

PRESCHOOL PTSD TREATMENT

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Michael S. Scheeringa, MD, MPH
Department of Psychiatry and Neurology
Section of Child and Adolescent Psychiatry
Tulane University Health Sciences Center
New Orleans, LA

Lisa Amaya-Jackson, MD, MPH
Department of Psychiatry and Behavioral Sciences
Duke University Medical Center
Durham, NC

Judith Cohen, MD
Center for Traumatic Stress in Children and Adolescents
Allegheny General Hospital
Pittsburgh, PA

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Address correspondence to Dr. Scheeringa, 1440 Canal St., TB52, New Orleans, LA
70112. mscheer@tulane.edu

INTRODUCTION

Manual Development

Preschool PTSD Treatment (PPT) is a theory-driven, manualized protocol based on cognitive-behavioral therapy (CBT) with modifications for young children. Some of these modifications involve parent-child relationship dynamics that are salient for this age group. The manual was created for use in a trial for 3-6 year-old children. Three years of age is about the lower limit at which children can understand and cooperate with CBT techniques. Use with children older than 6 years is possible with adaptations. PPT has similarities with Cognitive-Behavioral Therapy for Sexually Abused Preschool Children (CBT-SAP) (Cohen and Mannarino, 1996) and Trauma Focused Coping (TFC) for 8 to 18 year-old children (March and Amaya-Jackson, 1998). Some of the techniques of CBT-SAP were modified to adapt the protocol to other types of interpersonal traumas. Some of the techniques of TFC were modified to adapt that protocol to preschool children and the parent-child relationship. Modifications were also based on empirical data from the research on the assessment of PTSD in preschool children (Scheeringa et al., 1995, 2001; Scheeringa and Zeanah, 2001), the authors' clinical experiences, and pilot data in this population. One proof-of-concept paper has been published based on this manual (Scheeringa et al., 2007).

i. Cognitive-Behavioral Treatment for PTSD

CBT is an effective treatment modality for PTSD because of the focus on learning theories and cognitive distortions. While it is not known what causes PTSD at the neurocircuitry level, it is evident that these are new behaviors, thoughts, and feelings that were not present prior to a traumatic event that seem to be driven by magnified and automatic cognitive processes. **Behavior therapy** rests on a primary assumption that most behavior develops and is sustained through the principles of learning (Rimm & Masters, 1979). One type of learning, operant conditioning (Skinner, 1953), is particularly useful for treatment because it works by voluntary behaviors (operants) being reinforced by consequences (response). In theory, change in behavior is linked to the strength and frequency of the responses. These characteristics can be manipulated in treatment protocols. **Cognitive therapy** rests on the primary assumption that individuals interpret the world through cognitive structures (schemas) that have secondary impacts on altered feelings and behaviors (Beck, 1967). Cognitions and behaviors are, of course, not independent, and theorists have sought a more realistic amalgam of the two, such as in social learning theory (Bandura, 1969). **Cognitive-behavioral therapy** (CBT) is the rational blending of both modalities, which over the past 30 years has evolved into a diverse group of interventions (Thase & Wright, 1997). The empirically-driven theory and practice of CBT lend it well to systematic and structured treatment protocols.

CBT techniques can be simplified into two components: exposures (systematic desensitization, and prolonged/imaginal exposure) and anxiety management training (relaxation, cognitive restructuring, and biofeedback). Empirical support exists for both categories, plus for combined treatment packages (reviewed in Rothbaum & Foa, 1996). A review of studies identified three factors that were involved in successful treatments: **emotional engagement with the trauma memory, organization and articulation of a trauma narrative, and modification of basic core beliefs about the world and about oneself** (Zoellner, Fitzgibbons, & Foa, 2001). We will address all three of these in this manual. The challenge in working with younger children is how to apply these techniques in a developmentally-sensitive fashion that both the child and parent can

make use of. The ways that we have addressed these developmental challenges are discussed throughout the manual.

Two groups have demonstrated the effectiveness of CBT techniques in younger traumatized children. Cohen and Mannarino (1996a) (3- to 6-year-old children) and Deblinger, Stauffer, and Steer (2001) (2- to 8-year-old children) showed superiority in treatment outcome of CBT techniques in randomized trials. Their groups were limited to sexually abused children and they did not have to have PTSD to be included.

The March and Amaya-Jackson (March et al., 1998) and Cohen and Mannarino (1996a) manuals were blended and modified into a manual for this proposal. The studies that demonstrated the effectiveness of their manuals will be discussed in more detail below.

The Cohen and Mannarino Manual

Cohen (Judith) and Mannarino (1996a) manualized a 12-session CBT protocol for sexually-abused preschool children (CBT-SAP). In addition to using traditional CBT techniques with the children, such as detecting distorted attributions, thought stopping, positive imagery, and progressive relaxation, the sessions included time spent with the mothers. Their manual systematically addressed mother's ambivalence about the abuse, fears about their children's future, new skills to provide emotional support to the children, parent management training, and issues about mothers' own histories of abuse. Therapist adherence to these issues was confirmed with independent ratings of audiotaped sessions.

Sixty-seven 3- to 6-year old children were randomized to either CBT-SAP or nondirective supportive therapy (NST). Thirty-nine children completed the CBT-SAP protocol and 28 completed the NST protocol. Outcome measures were CBCL broad band scales (Internalizing, Externalizing, Total, and Social Competence), Child Sexual Behavior Inventory scores, and weekly ratings of 21 behavior problems. The CBT-SAP group significantly improved on all of these outcome measures except the CBCL Social Competence scale. Whereas the NST group improved on only one measure, the weekly ratings scale. This study provided strong support to show that children as young as 3 years of age can understand and utilize cognitive behavioral techniques.

The authors subsequently reported a strong correlation between parent depression and parent emotional distress scores with the child outcome posttreatment measures, independent of the type of treatment provided (Cohen & Mannarino, 1996b). This indicated the importance of addressing parental distress in providing treatment to sexually-abused preschool children.

The March and Amaya-Jackson Manual

March, Amaya-Jackson and colleagues (1998) manualized an 18-session group CBT protocol for older children and adolescents with PTSD. Children and adolescents were taught to rate the severity of traumatic reminders with a stress thermometer and they created a stimulus hierarchy list. The specific CBT techniques that were used included progressive muscle relaxation, diaphragmatic breathing, thought stopping, positive self-talk, realistic risk appraisal, repeated narrative and imaginal exposures with habituation to anxiety, detection of distorted thoughts, prescribed homework for in vivo exposure and response prevention, and relapse prevention. Seventeen children with PTSD were treated in a group setting at a school. Fourteen completed the entire protocol. Parents were not part of the treatment. Significant pre- to post-treatment improvements were found on multiple outcome measures, including rates of PTSD, depression, anxiety, and anger. This protocol was subsequently refined into a 14-week protocol with a highly-operationalized session-by-session manual.

Can young children do cognitive therapy? Certainly, young children do not have the mature cognitive skills for causal reasoning, perspective taking, self-reflection, verbal expression, or autobiographical memory that would make the cognitive aspects of CBT work smoothly. However, several aspects are listed here for consideration where cognitive therapy appears feasible with young children in this protocol.

- Because young children have probably never been asked to do this type of work before, they are potentially more open to a change in their way of thinking than at any other age, at least in concept, if not in depth.
- In session 1, their symptoms are given a name and put in a story form, which involves the cognitive tasks of self-reflection, autobiographical memory, and causal reasoning.
- In session 3 their fears are placed in a bigger context of other feelings and other situations, which also involves the cognitive tasks of self-reflection, autobiographical memory, and causal reasoning.
- In session 4, they are taught self-control with relaxation tools with the implicit message that these carry a change in locus of control of one's self.
- In sessions 5 through 11, they complete exposure exercises. The protocol does not explicitly identify automatic negative thoughts like CBT protocols for depression, but it is often unavoidable during these narratives to deal with thoughts of whether children felt appropriately or inappropriately safe, powerful, or effective. These are implicitly and sometimes explicitly dealt with during the narratives.
- By being asked by therapists to engage in exposure and relaxation exercises repeatedly, there is an implicit message that control over anxiety is possible.
- In session 11, children are asked to imagine themselves in future situations that may trigger anxiety. This is a purely cognitive task of perspective taking and causal reasoning.
- In sessions 10-12, children review their drawing and homework sheets in their books. This involves the cognitive tasks of autobiographical memory, verbal expression, and self-reflection.

ii. Parent-Child Relational Treatment

The importance of the caregiver relationship as a central feature of psychopathology in infancy and early childhood has been emphasized repeatedly (Crockenberg & Leerkes, 2000; Lyons-Ruth, Zeanah, & Benoit, 1996; Zeanah, Larrieu, Heller, & Valliere, 2000). Interventions designed to improve parent-child relationships have demonstrated improvement in child outcomes (McCarton, Brooks-Gunn, Wallace, & Bauer, 1997; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998; Urquiza & McNeil, 1996).

We reviewed all of the studies that assessed the parent-child association following a trauma that happened to the children (Scheeringa & Zeanah, 2001). Seventeen studies met our inclusion criteria that (a) the children had suffered DSM-IV-level life-threatening events, (b) the measures had to be standardized and replicable, and (c) the children and parents were assessed concurrently. A wide variety of constructs were measured and cannot all be reviewed in this space. In summary, all but one study found a significant association between worse parent outcome and worse child outcome. Many of the studies focused on PTSD symptoms. They found that children with more symptoms of or higher diagnosis rates of PTSD had parents with

more symptoms of or higher diagnosis rates of PTSD. How does this inform how we should treat young children?

These data do not automatically imply that we need to treat the parent or the parent-child relationship. The implications are complicated and there are at least four ways to interpret this association. (1) The shared genetic history of parents and children may equally predispose them to developing symptoms following traumatic events. Moderate associations between specific genes and PTSD are gradually emerging, and it has been shown repeatedly in adults that the highly heritable pre-trauma personality trait of neuroticism is a predisposing factor for PTSD (e.g., Fauerbauch, Lawrence, Schmidt, Munster, & Costa, 2000). (2) It may be that the parents and children who are the most symptomatic suffered relatively more severe traumas; and the less symptomatic dyads suffered less severe traumas. However, when the traumatic event is basically the same for all subjects, the association of more symptomatic parents with more symptomatic children is still found (Cornely & Bromet, 1986; Laor et al., 1996), some studies have shown that individual factors tend to be more important predictors than degree of exposure (e.g., McFarlane, 1989), and even when the severity of exposure is a significant predictor it does not predict the majority of the variance in PTSD symptoms. (3) More disturbed parents may influence their children's symptoms. This suggests a directional relationship effect. That is, parent symptomatology impacts adversely on the parent-child relationship, which has a causal, moderating, or mediating relationship on children's symptoms, at least for a subset of children. In addition, at least one case study has clearly identified parent-child relationship dynamics that hindered the successful adaptation of the child (e.g., MacLean, 1977, 1980). Case studies have also made it evident that caregivers don't have to be involved in the children's traumas at all to be symptomatic themselves and to appear important to treatment success (Pruett, 1979; Scheeringa, Zeanah, & Peebles, 1997). (4) More disturbed children may influence their parents' symptoms. This is also a directional relationship effect but in the opposite direction from what professionals typically think. Parents may develop or maintain their own symptoms because they are distressed by their children's situations. This explanation appears to have traction in our preliminary results.

These are not mutually exclusive interpretations. All four interpretations may be true for one case, or each interpretation may be true for different subsets of dyads. The main point is to recognize the different possibilities, not automatically blame the relationship, and evaluate each patient on a case-by-case basis.

Evidence for the effectiveness of parent-child relational treatment with young children. When it appears that an individual case can benefit from improved parent-child relations, treatment with young children can be conceptualized as having multiple ports of entry for the clinician to intervene into the family system (Stern, 1995). The therapist can target the child's behavior, the child's internal representations of how they feel about themselves and others, the parent's internal representations about themselves and their children, the parent-therapist relationship, and/or the parent-child relationship (Lieberman, Silverman, & Pawl, 2000). Entry at one port impacts the entire system theoretically, so which port of entry is chosen is a matter of therapist choice, convenience, and empirical study. Since intervention at the level of the parent-child relationship for clinical-level internalizing childhood disorders is barely studied, it is worth briefly describing several lines of emerging research in this area.

Eyberg and colleagues have developed an intervention called Parent-Child Interaction Therapy (PCIT) for oppositional defiant behavior in preschool children (Eyberg & Matarazzo, 1980; Hembree-Kigin & McNeil, 1995). The therapist coaches

parents on how to interact more positively with their children and how to improve child compliance with clear instructions and consequences. The technique uses a combination of education, role-playing practice, and bug-in-the-ear microphone coaching. In a randomized trial with wait list controls, they demonstrated improvement in positive interactions, increased child compliance, and decreased parenting stress (Schuhmann et al., 1998). The mean number of sessions for those who completed treatment was 13. They have also demonstrated long-term improvement with follow-up 18 months after treatment and generalization to the school setting (Funderburk et al., 1998). Urquiza and colleagues have extended this intervention to a trauma population. They have demonstrated improvement with case studies of physically abusive (Urquiza & McNeil, 1996) and at-risk for abuse families (Borrego, Urquiza, Rasmussen, & Zebell, 1999).

McDonough developed a technique called Interaction Guidance (McDonough 1993) for preventive intervention with high-risk families. It was specifically designed for families who were “hard-to-engage” and whose previous treatment attempts had been unsuccessful. The number of weekly hour-long sessions is not fixed but typically range from 10 to 12. This technique blends principles of family system theory into a multigenerational transactional preventive intervention. The child-parent relationship is the explicit focus nearly to the exclusion of addressing individual child or parent problems. In practice, the parent and therapist view observable interactions of the parent and child on videotape as the main therapeutic intervention. The therapist uses the videotape playback to elicit from the caregiver their thoughts and feelings about the experience. Sometimes this triggers memories from years ago that are useful to discuss. This method has shown effectiveness in case reports (e.g., McDonough, 1995) and a randomized trial (Robert-Tissot et al., 1996).

Cohen (Nancy) et al (1999) tested a technique called Watch, Wait, and Wonder (WWW) for clinic-referred 12- to 30-month-old children. WWW was designed to support a mother to follow her infant’s lead. For the first half of the session the mother is instructed to play with the child on the floor and to react only to the child’s initiatives. The second half of the session is spent with the therapist asking the mother about her observations and experiences of the child-led play. This is a traditional psychodynamic model in that the therapist does not instruct, give advice or interpret. However, unlike traditional therapy, the focus is on the relationship, not on an individual. In a controlled test against traditional mother-child play therapy with 67 children, WWW showed greater improvements in presenting problems, secure attachments, cognitive development, emotional regulation, parenting satisfaction, and maternal depression.

The PPT protocol dictates that the therapist spend at least part of every therapy session with the caregiver, which could potentially be spent on salient parental issues. The techniques described above are cited as viable examples of how to use the time with the caregivers who have different needs and different strengths. The therapists could be directive and give advice as in PCIT. The therapists could be non-directive and ask the caregivers to reflect on what they watched on the TV monitor between their children and the therapists. These reflections could be steered to discuss the caregivers past individual experiences (i.e., past traumas), akin to Interaction Guidance. Or the reflections could be steered to discuss the parent-child relationship, akin to WWW.

The experience with PPT to date suggests that all of those techniques have value for different situations. But caregivers who benefit above and beyond learning the basics of the CBT techniques from watching their children on the TV monitor and then reflecting about what they viewed with therapists are those caregivers who seemed primed to do this with minimal pressure from therapists. That is, the caregivers appear to do the reflecting and mental processing alone while they are watching the sessions.

They may have been provoked by therapists to think about salient issues, but they make changes in their perceptions, attitudes, and behaviors toward their children largely on their own.

Manual Development

A lower age limit of 36 months was decided upon for initial testing of this manual because that is the time when children have developed coherent narrative memory and verbal capacities. This allows them to fully participate in CBT techniques. This does not preclude using parts of the manual in the future for younger children, with some adaptations.

Developmental Considerations. Much of the prescribed verbal discussions between therapist and children in the TFC manual had to be adapted to be more concrete and/or replaced with drawing for younger children. Cartoons of PTSD symptoms will be used in the psychoeducation session to help children identify their symptoms. The DARRYL, a cartoon-based measure has been shown to be a suitable instrument to elicit PTSD symptoms in 7- to 9-year-old children in an empirical study (Neugebauer et al., 1999). The DARRYL has been used with good results in children as young as 4 years old previously (Richard Neugebauer, personal communication). We will use the Darryl cartoons only to educate the children about PTSD, not to elicit their symptoms.

Whereas the TFC manual prescribed drawing exercises only part of the time and/or as needed for reluctant children, nearly all of the prescriptive exercises in the PPT manual involve drawing. Drawing is a common technique to assist younger children with recall of past memories, to help express internalized thoughts and feelings (Gross & Haynes, 1998), and in particular to facilitate the expression of painful traumatic memories (Malchiodi, 1997; Steele, 2001).

We opted not to include positive self-talk as a cognitive relaxation exercise (such as in the TFC manual) because that would be difficult for most preschool children, although it could be considered for 5 & 6 year-old children. Fewer distressing reminders (5 instead of 10) were required for the stimulus hierarchy compared to the TFC manual because of the less well-developed verbal and abstract capacities of young children. More abstract discussions of how to handle experiences in the future and re-construct a cognitive world schema in the TFC manual were not incorporated because younger children can't conceptualize these dimensions as well.

A module on parent management of oppositional defiant behavior was added based on our pilot data that show this to be a common chief complaint for parents.

Parent-Child Relational Considerations. Consistent with the CBT-SAP manual, the parents are included in every session. However, in the PPT manual, we have operationalized this involvement more systematically and session-by-session.

Based on the research data that show mothers have enormous burdens of their own symptoms and on the clinical experience that mothers are often reluctant to recollect their children's traumatic experiences, we built in motivation and compliance sections for the mother in almost every session. The therapist is directed to preemptively anticipate with the mother that she will feel reluctant to come to subsequent sessions. This feeling is validated, systematically rated on a weekly basis, and addressed in more depth when needed.

Trauma Population Considerations. Based on the pilot data, some families face insurmountable hurdles with simply attending treatment. From a purely logistical standpoint, they may be temporarily homeless, without their own transportation, trying to find a job, and trying to juggle the raising of several children. Participation in treatment

has been identified as a problem specifically for minority families (e.g., Kazdin et al., 1995). From a purely developmental standpoint, preverbal and barely verbal children are often not able to verbalize their emotional distress and this allows caregivers to underestimate their level of disturbance (Scheeringa, 1999). When treatment has been successful at reducing the disruptive behaviors to the point that children are more manageable at home, caregivers are prone to stop coming for treatment, whether or not all internalized symptoms have been treated. From a purely psychodynamic standpoint, caregivers may have their own resistance to treatment because talking about the trauma may arouse memories of abusive or traumatic experiences from their own past. All of these issues will be addressed at the initial session and in a systematic ongoing fashion. In acknowledgement of all of these roadblocks, we have built in free taxi transportation to and from every session, although this may not be needed or affordable in every real-life clinical situation.

Overview of PPT

Session 1: Psychoeducation, overview

Session 2: Behavior management for defiance module

Session 3: Learn CBT tools – identify feelings.

Session 4: Learn CBT tools – relaxation exercises.

Session 5: Tell the story

Session 6: Easy narrative exposure

Session 7: Medium narrative exposure

Session 8: Medium narrative exposure

Session 9: Worst moment narrative exposure

Session 10: Worst moment narrative exposure

Session 11: Relapse prevention

Session 12: Review/Graduation

The Evidence Base

The protocol was tested in a controlled trial funded by the National Institute of Mental Health (R34 MH70827) from 2005 through 2008. One of the two main aims of the study was to examine the feasibility of the CBT techniques for young children. The second main aim of the study was to test the effectiveness of the protocol to reduce PTSD symptoms. The outcome data were published (Scheeringa, Weems, Cohen, Amaya-Jackson, and Guthrie, 2010) and the qualitative use of the manual was described with two brief case studies (Scheeringa, Salloum, Arnberger, Weems, Amaya-Jackson, and Cohen, 2007). Children had to be between 36 and 83 months at the time of the most recent trauma and at the time of enrollment. Exclusion criteria were few, and included moderate mental retardation (MR), autistic disorder, blindness, deafness, and foreign language speaking families. Also, children whose only trauma was sexual abuse were not enrolled because two previous studies had already shown the effectiveness of CBT for young victims of sexual abuse (Cohen and Mannarino, 1996a; Deblinger et al., 2001).

Children were assigned to either Immediate Treatment (IT) (n=51) or a 12-week wait list period (WL) (n=24) to test whether the treatment was superior to naturalistic recovery over time. More children were assigned to the IT condition because there was a six-month phase for refining the manual and the project was interrupted by Hurricane Katrina for about six months which necessitated re-building the case loads. Children were randomly assigned after the refining phase and after re-building the case loads. Thirty-two completed at least one session in the IT group, 20 completed all 12 sessions in the IT group, and 11 completed the waiting period in the WL group. For the test of the

participants randomized to IT versus WL groups, the interaction term for Time by Group was significant for PTSD symptoms, $F=12.97$, $df=28$, $p<.005$. In fact, the WL group showed no significant improvement during the waiting period (mean 7.7 PTSD symptoms pre-wait versus 7.2 symptoms post-wait). The WL showed essentially no change with time while the IT group markedly improved with treatment.

Ten of the 11 children who completed the WL waiting period still met the study inclusion criteria so they were treated with the same research protocol as the IT subjects. Six of these 10 children completed all 12 sessions. They were then combined with the IT group to form a single group to estimate effect sizes of the treatment. Table 1 shows that PTSD had the largest effect size, and the effect sizes for all the disorders were in the moderate to large range except for ADHD. In a series of random effects regression models using all participants, the number of symptoms significantly decreased for PTSD, major depressive disorder (MDD), separation anxiety disorder (SAD), and oppositional defiant disorder (ODD), but not attention-deficit/hyperactivity disorder (ADHD). Mean pre- and post-symptoms are shown in Table 1 only for treatment completers.

Of the 25 participants who completed treatment, 16 could be located and assessed for a six-month follow-up. The effect sizes were again moderate to large except for ADHD, indicating the stability of treatment gains (Table 1). Regression models indicated that the long-term decrease in symptoms was significant for PTSD, MDD, SAD, and ODD, but not for ADHD.

Table 1. Mean number of symptoms pre- and post- active treatment with Wait List and Immediate Treatment Groups combined ($n=22$ to 25).

Disorder	Pre-treatment Mean (SD)	Post-treatment Mean (SD)	Pre-Post Effect sizes Cohen's d	Six months follow up Mean (SD)	Six months effect sizes Cohen's d
PTSD	8.0 (2.8)	4.8 (3.6)	1.01	2.44 (3.12)	1.88
MDD	3.0 (2.2)	1.2 (1.5)	0.92	1.06 (1.57)	1.01
SAD	2.5 (1.8)	1.2 (1.7)	0.72	1.25 (2.08)	0.63
ODD	4.3 (2.5)	2.4 (1.8)	0.89	2.31 (2.36)	0.83
ADHD	7.8 (5.2)	5.8 (5.4)	0.40	7.31 (6.72)	0.09

The symptoms of the primary maternal caregivers were also measured in this study with diagnostic interviews. The maternal symptoms of MDD significantly decreased from 4.2 (SD 3.4) to 2.6 (SD 2.7), but maternal PTSD symptoms, which were 9.3 (4.8) pre-, remained high at 8.0 (4.8) post- and did not significantly decrease.

To confirm the feasibility of using CBT techniques in young children, the children were rated on the ability to complete 60 items over the 12 sessions. The overall frequency for children to cooperate was 83.5%. These ratings were made by the therapists, and an independent rater who scored 30.7% of the treatment sessions agreed with the therapists' ratings 96.2% of the time. The rater-therapists interrater agreement kappa was substantial at 0.86.

Therapists' self-rated fidelity to the protocol was 96.3%. An independent rater scored 30.7% of the treatment sessions for therapist fidelity from videotape and agreed with the therapists 97.1% of the time. The rater-therapist interrater kappa agreement was good at 0.61.

Therapist Prerequisites

This manual provides a highly structured session-by-session protocol for how to conduct PPT. Ideally, therapists ought to have prior training in the implementation of these techniques:

- Cognitive-behavioral treatment in children.
- Treatment of PTSD in children.
- Treatment of PTSD in adults.
- Parent-child relational treatment of preschool children.

Practical Matters

Each session will last approximately 45-90 minutes. In sessions 3-11 half of that time will be spent focused on the child and the second half with the mother. We have the mother watch the child's portion on TV in an adjacent room. This requires a camera and a TV monitor.

Candy and snacks are offered to the child every session. This practice is meant to help make the office an enjoyable place, since most young children are wary of doctors' offices. Food helps break the ice and make the child feel more comfortable. They are offered unconditionally. They are never to be used as rewards or withheld as enticements to influence participation in therapy sessions. Soft candy (e.g., tootsie rolls, Starbursts, caramel chewies) is offered at the beginning because it can be quickly consumed and leave the child's hands free. Chips and juice are offered as a snack after the child's work is done and the parent is busy with their portion. If a parent spontaneously attempts to use the food for contingent purposes, the therapist must gently correct the parent. Offering snacks and drinks to parents must be a more flexible option. Routinely offering a cold drink or snack to the parent for every session is not recommended. However, if this becomes an issue for needy parents, it is not expected that offering minimal snacks would pose a serious threat to the integrity of the treatment protocol.

Take notes while you converse with the children. You will frequently not understand what the children are talking about. Rather than "interrogate" them too much, which tends to be irritating because the children don't know how to express themselves more clearly, it is sometimes best to act as if you understand. Refer to your notes later in the session with the mother alone and have her interpret what the child was saying.

How Closely Should You Follow the Manual?

Follow the manual closely. Very closely. It is strongly recommended that you create "**cheat sheets**" that summarize the tasks that you are supposed to complete in each session. Keep these sheets in front of you during therapy sessions and refer to them often. If you don't create cheat sheets, then you must have the actual manual in front of you during sessions. You cannot memorize all of the manual tasks.

