

Cognitive Behaviour Therapy-3M (CBT-3M)

CBT-3M (Meanings, Memories and Management) - A trauma-based cognitive therapy protocol for young children aged 3-8 years

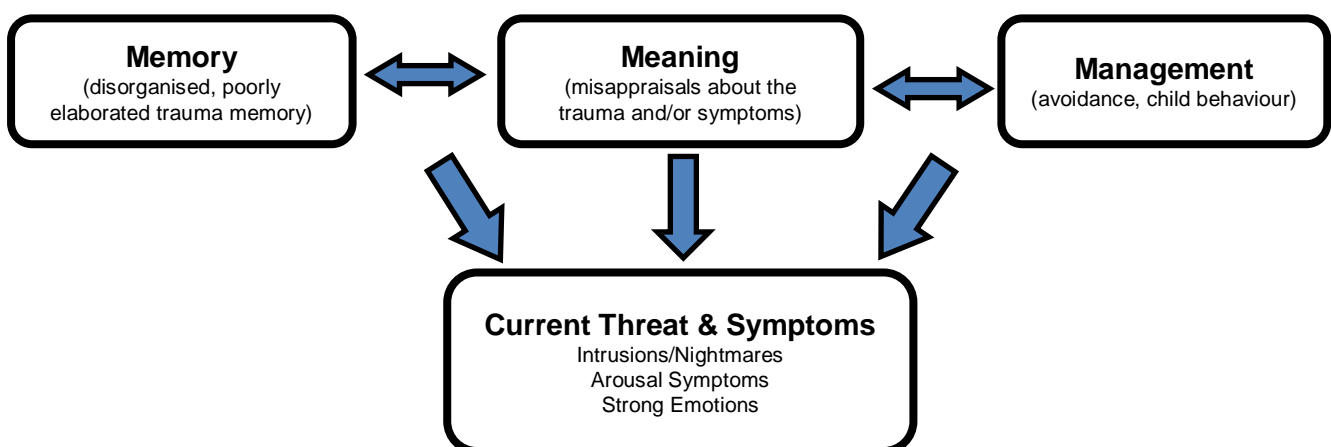
CBT-3M is a trauma-based cognitive therapy protocol for young children aged 3-8 years. It has been designed for children aged 3-8 years who have experienced a single traumatic event and have developed PTSD that has persisted for 3 months or longer. Any on-going threat to the child needs to be resolved before therapy commences. This treatment is not suitable for the treatment of children who have experienced multiple, complex traumas, including chronic sexual or physical abuse.

This manual is based on the treatment developed by Smith, Yule, Perrin, & Clark (2006) to treat PTSD in children aged 8-18 years, and has incorporated aspects of the treatment devised by Scheeringa, Weems, Cohen, Amaya-Jackson, and Guthrie (2002) to treat PTSD in children aged 3-6 years. These two manuals have been integrated and adapted for the 3-8 year old age group. Parts of this manual have been taken directly from Patrick Smith's manual and some materials have been taken directly from the ASPECTS trial (<http://c2ad.mrccbu.cam.ac.uk/projects/aspects.html>).

Treatment Rationale & Key Targets

CBT-3M is based on the cognitive-behavioural model of PTSD, as outlined by Dalgleish (2004) and Ehlers and Clark (2000). The key intervention targets that have been derived from this model are as follows:

- Memory – elaboration, organisation and updating of the trauma memory into autobiographical memory structures
- Meaning – interpretation of the event, appraisals about the trauma and symptoms
- Management – of avoidance, dysfunctional coping strategies, and child behaviour



Overview of Treatment

Frequency and duration of treatment

This treatment will consist of 10-20 weekly sessions of therapy, depending on the needs of the child. Each session will last between 60-90 minutes.

Treatment structure

The structure of the treatment will depend on the age and developmental stage of the child. The modules are not prescriptive in terms of how many sessions they require. If the child becomes fatigued or is not engaged, it is best to cover less and progress at a slower pace to ensure that they comprehend the material. The structure of therapy has been divided into two streams – Stream 1 for younger children aged between 3-5 years, and Stream 2 for children aged 6-8. Both streams of the treatment have been derived from the same model but have been tailored to the developmental stage of the child. An assessment will need to be made at the start of treatment which stream is likely to be most suitable for a given child, particularly for those around 5-6 years. In these cases (or indeed in cases where a younger child is very mature, or an older child less mature) clinical judgement will be needed to decide which stream to follow.

Session structure

Treatment will preferably take place in a dedicated clinic, or in the home of the family (when it is not possible to be seen in the clinic). The benefit of conducting therapy at a clinic is that it allows for separation between the child's everyday life by offering a clearly demarcated context in which the trauma is addressed. If therapy is to take place in the home of the family the child and parent will be able to be seen separately and together, without interruption from other siblings or family members. Therapy should be conducted in a common space and never in the child's bedroom.

The typical structure of a session will be to commence with both the child and parent to review the previous week's material and any homework tasks that have been set. The child will then work alone with the therapist, and then alone with the parent before concluding together. The exception is in certain modules that require greater parental involvement where joint sessions are more appropriate, or when the child is unwilling to separate (particularly likely in the younger age group).

Parental involvement

The session structure is flexible with respect to parental involvement and will need to be adapted according to the needs of the child. Generally, younger children will require more involvement from parents. In the case of younger children, it is also more probable that the parents will also have been exposed to the trauma and may require more support. If necessary, parents can

speak to the therapist alone or have individual sessions to help them support their child through the therapeutic process. Early in therapy, parents will be asked to provide a written account of the trauma and be instructed to repeat this process several times, each time incorporating new information into their account.

There are three reasons for this. First, completing narrative tasks that the child will later be asked to do places the parent in an excellent position to really understand and support their child through the same process. Second, the information garnered from parents in their written account provides useful details for the therapists to use to prompt the child when they commence narrative work. Finally, there is evidence to suggest that written exposure tasks reduce PTSD symptoms in adults. Therefore, it is possible that this may assist with the parent's symptoms and own response to trauma, which is invariably linked to the child's progress and the support parents are able to offer. The writing task has been adapted from the work of Sloan and colleagues (Sloan, Marx, Bovin, Feinstein, & Gallagher, 2012).

While parents are not the focus of treatment, if they are experiencing significant emotional difficulties of their own, they will be directed to self-help resources or a referral will be made if necessary. Treatment for parents will be indicated if their own distress is posing an obstacle to their child's treatment.

Parents play a key role throughout treatment. At assessment, they will need to provide information about the trauma, report on their child's symptoms, and describe changes in the family and child's routine since the trauma. During treatment, parents will be provided information about how to best support their child by helping to reduce avoidance, and use reinforcement strategies to manage their behaviour. Some treatment components will involve the parent only (ie., scheduling family activities) while others will involve both child and parent (i.e., agreeing upon regular bedtimes). Parents will also be enlisted as co-therapists to assist their child complete homework tasks which involve trauma memory work. Furthermore, parents will be interviewed following the completion of treatment so that the feasibility of the intervention can be evaluated from the family's perspective and issues including treatment experience, impact, and difficulties can be explored.

Treatment components

Early in treatment, sessions will focus on engaging the family, encouraging a return to the family's pre-trauma routine and activity level, providing psychoeducation and normalising the child's response. Following this, children will be taught how to identify different emotions and discriminate varying levels of emotional intensity. They will then learn basic relaxation and imagery-based anxiety reduction skills.

The greater part of this treatment is spent on facilitating sufficient processing and elaboration of the trauma memory, with a focus on integrating new information so that the memory can be updated. This is achieved by first developing a narrative of the trauma, either verbally or via

pictures/drawings, or both. This narrative is then organised and elaborated using detailed questioning and with the help of aids such as pictures and drawings. For younger children, detailed questioning around the narrative will constitute most of the memory work, while for older children, some reliving may be possible. Cognitive therapy techniques are used to examine and change maladaptive appraisals of the event and symptoms, although in younger children this takes on a more behavioural format. Throughout the memory work, the narrative is continually updated with new information as it becomes apparent, which assists in modifying maladaptive appraisals. The visit to the trauma site and exposure to distressing reminders is intended to bring about further appraisal change. Discrepancies that exist between the time of the site visit and when the trauma occurred are emphasised to give the event a clear context in the past. Adaptive coping skills will be explicitly addressed if the child has difficulty abandoning avoidance behaviours. Treatment will conclude with a relapse prevention session and review of the skills that have been developed. Additional techniques including sleep hygiene and nightmares, oppositional behaviour management, imagery work and managing poor motivation may be incorporated into treatment as required.

The workbook

During treatment, the child will place all their work, drawings and homework in a workbook. The value of using such a book gives a sense of focus to the sessions, and can symbolically contain the distressing memories of the child at the clinic, until the child is ready to process and deal with them. That is, the workbook can help to demarcate the clinic as a place where trauma work occurs. Towards the end of treatment, the child can reflect on all the work that has been done in the book which can give a sense of progress and achievement. Finally, the workbook is something that belongs to the child – they can decorate and personalise it how they wish and have the option of keeping it following the termination of treatment.

This manual

This manual is designed to guide an individually formulated treatment plan based on the needs of each child, rather than constitute a highly prescriptive, session-by-session structure. It is an integrated treatment that has been derived from the same model, although age-appropriate strategies distinguish the two streams. Key treatment techniques are intended to be adapted flexibly and appropriately to best suit the needs of involved families. CBT-3M is a pilot study and feedback from researchers and clinicians will be incorporated into the final treatment manual.

Treatment Overview - Core Components of Treatment

Number of Sessions	Content	Key Components	Homework
1	Diagnostic Assessment	Structured Clinical Assessment	-
1	Assessment, psychoeducation	Assessment, education, normalisation of child's response	Parents to read PTSD information
Less than 1	Narrative writing	Parent to write detailed account of event	Writing tasks
1	Activity scheduling	Reclaiming life & scheduling pleasant family activities	Scheduled activities
1-2	Feelings identification, relaxation skills	Feelings identification and guided relaxation exercise	Relaxation practice
As many as necessary	Developing the trauma narrative	Detailed narrative description, identification of worst moments, updating memory with new information	-
1-2	Cognitive restructuring	Assessing and modifying maladaptive appraisals Updating narrative with new information	Behavioural experiment
As many as necessary	Reliving and exposure to updated memory	Reliving with 'updated' memory, exposure to works parts of memory using aids as appropriate (e.g., cartoons, drawings, writing)	Worst moment exposure
1-2	In vivo exposure	Visit to trauma scene and/or graded exposure to reminders	Graded exposure to reminders
1	Relapse prevention	Review of skills	-

Supplementary Material (to be used as required)

When to Use	Content	Key Components
Early in treatment	Avoidance/defiance	Reinforcement strategies to manage avoidance/defiant behaviour
Early in treatment	Sleep hygiene	Sleep hygiene and addressing nightmares
Late in treatment	Imagery-based work	Imagery techniques

Treatment Streams

The treatment is divided into two age appropriate streams – both are derived from the same model and involve the same components, to be worked through chronologically. Key differences between the streams are summarised below:

Session	Stream 1 (3-5 years)	Stream 2 (6-8 years)
Assessment, psychoeducation	Rationale via jigsaw metaphor/toy	Rationale via cupboard metaphor Psychoeducation provided to child about anxiety
Activity Scheduling	Parent only	Child involved in generating activities
Feelings Identification	Stand-alone session	(relevant material covered in relaxation session)
Relaxation	Stand-alone session	Combined feelings identification and relaxation session
Narrative Work	Slower pace, most narrative work using drawings	Covered more quickly using both verbal and drawing mediums
Cognitive Restructuring	Joint session, mostly behavioural	Joint session, behavioural and cognitive
Imaginal Exposure and Reliving	Exposure via detailed discussion of drawings and imagery	Exposure via reliving (with here and now qualities)
In vivo Exposure	No difference	No difference
Relapse Prevention	More parental involvement	More child involvement

Diagnostic Assessment

Standardised diagnostic assessment for trial inclusion will have already taken place in the recruitment phase using the Diagnostic Infant and Preschool Assessment (DIPA; see PYCES protocol for details).

