

Trauma-Focused Cognitive Behavior Therapy

[Summary White Paper Developed by Louisiana OCDD Clinical Services Team]

Overview of TF-CBT

Cognitive Behavior Therapy (CBT) is often incorporated into treatment of **PTSD** and **trauma**. Trauma-focused CBT has become a special subset of CBT work. It has become one of the primary **treatment modalities** in addressing trauma and is increasingly being used effectively with persons with **Intellectual Disabilities** (IDs) in treating abuse and other forms of trauma.

The basic therapeutic approaches are the same whether CBT is applied to disorders like depression or to trauma. A person is **taught** to replace irrational, distressing thoughts with rational, more accurate thoughts that positively impact emotions. In trauma-focused CBT there is an emphasis on **changing thoughts** often associated with trauma. The cognitive elements of Trauma-Focused CBT (TF-CBT) are often employed **in conjunction with exposure therapy, preventive safety training, and other therapeutic elements** (below) which come together in comprehensive TF-CBT treatment.

In a large multi-site study with children comparing TF-CBT to child-centered therapy, the authors found participants assigned to TF-CBT exhibited significantly greater improvement with regard to PTSD, **feelings of shame, depression, and behavior problems**¹. In a pilot study employing group TF-CBT in people with IDs and complex PTSD, participants reported improvements in **feeling safe, feeling less isolated** and more **comfortable in groups**, and achieving and **maintaining** symptomatic **change**².

The following summary of TF-CBT and adaptations for persons with DDs come from the book Trauma-Focused CBT for Children and Adolescents.³ This important work, selected for discussion here because of the authors' dominant influence on shaping the field of TF-CBT, while referencing children, has **applicability across the age span** in terms of principles and approaches. The considerations in youth-based treatment translate nicely when applied to serving adults with, IDs given developmental factors associated with developmental disabilities. For additional applicability, the word "**caregiver**," expanding concepts to other supports, is added below in some places where parents are referenced. The components of TF-CBT are summarized by the following acronym, **PRACTICE**, and include

- **Psychoeducation and Parenting/Caregiver Supports**
- **Relaxation**
- **Affective Expression and Modulation**
- **Cognitive coping**
- **Trauma Narrative Development and processing**
- **In Vivo Exposure**

Trauma-Focused Cognitive Behavior Therapy

- Conjoint parent/caregiver-persons sessions
- Enhancing safety and future development.

Education, Relaxation, practicing regulating **emotions** and expressing emotions, and **cognitive coping** and reframing probably deserve little explanation and are practices most therapists would find familiar. **Trauma narrative** development and processing involves helping the person to develop a narrative, a story of his or her life, that includes components related to traumatic events. The person is assisted to write this story, to examine traumatic events in the safety of the therapy session and with support, and to process these events that allow the person to address the pain of these experiences and to write endings of resiliency and survival. There is a strong exposure aspect to processing the narrative; coping skills are utilized in the context of this. Cohen³ note **Gradual exposure** (GE) is critical to implementing TF-CBT and is incorporated into *all* of the TF-CBT components. During each subsequent PRACTICE component, the therapist carefully calibrates and increases exposure to trauma reminders while encouraging the child and parent to use skills learned in previous sessions and praising demonstrated mastery. "... As the child progresses through the model, the therapist encourages the child and parent to implement the skills with increasing specificity to reminders of the sexual abuse until, during the trauma narrative, the child is encouraged to recount his or her traumatic experiences and to share this with the parent during **conjoint sessions** when clinically appropriate. (Cohen³ p.10)." **Enhancing safety** encourages the development of safety and self-protection skills to reduce risk of future trauma including things like practicing assertiveness and reporting to others, risk awareness and avoidance, body safety, and other safety skills relevant to trauma. **Skills** are often **reviewed** and practiced in conjoint sessions.

TF-CBT in Intellectual Disabilities

Frequently discussed **adaptations** of TF-CBT for persons with IDs are **similar to the adaptations** commonly employed when modifying **other behavioral health therapies** for use with persons with IDs. Restated, when therapists attempt to modify traditional therapies to accommodate a person's cognitive and language deficits (Note: and this is true not only for persons with IDs but also for persons who have IQs over 70 but have cognitive or language deficits), similar modifications are often employed whether we are discussing TF-CBT, CBT, Multi-systemic Therapy, Exposure-based therapies, or other evidence-based behavioral health therapies. This includes:

- **Simplifying concepts** of therapy
- Using **language** that is **understandable** to the person
- **Teaching skills concretely**
- Increasing **modelling** to teach skills
- Increasing **caregiver involvement** in therapy and in supporting coping skill usage
- Overlearning skills with **extra practice** -- using more repetition and review
- **Shortening session length** to accommodate attention.

Trauma-Focused Cognitive Behavior Therapy

TF-CBT has been applied successfully to help many persons with IDs. The experiences of the authors and recommended adaptations for persons with IDs are discussed by Grosso⁴ and are included in the **following table**:

Treatment Strategies for Children with Developmental Disabilities⁴.

