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WEBINAR

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11:00:48 >> OPERATOR: The broadcast is now starting; all attendees are in listen-only mode.

11:01:21 >> OPERATOR: Welcome, everybody to today's SPARC webinar. Today's SPARC webinar is Trauma-Focused Cognitive-Behavioral Therapy. We're very happy
11:01:you could join us.

Before I get to introduce our presenter for today, there's just a few housekeeping
11:01:slides that we would like to go over.

Please note that we are recording this broadcast. And we will have it soon.
11:01:Available on our Web site. For viewing.

Live captioning services are available. And you have a contact email there. Dee is

11:02:our person for that.

Please move any electronic handheld devices away from your computer speakers.

11:02:They could interfere with the broadcast or your ability to hear the broadcast.

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11:02:video.

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11:02:presentation you can send questions to the organizer by typing it into the answer a

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11:03:that you have.

At the end of this webinar, we leave time to answer as many of those questions as

11:03:possible.

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11:03:27 Okay. And hopefully, if you have managed to connect to GoToWebinar

successfully, you have a dialogue pane like this. And this one is showing if you clicked

11:03:on telephone, it would give you the number to dial the access code and your unique

audio pin.

11:03:48 As well as the questions box, again, that's the area at the lower part of this pane

that we would like all questions to be submitted that you have.

11:04:04 Okay. So now that the housekeeping is out of the way, let me introduce our

esteemed presenter for today, Dr. Jessica Griffin. Doctor Griffin is an Assistant

11:04:Professor of psychiatry and pediatrics at the University of Massachusetts Medical

School where she has been a faculty member since 2006.

11:04:23 She is also a faculty member here at our research center, SPARC.

Dr. Griffin is a clinical and forensic psychologist with a specialty in forensic

11:04:assessment of children and families, particularly with regard to childhood trauma.

She has expertise in childhood maltreatment in trauma, psychological assessment

11:04:and high conflict relationships and divorce matters. Dr. Griffin is a nationally recognized

expert in Trauma-Focused Cognitive-Behavioral Therapy, or TF-CBT and is the only

11:05:nationally approved TF-CBT trainer in Massachusetts. In 2012 Dr. Griffin was awarded

a four year \$1.6 million National Child Traumatic Stress Network grant by the

11:05:Substance Abuse and Mental Health Services Administration to develop the UMass

Medical School Child Trauma Training Center, which is focused on training, treatment

11:05:and resolving access issues for court-involved youth who have experienced trauma.

With that, I will turn it over now to Dr. Griffin.

11:05:31 >> DR. JESSICA GRIFFIN: Great, thank you, everyone. Good afternoon,

everyone, it's wonderful to be here today. And I have a lot of material I'm going to cover

11:05:over the next 45 minutes, 50 minutes or so and then open it up for questions at the end.

I will be talking about some of the trauma initiatives here in Massachusetts. And then

11:05:trying to move quickly over into an overview of Trauma-Focused Cognitive-Behavioral

Therapy.

11:05:56 So here we go. These are my commercial disclosures. I receive funding from the

Substance Abuse and Mental Health Services Administration and the Administration for

11:06:Children and Families as well as some local foundations and television network.

Evidence-based treatments so very briefly, what are evidence-based treatments

11:06:and why do we care about them? Evidence-based treatments are treatments that we

know have research to support that they actually work so treatments that work that

11:06:have been tested the same which we might test a medication, for example.

So if I go to my doctor to get a prescription for an antibiotic I want to know that

11:06:antibiotic has proven to be effective to treat my strep throat. So these treatments go through the same kinds of rigorous scientific studies that we use to test medications.

11:06:So treatments like trauma-focused CBT has gone through that same sort of research process.

11:06:59 To learn the evidence-based treatments, it typically involves quite a bit of learning and consultation in that particular treatment model, which I'll talk about here

11:07:momentarily.

Where can you find out information about different evidence-based treatments for

11:07:trauma? A source would be the National Child Traumatic Stress Network site that's listed here there are some other resources on here, as well. And I believe that all of

11:07:these will be available on the SPARC Web site for everyone to review in addition to my slides, which will have links to all of this information and the resources that I'll talk about

11:07:today.

Briefly just to talk about the history of trauma work and treatments around

11:07:evidence-based treatments in the Commonwealth, starting back in 2006, actually in central Massachusetts we had our first learning collaborative in TF-CBT through

11:07:another SAMHSA system of care grant here in the Worcester area and that really kicked things off in the evidence-based treatment world when it comes to childhood

11:08:trauma in our state. In the last decade we've had a tremendous number of initiatives and projects focused on really trying to spread the training and different

11:08:evidence-based treatments for trauma.

In 2009, we received a National Child Traumatic Stress Network grant with LUK in

11:08:Pittsburgh to start the national trauma center then this 2012 we were funded here at the

university to establish the Child Trauma Training Center.

11:08:35 I can now today state that as of last week we were notified that we are refunded.

Our center. Until 2021. So we will be available here at UMass to offer the training and
11:08:resources I will talk about today for the next five years. And we expanded our
catchment area to include the entire state of Massachusetts. So that's our great news I
11:08:get to share with this group and I think that's the first time other than sending out an
email yesterday that I've been able to state that publicly.

11:09:03 Okay. Many of you may have heard of the Massachusetts Child Trauma Project.

That's an initiative we wrapped up with the Department of Children and Families where
11:09:we have trained providers across the state in a number of trauma treatments for
children which I'll list here in a moment. The Defending Childhood Initiative is a similar
11:09:effort we had focused in the Boston area. And then there have been a number of
funded National Child Traumatic Stress Network areas across Massachusetts since the
11:09:year 2000 and I will list a few others up here. I included in this set of slides and I'll send
these off to you, Dee, the brand-new grantees for this latest grant cycle, which will also
11:09:be resources to you all depending on where you live in the state.