Diagnostic and Symptom Measures

Primary Outcome:

- Diagnostic Infant and Preschool Assessment (DIPA) - Semi-structured interview

Secondary Outcome:

- Posttraumatic Diagnostic Scale (PDS) – Child self-report
- Parental Post-Trauma Cognitions Questionnaire (PPTCQ) – Parent self-report
- Pediatric Emotional Distress Scale (PEDS) – Parent report
- Preschool Feelings Checklist (PFC) – Parent report
- Young Child PTSD Checklist – Parent report

Feasibility and Acceptability Measures

- Acceptability Checklist-Child (ACC) – Clinician report
- Semi-structured interviews – Parents (evaluate experience and impact of intervention)
- Child and Adolescent Service Use Checklist (CASUS) – Service-manager report

CBT-3M Manual

Stream 1

Age 3-5

Stream 1 - Assessment & Psychoeducation

Aim

- Engage the family
- Assess areas of difficulty/impairment
- Provide basic psycho-education to the parent about trauma
- Normalise child's response
- Provide a treatment rationale
- Agree on treatment goals

Meeting Structure

The first session will commence together, but the parent and child will have to be seen separately as well. The child's willingness to separate will determine exactly how this will take place. If necessary, the assessment can be conducted more slowly or over several sessions until the child is comfortable with the therapist and willing to speak to them without their parent present.

Materials

Paper and pencils
A4 folder
About Me worksheet
Cartoon aids depicting trauma scenarios
Toys
Simple jigsaw puzzle
Spring up toy
PTSD parent information sheet
Parent writing task

Procedure

To begin, clarify the reason for coming to therapy and establish ground rules. Identify that these meetings will take place once a week about fifteen times. If therapy is being conducted at a medical clinic, ensure the child knows that this is not a doctor's surgery. If it is taking place in the home, set up a room in the house away from interruptions and that is private. This room will be used for therapy on subsequent occasions. Explain that this is a safe environment and all information provided will remain confidential.

Begin by asking the parent to provide a brief account of the trauma and an outline of current problems. Encourage the child to provide information as well. The aim here is for the child to begin to feel comfortable talking to the therapist, and for parents to give 'permission' for them to do so. Outline what this first session will involve, being clear that you will want to hear about the traumatic event from both the child and the parent. Then, separate. If the child is anxious about being alone with the parent, speak to the parent first. If not, commence with the child, and give the parent the PTSD information sheet to read while the child is seen.

Child

The initial work with the child is designed to develop rapport and learn a bit about them. Take this part very slowly. Introduce their workbook, which will remain at the clinic (or with the therapist if they are being seen in their home) and tell them that they will be doing various projects to be stored in the book. This book will be like a story about them. Tell them that they can decorate the book a little later on today, but for now, should fill out the About Me page. Here they are able to draw a picture of themselves, and record some of their favourite things. Give the child time to get used to talking. They need to become comfortable with you before moving on.

Ask the child whether they like stories and whether you can tell them a story. Use the cartoon aids to demonstrate symptoms of PTSD via a story. While telling the story draw a connection between the child and the character and look for cues indicating that they understand.

An example of suitable story might be:

'This is Annabelle. One day she was driving in the car with her mum and there was a big car crash. She wasn't hurt in the accident, but then Annabelle got nightmares about it and gets really scared when she has to get into a car. When Annabelle came here for treatment and talked about what happened it really helped get rid of her scary feelings and now she doesn't get scared anymore'.

During the story, pick several points and ask the child if they make the connection to themselves (i.e., 'this might be similar to what happened to you when you were in the car accident'). If the child is unable to make the connection, it might be useful to simulate the story using toys.

Ask for a narrative account of the trauma

Tell the child that you would now like them to tell you a bit about what has happened to them. Ask the child if it is okay with them to talk about what happened, even though it may be upsetting. Praise their courage for talking about the trauma. If the child is unwilling to talk about what happened, ask them to draw a picture and use it as a starting point. This will also be necessary if the child is not sufficiently advanced to articulate what happened. Also enquire about the worst parts of the trauma, and try to elicit appraisals if the child is able to report on what they were thinking.

Ask for details about symptoms

Ask the child about their symptoms using the term ‘scary feelings’. It may be necessary to refer to what the parents have said at the initial diagnostic assessment if the child is reluctant or unable to verbalise their symptoms. Also refer to the PDS to ask about symptoms.

Normalise response

Tell the child that everyone experiences some of the symptoms they have described soon after a trauma. In many adults and children, these symptoms can carry on. Give a brief example of another child who had similar problems and who was successfully treated, and talk about older children, or people like fire-fighters and police-officers having these problems. Inform the child that lots of people get these scary feelings after going through something like they have - it’s nothing to be ashamed of, and people get better after treatment.

Provide treatment rationale

Provide a rationale to the child for coming to treatment by drawing a link between intrusion and avoidance. Explain that they have been trying to push the memory of what happened away. This might work in the short term, but in the end, memories come back in dreams or during the day in pictures. Demonstrate this idea using a spring up toy – when you push it down it just keeps on springing back up. Explain to the child that instead of continually pushing it away, the answer is to deliberately let the memory out – it hates being out in the open. Deliberately facing up to the memory means they will be able to remember it when they want to, and without becoming scared when they do so.

Another way to demonstrate this point is by doing the thought suppression behavioural experiment. Illustrate the paradoxical effects of pushing thoughts away by asking children *not* to think about a rabbit eating the therapist’s hair. Most children will report that they have an image immediately and find that it returns when you check that they are not thinking about it. Use this to show how avoidance is unhelpful.

The jigsaw metaphor can also be used to assist with providing the rationale. Explain that their memory is like a jigsaw puzzle that is scattered around in bits everywhere, and they will keep tripping over the pieces. Rather than trying to throw the pieces away, what we’ll be doing is gathering them up on purpose, putting the jigsaw together, and having a really good look at it. Once it’s all put together,

you can put it away and look at it when you want to. If the child is not very engaged, do a simple jigsaw puzzle with them as a rapport building exercise designed to demonstrate this point.

Give the child an opportunity to ask questions. Provide reinforcement to the child for being so brave, and ask them whether they would like to decorate their workbook book while you speak to the parent.

Parent

It is necessary that the parent be interviewed alone because they need to be able to speak openly about the trauma, without concern about upsetting their child. Further, with younger children, parents are very likely to have been involved in the trauma themselves, and their own symptoms and difficulties need to be assessed so they can be referred on if necessary. Begin by relaying what the child has said and answer any questions about the PTSD information sheet that the parent has. Then, commence the assessment.

Narrative

Get an account of the trauma

Symptoms

What are you child's symptoms?

How have they influenced the child's functioning?

Parental Attributions

What do you think about their child's difficulties?

What do you find most difficult to cope with?

Are you concerned that your child is going crazy/will never be the same?

Parental Response and Discipline

Have there been any secondary gains for the child since the trauma (ie., missed play group, treats)?

Are you going easy on the child in some respects? How?

How have you managed their child's behaviour? Is this the view and approach taken by the other parent?

Do you encourage your child to talk about the trauma or do they avoid talking about it?

Who is the child talking to about the trauma?

Impact on Child's Functioning

Is your child participating in fewer activities now? What are they?

Are you more protective of your child now?

How has the trauma changed how your child spends their spare time?

Impact on Family

How has the trauma impacted on the family?

Is the family still doing the same activities as before (e.g., eating dinner together, weekend outings?)

Parent's Symptoms

Were you involved in the same trauma?

How are you coping?

Do you have adequate supports? (If not, direct to self-help resources or make a referral if necessary).

Provide Rationale

Provide a strong rationale for treatment in a way that the parent understands. Draw on the model to explain that the trauma memory will be targeted so that the memory can be updated and sufficiently processed. Explain how misappraisals of the trauma and symptoms maintain a sense of current threat, which maintains PTSD. By reducing avoidance, appraisals can be tested out and threat is reduced.

Provide an overview of what will be covered in treatment and emphasise the critical involvement of the parent in supporting their child through the process. Outline their role in modelling behaviour, setting boundaries, assisting their child to abandon avoidance behaviours and acting as a co-therapist to help with exposure and homework assignments. If both parents are not present, ask for this information to be passed onto them.

After the model has been explained and the parent understands that treatment involves confronting trauma memories and reminders, tell the parent that we will be asking them to write their own account of what happened during the trauma. Tell the parent that they will be asked to do a number of writing tasks over the first few weeks of treatment. Provide a rationale emphasising the need to gain first-hand experience in how difficult addressing the trauma memory can be, so that they will be optimally placed to support and help their child through treatment.

Additionally, explain that it will be really important to have detailed information about the trauma, which includes the worst parts of the event. This is so that when the child begins work on the memory (in approximately 3-4 weeks) the therapist has enough specific information from them to prompt the child to include relevant details if they cannot do this on their own.

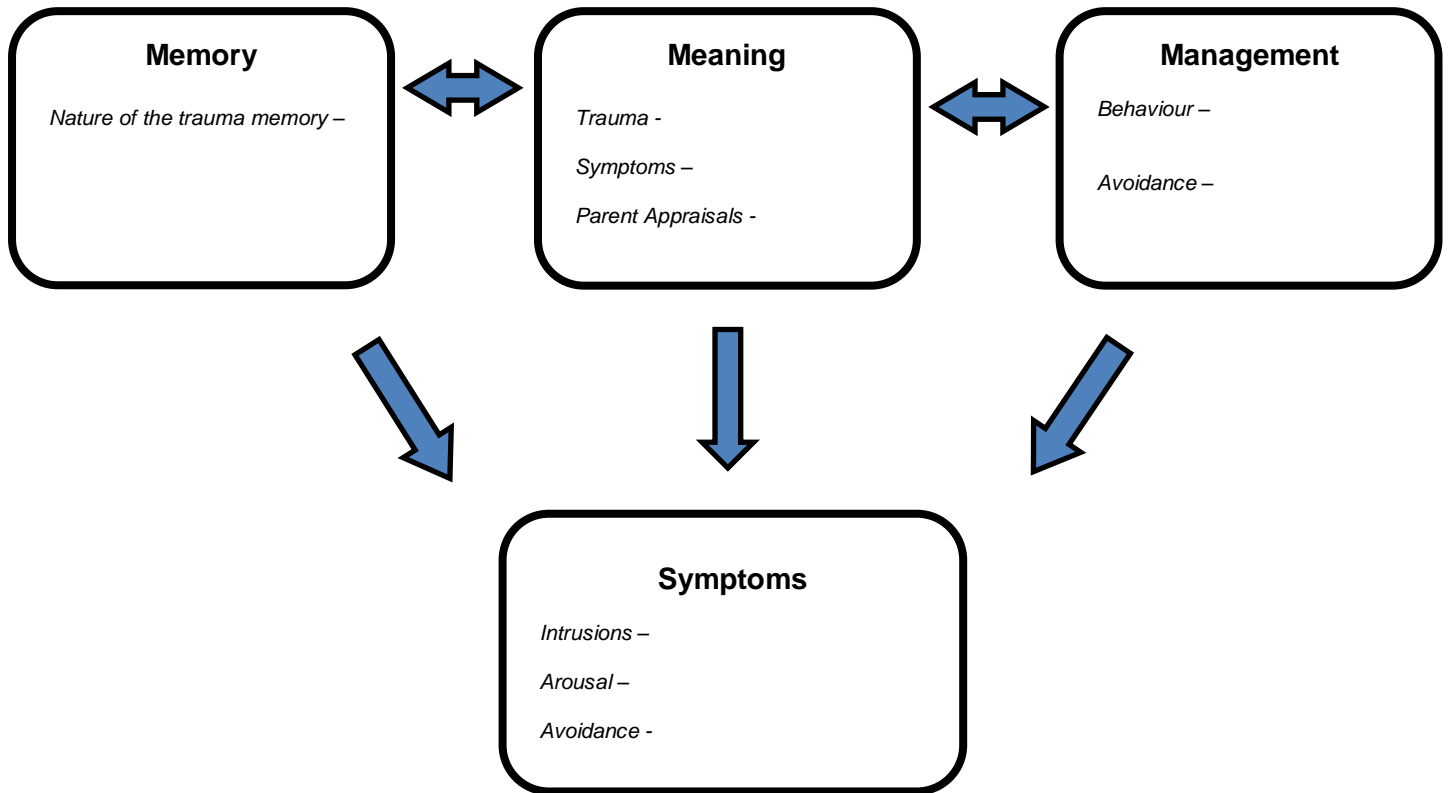
Once you are confident that the parent understands the importance of completing this task, direct them to the Parent Writing Task sheet and go through it slowly and thoroughly with them. Ask if they anticipate being able to complete it over the week, and instruct them to return it at the following session.

