Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for Youth with Parental Substance Abuse

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Inspiration for Today’s Talk

"Do the best you can until you know better. Then when you know better, do better." - Maya Angelou
Disclosures

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No industry funding; no off-label drug descriptions
Learning Objectives

At the conclusion of the session learners will be able to:

1) Describe the 9 core TF-CBT PRACTICE components
2) Describe additional TF-CBT components for traumatic separation and traumatic grief that may be applicable for youth with parental substance abuse
3) Describe results of a TF-CBT Quality Improvement project for youth with parental substance abuse
Review of Definitions

Opiates: Any of various sedative narcotics containing opium (from the poppy plant) or one or more of its natural or synthetic derivatives.

Natural opiates: opium, morphine, codeine, thebaine

Synthetic (“opioids”): man-made, do not occur in nature:
- Fentanyl—extremely potent, powerful against pain
- Heroin (synthesized from morphine)
- Oxycodone, oxymorphine (synthesized from thebaine)

All can become addictive, have similar adverse impacts
Scope of the Problem

- US opioid epidemic, > 70,000 fatal overdoses/year
- Despite modest decrease in prescription opioid OD’s 2015-2019, far outweighed by increase in fatal ODs from illicit opioids, e.g., fentanyl (from ~5700 to >36,000)
- CDC:>87,000 fatal ODs in 1st year since pandemic began—highest since start of opioid epidemic
- Impact on youth: increased risk for multiple traumas (e.g. abuse/neglect, traumatic separation/grief); possible chaotic, unstable placement with relatives; corresponding risk for PTSD and other comorbidities
- Challenges: unstable, chaotic placements, multiple system involvement, caregiver substance use
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

- Evidence-based trauma-focused treatment for youth ages 3-18 years and non-offending caregivers
- Provided in 8-25 parallel youth and caregiver sessions with several conjoint sessions
- For youth with any type of remembered trauma and significant trauma-related symptoms
- Components- and phase-based treatment, incorporates gradual exposure and includes caregivers whenever possible
Empirical Support for TF-CBT

• Evaluated in 23 randomized controlled trials (RCTs)
• TF-CBT significantly superior for improving:
  - PTSD diagnosis/symptoms
  - Depressive, anxiety symptoms
  - Externalizing behavioral problems
  - Sexual behavior problems
  - Negative cognitions (e.g., self-blame; “I am damaged.”)
• TF-CBT also significantly superior for improving parental support, distress, depressive symptoms, positive parenting
• TF-CBT effective for youth with ICD-11 Complex PTSD
TF-CBT Components

• PRACTICE
  ▪ Psychoeducation and Parenting Skills
  ▪ Relaxation
  ▪ Affective Modulation
  ▪ Cognitive Processing
  ▪ Trauma Narration and Processing
  ▪ In Vivo Mastery
  ▪ Conjoint parent-child sessions
  ▪ Enhancing safety and future development
# Components- and Phase-Based Treatment

## Practice Components

**Psychoeducation; Parenting Skills**

**Relaxation Skills**

**Affective regulation Skills**

**Cognitive processing Skills**

**Trauma narration and processing**

**In vivo mastery of trauma reminders**

**Conjoint child-parent sessions**

**Enhancing safety**

## TF-CBT PHASES

**STABILIZATION**

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TF-CBT Pacing and Proportionality

- Psychoeducation
- Relaxation
- Affective Modulation
- Cognitive Coping

Stabilization Phase

- Trauma Narration
- and Processing

Trauma Narration Phase

- In vivo mastery
- Conjoint sessions
- Enhancing safety

Integration/Consolidation Phase

Time: 8-16 sessions

1/3

1/3

1/3
TF-CBT Pacing – Complex Trauma

- Enhancing Safety
- Psychoeducation
- Relaxation
- Affective Modulation
- Cognitive Coping