So I would like to just play a brief video here. And this is about the National Child
11:10:Traumatic Stress Network, which is a wonderful resource for consumers, for schools,
for physicians or anyone working with children who have experienced trauma we have
11:10:all sorts of fact sheets, tools, even webinars on the National Child Traumatic Stress
Network site that are freely accessible at no cost to our community. But I just wanted to
11:10:play this video to let you know a little bit more about the resource for you.

[Music].

11:10:43 >> Children don't remember.

Children get over it.

11:10:51 That's been the conventional wisdom for many generations.

But for many children, that's more of a wish than a reality.

11:11:04 Because for the victims of child trauma, recovery and resilience are anything but guaranteed.

11:11:14 Although it's not always visible to the outside world, child trauma changes the course of a life.

11:11:27 The scars can become a part of who they are and how they see and react to the world.

11:11:36 It affects their relationships. Their families. Their jobs. Their sense of self-worth.

Often child trauma becomes life-long trauma. And it's a tragedy that occurs each and every day in America.

Each year, half of U.S. children age 17 and under are victims of a physical assault.

11:12:1 in 4 witnesses violence. 1 in 10 suffers sexual assault. And one recent year HHS

reported that 772,000 children experienced abuse or neglect. Society also pays the price. Up to 93% of youth entering the Criminal Justice System have been exposed to child trauma and of course significant costs are incurred by families, school systems,

law enforcement, social services, health care providers and systems. How significant?

One study estimated the annual cost of child abuse and neglect to be nearly \$104 billion. Child trauma is a national tragedy. Fortunately now there is help. Now there is hope.

11:12:56 >> The National Child Traumatic Stress Network and its partners are hard at work.

They have become the expert source for information, resources and treatment. They are fighting the consequences of child trauma every day helping children and families.

Developing new therapies. Moving best practices into real world. Helping more survivors. Providing effective treatment. Letting survivors know they are not alone.

Changing the course of children's lives by changing the course of their care.

11:13:45 We can't always prevent the trauma itself. But together we can minimize the impact on all of us. Now with your help. These children can enjoy a bright future.

11:14:04 >> DR. JESSICA GRIFFIN: Okay so that was just a brief overview of the National Child Traumatic Stress Network and the Web site to access the network is NCTSN.org,

11:14:which is also in these slides. And I'll pull it up at the end here, too.

So our last cycle of grantees included folks across the state, Baystate Family

11:14:Advocacy Center out in Springfield. LUK that I mentioned earlier. A Category II site Child Witness to Violence Program in Boston. We have another center focusing on

11:14:refugee children at Children's Hospital. Refugee children in Boston. Trauma Center at Brookline. And us, which we were focused on central Massachusetts but in this latest

11:14:cycle we have expanded as I said statewide.

So the goals of our center were to provide -- and this is pretty consistent with what

11:14:we're doing this next round is providing trauma-informed training to all sorts of groups that interact with children. If anyone is interested in training opportunities, please feel

11:15:free to reach out to me after today's webinar. But we're providing trauma-informed training for all sorts of groups. Courts. Law enforcement. Teachers. Physicians. And

11:15:others who are working with children who may have experienced trauma. Then what we're trying to do is help to get children into treatment as fast as possible. One of the

11:15:things that we have been trying to combat through our effort is the amount of time that children and families are waiting for treatment. With some -- in some agencies they are

11:15:waiting 6 to 12 months for that first therapy appointment which is just not acceptable what we have tried to do with our centralized referral system which is 1-855-LINK-KID

11:15:try to get them as fast as possible we track different agencies and so on I'll talk a little bit more about that later on.

11:16:04 The last thing we're doing is providing training to mental health professionals in Trauma-Focused Cognitive-Behavioral Therapy.

11:16:12 Our target goals, we exceeded in this last cycle. We said that we would train 1800 professionals. And we trained over 13,000.

11:16:24 We plan to impact 20,000 youth and we impacted so far over 160,000 youth. We have -- as of our last quarterly report we had enrolled 822 youth into treatment.

11:16:Our goal of 900. And expect that we will meet that 900 by the end of the month.

So not every area in our state has evidence-based treatments. We're trying to address that problem through ongoing training initiatives.

There's a number of reasons for that. Limited resources. It costs money to train providers in evidence-based treatments and to keep them sustained in agencies. Wait lists are high. Clinic turnover tends to be high in certain agencies in certain regions.

11:17:Our statewide effort we found that it's about a third of clinicians will turn over during the year of training in the evidence-based treatment. And just the demand for trauma

11:17:treatment outweighs our current capacity in the state right now.

So if you're looking -- if you cannot find an evidence-based treatment provider in your area, so someone who is trained to provide trauma-focused CBT you want to make sure they are at least able to provide some type of trauma-informed treatment it doesn't have to be evidence-based treatment that's ideal because if you're not able to find that we want to get children into treatment as fast as we can, you want to include these sorts of components in the work that they are doing with children and families.

So are they screening and using assessment tools? Do they know how to build a strong therapy relationship? Are they providing information about normal responses to trauma?