If time permits, move straight into scheduling pleasant events if there has been a reduced level of activity since the trauma (see next module).

Conclude the session with both parent and child together. Praise the child in front of the parent for being brave and provide a lot of encouragement for talking about the trauma and deciding to take the first step in making their scary feelings go away. Praise their About Me page and decorations and collect it back to be stored in the therapy room.

Schedule the next session, and give both parent and child the chance to ask any questions.

Following the assessment, put the specific details of the case into the blank formulation below. This is intended to be a guide, for the therapist to conceptualise the case and identify key aspects of the trauma and symptoms to be targeted.



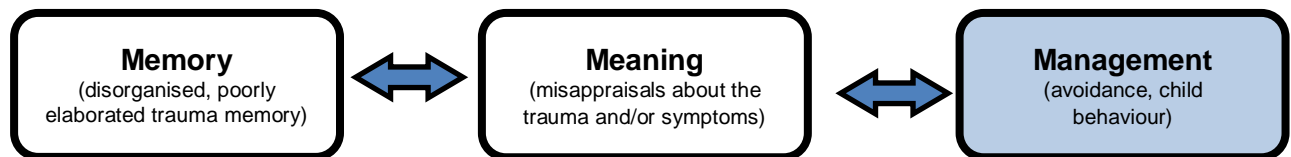
Stream 1 - Reclaiming Life & Activity Scheduling

Aims

- To provide opportunity for positive experiences for the child and family
- To reduce sense of current threat by re-engaging with world and regular activity
- To give a sense that things are returning to normal

Rationale

Young people with PTSD often show a reduced level of functioning relative to before the trauma. This can be the result of a generalised sense of fear due to the trauma, low mood, or greater protection of the child by their parents. Scheduling enjoyable activities provides an opportunity for enjoyment, communicates that things are returning to normal, and can be useful for the parent to reduce level of over-protectiveness (if this is a problem). This module targets the ‘management’ aspect of the model.



Materials

Activity Plan Sheet
Activity Record

Meeting Structure

Parent only session.

Procedure

This treatment component should be completed with the parent. Before commencing with this module, check how the parent went with writing out their memory. Ensure that they have been able to identify key thoughts and incorporate new information into the narrative. Discuss any difficulties and ask the parent to do the writing task again, but this time, including all the updated information that they identified from the initial task. Ask them to bring it in at the next session.

Based on information gathered during assessment, it will be apparent if there has been a reduction in the child and/or family’s level of activity. If it is unclear whether this is the case, some monitoring may be necessary. In this case, ask the parent to complete the Activity Record over the following week, which asks them to record activities that their child and family engage in, and rate how typical

this is compared to a regular day from before the trauma occurred. Once this information has been gathered, it will be obvious whether there has been a reduction in level of activity.

There are a several reasons why activity may have reduced. It may be due to parents' over-protectiveness. The work here is in encouraging parents to be less protective. Discuss what they fear may happen if the child is given more independence. How realistic are their fears? What are the advantages and disadvantages for the child (and family) in restricting activities? What do other children of his/her age do? What would their child be doing if they had not been involved in the trauma? Encourage the parent to experiment with allowing their child to engage in an activity they enjoy and monitor how the child responds and if it there is a positive impact. If the parent is quite anxious about this, engaging in more activity should be introduced in a graded way. Emphasise how increasing activities is an important part of treatment that will give the child a sense of moving on from the trauma, and allow him or her to get back on to a normal developmental trajectory. Resuming regular family activities also communicates to the child that life is returning to normal.

Another reason that activity levels may have declined is if the child has developed an overgeneralised sense of danger to the point that they are too scared or frightened to do any activities. If this is the case, the child should be encouraged and supported to return to their normal, pre-trauma activity level, and their activities should be fun and enjoyable - unrelated to the trauma.

Activities are scheduled with the parent. They need to involve enjoyable events as well as activities which will be soothing to the child. For example, the child might be given a choice to do something special with the parent, such as being read stories for half an hour, or listening to some calming music together. Where possible, the child should be involved in choosing some activities and efforts made towards facilitating quality time spent between child and parent.

Some activity suggestions include:

- *Reading a story with mum/dad*
- *Baking something delicious*
- *Scheduling a play-date*
- *Playing a game with the family that the child likes*
- *Getting ice-cream from the ice-cream van*
- *Going to watch sport such as football/cricket*
- *Special time with mum/dad that the child gets to choose what they do*
- *Going out for dinner*
- *Doing a drawing/painting*

Once chosen, they can be written down in the Activity Plan. Activity scheduling and strategies discussed here should be used as required throughout treatment. After activities have been scheduled for a few consecutive weeks, it is sufficient to enquire about activity level each week without going through it in a structured way. As a caveat, if activity levels in the family are very low, more time and attention should be directed to ensure that progress is made. This is especially the case if parent is depressed and increasing level of activity may be more challenging. If this is the case, activity scheduling is likely to also benefit the parent. By providing an opportunity for positive experiences, the functioning of the whole family should improve.

Homework

To complete scheduled activities and the second writing task.

Stream 1 - Feelings Identification & Bodily Sensations

Aims

- To identify different emotions
- To distinguish between varying levels of emotional intensity
- To link emotions with bodily sensations

Rationale

It is necessary to ensure that young children are able to identify their feelings. The feelings and bodily sensations exercise covered in this session provides the foundation for subsequent memory work and enables progress to be monitored. The introduction of the feelings thermometer early in therapy enables socialisation to thinking about and reporting different levels of distress and fear.

Materials

Paper and pencils
Workbook
Faces Chart
Feelings Thermometer
Feelings In My Body sheet

Meeting Structure

The session is to commence together, then the child is to be seen alone, then the parent alone, before finishing together. If it is not feasible to see the parent alone (ie., if the child becomes too distressed separating), organise to speak to the parent over the phone during the week to cover the remaining material.

Procedure

To begin, review what was covered in the last week in about five minutes. It is important to set up a consistent structure for treatment sessions. Ensure that the child remembers that they are here to talk about what happened to them. They probably won't recall much more than this. Revise the jigsaw metaphor as a reminder as to the purpose of therapy. Explain what will happen next – that the therapist and child are going to learn some new skills to help the scary feelings go away. Then the parent will spend some time with the therapist while the child can continue to decorate their workbook, and then the family will all meet back together at the end.

a) Identifying Feelings

The session commences with an activity to help the child identify different emotional states. Tell the child you would like them to answer some questions about feelings. Use the Faces Chart showing a

range of faces. Inform the child that you are going to ask them some questions about feelings. Provide scenarios and ask them to point to the correct face (ie., ‘I bet that when you open presents on your birthday you feel happy – show me the happy face’). Integrate drawings and props as necessary until the child can identify feelings correctly.

b) Grades of Emotion

The purpose of this exercise is to ensure that the child can differentiate between grades of emotion. Use the Feelings Thermometer to aid the identification of low, mid and high levels of ‘scary feelings’. Begin by teaching the child about different levels of fear using a relevant example. For instance, you might use the example of playing with a favourite toy as ‘not scary at all’, being alone as ‘a little scary’ but being in the dark ‘very scary’. Use aids such as drawings, toys and props to demonstrate.

Once the child appears to comprehend the idea of different grades of emotion, do an exercise where you ask them to point to the thermometer level which represents their emotion. For each point provide an emotional description (e.g., ‘not scary’, ‘very scary’) and an example (‘watching my favourite TV programme’, ‘waking up from a nightmare’). Try to keep the examples relevant to the child – some ideas include fear associated with the lights being turned off, getting in trouble, fear of animals, falling off a bicycle, watching something scary on television. Mark these anchor points. If the child does not understand, tell them a story and demonstrate the different levels of emotion on the thermometer. Tell the child that what happened to them is up in the ‘very scary’ zone.

c) Bodily Sensations

Once the child is able to distinguish between levels of emotion, introduce the notion that different feelings feel different in the body. Use the Faces Chart to play a game where you show how different expressions feel. For example, show ‘very happy’ and make the expression as well as laughing. Talk about how laughing feels in the chest. Repeat this with a few expressions. If this is too abstract, simply move on. Using the Feelings In My Body sheet, ask the child where they feel happy, sad, scared and angry in their bodies. The purpose of this exercise is to teach children about the relationship between feelings and bodily sensations. If the exercise is too difficult, provide suggestions (heart pounding, head hurts, stomach knots, lump in throat). Encourage the child to draw these feelings onto the body sheet and assist as required. Allow the child to colour it in and decorate the picture which they can continue working on while you meet with their parent.

Finish the session with the child at this point (or move onto relaxation) if time permits. Provide the child with reinforcement and praise for their work and cooperation during the session. Ask them if it's okay with them if you tell their parent what they have learnt today.

Report To Parent

Begin by asking the parent about how they got on with the activity homework. Address any obstacles and review the reasons for increasing activity levels to a pre-trauma level if necessary. Fill in the parent about the material covered. Review the feelings and bodily sensations activities. Also go through the second narrative that the parent has completed, ensuring they have been able to include updated information. Clarify any questions and ask the parent to repeat the exercise over the next week and again return with their account.

Enquire about the child's behaviour and whether they are being oppositional. Use the supplementary material as required. If the parent does not seem engaged in therapy it might be necessary to directly address their motivation and possible reluctance to attend therapy. Again see the supplementary material on ways to deal with parental apprehension and poor engagement.

Stream 1 - Relaxation & Happy Place Imagery

Aims

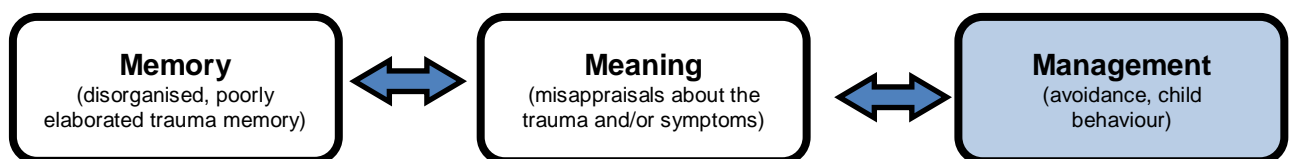
- To reduce symptoms of overarousal

Rationale

Teaching relaxation skills early in treatment may give the child a sense of control over their emotions and can reduce anxiety. It also reinforces the link between thoughts, feelings and bodily sensations. Positive imagery techniques can also be helpful in this respect, and provides a way to manage anxiety that will be useful for subsequent memory work. Many children complain of difficulty in getting to sleep at night, and relaxation and calming imagery can quickly help with this. Furthermore, giving children a skill that they can take away and practice may provide a sense of progress and change early on during therapy.