Minor challenges to stay on track arise when a parent asks for advice or information on other topics. These should be handled professionally within the limits of your expertise and comfort. You are always encouraged to use your clinical skills to engage the family, build the therapeutic alliance, and expertise in any way that the caregivers or children appear to need, as long as it is not counterproductive to the treatment strategies of this manual. More major issues are problems that prevent the completion of the treatment tasks, for example, a child who won't cooperate in the

session, or a mother who is too anxious to help her child perform the in vivo homework exposure.

Do not jump forward over topics that are needed for later sessions. The sessions are arranged in the order they need to be followed for skills to develop that are needed for later sessions.

Generally, do not move backward to repeat material. If children do not appear to master techniques initially, it is not likely that they will master them any better simply by repetition. In fact moving backwards to repeat sessions will most likely be frustrating to children who are unable to master them a second time. The manual is designed with much repetition already built into the sequence of sessions but with the repetition occurring in contexts that are increasingly salient to the children. As the office and homework exposures become increasingly anxiety provoking, the techniques naturally become more salient to the children, and this usually provides the motivation and/or relevance for the children to grasp the techniques.

Forbidden Actions

When using this protocol in research to test effectiveness theoretically different interventions need to be avoided to preserve the integrity of the intervention. The following is a list of prohibited interventions:

- Treatments for other disorders, such as depression or obsessive compulsive disorder, that are beyond the scope of this manual.
- Recommendations of reading materials on other techniques, such as flooding or medication, that target PTSD symptoms in either the child or parent.
- Psychodynamic interpretations of thoughts, feelings, or behavior patterns.
- Personal involvement with the children or parents outside the structure of the study.
- The child or parent involved with another mental health clinician simultaneously during the study.

What if New Traumas Occur During Treatment?

Unfortunately, bad things do not happen at random. Children who have suffered traumatic events often live in families that disproportionately experience trauma and adversity. We've developed the following guidelines to follow when a new trauma occurs in the middle of treatment. All of these may or may not be salient.

Mainly, step outside of the manual and spend a separate session (or more) on the new trauma to cover the following suggested topics:

- Get the details of what happened
- Find out what the child actually saw, heard, or understands about it
- Is there ongoing exposure or has the incident truly passed?
- Is the child truly not safe or does the child have an ongoing unrealistic sense of not being safe in the current environment? In other words, do you need to develop immediate safety and/or coping plans for real ongoing threats?
- Is the child repeatedly exposed to family or neighbors talking about it?
- Exposed to it daily from the television?
- Ask the mother what she has already been doing to help the child cope.
- If someone died, is a funeral planned?
- Is survival of the family an issue? That is, does the parent realistically need to be primarily concerned about shelter, food, and safety? If so, the daily nuances of parental sensitivity with children may be lost.
- Does one or more caregivers have PTSD symptomatology from the newest event?

In general, a wait and watch approach for about one month is advocated to determine if new PTSD symptoms will endure from this new trauma. If symptoms endure after one month, then new events should be treated like old events and sessions used to tell the narrative, incorporate events into the old stimulus hierarchy or create a separate one, and conduct office and homework exposures.

“Getting to Know Each Other”

A diagnostic evaluation has been conducted prior to session #1, but you also need to gather other kinds of information to have a good working relationship with the caregiver. You may or may not have been the clinician who conducted the evaluation. Even if you did conduct the evaluation, you often need more time to gather information that is more useful for therapy than for evaluation purposes. If not previously acquainted, you and the family need to go through the rituals of introductions and gather the following information that will be useful:

- Marriage and/or boyfriend history
- Other children
- Who else lives in the home
- Current employment
- Current daycare, preschool, and/or babysitting
- Detailed story of the traumatic event(s)
- Medical issues
- Caregiver’s guilt over “failure” to protect their child

You also could spend some engaging time with the child to build a positive therapeutic alliance. Spend about 15-30 minutes on the floor this session just playing and not asking any sensitive questions. Follow the child’s lead and allow the child to get to know you just by being with you a bit. This is best done with just you and the child, and the mother watching on TV in the next room. If the child doesn’t want to separate from the mother, have the mother stay in the room while you play.

SESSION 1: PSYCHOEDUCATION

CHILD GOALS:

- 1. Get acquainted**
- 2. Education about PTSD**
- 3. Overview of 12 sessions**

PARENT GOALS: Same as child, plus

- 4. Motivation/compliance preparation**

THERAPIST PREPARATION

Materials

- Candy and snacks. The ground rules about candy and snacks will need to be covered. Small, soft candy will be offered once at the beginning. Snacks (chips and juice) will be offered after the child's session, to be consumed while the child plays during the parent's session. For some children, giving the snack during their session actually helps "keep them at the table" literally and increases their compliance. Snacks are not to be used as a reward or withheld as an enticement.
- Two 3-prong binders for the child's book and homework.
- Stickers for the book cover and for homework sheets.
- Markers.
- Handout sheets for the Roadway Book (Appendix).
- Outline of the 12 sessions (Appendix).
- Handout of PTSD and common symptoms from trauma (Appendix).
- Cartoons of PTSD symptoms.

Roadway Books

This book will be one of several methods used to help the child develop a coherent narrative of the trauma absent cognitive and memory distortions. Over the course of the treatment, this book will be filled with projects and homework. It will be organized (session by session) in chronological order. Children will be asked to individualize their books by decorating the cover and naming it.

The book can also serve an important function of containing the distressing memories for the child. While exposure is a fundamental component of CBT, overwhelming exposure is not fruitful. The book can be used symbolically to contain memories until the child is ready to deal with them. The book, and symbolically the memories, stay in the office. At the end of treatment, the child is given the option of taking the book home.

Compliance/Motivation/Therapeutic Alliance

A warm therapeutic alliance makes therapy more pleasurable. However, treatment can be just as successful with more aloof alliances, and an aloof alliance should not slow down therapy. When this does not come so easily, the therapist must be able to adapt her/his interaction style to the temperament and personality level of each individual.

It is important to adopt a "matter of fact" attitude about discussing the trauma that is perhaps more important with younger children than older children. If the child is

reticent to discuss the trauma, the therapist may feel uncomfortable “pressing the issue” because the power differential of age, size, and verbal abilities are magnified relative to older children and adults. This may also feel uncomfortable to the therapist since every session is being observed by the caregiver. If a caregiver has made clear that they have avoided talking about the trauma with the child, the therapist now has two patients to worry about upsetting. Humor can be used to lighten the mood. Despite these potential challenges, the success of treatment depends on the child, and perhaps the caregiver, ultimately being able to confront these memories without disabling fears and anxiety.

An extra, novel emphasis is placed on the therapist telling the parent that it is highly likely that the parent will not want to come back for subsequent sessions. This can be for several reasons. The parent doesn’t want to confront painful memories. The parent doesn’t want to put the child through painful memories. The child improved a bit and the parent has an excuse to stop coming. The parent has started to dredge up traumatic memories from her own past. If one of these reasons stops a family from coming back for treatment, it is already too late to address it. In this protocol, the reluctance to return is anticipated and discussed in the first session and every session thereafter. This preemptively validates the parent’s experience. This intervention has the added benefit of showing competence in the therapist to the parent and helps build trust in the therapist. It shows that the therapist has been through this before and knows what’s coming down the road. Parents are given directive advice to ignore their reluctance and come back anyway.

Child Cooperation

Many young children are relatively unfocused, uncooperative, and energetic in the office for the first 2-3 sessions. They often settle down quickly as they learn the routine. They also settle down in session #3 and beyond because that’s when the caregiver starts going into the next room and the child is alone with the therapist. In most cases, no special plan is needed to manage this behavior if it can be waited out. Have patience.

TREATMENT PROTOCOL

Introduction and Rules

With both mother and child in the room, explain that this is the beginning of therapy and that there are some ground rules to cover: a typical sequence of events that will happen in every session: candy, work focused on child, work focused with parent while child snacks, and then plan homework.

Offer the candy to the child now. If the child is not interested, do not make it an issue. Make it clear that the candy will be put away (out of sight) and cannot come back out this session. For children who try to take more than one piece of candy, don’t use a dish full of candy; offer two choices, or just offer one piece.

Describe the purpose of the sessions

Next, explain to the child that we don’t give shots here. Young children associate doctor’s offices with vaccination shots. Then, make it clear at the start that both the child and the caregiver are here to deal with the trauma and the symptoms of PTSD. Tell them they will learn tools to help them feel better. Tell them we will meet 12 times. Give

the mother the outline of the 12 sessions (appendix: OVERVIEW OF THE 12 TREATMENT SESSIONS).

Describe Posttraumatic Stress Disorder

Briefly describe how we know that traumas can cause symptoms in people. Define a life-threatening trauma. Use examples that are relevant for adults and different ones for little children to give them perspective.

Next, introduce the terms “posttraumatic stress disorder” and “PTSD”. For the children, re-frame it as “your scary feelings” or “your scary thoughts.” We’ve found that the acronym “PTSD” is too abstract for young children.

Next, describe the different kinds of symptoms. Give the mother the handout of common trauma-related symptoms (appendix: HANDOUT OF PTSD). Avoid going through all 17 PTSD symptoms verbally as this is too much information to process. The handout has this detail for the parent to read later. Focus instead on the three types of symptom clusters. Use a made-up example that is different from their real trauma to illustrate.

Next, use the cartoons of some of the PTSD symptoms (available from the author) to help illustrate these concepts to the child. Typically, three cartoons are enough to try with the child. Let the child name the boy/girl in the cartoon (the potential problem with you picking the name is that you may inadvertently pick a name of someone with whom the child had a bad relationship in real life). If they refuse, go ahead and suggest a name for the boy or the girl. Do not encourage children to name the cartoon character after themselves. If they did, this would turn into an exposure exercise and they have not yet learned the relaxation exercises to deal with the negative emotions that might be aroused.

The cartoons often work best if presented as a story. “This is a story about Jimmy. He was crossing the street one day and got hit by a car. Now, every time he plays by the street and a car whizzes by fast, he gets scared and thinks about the time he got hit ...”

We’ve found that three of the reexperiencing items work well:

- psychological distress from reminders
- intrusive recollections of the event
- nightmares

As you go through this story, pick 3 or 4 points in the story to ask the child if they make the connection to him/herself. “That may be like what happened/happens to you, huh?” We don’t want this to become a discussion about the child, but we do want the child to make the connection that we really are talking about the child’s situation indirectly with these cartoons. A simple affirmation from the child is sufficient to confirm that connection.

For children who have experienced more than one type of traumatic event, it appears OK to lump these as you talk about the cartoons, e.g., “That may be like what happened to you when you were in the flood or saw that shooting.”

If the child is not responding much, encourage the mother to use her “influence” to encourage the child to talk. Due to the nature of some traumatic events and the parent-child relationship dynamics that have developed, some children may feel that they need permission from their mother to discuss the event(s). If this is truly salient, this will probably be obvious. You could say to the mother, “Hmm. I wonder if s/he

needs a little permission from you that it's OK to talk about this stuff. What do you think?"

Rarely the explanation of PTSD symptoms with the cartoons works better with the child if the mother is out of the room. If you see that the child is not engaging with the cartoons, consider excusing the mom to the next room to watch on TV and try again alone with the child.

Another option to try if the cartoons are too abstract and don't work well, is to use toy props to simulate the traumatic event. This is only to be done if the cartoons seem too abstract for the child's developmental level. Props should not be used to get the child to talk more about the story. It is contraindicated to re-expose the child to the memories of the event in too much detail before they have learned the relaxation exercises to deal with the anxiety.

End the cartoon story with a happy ending: "The boy/girl came here and got better." Show cartoon of child smiling. This also serves the purpose of educating the child about why they're coming here.

Finally, ask explicitly, "Do you want to come here to make your scary thoughts go away?" If the answer is affirmative, you and the child are essentially making a deal. If not, don't push it.

CHILD

Give the child a snack if they desire one.

Roadway Book

Show the child the 3-prong binder. Explain that over the course of your meetings, this book will be filled with projects. Explain that it will eventually be like a story of the child's life with a beginning, middle, and an end. Write their first name on the cover. They will be allowed to decorate the cover with stickers and/or markers. Do not have more stickers out than you are willing to allow the child to stick on the cover. A control battle over stickers on the first day is not a good start. Each child is asked to name their book. Inappropriate name choices ought to be vetoed or investigated further, as appropriate. If a child cannot think of a name, call it the Roadway Book. You or the child write the new name on the cover.

Complete the first assignment for the book (appendix: **SESSION 1: ABOUT YOU**). Help the child fill in the blanks. When asked what "the scary thing that happened to me was," some children will hesitate because they either don't want to talk about their trauma yet or really don't know what you're talking about. Go ahead and answer quickly for the child if the child hesitates. The point of this is to very briefly make it clear to the child why they are here, not to make it a quiz or a re-exposure episode. In other words, you don't want to spend a lot of time talking about the traumatic event yet. That is saved for Session 5 after the child has learned relaxation exercises.

What if you've got an oppositional child who won't cooperate with the exercise? Try these techniques:

- Don't ask them to do the exercise. Tell them (politely).
- Act indifferent about his/her participation, make no eye contact, and start doing the exercise alone and act like you're having fun. Two identical sheets are provided for this purpose – one for the therapist and one for the child. Provide a running

commentary of what you're doing. Sometimes if you act like you don't want the child to cooperate, this will pull defiant children in.

- Act indifferent about his/her participation, make no eye contact, and make it a competition. Oppositional children are typically competitive. Make gently indifferent comments such as, "Oh, I don't think you'll like this. You probably don't have a favorite color. Well, my favorite color is orange."

Place the completed sheet in the book.

Preview next week

Compliment the child's work. Tell the child that next time they will learn some new tools to make "scary thoughts go away".

Homework

None

PARENT

Motivation/Compliance

In addition to the above work, introduce the topic of resistance to come back for subsequent sessions. Explain that you know from experience that parents are often reluctant to come back. Sometimes it's because parents don't want to think about the trauma anymore. Sometimes it's because parents don't want to expose their young children to the trauma memories anymore. Sometimes it's because old memories get stirred up from the parent's past. Explain that this is very likely to happen as the time approaches to come for the next visit. This is natural and happens to almost every parent. This explanation validates the parent's experience as normal. Explain that unfortunately the success of therapy depends on being able to tolerate this short-term discomfort. Finally, explain that this reluctance will become less as therapy proceeds and you will be asking about this at every session.

In addition, briefly note that the child also may become resistant to return to therapy as the work gets harder, and that you will address that more later.

SESSION 2: Oppositional defiance module

- CHILD GOALS:**
1. Identify coping patterns: a. Child's defiance pattern
b. Parent's leniency due to guilt
 2. Make discipline plan for home
 3. Make plans for grieving, if appropriate

- PARENT GOALS:** Same as child, plus
4. Address reluctance

Therapist Preparation

Oppositional defiance is common in preschool children following trauma. This has been demonstrated in research and, in our experience, is the single most common reason parents bring their young children for treatment (as opposed to PTSD symptoms). Therefore, a special session is devoted to this problem at the beginning and followed up in subsequent sessions. Grieving can also be a problem that parents need help with for young children. The appropriate parts of this session can be "pulled out" and tailored to each child. If neither defiance nor grief are problematic issues for a child, skip this session and go on to Session 3.

Oppositional defiant disorder has no single, clear etiology and is probably the common result of multiple different pathways. That is, it may result from children with extremely difficult temperaments regardless of how their parents manage them. It may result from extreme stress within families. Or, it may result from a combination of these factors. However, in our clinical experience, defiance following trauma often has a clear thread. The parent feels guilty that the child has been through enough already and is reluctant to upset the child further by imposing discipline. Parents are quite cognizant of this dynamic and readily admit it. Fortunately, this type of defiance is usually easily remedied with parent training.

When a loved one has been lost in a trauma, grief can be an important issue. Grief can also be tricky for parents of young children to deal with because they are not sure whether young children should be encouraged to grieve or not. Sometimes the issue is that the parents don't want to think about the loss, and so, by proxy, they discourage the child from talking about the person and evolving through the normal grieving process.

The therapist spends the entire session with the child and parent together.

CHILD AND PARENT TOGETHER

Welcome

As usual, offer the candy to the child.

Review

Begin the usual protocol of reviewing what has been learned so far. Last week they learned about PTSD ("scary thoughts") and started the Roadway Book.

Defiance

Explain defiance. Review from the initial assessment on how much of a problem the parent thought this was. Re-evaluate the situation now. Re-confirm the time course that defiance is a problem that either started completely new or became markedly worse after the trauma.

Rather than ask for the parents' best guesses about why this developed or what to do about it, explain the theory about parental guilt and leniency with discipline. This is such a common scenario that jumping ahead like this saves time. If this theory is wrong, the parent will tell you. Ask for opinions from the both the child and parent about whether this is accurate. (Don't forget to ask about Dad, grandparents, or any other daily caregiver). If confirmed, move on to the intervention.

The key is to negotiate an agreement with the mother that she will work towards ignoring her guilt or empathy towards the child, and enforce discipline. Explain that this is a well-known cognitive therapy technique of recognizing maladaptive thoughts and replacing them with more appropriate thoughts. Instead of thinking, "Poor thing. He's been through too much already", replace it with, "Poor thing. But he still has to follow the rules. Following the rules isn't going to kill him".

If parental guilt leading to leniency is not the issue, ask more questions to explore for other etiologies. Sometimes the problematic issue is the other parent or a grandparent who undermines the mother. Ask systematically how other caregivers handle discipline with the children. Remain open to all possible etiologies of defiant behavior. Another plausible scenario is a parent who needs coaching to provide more positive parental attention and tips on how to promote more prosocial behavior. That is, work on rewards for positive behavior before considering punishments for negative behavior. If no clear cause can be found, the parent management techniques reviewed in this session may still be helpful.

Next, make a list of defiant behaviors on the worksheet for the Roadway Book (appendix: **SESSION 2: BEHAVIORS TO CHANGE**). There are usually one or two recurring situations that mothers would most like to see changed. Pick one behavior as the target behavior for the discipline plan.

Narrow this behavior down to a measurable, clear behavior that you (and more importantly, the mother) can tell when it has been accomplished. For example, if the mother explains that "He's mean" is her target behavior, this is not measurable and clear. Other unacceptable target behaviors include, "He's aggressive", "He hits" and "He doesn't listen."

Clear and measurable target behaviors include:

"He chokes his sister."

"He throws objects at the walls and/or people."

"He doesn't pick up his toys after I tell him three times."

Review the parents' history of discipline techniques, including use of time-out. Go over the rewards that will be used.

Write out the plan clearly and neatly on the worksheet for the parent to take home (appendix: **SESSION 2: DISCIPLINE PLAN FOR DEFIANT BEHAVIORS**). It is extremely important that they leave the session with the plan written on paper. Do not leave this planning of the task up to them to do at home.

NOTE ON TIME-OUT: Misunderstandings about time-out are so common that it is worth a special mention. We do not use time-out to extinguish bad behavior or instill morality. It may extinguish bad behavior in your average child who has no clinical-level disturbances, but that is not our clinical population. If a parent says, "I tried time-out and it doesn't work," then re-educate them on the true usefulness of time-out. Time-out is a last resort measure to temporarily interrupt disobedience or to stop children from harming themselves, others, or property. "Temporarily interrupt" is the key phrase. When time-out temporarily stops a child from doing the unsuitable thing that they were doing, it, by definition, has worked. We generally do not use time-out in discipline homework, but you may still want to address it as an aside.

The child is in the room during this time and may spontaneously interject comments or can be pulled in for suggestions. Most importantly, the child can often be helpful to suggest salient rewards. Sometimes the child can offer helpful information about why they act up. They can also, surprisingly, sometimes admit quite openly that they know mom won't punish them anymore. In addition, it is clinically useful for the child to hear that the therapist is backing up the mom to crack down. This implicit "show of force" helps the child understand that the old situation is changing.

One ought to feel free to talk with the caregiver about implementing a similar discipline plan with a sibling who also shows defiant behavior.

Grief

If a loved one was lost in the trauma, use this time to discuss how this loss has affected both the child and the parent. Explain the normal grieving process, and that, on average, this takes two years. Ask the child if they cry, and if they hide it from their mother. Ask the mother if they cry, and if they hide it from their child. Ask if it is allowed in the home to talk about the deceased. Ask if they went to the funeral. Are they allowed to visit the gravesite? What does the child understand about death? Does the child persistently ask where the deceased has gone? How has the parent answered this question? Did that satisfy the child? The concept of "Heaven" is often too abstract for very young children. A more concrete and satisfactory answer of where the deceased has gone is in a box, in the ground, at the cemetery.

If the child was not allowed to attend a funeral or a gravesite, or if the child simply wishes to memorialize the deceased more personally, a memorial can be created. This can be a picture for their Roadway Book, a letter, a poem, or listing that person's special characteristics.

PARENT

Give the child a snack if they desire one.

Prepare for Next Session

In Session #3, you will be covering feelings with the child. This works best if you know ahead of time what real-life non-traumatic things have made the child scared, mad, sad, and glad. Ask the mom to give a couple examples of each, including examples of different gradations. For example, you want an example of something that made the child a little mad and then something that made the child a lot mad.

Motivation/Compliance

Revisit the issue of reluctance to come to sessions. Ask if that happened prior to today's session. Ask them to grade how strong the feeling was on a scale of 1 to 10. This scaling will be a concrete way to grade the reduction in this reluctance as therapy proceeds. Ask what tricks they successfully used to overcome the feeling. Remember their answer so you can prompt them in the future to use the same trick. Remind the parent that the reluctant feelings are short term and will get better.

Ask if their child seemed reluctant also. Ask them to grade their child's reluctance on a scale of 1 to 10. If either person was reluctant, ask for the reason(s) why to complete the Reluctance Checklist.

Homework

Follow the new discipline plan.

In addition, the mother's homework, if appropriate, is to catch herself feeling guilty and try to ignore it. Fill out the worksheet and hand to the mother (appendix: **SESSION 2: FOR PARENTS: CHANGING MY THOUGHTS**).

Mom gets her own 3-clasp binder for homework. Place the discipline plan and stickers in her homework binder for the mother to take home.

Preview next week

Before they leave, explain that next week you will review the discipline plan and start learning new tools to make PTSD go away. Remind them that they'll start the routine of splitting up next week.

SESSION 3

CHILD GOALS: 1. Identify distressful feelings

PARENT GOALS: Same as child, plus
2. Discuss her own feelings
3. Address reluctance

Therapist Preparation

First, children will learn to identify their emotional and bodily (somatic) feelings in relation to trauma reminders. This is the first step in being able to practice interventions to reduce distress. This is also a key step in the larger goal of producing a coherent narrative of the entire traumatic experience without distortions. Discussion and questions will be used to explore emotional feelings. Drawing on an outline of the child's body will be used to explore bodily feelings.

In addition, if a discipline plan was instituted last week, you will need to vigorously follow up on it. There are generally three possible outcomes at this point. First, if the plan was successful, you will either need to negotiate how it needs to be modified for the upcoming week, or just left in place unmodified. Second, if the parent followed the plan, but the child's behavior did not improve, you will need to decide whether to stick with the same plan another week, "ratchet it up a notch" with more potent rewards or consequences, or choose a different target behavior. Third, **if the parent did not follow the plan, you will need to assertively address this issue now, rather than later.** That is, put the issue of the parent's noncompliance on the table straightforwardly, as opposed to glossing over it. It is highly probable at this point that it was not an accident that the parent did not follow the plan, and it will not be followed in the future if it is not enforced. The counselor is the enforcer. You must sensitively "hold their feet to the fire" and remind them that there are consequences, i.e., their child's defiant behavior, if the parent does not follow the behavior plan.

Welcome

Offer the candy once then put it away.

Review the last session and the homework with mom and child together

Briefly talk about last session. The therapist should do the reviewing as statements, not as questions to the child. It is not anticipated that the child will recall much detail but this sets up the practice of reviewing when it will become more important later. If a new discipline plan was started last week, review how that went. Don't spend more than about 5 minutes together at the start of each session. You just want to get a sense of how the homework went before you start working with the child. If the adults have a long discussion about the child's misbehavior in front of the child, while the child is bored and restless, this sets a negative tone. If needed, politely explain to the mother, "OK, that's exactly what I want to hear about later when we're split up. I want to get started with (child's name) right now, and when you and I talk later I'd like to hear those details."

Before splitting up, briefly explain what will happen next. "We're going to split up and (child's name) and I are going to work on the first tool about identifying different feelings."

Escort the mother into the next room to watch you and her child on TV.

CHILD

Teach the child to identify feelings

You need to make sure children can accurately identify different emotional states. Have a feelings chart laid out on the table for the child to look at with you. This should include faces of happy, sad, mad, and scared faces at a minimum. First, tell the child that this is a quiz about feelings. You must educate the child about what you're trying to do. In other words, don't just dive into the task without explaining what you're doing.

Then verbally give the child scenarios that would generate each type of emotion face. For example, say, *"I bet when you eat ice cream, you feel happy, right? Show me the happy face."* If they successfully pass that one, then do another. *"I bet that when another boy pushes you, you feel mad, right? Show me the mad face."* And so on for sad and scared faces. Lots of different play therapy techniques, drawings, and props can be used to help children identify feelings. Use your creativity.

Some children, particularly those under 5 years of age, may not be able to self-identify any feelings. Nonetheless, praise them for their efforts and move forward.

Second, you need to determine if the child can accurately rate gradations of an emotion. For the scary feelings score, children will have to identify not just feeling scared, but they will have to identify none, a little, and a lot scared. This skill cannot be assumed to be present in preschool children like it can be assumed in older populations. You will need to test to see if the child can do this. Again, this can work best if you have discussed this with the caregiver beforehand and learned what situations make the child a little scared and a lot scared (although this is not foolproof). It also works best if you have enough real life examples for two different discussions. The first set of examples is used for teaching the child about rating gradations of anxiety. The second set is used as a test for the child to make sure they understand it. Have the scary feelings score form on the table for you and the child to look at.

