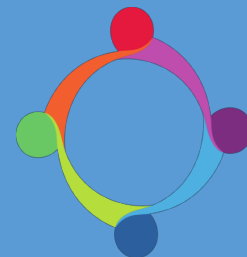


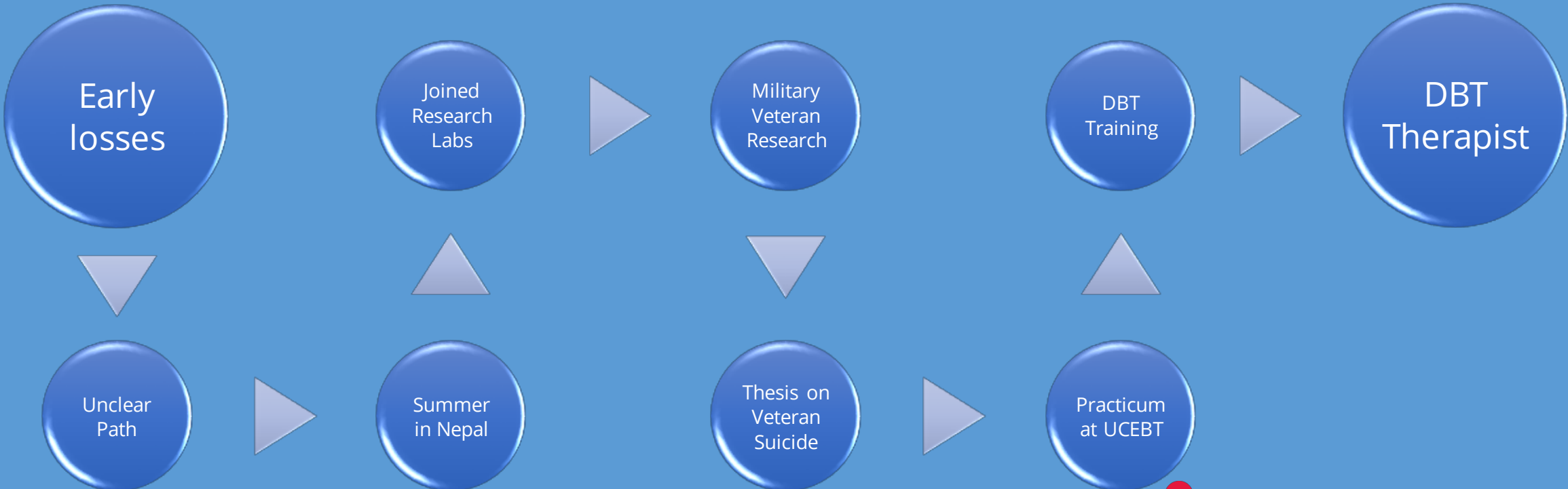
Under the Banner of Trauma: What Traditional Conceptualizations Miss

Jordan Kugler, Ph.D., Sloan Strike Ph.D., and Stephanie Taylor
Ph.D.



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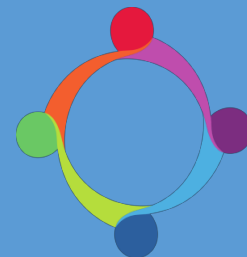
About me



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What to Expect

- Brief review of DSM-5 PTSD criteria
- Limitations of DSM for trauma in the general population
- Complex Trauma
 - Proposed criteria
 - Conceptualizations
 - Possible interventions and adaptations

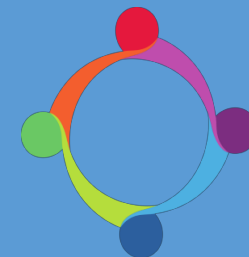


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PTSD Diagnostic Criteria

Criterion A stressor

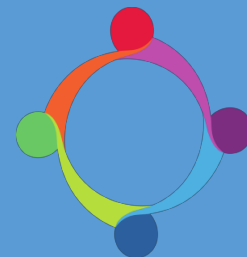
- The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (1 required)
 - 1) Directly experiences the traumatic event
 - 2) Witnesses the traumatic event in person
 - 3) Learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental)
 - 4) Experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).



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PTSD Diagnostic Criteria- Intrusive Memories

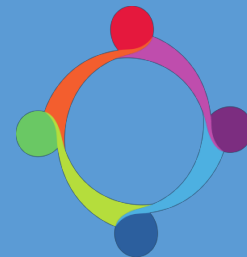
1. Recurrent, involuntary, and intrusive memories.
2. Traumatic nightmares.
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiological reactivity after exposure to trauma-related stimuli.



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PTSD Diagnostic Criteria-Avoidance

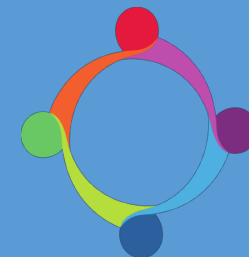
1. Persistent effortful avoidance of distressing trauma-related stimuli after the event:
 - Trauma-related thoughts or feelings (internal)
 - Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations) (external)



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PTSD Diagnostic Criteria- Negative Alterations in Cognition and Mood (2)

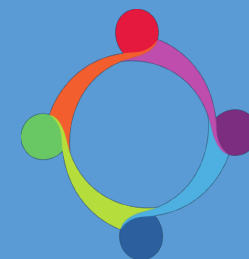
1. Inability to recall key features of the traumatic event (not due to head injury, alcohol or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world/others are completely dangerous.").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.



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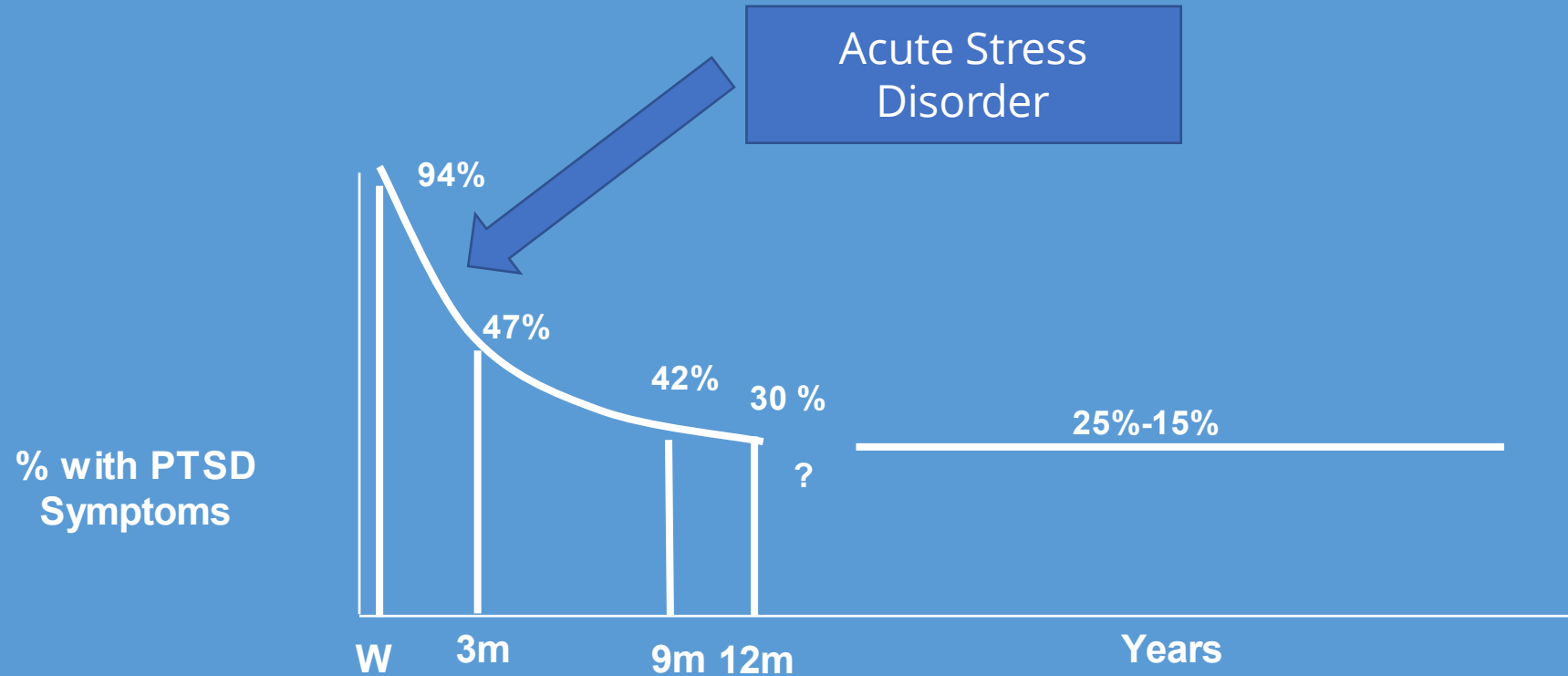
PTSD Diagnostic Criteria- Alterations in Arousal or Reactivity (2)

