, and it seems to be because the youth is avoidant of the topic and/or not yet accessing their anxious feelings for whatever reason, then explain that you need to keep going. "OK, you're not anxious yet. Let's keep going. Let's focus on something in the story that is more anxiety provoking."

Repeating this cycle of increasing the intensity of the exposure until it becomes salient for the youth to feel some anxiety is a critical feature.

After the SUDS has gone up, then gone back down to 2, and the drawing is complete, stop the exposure.

After the exposure, ask what inaccurate thoughts came up during the memories. "Remember a few sessions ago when we learned about inaccurate thoughts? What inaccurate thoughts came up while you were remembering this right now?"

Common inaccurate thoughts/cognitive distortions that occur following traumatic events include:

It was all my fault.
I should have been able to prevent all of it.
No one can like me because of how I've changed.
The place where it happened is now always dangerous and scary.
I deserve what happened to me for being careless/stupid/insensitive/forgetful.
I can never feel safe anywhere again.

Next, help them see how the inaccurate thought has a broader impact them. Use the cognitive triad template to try to connect a negative thought to how it influences their feelings and/or behaviors. For each type of inaccurate thought, walk slowly through what specific memory triggered the thought, connect how the thought influences feelings, and how those influence behaviors. Focus on data gathering; try not to get caught up in over-simplistic chestnuts of telling them it wasn't their fault or it's not going to happen again. It's validating to tell someone it wasn't their fault when that is appropriate but it takes more than that to extinguish entrenched symptoms.

Next, help them how the thought, or what parts of the thought, are inaccurate. Gather the evidence for and evidence against a thought. Write these down in the two columns on the worksheet (appendix SESSION 6: INACCURATE THOUGHT). Negotiate a conclusion with the youth about whether the evidence really supports their thought. Ideally, the youth will see on their own that the weight of the evidence is against their inaccurate thought. If they do not, suggest that you disagree but there is no need for one person to win or lose this in a contest. There will be plenty more sessions to revisit this issue.

For some, it may feel less negative to frame their thoughts as whether the thoughts "help them" or "don't help them" rather than being "inaccurate." An alternative

worksheet that you can use during the session is in the appendix, titled “Session 6: Changing My Thoughts.”

Finally, work together to suggest a positive replacement thought at the bottom of the sheet. If the inaccurate thought was “It’s my fault,” the replacement thought could be, “I was a child. I could not control what happened to me then.” If the inaccurate thought was “I can never feel safe anywhere again,” the replacement thought could be, “That’s just a reminder trying to trick me. It’s not happening again.”

(Not all children may have or all types of traumas may elicit inaccurate thoughts. If these types of thoughts truly seem absent, skip this material).

Do the relaxation exercises at least once even if the child claims to not be anxious for two reasons: (1) practice, and (2) more than likely they were anxious but wouldn’t admit it.

If the youth becomes very anxious during the exposure, do the exercises more than once to help them to be able to continue with the task.

Record the child’s scores on the SUDS form (appendix: SUDS FORM). This systematic data will be helpful to you to judge whether the exposure task is having its intended purpose (to create some anxiety that rises and then falls).

Watch out for some children, particularly boys, who don’t want to admit to being nervous. If you suspect this is happening, change YOUR wording from “How anxious are you?” to “How mad did that make you?”, or “How sad did that make you?” It may be useful to not use a feeling word at all and instead say “How hard was that?” You could also try referencing somatic feelings that may be easier for them to admit to. Refer back to session 3 when you discussed feelings in the body and remember what the child’s answers were; “How much did that make the butterflies in your stomach go up?”

There may also be the phenomenon of youth who truly cannot access their feelings early in the course of treatment but will be able to later in treatment. We have found that as long as youth are talking about the content of their traumatic memories during their exposure sessions, even if they cannot or will not admit to feeling nervous, this still seems to lead to therapeutic improvement, and often leads to them accessing their feelings later in therapy.

Place the drawing(s) in the Roadway Book.

Imaginal exposure

After drawing it, ask them to close their eyes and think about it for 30 seconds (imaginal exposure).

If the child has difficulty imagining a scene with his/her eyes closed, it might help to practice this skill. You might try the practice that was suggested in session #4 - tell them to look at a poster on your wall and then close their eyes but keep that picture of the poster in their head. With their eyes closed, quiz them about what’s on the poster. Do this a few times until they can tell you what’s on the poster with their eyes still closed.

After opening their eyes, ask them, “What new things came into your picture?” Notice the framing of the question is that it is not a yes/no question of “Did anything new come into your picture?” It is fairly guaranteed that anytime anyone does an imaginal thinking of any past event, they will focus on some new detail. The imaginal exposure technique can be very helpful to overcome avoidance by forcing the youth to sit still for the first time, think calmly, and focus with no distractions on the memory of the traumatic

event. The youth is not going to tell you the new details unless you ask. Discuss briefly what they remember about the new thing and take notes.

As with the drawing exposure, the effectiveness of this technique depends on becoming distressed (SUDS needs to be elevated), so check a SUDS.

Do this several times, each time perhaps suggesting they focus on the new thing that they remembered. If there was no distress (SUDS elevation) you can use the same explanation that you used before, "OK, you're not anxious yet. Let's keep going. Focus on something in the story that is more anxiety provoking."

Safety Planning

(If this session is running long, the start of Safety Planning can be delayed until Session #7 or #8).

Explain to the child that you will start something new this week. It is important to learn how to avoid trouble in the future. First, explain that you know how to tell when danger is coming before it happens. Each example ought to be individualized to the type of interpersonal trauma a child personally experienced (i.e., domestic violence, physical abuse, community violence, or dog attack). You know from talking to their families that, for example, before dads hit moms, they act angry and mean first. A lot of times they yell, slam doors, and throw things before they get really, really mad. Ask the child if they can remember how their dad acted before he fought with their mom. Below is a list of danger signals for different types of traumas:

Domestic violence	Physical abuse	Sexual abuse	Community violence
Slam door	Slam door	Isolating	Yelling
Red face	Red face		Pushing
Throw things	Throw things		Fist fight
Yelling	Yelling		

Dog attack	Car collision	Natural disaster
Growling	No seat belt	Weather reports
Snap jaws	Going too fast	hurricane tracks
Poke dog	Swerving	"Weather man"
Pull at leash	Walking in street	
	Bike in street	

Make a safety plan for the type of trauma the child experienced (appendix: SESSION 6: MY SAFETY PLAN). The ideal elements of a safety plan for older children are to remove oneself from the danger and to call for help if someone else (i.e., mother) is in danger. The safety plan will be different depending on the type of trauma and the developmental age of the child.

For domestic situations, children may have a number to call, or go to a neighbor's house, or say a cue to their mother and then she can call 911 or find a way to escape with the children.

For sexual abuse, there are many good resources to look up on how to help youth protect their body privacy, "good touch, bad touch", and protect themselves from potential predators.

For hurricanes, the typical plan is to pack personal belongings for a short evacuation, and make plans for pets.

Offer the snack to the child as usual.

Preview next week

Next, the child will move up a bit on the hierarchy and practice a little harder imaginal exposure.

Parent Alone

Review with the mother what was done today. Ask the usual open-ended question, "What did you think of that?"

At an appropriate time, find a way to transition to review the homework. Were the check sheets completed? If so, congratulate the mother. If not, explore why not. Make sure the mother still understands the proper use and purpose of the relaxation exercise for the child.

A Note About Mothers Who Surprise Their Children With the Homeworks

We've found that some mothers do not follow our carefully laid plan of conducting the trauma-related homework exposure as we discussed in sessions. Instead, they surprise the children with the exposure activity. This is not necessarily a bad thing. If the surprise homework produced a moderate amount of anxiety, the child was not overwhelmed, and the child was able to use a relaxation exercise to decrease the anxiety, then it was successful. Explore with the mother her reasons for doing it this way. She probably had a good reason. If not, and/or if the surprise was overwhelming, counsel the mother to use a more transparent tactic.

If discipline homework was assigned again for defiant behavior, go over that also.

Safety Planning

Review the safety plan with the parent as you did with the child. Discuss with the mother what they believe is feasible. You keep the worksheet for now.

Safety plans were originally created with domestic violence in mind. However, we've found safety plans helpful for just about any type of trauma. They seem to be very concrete exercises that children can appreciate.

Some tips for domestic violence include to emphasize the importance of removing themselves and their children from danger at the earliest warning signals. Review their options for calling for help from nearby friends and the police. Make a card with the plan that includes trusted friends, their addresses, and phone numbers.