For example, for teaching with the first set, say to the child, *"When you have to go the bathroom alone, this makes you a little scared, right? But when that spider walked on your hand, you were a lot scared. This face is a little scared (point to the little scared face), and this face is a lot scared (point to the a lot scared face)."*

The "fish size" method is often sufficient to help children understand a little and a lot. Hold your hands apart a little bit to demonstrate "a little," like a fisherman showing the size of a small fish that he caught. Then hold your hands apart wider to demonstrate "a lot." You could also use props such as a small stack of blocks for "a little" and a higher stack of blocks for "a lot."

Then, for testing with the second set, say to the child, *"OK, now here's your test. When I explain something that makes you scared, you point to the face of how you feel - none, a little, or a lot scared face. When your mom pushes you too high on the swing, how do you feel? (Hopefully, the child points to the little scared face, and you give praise). When your friend turned the lights off in your room that night at your house, how scared did you feel? (Hopefully, the child points to the a lot scared face, and you give praise)."*

Next, for repetition, make the scary situation into a story, with a drawing exercise. This makes it concrete (and drawing hopefully is fun) for the young child. In other words, don't just say, "When you see a spider, you're scared right? OK, let's draw a spider." Instead, start out by saying, "We're going to make a drawing from a story of when you get a little bit scared. So, this is a story about you, William. One day William was playing with his army soldiers in his bedroom. He was setting up the bad guy soldiers on the floor, and then he put some good guy soldiers up high by the window. When he put the good guy soldiers on the window sill, he saw a spider crawling on the window. The spider was black. This made William scared, and he yelled really, really loud, 'Mom! Mom! A spider. Aaaaaah! OK, let's draw that.'" While you're telling the story, draw this on a blank sheet of paper for extra visual aid. This ought to be about something that makes the child a lot scared, as opposed to a little scared, but each clinician can make a judgement call on what situation to use for each child. The therapist will likely have to assist the child a lot with the drawing.

Next, for repetition, tape a large sheet of butcher paper on the wall, ask the child to stand against it, and outline the body. Ask the child to draw on the body where mad, scared, sad, and happy are felt. Some children are shy or reluctant to have their bodies outlined on the paper on the wall. This may be a problem in particular about body space issues for maltreated children. If reluctant, make a life-size outline without them standing against the paper. It's more important to make it engaging and fun, than to have them comply with everything. If children have a hard time figuring out where to draw on the body outline, give suggestions: heart pounding, head hurts, stomach knots, lump in the throat, and fidgety. Ideally, the child will do the drawing. If reluctant, you do the drawing according to what the child tells you. You may need to make the first drawing to make the exercise clear to the child. It is OK to give suggestions for symbols such as lightning bolts, sun-rays, squiggles, etc.

Next, pull out today's worksheet for the Roadway Book and have the child recreate the drawing from the sheet on the wall to put in their Roadway Book (appendix: SESSION 3: FEELINGS IN MY BODY). Once children have got the concept of talking about feelings try to talk about feelings about reminders in a more abstract sense.

Roadway Book

Place the completed sheet in the book.

Homework

The homework will be on the oppositional behavior again, if needed. Explain this briefly to the child.

Preview next week

Tell them that next week they will learn more about feelings and one more tool to help with reminders.

PARENT

Give the child a snack if they desire one.

Review

Begin by briefly reviewing the last session. If a new discipline plan was started last week, discuss how it went. If the plan was not followed, you must find out in detail why and vigorously address the issues of noncompliance. Congratulate the mother on any attempt. If it was not attempted, gently ask why and why it was difficult. You may be walking a thin line on being too directive. Mothers who can't implement basic discipline at this point typically have an enormous amount of resistance to the idea. You should be directive but can soften it with humor. Remind them that they are the only person who can do this for their child. Their child needs them to do it for them. It may be evident that a particular mother simply can't attempt this intervention at this time. Perhaps the child has not been so oppositional that the mother is at the end of her rope. This time may come later and explain it to the mother this way. You can also "lay it out on the table" that maybe adding tougher discipline is not in the cards. If the mother can live with the child this way, then OK. Maybe this won't be a major issue until the child goes to school. Ultimately, remember that you can't force the mother to do anything. If they are unable or unwilling to work on discipline, then drop the issue and continue with the CBT work.

The mother should be bringing her homework binder with her to sessions. Ask to see it.

Teach about feelings

Review the feelings that were covered with the child. Ask the mother if any of this information was new or surprising.

Obtain any feedback as needed from the mother about what she watched you do with the child. For example, some of the child's garbled words, idiosyncratic phrases, or body language may need to be interpreted for you by the mom.

Motivation/Compliance

Revisit the issue of reluctance to come to sessions. Ask if that happened prior to today's session. Ask them to grade how strong the feeling was on a scale of 1 to 10. Record their answer. Once again, remind that the reluctant feelings are very likely to pop up again, maybe even worse than before for awhile, but that it is short term and will get better.

Next, ask them to grade their child's reluctance to come today on a scale of 1 to 10. If reluctant, ask for the reason(s) why to complete the Reluctance Checklist. Note to them again that reluctance might increase as the work gets harder and that this is natural.

Homework

The homework will be on the discipline plan again, if needed. Adjust the target behavior, reward, or overall plan as needed.

Preview next week

Tell them that next week they will learn more about feelings and one more tool to help with reminders.

FINAL NOTE: If the child showed little cooperation with or understanding of the tasks today, the rule of thumb is not to repeat the session. Move ahead next time with Session 4. Children will get more practice with these techniques in later sessions.

SESSION 4

CHILD GOALS:

1. Learn scary feelings score
2. Learn relaxation exercises

PARENT GOALS: Same as child, plus

3. Address reluctance

Therapist Preparation

Children and parents will learn relaxation exercises. These interventions will be practiced in session and be a homework assignment for practice in the “real world”. It is important to learn a relaxation exercise early on so that it can be used later when more distressing memories are addressed later in treatment.

Another tool for gradually building a coherent narrative with no cognitive distortions is the scary feelings score. This is called a stress thermometer in protocols with older populations. We’ve found empirically that young children don’t understand the word “stress”, but they do understand “scary feelings” usually. And they don’t understand thermometers yet. This is a concrete visual aid for rating the severity of distress. This will be used in later sessions as the child gradually builds up to confronting more distressing reminders.

All of the relaxation exercises described here may not work for some children. A child may completely dislike the relaxation exercises for an idiosyncratic reason, or cannot grasp them, or it may become apparent that another exercise works much better. For example, a child may get a better result from his mother rubbing his belly when he’s upset. Feel free to (a) ask caregivers for other options, and (b) substitute exercises that work.

Welcome

Offer the candy once, then put it away.

Review the last session and homework together

Briefly review last session. If you assigned the discipline plan homework, ask them how it went. If it was not attempted, talk about why it was difficult. Try to keep this all under 5 minutes and in a fairly light and positive mood. Escort the mom into the next room and begin working with the child alone.

Before splitting up, tell the mother that you are going to teach her child how to think of a calm image in his/her head today. Ask the mother what words you could use with her child to help him/her understand the concept. Does the child understand the word “imaginary” yet? How about “make believe” or “pretend?” The mother may be able to suggest a phrase for you to use that the child will understand.

CHILD

Teach relaxation exercises

Explain what you are trying to do before you do it. Following the “full disclosure beforehand” principle, explain that you will be teaching relaxation methods to help with

scary feelings, then you will both practice it. Explain that there are three parts – muscle relaxation, creating an imaginary “Happy Thought”, and slow breathing.

Explain that these will be the child’s tools in their toolkit to make the “scary feelings” or “scary thoughts” to go away.

Start with muscle relaxation since this one tends to be accepted more easily than the others. See the exercise description in the Appendix for an example. This description uses counting by two’s to make it rhythmic and concrete. We’ve found that it’s engaging to describe it as making your muscles “tight, tight” (demonstrate by squeezing your arm muscles) and then “go loose like noodles” (shake your arms around like noodles to demonstrate). You may use your own favorite method too. The point is to try to make it fun and engaging.

Next, explain happy place imagery. Children can learn to self-soothe by replacing scary feelings with this nice picture when they get too scared. You can call it “happy place” or “happy thought” or you may need a different term that they understand better. A happy thought can be some event that was fun (like a party), or someplace calm, like the beach, or someplace familiar, like their mother’s lap, or someplace isolated, like a favorite window seat in their home. Young children do not associate thoughts of being alone as happy thoughts because they are so rarely alone at this age and many are still concerned to some degree of separations. Younger children’s happy thoughts will tend to be about exciting events with other people. Be sure to take notes on the details that the child relates. Draw the image on the worksheet (appendix: **SESSION 4: DRAW YOUR SAFE OR HAPPY PLACE**). Have fun practicing thinking about this together for about 15-30 seconds.

If the child has difficulty imagining a scene with his/her eyes closed, it might help to practice this skill. Tell them to look at a poster on your wall and then close their eyes but keep that picture of the poster in their head. With their eyes closed, quiz them about what’s on the poster. Do this a few times until they can tell you what’s on the poster with their eyes still closed.

Next, teach them about diaphragmatic breathing. Children typically show the most resistance to this exercise. Try to make it engaging by putting your hand on your stomach and making it go in and out with big breaths. Have the child imitate you in a contest. Or, make it a contest about breathing in through the nose, and then out through the mouth. Show the child how to do it and use exaggerated facial expressions like a crinkled nose and puckered mouth. Another way to make it a contest is to have them blow hard and long on something like a pinwheel. Counting and tapping out beats can also make it rhythmic and easier to remember (e.g., “breathe in, one, two, breathe out, one, two, three”). Or, suggest that the child can lie down to make it more relaxing.

Show the training videotape of an “actor” child demonstrating the breathing and muscle relaxation exercises (not available at other sites unless you make your own).

If the child appears embarrassed offer to let them turn their chair away from you, or you turn your chair around.

Teach the scary feelings score

Review that you’ve already learned two tools – how to identify feelings and relaxation exercises. Explain that today you will teach tool #3. Show the child the “frowny face” Scary Feelings Score sheet that has three levels (appendix: **SESSION 4:**

SCARY FEELINGS SCORE). Give examples of mild stressors and severe stressors. Guide the child in filling in the scary feeling score sheet. The child may not be willing to include the trauma on the sheet yet but give them permission by saying, "You're trauma might be the number 3."

Practice a scary thought, the scary feelings score, and a relaxation exercise with the child. You must take the lead and do it together. This can be fun and engaging.

Optional: Alliance Building/Play Time

If you find that you have extra time, consider just playing with the child to increase the therapeutic alliance.

Homework

Show the child the homework sheet. Pick a tentative specific thing to expose themselves to that they know will make them slightly nervous (not related to the trauma). Confirm later in the session with the mother before writing it down.

Preview next week

Explain that next week you'll do another part of the Roadway Book and learn some new things about how to control reminders.

PARENT

Offer the snack to the child, if desired.

Review Last Session

Briefly review the last session.

Review Homework

Look over the discipline plan homework sheet. Discuss with the mother how this went. Ceremoniously place the completed homework sheet in the Roadway Book. If the homework was not completed, ask why, and help problem solve on how future homework can be facilitated.

Teach relaxation

Go through the steps of explaining the relaxation exercises. Make sure she understood what she viewed on TV. The mother will be expected to prompt the child to practice this at home so she needs to fully understand what is involved.

Some mothers may decide to use these exercises for themselves. While this manual does not prescribe that mothers use these exercises for themselves, it is entirely acceptable to go down that path with caregivers if it seems compelling.

In addition, ask the mother what she uses at home to comfort her child. These tried and tested methods may be able to be worked into the relaxation exercises.

Teach the scary feelings score

Review the scary feelings score. This can probably be done in abbreviated fashion if the mother was paying attention earlier. Ask the mother if any of the conversation with the child surprised her. The mother will be asked to help the child

practice this at home once next week so the mother will need to completely understand how it works.

Have Mom Draw Bird's-Eye-View Diagram of Traumatic Scene

In the next session (session #5) , you will be asking the child to tell the story of their worst traumatic experience. It will be enormously helpful to you to already possess a map drawn of the physical layout of the scene. Ask the mom to draw on a piece of paper a bird's-eye-view diagram of the scene.

Possible Boundary Issues

Some caregivers are inappropriately intrusive beyond their children's personal boundaries for privacy and confidentiality. By now, you will probably know if a caregiver has that issue. For example, a caregiver may tell family members inappropriate things about what the child is doing in therapy. Or, the caregiver may try to get the child to do their homework and relaxation in front of other family members even though the child is obviously embarrassed. But even if the caregiver does not appear to have a boundary issue, it is worthwhile to give all caregivers the following spiel to preempt an awkward scene in the future.

"In our experience, some children get embarrassed if their therapy is talked about with other family members. And if this happens, they won't do the homework or they won't talk to me anymore in therapy sessions. I just need to warn you about that ahead of time."

Motivation/Compliance

Revisit the issue of reluctance to come to sessions. Ask if that happened prior to today's session. Ask them to grade how strong the feeling was on a scale of 1 to 10. Compare this to their rating last week. Ask what tricks they successfully used to overcome the feeling. You may need to prompt them to use the trick they used before that worked. Once again, remind them that the reluctant feelings are very likely to pop up again, maybe even worse than before for awhile, but that it is short term and will get better.

Next, ask them to rate the child's reluctance to come today on a scale of 1 to 10. If reluctant, ask for the reason(s) why. Remind them that if reluctance is going to increase it typically happens around sessions 4-8 and is natural. Give them verbal support that they will need to tolerate the reluctance to get through this hard part of the treatment.

Homework: Test drive the rating and exercises

Fill out the homework worksheet (appendix: **SESSION 4: HOMEWORK: HOW MUCH I'M SCARED**). Place the new relaxation homework check sheet and stickers in the homework binder. Explain that they will need to prompt their child to (1) expose him/herself one time to a specific thing that is known to make the child slightly nervous, (2) rate him/herself on the scary feelings score scale, and then (3) practice the relaxation exercises. This must be done at home with the parent.

If you and the mother picked a target that is different from what you discussed with the child, bring the child in the room to explain this briefly.

This must be done one time at home with the parent. The plan must be very explicit with the VERY SPECIFIC target, date, and time written down on paper BEFORE THEY LEAVE.

Explain to the mother explicitly that another purpose of this homework is to figure out which of the three relaxation exercises the child likes the best. Tell the mother to remind the child of and do all three exercises during the homework, but the child doesn't have to do all three.

Explain that the purpose of this homework is a test to see if the child really understands how to use what has been learned about these exercises. Make it enormously clear to the parent that this is to be a planned time for practicing. They are not to make their children use the relaxation exercises in the midst of a temper tantrum. These exercises are not for that purpose.

This has the potential to become a control battle. Explain extremely clearly to the parent that if the child does not want to do it that they should never be pressured or coerced. They can remind the child of the reward sticker once a day, but then it should be dropped. A paradoxical "Tom Sawyer" trick may be for the parent to do the relaxation exercise and act like it is enormous fun.

Keep an eye out for the subset of children who have anxiety sensitivity (Weems et al., 2007). That is, they get anxious about becoming anxious. They will get so worked up about the prospect of doing any exposures that might make them anxious that they can't ever get to the point of actually doing the exposures. If you suspect this, investigate this systematically as soon as possible by interviewing the mother to confirm or disconfirm it from past history. If anxiety sensitivity appears to interfere, then candidly ask the child about this, and this can then become the actual early target for homework.

CAUTION: Do not give caregivers permission to do this homework more than one time in the next week: There is a subset of caregivers who will either misunderstand this homework or deliberately do it differently no matter how persuasively you explain it. The worst-case scenario is a caregiver who jumps the gun and decides to start breaking their child of a phobia. For example, one caregiver decided to try to cure her child of being afraid of the dark immediately by placing her child in a dark room and telling the child to use the exercises daily. This was inappropriate, too fast, too scary, and had the potential to sabotage the rest of treatment. Another caution is that if they do the exercises incorrectly for some reason, you don't want them doing that daily. There is absolutely no reason to assign this homework more than once per week.

Think of this homework as the test drive. You don't need to test drive daily. Once per week is all that is needed to practice this.

Preview next week

Explain that next week you'll start talking more about the child's actual symptoms and how to use the tools they've learned.

FINAL NOTE: If the child showed little cooperation with or understanding of the tasks today, the rule of thumb is not to repeat the session. Move ahead next time with Session 5. Children will get more practice with these exercises in later sessions.

SESSION 5

CHILD GOALS:

1. Tell the story
2. Create the stimulus hierarchy

PARENT GOALS: Same as child, plus

3. Explore caregiver's own trauma history and current symptoms
4. Address reluctance

Therapist Preparation

Now that the child has learned about PTSD and developed tools to deal with distressing reminders, the next task is to start constructing the coherent narrative. The child will be asked to tell the whole story of what happened from start to finish. The two goals of today are to use this session as narrative exposure for habituation to anxiety, and to build a stimulus hierarchy of distressing reminders. This may seem too stressful to the inexperienced clinician, but most children welcome the opportunity to talk about what happened to them.

Helpful comments from the therapist ought to be geared to helping the child understand that it is important to have an organized and accurate story of what happened, including their thoughts and feelings along the way. Include smells, sights, sounds, tastes, or touch sensations that were relevant. This will help the child think, feel, and behave in ways that are consistent with their past experience, rather than in ways that perceive the whole world to be threatening and dangerous.

You ought to take notes during the story to record details accurately. Make sure you record events in the correct timeline. The stimulus hierarchy is simply a list of reminders arranged from the least scary to the most frightening. This list will be used to pick items for office exposures and homework exposures.

What if children had more than one traumatic event in their lives? Which story do they tell? Can you mix and match events on the stimulus hierarchy? Obviously, children can only tell one story at a time. Discuss with the children (and/or the caregivers) which single event was most scary or memorable, and start with that one. If children spontaneously start talking about additional events, allow them to do this freely. The stimulus hierarchy can include reminders from more than one event.

You may be finding that you're energy is drawn more to dealing with the mother than the child. In contrast to protocols for older children, we encourage dealing directly with the caregiver's symptomatology. You will be talking with the mothers as much as with the children. We generally do not initiate referrals for mothers to other therapists during this protocol for a variety of reasons, with exceptions.

Welcome

Offer the candy once, then put it away.

Review the last session and homework together

Briefly review last session. Discuss the homework practice, and ask about how it went. Congratulate the child on good reports.

As usual, try to keep this all under 5 minutes and in a light and positive mood. Escort the mom into the next room and begin working with the child alone.

CHILD

Rehearse the Relaxation Exercises

Briefly review the three relaxation tools – muscle relaxation, happy place imagery, and diaphragmatic breathing – for practice. Repeat what you did in Session 3, but you will be able to do it much faster this time. Children really need to demonstrate these all in front of you to make sure they remember how to do them.

Tell the trauma story

Explain that you're going to do something new together. Then explain why you're doing it. Explain that you will take notes on the worksheet (appendix: **SESSION 5: THE WHOLE STORY ABOUT WHAT HAPPENED**). The way this task is explained to the child will depend on the developmental levels each child shows for verbal and abstract capacities. Basically, you need to get a complete picture of the trauma story. Explain that you know this probably will not be fun to talk about but that it is an important job. Older children may be able to grasp that the purpose is to develop a complete story of the trauma in order to help with the child's treatment. Younger children may not find this a compelling rationale. Greater cooperation may be obtained from younger children by telling them that we need to get the whole story of the trauma for the Roadway Book. Show them the work sheet that needs to be filled in with your help. Other explanations could be that you need the child's help to make sure we're not missing any important details of what happened. You will be like detectives to look for clues. The more "competitive"/ oppositional children may find more motivation if this is made into a contest.

During the process, ask the child how they felt during key parts of the trauma. Help them with cues by asking about fear, helplessness, and anger. Use these details to complete the work sheet for today.

Young children do not have the skills yet to give lengthy, detailed narratives of past events. Without guidance, most children would tell their stories in less than a minute. After allowing each child to tell their stories uninterrupted, you will need to go back and lead each child through their stories step by step:

- What was happening before the trauma happened?
- Who was present?
- Don't forget to ask about pets.
- Where exactly was everybody and what were they doing?
- What exactly was the child doing before the trauma happened?
- What were the first signs of danger?
- What was the child's first reactions?
- What did the child wish they had done but didn't?
- Does the child remember what s/he was wearing?
- Any smells or tastes associated with the events?
- For car accidents, was the other vehicle a car, van, SUV, pickup, or truck?
What color was it?
- For domestic violence and maltreatment, what other objects or furniture in the environment were memorable?

Write down notes for yourself of a tentative stimulus hierarchy of the most distressing moments. Try to get at least five moments on the list.

After recounting the whole story, check the anxiety level of the child. Practice the relaxation exercises regardless of their score. If anxiety is a 2 or 3 on the scary feelings score, use the exercises to bring down their anxiety to 1. Keep working with the child until the anxiety comes down.

Congratulate the child on bravery and a job well done.

Ceremoniously place the worksheet in the book.

Completing the stimulus hierarchy

Show the child the worksheet (appendix: SESSION 5: STIMULUS HIERARCHY) that needs to be completed today. Explain that the job today is to list the scary moments from the least scary to the most scary. This sheet will be put in the Roadway Book and used in later sessions. It's quite important that the reminders are listed in the correct order. The therapist uses the notes made earlier. Rank the reminders using the scary feelings score. Complete the work sheet. Three to five items for the list are the most that young children can be expected to comprehend. Compliment the child on bravery again.

What if the child rates all reminders the same? We've found that some children rate everything the most scary. One possible solution is to ask the caregiver to decide which are really the least and most scary. Also keep in mind what can be turned into homework exposures and what might be physically impossible.

Homework

Show the child the worksheet for the next week of homework and that will be similar or the same as last week. The assignment is one practice.

Preview next week

Tell the child you look forward to seeing them next week.

PARENT

Offer the snack to the child as usual.

The trauma story from the mother's perspective

Typically, a parent has never heard their child tell the whole story of the trauma from start to finish. This can be a powerful experience, not only in the sense of their feelings of empathy for their child but in the memories that are stirred up in themselves. A good opening question is usually, "What did you think while you were listening to that?"

Her responses will most likely be from the trauma, but can also be from the mother's childhood. The mother ought to be given the opportunity to express any and all of these. Some mothers will need no prompting to talk. Others will need an invitation that is OK to focus on themselves.

Some mothers may be visibly upset. This can be a good time to ask the mother whether her distress is evident to the child at home and possibly impacting on the child. Ask if this kind of distress she is showing occurs at home and can the child can tell when this happens? Does this stop the mother from talking about the child's trauma?

Begin thinking to yourself whether the mother is focused primarily on her child's traumatic experiences or is preoccupied by her own. The goal of this therapy is to have the mother focused on the child. If the mother appears preoccupied with other

experiences, this is not yet the time to be directive with her, but the therapist should be keeping mental or written notes about it.

When you have either run out of time or run out of material, transition sensitively from this topic to stay on track with the protocol.

Review Last Session

Review the old worksheet for the relaxation homework. Make sure they are filling out the scary feelings score correctly. Review the relaxation exercises and make sure they still understand the purposes of this.

Possible Boundary Issues

Revisit the boundary issue if you feel that your preemptive discussion in session #4 was not enough. "I mentioned this last session, and I want to remind you again of how important confidentiality is for children. It appears that your child does not like (fill in the blank of the situation that embarrasses the child, i.e., caregiver asks too many questions, caregiver tells family members the child's personal business, etc). I'm afraid this could get in the way of him/her cooperating with me. So, I want you to try to catch yourself when you're about to (fill in the blank of what the caregiver does inappropriately). When you catch yourself about to do this, try to stop yourself. When you come in next week, tell me how many times you caught yourself, OK?"

Motivation/Compliance

Revisit the issue of reluctance to come to sessions. Ask if that happened prior to today's session. Ask them to grade how strong the feeling was on a scale of 1 to 10. Compare this to their rating last week. Remind them that especially after today's session the reluctant feelings are very likely to pop up again, but that it is short term and will get better.

Next, ask them to rate the child's reluctance to come today on a scale of 1 to 10. If reluctant, ask for the reason(s) why. Remind them that if reluctance is going to increase it typically happens around sessions 4-8 and is natural. Give them verbal support that they will need to tolerate the reluctance to get through this hard part of the treatment.

BRING CHILD BACK INTO ROOM

Homework

Give them the homework worksheet (appendix: **SESSION 5: HOMEWORK CHECK SHEET: PRACTICE ONCE, SCARY FEELING SCORE**). Explain that they will need to prompt their child to practice the scary feelings score and relaxation exercise once in the next week, just like last week. (not related to the trauma). The plan must be very explicit with the VERY SPECIFIC target, date, and time written down on paper BEFORE THEY LEAVE. They will need to place a sticker in the box at home when completed.

As with the previous homework, you may still be trying to determine which of the three relaxation exercises the child likes the best. Explain this again to the mother. Tell the mother to remind the child of and do all three exercises during the homework, but the child doesn't have to do all three.

(Note: in this and future homeworks, children may spontaneously use relaxation for innovative and/or unique purposes. For example, a child may integrate a relaxation exercise into a magical destruction of a bad object on their own. If this happens, go with it as long as it appears positive towards the child's healing.)

Preview next week

Explain that you'll start practicing narrative exposure for the next 5 sessions.

FINAL NOTE: If this session did not produce much detail in the trauma narrative or cooperation from the child, it is tempting to want to try to repeat this session, but don't. For a variety of reasons, if it didn't work smoothly in Session 5, it is unlikely to work more smoothly one week later. Keep moving ahead and stay on track with the protocol because the children will get more practice with narratives in the subsequent exposures.

SESSION 6

- CHILD GOALS:**
1. Easy narrative exposure
 2. Safety planning
- PARENT GOALS:**
- Same as child, plus
 3. Follow-up on caregiver's history and symptoms
 4. Address reluctance

Therapist Preparation

The main task today is to practice an easy narrative exposure. Easy items that the child can already tolerate fairly well are picked first. You will work together over the next five sessions up the list toward the "worst moment". Do not let an over-eager child pick their worst moment for their first exposure practice. Conversely, you may need to encourage anxious children to move more quickly up the list.