1. Irritable or aggressive behavior.
2. Self-destructive or reckless behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems in concentration.
6. Sleep disturbance.



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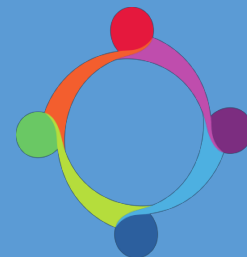
Exposure to Trauma and Recovery



Data from Rothbaum et al., 1992

What the DSM misses: Event or Reaction

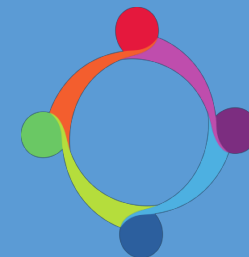
- Criterion A implies a deep connection between specific events and PTSD symptoms
 - Trauma is associated with several other mental health disorders
- If the collective post-trauma reaction causes significant impairment, does the event itself matter?
 - As many as 60% of individuals exposed to a criterion A event recover within a year
- Interventions and funding follow diagnostic criteria



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What the DSM misses: Event or reaction?

- A study by Mol and colleagues (2005) examined post trauma reactions in the general population
 - 2997 randomly selected from a large health care network of over 65,000.
 - 832 reported post-trauma reactions
 - Split into groups based on “worst event of their life”
 - Criterion A group (n=299) , administered PCL
 - “Life Events” group (n=533), administered PCL
 - Non-sudden death of a loved one and serious illness (self), Burglary without confrontation violence. Burglary without confrontation with the burglar, relational problems, problems with study or work, chronic illness
 - Life events group reported higher average PCL scores even after adjusting for time since the trauma and all demographic variables.



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What the DSM misses: Multiple Traumas

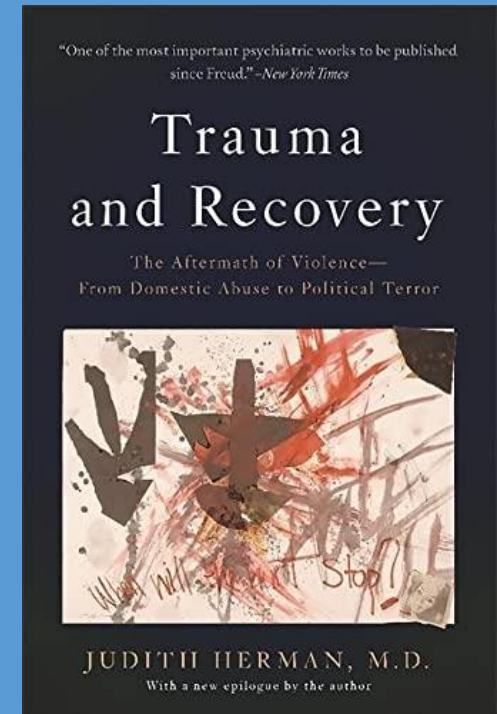
- Exposure to multiple criterion A events, particularly in childhood can create complex symptoms
 - Meet criteria for PTSD AND
 - Problematic affective and interpersonal symptoms AND
 - Difficulties with emotion regulation
- Exposure to more and different types of trauma is associated with increased symptom complexity (Cloitre 2009)
 - Strongest with multiple types of childhood trauma (increase in symptom complexity by 17%)
 - Lifetime cumulative trauma (child plus adult total traumas) increased symptom complexity by 13% per event



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Complex Trauma Reactions

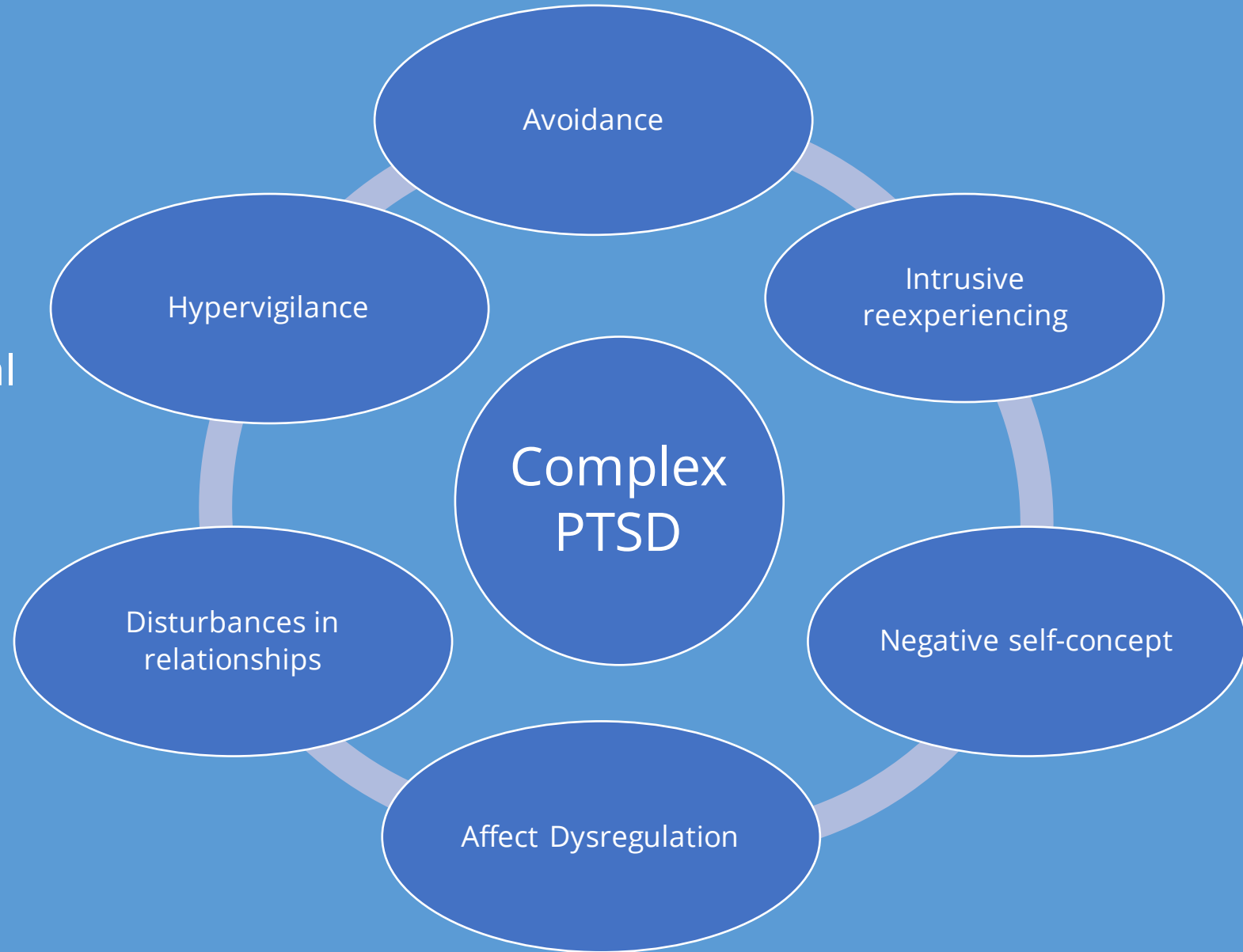
- *Trauma and Recovery* (1997), Judith Herman
 - Key facets of this type of abuse included its chronic nature and relational aspects; more specifically, survivors were frequently in situations in which they were unable to find protection from a perpetrator who was typically in a position of power over them.
- ICD 10: “Enduring personality change following a catastrophic experience”
 - Describes disturbances in self organization that can sometimes result from multiple, chronic or repeated traumas, particularly where escape was not possible