Stabilization Phase

Trauma Narrative Phase

Integration/Consolidation Phase

Parenting Skills

Gradual Exposure

Time: 16-25 sessions

1/2

1/4

1/4
Composite Case

- 10 year-old boy (Sean); currently living with maternal grandparents
- Mother had history of opioid addiction; died of overdose
  - Sean found mother; tried to perform CPR
  - Called 911
- Mother’s boyfriend had provided drugs; he was physically abusive of both mother and Sean for over two years
- Father was incarcerated for drug charges
- Sean had score on Child PTSD Symptom Scale of 42 (severe PTSD)
- Sean blamed himself for not saving mother; other distortions
  - “It was my fault my Mom died. I should have been able to save her.”
  - “She didn’t love me; she chose drugs over me”
Psychoeducation

- Educate about the child’s trauma experiences, trauma reminders and common reactions to trauma
- Provide education about parental substance abuse
- Provide information about PTSD or other child problems.
- Normalize the child’s and parent’s reactions.
- Provide hope for recovery
- GE: Use direct words for trauma experiences, model mastery not avoidance
Parenting Component

- Parents receive individual sessions for all PRACTICE components.
- Parenting skills to enhance child-parent interactions including:
  - Praise, effective attention, contingency reinforcement schedules
- Help parent connect the child’s behavioral problems to trauma experiences
Relaxation Skills

• Reverse physiological arousal effects of trauma:
• Self-monitoring, daily practice of:
• Focused breathing, mindfulness
• Progressive muscle relaxation
• Exercise
• Yoga
• Songs, dance, blowing bubbles, reading, prayer, other relaxing activities
• GE: Use relaxation strategies when trauma reminders occur
Affective Modulation Skills

- Identify and modulate upsetting affective states:
- Feeling identification and expression
- Problem solving
- Anger management
- Present focus
- Obtaining social support
- Positive distraction activities
- GE: Use skills in relation to trauma reminders
Cognitive Processing Skills

- Recognize connections among thoughts, feelings and behaviors
- Replace thoughts with more accurate, more helpful, and/or more balanced thoughts
- Child’s cognitive processing of personal trauma experiences typically occurs during trauma narration
- TF-CBT Triangle of Life app—freely available via Google Play or Apple Store
Is it accurate?
Is it helpful/does it make me feel better?
Trauma Narration & Processing

• “Speak the unspeakable, make new meaning”
• Gradually develop a detailed narration of child’s personal trauma experiences.
• Develop more helpful, accurate or balanced trauma-related thoughts.
• Not reviewing TN but continuing to use PRAC skills between sessions
In Vivo Mastery of Trauma Reminders

- Only optional component, for ongoing avoidance of generalized reminders (e.g., school, sleeping in own bed, using bathroom)
- Develop fear hierarchy, gradually master increasingly feared stimuli
- May start during stabilization phase—can take several weeks
Conjoint Parent-Child Sessions

- Share TN directly with parent
- May also develop a family safety plan
- Discuss healthy sexuality
- Improve general communication
- Bridge to traumatic grief/traumatic separation components
Enhancing Safety and Future Development

- Safety planning tailored for individual
- Social skills, problem solving, drug refusal, etc.
- Additional skills as individual child/family need
Applications for Complex Trauma

- Engaging in unsafe regulation strategies → safety 1\textsuperscript{st}
- Affect and behavioral dysregulation and lower trust → longer total treatment; longer stabilization phase
- Trauma themes (e.g., “The person who should have protected me hurt me”; “I’ve lost everyone I ever loved.”)
  - Focus of reminders and trauma narration
  - Weave specific trauma experiences into trauma themes
- Parenting component is even more critical to enhance safety and trust for youth with complex trauma
Tasks of Typical Childhood Grief

• Accept reality of death
• Acknowledge what has been lost; address ambivalence
• Preserve positive memories and incorporate positive aspects of the deceased into own identity
• Convert the relationship into one of memory
• Commit to ongoing relationships with living family members and friends
• Prepare for future reminders

Worden, Wolfelt (1998)
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Quality Improvement Study

- Two year project at AGH Center for Traumatic Stress in Children and Adolescents
- Evaluated these TF-CBT applications for youth with parental substance abuse (PSA) vs usual TF-CBT for youth without PSA
- 532 consecutively evaluated youth 7-17 years old
- 182 (34.2%) reported PSA via standard clinical assessment; mean age = 11.9 years, SD = 3.2; 60% female, 67% white
- Outcomes: Treatment retention and PTSD improvement: Child PTSD Symptom Scale (CPSS-5)
CONSORT Flow Chart for Youth with PSA