Producing the ideas for the exposures for the children often requires creativity. To help with that, the drawing/narrative exposures in the office and the homework exposures that we've done with over a dozen actual patients are listed for a variety of types of traumatic events at the end of this session.

A new topic will be introduced today on safety planning (Runyon et al., 1998). Over the next four sessions, the children will learn to identify early signs of danger, how to remove themselves from dangerous situations, and how to get help. Today's session will focus on the identification of early danger signals and making the safety plan.

As mentioned for the last session, the time spent with the mother in this and subsequent sessions, may be the most energy-consuming for you. If a mother is compelled to talk about her own intense symptoms and/or horrific childhood experiences, it may feel to the therapist as if the work with the child is being overshadowed. Remember that the child is not being shortchanged because you always have individual time with the child. Furthermore, one premise of this protocol is that it can be partially a dyadic treatment. Improvement in the mother's symptomatology may lead to improvement in the child. Continue to explore and pay attention to whether the mother seems focused on the child's traumatic experiences or seems preoccupied by her own.

Welcome

Offer the candy once and then put it away as usual.

Review the last session and homework together

Briefly review in under 5 minutes. Mention that you had an important session last time. The child was very brave in talking about the whole trauma story. This was enormously important for making PTSD symptoms go away. You are very proud of the child.

Ask how the homework went.

Next, split up as usual.

CHILD

Easy Drawing/Imaginal exposure

Next, explain that the child is going to start making scary feelings (PTSD) go away. They will need to pick an easy item from their list, draw it, then imagine it, and tolerate the anxiety until their fear goes down to a 1 rating. For this easy task, this may not take long. Give some examples first, such as going to a new place, hearing thunder, or going to the doctor. The first time is the most scary, but it gets less scary the fifth time, and is not scary at all the tenth time. This is what will happen with the PTSD list.

Pick an example from the child's PTSD list and explain the same way that the scary feeling will go away with exposure.

Some children feel relatively more anger than fear from these exposures. If you only use the words "scared", "nervous", or "anxious" with them, the task may not have salience for them, and it will look like it is not working with them. If this appears to be the case, consider using an emotion word that more accurately reflects their feelings stirred up by the reminders. If it's not fear or nervousness, it is usually anger, but it could be sadness or some other negative emotion. Older children can adapt on their own if you are using the wrong emotion words, but preschool children tend to follow your directions more literally.

Finally, have the child pick an easy item from the list for the first in-office exposure. Ask the child to draw a picture of this item. Give the child the worksheet for the Roadway Book with empty space for drawing (appendix: **SESSION 6: DRAW THE "NOT TOO SCARY" REMINDER**). This is labeled the "easy reminder". The purpose is to stay mentally in the situation until they are not scared at all. They may even get bored. Overall, this ought to last several minutes, or the amount of time it takes to draw the picture. The child can use the relaxation exercise to help him/her stay with the scene until the scary feelings go away. This sounds simple, but it can be a rather long affair for children who have difficulty and need guidance on what and how to draw. For children who simply can't or won't do the drawing, you can do the drawing and narrate out loud as you go. Other children may take a long time because they want to spend a lot of time on the drawing. Have patience.

Ask for the scary feelings score at the beginning for a baseline rating and then every three to five minutes thereafter. "How scared are you now. None, a little, or a lot?" Keep a copy of the scary feelings score in view on the table for the child to reference. We've found that we need to be a bit leading with young children. Young children do not have fully developed skills yet for the meta-cognitive task of self-monitoring their internal states and then reporting these states to another person. They need some scaffolding to understand this exercise. It is useful to remember that in the early sessions you are probably educating the child on how to do this exercise as much as anything. We approach it in a two- or three-step ritual:

1. Before asking the child for their rating, ask the child, "*Did that make you feel more nervous? Did your scary feeling score go up?*"
2. Then ask the child to point on the rating sheet to the face that matches how s/he feels. They can also hold up the number of fingers – 1, 2, or 3.

3. If the child has finished the drawing and the score is still “a lot scared”, or the child seems particularly anxious before the drawing is finished, say, “*Now, we’re going to do one of our tools to make the scary feelings go away.*”

Do the relaxation exercises even if the child claims to not be anxious for two reasons: (1) practice, and (2) more than likely they were anxious but wouldn’t admit it.

Record the child’s scores on the Scary Feelings Scores form (appendix: SCARY FEELINGS SCORE FORM). This systematic data will be helpful to you to judge whether the exposure task is having its intended purpose (to create some anxiety that rises and then falls). When the scary feelings score has gone down to 1, and the drawing is complete, stop the exposure. If the child stops before then, or the exposure goes on longer than 5 minutes with no change, reassure the child that this is practice and they will get better at it.

Watch out for some children, particularly boys, who don’t want to admit to being scared. If you suspect this is happening, change YOUR wording from “How scared are you?” to “How hard was that? None, a little, or a lot?”

After drawing it, ask them to close their eyes and think about it for 30 seconds (imaginal exposure).

You may need to teach the child how long 30 seconds lasts. It’s good to have a clock on the wall with a second hand. Simply sit with the child while you mark the start (second hand hits 12) until the end (second hand hits 6).

If the child has difficulty imagining a scene with his/her eyes closed, it might help to practice this skill. You might try the practice that was suggested in session #4 - tell them to look at a poster on your wall and then close their eyes but keep that picture of the poster in their head. With their eyes closed, quiz them about what’s on the poster. Do this a few times until they can tell you what’s on the poster with their eyes still closed.

Place the drawing in the Roadway Book.

Safety Planning

(If this session is running long, the start of Safety Planning can be delayed until Session #7 or #8).

Explain to the child that you will start something new this week. It is important to learn how to avoid trouble in the future. First, explain that you know how to tell when danger is coming before it happens. Each example ought to be individualized to the type of interpersonal trauma a child personally experienced (i.e., domestic violence, physical abuse, community violence, or dog attack). You know from talking to their families that, for example, before dads hit moms, they act angry and mean first. A lot of times they yell, slam doors, and throw things before they get really, really mad. Ask the child if they can remember how their dad acted before he fought with their mom. Below is a list of danger cues for different types of traumas:

Domestic <u>violence</u>	Physical <u>abuse</u>	Community <u>violence</u>	Dog <u>attack</u>	Car <u>collision</u>
Slam door	Slam door	Yelling	Growling	No seat belt
Red face	Red face	Pushing	Snap jaws	Going too fast
Bang things	Bang things	Fist fight	Poke dog	Swerving
Throw things	Throw things		Pull at leash	Walk in street
Yelling	Yelling			Bike in street

Busy street

Natural disaster: Weather reports, hurricane tracks, and warnings from the “weather man” are typical danger cues.

Make a safety plan for the type of trauma the child experienced (appendix: SESSION 6: MY SAFETY PLAN). The ideal elements of a safety plan for older children are to remove oneself from the danger and to call for help if someone else (i.e., mother) is in danger. The safety plan will be different depending on the type of trauma and the developmental age of the child.

For hurricanes, the typical plan is to pack personal belongings for a short evacuation, make plans for pets, and secure toys.

For domestic situations, young children cannot be expected to leave the house and go to a neighbor’s house. A 3-year-old child cannot dial 911, but 5- and 6-year old children usually can. All children in this age group can identify angry people. They can be taught to say to their caregivers, “Mommy, daddy’s angry.” This may cue the mother to pay increased attention to the father’s rising anger, and then she can call 911 or find a way to escape with the children.

Preview next week

Next, the child will move up a bit on the scary feelings score and practice a little harder imaginal exposure.

PARENT

Offer the snack to the child as usual.

Ask the mother, as usual, “What did you think?”.

Find out where the mother’s mind is primarily focused during the child’s portion of the session. Is it on her child? Is it on her own thoughts and feelings about the trauma? Is it about some trauma from her own childhood? Then give the mother permission and encouragement (again) to express these with you. Follow the same guidelines from the last session.

At an appropriate time, find a way to sensitively transition to review the homework. Were the check sheets completed? If so, congratulate the mother. If not, explore why not. Make sure the mother still understands the proper use and purpose of the relaxation exercise for the child.

A Note About Mothers Who Surprise Their Children With the Homeworks

We’ve found that some mothers do not follow our carefully laid plan of conducting the trauma-related homework exposure as we discussed in sessions. Instead, they surprise the children with the exposure activity. This is not necessarily a bad thing. If the surprise homework produced a moderate amount of anxiety, the child was not overwhelmed, and the child was able to use a relaxation exercise to decrease the anxiety, then it was successful. Explore with the mother her reasons for doing it this way. She probably had a good reason. If not, and/or if the surprise was overwhelming, counsel the mother to try a more transparent tactic.

If discipline homework was assigned again for defiant behavior, go over that also.

Safety Planning

Review the safety plan with the parent as you did with the child. Discuss with the mother what they believe is feasible. You keep the worksheet for now.

Safety plans were originally created with domestic violence in mind. However, we've found safety plans helpful for just about any type of trauma. They seem to be very concrete exercises that young children can appreciate.

Some tips for domestic violence include to emphasize the importance of removing themselves and their children from danger at the earliest warning signals. Review their options for calling for help from nearby friends and the police. Make a card with the plan that includes trusted friends, their addresses, and phone numbers.

One More Reminder About Possible Boundary Issues

Revisit the boundary issue if you feel that your discussions in sessions #4 and #5 were not enough. Consider using the worksheet in the appendix to make homework for the parent on this issue (appendix" **SESSION 6: FOR PARENTS: RESPECTING BOUNDARIES**). "I mentioned this last session, and I want to remind you again of how important confidentiality is for children. It appears that it's still an issue that your child does not like (fill in the blank of the situation that embarrasses the child, i.e., caregiver asks too many questions, caregiver tells family members the child's personal business, etc). So, I want to remind you again to try to catch yourself when you're about to (fill in the blank of what the caregiver does inappropriately). Let's fill out this sheet as a homework for you."

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Even if no or little resistance has been detected so far, do not let up on this task. The lack of resistance may have been precisely because you have been preemptively addressing it.

Next, ask them to rate the child's reluctance to come today on a scale of 1 to 10. If reluctant, ask for the reason(s) why. Remind them that if reluctance is going to increase it typically happens around sessions 4-8 and is natural. Give them verbal support that they will need to tolerate the reluctance to get through this hard part of the treatment.

BRING CHILD BACK INTO ROOM

Homework

At the end of the session, explain to them both that it is time to take the next step and add real life (in vivo), not imaginary exposure. Picking an item from the easy end of the stimulus hierarchy, assign the homework of exposing the child to that situation until the anxiety goes down to a 1. This will, of course, require the parents' participation. As with the instruction for picking imaginal exposures, make sure they pick an easy task to start with. Practice it once in the next week. Give them the new worksheet (appendix: **SESSION 6: HOMEWORK CHECK SHEET: PRACTICE REAL LIFE EXPOSURE ONCE TO SOMETHING NOT TOO SCARY DURING THE NEXT WEEK**).

Preview next week

Normalize for the mother that some children regress around this point in treatment because we are increasing the anxiety level. Make sure she understands how to reach you by phone if needed.

Briefly state that you look forward to hearing how the “real life” practice went. Next week, you’ll work on a little bit harder exposure.

End of Session 6

Tips on Creating Drawings/Narratives and Homeworks for Different Types of Traumatic Events.

This list of drawings and homework assignments are derived from actual patients. Identifying details have been changed in examples to protect the personal identifying information of the subjects.

Sexual abuse

This was a case of a 3-year-old female who suffered sexual abuse from an adult male who was not a family member at a location outside of the home.

Session	Drawing/narrative	Homework
6	Sitting in the room in the house where the abuse occurred just before the abuse happened.	Mom and child drove past the house where it happened but did not stop.
7	Driving in mom’s car to the house where it happened.	Mom and child drove to the house where it happened and sat in the car outside.
8	Picture of the perpetrator.	Sat in car outside the house where it happened. Made it more intense by sitting there longer.
9	Room where abuse occurred.	Drove to house where abuse occurred, and got out of car briefly.
10	Child lying down, perpetrator standing next to her.	Got out of car at house again. Did it for a little longer than last time.
11	Near future: going to a new house next week. Distant future: Next month, going to a new house.	Got out of car at house again. Did it for a little longer than last time.

Domestic violence

This child witnessed many instances of domestic violence that culminated in the mother being shot by the father when he was 5-years-old. The shooting incident was immediately preceded by an argument between the mother and father in their car, in which their car hit a telephone pole in front of their house (the child was not in the car). The mother then ran into the house where she was shot in front of the children. The children fled the house through the front yard. These types of details are important for helping to structure the children, walk them through the events, and heighten the intensity of the exposures. Treatment started when he was 6-years-old.

Session	Drawing/narrative	Homework
6	Outside of the house, car, telephone pole.	Drive to the old house and sit in the car.
7	Children running from the house into the front yard.	Drive to old house. Increase intensity by mother talking to child about events, and child touching the telephone pole
8	Drew himself after the shooting feeling sad about not being able to see his mom. Second drawing on what he imagined his mom looked like when she was shot.	At the old house, got out of the car, walk onto the driveway.
9	Actual scene of the shooting with mom, dad, and siblings.	Increase the anxiety by looking through house windows (nobody lived in the old house).
10	Add detail to the scene of the shooting with furniture and police.	Unable to look in windows of old house; somebody moved into the house.
11	Near future: Next week, mom argues with another adult. Distant future: Next year, neighbor woman fighting with her husband.	Drove to old house, sat in car. Increased intensity by talking about the incident for about 1-2 minutes.

1) Domestic violence (DV) and 2) motor vehicle accident (MVA)

This child witnessed domestic violence between his mother and father from 1-3 years of age and was in a motor vehicle accident with his mother at 3 years of age. At 4 years of age, he was in the custody of his maternal grandmother who participated in the therapy with him.

Session	Drawing/narrative	Homework
6	MVA: Mom and himself in car.	MVA: Listen to sirens. This happened naturalistically by their home.
7	DV: Mom and dad fighting.	DV: Look at an old photo of mother's bruises after a fight.
8	DV: Mom's bruised face after the fight.	DV: Look at an old photo of mother's face after a fight
9	MVA: a truck hitting their car.	MVA: Find a truck that looks similar to the one in the MVA. Either drive up it or walk up to for 1-2 minutes.
10	MVA: Driving with car spinning.	DV: Stand in the bedroom where parents fought and think about the fight.
11	Near future: Next week, mom gets a phone call from dad and he's angry. Next year: Driving in the car and it starts swerving.	DV: Create a make-believe phone call that seems stressful, pretend it's from mother.

Motor vehicle accident

This child was a passenger in a car when their car stalled at a stoplight and was rear-ended by a white pickup truck. He was 4-years-old for the accident and the treatment.

Session	Drawing/narrative	Homework
6	White pickup truck.	Find a white pickup truck and stand near it for 1-2 minutes.
7	White pickup truck at a stop light	Get closer to a white pickup truck and touch it.
8	Their car and white pickup truck.	Because last homework was very intense, repeat it - touch a white pickup truck again.
9	Their car, white pickup truck, and the stop light.	Drive through the stop light where the accident happened.
10	Their car, white pickup truck, and the stop light.	Drive through the stop light where the accident happened. By chance, they also witnessed an accident at a stop sign.
11	Near future: next week, seeing a white truck at a stop light. Distant future: next month, their car stalls at a stop sign.	Drive through the stop light again. The parent was too anxious to do the homework so the grandparents drove for the homework.

Motor vehicle accident plus medical treatments

This boy was a passenger in a car that flipped on an interstate highway and suffered a severe injury to an extremity that required repeated trips to the doctor for painful and scary medical treatments. He was 6-years-old for the accident and the treatment.

Session	Drawing/narrative	Homework
6	The restaurant that they stopped at before the accident.	Drive to a restaurant and visualize being at the restaurant before the accident.
7	Their car on the highway.	Drive through the scene of accident.
8	Their cars plus several other cars on the highway.	Drive by the actual restaurant that they stopped and the scene of accident. Saw the tire skid marks on the pavement.
9	Drew multiple scenes: receiving emergency medical treatment at the scene, the ambulance, getting stuck by the doctor in the emergency room, and wearing the neck brace.	Used an actual doctor visit that was planned the next week.
10	Lying in the car right after the accident.	Used actual doctor visit that was planned the next week.
11	Near future: next week, going to the doctor. Distant future: as a teenager, riding in a car on the highway that swerves.	Go to actual doctor's office.

Motor vehicle accident: pedestrian

This child was 3-years-old when he was playing with a football in his front yard and was struck by a car when he chased the ball into the street. The car knocked the child into a row of bushes. Treatment started when he was 4-years-old.

Session	Drawing/narrative	Homework
6	Playing football in the front yard.	Go into the front yard.
7	Playing football in the front yard with more detail.	Walk around the front yard with parent and toss the football several times.
8	The front yard, the street, and the row of bushes.	Played football in the front yard; talked to child about the bushes.
9	Added the car to the scene and how he got hit.	Stand into the bushes where he was found.
10	Car hitting him and knocking him into the bushes.	Go to the bushes, play football in the front yard, talk about the accident
11	Near future: standing too close to the curb and car whizzes past. Distant future: Crossing a busy street as a teen.	Go to the bushes, play football in the front yard, talk about the accident

Crime scene where father was murdered

When this child was 5-years-old, her father was murdered on a city street. The mother and child drove to the crime scene late at night. The mother got out of the car to see her husband's body but the children stayed in the car with another relative. The child saw police, flashing lights, yellow crime scene tape, and a crowd. It's not clear if she actually saw any part of the father's body on the ground. The child also saw a newspaper story photo of the crime scene the next day. It was difficult to tell if the child had been scared by the crime scene. In addition, the child was nervous about visiting the father's grave for unclear reasons (perhaps because she never saw his body, perhaps because mom was nervous), so this was incorporated into the homework. Treatment started when the child was 6-years-old.

Session	Drawing/narrative	Homework
6	Driving over the Mississippi River bridge to the crime scene.	Re-drive part of the route to get to the crime scene. Drive over the bridge, but don't go to crime scene yet. Talk about the neighborhood where father was murdered
7	Mom getting out of the car at the crime scene and blood on the street at the scene.	Drive on street near the scene and talk about what happened.
8	Father's funeral.	Visit father's grave.
9	Sitting in the car in front of the police station.	Park in front of police station. Have them talk about the incident to heighten the focus.
10	1) Father's funeral. 2) Crime scene.	Visit father's grave.
11	Near future: Next week, see a crime scene. Distant future: a funeral as a teen.	Drive close as possible to crime scene and get out of car, talk about what happened.

Frightening overheard story; and anxiety sensitivity (afraid of becoming afraid)

This 5-year-old boy was going to the bathroom in a stall at his school when three older boys came into the dark, creepy restroom and did not notice that he was in there. They dared each to recite a phrase that would make a ghost come out of the hissing air vent in the wall that would capture children. One of the boys recited the phrase and then they ran out of the restroom. The child was terrified because he thought the events were really happening and he feared for his life. He became fearful of all public bathrooms and some features of that bathroom in particular. This child also had **anxiety sensitivity**, which means afraid of becoming afraid. This probably explained why this child was vulnerable to develop symptoms from this type of incident in the first place. It was decided to structure some of the exposures around the boy's own anxiety about becoming afraid rather than focusing on reminders of the event.

Session	Drawing/narrative	Homework
6	Three boys in the bathroom.	Stand in his bathroom at home with mom visible outside in the hallway.
7	The boy who told the story.	Stand in home bathroom, mom out of his sight, turn out some of the lights.
8	The creepy air vent and lights in the bathroom.	Go in a public restroom for 1-2 minutes.
9	The three boys and the one telling the story. Include his anxiety about becoming nervous.	Use a public restroom. Include his anxiety about becoming nervous.
10	Boys in bathroom with more details.	Return to the school bathroom with mom.
11	Near future: Next week, seeing something scary on TV. Distant future: 20 years old, someone telling a ghost story.	Return to the school bathroom with mom. Include his anxiety about becoming nervous.

Hostage

This child was 3-years-old when a criminal running from the police held her day care hostage. The staff were threatened with a gun. A glass window broke when he shot at the police through a window. There was a thunderstorm that day and she associated thunderstorms with the event.

Session	Drawing/narrative	Homework
6	She and her sibling at the day care.	Drive past the day care, talk about the glass, and talk about getting out of the day care safely.
7	The broken window.	Stop at the day care for 1-2 minutes and talk about what happened
8	She, her sibling, and the bad man at the day care.	Go to the day care, get out of the car, and stand on the sidewalk.
9	The bad man threatening to shoot staff.	A thunderstorm happened by chance that week.
10	When several of the children cried and they were all scared.	Mom found a building with a broken window like the one at the day care. They drove to it and remembered the day care for 1-2 minutes.
11	Near future: Next week, thunderstorm when she's at kindergarten. Distant future: Next year, when she's at school and hears police sirens.	Drive to old day care, walk inside.

DISASTERS

While all traumas vary from individual to individual, and the details of each individual type of traumatic event are complicated, it seems that disasters are more varied than other types of traumas. Whereas motor vehicle accidents always involve a car, or sexual abuse always involves perpetrators, disasters do not have a common denominator. One's house is not always destroyed, there is not always floodwater, a loved one does not always die, etc. Therefore, relatively more examples of disasters are presented to illustrate the different types of events that one may have to work with.

1) Rode out hurricane; 2) trapped in floodwater; 3) overwhelmed in Superdome evacuation crowd.

This 4-year-old child experienced Hurricane Katrina in New Orleans with his father in their house. The next day they were trapped in the house by the quickly rising flood water. They escaped the house by the father walking through the waist-high water and either carrying the child on his shoulders or floating him in make-shift rafts. They saw snakes in the water. Eventually, they walked to the Superdome.

Session	Drawing/narrative	Homework
6	Pulled by dad through flood waters in make-shift raft.	Walk on the ramp by the Superdome.
7	Superdome crowd.	Go to the old house. Talk about the experience to heighten the focus.
8	A different make-shift raft than the one drawn in session 6.	Look at a snake.
9	Riding on dad's shoulders in the floodwater.	Drive by houses damaged by the floodwater.
10	Riding on dad's shoulders in the floodwater.	Get on father's shoulders and talk about what it was like in the floodwater.
11	Near future: Next week, drive by Superdome by chance. Distant future: Next month, street floods during a thunderstorm.	Get on father's shoulders again.

1) Rode out hurricane; 2) trapped in floodwater; 3) saw pet die; 4) airlifted by helicopter.

This child was with family at an uncle's house when Hurricane Katrina struck. They witnessed the family's dog drown in the floodwaters. They walked from the house through floodwater to higher ground. The boy tripped and fell into the flood water. They were eventually airlifted by helicopter. Treatment started when he was 6 years old.

Session	Drawing/narrative	Homework
6	Uncle's house.	Walk to uncle's house. By chance they saw a dog in the neighborhood.
7	Dog, crying for someone to come get him.	Go to uncle's house, talk about the dog
8	Family in the helicopter.	Go to uncle's house, talk about the dog
9	Tripping and falling in the floodwater.	Go to uncle's house, talk about the dog
10	Uncle's house.	Go to uncle's house, talk about the dog and the rescue.
11	Near future: Next week, rainstorm. Distant future: As a teenager, seeing a dog crying.	Go to an indoor pool and look at the water.

1) Rode out hurricane; 2) trapped in floodwater; 3) airlifted from roof of a school shelter by helicopter; 4) overwhelmed in evacuation crowd waiting for buses; 5) scared in mass evacuation shelter.

This 5-year-old child experienced numerous scary events during the week-long Hurricane Katrina event.

Session	Drawing/narrative	Homework
6	Mass evacuation shelter.	View picture of mass shelter.
7	School shelter.	Drive to the school shelter.
8	Crowd waiting for the buses.	Drive to the school shelter again.
9	First boat they took through the flood water.	Drive by the site where they waited for the buses.
10	Helicopter ride.	Thunderstorm (naturalistic opportunity).
11	Near future: Next week, rain. Distant future: 16 years old, hurricane.	Go see the boat at a neighboring house that was used to rescue them.

Disaster: Children Who Had Not Been in Harm's Way

One of the important findings of our work after Hurricane Katrina was that young children who had evacuated prior to the storm and had never been in harm's way developed PTSD after they returned and witnessed their devastated homes (Scheeringa and Zeanah, 2008). This happened so many times that it did not appear to be a fluke of a few children. The onsets of their symptoms were carefully tracked to the day they returned and stood on the curb outside their old home or stepped inside their gutted home and witnessed the loss of everything they had known there. Their emotional and behavioral reactions were recorded and told to us by their parents.

The mechanism of how PTSD developed in these cases is interesting. The development of PTSD requires a moment of panic or terror when one fears for their life or personal safety. All of these children had already seen images of the disaster on television and doubtless knew that they were going to see their homes in some state of ruin. We cannot be sure what these children thought at these moments that may have led to the development of PTSD. One speculation is that when children saw their devastated homes in person, they finally realized that if their parents had not evacuated them they would have been in danger; they could have been covered in mud and mold just like their stuffed animals and toys lying all over the ground. Another speculation is that witnessing the immensity of the destruction to their personal possessions firsthand, they suddenly believed that they were no longer safe. The next rainstorm could be another Katrina. Every rainstorm could be a Katrina.

Nevertheless, treatment of these children's PTSD symptoms was as straightforward as treating the symptoms from any other type of event. Exposure to gutted homes or rainstorms were often the triggers for their distress.

1) Evacuated and then returned to see destroyed home.

This child evacuated with his family before Hurricane Katrina. Their home was flooded with over four feet of water and completely destroyed with mud on the floor, mold on everything, and broken furniture. He was 6 years old for the flood and treatment.

Session	Drawing/narrative	Homework
6	Stuffed animal covered with mold.	Looked through the window of a house that was damaged by Katrina
7	Child's toys that were destroyed by the flood.	Go to a store and look at similar toys that child lost in the storm
8	Decorations on wall inside house that were destroyed.	Walk through the house that has been cleaned and gutted to the studs.
9	Child's broken and moldy bed.	Look at pictures of his house when it was damaged.
10	Living room with mold and furniture tossed around and broken.	Because home exposures seemed to have worked and then lost their intensity, switched to exposure to water. Drove to the lake, look at the water and talk about the hurricane.
11	Near future: Next week, rainstorm. Distant future: As a teen, hurricane evacuation.	Go to the lakefront where homes were destroyed and go to the water's edge.