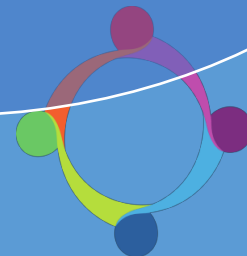
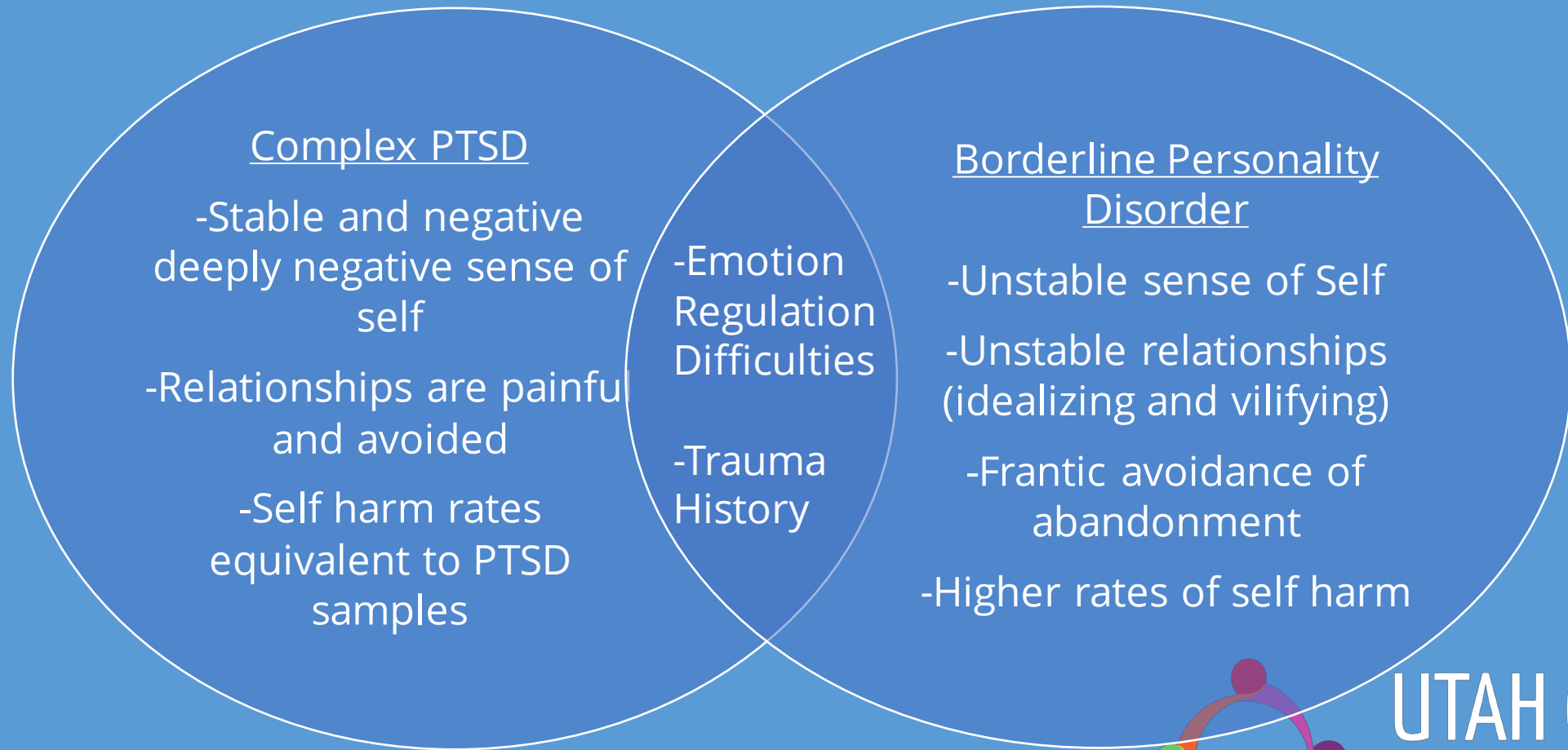
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Complex PTSD: ICD 11

- Meet full criteria for PTSD
- Adds key affective, regulatory and interpersonal symptoms
- Childhood trauma a common but not necessary feature
- Presentation is distinct from PTSD
 - Supported by factor analysis research and qualitative studies

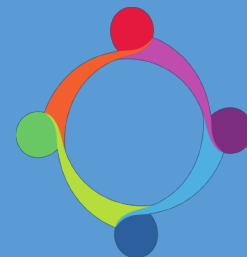


Complex PTSD and Borderline Personality Disorder



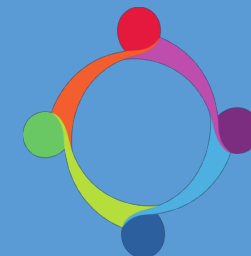
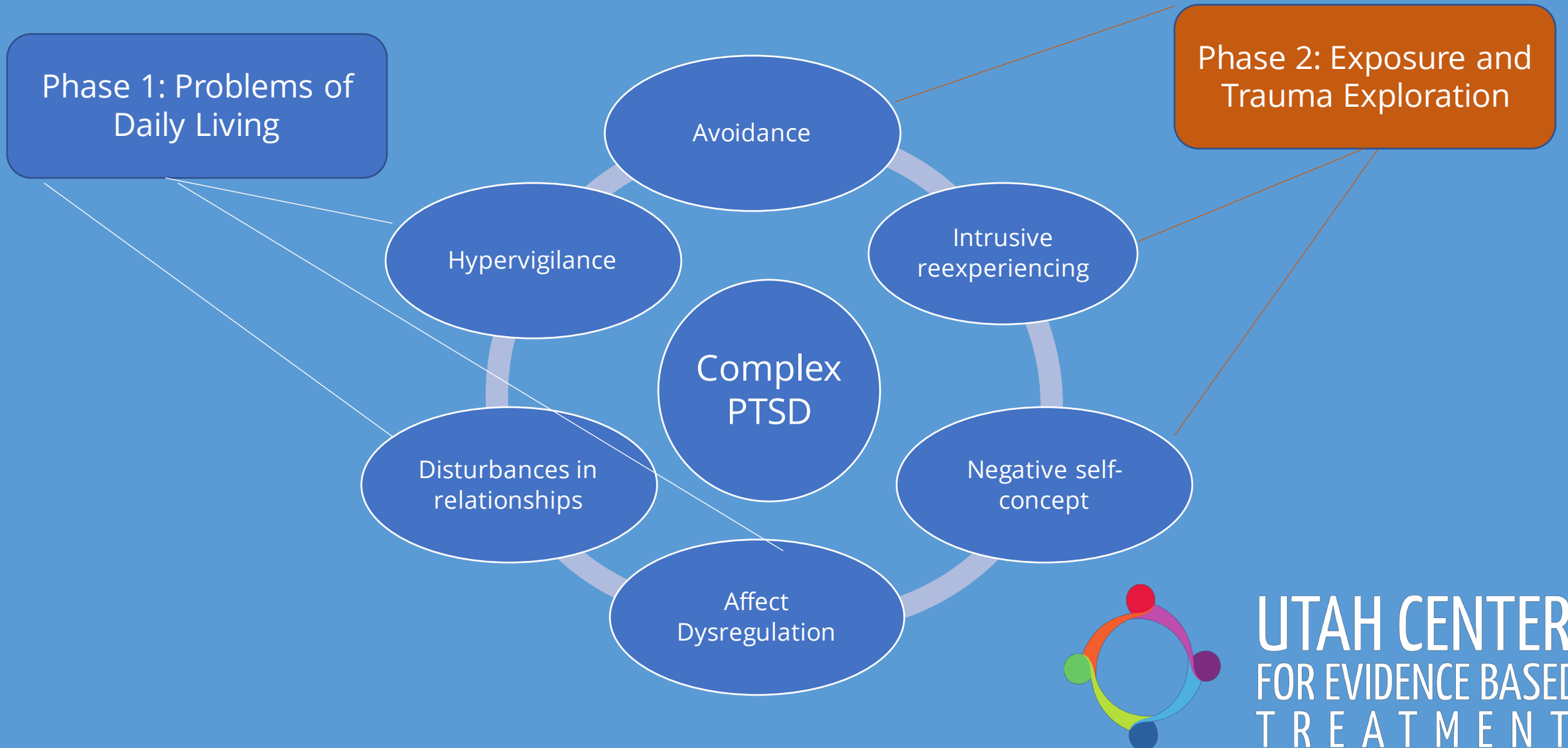
Treatment for Complex PTSD