Care must be taken that relaxation is not used as an additional avoidance strategy by the child. State from the outset that relaxation is part of their ‘toolkit’ in overcoming their ‘scary feelings’ and that eventually, they will not need to use it often. While children may find regular relaxation useful in the initial stages of therapy, it often drops naturally from their repertoire of behaviours as symptoms subside.

Relaxation is derived from the management component of the model as it provides the skills necessary to begin reducing avoidance behaviours. Additionally, it offers direct symptom reduction by targeting arousal.



Meeting Structure

The session is to commence together, then the child is to be seen alone, then the parent alone, before finishing together.

Materials

Happy Place Sheet
Feelings Thermometer
Relaxation Practice Sheet

Procedure

Spend five minutes reviewing what was learnt last week and have a look at the child's decorated picture of the Feelings In My Body sheet if you have not already done so. Provide praise for completing the exercise. Inform the family that today the child will be learning their first skill to help them with their scary feelings and help them relax and draw the link between scary feelings and bodily sensations (using the picture they have decorated) if necessary. Tell them that they will do a relaxation exercise and can tell their parent about it at the end. Proceed to work with the child alone.

Tell the child there will be two parts to the exercise that they are going to do today – relaxation and imagining a happy place. Begin by asking the child what they do to relax or for fun, and provide prompts if required. Encourage them to continue with these activities and that today they are going to learn another way to relax. Tell them that it is very hard to feel scared when the body is relaxed (making reference to the Feelings In My Body exercise).

a) Relaxation

Teach, through modelling, a simple form of progressive relaxation. Explain and demonstrate what you will ask them to do. Tell the child that you will be asking them to make their muscles “tight tight” and then “go loose like spaghetti”, with an exaggerated body demonstration.

Start with the child sitting comfortably in a chair. Take normal steady breaths and allow the body to relax a little more with each breath out. Instruct the child to tense and relax the following muscle groups in turn: fists and forearms; triceps; biceps; shoulders; stomach; legs. Focus on steady breathing throughout. If the multiple muscle groups are too complex, use a two-step procedure that involves tightening arm muscles and holding for two counts, and then letting them fall like spaghetti, and then repeating this procedure twice.

A game can be used to practice this and the child might be able to think of other ways to tense and then relax. Humour can be used to design some tense and relax moves where appropriate. Introduce the Feelings Thermometer into practice, and demonstrate that before, your body feels ‘scared’, but after, it is more relaxed. Ask the child to show you how their body feels on the thermometer, both before and after practicing.

b) Happy Place Imagery

Following the relaxation practice, ask the child to think of a relaxing scene. Some suggestions could be at a beach, their birthday, on their mothers' lap, playing with their pet. Once the child has decided

on a happy place, help them to draw it onto the Happy Place Sheet which they can colour it in at the end of the session.

Tell the child that you are going to practice holding this picture of their happy place in their minds with their eyes closed. If the child has difficulty imagining the scene with their eyes closed, help them to practice by using the drawing of the picture, and then closing their eyes but keeping the picture in their mind. Ask them on what it looks like and oscillate between the open and closed eyes until they can imagine it. Once the child can keep a picture in their mind tell them that they are now going to put their two new skills together.

c) Combined Relaxation and Imagery

Tell the child that they are now going to practice their new skills by doing relaxation and then thinking about their happy place. Ask the child to use the Feelings Thermometer to demonstrate their level of 'scary feelings' right now. Then, guide the child through the relaxation exercise. Then, ask them to remain quiet, relaxed in their body, imagining their happy place. Instruct them to open their eyes when they are ready. When they have finished, take a rating on the thermometer. If anxiety decreases, use this as a rationale for completing the exercise at home over the week. If it does not, frame these tools as skills that need to be practiced in order to be effective and set practice as homework. Remind the child that they can use relaxation when they feel scared in their body, and can use their happy place picture to replace scary pictures. Allow the child to colour and decorate their Happy Place sheet.

Report to Parent

Discuss the material that has been covered. Identify the role of relaxation as an anxiety management skill that can use to help their child relax and to fall asleep if this is a problem. If nightmares and sleep difficulties are causing difficulty, see the supplementary material to address these problems directly.

Ask the parent to prompt and encourage their child to practice relaxation each day and to do it with them. Explain that they will become better at it with repeated practice and ask parents to monitor and record their child's scary feelings score using the Feelings Thermometer on the occasions that they assist, and to record it on the Relaxation Practice Record. Discuss the potential for relaxation techniques to become a form of avoidance, and present this as an additional reason for continued monitoring.

Check in with how the parent has gone with the writing task, and ask them to repeat it one final time over the week. Tell the parent that next week the child will commence memory work, and that they

are now in a much better position to understand what this involves and support them through the process.

Conclude the session together. It may be useful to ask the child to explain to the parent what they learnt in the relaxation activity as a way to assess comprehension. Assist the child as necessary. Agree to practice it once each day during the week and give the Relaxation Practice sheet to assist. If the child completes the relaxation they can have a sticker on their chart for each time they do it. Be mindful of the possibility that relaxation could develop into an avoidance strategy and to this end, monitor how it is used by enquiring about it intermittently.

Homework

Relaxation practice and writing task (for parent).

Stream 1 - The Trauma Narrative Part I

Aims

- To develop a coherent account of the trauma
- For sufficient memory elaboration to enable emotional processing
- To incorporate new information into the memory

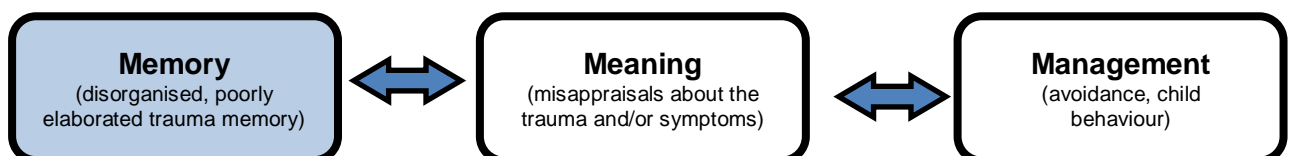
Rationale

The goal of narrative work is to build up a complete, chronological and accurate story of the trauma. The narrative needs to include key hotspots or ‘worst moments’ as well as the child’s cognitions about what they thought was going to happen at these moments. These moments reflect the critical aspects of the memory that need to be targeted and updated during these sessions.

There need to be at least two narrative sessions, but will most likely be several more than that. The rate at which the narrative work is moved through will have to be set at the child’s pace. The goal of the first session is to get key information from the child about the trauma. The initial narrative provided by the child will include limited detail so subsequent sessions are intended to elicit further information to be incorporated into the memory so some updating can occur.

It is an overarching goal of therapy to emerge with a highly elaborated and detailed narrative of the event, which includes new information that the child now has access to, which they may not have had at the time. Developing the narrative will involve drawing, cartoons, and written stories and should be adapted to the stage of the child. When new information is added to the narrative, it needs to be clearly marked (ie., using a different coloured pen/drawing on a different coloured piece of paper).

Narrative work comes under the ‘memory’ component of the model, although the meaning of the memory is also addressed.



Meeting Structure

The session is to commence together, then the child is to be seen alone, then the parent alone, before finishing together.

Materials

Pencils and paper for drawing
Feelings Thermometer
Scary Feelings Scoresheet
The Story of What Happened To Me sheet
Worst Moments Chart
Workbook

Procedure

Spend the first five minutes with the family and ask how they went with relaxation practice. Provide reinforcement and enquire about its effectiveness. Spend a few minutes doing a short in-session practice to ensure that the child remembers how to do relaxation. Place the homework record in the workbook and then commence the session with the child.

Explain to the child what they will be doing today. Inform them that they will be telling the whole story about what happened, all the way from the beginning, right up until the end when they felt safe again. Most children will understand that they will have to face up to what has happened to them.

Drawing upon the jigsaw metaphor may help the child to understand the purpose of telling the story. Ask the child to assist you with some detective work to help find clues as to what really happened. If the child is unconvinced, tell them that you need them to tell you the story of what happened to go into their workbook, and take out the Story of What Happened To Me sheet.

Before asking for the narrative, explain that telling the story will be difficult but is very important and represents a big step towards making their scary feelings go away. Provide encouragement - talking about the trauma is a sign that they are being brave and ready to get better. Tell the child that you will be writing down what they are saying so that you can remember everything that they tell you. You will need to decide whether providing the story verbally is too advanced for the child and in this case, do the exercise either via creating drawings or by using pictures.

Ask for an anxiety rating using the Feelings Thermometer. Ask the child to tell you (or draw) the story right from the very beginning using the Story of What Happened To Me sheet for this exercise choosing the appropriate version (either text, pictures, or both). Children of this age do not yet have the skills to provide detailed narratives of past events and will give a very brief account. First allow children to tell their story uninterrupted. Write down this account verbatim as the child tells the story. If using drawings, ask the child to draw a series of pictures showing what happened. Ask the child to draw a scene of the beginning, middle and end of what happened (as prompted on the sheet). The drawings don't have to be good, but should be something they can talk about. Use the drawings as a basis to talk about what happened. Take the lead from the child. Ask them to tell you about the worst

parts. Ask similar sorts of questions as you would for the verbal narrative. Help them to begin constructing a narrative, getting the sequence of events in order.

If the child is unable to create a picture and helping them do so does not result in sufficient detail, be more prescriptive. Use a series of cartoons or pictorial representations of the trauma. You can then lead the child and ask for details as you take them through the event, prompting as necessary, using the questions listed below.

Once the child has told the story for the first time, lead the child through their narrative again more slowly, ensuring you ask about important domains including factual details, thoughts, feelings and sensory details as well as hotspots and worst moments. It is important to get a sense of the hotspots from the child – ask about the ‘scariest’ parts. Clarify key facts about the trauma from the parent before the narrative exercise as a way to prompt the child if they find this task too challenging.

Pace the session according to the capabilities and distress level of the child. Be sure to guide the child through the narrative sensitively, reminding them to use their relaxation skills if necessary, and do not do too much work around hotspots until some anxiety has habituated and they become more comfortable speaking about the trauma.

Some useful questions to assist include:

Factual Details

What was happening before it happened?
Who was there?
Where was everyone and what were they doing?
What were you doing before the trauma?
What were the first signs of danger?
What was your first reaction?
What happened next?
What happened afterwards?
When were you safe again?

Thoughts

What did you think was going to happen?
What did you wish you did but didn't do?
What did you think was going to happen to you/others?

Feelings

When did you feel most scared?
When did you feel most sad?
When did you feel most angry?
Were you worried you might get in trouble?
Were you worried that other people might get hurt? Who?

Sensory Details

Do you remember what you were wearing?

What was the weather like?

Do you remember any tastes or smells?

Where were there any objects that stand out in your mind?

What colour was the X?

After the story has been recounted, go back through the parts of the memory that the child identified as the 'worst moments' and try to get three to five to put on the Worst Moments hierarchy. Ask the child for a scary feelings rating for each so that they can be ordered.

Provide encouragement and reinforcement for being so brave. If the child is very distressed, relaxation and happy place imagery can be practiced as a way to help. This also has the benefit of communicating to the child that they can use these strategies as needed. Continue to take scary feelings ratings until there is a decline in distress. Tell the child that they have shown that they can tolerate thinking about these memories, and even when they become upset, they feel better a short time after. The Story of What Happened To Me sheet and Worst Moments sheet should be placed in the workbook at the end of the session.

Report to Parent

Set aside more time than usual to speak to the parent in this session. This is because the parent may not have heard about the trauma from their child's perspective, and hearing about what they have said can be a powerful experience. Revisit the model and rationale for memory work if necessary – it is important the parent really understand the reasons for addressing the memory, and how this will aid emotional processing and symptom reduction.

Ask the parent for their writing task and review it with them.