Strategy	Purpose	Examples	Goals
Provide structure , create routines	Children with developmental delays will often have difficulty and discomfort with change	<ul style="list-style-type: none"> -Have a consistent meeting day/time -Create a routine for sessions with opening and closing rituals -Help family and caregivers create schedules/routines in the home and school (e.g., set times for meals, homework, bed) 	<ul style="list-style-type: none"> -Create consistency and expectation -Enhances predictability and comfort -Increases capacity for autonomy -Increases opportunity for repetition
Shorten sessions	Children with developmental delays will often have shorter attention spans and can be easily agitated	<ul style="list-style-type: none"> -Adjust session time according to attention span -Adjust dosage and pacing of gradual exposure 	<ul style="list-style-type: none"> -Increases sense of competence and success -Increases capacity for self-control and affect regulation
Slow down	Children with developmental delays have difficulty breaking down tasks and interpreting complex and compound messages	<ul style="list-style-type: none"> -Slow speech down -Give simple messages -Present one topic at a time -Be specific 	-Increases comprehension and competence
Use art/visuals	Children with developmental disabilities are often visual thinkers and “think in pictures”	<ul style="list-style-type: none"> -Provide images to illustrate directions and tasks. -Utilize visual aids when teaching skills -Encourage children to draw, paint, sculpt their thoughts and feelings 	<ul style="list-style-type: none"> -Increases comprehension -Increases ability to communicate

Trauma-Focused Cognitive Behavior Therapy

Strategy	Purpose	Examples	Goals
Use play	Children with developmental disabilities are visual thinkers and require movement and activation to remain focused	-Use puppets, figurines, sand play, and dollhouses to create story and metaphor	-Increases comprehension -Increases ability to communicate
Provide repetition	Children with developmental disabilities have cognitive limitations , including poor comprehension and retention and decreased capacity for generalization	- Repeat skills and concepts in session -Assign homework to practice skills taught in session -Use consistent praise and rewards as reinforcement of positive behavior	-Creates consistency and expectation -Enhances predictability and comfort -Increases capacity for autonomy
Use interests and fixations	Children with developmental disabilities often have fixations or special interests	-Ask, discover children's special interests -Use fixation on favorite character , person, place, thing to teach skill -Use shared interests to increase socialization	-Increases engagement in treatment -Increases communication -Increases retention of skill -Increases socialization

Note. Ideas provided in the above table were influenced by additional clinicians/researcher⁵⁻⁷.

The reader is encouraged to read the content of the above table with the idea that many of these concepts will apply to many children and adults with DDs while acknowledging this is not always the case and that there are certainly **individual differences**. For **some persons with Mild ID, little or no adaptations** of traditional therapies are required. Also, referenced supports related to **play would not be appropriate for many adults** with DDs whose interests and developmental functioning are more consistent with their chronological age.

TF-CBT is being increasingly used in the treatment of trauma in persons with IDs. Most clinicians find, and research supports, that **Mild to Moderate cognitive limitations do not pose a barrier** to the response to and benefits of **graduated exposure**-based approaches, **cognitive reframing**, and the **skills building** elements of TF-CBT. TF-CBT is increasingly discussed in the ID

Trauma-Focused Cognitive Behavior Therapy

literature. It is commonly highlighted in national developmental disabilities conferences, and use is becoming ubiquitous. Given the high rates of abuse and neglect that occur in persons with developmental disabilities, consideration of the full arsenal of effective approaches is warranted in treatment planning.

REFS

- ¹ Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A multi-site, randomized, controlled trial for children with sex-abuse related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 393-402.
- ² Kroese, B. S., Willot, S., Taylor, F., & Willner, P. (2016). Trauma-focused cognitive-behaviour therapy for people with mild intellectual disabilities: outcomes of a pilot study. *Advances in Mental Health and Intellectual Disabilities*, 10(5), 299-310.
- ³ Cohen, J.A., Mannarino, A. P., & Deblinger, E. (2012). *Trauma-focused CBT for children and adolescents: treatment applications*. New York, NY: The Guilford Press
- ⁴ Grosso, C. A. (2012). Children with developmental disabilities. In Cohen, J.A., Mannarino, A. P., & Deblinger, E. (eds). *Trauma-focused CBT for children and adolescents: treatment applications*. New York, NY: The Guilford Press
- ⁵ Charlton, M., Kliethermes, M., Tallant, B., Taverne, A., & Tisherlman, A. (2004). *Facts on traumatic stress and children with developmental disabilities*. Retrieved from National Child Traumatic Stress Network, www.nctsn.org/products/facts-traumatic-stress-and-children-developmental-disabilities-2004.
- ⁶ Grandin, T. (2010). The world needs all types of minds. Retrieved June 21, 2011, from http://blog.ted.com/talks/lang/en/temple_grandin_the_world_needs_all_kinds_of_minds.html.
- ⁷ Reaven, J. A. (2009). Children with high-functioning autism spectrum disorders and co-occurring anxiety symptoms: Implications for assessment and treatment. *Journal for Specialists in Pediatric Nursing*, 14(3), 192-198.