- Some disagreement on whether trauma focused treatments (i.e., CPT, TF CBT, PE and EMDR) are effective for the complex presentation
 - Compared to usual, CBT, PE and EMDR perform relatively well, but fluctuated with severity of CPTSD-specific symptoms
- Phase based model of treatment (Herman 1992; Coitre et al 2012) has received support but needs more attention



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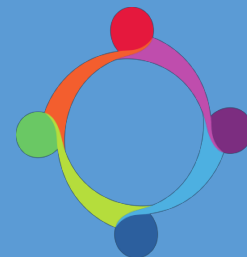
Treatment for Complex PTSD



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Clinical Implications

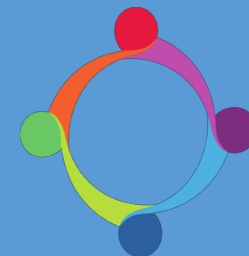
- Use clinical judgement when considering Criterion A (Brewin 2009)
- Focus on the core symptoms of Post-trauma reactions and the timeline for when these developed
 - Re-experiencing in the present: Intrusive, multisensory memories marked by fear/horror
- Consider skills deficits that magnify these reactions
 - Low or high distress tolerance
 - Slow return to baseline
 - Lack of emotion regulation
 - Avoidance of interpersonal relationships



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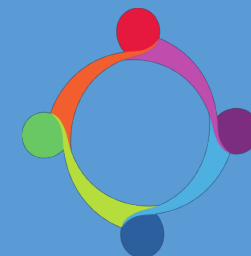
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What is Trauma?

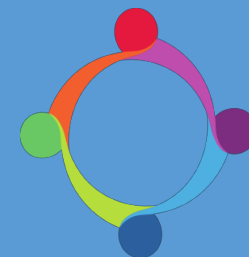
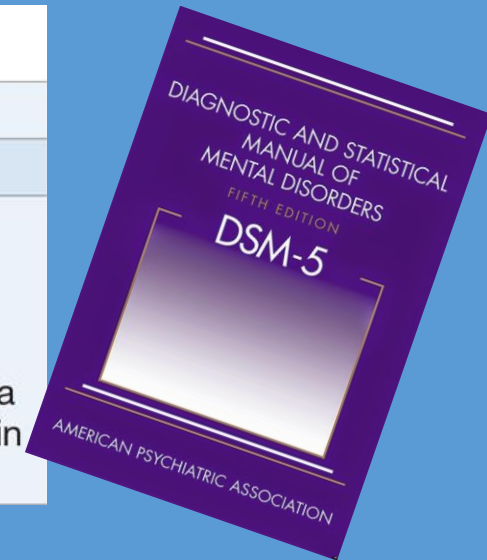


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DSM-5 criteria for PTSD

Trauma exposure

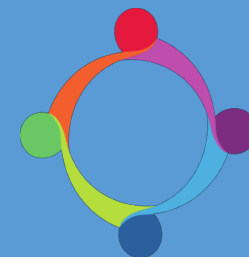
Trauma	Actual or threatened violent death, serious injury or accident, or sexual violence
A. Exposure	Via any of the following: <ol style="list-style-type: none">1. Directly exposed to trauma2. Eyewitness (in person) to others directly exposed to trauma3. Learning of direct exposure to trauma of a close family member or close friend4. Repeated or extreme exposure to aversive details of traumatic event (eg, trauma workers viewing human remains or repeatedly exposed to details of child abuse), in person or via work-related electronic media



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What is Trauma?

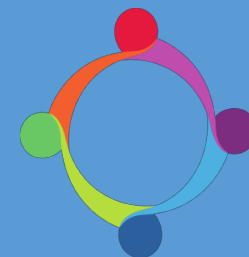
- What have you treated or seen outside of traditional conceptualizations of trauma?



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What is Trauma?

- Poverty
- Racial trauma
- Disaffiliation from religion
- Transgender within the family unit
- Adoption
- Pandemic
- Substance abuse/codependency
- Divorce
- Betrayals



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B. Intrusion *≥1 intrusion symptoms:*

1. Recurrent, involuntary, distressing trauma memories
2. Recurrent, distressing trauma-related dreams
3. Dissociative reactions/flashbacks related to trauma
4. Intense or prolonged psychological distress to trauma reminders
5. Marked physiological reactions to trauma reminders

C. Avoidance *≥1 avoidance symptoms:*

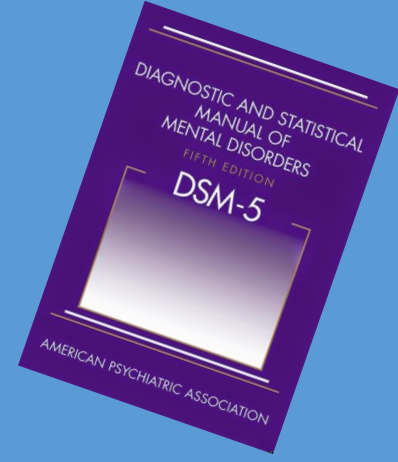
1. Avoidance/efforts to avoid distressing internal trauma reminders (memories, thoughts, feelings)
2. Avoidance or efforts to avoid distressing external trauma reminders (people, places, activities)

D. Negative cognition and mood *≥2 negative cognition/mood symptoms:*

1. Amnesia for important parts of trauma exposure
2. Persistent, exaggerated negative beliefs about self, others, or the world
3. Persistent, distorted trauma-related cognitions leading to inappropriate blame of self/others
4. Persistent negative emotional state (eg, fear, horror, anger, guilt, shame)
5. Loss of interest or participation in significant activities
6. Detached/estranged feelings from others
7. Persistent loss of positive emotions (eg, happiness, satisfaction, love)

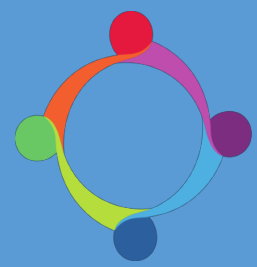
E. Hyperarousal *≥2 marked alterations in trauma-related arousal and reactivity:*

1. Irritability and angry outbursts with little/no provocation (eg, verbal/physical aggression toward people/objects)
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle
5. Concentration problems
6. Sleep disturbance (eg, difficulty falling or staying asleep, restless sleep)



Additional criteria	
F. Duration	>1 month
G. Distress/impairment	Clinically significant distress; social/occupational/other important functioning impairment
H. Not attributable to another disorder	Independent of physiological effects of a substance (eg, medication, alcohol) or another medical condition

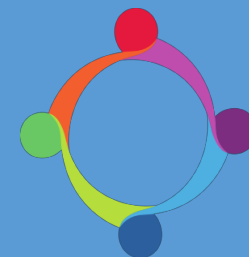
• Does survival pertain to our physical body?