Relay the child's version of the event. Ask the parent what they thought of while they were listening to the narrative and normalise any distress that the parent might experience. Spend some time addressing the importance of the child feeling able to talk about what happened. Ask whether any key details have been omitted from the child's report which the child can be asked about next session and integrated into the narrative. There is no need to set homework this week.

Stream 1 - The Trauma Narrative (Part II)

Subsequent narrative sessions are very similar to the first but are intended to enable additional details of the trauma to begin to be incorporated into the memory. This needs to happen in combination with cognitive restructuring (the following module). Providing an opportunity for elaboration and the incorporation of new information (possibly garnered from the parent at the end of the previous session) will allow for some updating to occur. The same procedures and materials are used as the previous session.

Procedure

Explain to the child that they will be doing something very similar to what they did last week by continuing with their detective work in finding out what really happened. Provide encouragement and reinforcement for how brave they were last week, and inform them that this week they are going to tell the story again and tell them that you will be stopping them to ask questions so that you can get the full story.

Ask for a scary feelings rating using the Feelings Thermometer before the child begins. Remind them that the first few times they do this will be the scariest, but after doing it a few more times, it will become much less scary. Use non-trauma examples to explain this – for example, hearing thunder for the first time is really scary, but after you've done it a few times, it's not so bad.

Ask the child to start telling you or drawing a picture of what happened right from the very beginning. While they recount the story, stop them at various points to prompt for additional details that their parent may have provided at the end of the last session. Ensure you ask about thoughts, feelings, worst moments and sensory experiences. Use gentle questioning and discussion to integrate new information into the memory. For example, if a child reports that they thought they were going to be trapped and never get out, it is valuable to ask them what they know now that they didn't know then (ie., that they ambulance was on the way and would get them out as soon as they arrived). For children doing a picture version of the narrative, drawing a picture of an ambulance would be analogous in this example.

As new information is added to the memory, record this and note that it has been added. For example, in the case of a narrative being transcribed, add in new information in a different colour. If an additional picture is drawn, do this on different coloured paper so it is distinguishable from the initial memory. This can be used to communicate any discrepancies between what the child thought at the time, and what they know now, which can reduce the sense of current threat and emphasise that the trauma is something that happened in the past and now they are safe.

Throughout the narrative, ask for a Scary Feelings rating. The child needs to continue to discuss the narrative until their anxiety rating has reduced by at least some degree. Provide encouragement for their bravery and if they are very distressed, prompt them to use their relaxation/happy place imagery to help. Continue to take scary feelings ratings until there is a decline in distress.

Building up the narrative is a work in progress and will need to continue until there has been a marked decrease in memory-elicited anxiety.

Report to Parent

Describe to the parent what the session has involved and relay the narrative provided by the child. Explain the importance of 'updating' the trauma memory as a way to reduce sense of current threat and clearly distinguish between the past traumatic event, and the here and now. This material may have been covered in the previous session.

If time permits, speak to the parent about the child's likely appraisals and what will be covered next session (see next module).

Conclude the session together. There is no need to set homework this week.

Stream 1 - Cognitive Restructuring

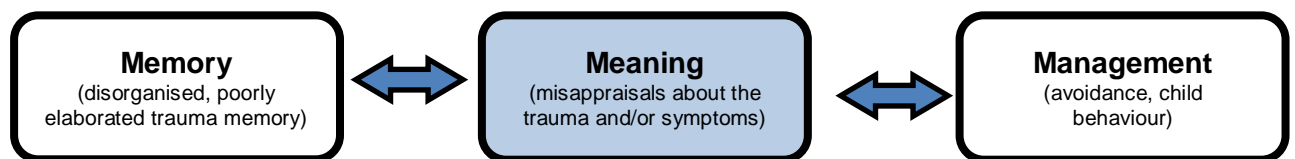
Aims

- To identify misappraisals of the trauma and/or PTSD symptoms
- To modify misappraisals and reduce sense of current threat

Rationale

Children may show maladaptive cognitions about the trauma itself, and/or about symptoms of PTSD. Appraisals about the trauma are likely to do with responsibility, guilt, or shame and some children may show magical thinking or omen formation. For traumatic symptoms, appraisals are often related with going crazy and having an unrealistically heightened sense of danger. The goal here is to identify and modify maladaptive appraisals in order to reduce perceived threat. Sensitive interviewing and attention to common themes is needed as children of this age may be unable to verbalise their concerns.

This module addresses the ‘meaning’ component of the model. In doing so, the memory is also addressed.



Materials

Scary Moments sheet
Testing Things Out For Myself sheet

Meeting Structure

This session is a joint session.

Procedure

Although cognitive restructuring takes place as a joint session, the parent needs to be seen individually before the session so that they can be prepared for some of the concerns that their child may have. This should occur at the start of the session, or at the conclusion of the previous session.

Parents need to know that many of their child’s misappraisals may be to do with them and could be guilt driven. For example, their child may have thought that their parent was going to die during the trauma; they may be concerned that their parent blames them for the accident; that awful things happened to their parent if they were separated; that their parent is now at risk of dying because they

had to go to hospital in the aftermath and so on. It is useful for parents to know this prior to the session so they can be prepared. Once the parent understands that nature of what their child's concerns are likely to be, the joint session can commence.

It can often be very helpful for the child to tell their parent of their worst fear. Depending on the nature of the trauma and the verbal stage of the child, when children tell parents of their fears – for instance, that they thought that mum or dad was going to die, most parents will respond with great warmth and care. This can have the effect of freeing the child and parent to talk to one another outside the session about the trauma.

If the child and parent were separated during the trauma, it can be very helpful for children to hear about what happened from the parent's point of view (e.g., what happened to the parent in the hospital while separated). Take care that the parent is able to do this without becoming too overwhelmed or upset.

Maladaptive appraisals need to be elicited and assessed in collaboration with the parent. Any misappraisals that came out of narrative and exposure work should be assessed further, and questions about blame, interpretation of symptoms, an overgeneralised sense of danger and feeling like something terrible will happen again need to be enquired about.

If the child is too young to coherently verbalise thoughts and feelings, use drawings from the memory work as a foundation for asking questions such as 'What were you thinking at the time?' and 'What were you scared might happen?'. Provide options for the child to choose from if necessary.

Information about the facts of the traumatic event can be obtained from parents and may help in changing cognitions to do with guilt (e.g., a mother tells her son that although he was talking to her when they crashed, he didn't cause the accident by distracting her). As well as self-blame, children may mistakenly perceive blame from parents, and this can impede recovery. Again, discussion with the parent can modify this belief.

To modify misappraisals that do not shift in response to providing contradictory information, take a behavioural and concrete approach to testing out these beliefs. For example, in the case that a child is afraid of going out into the rain because it makes things slippery (following a car accident due to poor weather conditions), you might set the task of watching the road from inside when it's raining to see if cars slip off the road.

Develop new cognitions in response to behavioural experiments. These can then be incorporated into the narrative as a way to update the memory. Appraisal modification and memory updating should occur together in this way. That is, cognitive restructuring and updating of the narrative take place concurrently. It is necessary to continually be thinking about how information which is now available (but was not available at the time) can be used to develop the trauma memory and really distinguish between the time that the trauma occurred, and the here and now. For example, having the thought that the child's parents were going to die can be updated with knowledge that they didn't die. This continually evolving record of the narrative is something that the family will be able to keep and gives a sense of progress.

At the end of the session, provide encouragement and reinforcement for the child's bravery. Really emphasise how well they are doing in being able to overcome the scary memory.

Homework

Homework is to test out a belief by conducting a behavioural experiment. Agree on what this will be during the session by filling in the first part of the Testing Things Out For Myself sheet. The help of the parent should be enlisted to assist with the task and completion of the sheet.

Stream 1 – Reliving

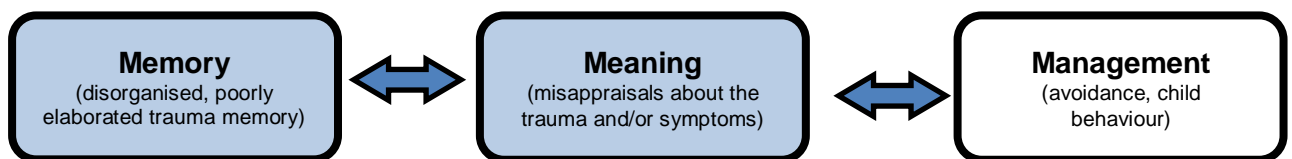
Aims

- To elaborate and integrate the updated traumatic memory into autobiographical memory
- To modify misappraisals during the trauma to reduce current sense of threat

Rationale

Reliving in this stream is really just an extension of narrative work that incorporates new, updated information which the child now has access to. It involves detailed discussions of drawings of the trauma, with a focus on worst moments and appraisals during these moments, but incorporates all the new, safety information that the child has identified in the previous sessions. The objective of reliving is for the child to be able to focus on difficult parts from the trauma scene and to talk through the events in detail, including new safety information, to the point that there are markedly lower levels of anxiety.

Reliving (with updated material) is concerned with aiding the integration of the trauma memory into autobiographical memory, as well as updating the meaning and appraisals of the memory.



Meeting Structure

The session is to commence together, then the child is to be seen alone, then the parent alone, before finishing together.

Materials

Feelings Thermometer
Scary Feelings Scoresheet
Worst Moments Hierarchy
Worst Moment Picture

Procedure

Commence working with the child and agree on an item from the hierarchy that is moderately scary. Ask the child to draw the moment on the Worst Moment Picture sheet and use this to enter into a detailed discussion of that part of the trauma. Do this very slowly so that the child has an opportunity to really engage with the emotions that come up. Ensure to ask about key cognitions, and themes about blame and concern for the welfare of those involved. It may be necessary to be quite

prescriptive to elicit confirmation about the content of key cognitions and appraisals. Prompt the child to include new information into their drawing if they don't do this spontaneously.

Repeat this procedure and address the worst moments on the hierarchy until there has been a notable reduction in fear.

Report To Parents

Explain the rationale and purpose of reliving to the parents. It may be useful to revisit the model and use it to explain how reliving aids the emotional processing of the memory.

If the parent is still reluctant to speak openly about the trauma to their child, or if they are worried about upsetting them, it might be helpful to have some time with both child and parent and encourage the child to tell the parents about their memory of what happened.

Over the week, the parent will have to encourage their child to complete their homework by drawing one of their difficult moments from the trauma, making sure updated information is incorporated into the picture.

Homework

With the assistance of the parent, the child is asked to draw a picture of one of their worst moments and record it on the Scary Moment Exposure sheet. Parents need to ensure that their child continues with the exercise until scary feelings reduce.

Stream 1 - In Vivo Exposure

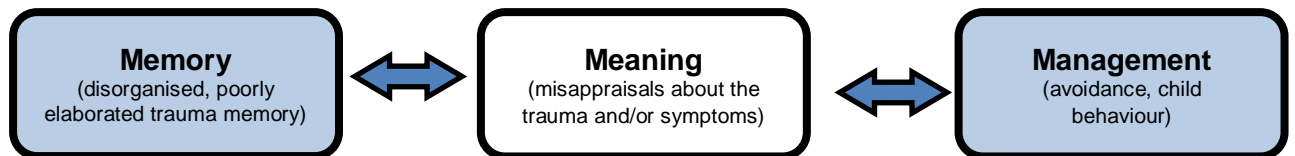
Aims

- To extinguish anxiety in response to trauma cues
- To reduce behavioural avoidance
- To provide a context to the trauma as being in the past

Rationale

Children will often avoid the site of the accident or reminders of it. According to cognitive models of PTSD, this avoidance plays a key role in the maintenance of the disorder. Exposure to the trauma site and related cues allows for the anxiety response to extinguish and for the trauma memory to be compared to how the scene is in reality. This enables the temporal processing of the event and for it to be recognised as something that occurred firmly in the past.