11:18:01 Are -- is their care -- is there a caregiver element involved it's so critical to be

working closely with parents, caregivers whoever is in a caregiving role for that

11:18:treatment when doing treatment with a trauma component. Are they knowledgeable about child development? Do they know affective regulation skills or feelings are they 11:18:able to talk about feelings, help children understand how to express their feelings more effectively. Are they working on stress management, how to reduce anxiety? How to 11:18:help children improve their relaxation skills? Are they doing some sort of work around cognitive processing or reframing? Helping to challenge childrens' thinking such as it's 11:18:all my fault I was sexually abused. Are they able to talk to kids about those kinds of thoughts? Is there some sort of trauma narration or organization. So giving kids an 11:18:opportunity to talk about what happened. Help them make that unspeakable more speakable for them.

11:18:55 And lastly, are they promoting safety? And many times we want to make sure they are promoting safety in every session with the child and family.

11:19:07 Does every child who has experienced trauma need an evidence-based treatment, absolutely not every child that's been traumatized needs an evidence-based treatment 11:19:or even treatment in that children can be resilient trauma unfortunately is a very common occurrence and there are a lot of factors that go into how resilient a child may 11:19:be.

So you want to look at is there a trauma -- traumatic event or series of events. And 11:19:for many kids we work with, for example, in our project here at UMass, the average number of types of trauma that kids experience is almost six different types of trauma. 11:19:So we need to have at least one type of trauma as well as some sort of trauma-related symptoms. It does not mean they have to have Post Traumatic Stress Disorder. But 11:19:some symptoms so that we know the trauma has impacted this child's functioning. And that there's a change in their functioning and it's impacted them in multiple domains.

11:20:That's why that assessment piece is so important. If you do not ask about trauma, most of the time kids are not just going to freely volunteer that information. So we're

11:20:really working with whoever professionals we're training and talking with, are you asking questions about trauma? What kinds of questions are you asking? It is okay to ask

11:20:those questions. Because most of the time if you don't ask, and there are rare exceptions to this but if you don't ask about it, you're not going to have that information.

11:20:And that can be really important information. Depending on what your role is. For example, we talk with -- do a lot of training for attorneys. Work with attorneys to

11:20:understand have you asked about this child you're representing child's trauma history that may help explain some of the behavior you are seeing they may explain the

11:20:behavior in the courtroom so we're working with attorneys in how to ask those questions.

11:20:56 Okay. Symptoms very briefly here. So trauma can impact kids and adults in a variety of different ways. And it can look different from one person to another. As I said

11:21:earlier, people can be incredibly resilient we can all go through the same traumatic event, everyone on this call or webinar. And about a third of us won't be affected.

11:21:18 And that's dependent on a number of different factors. Related to resiliency which is a whole separate talk here.

11:21:25 We are very acronym happy in the trauma world. So bear with me when I use acronyms and I'll try to spell them out when I can. But one that we use to organize

11:21:trauma symptoms is CRAFTS the symptoms tend to fall into these different domains. Cognitive problems, difficulty paying attention. Difficulty concentrating. Difficulty

11:21:focusing. You may see some academic decline. Even some developmental disabilities for kids who have been exposed to trauma over a long period of time or developmental

11:21:delays for children who have been in chronically neglectful homes or multiple layers of

trauma.

11:22:04 Relationship problems. This could be within -- with their peers. With romantic relationships. But difficulties with attachment. So we may have children who are
11:22:indiscriminately attaching to people. So this may be a child who comes into your waiting room or whatever setting you're seeing youth in and who tells you the first day
11:22:they meet you that they love you or want to sit on your lap. Versus the flip side of that where we have kids who keep you at way more than an arm's length so trauma does
11:22:impact the way we relate to other people.

Affective problems that just refers to feelings and mood. Do we see disturbance of
11:22:mood, more depression symptoms? Anxiety and so on?

Family problems, we know that trauma doesn't just impact that particular child. But
11:22:it can devastate a family system or have significant impact on a family system.

Traumatic behavior problems. This would be things like in young children
11:23:reenacting in their play. I worked with a little boy who was in a car accident with his mother and his mom was killed and he had some minor injuries but he would continue
11:23:to crash Matchbox cars into each other over and over and over again. And in every session. And would reenact this in his play.

11:23:20 In older youth, we might see other types of traumatic behavior, whether it's cutting, other self-destructive kinds of behavior. Poor relationship choices and so on.

11:23:32 Somatic problems would be things like bodily complaints, headaches, tummy aches, frequent trips to the school nurse. And other bodily symptoms.

11:23:43 Complex trauma I'll just talk very briefly about complex trauma. But this refers to youth who don't go through one type of trauma on one day but children who have had
11:23:multiple layers of trauma, so multiple traumas over a period of time. Usually starting in early childhood. And usually involving a caregiver. Not always. But usually involving a

11:24:caregiver. So they grow up learning that the people in my life who I'm supposed to trust, who are supposed to take care of me hurt me or leave me or don't meet my 11:24:needs. And that's an ongoing long-standing theme in their lives. And so what we found and researchers have found and clinicians over the years is that youth with complex 11:24:trauma, treatment tends to look different. It may take a longer time. Even just to establish that trusting relationship. We need to focus more on attachment. And we 11:24:may be addressing safety at every session.

So there are ways in which that complex trauma, multiple traumas over a period of 11:24:time don't always result just in Post Traumatic Stress Disorder but you may have Post Traumatic Stress Disorder but it may also impact them in multiple domains in their 11:24:functioning from relationships to their own biology.

So currently in Massachusetts, right now, the main evidence-based treatments that 11:25:are being disseminated are trauma-focused CBT I'll be talking about in a minute, child parent psychotherapy for young children ages 0 to 6. Attachment self-regulation and 11:25:competency is an evidence informed practice they don't have a trial yet but a terrific treatment focused on complex trauma and parent-child interaction therapy is the newer 11:25:one in our state. Where folks out of Judge Baker Children's Center are providing training in PCIT. And as we have more initiatives in this latest round of funding and 11:25:additional treatments come into the state, we will also include these treatments in our LINK-KID referral system and I'll talk more about that here.