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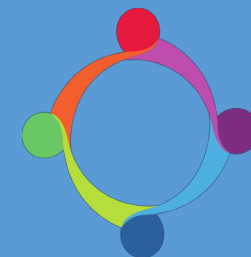
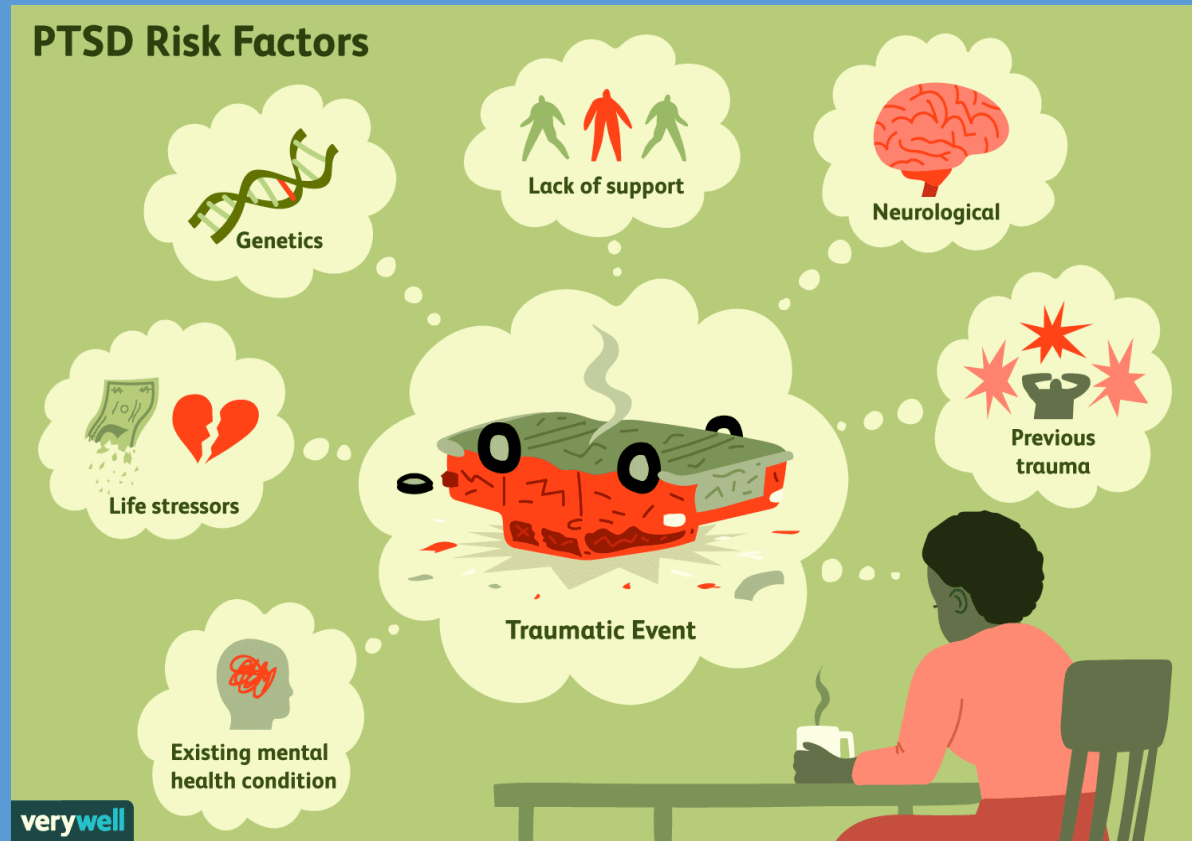
Trauma and our Internal World

- Unpredictable



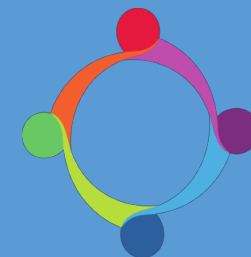
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What Makes Something Traumatic?



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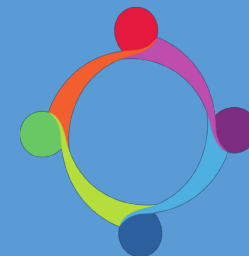
Interpersonal Piece the DSM Misses



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Phases of Love in a Lifetime

- PHASE 1: Falling in Love
- PHASE 2: Trust
- PHASE 3: Commitment



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PHASE 1: The Physiology of Falling in Love

1. The hypothalamus releases dopamine into the body, causing feelings of ecstasy and excitement.

2. As dopamine levels increase, serotonin levels decrease.

Serotonin is responsible for a person's mood and appetite, among other things.



The lower levels of serotonin are similar to levels found in people with obsessive compulsive disorders.

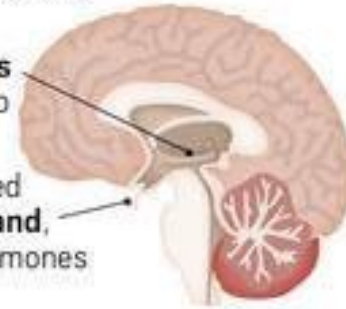
This may result in feelings of obsession or infatuation.

3. Along with dopamine, the body also produces a substance called nerve growth factor.

- NGF is more prevalent in people who are newly in love.
- People who are not in love or are in long-term relationships have lower levels of NGF than recent lovers.
- The amount of NGF in the body directly relates to the intensity of romantic feelings.

4. Oxytocin and vasopressin are responsible for feelings of connection and commitment.

- The **hypothalamus** produces these two hormones.
- They are then stored in the **pituitary gland**, which secretes hormones into the body.
- In times of extreme passion – such as during orgasm – these hormones enter the bloodstream.
- The presence of the two chemicals is often attributed in part to the success of long-term relationships.

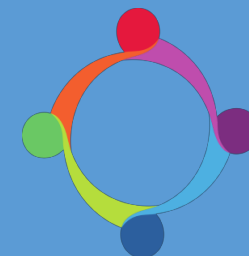


5. These hormones affect different parts of the brain. Because of these sections' nearness, certain responses occur:

Activity increases in the romantic core of the brain. → The amygdala deactivates.

A person's standards for judging others grow blurry. → The person in love feels less stress and fear.

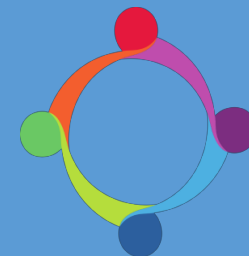
The result is an overall feeling of unity between people in love.