One More Reminder About Possible Boundary Issues

Revisit the boundary issue if you feel that your discussions in sessions #4 and #5 were not enough. Consider using the worksheet in the appendix to make homework for the parent on this issue (appendix" SESSION 6: FOR PARENTS: RESPECTING BOUNDARIES). "I mentioned this last session, and I want to remind you again of how important confidentiality is for children. It appears that it's still an issue that your child does not like (fill in the blank of the situation that embarrasses the child, i.e., caregiver asks too many questions, caregiver tells family members the child's personal business,

etc.). So, I want to remind you again to try to catch yourself when you're about to (fill in the blank of what the caregiver does inappropriately). Let's fill out this sheet as a homework for you."

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Even if no or little resistance has been detected so far, do not let up on this task. The lack of resistance may have been precisely because you have been preemptively addressing it. If reluctance has been a substantial issue, highlight at this time that you're more than halfway through. The worst parts are probably behind. Even though you are building up to addressing more distressing reminders, the child has been gaining practice at CBT exercises. Most importantly, the fact that the mother and child have gotten this far is a good prognostic sign that they will stick it out.

Next, ask them to rate the child's reluctance to come today on a scale of 1 to 10. If reluctant, ask for the reason(s) why. Remind them that if reluctance is going to increase it typically happens around sessions 4-8 and is natural. Give them verbal support that they will need to tolerate the reluctance to get through this hard part of the treatment.

Child and Parent Together

Homework

With both of them together at the end of the session, explain to them that it is time to take the next step and add real life (in vivo), not imaginary exposure. Picking an item from the easy end of the stimulus hierarchy, assign the homework of exposing the child to that situation until the anxiety goes down to a 2. This will most likely require the parents' participation. As with the instruction for picking imaginal exposures, make sure they pick an easy task to start with. Practice it once in the next week. Give them the new worksheet (appendix: SESSION 6: HOMEWORK CHECK SHEET: PRACTICE REAL LIFE EXPOSURE ONCE TO SOMETHING NOT TOO ANXIOUS DURING THE NEXT WEEK).

Preview next week

Normalize for the mother that some children regress around this point in treatment because we are increasing the anxiety level. Make sure she understands how to reach you by phone if needed.

Briefly state that you look forward to hearing how the "real life" practice went. Next week, you'll work on a little bit harder exposure.

SESSION 7

CHILD GOALS: 1. Medium narrative exposure
2. Safety planning
PARENT GOALS: Same as child, plus
3. Address reluctance

THERAPIST PREPARATION

Sessions #7 and #8 are nearly identical to each other. The aims are for the child to have more narrative exposure and habituation, more practice with the anxiety-reducing tools, and move up the stimulus hierarchy list.

The safety plan will be reviewed and rehearsed in session with the child.

The treatment is halfway completed at this point and it's time to consider more directive advice for the parent if she seems preoccupied by her own past experiences rather than focused on the child's experiences. This process can begin this session, if needed, with the usual tactic of being open and straightforward about the aim. The aim is to have mothers able to maximize their resources to help their children. If mothers are preoccupied by other concerns, it is self-evident how this might detract from the attention they can give to their children. However, it is also self-evident that mothers may need time to process their own pasts before they can devote maximal resources to their traumatized children. With limited time available in therapy, one has to balance the time spent on each with the ultimate aim in sight of focusing on the children.

TREATMENT PROTOCOL

Child and Parent Together

Welcome

Offer the candy and then put it away as usual.

Review the homework and homework together

Review, in less than 5 minutes, how the homework went. Did the child practice the "real life" exposure? If so, go over briefly what they did, what the feelings were, and how the anxiety resolved. Be sure to ask about multiple possible sensory experiences, such as sight, smell, hearing, touch (and maybe taste).

Next, split up as usual.

Child Alone

Medium Drawing/Imaginal Exposure

Drawing exposure

Just like last week, explain that the child is going to make the PTSD symptoms (or "scary feelings" or "scary thoughts") go away. If they had trouble with the easy item last time, start with that one again this time. If not, move up to a harder item on their stimulus hierarchy. They will need to tolerate the anxiety until their fear goes down to a 2 rating. You might give non-trauma examples again to educate them on the purpose, if needed, such as moving to a new school. The first time is the most nerve-wracking, but it gets easier with practice. This is what will happen with the PTSD list. Pick a medium

example from the list and explain the same way that the anxious feeling will go away with exposure.

Give the child today's worksheet with empty space for drawing (appendix: SESSION 7: DRAW MEDIUM SCARY REMINDER). Tell them the plan is to stay in the situation until they get anxious and then use the relaxation exercises until the anxious feelings go away. Have the child start drawing a picture of this item and build a narration of the story around that. Get the baseline SUDS rating. Write it on the SUDS form.

Ask for the SUDS rating every 5 minutes or so (or whatever pace seems appropriate for each child). Keep a copy of the SUDS in view on the table.

Just like in Session 6, the youth needs to be become distressed (SUDS needs to be elevated) for the exposure to be effective. If the SUDS is not elevated, and it seems to be because the youth is avoidant of the topic and/or not yet accessing their anxious feelings for whatever reason, then use the same technique that will be used in any exposure session where this occurs; explain that you need to keep going. "OK, you're not anxious yet. Let's keep going. Let's focus on something in the story that is more anxiety provoking." Push or challenge the youth to explore the memory more slowly, more intensely, or in more detail until their anxiety does increase.

Repeating this cycle of increasing the intensity of the exposure until it becomes salient for the youth to feel some anxiety is a critical feature.

After the exposure, ask what inaccurate thoughts came up during the memories. As in Session 6, use the cognitive triad template to try to connect a negative thought to how it influences their feelings and/or behaviors.

For each type of inaccurate thought, again, walk slowly through the scenario with a drawing to connect what specific memory triggered the thought, and then connect how the thought influences feelings, and how those influence behaviors.

Gather the evidence for and evidence against the inaccurate thought and write these in the worksheet (appendix SESSION 7: INACCURATE THOUGHT). Negotiate a conclusion with the youth about whether the evidence really supports their thought. Ideally, the youth will see on their own that the weight of the evidence is against their inaccurate thought, but, again, as in Session 6, it is not critical that you or the youth win the argument. The point is that the youth is learning for the first time about inaccurate thoughts, making connections from past events to current triggers, and making connections to feelings and behaviors. A tall order.

Work together to suggest a positive replacement thought at the bottom of the sheet.

After the SUDS has gone up, then gone back down to 2, and the drawing is complete, stop the exposure.

Do the relaxation exercises at least once even if the child claims to not be anxious for two reasons: (1) practice, and (2) more than likely they were anxious but wouldn't admit it.

If the youth becomes very anxious during the exposure, do the exercises more than once to help them to be able to continue with the task.

Place the drawing in the Roadway Book.

Imaginal exposure

After drawing it, ask them to close their eyes and think about it for 30 seconds. After opening their eyes, ask them, "What new things came into your picture?" Discuss briefly what they remember about the new thing and take notes.

Check a SUDS because, as with the drawing exposure, the effectiveness of this technique depends on becoming distressed (SUDS needs to be elevated).

Just like in Session 6, do this several times, each time perhaps suggesting they focus on the new thing that they remembered. If there was no distress (SUDS elevation) you can use the same explanation that you used before, "OK, you're not anxious yet. Let's keep going. Focus on something in the story that is more anxiety provoking."

Ask for a SUDS rating at the end and use relaxation if needed to get it down to 2.

Safety Planning

Review the safety plan from last week. Remind them what the danger signals were and what the child's response would be. Then rehearse the plan with age-appropriate methods. Younger children may engage in forms of age-appropriate role-playing with props, dolls, and action figures to rehearse recognition of the danger signal and respond with the safety plan. The therapist is the angry person. The therapist will have to use their own face to demonstrate an angry face as one of the danger signals. Provide a running commentary on the action to emphasize the danger signals. The child rehearses recognizing the danger signals and then enacts the safety plan. For older youth, a more mature method is to write out the correct responses on a sheet of paper and/or to verbally discuss them.

Offer the snack to the child as usual.

Preview next week

Next, the child will move up a bit on the SUDS score and practice a little harder imaginal exposure.

Parent Alone

Start with, "What did you think of that?"

