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 adaptions 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

- **P**sychoeducation and Parenting/Caregiver Supports
- **R**elaxation
- **A**ffective Expression and Modulation
- **C**ognitive coping
- **T**rauma Narrative Development and processing
- **I**n Vivo Exposure

- **C**onjoint parent/caregiver-persons sessions
- **E**nhancing 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. Cohen[3] 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. (Cohen[3] 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.

TF-CBT has been applied successfully to help many persons with IDs. The experiences of the authors and recommended adaptions for persons with IDs are discussed by Grosso[4] and are included in the **following table**:

Treatment Strategies for Children with Developmental Disabilities[4].

Strategy	Purpose	Examples	Goals
Provide **structure**, create **routines**	Children with developmental delays will often have **difficulty** and discomfort **with change**	-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)	-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**	-Adjust **session time** according **to attention span** -**Adjust** dosage and pacing of **gradual exposure**	-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**	-**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"	-Provide **images to illustrate directions** and tasks. -Utilize **visual aids** when teaching skills -**Encourage** children to **draw, paint, sculpt** their **thoughts and feelings**	-Increases **comprehension** -Increases ability to **communicate**

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/researcher[5-7].

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

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.*

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[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.*