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PHASE 2: Trust

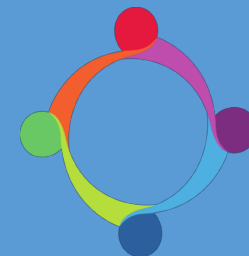
- Will you be there for me?
- Percentage of time we are emotionally available
- Ability to address conflict
- Ability to process negativity
- Attunement



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PHASE 3: Commitment

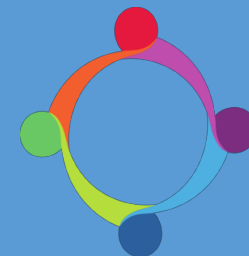
- Loyalty versus Betrayal
- Cultivate gratitude or resentment
- PERSPECTIVE



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An Affair

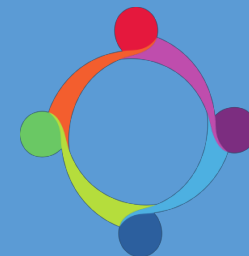
- Clandestine physical or emotional liaison
- Violates agreed upon terms of relationship
- Poses a threat to the primary relationship
- Regardless of its length or meaning



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The Glacial Gottman-Rusbult-Glass Cascade Toward Betrayal

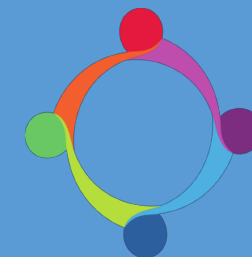
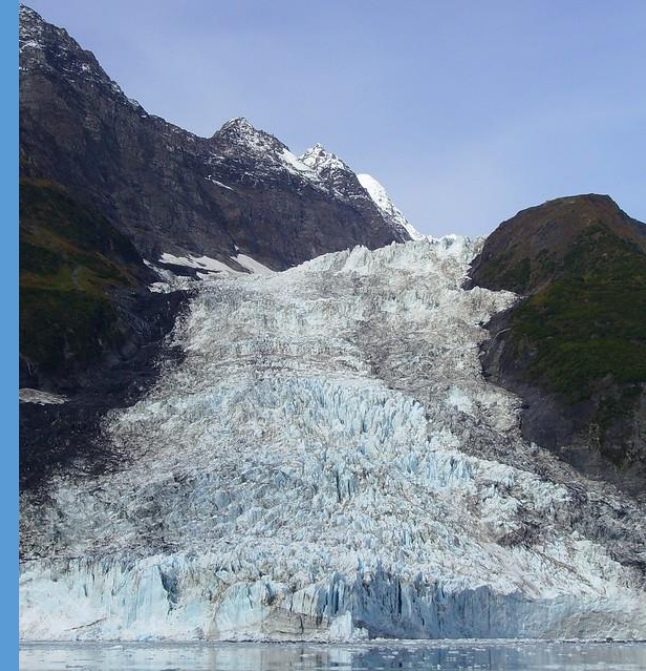
- Conflict Avoidant
- Self-Disclosure Avoidant



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Cascade Effect

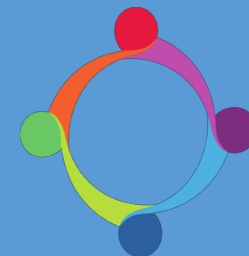
- Turning Away
- Negative Comparisons
- Not there for me
- Flooding
- Conflict absorbs; repair doesn't work
- Avoids conflict
- Avoids self-disclosure
- No more bids
- Invests less/loneliness builds
- No confiding
- Substitution
- Maximizing negative traits/increase in defensiveness
- Minimizing positive traits/increase in criticisms
- Trashing versus cherishing/increase in contempt
- Resentment over gratitude
- Loneliness builds; vulnerability starts
- Sexual needs not met
- Increase in anti-relationship cognitions
- Not denigrating alternative relationships/secret liaisons
- Little fence
- Secrets
- Turning towards others
- Crossing boundaries



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The Glacial Gottman-Rusbult-Glass Cascade Toward Betrayal

- Conflict Avoidant
- Self-Disclosure Avoidant



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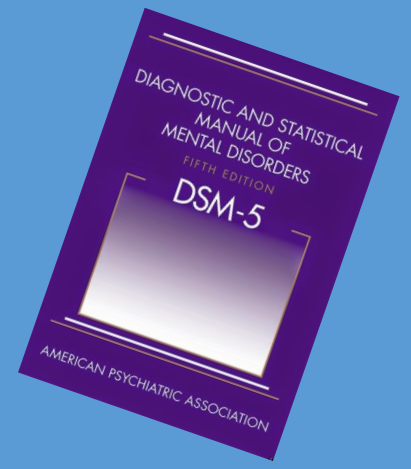
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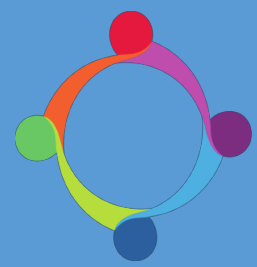
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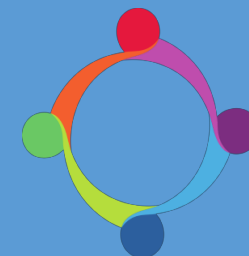


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Trauma Treatment for the Affair



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Allen, E. S., Atkins, D. C., Baucom, D. H., Snyder, D. K., Gordon, K. C., & Glass, S. P. (2005). Intrapersonal, Interpersonal, and Contextual Factors in Engaging in and Responding to Extramarital Involvement. *Clinical Psychology: Science and Practice*, 12(2), 101–130. <https://doi.org/10.1093/clipsy.bpi014>

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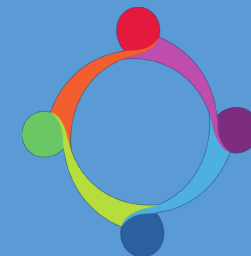
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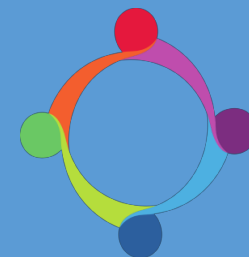
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Considerations for Trauma Work with Children and Adolescents

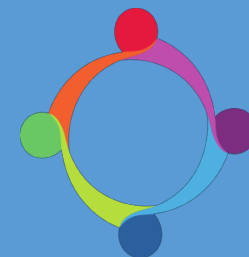
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Prevalence of Child Trauma

- 40% of U.S. youth are exposed to traumatic events, such as sexual abuse, physical abuse, and bereavement due to traumatic circumstances (Finkelhor et al.)
- A national survey of U.S. teens found (National Center for PTSD):
 - 8% experienced sexual assault
 - 22% experienced physical assault
 - 39% witnessed violence
- 75-90% of youth seen in mental health settings have experienced trauma (Shemesh et al.)

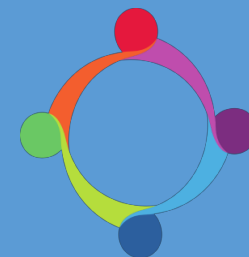


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What Gets Missed

Considerations for trauma-informed care for children and adolescents:

1. Thorough assessment / differential diagnosis
 - Many trauma symptoms look like other common mental health issues in childhood
2. Parental trauma
 - Parents of traumatized children are often suffering from trauma symptoms or PTSD themselves



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Symptoms of Trauma in Children

Affective symptoms

- Anxiety
 - Fear
 - Worry
 - Edginess
 - Night terrors
 - Panic attacks
- Anger or irritability
- Sadness
- Mood swings, emotional outbursts

Behavioral symptoms

- Avoiding reminders of event (thoughts, conversations, places)
- Difficulty sleeping
- Avoidance
- Modeling maladaptive behaviors
 - Sexualized behaviors
 - Violent behaviors
 - Bullying
- Traumatic attachment
- Substance abuse
- Self-injury

Cognitive Symptoms

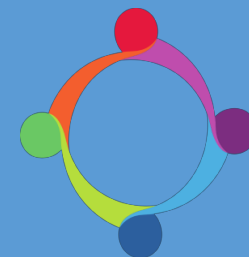
- Irrational beliefs
 - "Life is less worthwhile because of what happened"*
- Distrust
 - "Most people are bad"*
- Distorted self-image
 - "I'm damaged"*
- Accurate but unhelpful cognitions
 - "I should have told sooner"*

Hyperarousal

- Irritability, angry outbursts
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Trouble concentrating
- Sleep disturbance