11:25:45 So those are the ones being widely disseminated. How do you know if a clinician has been trained in these? You want to ask. The training looks different across the 11:25:treatments. We suggest that if clinicians are trained in one of these evidence-based treatments they are trained through some sort of learning collaborative or learning 11:26:community model where they are trained with a group of people over a period of time.

That includes a basic training, supervisor training, and consultation, while they are
11:26:working with children and families. They really have found that that helps to deepen the
level of learning and improve the practice in that model. And we can ensure fidelity to
11:26:those particular treatments.

Some of the treatments have national certification programs or rostering systems
11:26:that they are just starting to roll out over the last couple of years.

This is an example of what a learning community or collaborative would look like so
11:26:you have your basic training in that treatment. And then there may be a supervisor
training. An advanced training. That's four to six months after that first basic training.
11:26:But there's monthly consultation as well as team meetings within agencies amongst
clinicians. We also have evaluation data that we collect during the course of that
11:26:training year.

Okay. Trauma-focused CBT that's the picture of the TF-CBT original manual which
11:27:was released in 2006 and there are a couple of new materials I'll highlight at the end
that are also available.

11:27:19 So TF-CBT was developed by Judy Cohen, Tony Mannarino at the Allegheny
General Hospital in Pittsburgh, Pennsylvania and Esther Deblinger is now with Rutgers
11:27:and the TF-CBT is an evidence-based practice as we talked about before.

For traumatized children, adolescents and their caregivers. Although children are
11:27:the identified client in this particular treatment, we're focusing on children, there's a very
heavy caregiver role in TF-CBT but we do think about caregiver relatively broadly
11:27:because not every family we work with has biological parents we work with in treatment.

We may be working with foster parents or with someone else in a caregiver role
11:28:whether it's an Auntie or a baseball coach, whoever is in a caregiver role for that child
we may want to bring them into treatment to help to support the work that we're doing.

11:28:13 So it's a hybrid model so even though it's Trauma-Focused Cognitive-Behavioral Therapy, the CBT at the end, it's much more of a hybrid treatment approach there are 11:28:CBT practices and principles that we see in some of the treatment components but it really is more than just a CBT model there's a very heavy emphasis on family systems 11:28:work and attachment and -- as well those cognitive-behavioral principles.

So the age range right now are youth ages 3 to 18 years although we will be piloting 11:28:TF-CBT with an older age group here for transition age youth hopefully with this new round of SAMHSA funding.

11:29:01 Any type of trauma could be addressed in the TF-CBT model. So it could be a single type of trauma such as a house fire to children who have had multiple traumas 11:29:over a period of time and complex trauma. You need to have some kind of trauma symptoms it to be PTSD but doesn't have to be it could be depression, anxiety or other 11:29:behavioral symptoms although that model we talked about earlier you can do that without the caregiver component although we'll work closely with clinicians to identify 11:29:who could potentially serve in that caregiver role. Done in a number of settings. So from outpatient settings to schools, inpatient we are doing a tremendous amount of this 11:29:within the in-home therapy setting as well as other settings.

We have a very large body of evidence that TF-CBT works. There are over 19 11:30:randomized control clinical trials that have been conducted. And that makes TF-CBT the most rigorously tested treatment for childhood trauma to date. There are no other 11:30:trauma treatments that have that evidence base that TF-CBT does.

It's also been around the longest so we've had more time to conduct those trials. 11:30:And some of the other treatments that are available are also really terrific treatments for kids.

11:30:25 What we have found and I'll just give my very brief summary of the research, when

you compare TF-CBT to a treatment as usual so client-centered therapy or

11:30:child-centered therapy to some sort of control group the good news is that kids in both treatment groups, TF-CBT, and treatment as usual, do better. So that's great so even if

11:30:you're not doing TF-CBT, children are doing better in the client-centered or

child-centered treatments versus in the control group. However children in the TF-CBT

11:31:groups do better faster over many more symptom domains and their caregivers also improve. And those gains are sustained over time.

11:31:10 So caregivers who are participating in the model also have decreased depression, impressed confidence and competence in their parenting abilities, decreased parenting

11:31:stress. And we see significant improvements in trauma-related symptoms in children, anxiety symptoms, behavioral problems, compared to both groups.

11:31:33 And we have done studies in a number of different places. The original studies started in the United States. But several of them -- the more recent research studies

11:31:have included youth who are in the democratic Republic of Congo and Zambia, in the Netherlands. We've had TF-CBT research trials looking at war exposed children,

11:31:children who were child soldiers. Youth rescued from brothels in other countries. And sex traffic victims.

11:32:03 So when we think about can you use TF-CBT for complex trauma the answer there is absolutely yes.

11:32:12 Here is just a list of some of the newer research studies that have come out. Most of these are outside of our country. Illinois Foster Care Study. It was a very large study

11:32:comparing kids in TF-CBT with the typical system of care in Illinois. Who were also in foster care.

11:32:33 Very briefly, our data here, we have -- we just did another download in the last couple of weeks here. We have almost 300 youth in our project. Anywhere between 5

11:32:and a half to 6 types of trauma. So that's different types of trauma. So domestic violence, sexual abuse, community violence, physical abuse and so on. So that's very high as you can see. 40% of our -- kids in our study have identified as Hispanic which we are really proud of. Because we have done so much outreach to try to better improve access for Latino Hispanic families.