If it has become apparent that the mother seems preoccupied by her own past experiences to the detriment of maximizing her resources to focus on her child, now may be the time to start addressing that openly and some time may be needed alone without the child in the room. Begin with an open and straightforward discussion that this is the issue on the table. (The aim is to have mothers able to maximize their resources to help their children. If mothers are preoccupied by other concerns, this might detract from the attention they can give to their children. On the other hand, mothers may need time to process their own pasts before they can devote maximal resources to their traumatized children. These concerns need to be balanced with the limited time you have in treatment.) Your job at this point is simply to think about it out loud with the mother, without making premature conclusions or appearing to shut the door on future discussions of the mother's past. After stating the issue, ask the mother what she thinks about it. At this point, mostly listen, and then say that this is something you will pay attention to together in the future.

At an appropriate time, find a way to sensitively transition to review the homework. Were the check sheets completed? If so, congratulate the mother. If not,

explore why not. Make sure the mother still understands the proper use and purpose of the relaxation exercise for the child.

If discipline homework was assigned again for defiant behavior, go over that also.

Safety Planning

Review the child's and parent's safety plans with the parent. Make sure they can identify the salient danger signals for themselves, which may be more subtle than the signals that children can detect. Discuss where the thresholds are for that parent for sensing danger.

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Reluctance should be decreasing. Complete the Reluctance Checklist as usual for both mother and child. Remind them that if reluctance is going to increase it typically happens around sessions 4-8 and is natural. Give them verbal support that they will need to tolerate the reluctance to get through this hard part of the treatment.

Child and Parent Together

Homework

With both of them together, explain that they need to pick another real life (in vivo) exposure to practice for homework. The child, ideally, needs to pick an item from the middle part of the stimulus hierarchy. The child needs to stay with the situation until the SUDS goes down to a 2. This will likely require the parents' participation. Practice it once in the next week. Give them the worksheet for homework (appendix: SESSION 7: HOMEWORK CHECK SHEET: PRACTICE REAL LIFE MEDIUM SCARY EXPOSURE ONCE DURING THE NEXT WEEK).

Preview next week

Briefly state that you look forward to hearing how the "real life" practice went. Next week, you'll work on a little bit harder exposure.

SESSION 8

CHILD GOALS: **1. Medium narrative exposure**
2. Safety planning
PARENT GOALS: **Same as child, plus**
3. Address reluctance

THERAPIST PREPARATION

This session is nearly identical to session #7. The only differences are that you move up the stimulus hierarchy list in practicing the narrative exposure and in picking goals for the homework, and make progress on the safety plan. For youth with more horizontal, as opposed to vertical stimuli hierarchies, the notion of "moving up" the stimulus hierarchy makes less sense. For them, it makes more sense to talk about "repeating" the exposure, "going into more detail," and "covering new aspects."

TREATMENT PROTOCOL

Child and Parent Together

Welcome

Offer the candy and then put it away as usual.

Review the homework and homework together

Ask how the homework went. Review in less than 5 minutes. Did the child practice the "real life" exposure? If so, go over briefly what they did, what the feelings were, and how the anxiety resolved. Be sure to ask about multiple possible sensory experiences, such as sight, smell, hearing, taste, and touch.

Next, split up as usual.

Child Alone

Medium Drawing/Imaginal Exposure

Drawing exposure

Just like last week, explain that the child is going to make PTSD go away. If they had trouble with the item from last week, start with that one again this time. If not, move up to a harder item on their stimulus hierarchy for the vertical hierarchies. For horizontal hierarchies, move on to other memories or "explore it in more detail." Remember that you may need to be explicit in explaining that you are moving up to a "more anxious" thing this week. Some children believe that since they did a drawing last week, that it's stupid to do the same thing again this week ("I already did that!"). Explain briefly how this is a new one. Follow the instructions from the last session in the protocol.

Start drawing the scene (appendix: SESSION 8: DRAW MEDIUM SCARY REMINDER).

Obtain a baseline SUDS rating.

Ask for a SUDS rating every 5 minutes or so. Record the scores on the SUDS form.

If the exposure does not naturally increase the youth's anxiety, push/challenge the youth to explore the memory more slowly, more intensely, or in more detail so that the anxiety does increase.

Use one or more relaxation exercises even if child claims not to have any anxiety (for practice).

As usual, after the exposure, ask what inaccurate thoughts came up during the memories. They should be in the routine now of walking through what specific memory triggered the thought, connecting it to feelings and behaviors.

Gather the evidence for and evidence against the thought, write these in the worksheet (appendix SESSION 8: INACCURATE THOUGHT), and fill in the conclusion at the bottom (i.e., do they believe the evidence favors the inaccurate thought or not).

Work together to suggest a positive replacement thought at the bottom of the sheet.

Imaginal exposure

Do the imaginal exposure. Close eyes for 30 seconds.
Ask "What new things came into your picture?"
Do this several times.
Re-check SUDS scores.
Do relaxation exercises at least once.

Offer the snack to the child as usual.

Safety Planning

Review the safety plan for one more repetition. Have the child identify the danger signals and rehearse their safety plan. Last week the therapist should have been guiding the child through the plan. This week try to have the child take more of the lead and ownership in walking through the danger signals and response of the plan. One can use whatever types of props and sheets that were used last week if desired.

Preview next week

Next, the child will move up a bit on the SUDS score and practice a little harder imaginal exposure.

Parent Alone

Ask, "What did you think?"
Briefly review how the session went for the mother.

Safety Planning

Explain that a new homework will be to rehearse the safety plan in the home once before the next session. The parent will need to initiate the rehearsal at home. The parent can either role play the danger signals themselves or just verbally describe them. The child will be asked to walk through the safety plan.

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Fill out the Reluctance Checklist.

Reluctance might increase as the drawing and in vivo exposures become harder.

Child and Parent Together

Homework

With both of them together, use the same directions as in the protocol for session 7. Give the mother the worksheet (appendix: SESSION 8: HOMEWORK CHECK SHEET: PRACTICE REAL LIFE MEDIUM SCARY EXPOSURE ONCE DURING THE NEXT WEEK).

An additional homework this week is to rehearse the safety plan in the home, as described above. Fill out collaboratively and give the parent the homework sheet for the safety plan (appendix: SESSION 8: SAFETY PLAN). At home, the mother and child must walk through the child's safety plan. Explain that we need to see if the plan needs to be tweaked after they walk through it in the real environment.

Preview next week

Briefly state that you look forward to hearing how the "real life" practice went. Next week, you'll work on a little bit harder exposure.

SESSION 9

CHILD GOALS: 1. Worst moment narrative exposure
2. Safety planning
PARENT GOALS: Same as child, plus
3. Address reluctance

THERAPIST PREPARATION

The next two sessions mark the last sessions of new exposures. The final two sessions after these are for consolidation, generalization, and relapse prevention. These two sessions should be exposure to the worst moment – the highest item on the stimulus hierarchy. The same format will be used as in the previous three sessions. Children who have had difficulty advancing up the stimulus hierarchy should still be encouraged to use their worst moment.

The safety plan should have been rehearsed at home over the last week.

TREATMENT PROTOCOL

Child and Parent Together

Welcome

Offer the candy and then put it away as usual.

Review the last session and homework together

Ask how the homework went. Review in less than 5 minutes. Did the child practice the "real life" exposure? Go over it as usual.

Then, split up as usual.

Child Alone

Worst Moment Drawing/Imaginal Exposure

Drawing exposure

Just like last week, explain that the child is going to make PTSD go away. Even if they had trouble with the memory from last week, try to move up to their worst moment. For a youth with a vertical stimulus hierarchy, this is usually straightforward to pick the target memory. For a youth with a horizontal stimulus hierarchy, one option for this session is to frame it as "putting the whole story together" or "telling the whole story," whereas previous sessions were telling only parts of the story. Another option could be that by the time you have gone through the detail of sessions 6-8, you both realize that there really are moments of more salience than others after all. It helps if you have been paying attention and taking notes during sessions 6-8 of when the youth felt the most emotional release during the exposures.

They will need to tolerate the anxiety until their fear goes down to a 2 rating. By now, giving examples of how this should work are not needed.

Start drawing the scene (appendix: SESSION 9: DRAW WORST MOMENT EXPOSURE).

Ask for SUDS ratings at baseline and every 5 minutes or so. Record the scores on the SUDS form.

Make sure the youth's anxiety eventually increases either naturally or with you pushing up the intensity of the exposure.

Ask what inaccurate thoughts came up during the memories. Go through the routine walking through what specific memory triggered the thought and connecting it to feelings and behaviors.