Why Childhood PTSD is Missed

- Age / developmental level of the child
- Memory problems
- Avoidance
- Inaccurate reporting
- Confusing symptoms and/or multiple mental health disorders



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Differential Diagnosis

Hyperarousal

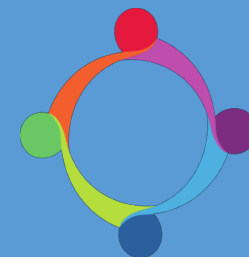
- Irritability, angry outbursts
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

Generalized Anxiety Disorder

- Irritability
- Restlessness
- Feeling keyed up or on edge
- Muscle tension
- Easily fatigued
- Problems with concentration
- Sleep disturbance

Differential Diagnosis

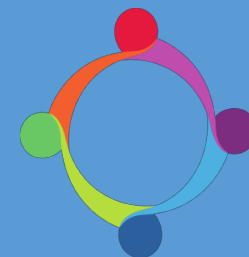
- Hypervigilance can look like paranoia
- Aggression + oppositional behavior can look like ODD
- Self injury + emotional instability can look like borderline personality disorder
- Mood swings + oversensitivity to emotional/environmental triggers can look like disruptive mood dysregulation disorder



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Differential Diagnosis

- Lack of concentration + hyperarousal can look like ADHD
- Avoidance + sleep disturbances can look like depression
- Irrational fears can look like phobias



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Symptoms of PTSD from Birth to 3

Intrusive symptoms:

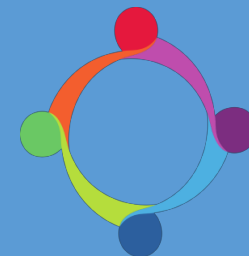
- Sleep disruptions (trouble falling asleep, nightmares)

Arousal symptoms:

- Startle easily, temper tantrums, severe separation anxiety, excessive fussiness

Avoidance symptoms:

- Withdrawing, avoiding people associated with the trauma, lack of any demonstration of emotion



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Symptoms of PTSD from 4 to 6

Intrusive symptoms:

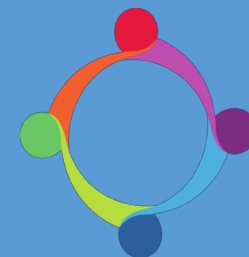
- Sleep disruptions (trouble falling asleep, nightmares)
- Trouble concentrating in school

Arousal symptoms:

- Acting out, uncontrollable temper, aggressiveness
- Stomach aches, headaches, startle easily

Avoidance symptoms:

- Afraid of being away from parents or near anyone associated with the trauma
- Appear anxious and insecure



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Symptoms of PTSD from 7 to 12

Intrusive symptoms:

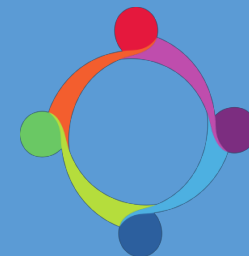
- Sleep disruptions (trouble falling asleep, nightmares)
- Trouble concentrating in school

Arousal symptoms:

- Acting out, uncontrollable temper, aggressiveness
- Stomach aches, headaches, startle easily (“overly dramatic”)

Avoidance symptoms:

- May complain of somatic symptoms to avoid situations they fear
- Appear anxious and insecure
- Emotional numbness



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Symptoms of PTSD from 13 to 18

Intrusive symptoms:

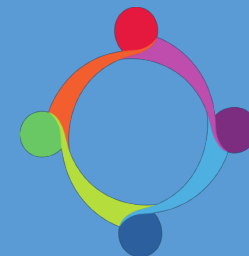
- Sleep disruptions
- Trouble concentrating in school
- Discussing trauma often and in great detail

Arousal symptoms:

- Impulsivity
- Hypervigilance

Avoidance symptoms:

- Drug/alcohol use to numb feelings and fears
- Emotional numbness, refusal to discuss trauma
- Eating disorders or self-harming behaviors



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Assessment of Trauma

Assessment Goals

- Identify history of traumatic exposure
- Identify PTSD symptoms
- Establish baseline
- Assess existing risk and safety

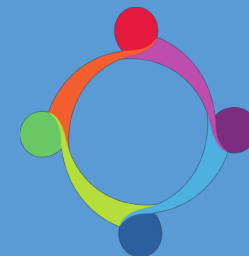
Assessment Measures

- Formal, standardized measures
- Read a book like “A Terrible Thing Happened” and discuss symptoms (informal assessment)
- Get caregiver perspective about child’s symptoms and behaviors
- Assess environmental, developmental and social context
- Clinical observation

Assessment of Trauma

Formal Instruments:

- UCLA Posttraumatic Stress Index
- Trauma Symptom Checklist for Children
- Child PTSD Symptom Scale (CPSS)
- Children's Impact of Traumatic Events Scale
- Child Dissociative Checklist
- Traumatic Events Screening Inventory

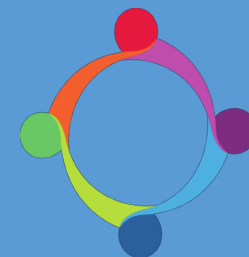


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What Gets Missed

Considerations for trauma-informed care for children and adolescents:

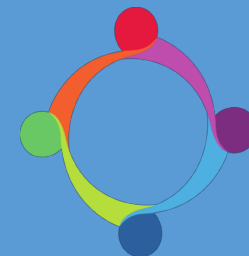
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TF-CBT Treatment Components

- Psychoeducation + parenting skills
- Affect identification and regulation
- Relaxation and mindfulness
- Maladaptive cognitions and cognitive distortions
- Trauma narrative and processing
- In-vivo desensitization
- Conjoint parent-child sessions
- Enhancing safety



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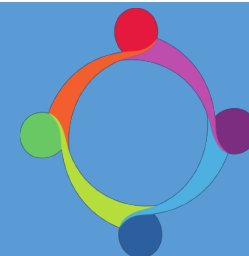
Treatment Goals

Short term

- Stabilize
- Ensure safety
- Engage non-offending parent or caregiver in treatment

Long term

- Desensitization to trauma memories and reminders
- Correction of cognitive distortions about the trauma (e.g., selfblame, stigma)
- Enhancing parent support of the child and increasing support to the caregiver
- Increasing structure and predictability in the home