1) Invasive medical procedures; 2) Evacuated and then returned to see destroyed home.

The child had repeated invasive diagnostic medical procedures performed on her when she was 0-3 years old. When she was 4 years old, her home and all of her belongings were destroyed by Hurricane Katrina. The child had evacuated the home prior to the hurricane but was unnerved when she returned to see the devastation of the home and the neighborhood.

Session	Drawing/narrative	Homework
6	1. House destroyed. 2. Going to the doctor.	Drive to the doctor's office, stand outside in the hallway.
7	1. House destroyed with more detail. 2. Going to the doctor with more detail.	Drive to the doctor's office, walk into office and see equipment.
8	1. Rainstorm 2. Sitting in doctor's office.	Go to doctor's office and walk into the room and sit on the table.
9	1. Thunder, lightning, crashing 2. Lying on the exam table.	Go to doctor's office, talk to doctor, and lie on the table
10	1. Hurricane 2. Lying on table with doctor doing procedure on her.	1. Go to relative's house that was still damaged. 2. Go to doctor's office again.
11	1. Near future: Next week, a thunderstorm. 2. Distant future: As a teenager, going to the doctor.	The next week she had a real doctor's visit.

1) Multiple surgeries for a medical condition prior to the disaster; 2) Evacuated and then returned to see home that was only partially damaged.

This child had multiple major life-saving surgeries from 0-6 years. Hurricane Katrina struck when he was 6 years old. They evacuated before the storm. Their house was partially damaged by a tornado. He became afraid of tornados and storms even though he never saw the tornado. He may have seen smaller versions of tornados when they drove over a lake (waterspouts) and they experienced extremely heavy winds and rain when they stayed in a motel during the storm. It was not clear which event was most salient, so the multiple types of exposures were tried for the drawings and homeworks to try to find what made him the most anxious.

Session	Drawing/narrative	Homework
6	Surgery.	Turn off lights like when the motel lost power.
7	Tornado, rain, lightning.	Drive to the motel.
8	Tornado, rain, lightning.	Drive to the motel.
9	Tornado hitting their home while the family is in the motel.	Drive over the lake where they saw the waterspouts (mini tornados).
10	Thunder and lightning.	Drive by damaged apartments and damaged mall.
11	Near future: Next week, rain disappears, then tornado comes. Distant future: As a teen, heavy rain.	Drive through a neighborhood where there are still many damaged homes.

SESSION 7

- CHILD GOALS:**
1. Medium narrative exposure
 2. Safety planning
- PARENT GOALS:**
- Same as child, plus
 3. Follow-up on caregiver's history and symptoms
 4. Address reluctance

Therapist Preparation

Sessions #7 and #8 are nearly identical to each other. The aims are for the child to have more narrative exposure and habituation, more practice with the anxiety-reducing tools, and move up the stimulus hierarchy list.

The safety plan will be reviewed and rehearsed in session with puppets first and then with the child.

The work with the mother continues in parallel as before. Your job is to encourage expression, be supportive, and give advice on handling parenting matters as needed.

Welcome

Offer the candy and then put it away as usual.

Review the homework and homework together

Review, in less than 5 minutes, how the homework went. Did the child practice the "real life" exposure? If so, go over briefly what they did, what the feelings were, and how the anxiety resolved. Be sure to ask about multiple possible sensory experiences, such as sight, smell, hearing, taste, and touch.

Next, split up as usual.

CHILD

Medium Drawing/Imaginal Exposure

Just like last week, explain that the child is going to make the "scary feelings" or "scary thoughts" go away. If they had trouble with the easy item last time, start with that one again this time. If not, move up to a harder item on their stimulus hierarchy. They will need to tolerate the anxiety until their fear goes down to a 1 rating. You might give non-trauma examples again to educate them on the purpose, such as going to a new place, hearing thunder, or going to the doctor. The first time is the most scary, but it gets less scary the fifth time, and is not scary at all the tenth time. This is what will happen with the PTSD list.

Pick a medium example from the list and explain the same way that the scary feeling will go away with exposure. Get the baseline scary feeling score. Write it on the Scary Feelings Scores form.

Finally, have the child draw a picture of this item. Give the child today's worksheet with empty space for drawing (appendix: **SESSION 7: DRAW MEDIUM**)

SCARY REMINDER). Tell them to stay in the situation until they are not scared at all. They may even get bored. They can use the relaxation exercise to help them stay with the scene until the scary feelings go away.

Ask for the scary feelings score every 3 to 5 minutes (or whatever pace seems appropriate for each child). Keep a copy of the scary feelings score in view on the table. Do the relaxation exercises. When the scary feelings score has gone down to 1, you can stop. If the child stops before then, or the exposure goes on longer than 5 minutes with no change, reassure the child that this is practice and they will get better at it.

After drawing it, ask them to close their eyes and think about it for 30 seconds (imaginal exposure). Ask for scary feelings score at the end and use relaxation if needed to get it down to 1.

Watch out for children who don't like doing the relaxation exercises and report a lack of anxiety to get out of doing it.

Place the drawing in the Roadway Book.

Safety Planning

Review the safety plan from last week. Remind them what the danger signals were and what the child's response would be. Then use two puppets to play out the danger scenario. One puppet is the angry person, and the second puppet is the child. The therapist will have to use their own face to demonstrate an angry face as one of the danger signals. Provide a running commentary on the action to emphasize the danger signals. The child puppet recognizes the danger signals and then enacts the safety plan.

Next, use only the angry puppet and have the child role play the child's part. The child may choose to wear the child puppet or simply talk for themselves as the child. Display the danger signals again and ask the child to identify them. Ask the child what they will do for the safety plan.

Preview next week

Next, the child will move up a bit on the scary feelings score and practice a little harder imaginal exposure.

PARENT

Offer the snack to the child as usual.

Check in with the mother again on what she thought while watching. "Well, what did you think of that?" Continue to give the mother permission and encouragement to express her own thoughts and feelings with you.

If it has become apparent that the mother seems preoccupied by her own past experiences, it is often best to allow her the opportunity to talk. These concerns need to be balanced with the limited time you have in treatment.) Your job is to encourage talking and gather information.

At an appropriate time, find a way to sensitively transition to review the homework. Were the check sheets completed? If so, congratulate the mother. If not, explore why not. Make sure the mother still understands the proper use and purpose of the relaxation exercise for the child.

If discipline homework was assigned again defiant behavior, go over that also.

Safety Planning

Review the child's and parent's safety plans with the parent. Make sure they can identify the salient danger signals for themselves, which may be more subtle than the signals that children can detect. Discuss where the thresholds are for that parent for sensing danger.

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Reluctance should be decreasing. Complete the Reluctance Checklist as usual for both mother and child. Remind them that if reluctance is going to increase it typically happens around sessions 4-8 and is natural. Give them verbal support that they will need to tolerate the reluctance to get through this hard part of the treatment.

BRING CHILD BACK INTO ROOM

Homework

At the end, explain that they need to pick another real life (in vivo) exposure to practice for homework. The child, ideally, needs to pick an item from the middle part of the stimulus hierarchy. The child needs to stay with the situation until the anxiety goes down to a 1. This will, of course, require the parents' participation. Practice it once in the next week. Give them the worksheet for homework (appendix: **SESSION 7: HOMEWORK CHECK SHEET: PRACTICE REAL LIFE MEDIUM SCARY EXPOSURE ONCE DURING THE NEXT WEEK**).

Preview next week

Briefly state that you look forward to hearing how the "real life" practice went. Next week, you'll work on a little bit harder exposure.

SESSION 8

- CHILD GOALS:**
1. Medium narrative exposure
 2. Safety planning
- PARENT GOALS:**
- Same as child, plus
 3. Follow-up on caregiver's history and symptoms
 4. Address reluctance

Therapist Preparation

This session is nearly identical to session #7. You will move up the stimulus hierarchy list in practicing the narrative exposure and in picking goals for the homework, and make progress on the safety plan.

An optional task is to ask about strong negative relational feelings in the dyad. Because of the unique salience of young children's dependence on their caregivers, negative feelings in the relationship may need to be detected and addressed. The child may have appropriately angry feelings at the mother and the mother may have appropriately angry feelings at the "perpetrator". The child may blame the mother for what happened. If this is realistic, some form of restitution, such as an apology or a sensitive, but simple, explanation may be needed. This can be validation for the young child. The parent may have angry and hurt feelings toward the "perpetrator". For example, if the trauma was domestic violence, the mother may be angry with their spouse. Or, if the trauma was a dog mauling, the mother may be angry with the aunt who let the dog get loose. While it is typically unrealistic to expect an apology from the other adult, it is a validating experience for the mother to discuss these feelings with the therapist and have them acknowledged as normal.

Welcome

Offer the candy and then put it away as usual.

Review the homework and homework together

Ask how the homework went. Review in less than 5 minutes. Did the child practice the "real life" exposure? If so, go over briefly what they did, what the feelings were, and how the anxiety resolved. Be sure to ask about multiple possible sensory experiences, such as sight, smell, hearing, taste, and touch.

Next, split up as usual.

CHILD

Medium Drawing/Imaginal Exposure

Just like last week, explain that the child is going to make PTSD go away. If they had trouble with the item from last week, start with that one again this time. If not, move up to a harder item on their stimulus hierarchy. Remember that you may need to be explicit in explaining that you are moving up to a "more scary" thing this week. Some children believe that since they did a drawing last week, that it's stupid to do the same thing again this week ("I already did that!"). Explain briefly how this is a new one. Follow the instructions from the last session in the protocol.

Draw the scene (appendix: **SESSION 8: DRAW MEDIUM SCARY REMINDER**).

During the drawing, an optional task is to detect any negative relational feelings the child has toward close adults because of their trauma. Ease into this by first asking who the child believes was a fault for what happened. If needed, go through a menu of logical possibilities – the other driver, the perpetrator, dad, mom, and the police. At some point, ask about the mother because she is the one involved in the treatment.

Possible questions include “Do you feel mad at (the person)?” If so, ask why. Eventually, proceed to asking whom the child blames for what happened.

The other salient persons involved in the traumas will usually have been adults, but keep in mind that you may need to ask about other children.

Also, be sure to ask if the child thinks it’s their own fault.

- Is there something the child thinks they should have done to prevent it?

- Something they wish they could do now about it?

- Something they wish they could do now just to make themselves feel better?

You don’t need to have advice or a plan for these right now. You need to just gather data about what the child is thinking. If distorted thoughts or feelings are detected, caution is urged not to prematurely assume that it is distorted. For example, a child may say that they blame their mother for the fight that led to the battering. With more careful exploration, this may lead to finding new details about the event that the mother wasn’t willing to disclose at first.

If negative or ambivalent feelings are detected, it is important to express empathy and to make some acknowledgement that the child was heard. This can be as simple as a sympathetic “Ooh”, or saying, “I’m sorry that happened to you”, or “That’s important and we need to talk with your mom about that too.”

Ask for scary feelings score at baseline and every 3 to 5 minutes during the drawing. Record the scores on the Scary Feelings Scores form.

Use one or more relaxation exercises even if child claims not to have any anxiety (for practice).

Do the imaginal exposure. Close eyes for 30 seconds. Re-check scary feelings score.

Safety Planning

Review the safety plan. Role play the danger signals with the puppet again. Have the child identify the danger signals and rehearse their safety plan.

Preview next week

Next, the child will move up a bit on the scary feelings score and practice a little harder imaginal exposure.

PARENT

Offer the snack to the child as usual.

Almost identical to last session, check in with the mother again on what is most pressing on her mind. If you began a discussion last week about the mother’s past experiences, this needs to be followed up this week. The mother has undoubtedly thought about your discussion at home over the last week. Ask for her thoughts. See if

there has been any shift in her thinking. The goal this week is, again, simply to listen, think out loud about the topic with the mother, and don't make any premature directives.

If mothers seem critical or offended by anything their children brought up, remind them to be non-judgmental for now because we're teaching children to talk about their feelings. If you asked the child about blame and you suspect the child has some distorted cognitions, ask the mother to help clarify them. This may lead to finding new details about the event that the mother wasn't willing to disclose at first. Make notes of distorted thoughts or feelings that may need to be addressed later.

Optionally, use this opportunity to append an inquiry about angry relational feelings just like you did with the child. Ask the same questions you asked the child. Start with an open-ended question of how the mother feels about the other person(s). Then move to more specific questions, such as, "Do you feel mad at (the person)?" If so, ask why. Eventually, proceed to asking whom the mother blames for what happened. Caution is urged about confronting a mother about whether her perceptions are really distorted or not. It is natural for parents to blame themselves because they are protective of their children. Blaming themselves is not a bad thing per se. On the other hand, if the self-blame leads to leniency with discipline or personal problems, then it could be addressed later.

If the case is the type where you're dealing with the "crisis of the week" continue that as much as time allows.

Safety Planning

Explain that a new homework will be to rehearse the safety plan in the home once before the next session. The parent will need to initiate the rehearsal at home. The parent can either role play the danger signals themselves or just verbally describe them. The child will be asked to walk through the safety plan.

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Fill out the Reluctance Checklist.

Reluctance might increase as the drawing and in vivo exposures become harder.

BRING CHILD BACK INTO ROOM

Homework

Same directions as in the protocol for session 7. Give the mother the worksheet (appendix: SESSION 8: HOMEWORK CHECK SHEET: PRACTICE REAL LIFE MEDIUM SCARY EXPOSURE ONCE DURING THE NEXT WEEK).

An additional homework this week is to rehearse the safety plan in the home, as described above. Fill out collaboratively and give the parent the homework sheet for the safety plan (appendix: SESSION 8: SAFETY PLAN). At home, the mother and child must walk through the child's safety plan. Explain that we need to see if the plan needs to be tweaked after they walk through it in the real environment.

Preview next week

Briefly state that you look forward to hearing how the "real life" practice went. Next week, you'll work on a little bit harder exposure.

SESSION 9

CHILD GOALS:

1. Worst moment narrative exposure
2. Safety planing

PARENT GOALS: Same as child, plus

3. Follow-up on caregiver's history and symptoms
4. Address reluctance

Therapist Preparation

The next two sessions mark the last sessions of new exposures. The final two sessions after these are for consolidation, generalization, and relapse prevention. These two sessions should be exposure to the worst moment – the highest item on the stimulus hierarchy with a scary feelings score rating of 3. The same format will be used as in the previous three sessions. Children who have had difficulty advancing up the stimulus hierarchy should still be encouraged to use their worst moment.

If the optional task last week of asking about negative relational feelings was done and produced anything of significance, this might need some follow-up this session.

The safety plan should have been rehearsed at home over the last week.

Welcome

Offer the candy and then put it away as usual.

Review the last session and homework together

Ask how the homework went. Review in less than 5 minutes. Did the child practice the “real life” exposure? Go over it as usual.

Then, split up as usual.

CHILD

Worst Moment Drawing/Imaginal Exposure

Just like last week, explain that the child is going to make PTSD go away. If they had trouble with the item from last week, start with that one again this time. If not, move up to their worst moment. They will need to tolerate the anxiety until their fear goes down to a 1 rating. By now, giving examples of how this should work are not needed.

Draw the scene (appendix: SESSION 9: DRAW WORST MOMENT EXPOSURE).

Ask for scary feelings score at baseline and every 3 to 5 minutes. Record the scores on the Scary Feelings Scores form.

Use one or more relaxation exercises even if child claims not to have any anxiety (for practice).

Do the imaginal exposure. Close eyes for 30 seconds. Re-check scary feelings score.

If the stress rating is not decreasing, make sure the child is using the relaxation exercise. If the stress does not come down to a 1 rating after 30 minutes, you will need to intervene. Engage the child in a conversation about what they are thinking about. Gradually shift the conversation away from the trauma reminder and distract them with other topics. If this doesn't work, it may be appropriate to bring the mother over to break the atmosphere, to help soothe and/or distract. The child can be led to the next room and engaged with the usual snack and games. The child should not leave the office with a rating still above 1. The session may have to be prolonged.

Place the drawing in the Roadway Book.

Safety Planning

Ask the child if they practiced the safety plan at home last week. If they did, how did it go? In the process, review the danger signals and the safety plan for the sake of one more iteration with the child. If it was not practiced, ask why not? This discussion can be all without puppets, but puppets can be used if that helps. Troubleshoot as needed.

Preview next week

The plan is for the child to practice the worst moment exposure again.

PARENT

Offer the snack to the child as usual.

Follow the usual procedure with the mother.

If you have been discussing the mother's preoccupation with her own past experiences the last two weeks, now may be the time to start being directive, if needed.

Some mothers may simply need time to keep talking about their own pasts. Sometimes it is hard to tell if this is being productive or not. If it's not clear, then a rule of thumb is that as long as she is talking and the sessions are not lasting so long that it becomes too long for the child to play next door, then keep listening up to 90 minutes for the full session.

There are 3 weeks left in the protocol. It may be time to make a joint decision about seeking a referral for her own individual therapy.

Before ending, be sure to review the homework. Were the check sheets completed? If so, congratulate the mother. If not, explore why not.

Oppositional problems ought to have significantly reduced by now if the mother has been following the homework. If the behaviors have not substantially reduced by this time (whether they need a different intervention or the mother has not followed through on the homework) further time ought not to be spent on this topic in the protocol.

Safety Planning

Ask the parent if they practiced the safety plan at home last week. If they did, how did it go? In the process, review the danger signals and the safety plan for the sake of one more iteration with the parent. If it was not practiced, ask why not? Troubleshoot as needed.

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Be sure to get the rating between 1 to 10. Reluctance should be decreasing.

BRING CHILD BACK INTO ROOM**Homework**

At the end, explain that they need to pick another real life exposure to practice for homework. The child, ideally, needs to pick a more difficult item than last week. The child needs to stay with the situation until the anxiety goes down to a 1. Practice it once in the next week. Give them the check sheet (appendix: *SESSION 9: HOMEWORK CHECK SHEET: REAL LIFE ALMOST TOO SCARY OR MOST SCARY EXPOSURE ONCE DURING THE NEXT WEEK*).

Preview next week

Next week will be similar to this week. Tell them there are 3 more sessions left.

SESSION 10

CHILD GOALS:

1. Worst moment narrative exposure
2. Start reviewing Roadway Book

PARENT GOALS: Same as child, plus

3. Follow-up on caregiver's history and symptoms
4. Address reluctance

Therapist Preparation

This session is nearly identical to session #9 except the safety planning has been completed and the review of the Roadway Book begins.

The child, mother, and therapist will begin the process of reviewing the Roadway Book together. This will be accomplished gradually over these final 3 sessions. The two aims of this review are to have one more iterative process for instilling the CBT techniques in the child, and to solidify the coherent narrative of the trauma experience. In this session you will review sessions #1-6 in the Roadway Book. This gradual process will give you and the family time to process any new distortions or difficulties that arise from the review process.

Welcome

Offer the candy and then put it away as usual.

Review the last session and homework together

Ask how the homework went. Review in less than 5 minutes. Did the child practice the "real life" exposure? Go over it as usual.

CHILD

Worst Moment Drawing/Imaginal Exposure

If they had trouble with the item from last week, start with that one again this time. If not, move up to their worst moment. They will need to tolerate the anxiety until their fear goes down to a 1 rating. By now, giving examples of how this should work are not needed.

Draw the scene (appendix: SESSION 10: DRAW WORST MOMENT EXPOSURE).

Ask for scary feelings score at baseline and every 3 to 5 minutes. Record the scores on the Scary Feelings Scores form.

Use one or more relaxation exercises even if child claims not to have any anxiety (for practice).

Do the imaginal exposure. Close eyes for 30 seconds. Re-check scary feelings score.

Place the drawing in the Roadway Book.

Preview next week

You will talk about planning for the future.

PARENT

Offer the snack to the child as usual.

Follow the usual procedure with the mother.

Before ending, be sure to review the homework. Were the check sheets completed? If so, congratulate the mother. If not, explore why not.

Follow up on the oppositional behavior plan if that is still a problem.

Motivation/Compliance

Review, as usual, any reluctance to come to therapy. Be sure to get the rating between 1 to 10. Reluctance should be decreasing.

BRING CHILD BACK INTO ROOM**Review of the Roadway Book**

Do this with the child and parent together. The goal is to review the importance of every single page for sessions #1-6. It is a tall order for a child to be in charge of that task and reading some of the words will be impossible for the younger children. Therefore, the therapist is ultimately in charge of exploring the pages and turning to the next one at an appropriate pace. Try to have the child remember what each page was about and what they learned. If the child can't, or won't, recall, the therapist must verbalize it. Use lots of praise for their accomplishments. This should take 5-15 minutes.

Homework

Explain they need to pick another real life exposure to practice for homework. The child, ideally, needs to pick a more difficult item than last week. The child needs to stay with the situation until the anxiety goes down to a 1. Practice it once in the next week. Give them the check sheet (appendix: **SESSION 10: HOMEWORK CHECK SHEET: REAL LIFE ALMOST TOO SCARY OR MOST SCARY EXPOSURE ONCE DURING THE NEXT WEEK**).

Preview next week

Tell them there is only 2 more sessions left. We need to start preparing to say goodbye. Next week we will talk about how to use their tools in the future.

SESSION 11

CHILD GOALS: **1. Learn about relapse prevention**
2. Review Roadway Book

PARENT GOALS: **Same as child**

Therapist Preparation

PTSD symptoms ought to be markedly reduced by now. You can begin to talk about the future more and what to expect. Relapse, in the sense of a return of some symptoms from time to time, is a common occurrence and the child and parent need to anticipate this. They first need to understand that this is a natural thing and it doesn't mean the end of the world. Then they need to be prepared to use the tools they have learned when this occurs.

Talking about the long-term future is a developmental impossibility for most preschool children. They can talk about what they want to be when they grow up, but they have no sense of how far away that is in the future. The future to them is tomorrow, at the most, next week. Concentrate on that time frame. However, make an attempt to explore longer term planning capacities to see if an individual child is able to grasp the concept.

The review of the Roadway Book advances to cover sessions 7-11 this time.

Welcome

Offer the candy and then put it away as usual. Remind the child that you have only 2 more sessions left.

Review the last session and homework together

Ask how the homework went. Review in less than 5 minutes. Did the child practice the "real life" exposure? Go over it as usual.

CHILD

Learn about relapse prevention

Remind the child that a lot of the bad feelings have gone away and don't bother them anymore. Things will probably stay that way but sometimes bad memories jump back up and scare you. Talk about this in the time frame of tomorrow or next week. Explain that this is normal.

First, ask the child if they think they might do something tomorrow or the next day that would bring back a bad memory. If the child has difficulty with the concept of tomorrow, consider showing the child a calendar to make it more concrete. If the child can't think of something, think of a salient example for them. Think of an item from the middle of their stimulus hierarchy list so as not to pick the scariest moment. Tell a brief story of how the child might be somewhere next week when they run into a bad reminder.

Have the child draw a picture of this situation (appendix: **SESSION 11: DRAW CHILD IN NEAR FUTURE AND A REMINDER**). Ask the child what they would do. Appropriate answers would be to wait it out until they feel less scared, relaxation, or talking to someone until they felt better.

Next, ask the child to draw a picture of them when they are grown up. If they have an older sibling that may be a better age to focus on. If they have difficulty with concept of being grown up, make it more concrete by drawing a picture for them with a little child next to a bigger drawing of them all grown up. Ask them to try to think of a situation then that might bring back a bad memory. You may have to help the child think of salient example, as above. Have the child draw a picture of this situation (appendix: **SESSION 11: DRAW CHILD AS ADULT AND A REMINDER**). Again, ask the child how they could handle to make the bad feelings go away.

Place the drawings in the Roadway Book.

Ask for the scary feelings score. These scores are only to check on the child's level of anxiety. This is not meant to be one of the graded exposure exercises. Spend extra time for relaxation or distraction if the score is above a 1.

Preview next week

Tell the child that next week is the last week and you will have a graduation. Ask for ideas for small food items (not meals). (Tip: do not call this a "party". Children this age might think a party means other children, a tea party, a spacewalk, balloons, cake, etc.)

PARENT

Offer the snack to the child as usual.

Make sure that the mother is aware that next session is the last session. This will help her gauge the time remaining and what topics she feels compelled to talk about.

If the mother's preoccupation with her own past experiences has been a relevant topic in past sessions, make sure to review that again as in sessions 9 and 10.

Be sure to review the homework. Were the check sheets completed? If so, congratulate the mother. If not, explore why not.

Spend some time reviewing the child's overall progress. Compare their presenting symptoms to now. Get a sense of the mother's satisfaction with treatment progress. If there are specific complaints that she has, you may want to use this session and next session to address these for the first time, or perhaps, again. This is not only good "customer service" but is an acknowledgement that trauma symptoms can be many and diverse, and you may not have had time to address all of them. For example, sleep difficulty is often a difficult symptom to treat, for a variety of reasons. It is also one of the symptoms that most distresses a parent because it can cause lack of sleep for the whole family. You may not have had time to talk about sleep hygiene principles and make suggestions on how to handle this.

Start to tie up any loose ends with the personal issues the mother has been talking about. For example, if you ran out of time when she was telling the story of her father's domestic abuse of her mother, make sure to offer the time to finish that story with closure with you. Or, if her main concern has been a custody battle with her ex-husband, offer the time for her to discuss her concerns and help her problem solve if appropriate.

Finally, if the mother has been symptomatic, you must make an estimate of whether she needs continued individual treatment and make referral suggestions. Cover that this session so you can follow up with it at the last session.

Motivation/Compliance

Review any reluctance to come to today's session, on a scale of 1 to 10. Reluctance for the last session should not be an issue.

BRING CHILD BACK INTO ROOM

Review of the Roadway Book

Do this with the child and parent together. The goal is the same as last session, except sessions 7-11 are to be reviewed this time. Remember to cover each page carefully. Use lots of praise for their accomplishments. This may be more distressing than last session because you will be reviewing the more difficult graded exposure practice sessions and homework. This should take 5-15 minutes.