The site visit aids with the processing of the trauma memory and targets behavioural avoidance.



Materials

Feelings Thermometer
Scary Feelings Scoresheet
Scary Reminders Chart
Testing Things Out For Myself Sheet

Procedure

In vivo exposure will typically involve a site visit with the family, as well as a series of graded exposures to reminders (for the child to practice for homework). It is useful for the parent to see how to conduct exposure, as parents will need to assist their child with in-vivo exposure that is set for homework. A caveat to this is if the parent is also experiencing significant PTSD symptoms and is unwilling to do so. In this case, the child should be accompanied by two therapists to do the site visit.

a) Provide a Rationale

Enquire why the child is avoiding reminders, and what might happen if they confront them. If they are unable to verbalise their fears, provide sensible options (ie., 'Are you worried that if you go back it may happen again?'). Then, setup the visit as a behavioural experiment to test out their fear.

Conceptualise the site visit as a demonstration that they are fighting back against the trauma. Provide encouragement and recognition that the task at hand will be scary, but will help them to get better. Remind the child of how well they have done in the past in facing up to the memory and being brave during their previous work.

b) Preparation

The activity can be framed as detective work to gather clues from the site. Set it up verbally as a behavioural experiment. Inform the child you will be asking for their ‘scary feelings’ score and explain that part of the reason for going back to the site is to see how things are different from their memory of it. Ask for details as to what they expect to see so that you can draw out discrepancies during the visit. Information garnered from the visit can then be used as a comparison to what the child remembers. To this end, pay close attention to any discrepancies that emerge so that the memory can be richly updated following the site visit.

c) Exposure

Visit the site with the family and monitor ‘scary feelings’ throughout. Remain in the situation until anxiety has declined. After the exposure, check the child’s predictions. Spontaneous intrusive memories are likely: ask them what is different about the scene now. One of the main objectives is to really draw out the discrepancy in time between the here and now compared to when the trauma occurred. Use any differences such as in the weather, the angle the scene is approached from, buildings that may have been painted and so on to emphasise that the trauma is in the past and visiting now is very different. This will aid with the temporal processing of the memory and to give it a clear context in the past.

d) After Exposure

Give the child lots of praise for being brave. Ask what they have learnt. Key take home messages are that the child can confront reminders and tolerate scary feelings. Highlight differences between the memory and the actual scene, and emphasise that the traumatic event is in the past and that things have moved on since then. This is known as “time-tagging” – the purpose of which is to really give the child a sense that the trauma is firmly rooted in the past and things now are different, which reduces sense of current threat.

Plot the scary feelings rating on the Scary Feelings Scoresheet to demonstrate to the child what happens to their scary feelings over time. Use this as a rationale for setting up exposure to reminders as homework.

Once back at the clinic, construct a hierarchy of feared situations and scary reminders using the Scary Reminders Chart. This can be developed in a very straightforward way – by now it should be clear the kinds of reminders that trigger fear. Ask the child to rate these in terms of scary feeling level, and they can then be put onto the reminders chart hierarchically. Spend some time with the parent discussing how to assist their child to completing exposures for homework. These should not be as difficult as the site visit, but needs to elicit at least some anxiety. It is important that the child remain in the situation until fear decreases. They will also need to measure anxiety before and after the exposure.

Lead the parent through the Testing Things Out For Myself sheet in detail, explaining their role to support their child and to remind their child of their anxiety management skills if necessary.

Homework

Homework is to do an exposure to a trauma reminder (as per the hierarchy). Assigning exposure for homework ensures that the child does not become dependent on the therapist to confront avoided reminders. The task should be set up at the end of the session by completing the Testing Things Out For Myself sheet and parental assistance needs to be enlisted for logistics and support (ie., to take the child to the site, to drive them in a car, to monitor anxiety ratings). Ensure that anticipated outcomes are specific so that success can be measured.

Further Exposure Work

Commence the next session by carefully reviewing the homework assignment with both the child and parent. Depending on level of progress, additional exposure sessions may be necessary. If the child still experiences significant distress in response to reminders, continue working up the exposure hierarchy until there is a notable reduction in cue-elicited fear.

Stream 1 - Relapse Prevention

Aims

- To consolidate what has been learnt
- To provide a sense of achievement
- To review skills that can be used to manage future symptoms

Rationale

By the time the child reaches the end of the program, there will hopefully have been a marked reduction in symptoms. However, the periodic return of some symptoms is common, and families need to know how to respond when this happens. Much of the relapse prevention work is intended to educate the parent as to how they can support and remind their child of the skills they have developed which can be used to cope with future difficulties. Accordingly, this final session is a joint session.

This session is also designed to give the child a sense of accomplishment by reviewing all that they have learnt. The presentation of their completed workbook and certificate represents what they have achieved in therapy. They have the option of keeping their book.

Meeting Structure

This session is a joint session.

Materials

Workbook
Things I Have Learnt Sheet
Achievement Certificate
Updated Narrative

Procedure

Commence the session with a review of all the child has learnt. Go through the workbook page by page and ask the child to recall each skill they learnt. Have the parent write these out on the Things I Have Learnt sheet. Prompt as necessary and be sure to include relaxation, happy place imagery, imagining 'worst moments' from the scary story, being a detective to test things out, visiting the site and tolerating scary reminders. Include any additional skills that may have developed during treatment (i.e., imagery techniques, rehearsal of nightmares).

Spend some time discussing the updated trauma narrative (clearly distinguishable from their initial narrative) and emphasise their success in gathering clues about what really happened.

Provide encouragement and praise for all the child has achieved. Really emphasise the new tools that they now have for dealing with their scary feelings and getting back to their life. Return to the jigsaw metaphor and explain that now they have done some detective work, organised the memory and put everything piece back together in an ordered way so that it isn't scary anymore.

Tell the child that while many of their scary feelings have reduced and no longer bother them, sometimes, scary memories might jump and scare them when they're not expecting it. Explain that this is normal and happens to everyone. Ask the child if they can think of something they might do tomorrow or the next day that would bring back a scary memory. If the child can't think of something, provide an example. Hopefully the child will be able to recognise that coming across a scary reminder may inadvertently scare them.

Ask the child how they might respond to this. Use this as an opportunity to go through the list again of skills and see if they can identify what might be helpful. Use a few examples to get the child to identify appropriate strategies. You may need to use drawings or cartoons to demonstrate this.

Conclude the session with a final review of the child's accomplishments. Present them with a certificate recognising all their hard work and ask them to colour and decorate it. This should be placed in the workbook which is for them to keep.

CBT-3M Manual

Stream 2

Age 6-8

Stream 2 - Assessment & Psychoeducation

Aims

- Engage the family
- Assess areas of difficulty/impairment
- Provide basic psycho-education about anxiety and trauma
- Normalise child's response
- Provide a treatment rationale

Meeting Structure

The first session will commence with the family. The child and parent will then separate so that the therapist can speak with the child alone, followed by the parent alone, before finishing up together. If the child is too anxious to separate, just proceed together, interview the parent first and spend some time developing rapport with the child until they are willing to be seen alone. You may need to follow-up with the parent on the phone to ensure that you have any information they did not disclose in front of the child.

Materials

Paper and pencils
Folder
About me page
Cartoon aids depicting trauma scenarios
Toy animals
PTSD parent information sheet
Parent writing task sheet

Procedure

To begin, clarify the reason for coming to therapy and establish ground rules. Identify that these meetings will take place once a week about fifteen times. If therapy is being conducted at a medical clinic, ensure the child knows that this is not a doctor's surgery. If it is taking place in the home, set up a room in the house away from interruptions and that is private. This room will be used for therapy on subsequent occasions.

Explain that this is a safe environment and all information provided will remain confidential.

Ask the family to provide a brief account of the trauma and an outline of current problems. This is likely to come from the parent, but encourage the child to provide information as well. The aim here is for the child to begin to feel comfortable talking to the therapist, and for parents to give 'permission' for them to do so. Explain what this first session will entail, being clear that you will want to hear about the traumatic event, and ask the child if it is okay for them to be seen alone first. If

not, see them after you speak to the parent alone. Offering a choice as to when they would like to be seen gives some control back to the child.

Before separating, briefly discuss what common symptoms of posttraumatic stress disorder (PTSD), and label as PTSD or 'your scary feelings' if PTSD is too abstract for the child. If you see the child first, give the parent the PTSD information sheet to read through while you meet with the child. If you see the parent first, introduce the workbook to the child and ask them if they would like to decorate the book and start filling out the About Me page while you speak to their parent.

Child

The initial work with the child is designed to develop rapport and learn a bit about them. Take this part very slowly. If you haven't already, introduce their workbook, which will remain at the clinic (or with the therapist if they are being seen in their home) and tell them that they will be doing various projects to be stored in the book. This book will be like a story about them. Tell them that they can decorate the book a little later on today, but for now, should fill out the About Me page. Here they are able to draw a picture of themselves, and record some of their favourite things. Ask them about these things and other neutral topics (e.g., toys, colours, friends, free time, television shows). Give the child time to get used to talking. They need to become comfortable with you before moving on. Ask the child whether they like stories and whether you can tell them a story. Use the cartoon aids to demonstrate symptoms of PTSD via a story. While telling the story draw a connection between the child and the character and look for cues indicating that they understand.

An example of a suitable story might be:

'This is James. One day James was walking home from school and some big boys ganged up on him in the park and tried to steal his bag. When he told them to leave him alone one of the boys hit him really hard and he fell on the ground and they ran off with his bag. James wasn't hurt, but after the accident he would get very scared thinking about what happened and had nightmares about it. Then he came here and talked about what happened which helped make his scary feelings go away.'

During the story, pick several points and ask the child if they make the connection to themselves (i.e., 'this might be similar to what happened to you when you were attacked').

Ask for a narrative account of the trauma

Tell the child that you would now like them to tell you a bit about what has happened to them. Ask the child if it is okay with them to talk about what happened, even though it may be upsetting. Praise their courage for talking about the trauma. If the child is unwilling to talk about what happened, ask them to draw a picture and use it as a starting point. This will also be necessary if the child is not sufficiently advanced to articulate what happened. Also enquire about the worst parts of the trauma, and try to elicit appraisals if the child is able to report on what they were thinking.

Ask for details about symptoms

Ask the child about their symptoms using the term 'scary feelings'. It may be necessary to refer to what the parents have said at the initial diagnostic assessment if the child is reluctant or unable to verbalise their symptoms. Also refer to the PDS to ask about symptoms.

Normalise response

Tell the child that everyone experiences some of the symptoms they have described soon after a trauma. In many adults and children, these symptoms can carry on. Give a brief example of another child who had similar problems and who was successfully treated, and talk about older children, or people like fire-fighters and police-officers having these problems. Inform the child that lots of people get these scary feelings after going through something like they have - it's nothing to be ashamed of, and people get better after treatment.

Provide treatment rationale

Provide a rationale to the child for coming to treatment by drawing a link between intrusion and avoidance. Explain that they have been trying to push the memory of what happened away. This might work in the short term, but in the end, memories come back in dreams or during the day in pictures. Present the overfull cupboard metaphor to demonstrate the point. The memory is like things to be put away in a cupboard. By avoiding the memory, all the things have been stuffed into the cupboard quickly, you can't shut the door, and things keep tumbling out. We will be taking each bit out deliberately, having a good look at it, and putting all the pieces away neatly, in order. Then the cupboard can be open and shut at will – they will not forget what happened, but will be able to recall it when they want to, not when things fall unexpectedly out of the cupboard.

Another way to illustrate this is by doing the thought suppression behavioural experiment. Illustrate the paradoxical effects of pushing thoughts away by asking children *not* to think about a rabbit eating the therapist's hair. Most children will report that they have an image immediately and find that it returns when you check that they are not thinking about it. Use this to show how avoidance is unhelpful.