Gather the evidence for and evidence against the negative, write these in the worksheet (appendix SESSION 9: INACCURATE THOUGHT), and fill in the conclusion at the bottom (i.e., do they believe the evidence favors the inaccurate thought or not).

Work together to suggest a positive replacement thought at the bottom of the sheet.

Use one or more relaxation exercises even if child claims not to have any anxiety (for practice).

Place the drawing in the Roadway Book.

Imaginal exposure

Do the imaginal exposure. Close eyes for 30 seconds.
Ask "What new things came into your picture?"
Do this several times.
Re-check SUDS scores.
Do a relaxation exercise at least once.

If the stress rating is not decreasing, make sure the child is using the relaxation exercise. If the stress does not come down to a 2 rating after 30 minutes, you will need to intervene. Ask what the child is thinking about. Shift the conversation away from the trauma reminder and distract them with other topics. It may be appropriate to bring the mother over to break the atmosphere, to help soothe and/or distract. Other distraction techniques can be used and the session may have to be prolonged.

Offer the snack to the child as usual.

Safety Planning

Ask the child if they practiced the safety plan at home last week. If they did, how did it go? In the process, review the danger signals and the safety plan for the sake of one more iteration with the child. If it was not practiced, ask why not? The props and sheets that have been used before can be used again if needed, but probably won't be needed if the child really knows their safety plan by now. Troubleshoot as needed.

Preview next week

The plan is for the child to practice the worst moment exposure again.

Parent Alone

Follow the usual procedure with the mother.

Before ending, be sure to review the homework. Were the check sheets completed? If so, congratulate the mother. If not, explore why not.

Safety Planning

Ask the parent if they practiced the safety plan at home last week. If they did, how did it go? In the process, review the danger signals and the safety plan for the sake

of one more iteration with the parent. If it was not practiced, ask why not? Troubleshoot as needed.

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Be sure to get the rating between 1 to 10. Reluctance should be decreasing.

Child and Parent Together

Homework

With both of them together, explain that they need to pick another real life exposure to practice for homework. The child, ideally, needs to pick a more difficult item than last week. The child needs to stay with the situation until the SUDS goes down to a 2. Practice it once in the next week. Give them the check sheet (appendix: SESSION 9: HOMEWORK CHECK SHEET: REAL LIFE ALMOST TOO ANXIOUS OR MOST ANXIOUS EXPOSURE ONCE DURING THE NEXT WEEK).

Preview next week

Next week will be similar to this week. Tell them there are 3 more sessions left.

SESSION 10

CHILD GOALS: **1. Worst moment narrative exposure**
2. Start reviewing Roadway Book
PARENT GOALS: **Same as child, plus**
3. Address reluctance

THERAPIST PREPARATION

This session is nearly identical to session #9 except the safety planning has been completed and the review of the Roadway Book begins.

The child and therapist will begin the process of reviewing the Roadway Book together. This will be accomplished gradually over these final 3 sessions. The two aims of this review are to have one more iterative process for instilling the CBT techniques in the child, and to solidify the coherent narrative of the trauma experience. In this session you will review sessions #1-6 in the Roadway Book. This gradual process will give you and the family time to process any new distortions or difficulties that arise from the review process.

TREATMENT PROTOCOL

Child and Parent Together

Welcome

Offer the candy and then put it away as usual.

Review the last session and homework together

Ask how the homework went. Review in less than 5 minutes. Did the child practice the "real life" exposure? Go over it as usual.

Child Alone

Worst Moment Drawing/Imaginal Exposure

Even if they had trouble with the item from last week, try to use their worst moment. They will need to tolerate the anxiety until their fear goes down to a 2 rating. By now, giving examples of how this should work are not needed.

Start drawing the scene (appendix: SESSION 10: DRAW WORST MOMENT EXPOSURE). .

Ask for SUDS ratings at baseline and every 5 minutes or so. Record the scores.

Make sure the youth's anxiety eventually increases either naturally or with you pushing up the intensity of the exposure.

Ask what inaccurate thoughts came up during the memories. Go through the routine walking through what specific memory triggered the thought and connecting it to feelings and behaviors.

Gather the evidence for and evidence against the thought, write these in the worksheet (appendix SESSION 10: INACCURATE THOUGHT), and fill in the conclusion at the bottom (i.e., do they believe the evidence favors the inaccurate thought or not).

Work together to suggest a positive replacement thought.

Use one or more relaxation exercises even if child claims not to have any anxiety (for practice).

Place the drawing in the Roadway Book.

Imaginal exposure

Do the imaginal exposure. Close eyes for 30 seconds.
Ask "What new things came into your picture?"
Do this several times.
Re-check SUDS scores.
Do a relaxation exercise at least once.

Offer the snack to the child as usual.

Review of the Roadway Book

The goal is to review the importance of every single page for sessions #1-6. It is a tall order for a child to be in charge of that task and reading some of the words will be impossible for the younger children. Therefore, the therapist is ultimately in charge of exploring the pages and turning to the next one at an appropriate pace. Try to have the child remember what each page was about and what they learned. If the child can't, or won't, recall, the therapist must verbalize it. Use lots of praise for their accomplishments. This should take 10-15 minutes.

Preview next week

You will talk about planning for the future.

Parent Alone

Follow the usual procedure with the mother. Include the purpose of reviewing the Roadway Book (building the coherent trauma narrative).

Before ending, be sure to review the homework. Were the check sheets completed? If so, congratulate the mother. If not, explore why not.

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Be sure to get the rating between 1 to 10. Reluctance should be decreasing.

Child and Parent Together

Homework

With both of them together, explain they need to pick another real life exposure to practice for homework. The child, ideally, needs to pick a more difficult item than last week. The child needs to stay with the situation until the SUDS goes down to a 2. Practice it once in the next week. Give them the check sheet (appendix: SESSION 10: HOMEWORK CHECK SHEET: REAL LIFE ALMOST TOO ANXIOUS OR MOST ANXIOUS EXPOSURE ONCE DURING THE NEXT WEEK).

Preview next week

Tell them there are only 2 more sessions left. We need to start preparing to say goodbye. Next week we will talk about how to use their tools in the future.

SESSION 11

CHILD GOALS: **1. Learn about relapse prevention**
2. Review Roadway Book

PARENT GOALS: **Same as child**

THERAPIST PREPARATION

PTSD symptoms ought to be markedly reduced by now. You can begin to talk about the future more and what to expect. Relapse, in the sense of a return of some symptoms from time to time, is a common occurrence and the child and parent need to anticipate this. They first need to understand that this is a natural thing and it doesn't mean the end of the world. Then they need to be prepared to use the tools they have learned when this occurs.

Talking about the long-term future may not be too realistic for younger children. They can talk about what they want to be when they grow up, but they have a limited sense of how far away that is in the future. However, make an attempt to explore longer term planning capacities to see if an individual child is able to grasp the concept.

The review of the Roadway Book advances to cover sessions 7-11 this time.

TREATMENT PROTOCOL

Child and Parent Together

Welcome

Offer the candy and then put it away as usual. Remind the child that you have only 2 more sessions left.

Review the last session and homework together

Ask how the homework went. Review in less than 5 minutes. Did the child practice the "real life" exposure? Go over it as usual.

Child Alone

Learn about relapse prevention

Remind the child that a lot of the PTSD symptoms have gone away and don't bother them anymore. Things will probably stay that way but sometimes bad memories jump back up and scare you. Talk about this in the time frame of next week or next year. Explain that this is normal.

First, ask the child if they think they might do something next week that would bring back a bad memory. If the child has difficulty with the concept of next week, consider showing the child a calendar to make it more concrete. If the child can't think of something, think of a salient example for them. Think of an item from the middle of their stimulus hierarchy list so as not to pick the scariest moment. Tell a brief story of how the child might be somewhere next week when they run into a bad reminder.

Obtain SUDS ratings at baseline and periodically through this exercise.

Have the child draw a picture of this situation (appendix: SESSION 11: DRAW CHILD IN NEAR FUTURE AND A REMINDER). Ask the child what they would do. Appropriate answers would be to wait it out until they feel less anxious, relaxation, or talking to someone until they felt better.

Unlike Sessions 6-10, you do not necessarily expect the youth to become distressed (SUDS elevated) during these tasks. These are hypothetical future scenarios, not things that actually happened to them. Nevertheless, check SUDS ratings every so often just like you usually do. The larger purpose of this task is to instill in their memory a "fire drill" plan to normalize their future distress and instill a plan of action.