Homework

Explain that they need to pick another real life exposure to practice for homework. The child, ideally, needs to pick a more difficult item than last week. The child needs to stay with the situation until the anxiety goes down to a 1. Practice it once in the next week. Give them the check sheet (appendix: **SESSION 11: HOMEWORK CHECK SHEET: REAL LIFE ALMOST TOO SCARY OR MOST SCARY EXPOSURE ONCE DURING THE NEXT WEEK.**).

Preview next week

Next week is the final session and the graduation.

SESSION 12

CHILD GOALS: **1. Review the Roadway Book**
2. Graduation

PARENT GOALS: **Same as child**

Therapist Preparation

You and the mother will likely feel a sense of accomplishment during this session. You will be able to compare in your head where the child was at the beginning to now. The graduation certificate will symbolize all of the hard work and risks taken during therapy sessions. The tangible result of that work that can be touched and felt is the Roadway Book. The child, on the other hand, may be more focused on the special snacks and wanting to play with your games one more time. The child will proudly, you hope, take home their decorated and personalized Roadway Book.

You will want to conduct an overall review of the treatment as one more effort to solidify the child's coherent narrative of the trauma and stress the importance of their new tools.

Try to go through the Roadway Book page by page and narrate the story from beginning to end. If the child is reluctant or tries to breeze over pages too fast, intervene by prompting, speaking for them, or slowing them down, as appropriate.

CHILD AND PARENT TOGETHER

Welcome

Explain the plan for today. The main job is to review the Roadway Book. After that is a special snack and a little play time, if desired.

Review the last session and homework together

Review how the homework went. Did the child practice the "real life" exposure? Take more than the usual 5 minutes if needed because you will not split up and talk about it separately today.

The Roadway Book

The goal is to review every single page of sessions #1-11. There are approximately 18 pages that spanned at least 3 months. As usual, the therapist is ultimately in charge of exploring the pages and turning to the next one at an appropriate pace. Try to have the child remember what each page was about and what they learned. If the child can't, or won't, recall, the therapist must verbalize it. Use lots of praise for their accomplishments. This should take 15 or more minutes.

There may or may not be compelling reasons to spend individual time with the mother. If needed, the end of this session can be used for that.

Present a decorated graduation diploma. Break out the special snack. Sign the diploma. From past mistakes, we've learned that the children really like the diploma signed; an unsigned diploma is rather disappointing.

Free electronic versions of a diploma can be found on the internet fairly easily with search engines. Each clinic or practitioner will have to find their own version for personal use. Our diploma states:

Tulane University
This diploma is presented on
Month X, Year to
<Child's Name>
for successfully completing the
cognitive-behavior therapy protocol
that includes recognizing feelings,
learning relaxation skills, and self-
control of behavior.

Therapist signature

Homework
None

APPENDIX

Overview of the 12 session overview

Posttraumatic Stress Disorder

Session 1: About You

Session 2 For Parents: Changing My Thoughts

Session 2: Behaviors to Change

Session 2: Discipline Plan for Defiant Behaviors

Session 3: Feelings in My Body

Session 4: Draw Your Safe or Happy Place

Session 4: Scary feelings score

Session 4 Homework: How Much I'm Scared

Session 5: The Whole Story About What Happened

Session 5: Stimulus hierarchy

Session 5: Homework Check Sheet: Practice Once, Scary Feeling Score

Session 6: Draw the "Not Too Scary" Reminder

Session 6: My Safety Plan

Session 6: Homework Check Sheet: Practice Real Life Exposure Once to Something
Not Too Scary During the Next Week

Session 7: Draw Medium Scary Reminder

Session 7 Homework Check Sheet: Practice Real Life Medium Scary Exposure Once
During the Next Week

Session 8: Draw medium Scary Reminder

Session 8: Safety Plan

Session 8 Homework Check Sheet: Practice Real Life Medium Scary Exposure Once
During the Next Week

Session 9: Draw Worst Moment Reminder

Session 9 Homework Check Sheet: Real Life Almost Too Scary or Most Scary Exposure
Once During the Next Week

Session 10: Draw Worst Moment Reminder

Session 10 Homework Check Sheet: Real Life Almost Too Scary or Most Scary
Exposure Once During the Next Week

Session 11: Draw Child in Near Future and a Reminder

Session 11: Draw Child as Adult and a Reminder

Session 11 Homework Check Sheet: Real Life Almost Too Scary or Most Scary
Exposure Once During the Next Week

Scary Feelings Score Form

The Relaxing Two Step Exercise

PTSD Parent-Child Weekly Rating Scale (PPCWRS)

Reluctance Checklist (RC)

Other Checklists (Used in Research)

Overview of the 12 treatment sessions

CBT=cognitive-behavioral treatment

Session	Child Goals	Parent Goals
1	1. Education about PTSD 2. Overview the 12 sessions	Same as child, plus 3. Discuss reluctance
2	1. Discipline plan for defiance 2. Grieving	Same as child, plus 3. Discipline plan
3	1. Identify stressful feelings 2. Relationship repair	Same as child
4	1. Learn relaxation exercises 2. Learn scary feelings score 3. Detect distorted thoughts about the ones at fault	Same as child
5	1. Tell the story 2. Create stimulus hierarchy	Observe child's work, plus 3. Parental feedback
6	1. Easy narrative exposure 2. Safety planning	Observe child's work, plus 3. Parental feedback
7	1. Medium narrative exposure 2. Safety planning	Observe child's work, plus 3. Parental feedback
8	1. Medium narrative exposure 2. Safety planning	Observe child's work, plus 3. Parental feedback
9	1. Worst moment narrative exposure 2. Safety planning	Observe child's work, plus 4. Parental feedback
10	1. Worst moment narrative exposure 2. Start review of Roadway Book	Observe child's work, plus 3. Parental feedback
11	1. Learn relapse prevention 2. Review book	Same as child
12	1. Review the Roadway Book 2. Graduation	Same as child

POSTTRAUMATIC STRESS DISORDER (PTSD)

PTSD is a syndrome that some people get after the experience a life-threatening trauma.

WHAT IS A TRAUMA?

A trauma is something that is *life-threatening or threatens serious harm*. People can be traumatized by just witnessing something happen to someone else. Here is a list:

- Physical abuse
- Sexual abuse
- Serious accidents, such as car crashes
- Dog or large animal attacks
- Seeing someone stabbed, shot, or killed
- Seeing their mother beaten

WHAT ARE THE SYMPTOMS?

There are 3 categories of symptoms:

1. Re-experiencing symptoms.

Children cannot stop thinking about the bad event even if they want to:

- ✓ Nightmares
- ✓ Intrusive daydreams
- ✓ Plays games that repeatedly reenact the trauma
- ✓ Flashbacks
- ✓ Gets very upset if something happens that reminds them of the trauma
- ✓ Their bodies get worked up with the reminders, including sweating, shaking, and fast heart rate.

2. Numbing and avoidance symptoms.

Children emotionally shut down, and try to avoid any reminders of what happened:

- ✓ Avoids places or things that remind them of the trauma
- ✓ Withdrawn from people
- ✓ Looks less happy and is less loving
- ✓ Plays less than before

3. Hyper-arousal symptoms.

Children are more agitated and restless:

- ✓ Difficulty sleeping
- ✓ Difficulty concentrating
- ✓ Irritable, temper tantrums
- ✓ More aggressive
- ✓ More jumpy and scared

Session 1: About You

My name is _____

I am _____ years old

My family:

My favorite game is _____

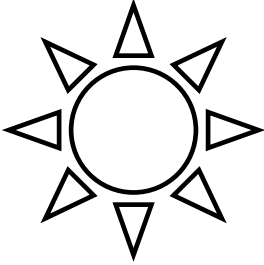
My favorite TV show is:



My favorite color is _____

The scary thing that happened to me was

Session 2: For Parents: Changing My Thoughts

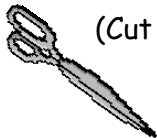


Parental guilt may lead to being too lenient where discipline is not enforced or consistent. Young children need consistent, loving, discipline.

If you have been too lenient because you feel guilty about what has happened or feel sorry for your child, admitting this is the first step. The second step is changing or replacing the thought. This technique is a well known cognitive therapy strategy. This week work on changing your maladaptive thoughts with more appropriate thoughts. For example: Instead of thinking "poor thing he or she has been through enough (and you don't discipline him or her)," think "Poor thing. But he or she still has to follow the rules (and follow through with appropriate discipline)."

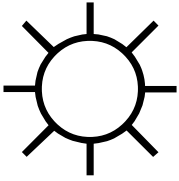
Step one: What is your guilty thought?

Step two: What is a more appropriate thought that you can say to yourself?



(Cut the appropriate thought out below and place it in your wallet, kitchen, or someplace where you will see it everyday)

I need to remember to say to myself:

SESSION 2: Behaviors to Change

List of defiant behaviors to target for change

1. _____

2. _____

3. _____

Session 2: Discipline plan for defiant behaviors

TARGET BEHAVIOR:

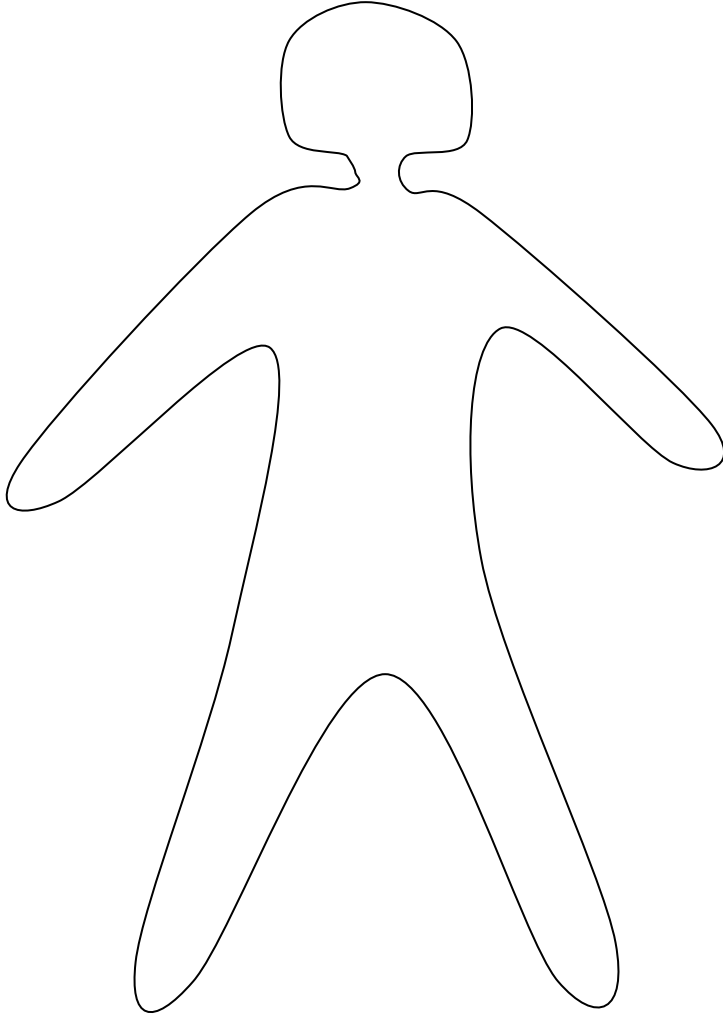
Sun	Mon	Tue	Wed	Thu	Fri	Sat
Sticker or ✓	Sticker Or ✓	Sticker or ✓	Sticker or ✓	Sticker or ✓	Sticker or ✓	Sticker or ✓

Need to comply for _____ out of _____ days for...

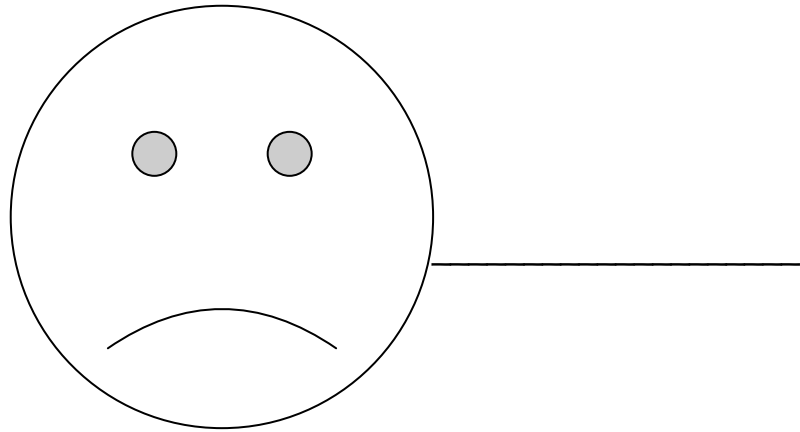
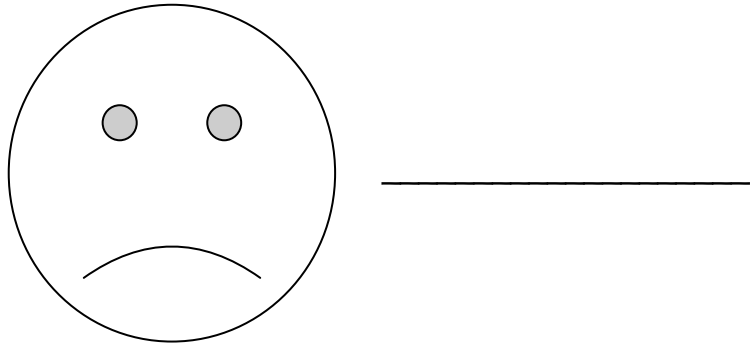
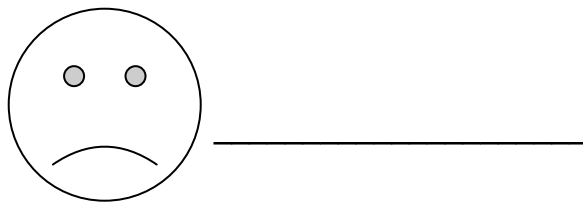
 REWARD =

SESSION 3: Feelings in my Body

DRAW THE BAD FEELINGS ON YOUR BODY



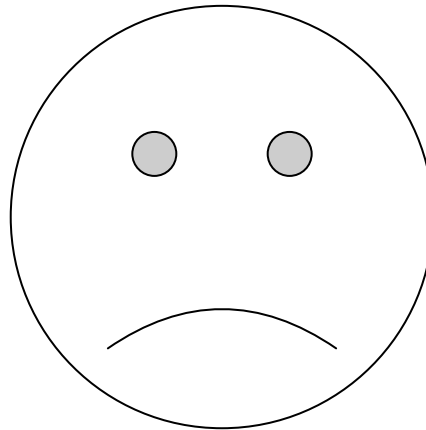
Session 4: Draw your Safe or Happy Place

SESSION 4: Scary feelings score**STRESSOR:****3. A lot****2. Medium****1. A little****0. None**

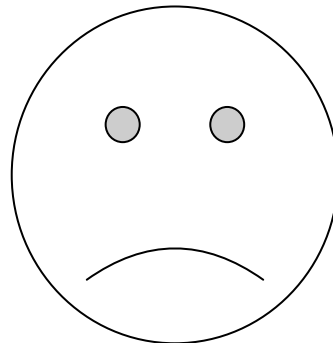
SESSION 4: HOMEWORK: HOW MUCH I'M SCARED

PLAN: _____

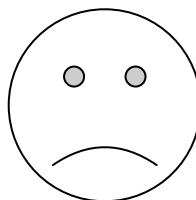
DAY/TIME: _____

3. A lot

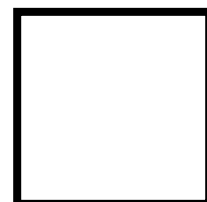
(Don't do this yet)

2. Medium

Aim for this one.

1. A little**0. None**

PLACE STICKER HERE:



SESSION 5: THE WHOLE STORY ABOUT WHAT HAPPENED

Details of the whole story

WHAT HAPPENED:

WHEN:

WHO:

WHERE:

SEE:

HEAR:

SMELL:

TASTE:

TOUCH:

FEELINGS: _____

SESSION 5: Stimulus hierarchy

From the Not Too Scary to the Most Scary

MOST SCARY:

ALMOST THE MOST SCARY:

MEDIUM SCARY:

MEDIUM SCARY:

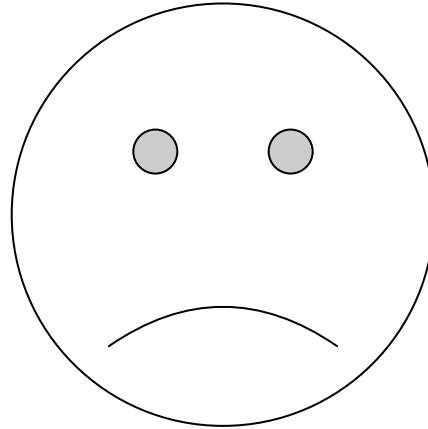
NOT TOO SCARY:

SESSION 5: HOMEWORK CHECK SHEET: Practice once, scary
feeling score

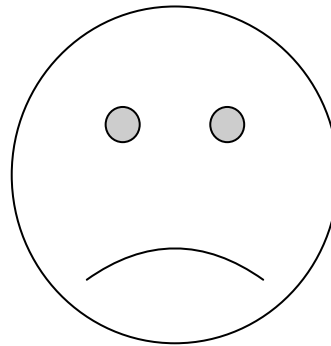
PLAN: _____

DAY/TIME: _____

3. A lot

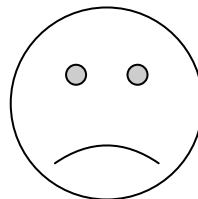


2. Medium



Aim for this one.

1. A little



0. None

PLACE STICKER HERE:



Session 6: Draw the "Not Too Scary" Reminder

Session 6: MY Safety Plan



Danger Signs

1. _____
2. _____
3. _____

MY Safety Plan:

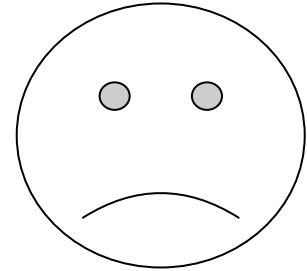
SESSION 6: HOMEWORK CHECK SHEET: Practice real life exposure once to something NOT TOO SCARY during the next week.

PLAN: _____

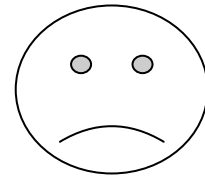
DAY/TIME: _____

How scared did you get?

3. A lot



2. Medium



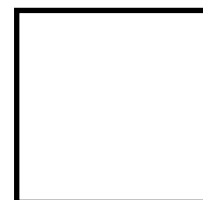
1. A little



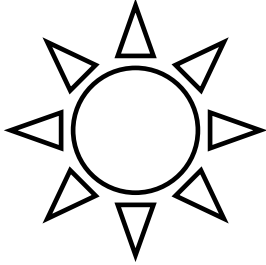
0. None

Write down what you really did:

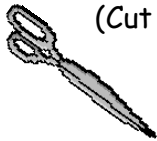
PLACE STICKER HERE



Session 6: For Parents: Respecting Boundaries



Sometimes parents' enthusiasm to help their children heal from trauma can unintentionally lead to infringing past their boundaries. Respecting your child's need for privacy will improve their response to therapy. This is often accomplished by ensuring a safe emotional space for the child to share feelings by not pushing them to share what they are learning with others.



(Cut the appropriate boundaries out below and place it in your wallet, kitchen, or someplace where you will see it everyday)

What are some appropriate ways to support my child's healing while respecting their privacy boundaries?

Homework: Am I respecting my child's boundaries concerning their therapy and trauma recovery?

SESSION 7: Draw MEDIUM SCARY reminder

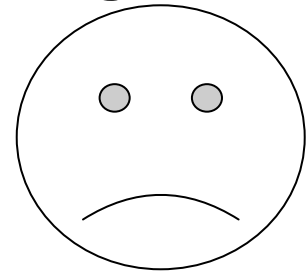
SESSION 7: HOMEWORK CHECK SHEET: Practice real life
MEDIUM SCARY exposure once during the next week

PLAN: _____

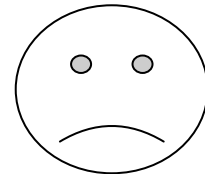
DAY/TIME: _____

How scared did you get?

3. A lot



2. Medium



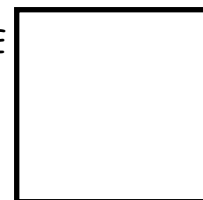
1. A little



0. None

Write down what you really did:

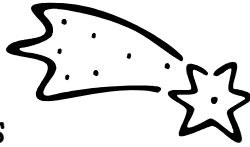
PLACE STICKER HERE



SESSION 8: Draw MEDIUM SCARY reminder

Session 8: Safety Plan

Did you practice your safety Plan? Circle Yes or No



If yes, congratulations

If no, Practice Now!

 *MY Official Safety Plan:* 

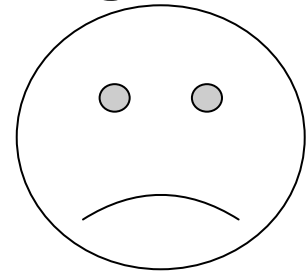
SESSION 8: HOMEWORK CHECK SHEET: Practice real life
MEDIUM SCARY exposure once during the next week

PLAN: _____

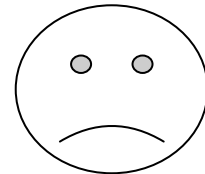
DAY/TIME: _____

How scared did you get?

3. A lot



2. Medium



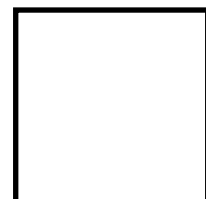
1. A little



0. None

Write down what you really did:

PLACE STICKER HERE



Session 9: Draw WORST MOMENT reminder

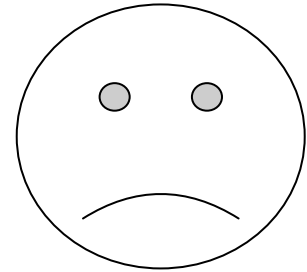
SESSION 9: HOMEWORK CHECK SHEET: Real life ALMOST TOO SCARY or MOST SCARY exposure once during the next week

PLAN: _____

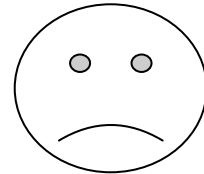
DAY/TIME: _____

How scared did you get?

3. A lot



2. Medium



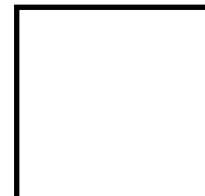
1. A little



0. None

Write down what you really did:

PLACE STICKER HERE



Session 10: Draw WORST MOMENT reminder

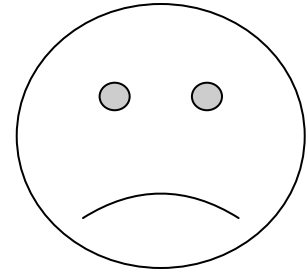
SESSION 10: HOMEWORK CHECK SHEET: Real life ALMOST TOO SCARY or MOST SCARY exposure once during the next week.

PLAN: _____

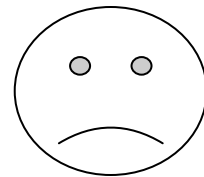
DAY/TIME: _____

How scared did you get?

3. A lot



2. Medium



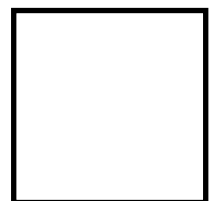
1. A little



0. None

Write down what you really did:

PLACE STICKER HERE



SESSION 11: Draw child in near future and a reminder

SESSION 11: Draw child as adult and a reminder

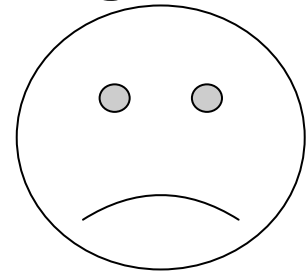
SESSION 11: HOMEWORK CHECK SHEET: Real life ALMOST TOO SCARY or MOST SCARY exposure once during the next week.

PLAN: _____

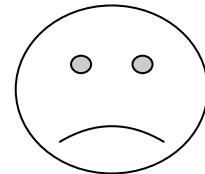
DAY/TIME: _____

How scared did you get?

3. A lot



2. Medium



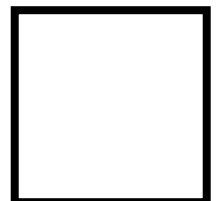
1. A little



0. None

Write down what you really did:

PLACE STICKER HERE



The Relaxing Two Step Exercise

This simple relaxation exercise is for young children. All of the steps are in twos so that they can remember how to complete it. When teaching this exercise, the instructor should do it with the child so that he/or she understands the steps. Have the child practice this with their caregiver and on their own.

Encourage the child to go through the imagery, breathing and muscle relaxation. If they prefer one piece more than the other, that's OK too.

After the child has mastered this exercise some children may want to make up their own, "Fun Two Step Exercise" with fun moves as a way to be silly and interact with the teaching adult.

Imagery

1. Close your eyes
2. Imagine yourself in a happy, safe place or event (for 15-30 seconds)

Breathing - Repeat Twice

1. Breathe in slowly through your nose and fill your belly with air like a balloon
(in for two counts, hold for two, blow out for two)
2. Breathe in slowly again through your nose and fill your belly with air like a balloon
(in for two counts, hold for two, blow out for two)

Muscle Relaxation - Repeat Twice

1. Tighten your arm muscles (hold for two counts) and let them fall like noodles
2. Tighten your arm muscles again (hold for two counts) and let them fall like noodles

****Optional Stretching ** - Repeat Twice**

Stretch up ("reach for the stars") and relax

(Alison Salloum; revised by Theresa Stockdreher and Michael Scheeringa).

PTSD Parent-Child Weekly Rating Scale (PWRS)

Peebles CD & Scheeringa MS, 1996, 2007

Version 1.4

Session # _____ Date: _____

Circle the number that best describes how severe your **CHILD'S** symptoms were over the last week. Compare this to the week before. Circle -9 if it was **NOT** a problem when treatment started.