Give the child an opportunity to ask questions. Provide reinforcement to the child for being so brave, and ask them whether they would like to decorate their workbook while you speak to their parents. Get permission from the child to speak to the parent about what they have talked about.

Parent

Begin by relaying what the child has said and answer any questions about the PTSD information sheet that the parent has. Then, commence the assessment.

Narrative

Get an account of the trauma

Symptoms

What are your child's symptoms?

How have they influenced the child's functioning?

Parental Attributions

What do you think about their child's difficulties?

What do you find most difficult to cope with?

Are you concerned that your child is going crazy/will never be the same?

Parental Response and Discipline

Have there been any secondary gains for the child since the trauma (ie., missed play group, treats)?

Are you going easy on the child in some respects? How?

How have you managed their child's behaviour? Is this the view and approach taken by the other parent?

Do you encourage your child to talk about the trauma or do they avoid talking about it?

Who is the child talking to about the trauma?

Impact on Child's Functioning

Is your child participating in fewer activities now? What are they?

Are you more protective of your child now?

How has the trauma changed how your child spends their spare time?

Impact on Family

How has the trauma impacted on the family?

Is the family still doing the same activities as before (e.g., eating dinner together, weekend outings?)

Parent's Symptoms

Were you involved in the same trauma?

How are you coping?

Do you have adequate supports? (If not, direct to self-help resources or make a referral if necessary).

Provide Rationale

Provide a strong rationale for treatment in a way that the parent understands. Draw on the model to explain that the trauma memory will be targeted so that the memory can be updated and sufficiently

processed. Explain how misappraisals of the trauma and symptoms maintain a sense of current threat, which maintains PTSD. By reducing avoidance, appraisals can be tested out and threat is reduced.

Provide an overview of what will be covered in treatment and emphasise the critical involvement of the parent in supporting their child through the process. Outline their role in modelling behaviour, setting boundaries, assisting their child to abandon avoidance behaviours and acting as a co-therapist to help with exposure and homework assignments. If both parents are not present, ask for this information to be passed onto them.

After the model has been explained and the parent understands that treatment involves confronting trauma memories and reminders, tell the parent that we will be asking them to write their own account of what happened during the trauma. Tell the parent that they will be asked to do a number of writing tasks over the first few weeks of treatment. Provide a rationale emphasising the need to gain first-hand experience in how difficult addressing the trauma memory can be, so that they will be optimally placed to support and help their child through treatment.

Additionally, explain that it will be really important to have detailed information about the trauma, which includes the worst parts of the event. This is so that when the child begins work on the memory (in approximately 3-4 weeks) the therapist has enough specific information from them to prompt the child to include relevant details if they cannot do this on their own.

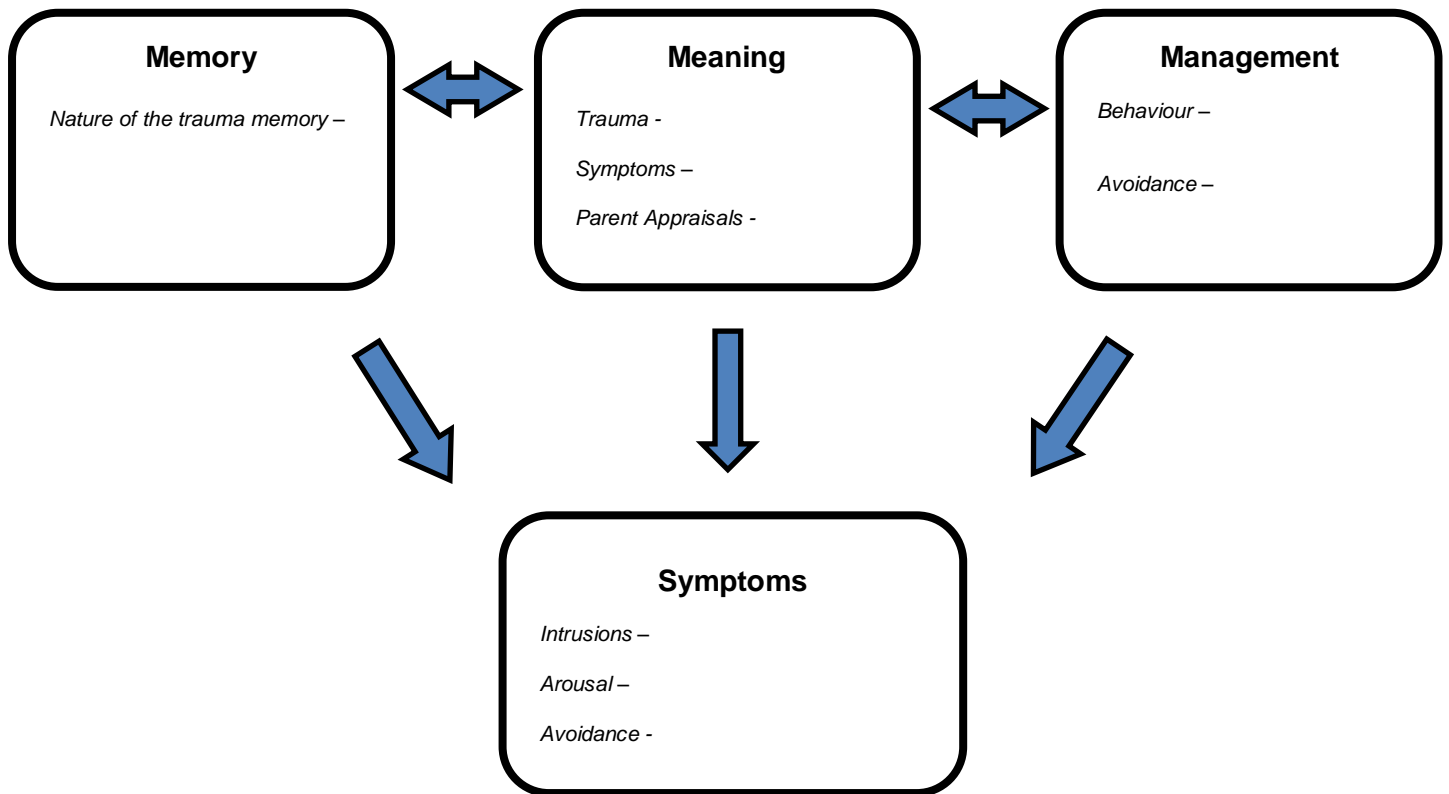
Once you are confident that the parent understands the importance of completing this task, direct them to the Parent Writing Task sheet and go through it slowly and thoroughly with them. Ask if they anticipate being able to complete it over the week, and instruct them to return it at the following session.

If time permits, move straight into scheduling pleasant events if there has been a reduced level of activity since the trauma (see next module).

Conclude the session with both parent and child together. Praise the child in front of the parent for being brave and provide a lot of encouragement for talking about the trauma and deciding to take the first step in making their scary feelings go away. Praise their About Me page and decorations and collect it back to be stored in the therapy room.

Schedule the next session, and give both parent and child the chance to ask any questions.

Following the assessment, put the specific details of the case into the blank formulation below. This is intended to be a guide for the therapist to conceptualise the case and identify key aspects of the trauma and symptoms most relevant to be targeted in treatment.



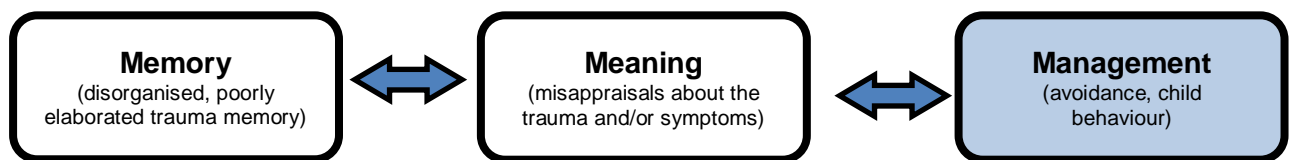
Stream 2 - Reclaiming Life & Activity Scheduling

Aims

- To provide opportunity for positive experiences for the child and family
- To reduce sense of current threat by re-engaging with world and regular activity
- To give a sense that things are returning to normal

Rationale

Young people with PTSD often show a reduced level of functioning relative to before the trauma. This can be the result of a generalised sense of fear due to the trauma, low mood, or greater protection of the child by their parents. Scheduling enjoyable activities provides an opportunity for enjoyment, communicates that things are returning to normal, and can be useful for the parent to reduce level of over-protectiveness (if this is a problem). This module targets the ‘management’ component of the model.



Meeting Structure

This session is with the parent, although suggestions for activities should be raised with both parent and child, possibly at the end of the session or the start of the following session.

Materials

Activity Plan Sheet
Activity Record

Meeting Structure

This session may take place with the parent only, although, the child can be involved towards the end of the session to suggest some activities that they would like to do. These can be developed collaboratively and agreed upon by both parent and child.

Procedure

This treatment component should be completed with the parent. Before commencing with this module, check how the parent went with writing out their memory. Ensure that they have been able to identify key thoughts and incorporate new information into the narrative. Discuss any difficulties and ask the parent to do the writing task again, but this time, including all the updated information that they identified from the initial task. Ask them to bring it in at the next session.

Based on information gathered during assessment, it will be apparent if there has been a reduction in the child and/or family's level of activity. If it is unclear whether this is the case, some monitoring may be necessary. In this case, ask the parent to complete the Activity Record over the following week, which asks them to record activities that their child and family engage in, and rate how typical this is compared to a regular day from before the trauma occurred. Once this information has been gathered, it will be obvious whether there has been a reduction in level of activity.

There are a several reasons why activity may have reduced. It may be due to parents' over-protectiveness. The work here is in encouraging parents to be less protective. Discuss what they fear may happen if the child is given more independence. How realistic are their fears? What are the advantages and disadvantages for the child (and family) in restricting activities? What do other children of his/her age do? What would their child be doing if they had not been involved in the trauma? Encourage the parent to experiment with allowing their child to engage in an activity they enjoy and monitor how the child responds and if there is a positive impact. If the parent is quite anxious about this, engaging in more activity should be introduced in a graded way. Emphasise how increasing activities is an important part of treatment that will give the child a sense of moving on from the trauma, and allow him or her to get back on to a normal developmental trajectory. Resuming regular family activities also communicates to the child that life is returning to normal.

Another reason that activity levels may have declined is if the child has developed an overgeneralised sense of danger to the point that they are too scared or frightened to do any activities. If this is the case, the child should be encouraged and supported to return to their normal, pre-trauma activity level, and their activities should be fun and enjoyable - unrelated to the trauma.

These enjoyable activities can be agreed upon collaboratively with the parent and child. They need to involve enjoyable events as well as activities which will be soothing to the child. For example, the child might be given a choice to do something special with the parent, such as going out for a walk to somewhere peaceful. Efforts should be directed towards facilitating quality time spent between child and parent.

Some specific suggestions include:

- *Reading a story with mum/dad*
- *Baking something delicious*
- *Scheduling a play-date*
- *Playing a game with the family that the child likes*
- *Getting ice-cream from the ice-cream van*

- *Going to watch sport such as football/cricket*
- *Going to a movie*
- *Going into town to go shopping with mum/dad*
- *Going out for dinner*
- *Doing a drawing/painting*
- *Starting swimming/gymnastics/ballet/football lessons*

Once chosen, they can be written down in the Activity Plan.

Activity scheduling and strategies discussed here should be used as required throughout treatment. After activities have been scheduled for a few consecutive weeks, it is sufficient to enquire about activity level each week without going through it in a structured way. As a caveat, if activity levels in the family are very low, more time and attention should be directed to ensure that progress is made. This is especially the case if parent is depressed and increasing level of activity may be more challenging. If this is the case, activity scheduling may also benefit the parent. By providing an opportunity for positive experiences, the functioning of the whole family should improve.