Next, ask the child to draw a picture of them when they are grown up. If they have an older sibling that may be a better age to focus on. If they have difficulty with concept of being grown up, make it more concrete by drawing a picture for them with a little child next to a bigger drawing of them all grown up. Ask them to try to think of a situation then that might bring back a bad memory. You may have to help the child think of salient example, as above. Have the child draw a picture of this situation (appendix: SESSION 11: DRAW CHILD AS ADULT AND A REMINDER). Again, ask the child how they could handle to make the bad feelings go away.

Place the drawings in the Roadway Book.

Spend extra time for relaxation or distraction if the SUDS rating is above a 1.

Offer the snack to the child as usual.

Review of the Roadway Book

The goal is the same as last session, except sessions 7-11 are to be reviewed this time. Remember to cover each page carefully. Use lots of praise for their accomplishments. This may be more distressing than last session because you will be reviewing the more difficult graded exposure practice sessions and homework. This should take 10-15 minutes.

Preview next week

Tell the child that next week is the last week and you will have a graduation. Ask for ideas for a small food treat (not meals). (Tip from experience: do not call this a "party". Children may mistake that term to think you will be loading up with other traditional party items such as decorations and gifts.)

Parent Alone

Review what you just did with the child for the parent.

Make sure that the mother is aware that next session is the last session. This will help her gauge the time remaining and what topics she feels compelled to talk about.

Be sure to review the homework. Were the check sheets completed? If so, congratulate the mother. If not, explore why not.

Spend some time reviewing the child's overall progress. Compare their presenting symptoms to now. Get a sense of the mother's satisfaction with treatment

progress. If there are specific complaints that she has, you may want to use this session and next session to address these for the first time, or perhaps, again. This is not only good "customer service" but is an acknowledgement that trauma symptoms can be many and diverse, and you may not have had time to address all of them. For example, sleep difficulty is often a difficult symptom to treat, for a variety of reasons. It is also one of the symptoms that most distresses a parent because it can cause lack of sleep for the whole family. You may not have had time to talk about sleep hygiene principles and make suggestions on how to handle this.

Finally, if the mother has been symptomatic, you must make an estimate of whether she needs individual treatment and make referral suggestions. Cover that this session so you can follow up with it at the last session.

Motivation/Compliance

Review any reluctance to come to today's session, on a scale of 1 to 10. Reluctance for the last session should not be an issue.

Child and Parent Together

Homework

With both of them together, explain that they need to pick another real life exposure to practice for homework. The child, ideally, needs to pick a more difficult item than last week. The child needs to stay with the situation until the SUDS goes down to a 2. Practice it once in the next week. Give them the check sheet (appendix: SESSION 11: HOMEWORK CHECK SHEET: REAL LIFE ALMOST TOO ANXIOUS OR MOST ANXIOUS EXPOSURE ONCE DURING THE NEXT WEEK.).

Preview next week

Next week is the final session and the graduation.

SESSION 12

CHILD GOALS: **1. Review the Roadway Book**
2. Graduation

PARENT GOALS: **Same as child**

THERAPIST PREPARATION

You and the caregiver will likely feel a sense of accomplishment during this session. You will be able to compare in your head where the child was at the beginning to now. The graduation certificate will symbolize all of the hard work and risks taken during therapy sessions. The tangible result of that work that can be touched and felt is the Roadway Book. The child, on the other hand, may be more focused on the special snack. The child will proudly, you hope, take home their decorated and personalized Roadway Book.

You will want to conduct on overall review of the treatment as one more effort to solidify the child's coherent narrative of the trauma and stress the importance of their new tools.

Try to go through the Roadway Book page by page and narrate the story from beginning to end. If the child is reluctant or tries to breeze over pages too fast, intervene by prompting, speaking for them, or slowing them down, as appropriate.

TREATMENT PROTOCOL

Child And Parent Together

Welcome

Explain the plan for today. The main job is to review the Roadway Book.

Review the last session and homework together

Review how the homework went. Did the child practice the "real life" exposure? Take more than the usual 5 minutes if needed because you will not split up and talk about it separately today.

The Roadway Book

The goal is to review every single page of sessions #1-11. There are approximately 24 pages that spanned at least 3 months. As usual, the therapist is ultimately in charge of exploring the pages and turning to the next one at an appropriate pace. Try to have the child remember what each page was about and what they learned. If the child can't, or won't, recall, the therapist must verbalize it. Use lots of praise for their accomplishments. This should take 15-30 minutes.

The special snack can be given either during or after the review of the book.

Present a decorative graduation diploma.

Sign the diploma. We've learned from out past mistakes that youth want the diploma signed (Think about it – they could have printed out an unsigned diploma from the internet).

An electronic version of a diploma for re-use can't be supplied with this manual. Each clinic or practitioner will have to find their own version for personal use. Our diploma states:

Tulane University
This diploma is presented on
Month X, Year to
<Child's Name>
for successfully completing the
cognitive-behavior therapy protocol
that includes recognizing feelings,
learning relaxation skills, and self-
control of behavior.

_____
Therapist signature

There may or may not be compelling reasons to spend individual time with the mother. If needed, the end of this session can be used for that.

Homework
None.

APPENDIX

Overview of the 12 treatment sessions
CBT=cognitive-behavioral treatment

Session	Child Goals	Parent Goals
1	1. Education about PTSD 2. Overview the 12 sessions	*Same as child, plus* *3. Discuss reluctance*
2	1. Discipline plan for defiance 2. Grieving	*Same as child, plus* *3. Discipline plan*
3	1. Identify stressful feelings	*Same as child*
4	1. Learn relaxation exercises 2. Learn SUDS score	*Same as child*
5	1. Tell the story 2. Create stimulus hierarchy	*Same as child*
6	1. Easy narrative exposure 2. Safety planning	*Same as child*
7	1. Medium narrative exposure 2. Safety planning	*Same as child*
8	1. Medium narrative exposure 2. Safety planning	*Same as child*
9	1. Worst moment narrative exposure 2. Safety planning	*Same as child*
10	1. Worst moment narrative exposure 2. Start review of Roadway Book	*Same as child*
11	1. Learn relapse prevention 2. Review book	*Same as child*
12	1. Review the Roadway Book 2. Graduation	*Same as child*

POSTTRAUMATIC STRESS DISORDER (PTSD)

PTSD is a syndrome that some people get after the experience a life-threatening trauma.

WHAT IS A TRAUMA?
A trauma is something that is *life-threatening or threatens serious harm*. People can be traumatized by just witnessing something happen to someone else. Here is a list:

- Physical abuse
- Sexual abuse
- Serious accidents, such as car crashes
- Dog or large animal attacks
- Seeing someone stabbed, shot, or killed
- Seeing their mother beaten

WHAT ARE THE SYMPTOMS?
There are 3 categories of symptoms:
1. Re-experiencing symptoms.
Children cannot stop thinking about the bad event even if they want to:

- ✓ Nightmares
- ✓ Intrusive daydreams
- ✓ Plays games that repeatedly reenact the trauma
- ✓ Flashbacks
- ✓ Gets very upset if something happens that reminds them of the trauma
- ✓ Their bodies get worked up with the reminders, including sweating, shaking, and fast heart rate.

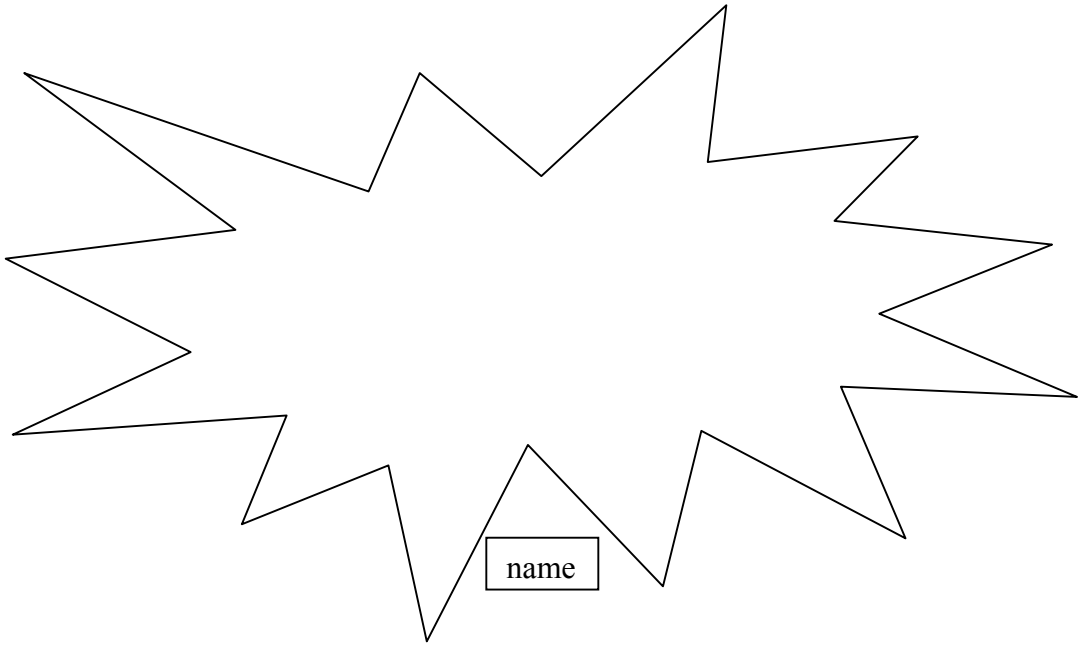
2. Numbing and avoidance symptoms.
Children emotionally shut down, and try to avoid any reminders of what happened:

- ✓ Avoids places or things that remind them of the trauma
- ✓ Withdrawn from people
- ✓ Looks less happy and is less loving
- ✓ Plays less than before

3. Hyper-arousal symptoms.
Children are more agitated and restless:

- ✓ Difficulty sleeping
- ✓ Difficulty concentrating
- ✓ Irritable, temper tantrums
- ✓ More aggressive
- ✓ More jumpy and scared

Session 1: About You



I AM _____ YEARS OLD

I AM IN _____ GRADE

MY SCHOOL IS _____

I LIVE WITH _____

_____

FOR FUN, I LIKE TO _____

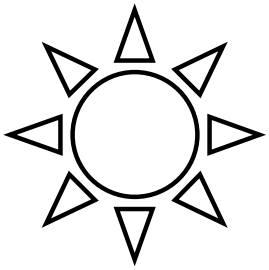
_____

ONE WORD THAT DESCRIBES ME IS _____!

THE EVENT THAT HAPPENED TO ME IS

_____

Session 2: For Parents: Changing My Thoughts



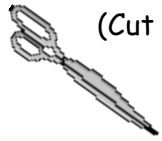
Parental guilt may lead to being too lenient where discipline is not enforced or consistent. Young children need consistent, loving, discipline.

If you have been too lenient because you feel guilty about what has happened or feel sorry for your child, admitting this is the first step. The second step is changing or replacing the thought. This technique is a well-known cognitive therapy strategy. This week work on changing your maladaptive thoughts with more appropriate thoughts. For example: Instead of thinking "poor thing he or she has been through enough (and you don't discipline him or her)," think "Poor thing. But he or she still has to follow the rules (and follow through with appropriate discipline)."

Step one: What is your guilty thought?

_____

Step two: What is a more appropriate thought that you can say to yourself?



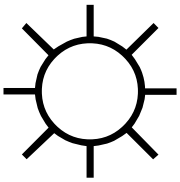
(Cut the appropriate thought out below and place it in your wallet, kitchen, or someplace where you will see it every day)

I need to remember to say to myself:

_____

_____

SESSION 2: Behaviors to Change



List of defiant behaviors to target for change

1._____

2._____

3._____

Session 2: Discipline plan for defiant behaviors

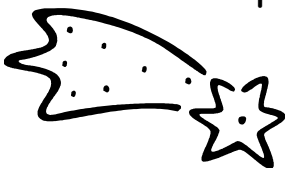
TARGET BEHAVIOR:

_____

_____

Sun	Mon	Tue	Wed	Thu	Fri	Sat
Sticker or ✓	Sticker Or ✓	Sticker or ✓	Sticker or ✓	Sticker or ✓	Sticker or ✓	Sticker or ✓

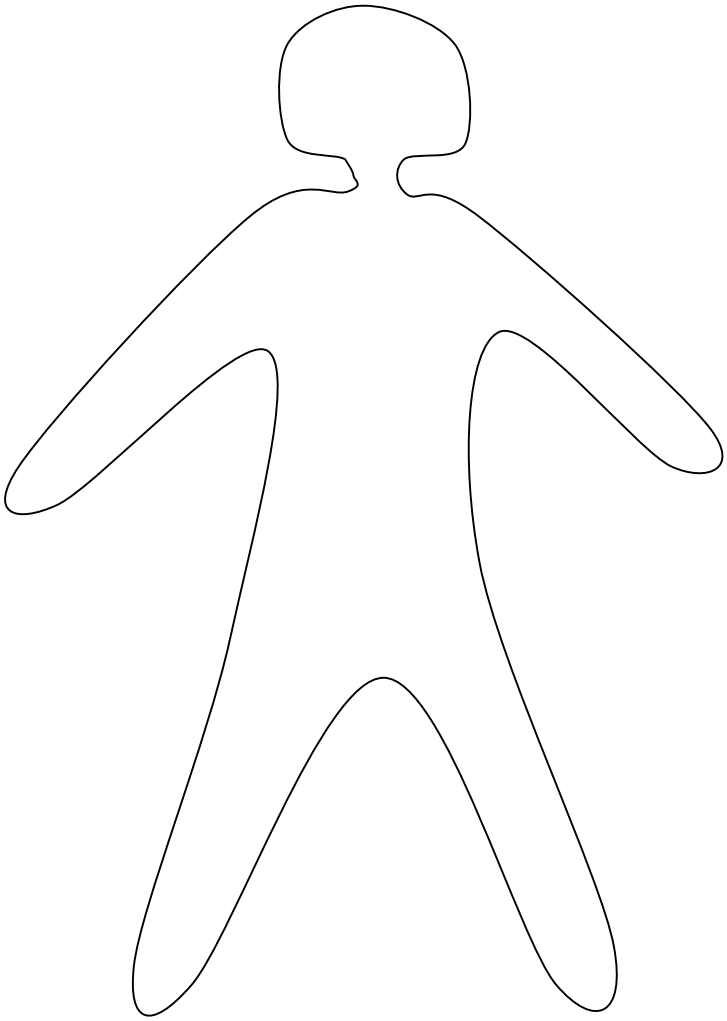
Need to comply for _____ out of _____ days for…