-9	1. Sleep problems (circle one: trouble falling asleep, staying asleep, nightmares):
Never was present	<u> -2 -1 0 1 2</u> Much less severe Less severe No change More severe Much more severe
-9	2. Irritable, fussy, temper tantrums:
	<u> -2 -1 0 1 2</u>
-9	3. Fears (of the dark, of toileting alone, of strangers):
	<u> -2 -1 0 1 2</u>
-9	4. Talks about or plays out the trauma event spontaneously:
Never was present	<u> -2 -1 0 1 2</u> Much less severe Less severe No change More severe Much more severe
-9	5. Startles easily, "jumps" from surprises or loud noises:
	<u> -2 -1 0 1 2</u>
-9	6. Avoiding reminders of the trauma (conversations, photos, places):
	<u> -2 -1 0 1 2</u>
-9	7. Distress at being reminded of the trauma:
Never was present	<u> -2 -1 0 1 2</u> Much less severe Less severe No change More severe Much more severe
-9	8. Always on the lookout for danger (hypervigilance):
	<u> -2 -1 0 1 2</u>
-9	9. Loss of developmental skills (speech, toileting, acting like a baby):
	<u> -2 -1 0 1 2</u>
-9	10. Nightmares:
	<u> -2 -1 0 1 2</u>

RELUCTANCE CHECKLIST

Today's Date ___/___/_____

Session # _____

HOW RELUCTANT DID THE PARENT FEEL BEFORE COMING TO TODAY'S SESSION?

Say to the parent, "The ratings are based on how much you don't want to do something. 10 = the worst imaginable anxiety, and 5 = something that is half that bad. For example, most people rate having to stand up and talk in front of people around a 9. Going to the dentist is around a 6. Cleaning the dishes is around a 2. How did you feel today before leaving the house to come to this visit?"

1	2	3	4	5	6	7	8	9	10	prc1
None									Worst Imaginable Anxiety	

WHY DID THE PARENT NOT WANT TO COME TO TODAY'S SESSION?

	Yes, a little	Yes, a lot		
No				
0	1	2	prc2	Thought child would be distressed.
0	1	2	prc3	Thought parent would be distressed.
0	1	2	prc4	Believed child improved enough/didn't need more therapy.
0	1	2	prc5	Believed child was not improving/this was a waste of time.
0	1	2	prc6	Not enough time for this because of other life pressures.

HOW RELUCTANT DID THE CHILD FEEL BEFORE COMING TO TODAY'S SESSION?

Ask the parent how anxious the child seemed about coming to the session today.

1	2	3	4	5	6	7	8	9	10	crc1
None									Worst Imaginable Anxiety	

WHY DID THE CHILD NOT WANT TO COME TO TODAY'S SESSION?

	Yes, a little	Yes, a lot		
No				
0	1	2	crc2	Thought child would be distressed.
0	1	2	crc3	Thought parent would be distressed.
0	1	2	crc4	Believed child improved enough/didn't need more therapy.
0	1	2	crc5	Believed child was not improving/this was a waste of time.
0	1	2	crc6	Not enough time for this because of other interests.

OTHER CHECKLISTS

(Scheeringa, Amaya-Jackson, Cohen, 2002)

Version 02/03/07

Multiple weekly checklists are prescribed for research use of the PPT manual. The adherence (TAC), compliance (ACC and ACP), and acceptance (PAC) checklists are primarily research tools for data gathering but could be used by clinicians who are not conducting research because they are useful for systematically tracking that one is adhering to the manual and that the child and parent are complying with the treatment. The following sets of checklists are available upon request from the author at mscheer@tulane.edu:

THERAPIST ADHERENCE CHECKLISTS (TAC)

A 142-item checklist filled out by the therapist about their own implementation of the manual.

ADAPTATION CHECKLIST-CHILD (ACC)

A 60-item checklist filled out by the therapist on whether the child completed the tasks in therapy.

ADAPTATION CHECKLIST-PARENT (ACP)

A 68-item checklist filled out by the therapist on whether the parent completed the tasks in therapy.

PARENT ACCEPTANCE CHECKLIST (PAC)

A 134-item checklist filled out by the parent on their impressions of the therapy and the therapist. These should only be used in a manner that they can be confidential. That is, the therapist should not know the identity of the person who gave specific ratings. This protects the confidentiality of the parent and helps to ensure that they will give accurate feedback without concern that this will impact their relationship with the therapist.

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PTSD Cartoons

version 6/16/08

© Michael S. Scheeringa, M.D. and Carol Peebles
Modified from Neugebauer et al., (1999).

This set of 19 cartoons was modified from the Darryl cartoons created by Richard Neugebauer, Ph.D. The original Darryl cartoons¹ depicted acts of community violence with one man assaulting another. I expanded this concept with the artist Carol Peebles who modified the central boy character, added a central girl character, and drew the scenes of domestic violence and motor vehicle accidents. Other cartoons have since been created by others as needed by tracing or mimicking her work as templates.

We used the cartoons with preschool-age children to educate them about posttraumatic stress disorder (PTSD) symptoms, beginning with an NIMH-funded clinical trial in 2005 (R34 MH70827). Our main goal was to teach them that these behaviors are symptoms. This contrasts with the original purpose of the Neugebauer cartoons, which was to interview school-age children to find out if they had symptoms of PTSD (Neugebauer et al., 1999).

For the education process to work optimally, the cartoon trauma scenes need to be individualized to each child's personal trauma. That is why the Darryl scenes of community violence were not the best suited for children who had other types of traumatic experiences. If a child you are working with has a trauma experience that does not match one of the scenes in these cartoons, you have my permission to replace the scenes in the thought bubbles with a drawing of your own. If you share your creation with anyone else, you must add in writing somehow on the cartoon that it was your modification so that neither Scheeringa, Peebles, nor Neugebauer are credited and/or held responsible for your effort.

- Michael S. Scheeringa
mscheer@tulane.edu

Neugebauer, R., Wasserman, G. A., Fisher, P. W., Kline, J., Geller, P. A., & Miller, L. S. (1999). Darryl, a cartoon-based measure of cardinal posttraumatic symptoms in school-age children. *American Journal of Public Health, 89*, 758-761.

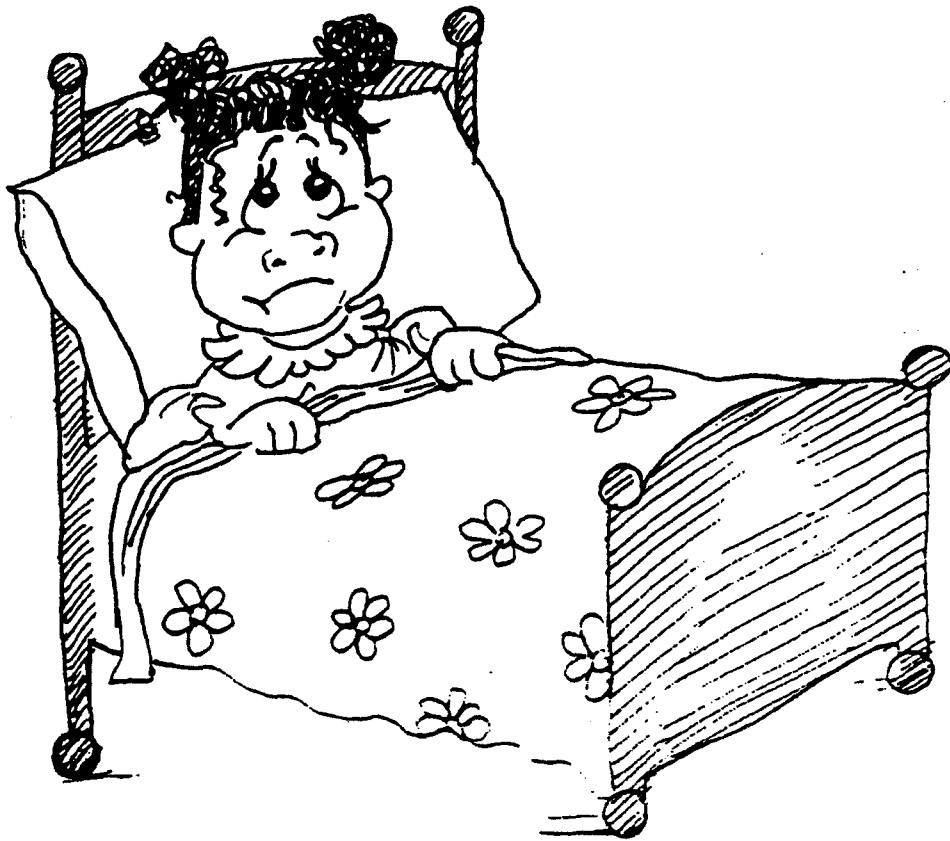
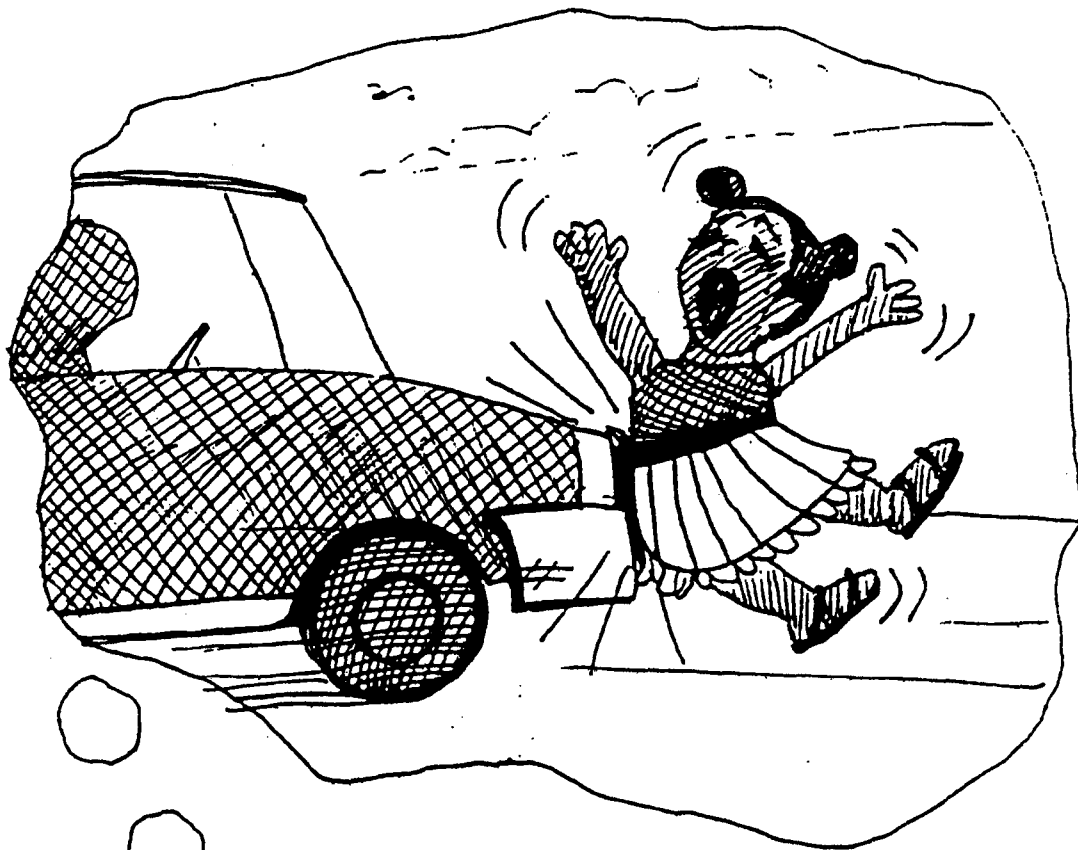
¹ Available from Dr. Neugebauer, rn3@columbia.edu.



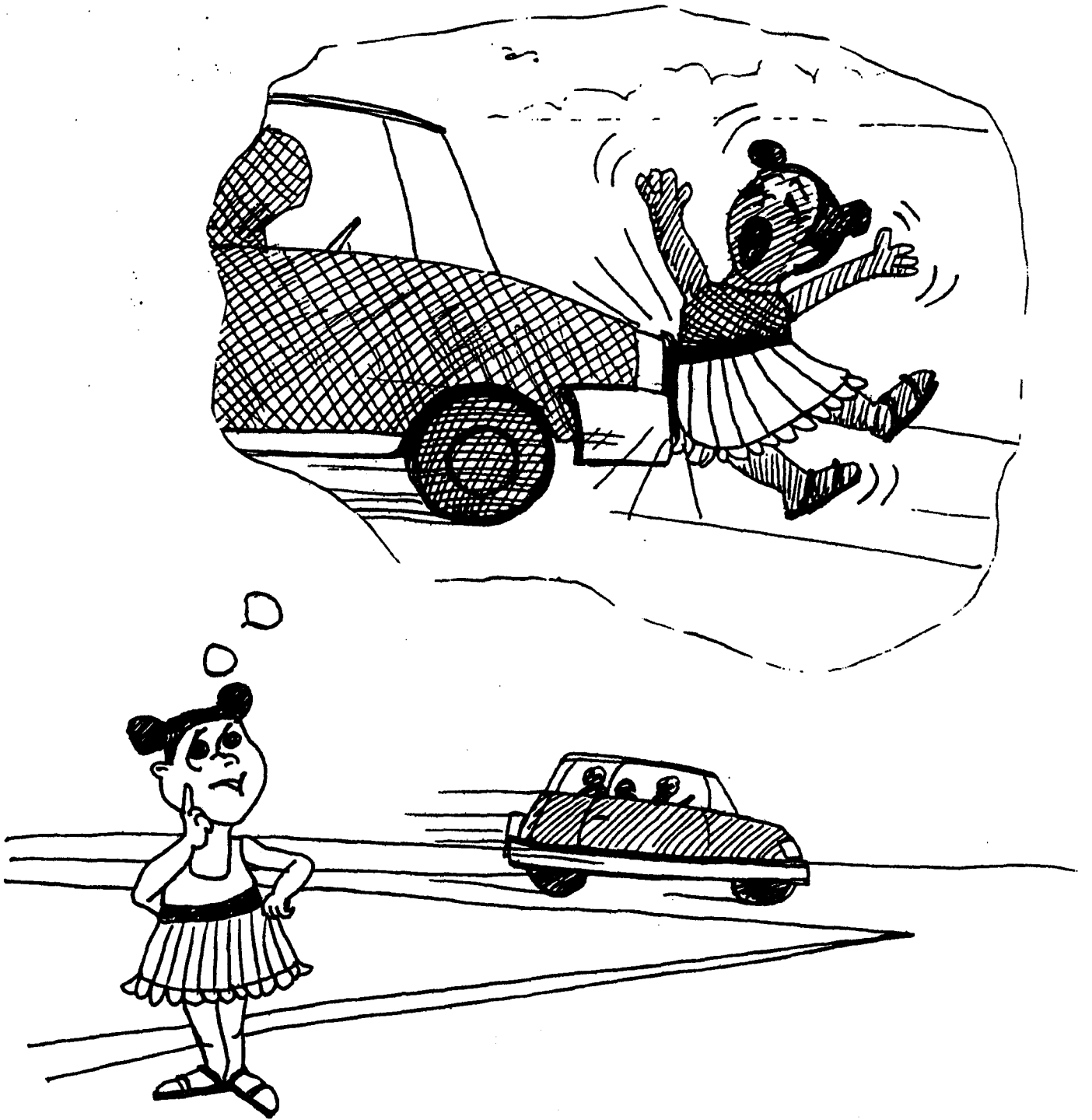
© Michael Scheeringa, M.D. and Carol Peebles. Modified from Neugebauer et al., (1999).



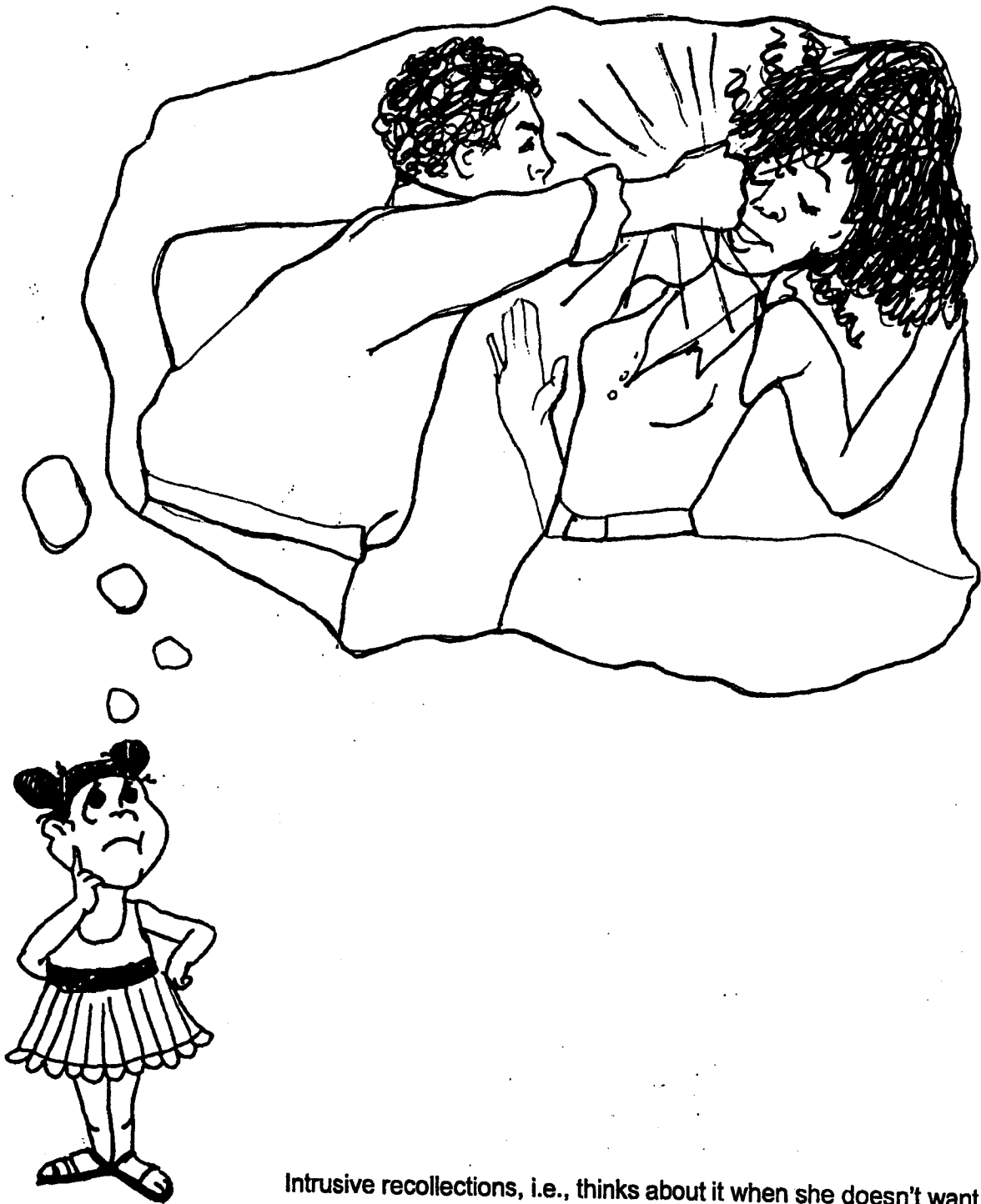
Intrusive recollections, i.e., thinks about it when she doesn't want to.



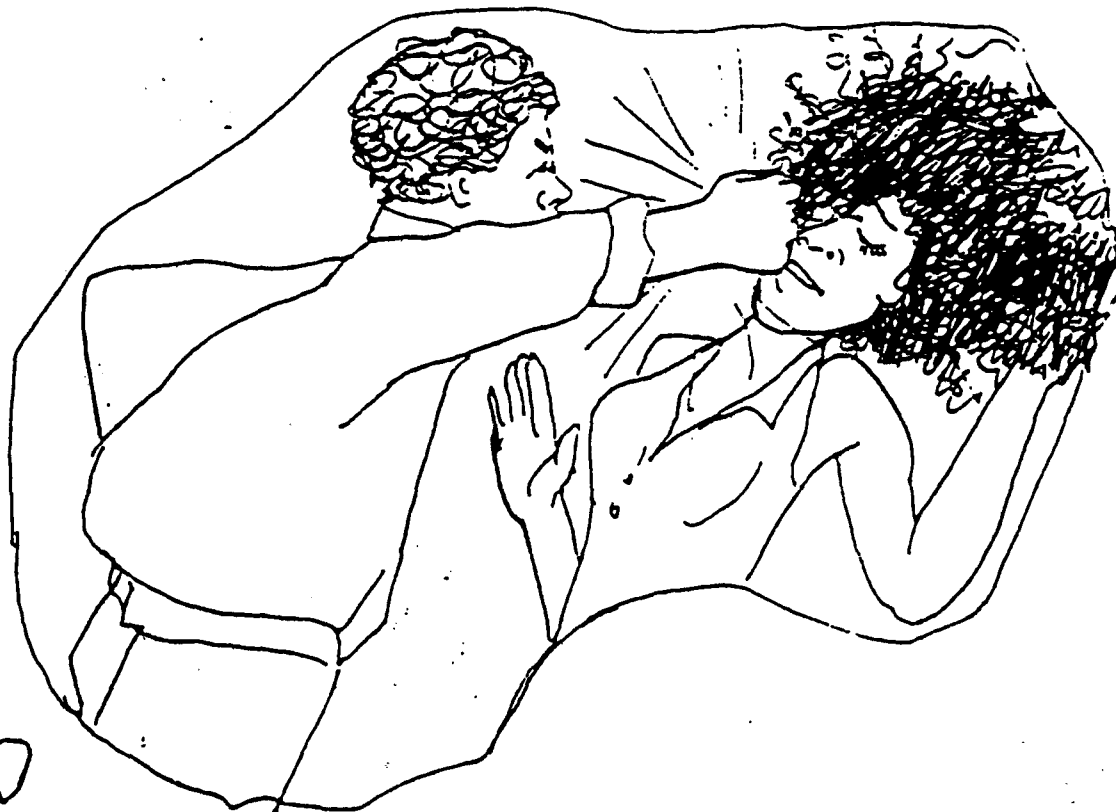
Nightmares.



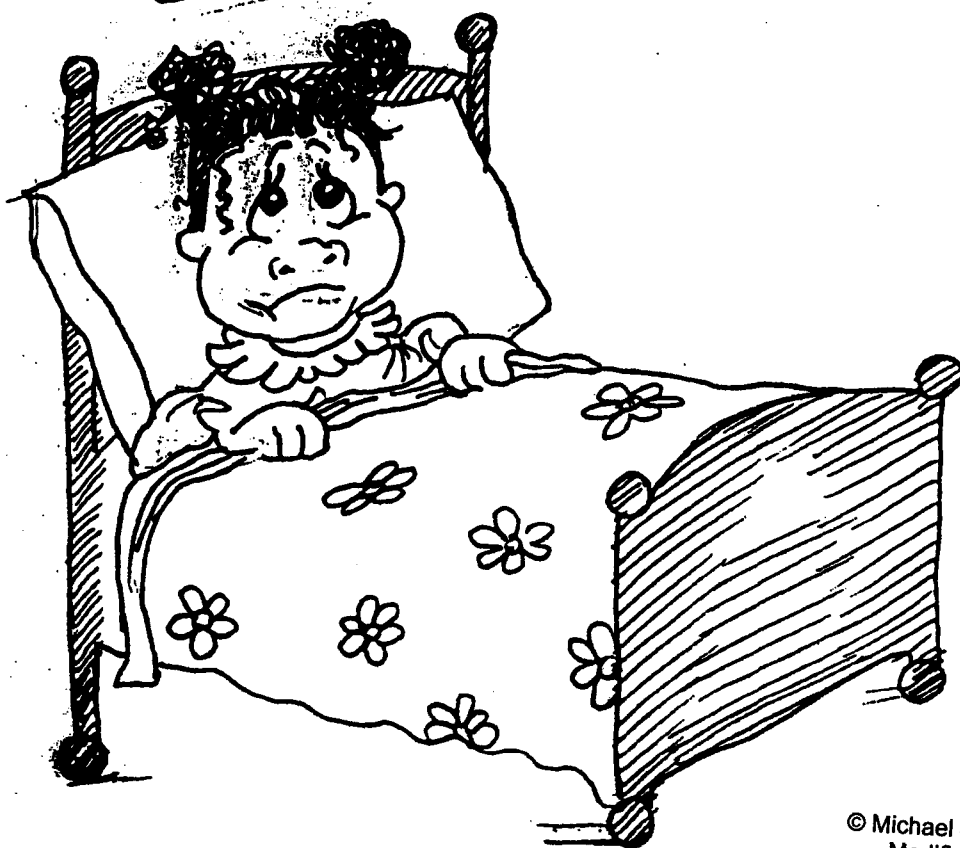
Distress at reminders.



Intrusive recollections, i.e., thinks about it when she doesn't want to.



Nightmares.