- 532 referrals → 182 7-17 year olds identified as PSA →

- 22 with CPSS scores < 14 (excluded from study)
- 4 developmentally delayed or used YCPC (excluded) → 156

- 21 referred for non-trauma-focused treatment
- 16 received TF-CBT not related to PSA → 119 started TF-CBT

- 69 completed TF-CBT (58% retention rate)
- 50 dropped out of TF-CBT (42% drop out rate)
TF-CBT Retention Rate

- PSA retention rate: 58%, Non PSA youth: 79.3%, Chi square = 14.07, p < 0.05
- Common reasons for PSA group non-retention:
  - Frequent moves (e.g., back/forth between various relatives, to/from parent with PSA, out of area, etc.)
  - Chaotic living circumstances (e.g., many other children; overwhelmed caregiver; poverty, etc.)
  - Return to parent with substance use D/O
PTSD Improvement

• PSA Group: CPSS-5 improved significantly, from 40.57 (SD = 15.1) to 23.69 (SD = 15.9); t = 8.672; p < 0.001.

• These scores do not significantly differ from those of children without PSA at pretreatment (mean = 42.59; SD = 15.6); t = 0.821; p = 0.412) or posttreatment (mean = 20.93; SD = 13.7; t = −1.139; p = 0.256)
Clinical Significance

- Retention rate for youth receiving parental substance abuse TF-CBT significantly less than other youth receiving TF-CBT.
- TF-CBT applications for complex trauma, traumatic grief, or traumatic separation components can effectively address PTSD symptoms for youth with parental substance abuse.
Impact of Telehealth Services

• Telehealth services during the pandemic has cut cancellation/no show rate at our Center by 50% (to about 10%)
• This has also improved the retention rate for youth with parents with substance abuse issues (to ~ 80%)
  - Can do telehealth wherever they are living
• Recent research has demonstrated that tele-TF-CBT is engaging with patients and has good efficacy
• Challenges still remain re: chaotic living circumstances, frequent/unpredictable changes in caregivers, lack of internet access, especially in rural/remote areas
NCTSN Traumatic Separation Resources

Applying Evidence-Based Trauma Treatments for Childhood Traumatic Separation (webinar):

TF-CBT CTG Resources

TF-CBT Web 2.0: https://tfcbt2.musc.edu

NCTSN Childhood Traumatic Grief webpages: https://nctsn.org/trauma-types/traumatic-grief


Rosie Remembers Mommy: Forever in her Heart: https://www.nctsn.org/resources/rosie-remembers-mommy-forever-her-heart (Spanish and animated versions)

Treating Trauma and Traumatic Grief in Children and Adolescents, 2nd Edition: www.guilford.com/p/cohen
Ready to Remember
Jeremy’s Journey of Hope and Healing
Parenting Skills

• TF-CBT views parents/caretakers as critical therapeutic agent for change
• Explain the rationale for parent inclusion in treatment – Not because parent is part of the problem but because parent can be the child's strongest source of healing
• Emphasize positive parenting skills and enhancing enjoyable child-parent interactions
• Clinical anecdotal data that TF-CBT enhances the quality of the parent-child relationship, including youth with attachment-related issues
TFCBT Web2.0 is a self-directed, asynchronous, distance-learning course for mental health professionals. It provides an overview of basic TF-CBT principles, techniques, and strategies. The course costs $35 per learner and provides 11 CEUs.
CTG Web is a follow-up course that teaches how to apply TF-CBT to cases of child traumatic grief. CTG Web is offered free of charge. 6 hours of CE.

CTG Web was launched on September 1, 2008.

www.musc.edu/ctg
Summary

• TF-CBT includes 9 PRACTICE components provided in 3 phases with complex trauma applications
• Additional traumatic separation or traumatic grief-focused components may be helpful for youth with parental substance abuse
• A Quality Improvement study documented TF-CBT effectiveness for improving PTSD symptoms among youth with parental substance abuse; however, retention rates were lower for these youth.
• Telehealth may be an effective strategy for addressing some access issues and improving retention.
References


“The world is changed one child at a time”
Maya Angelou

Thank you for all you do to help children impacted by trauma!