And we have not yet written this up yet because we just found out in the last few weeks. But our data when we look at all of the different measured domains, children before and after TF-CBT have shown clinically significant improvement in all but 1 area of 20 something different areas that we measured. So it's really terrific news for kids who have received treatment here locally.

11:33:43 TF-CBT is both a components-based treatment and a phase-based treatment.

And we are providing gradual exposure across all TF-CBT components. So we are helping children to be able to talk about trauma in a gradual way over time throughout the course of the treatment.

11:34:01 Just a few, if you look at this slide, it lists the treatment components there on the left starting at the top with psychoeducation all the way to the bottom which is

enhancing safety those are the components of TF-CBT but you'll see it's broken into three phases so first is the stabilization phase that where we're really teaching coping

skills. The second phase is the trauma narrative phase where we're helping children tell their story about their trauma experiences. And the last phase is really an

integration/consolidation phase where we're trying to bring it altogether in treatment, help children make meaning out of what's happened to them. Focus on safety and then

what do they want their future to look like? What do they want their future relationships to look like and those types of themes we'll address in that last phase of treatment.

11:34:46 Here is another slide I have a couple here that just show you what treatment might

look like over time. So here this would be an 8 to 16 session model so this is not for
11:34:complex trauma. This is 8 to 16 sessions. You can do TF-CBT from 8 to 16 sessions
from start to finish. The whole time we're working on parenting skills. And gradual
11:35:exposure to trauma but here are the phases again so your coping skills are in that
stabilization phase. The middle phase is your trauma narrative phase where they are
11:35:telling their story about their trauma and the last third is the integration phase. When
we're working with complex trauma however it looks different so you may need to
11:35:double the number of sessions from 16 to 25 sessions no more than 30 sessions,
though from start to finish in TF-CBT. When we see that happen, we become
11:35:concerned that there may be other issues that are contributing to treatment taking that
long. It should not go more than 30 sessions which if you think about it is less than a
11:35:year of treatment if they are being seen weekly.

Parenting skills again and gradual exposure happen throughout but you'll see we
11:35:start with safety rather than psychoeducation we are starting with safety and the first
half of treatment is focused just on that stabilization phase, safety and coping skills.
11:36:With the second half focused on trauma narration and that integration phase. 16 to 25
sessions. Should be no more than 30.
11:36:14 Always get concerns when clinicians are learning about evidence-based treatments
it's going to be like a cookie cutter approach or feel like a cookbook I'm here to say as a
11:36:clinician and someone who has supervised folks for the last 15, 16 years in TF-CBT
that it does not feel like that when you're actually practicing the model you are very
11:36:much able to use your clinical judgment and ultimately when we're on call -- I'm on calls
with clinicians and doing some case consultation and they will ask a question, a lot of
11:36:times I'll say, what would you do if you weren't doing TF-CBT and 90% of the time that's
going to be the answer.

11:36:51 So it's not going to make you a good clinician. That comes first. There's a lot of flexibility in the model and sure there are components that we do need to watch. And

11:37:part of my role with clinicians is to make sure they are following the model with fidelity. Going through each treatment component in the order that they are expected to be

11:37:administered. But there are a number of ways in which we can be creative with implementing the components from using music to different YouTube videos to help

11:37:illustrate a point. If we want to use play therapy techniques in there we are able to do that as long as you're maintaining fidelity to the model there are some myths out there

11:37:about TF-CBT I'll hit a few of these I think I have talked about some. Yes you can use TF-CBT if there's no parent or caregiver available. Yes, you can use TF-CBT with kids

11:37:in foster care, with complex trauma. The age range, again is 3 to 18 although we are going to be expanding that here for transition age youth. For youth with developmental

11:37:delays or disabilities, you can absolutely use the TF-CBT model. We do additional training in what that treatment looks like with youth with developmental delays and

11:38:disabilities and TF-CBT has been implemented and studied with kids from a variety of different cultural backgrounds, settings, geographic regions and so on.

11:38:15 So here are your treatment components. Psychoeducation and parenting skills. Relaxation and stress management. Affective expression and regulation. That's just

11:38:our fancy phrase for feelings. Cognitive coping. The trauma narrative. In vivo exposure. Joint parent-child sessions and that safety component and future

11:38:development so I'll talk about each of these very briefly.

So the psychoeducation component, this is where we're providing information about

11:38:trauma. This helps children understand that their past is actually affecting their present.

The behavior we're seeing Johnny is not this bad kid who does bad things but that bad

11:38:things have happened to Johnny in Johnny -- Johnny's body and his brain are

responding exactly how we would expect them based on how we would expect them to

11:39:unfortunately it's getting in the way of his functioning kids who have been through
traumatic experiences sometimes feel like they are going crazy part of what we're trying
11:39:to do is normalize the responses and also normalize the responses of caregivers after
having a child who has been traumatized.

11:39:20 And helping caregivers see that those behaviors that are driving them nuts are --
may in fact be related to the trauma that that child has experienced.

11:39:31 Parenting skills. The next component is we're working very closely with caregivers
across treatment components and trying to improve positive parenting practices in that
11:39:parent-child relationship. We use a number of techniques to do so. But we do that
from the very beginning. Because that typically a children's behavioral issues are
11:39:what's bringing them into treatment in the first place. So we're trying to address those
right away. We do that within the parent component here, as well. But also providing
11:40:parent support. And throughout the process. Even if you have a caregiver who comes
in and doesn't believe that their child has been abused, you can still work with them in
11:40:this model. We may not bring them together with their child until we have had some
time with that but helping to support the parent in -- wherever they are in their own
11:40:understanding of the child's trauma experience.