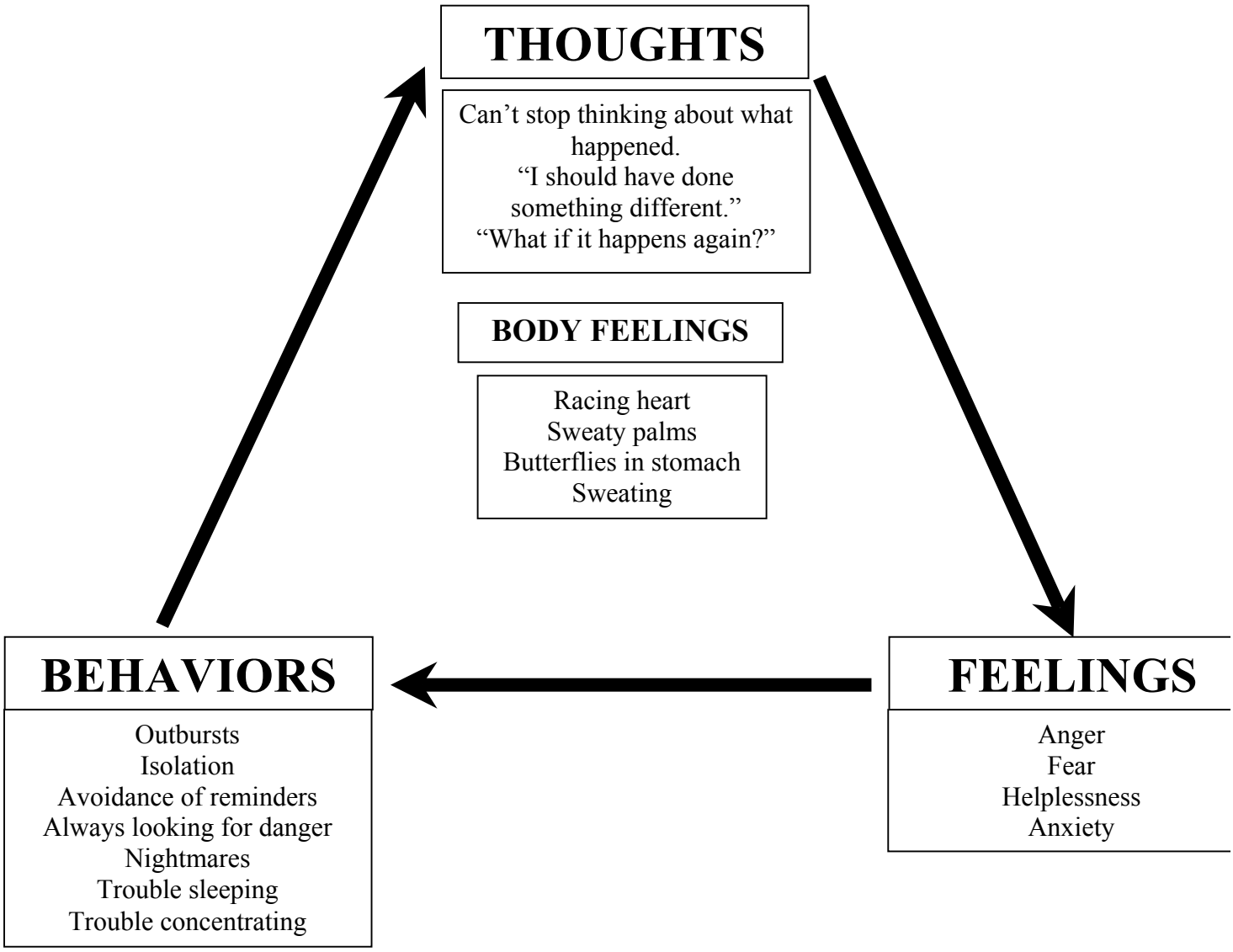
REWARD =

SESSION 3: Feelings in my Body

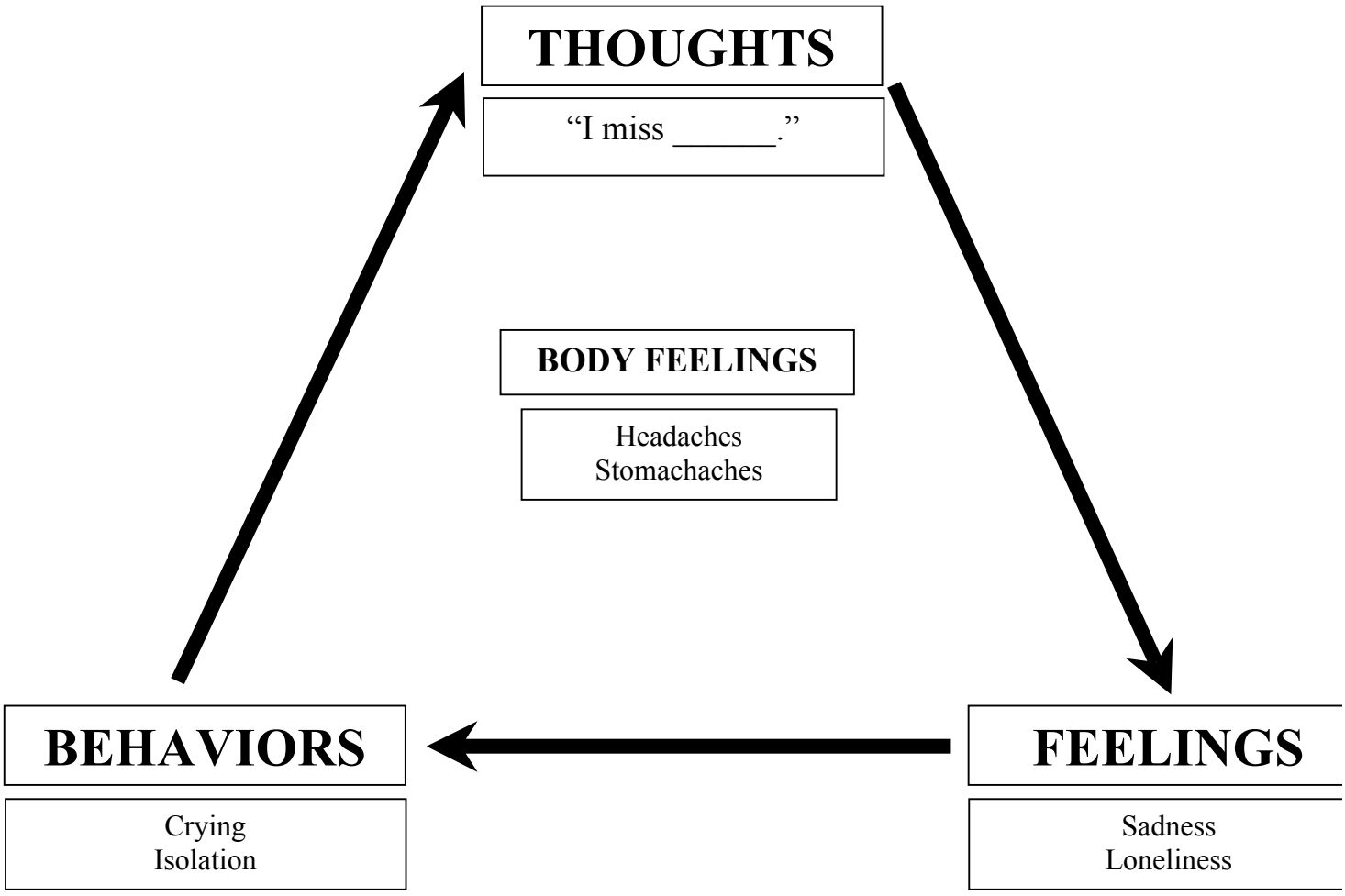
DRAW THE BAD FEELINGS ON YOUR BODY



COGNITIVE TRIAD



GRIEF TRIANGLE



Session 4: Draw your Safe or Happy Place

SESSION 4: Subjective Units of Distress Scale (SUDS)

STRESSOR:

10 – most anxious possible
9
8
7
6
5 – Medium anxious
4
3
2 – A little anxious
1
0 – Not anxious

SESSION 4: HOMEWORK: HOW MUCH I'M ANXIOUS

PLAN: _____

DAY/TIME: _____

10 – most anxious possible

9

8

7

6

5 – Medium anxious

4 Aim for this

3

2 – A little anxious

1

0 – Not anxious

PLACE STICKER

SUDS LOG

Write the child's SUDS score (0-10) in the boxes below. Use a second sheet if more columns are needed.

Clock time to nearest minute:	Base -line										
Session 5 "Tell the Story"											
Session 6 Easy exposure											
Session 7 Medium exposure											
Session 8 Medium exposure											
Session 9 Worst exposure											
Session 10 Worst exposure											
Session 11 Future											

SESSION 5: THE WHOLE STORY ABOUT WHAT HAPPENED

Details of the whole story

WHAT HAPPENED:

_____

_____

_____

_____

_____

_____

_____

_____

WHEN:
WHO:
WHERE:
SEE:
HEAR:
SMELL:
TASTE:
TOUCH:
FEELINGS:_____

_____

SESSION 5: Vertical stimulus hierarchy

From the Not Too Anxious to the Most Anxious Memories

MOST ANXIOUS:

ALMOST THE MOST ANXIOUS:

MEDIUM ANXIOUS:

MEDIUM ANXIOUS:

NOT TOO ANXIOUS:

SESSION 5: Horizontal stimulus hierarchy

Write each anxious memory on a line.

_____

_____

_____

_____

_____

_____

_____

_____

SESSION 5: HOMEWORK CHECK SHEET: Practice once, SUDS

PLAN: _____

DAY/TIME: _____

10 – most anxious possible

9

8

7

6

5 – Medium anxious

4 Aim for this

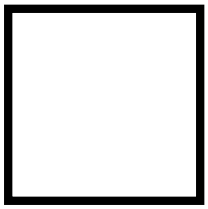
3

2 – A little anxious

1

0 – Not anxious

PLACE STICKER HERE:



Session 6: Draw the "Not Too Anxious" Reminder

Session 6: Inaccurate Thought

The thought: _____

Evidence For	Evidence Against
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Conclusion: _____

_____

Positive Replacement Thought:

_____

_____

Session 6: Changing My Thoughts

The thought: _____

Ways this thought helps me:	Ways this thought doesn't help me:
_____	_____
_____	_____
_____	_____

This thought is true because:	This thought is false because:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Positive Replacement Thought:

_____

Session 6: MY Safety Plan

Danger Signs

1. _____

2. _____

3. _____

MY Safety Plan:

SESSION 6: HOMEWORK CHECK SHEET: Practice real life exposure once to something NOT TOO ANXIOUS during the next week.