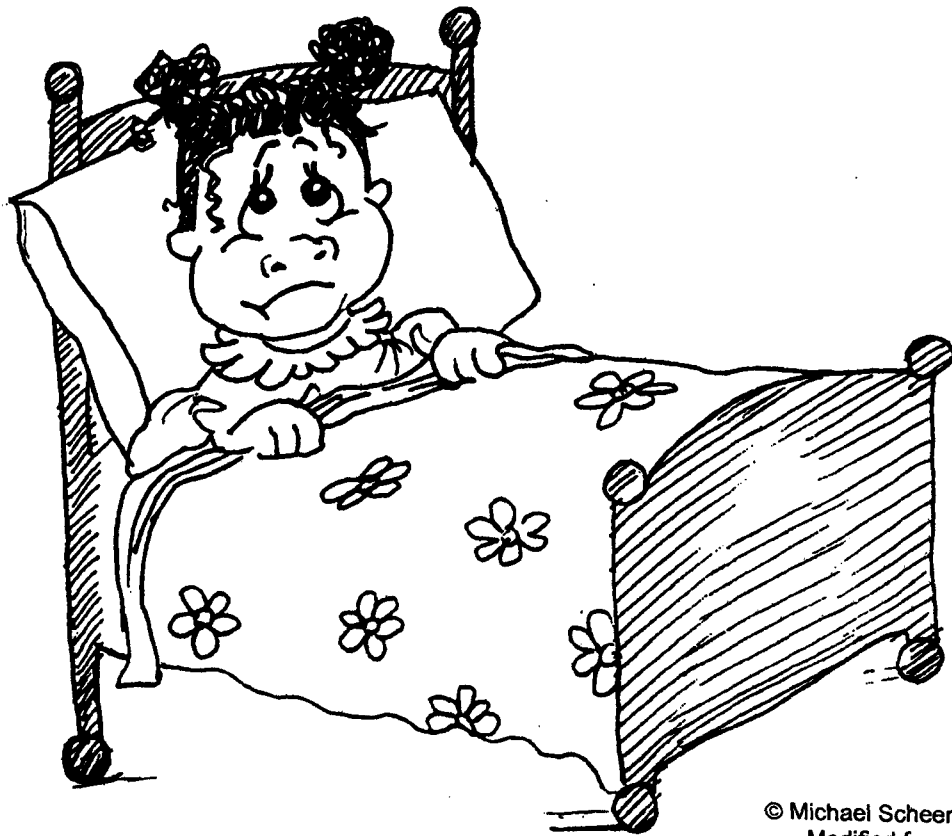


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Modified from Neugebauer et al., (1999).

Modified from Neugebauer et al., (1999).
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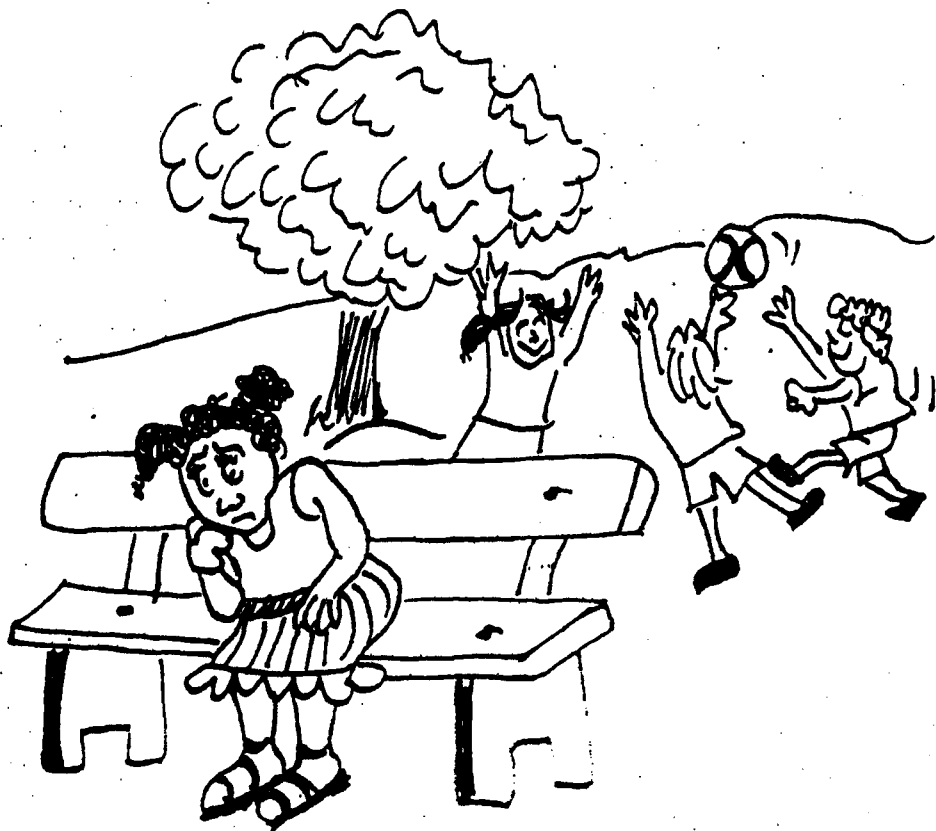
© Michael Scheeringa, M.D. and Carol Peebles. Modified from Neugebauer et al., (1999).



Nightmares.

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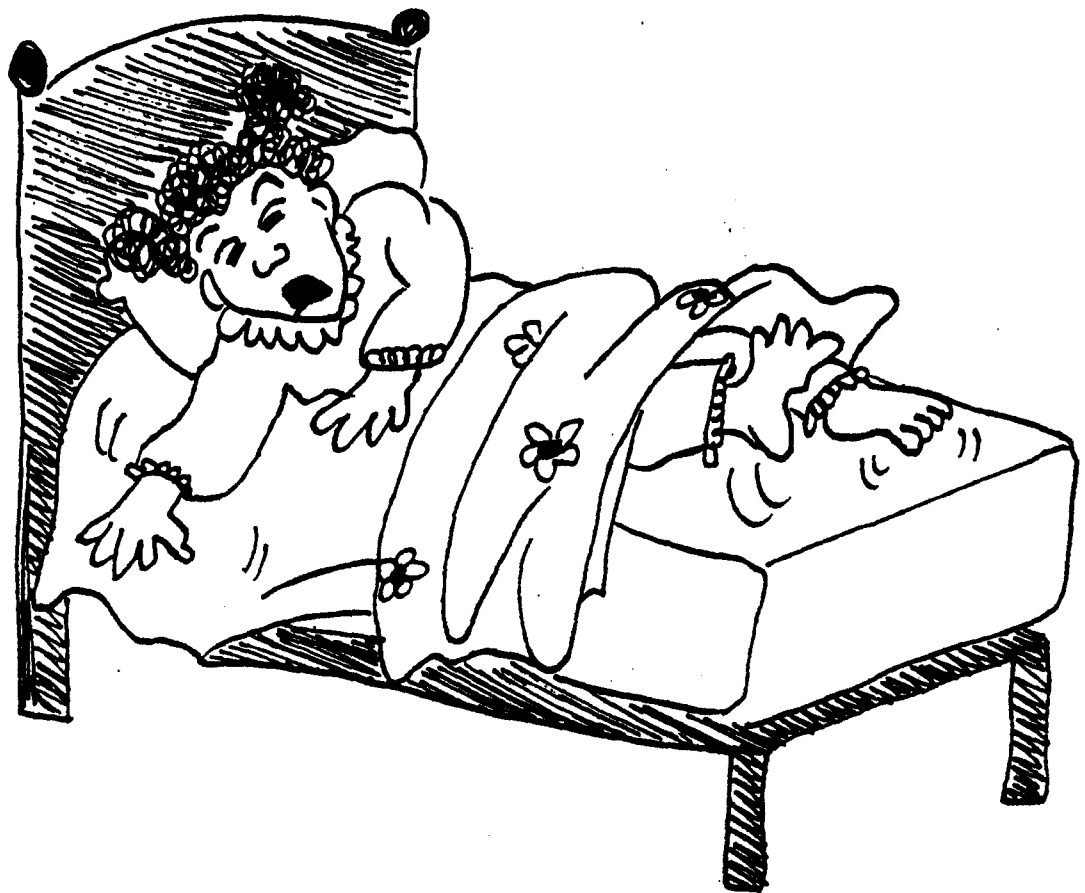
Loss of interest in usual activities, i.e., constriction of play.

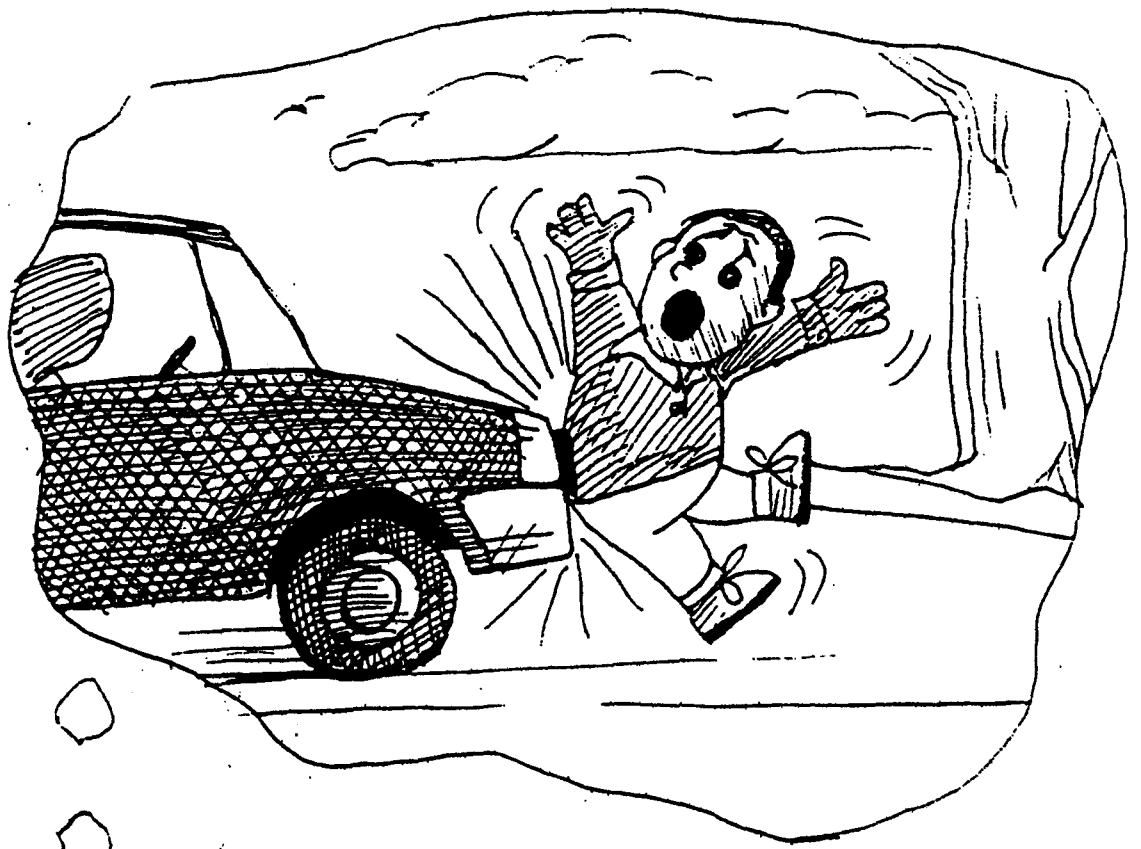


Irritability or outbursts of anger. Extreme temper tantrums.

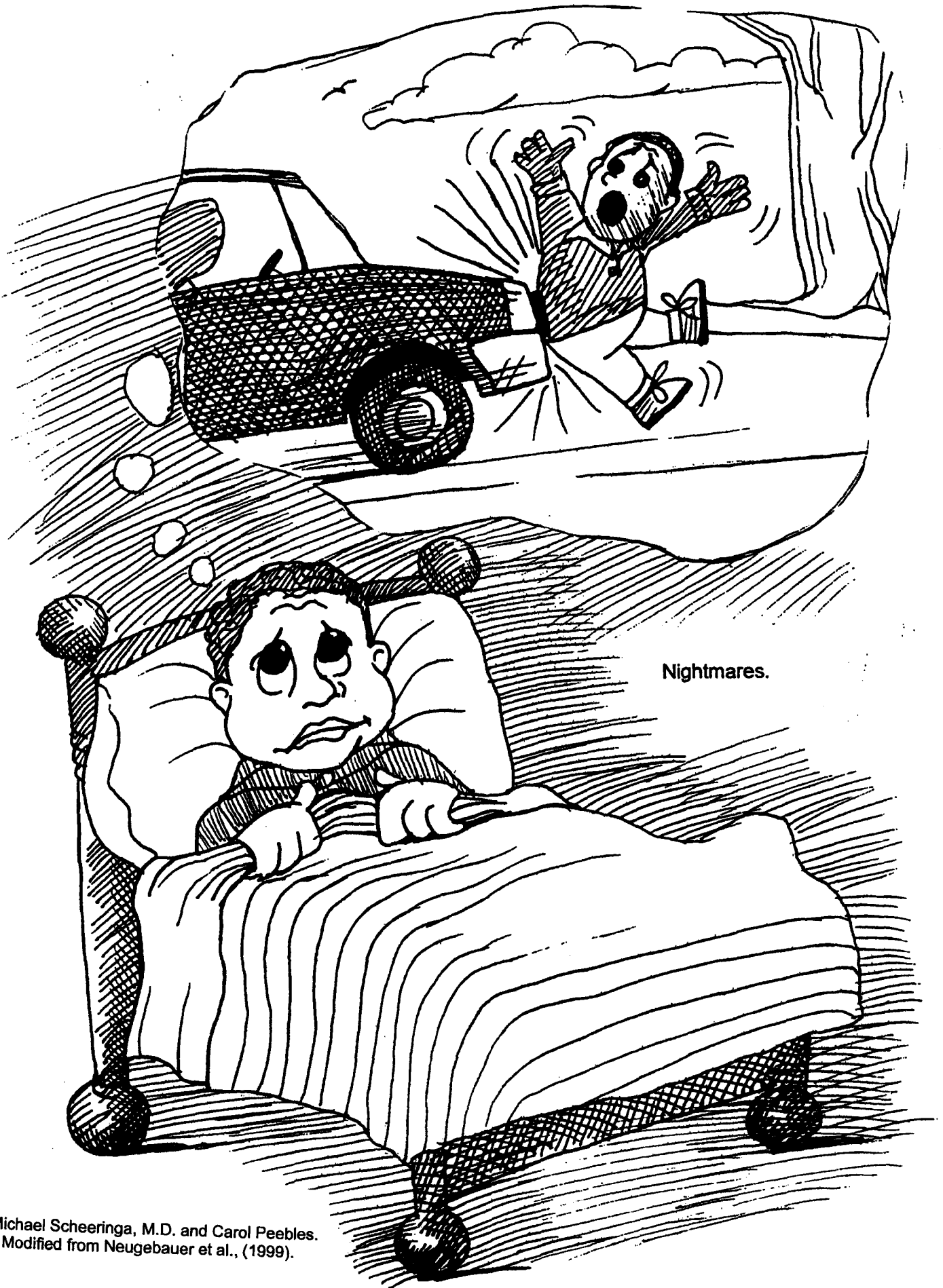


Difficulty sleeping.



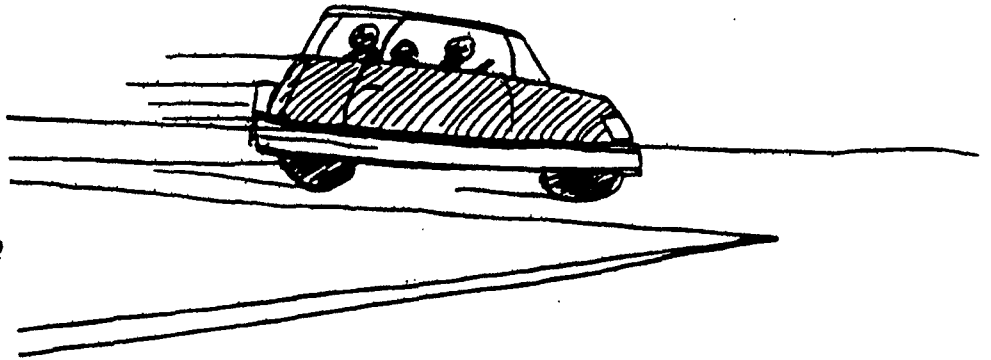
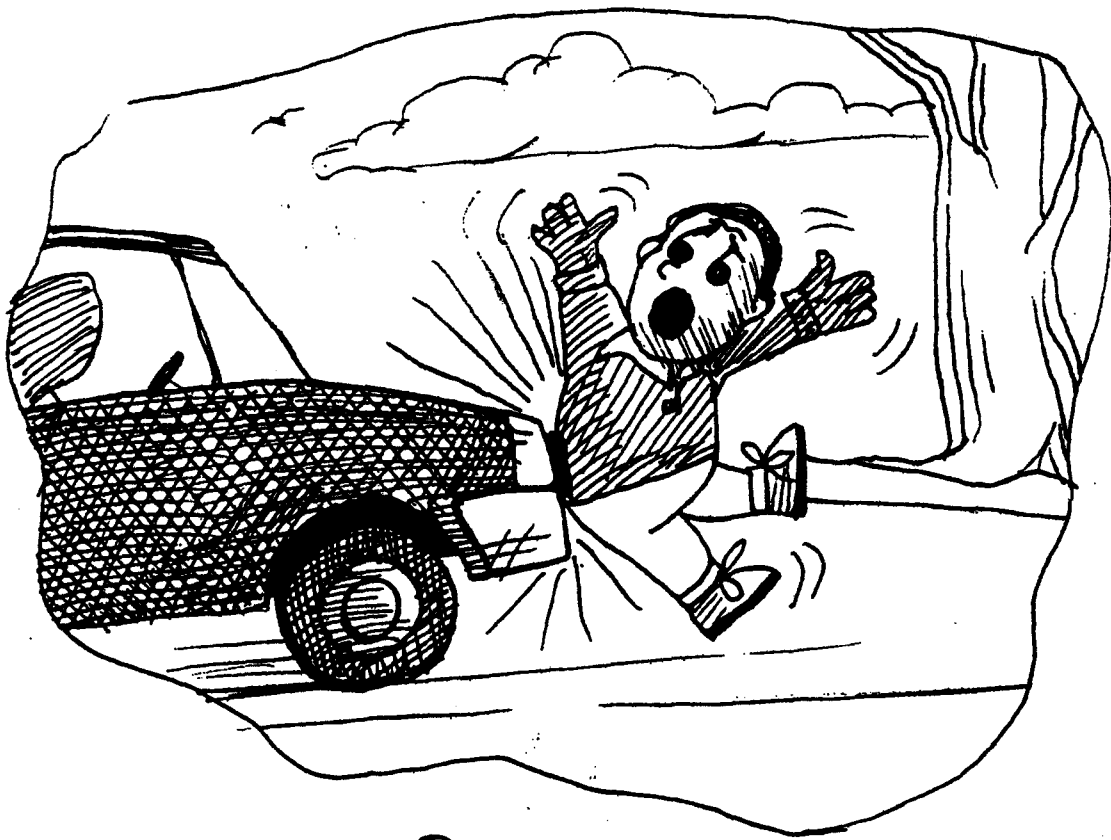


Intrusive recollections, i.e., thinks about it when he doesn't want to.



Nightmares.

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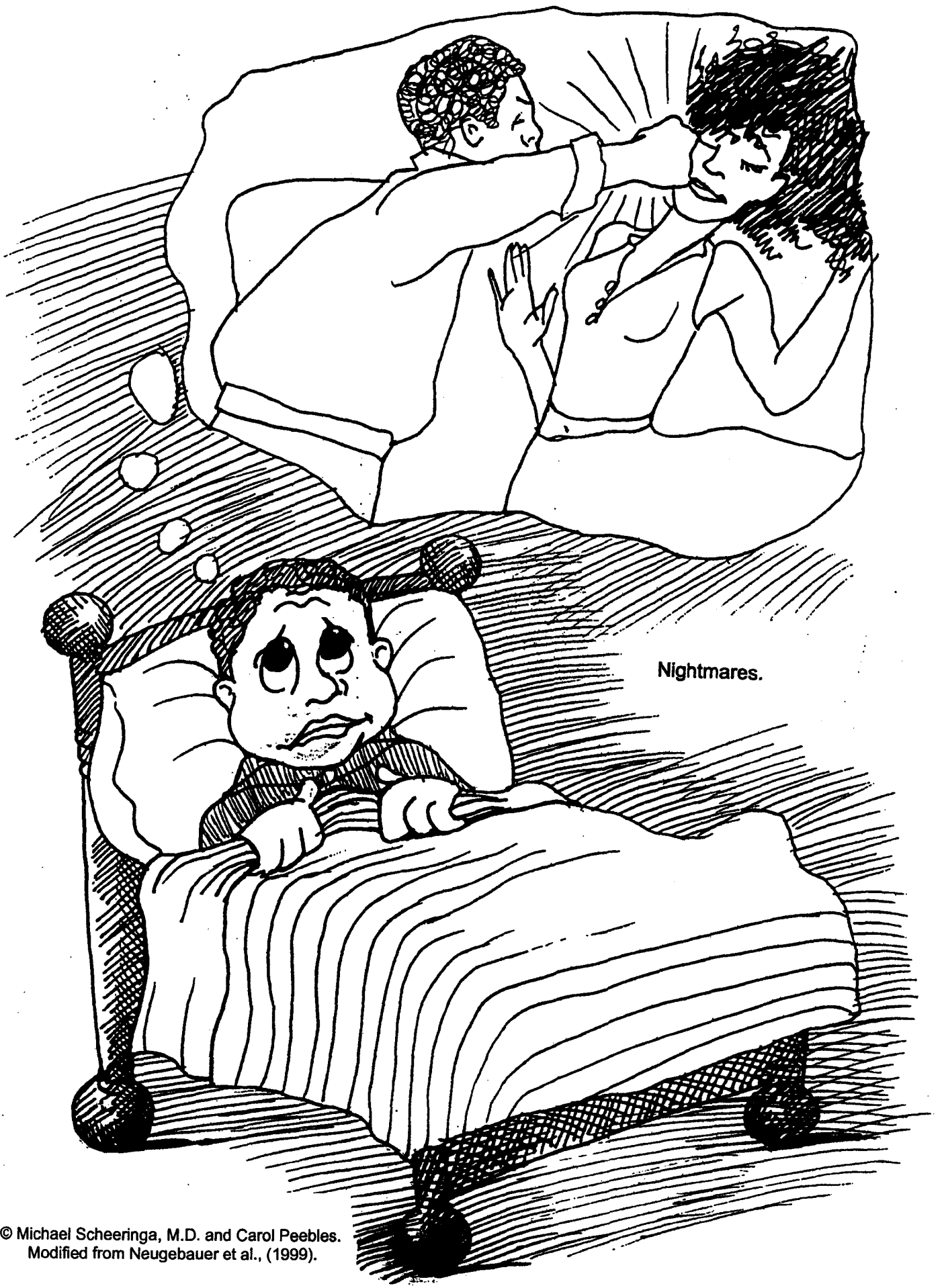


Distress at reminders.



Intrusive recollections, i.e., thinks about it when he doesn't want to.

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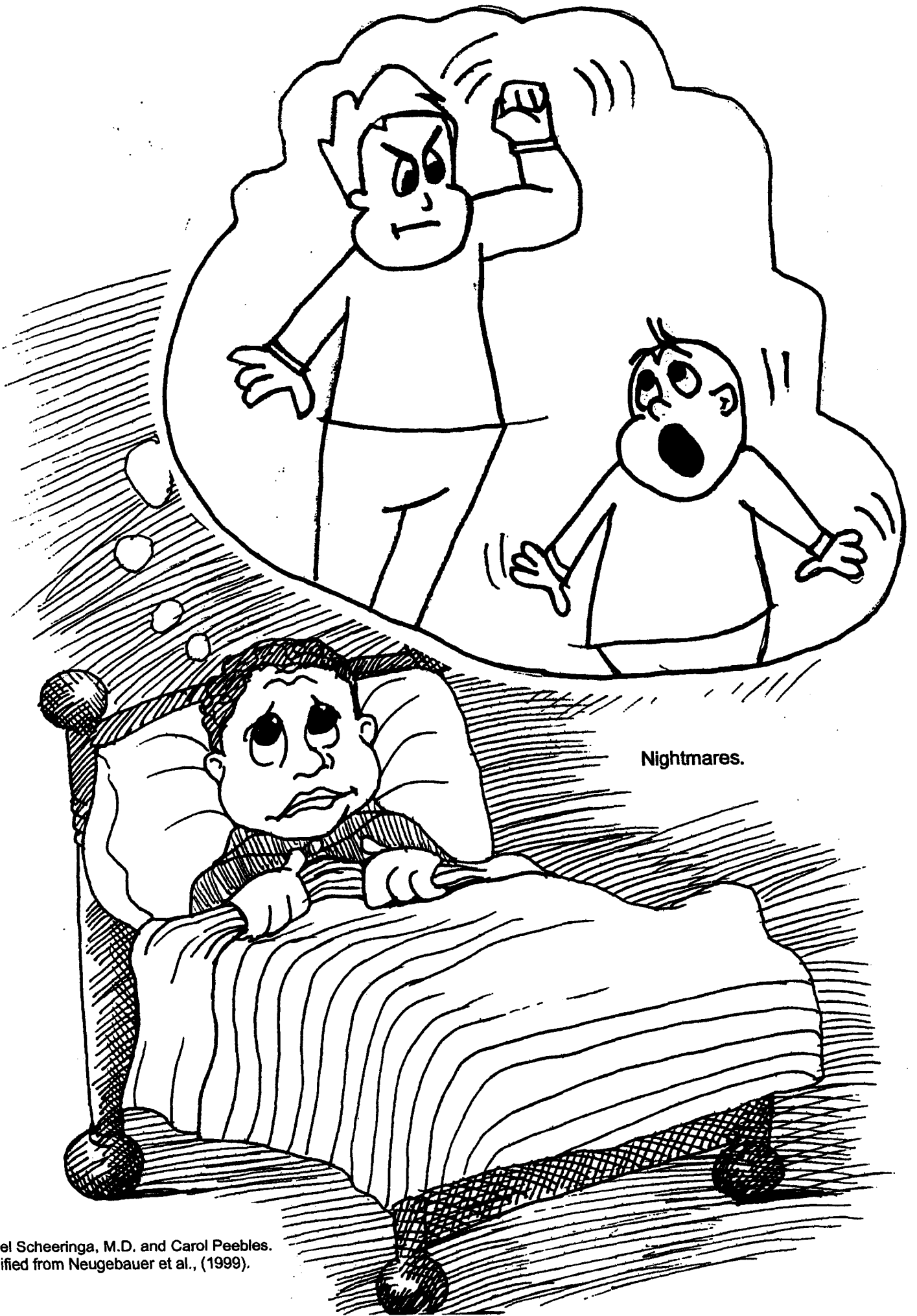
Nightmares.

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Modified from Neugebauer et al., (1999).



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Nightmares.