Relaxation, stress management. This is where we're trying to reduce that

11:40:hyperarousal that many children who have experienced trauma. So when their brains
and bodies are working on overdrive and they are used to their -- their physiology is
11:40:used to having heightened levels of cortisol norepinephrine adrenaline being released
through the body frequently that's going to result in things like irritability, restlessness,
11:40:difficulty sitting still so what we're trying to do is reduce that hyperarousal so they are
able to attend better in treatment but also that can improve a lot of the symptoms that

11:41:we may be seeing outside of the therapy session.

So we're trying to reduce that physical signs of stress. And we do that in a number
11:41:of different ways and techniques from deep breathing to other techniques that may be
considered more out of the box. But they work for that particular child so when we're
11:41:working with an adolescent we'll talk about what makes you chill it may be that shooting
hoops helps them to relax so we may include that into relaxation menu that we work
11:41:from with that family. But we approach the relaxation component very creatively. But
also provide training in more traditional relaxation techniques.

11:41:45 Affective expression and modulation, we're helping kids be able to better identify
their feelings. Increase their feelings vocabulary and express more effectively. And the
11:41:idea is that if children are able to name the feelings and express the feelings more
effectively, they are less likely to use more maladaptive strategies or symptoms that are
11:42:getting in the way of their functioning and/or impacting their relationships.

Cognitive coping and processing. This is where we're helping children and adults
11:42:address their thoughts that may not be accurate or may not be helpful such as it's all
my fault. I was sexually abused. Or you never know when someone is going to come
11:42:into your school and start shooting. So we're working very closely with kids to identify
how to change those thoughts. How our thoughts are related to our feelings and
11:42:behavior and if we impact or change the way we think about a situation, we can have a
really big impact on how we feel and what we do with that and how other people
11:42:behave toward us.

The trauma narrative, this is what I think sets TF-CBT apart from some of the other
11:42:treatments in that we do emphasize the development of a trauma narrative and
treatment. So where children tell their story about what happened to them, about their
11:43:traumatic experiences. And we do this in a variety of different ways.

But this is done so that we can help to desensitize children to any trauma reminders
11:43:they may have, decrease the physiological response they have to trauma. Help them to
make meaning out of their experiences. And also be able to communicate this with
11:43:caregivers. So that ultimately when treatment is done and we're no longer working with
youth, they are able to go to their caregivers should they have a memory again or be
11:43:retriggered by something on a particularly bad day. So they are able to talk with their
caregiver more comfortably about it.

11:43:43 And we do this over a period of time. It's done gradually. We don't jump all in at
once. But we do this over a gradual period of time. And they are able to tell their story.
11:43:So they could do it in the form of a chapter book. Or a three-act play if they like theater
or if they like music they can write a song about it so we work with kids to identify how
11:44:they might want to tell their story about what happened.

The in vivo component is one of the components we don't always do. This is where
11:44:we work with children to develop a plan regarding a feared situation. So it may be that
they are afraid of going to the bathroom in a public restroom or fear of sleeping in their
11:44:own bed or a fear of going to a pool. So we work on an in vivo desensitization plan also
known as baby steps to help them be able to conquer that feared situation.

11:44:39 Joint parent-child sessions. So this is where we bring children and their caregivers
together for children to share their trauma narratives with their parents. But there also
11:44:may be other points in treatment where children and caregivers can come together
around neutral topics. Let's say we want to have a session about psychoeducation and
11:45:about safety. We bring everyone together to do a joint session around that.

So if the clinician determines it's appropriate to do so, you may have joint sessions
11:45:earlier in treatment but toward the end of treatment, most of our sessions are done in
parent-child group family sessions. So that we're trying to promote that communication,

11:45:encourage healing from the trauma.

And the last component is focused on safety. So both bodily safety. But also

11:45:psychological safety. We'll talk about what trauma triggers are. Trauma reminders.

How to plan for those. We'll also talk about future development. Making meaning

11:45:about what's happened to them. So for example, what would you tell other kids who

were sexually abused? Or what would you want people to know if they lost someone

11:45:close to them in a house fire?

And so exclusionary criteria TF-CBT is not appropriate for kids where we don't

11:45:know what the trauma is. We suspect that there's something bad that's happened to

this child but we have no idea what it is, we would not do TF-CBT with that child. We

11:46:need to have at least one identifiable trauma. Now you can know at least one and

suspect that something else has happened you know there's domestic violence but may

11:46:suspect this child has been sexually abused that's okay you can certainly refer that child

to TF-CBT. If the child doesn't have any symptoms and they are doing just fine they

11:46:would not require full course of TF-CBT. You might want to do something abbreviated.

Talk to them about how to keep themselves safe and warning signs to look out for and

11:46:some psychoeducation about trauma but they would not require a full course of

TF-CBT.

11:46:41 Children younger than 3 would not be appropriate for the TF-CBT model. There

are some three and four-year-olds that may not be a good fit depending on where they

11:46:are with their verbal skills and developmental functioning they need to be able to talk

about what happened and have a memory of their trauma experiences.

11:47:00 If youth are actively suicidal, psychotic or substance abusing meaning they are

intoxicated in session not they are just reporting well I smoke weed with my friends

11:47:those who are actively substance abusing meaning they cannot stay sober in session or

if they are actively suicidal or actively psychotic we wouldn't do TF-CBT with those
11:47:youth until they are better stabilized.

It's been adapted for a number of different settings and populations from
11:47:developmental disabilities and young children to juvenile justice settings. Military
families. And other groups.

11:47:33 There are multiple resources available. There's a treatment manual. Additional
texts available. There's web-based training that folks can do in TF-CBT and also
11:47:childhood traumatic grief and if you have done those you have access to web-based
TF-CBT consultation. By the way those are all free. And I'll pull the Web sites up for
11:47:those.