PLAN: _____

DAY/TIME: _____

How anxious did you get?

Most anxious possible - 10

9

8

7

6

Medium anxious - 5

4

3

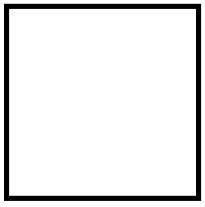
A little anxious- 2

1

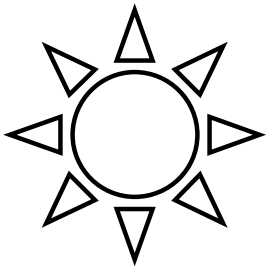
Not anxious – 0

Write down what you really did:

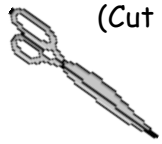
PLACE STICKER HERE



Session 6: For Parents: Respecting Boundaries



Sometimes parents' enthusiasm to help their children heal from trauma can unintentionally lead to infringing past their boundaries. Respecting your child's need for privacy will improve their response to therapy. This is often accomplished by ensuring a safe emotional space for the child to share feelings by not pushing them to share what they are learning with others.



(Cut the appropriate boundaries out below and place it in your wallet, kitchen, or someplace where you will see it every day)

What are some appropriate ways to support my child's healing while respecting their privacy boundaries?

_____

_____

Homework: Am I respecting my child's boundaries concerning their therapy and trauma recovery?

_____

_____

SESSION 7: Draw MEDIUM ANXIOUS reminder

Session 7: Inaccurate Thought

The thought: _____

Evidence For	Evidence Against
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Conclusion: _____

_____

Positive Replacement Thought:

_____

_____

SESSION 7: HOMEWORK CHECK SHEET: Practice real life MEDIUM ANXIOUS exposure once during the next week

PLAN: _____

DAY/TIME: _____

How anxious did you get?

Most anxious possible - 10

9

8

7

6

Medium anxious - 5

4

3

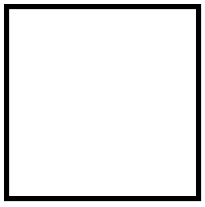
A little anxious- 2

1

Not anxious – 0

Write down what you really did:

PLACE STICKER HERE



SESSION 8: Draw MEDIUM ANXIOUS reminder

Session 8: Inaccurate Thought

The thought: _____

Evidence For	Evidence Against
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Conclusion: _____

_____

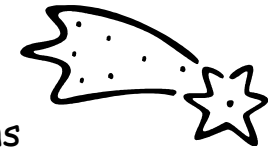
Positive Replacement Thought:

_____

_____

Session 8: Safety Plan

Did you practice your safety Plan? Circle Yes or No

If yes, congratulations 

If no, Practice Now!

MY Official Safety Plan:

_____

_____

_____

_____

_____

_____

_____

_____

SESSION 8: HOMEWORK CHECK SHEET: Practice real life MEDIUM ANXIOUS exposure once during the next week

PLAN: _____

DAY/TIME: _____

How anxious did you get?

Most anxious possible - 10

9

8

7

6

Medium anxious - 5

4

3

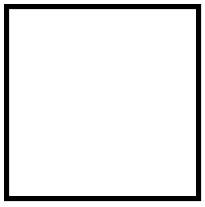
A little anxious- 2

1

Not anxious – 0

Write down what you really did:

PLACE STICKER HERE



Session 9: Draw WORST MOMENT reminder

Session 9: Inaccurate Thought

The thought: _____

Evidence For	Evidence Against
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Conclusion: _____

_____

Positive Replacement Thought:

_____

_____

SESSION 9: HOMEWORK CHECK SHEET: Real life ALMOST TOO ANXIOUS or MOST ANXIOUS exposure once during the next week

PLAN: _____

DAY/TIME: _____

How anxious did you get?

Most anxious possible - 10

9

8

7

6

Medium anxious - 5

4

3

A little anxious- 2

1

Not anxious – 0

Write down what you really did:

PLACE STICKER HERE

Session 10: Draw WORST MOMENT reminder

Session 10: Inaccurate Thought

The thought: _____

Evidence For	Evidence Against
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Conclusion: _____

_____

Positive Replacement Thought:

_____

_____

SESSION 10: HOMEWORK CHECK SHEET: Real life ALMOST TOO ANXIOUS or MOST ANXIOUS exposure once during the next week.

PLAN: _____

DAY/TIME: _____

How anxious did you get?

Most anxious possible - 10

9

8

7

6

Medium anxious - 5

4

3

A little anxious- 2

1

Not anxious – 0

Write down what you really did:

PLACE STICKER HERE

SESSION 11: Draw child in near future and a reminder

SESSION 11: Draw child as adult and a reminder

SESSION 11: HOMEWORK CHECK SHEET: Real life ALMOST TOO ANXIOUS or MOST ANXIOUS exposure once during the next week.

PLAN: _____

DAY/TIME: _____

How anxious did you get?

Most anxious possible - 10

9

8

7

6

Medium anxious - 5

4

3

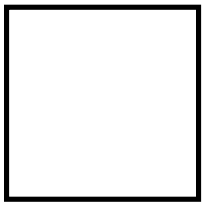
A little anxious- 2

1

Not anxious – 0

Write down what you really did:

PLACE STICKER HERE



The Relaxing Two Step Exercise

This simple relaxation exercise is for young children. All of the steps are in twos so that they can remember how to complete it. When teaching this exercise, the instructor should do it with the child so that he/or she understands the steps. Have the child practice this with their caregiver and on their own.

Encourage the child to go through the imagery, breathing and muscle relaxation. If they prefer one piece more than the other, that's OK too.

After the child has mastered this exercise some children may want to make up their own, "Fun Two Step Exercise" with fun moves as a way to be silly and interact with the teaching adult.

Imagery
1. Close your eyes
2. Imagine yourself in a happy, safe place or event (for 15-30 seconds)

Breathing – Repeat Twice
1. Breathe in slowly through your nose and fill your belly with air like a balloon
   (in for two counts, hold for two, blow out for two)
2. Breathe in slowly again through your nose and fill your belly with air like a balloon
   (in for two counts, hold for two, blow out for two)

Muscle Relaxation – Repeat Twice
1. Tighten your arm muscles (hold for two counts) and let them fall like noodles
2. Tighten your arm muscles again (hold for two counts) and let them fall like noodles

**Optional Stretching ** – Repeat Twice
Stretch up ("reach for the stars") and relax

(Alison Salloum; revised by Theresa Stockdreher and Michael Scheeringa).

RELUCTANCE CHECKLIST

Today's Date ____/____/_____ Session # ____

HOW RELUCTANT DID THE *PARENT* FEEL BEFORE COMING TO TODAY'S SESSION?

Say to the parent, "The ratings are based on how much you don't want to do something. 10 = the worse imaginable anxiety, and 5 = something that is half that bad. For example, most people rate having to stand up and talk in front of people around a 9. Going to the dentist is around a 6. Cleaning the dishes is around a 2. How did you feel today before leaving the house to come to this visit?"

1	2	3	4	5	6	7	8	9	10	prc1
None									Worst Imaginable Anxiety	

WHY DID THE *PARENT* NOT WANT TO COME TO TODAY'S SESSION?

No	Yes, a little	Yes, a lot		
0	1	2	prc2	Thought child would be distressed.
0	1	2	prc3	Thought parent would be distressed.
0	1	2	prc4	Believed child improved enough/didn't need more therapy.
0	1	2	prc5	Believed child was not improving/this was a waste of time.
0	1	2	prc6	Not enough time for this because of other life pressures.
0	1	2	prc7	Other:

HOW RELUCTANT DID THE *CHILD* FEEL BEFORE COMING TO TODAY'S SESSION?

Ask the parent how anxious the child seemed about coming to the session today.

1	2	3	4	5	6	7	8	9	10	crc1
None									Worst Imaginable Anxiety	

WHY DID THE *CHILD* NOT WANT TO COME TO TODAY'S SESSION?

No	Yes, a little	Yes, a lot		
0	1	2	crc2	Thought child would be distressed.
0	1	2	crc3	Thought parent would be distressed.
0	1	2	crc4	Believed child improved enough/didn't need more therapy.
0	1	2	crc5	Believed child was not improving/this was a waste of time.
0	1	2	crc6	Not enough time for this because of other interests.
0	1	2	crc7	Other

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