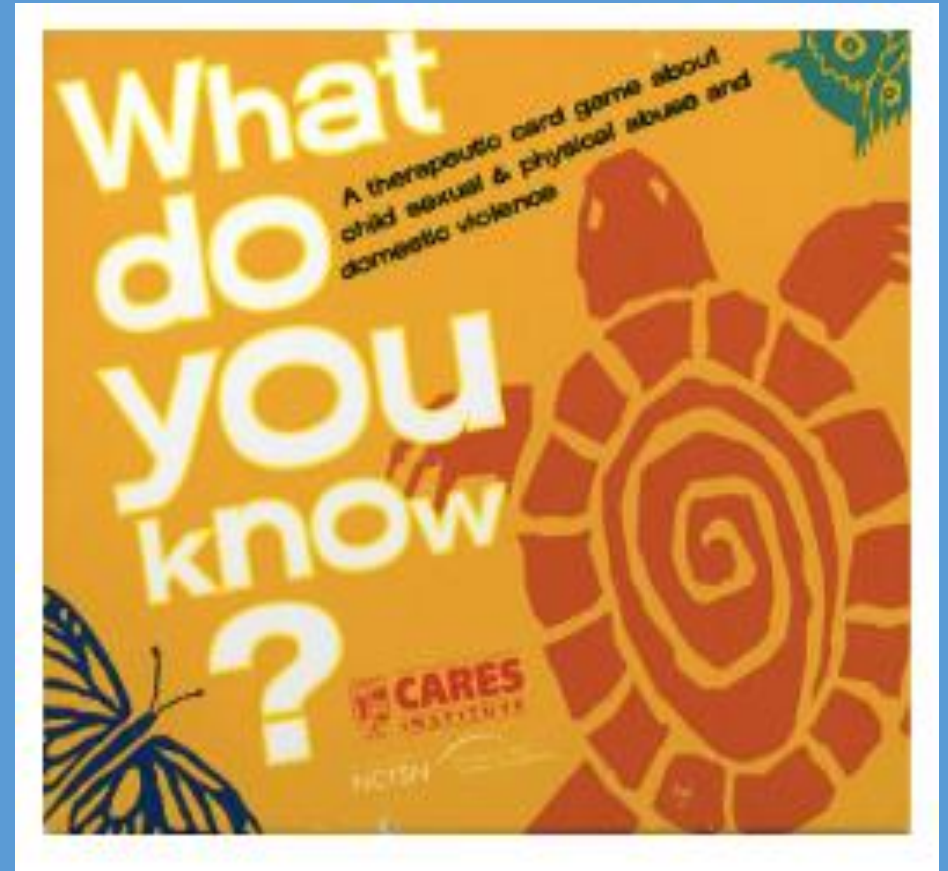
Psychoeducation

Helping child and caregiver to understand the child's symptoms through the context of trauma

Providing specific information about what the child has experienced

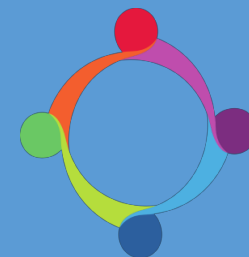
- *What is it called? What does that mean?*
- *Are there a lot of kids who experience this?*
- *Why does this happen?*
- *What are common responses?*
- *What can kids do if this happens to them?*

Gradual exposure should be a part of every step of treatment



Parenting Skills

- Parents' vicarious trauma
- Parent role as child's coach in developing skills to manage difficult feelings, thoughts, and behaviors
- Behavior Management Training
 - Traumatized children are often disruptive, aggressive, and non-compliant
 - Parents may feel guilty about discipline



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Cognitive Processing

Irrational beliefs

- “Life is less worthwhile because of what happened”
- “You can never tell when a drive-by shooter might hit you”
- “It’s my fault because I didn’t resist”

Distrust

- “Most people are bad”

Distorted self-image

- “I’m damaged”

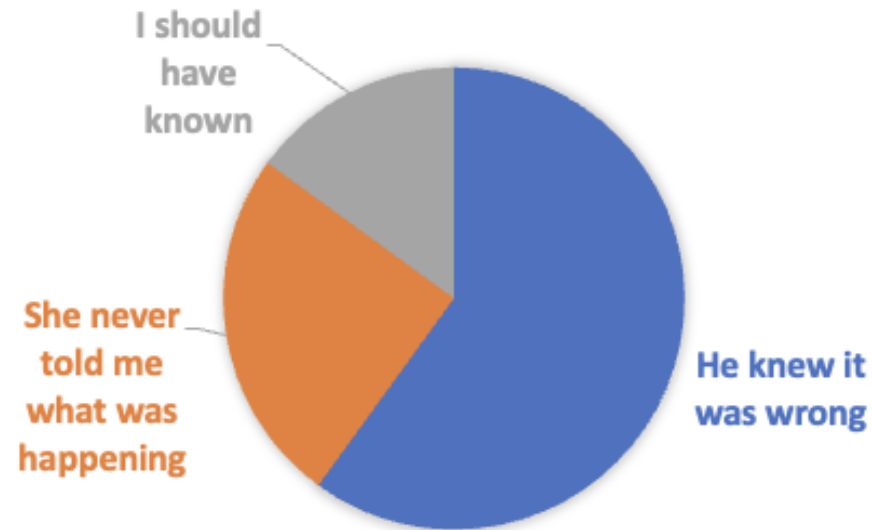
Accurate, but unhelpful, cognitions

- “I should have told sooner”

Cognitive Processing

Identifying inaccurate thoughts (*"It's my fault that I didn't know what was happening"*)

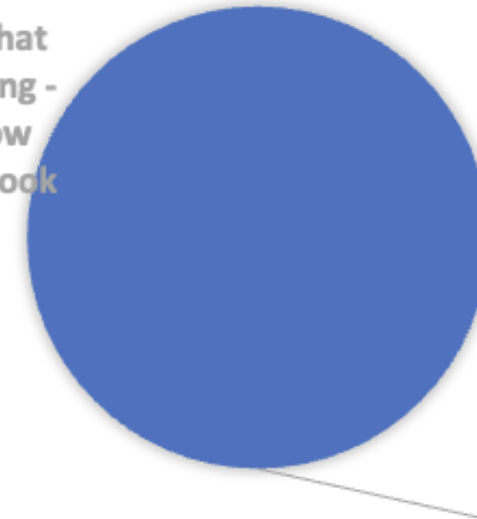
Allocation of blame/fault: If you had a pie and divided up responsibility for what happened, how would you draw it?



I didn't recognize what was happening - I didn't know the signs to look for

She was scared

He knew it was wrong; he is responsible



Narrative Work

Round 1	Describing facts, minimal prompting, only open-ended questions
Round 2	Name thoughts and feelings during the event, prompt for increased level of detail
Round 3	Should include the worst part of trauma, address specific thoughts and beliefs with cognitive reframing

Cognitive Processing

Exploring thoughts specifically related to the trauma and its meaning in the child's life:



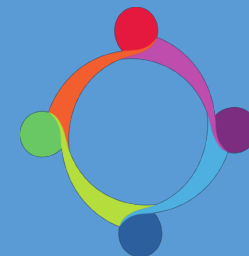
Child

- Difference between accurate and inaccurate cognitions related to their traumatic experience
- Correct cognitive errors



Parent

- Examine their own thoughts about the child's traumatic experience for both accuracy and helpfulness
- Learn to effectively challenge the child's cognitive errors



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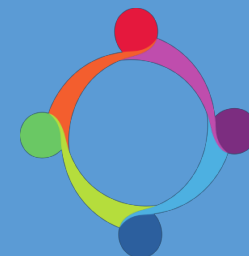
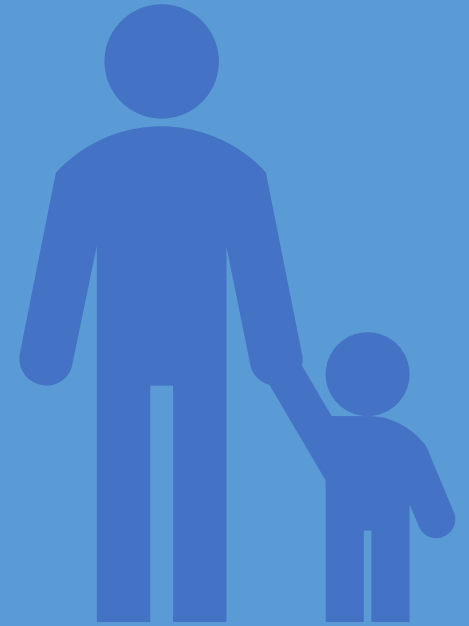
Conjoint Parent-Child Sessions

Prepare parents for potential reactions to hearing trauma narrative

- Introduce stress-management skills
- Encourage and empower parent to take care of child (beginning of termination)

Child shares the trauma narrative

- Launching pad for open dialogue
- Opportunity for each to ask the other questions
- Parent demonstrates comfort in hearing and talking about the trauma, models appropriate coping
- Child's feelings of shame and distress are alleviated



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Resources

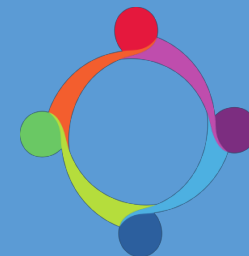
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Questions:

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