The national certification program in TF-CBT is a at TF-CBT.org this is the online
11:48:training so this is free you can take online they are actually updating it this fall I don't
know the release date yet but I want to let folks know in case you need to -- you go to
11:48:do it and next month the new one is up they released this back in 2012 and 2006
there's the web address if you want to look at the online training.

11:48:20 How to make a referral to EBT's you can contact agencies who have been trained
already but what we're trying to do is utilize the LINK-KID system that we have here.

11:48:We are available statewide now and have a very large database of providers who have
been trained in a variety of different evidence-based treatments, including TF-CBT and
11:48:others.

So any time there's an initiative in the state that does trauma training for EBTs we
11:48:are trying to connect with those clinicians to enroll them in our database and try to make
referrals to those agencies. We're tracking wait lists and so on.

11:48:55 And again this was developed out of a need to improve access. Children were
waiting just way too long for treatment, for trauma treatment, despite all of these

11:49:different training initiatives that have been done kids are still continuing to wait
sometimes when we first were starting 9 to 12 months for a first therapy appointment
11:49:and these were traumatized children, which is not okay.

So because we know the sooner they receive treatment, the better.

11:49:24 So we have two full-time clinical staff who have been trained in the different
treatment models so can work with families to help to make a referral. Anyone can call
11:49:our line we provide a trauma screening on that call. And work with families to try to
make the referral happen as quickly as possible for their children.

11:49:46 And questions you can ask a provider to determine if they are trauma informed.

And these will be in my slides so I won't go through each of these. But you want to
11:49:make sure that you're also asking questions of clinicians if they are not trained in an
evidence-based treatment how do you know if they are trauma informed? Are they able
11:50:to talk about what their practice looks like? Do they have those components I talked
about at the beginning of treatment that are components necessary to be a
11:50:trauma-informed treatment and these are from the National Child Traumatic Stress
Network.

11:50:22 And we are at our Q&A. So I will stop talking here.

>> OPERATOR: Okay. Thank you, Dr. Griffin. We do have a question that came
11:50:in.

Have you had the experience of working with families where the caregivers do not
11:50:seem to be able to make use of what they are being taught through TF-CBT?

>> DR. JESSICA GRIFFIN: Yes. The answer to that is yes. And we will work very
11:50:closely with clinicians to try to troubleshoot, to try to troubleshoot that. Because you are
able to go forward in TF-CBT and just do the child focused components but there may
11:51:be other ways in which let's say a caregiver is just at a point in their life where they are

not able to engage. Or maybe they have their own trauma history and they are being
11:51:triggered by the child's treatment or behaviors and even talking about the trauma is just
too much for them. So we will work with them over time. We may decide that, look,
11:51:this particular parent it seems they would benefit from working with us around safety
and psychoeducation. But as far as being someone who can sit and hear their child's
11:51:trauma story or trauma narrative it may not be the most appropriate decision. So we
may decide to work with additional caregivers who are other sources of support we can
11:51:work with in treatment. But we really address that on a case-by-case basis.

>> OPERATOR: Great. Another question came in. Earlier in your presentation
11:51:you mentioned that in a study of TF-CBT that youth improved in 19 out of 20 areas.
What is the one area where there was no improvement?

11:52:06 >> DR. JESSICA GRIFFIN: Great question. So this is -- and this is actually my
center's data here. And so it's 20 something symptoms. I don't know the exact number
11:52:but there's an area having to do with caregiver externalization. And so we're looking
into what exactly we meant by that. But as far as the child's symptoms go, every single
11:52:area that we measured for kids who are receiving TF-CBT through our project we had
clinically significant findings from pre to post treatment every single area which we don't
11:52:usually see so we're looking at the data again to make sure that is in fact true. We will
be reporting out the results of that in a variety of different formats from presentations to
11:52:some research papers that will be coming out here shortly. But that's actually from our
center.

11:52:59 >> OPERATOR: Great. Another question just came in. How does this approach
work with kids with developmental disabilities?

11:53:06 >> DR. JESSICA GRIFFIN: Great. So we do -- there's a whole specialized training
that I do with clinicians to focus on that issue because it is more than just taking longer

11:53:and repeating things there are ways in which we modify treatment to really leverage a child's interest. So some youth with developmental disabilities have tremendous
11:53:amount of strengths or interests in something like let's say they have a fascination with math or Batman, how am I going to use Batman in every treatment component? There
11:53:may be other ways we want to change the structure of sessions if I know I'm only going to get their attention for a total of 7 minutes then I want to really think about those 7
11:53:minutes and maybe I'm not going to see that child for an hour a week maybe it's three times a week with shorter sessions so it depends on the child it depends on a number
11:53:of different factors but you can use the model yes it does tend to take longer with youth with developmental disabilities. But there also are ways in which we make
11:54:modifications. We do a lot more involving visuals. And for those who tend to think more in pictures, we try to involve more visuals in the work that we're doing. In addition
11:54:to talking about things. We may involve more of the body particularly if they tend to be more on the active side. And try to work with that particular child's individual strengths
11:54:and how can we capitalize on those in treatment to keep them more engaged.

So if they are really interested in Teenage Mutant Ninja Turtles I'm going to think
11:54:about how I can make Teenage Mutant Ninja Turtles in a cognitive triangle to teach them about thoughts, and behaviors so there are a number of ways we make
11:54:adjustments with trainings that's a whole separate training we do with clinicians.

>> OPERATOR: Another question came in are most of your TF-CBT therapists
11:55:providers for Mass Health?

>> DR. JESSICA GRIFFIN: I would say you know I don't know the exact answer to
11:55:that. I would say most of them are providers of Mass Health but also different types of insurances.

11:55:24 We have in our efforts here done a lot of outreach to private practice agencies as

well in addition to our larger mental health agencies. But I would say the vast majority

11:55:of our clinicians do take Mass Health.

>> OPERATOR: And another question has to do with how can independent

11:55:clinicians get training in TF-CBT?

>> DR. JESSICA GRIFFIN: I'm so glad somebody asked that. So because this

11:55:new grant just got funded, we are going to have a private practitioners track in addition

to training. So we're going to have a lot of training opportunities between our center as

11:56:well as our partner site Baystate Medical Center was also funded and they are doing

TF-CBT training statewide focused on clinicians doing in-home therapy.

11:56:10 So between the two programs, we'll have a lot of training opportunities for clinicians

in TF-CBT. I'm going to pull up -- let me just -- ignore the Q&A on my screen and I'm

11:56:going to go down to, this is Genevieve Kane-Howse our program you can email her or

myself if you're interested in TF-CBT training and we can let you know more details our

11:56:first training for our project will be I think in the spring although we have some other

initiatives that may be happening late this fall but no one has decided on the dates or

11:56:times. But yes private practitioners will be able to be trained in our -- through our effort.

>> OPERATOR: Okay. Another question came in, how do you handle working

11:56:with caregivers that do not speak English but they are -- the youth do. And do you have

trained bilingual clinicians? Do you provide the training for bilingual clinicians?

11:57:13 >> DR. JESSICA GRIFFIN: Yes. So we do have trained bilingual clinicians. And a

large number of clinicians in our database are multicultural bilingual clinicians. It

11:57:depends what area they live in as to what the wait times look like but we do provide

training to multicultural bilingual clinicians in fact our last training cohort we did outreach

11:57:and prioritized those clinicians in that training cohort and I think that that's why we see

our numbers reflect -- really reflecting that 40% Hispanic rate we see as a big success

11:57:of our project in engaging those youth. Because we have providers -- culturally competent providers who are able to provide the treatment in English and Spanish.

11:58:05 >> OPERATOR: Okay. And we have a few minutes for a couple more questions.

Actually someone made more of a comment. As a family law attorney, it seems

11:58:courts and attorneys are increasingly trying to discount childhood trauma by labeling it as parental alienation and using it to try to get custody away from the custodial parent.

11:58:I'm not sure if that's something you would want to comment on, Dr. Griffin.

>> DR. JESSICA GRIFFIN: I think that's a really hot topic and a controversial one.

11:58:Looking at parental alienation versus true childhood trauma is something that requires a lot of work on the -- in the form typically of an evaluator or somebody who is appointed

11:58:by the Court to look more closely at that because there are instances in which children are led to believe they have been traumatized by one parent when in fact they have not

11:59:or been abused by one parent when in fact they have not and it looks more like parental alienation but it gets really complicated.

11:59:09 I think we are doing a good job trying to work with the legal system in

Massachusetts and I'm hopeful over the next five years we'll do an even better job

11:59:regarding training. Judges, probation, et cetera. And the impact of trauma. And what childhood trauma looks like. Including in the probate and family courts.

11:59:35 >> OPERATOR: Okay. We have time for just one more question.

It's a long one. I'm just going to read it.

11:59:43 As a parent of two children currently being treated for trauma, what should I expect about my involvement in the last part of the process following the narrative? The -- my

11:59:daughter now 11 was emotionally physically and sexually abused by her brother now 14. And the two children will be involved together in the final part of the treatment.

12:00:08 >> DR. JESSICA GRIFFIN: Okay. So I'm not sure about the -- bringing the

children together piece I would need to know more from that particular clinician around
12:00:the thinking there but the caregiver can expect in the last phase of treatment to be more
actively involved in family sessions so there should be more family sessions as you
12:00:progress towards the end of treatment. It really is like you're passing off the baton from
the clinician back to the caregiver to be the person that that child can turn to for a
12:00:source of support.

So although they have been able to talk about their trauma with their clinician,
12:00:there's no treatment that's going to erase the bad things that have happened to kids
what we're trying to do is help them be able to handle that more effectively so it doesn't
12:00:undo them, trauma doesn't define who they are, and that they are able to have mastery
over what's happened to them.

12:00:58 Part of doing that is allowing them to have someone to turn to when they are having
a tough day or maybe there's a certain time of year that reminds them of what
12:01:happened and they need to lean on someone. We hope that whoever is in that
parental role. So I would expect a lot more involvement in that last phase.

12:01:19 >> OPERATOR: Okay. And with that, I want to thank Dr. Griffin for taking the time
to present her important work during this webinar. We will be posting the webinar and
12:01:slides to our SPARC Web site.

If you still have questions that you would like us to answer, you can email those to
12:01:our webinar organizer at -- it's Deirdre.Logan@Umassmed.edu it will be in the same
email that when you registered that you received. And lastly, be on the lookout for
12:01:email announcements for future SPARC webinars. Don't forget to visit our SPARC
Web site. And to join our mailing list so you'll get announcements of those webinars
12:02:when they are coming up. And always you can find us on Facebook, Twitter and
YouTube so with that thank you very much, everybody.

12:02:13 >> DR. JESSICA GRIFFIN: Thanks, everyone. Take care.

12:02:13 ***

This is being provided in a rough-draft format. Communication Access Realtime

12:02: Translation (CART) is provided in order to facilitate communication accessibility and

may not be a totally verbatim record of the proceedings.

12:02:13 ***