Homework

To complete scheduled activities and writing exercise for the parent.

Stream 2 – Feelings Identification & Relaxation

Aims

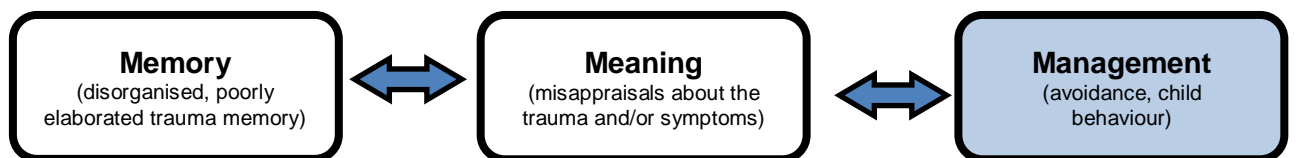
- To identify and distinguish between grades of emotion
- To link emotions with bodily sensations
- To reduce symptoms of overarousal

Rationale

Children in this stream should be able to identify different feelings and be able to distinguish between varying levels of emotional intensity. However, it is necessary to ensure this is the case before continuing. In this session, children are also taught about the physical manifestations of anxiety symptoms in the body, and learn relaxation skills to reduce these symptoms. Teaching relaxation skills early in treatment may give the child a sense of control over their emotions and can reduce anxiety. It also reinforces the link between thoughts, feelings and bodily sensations. Many children complain of difficulty in getting to sleep at night, and relaxation and calming imagery can quickly help with this. Furthermore, giving children a tool that they can take away and practice may provide a sense of progress and change early on during therapy.

Care must be taken that relaxation is not used as an additional avoidance strategy by the child. State from the outset that relaxation is part of their ‘toolkit’ in overcoming their ‘scary feelings’ and that eventually, they will not need to use it often. While children may find regular relaxation useful in the initial stages of therapy, it often drops naturally from their repertoire of behaviours as symptoms subside.

Relaxation is derived from the management component of the model as it provides the skills necessary to begin reducing avoidance behaviours. Additionally, it offers direct symptom reduction by targeting arousal.



Meeting Structure

The session is to commence together, then the child to be seen alone, and then the parent alone, before concluding together.

Materials

Workbook
Faces Chart
Feelings Thermometer
Feelings In My Body sheet
Relaxation Practice Sheet
Happy Place Sheet

Procedure

To begin, review what was covered in the last week in about five minutes. It is important to set up a consistent structure for treatment sessions. Ensure that the child remembers that they are here to talk about what happened to them and draw on the cupboard metaphor if necessary.

Explain what will happen next – that the therapist and child are going to learn some new skills to help the scary feelings go away. Then the parent will spend some time with the therapist while the child can decorate their workbook, and then the family will all meet back together at the end.

a) Feelings & Grades of Emotion

Use the Faces Chart showing a range of faces and tell the child you are going to do a quiz about feelings. Give them a few relevant scenarios (ie., ‘when you wake up on Christmas day and feel excited to open your presents’) and ask them to point to the correct face. Once they have demonstrated that they can recognise emotions, introduce the Feelings Thermometer to aid the identification of low, mid and high levels of ‘scary feelings’. Begin by teaching the child about different levels of fear using an example. For instance, you might use the example of playing catch at school with a friend as ‘not scary at all’, but getting in trouble from the teacher as ‘a bit scary’.

Ask the child to rate their level of fear in response to a number of examples which may include falling off a bicycle, watching something scary on television, being afraid of a spider. Mark these anchor points and tell the child that what happened to them is up in the ‘very scary’ zone.

b) Bodily Sensations & Introduction to Relaxation

Once the child is able to distinguish between levels of emotion, introduce the notion that different feelings feel different in the body. Use the Faces Chart to play a game where you show how different expressions feel. For example, show ‘very happy’ and make the expression as well as laughing. Talk about how laughing feels in the chest. Repeat this with a few expressions. If this is too abstract, simply move on. Using the Feelings In My Body sheet, ask the child where they feel happy, sad, scared and angry in their bodies. The purpose of this exercise is to teach children about the

relationship between feelings and bodily sensations. If the exercise is too difficult, provide suggestions (heart pounding, head hurts, stomach knots, lump in throat). You may need to make reference to what you know about their physical symptoms from the assessment interview to do this. Encourage the child to draw these feelings onto the outline of the body and assist as required. Allow the child to colour it in and decorate the picture which they can continue working on while you meet with their parent.

Tell them that today they will be learning their first skill to help them relax and make their scary feelings go away. Ask the child what they do to relax or for fun, and provide prompts if required. Encourage them to continue with these activities. Today they will be learning another way to relax because it is very hard to feel scared when the body is relaxed.

c) Relaxation

Tell children that they will probably not feel completely relaxed by the end of the exercise, but that with some practice they will get better at it. Teach, through modelling, a simple form of progressive relaxation.

Start with the child sitting comfortably in a chair. Tell the child to take normal steady breaths and allow the body to relax a little more with each breath out. Instruct the child to tense and relax the following muscle groups in turn: fists and forearms; triceps; biceps; shoulders; stomach; legs. Focus on steady breathing throughout. If necessary, use body demonstrations to show that the aim is to make the body 'tight tight' and then go loose like spaghetti.

Play a game to practice tightening and relaxing the body, and ask if the child can think of other ways to tense and then relax. Humour can be used to design some tense and relax moves where appropriate. Incorporate the Feelings Thermometer into relaxation practice, and demonstrate that before, the body feels 'scared', but after, it is more relaxed. Ask the child to show you how their body feels on the thermometer, both before and after practicing.

b) Happy Place Imagery

Following the relaxation practice, ask the child to think of a relaxing scene. Some suggestions could be at a beach, their birthday, on their mothers' lap, playing with their pet. Once the child has decided on a happy place, ask them to draw it for you on the Happy Place sheet.

Tell the child that you are going to practice holding a picture of their happy place in their minds with their eyes closed. Ask the child to imagine what they can see, hear, feel, taste and touch. If the child has difficulty imagining a scene with their eyes closed, help them practice by looking at their drawing of the picture, and then closing their eyes but keeping the picture in their mind. Ask them on what it looks like until they can imagine it. Once the child can keep a picture in their mind tell them that they are now going to put their two new skills together.

c) Combined Relaxation and Imagery

Tell the child that they are now going to practice their new skills by doing relaxation and then thinking about their happy place straight after. Ask the child to use the Feelings Thermometer to demonstrate their level of 'scary feelings' right now. Then, guide the child through the relaxation exercise. Then, ask them to spend 30 seconds quietly, relaxed in their body and then to imagine their happy place. Instruct them to open their eyes when they have finished and take a rating on the thermometer. If anxiety decreases, use this as a rationale for completing the exercise at home over the week. If it does not, frame these tools as skills that need to be practiced in order to be effective and set practice as homework. Remind the child that they can use relaxation when they feel scared in their body, and can use their happy place picture to replace scary pictures. Allow the child to colour and decorate their Happy Place sheet, which will go into their workbook.

Report To Parent

Begin by asking the parent about how they got on with the activity homework (if relevant) and address any obstacles. Fill in the parent about the material covered. Review the feelings and bodily sensations activities and provide some basic psychoeducation about the role of relaxation as an anxiety management skill that can help their child relax (and go to sleep if this is problem). If nightmares and sleep difficulties cause significant interference or distress, see the supplementary material to address these directly.

Ask the parent to prompt and encourage their child to practice relaxation each day. Ask parents to monitor and record their child's scary feelings score using the Feelings Thermometer, and to record it on the Relaxation Practice Record. Discuss the potential for relaxation techniques to become a form of avoidance, and present this as an additional reason for continued monitoring.

Check in with how the parent has gone with the writing task, and ask them to repeat it one final time over the week. Tell the parent that next week the child will commence memory work, and that they are now in a much better position to understand what this involves and support them through the process.

Enquire about the child's behaviour and whether they are being oppositional. Use the supplementary material as required. If the parent does not seem engaged in therapy it might be necessary to directly address their motivation and possible reluctance to attend therapy. Again see the supplementary material on ways to deal with apprehension and poor engagement.

Conclude the session together. Ask the child to explain to the parent what they learnt in the relaxation activity. Assist the child as necessary. Agree to practice it once each day during the week and give the Relaxation Practice sheet to assist. If the child completes the relaxation they can have a sticker on their chart for each time they do it. Be mindful of the possibility that relaxation could develop into an avoidance strategy and monitor throughout treatment.

Homework

Relaxation practice and writing task (parent)

Stream 2 - The Trauma Narrative (Part I)

Aims

- To develop a coherent account of the trauma
- To elaborate the trauma memory

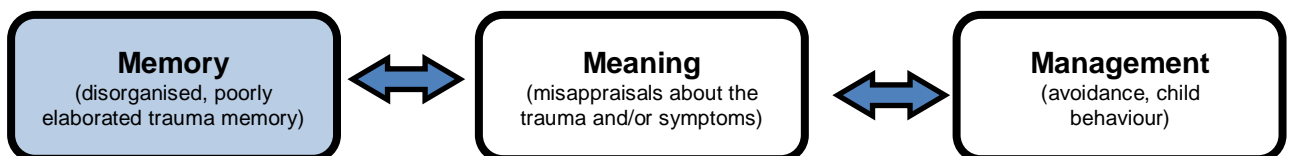
Rationale

The goal of narrative work is to build up a complete, chronological and accurate story of the trauma. The narrative needs to include key hotspots or ‘worst moments’ as well as the child’s cognitions about what they thought was going to happen at these moments. These moments reflect the critical aspects of the memory that need to be targeted and updated during these sessions.

There need to be at least two narrative sessions, but will most likely be several more. The rate at which the narrative work is moved through will have to be set at the child’s pace. The goal of the first is to get key information from the child about the trauma. The second narrative session is designed to consolidate the memory and begin incorporating additional details. The initial narrative provided by the child will include limited detail so subsequent sessions are intended to elicit further information to be incorporated into the memory so some updating can occur.

It is an overarching goal of therapy to emerge with a highly elaborated and detailed narrative of the event, which includes new information that the child now has access to, which they may not have had at the time. Developing the narrative will involve a verbal narrative and accompanying pictures of worst moments from the trauma. When new information is added to the narrative, it needs to be clearly marked (ie., using a different coloured pen/drawing on a different coloured piece of paper).

Narrative work comes under the ‘memory’ treatment target, although the meaning of the memory is also addressed.



Meeting Structure

The session is to commence together, then the child to be seen alone, and then the parent alone, before concluding together.

Materials

Pencils and paper for drawing
Feelings Thermometer
Scary Feelings Scoresheet
The Story of What Happened To Me sheet
Worst Moments Chart
Workbook

Procedure

Spend the first five minutes with the family and ask how they went with relaxation practice. Provide reinforcement and enquire about its effectiveness. Spend a few minutes doing a short in-session practice to ensure that the child remembers how to do relaxation. Place the homework record in the workbook and then commence the session with the child.

Explain to the child what they will be doing today. Inform them that they will be telling the whole story about what happened, all the way from the beginning, right up until the end when they felt safe again. Most children will understand that they will have to face up to what has happened to them. Drawing upon the cupboard metaphor may help the child to understand the purpose of telling the story and ask the child to assist you with some detective work to help find clues as to what really happened. Take out the 'Story of What Happened To Me' sheet.

Before asking for the narrative, explain that telling the story will be difficult but is very important and represents a big step towards making their scary feelings go away. Provide encouragement - inform the child that deciding to talk about the trauma in detail is a sign that they are being brave and ready to get better. Tell the child that you will be writing down what they are saying so that you can remember everything that they tell you.

Ask for an anxiety rating using the Feelings Thermometer and then ask the child to tell you the story right from the very beginning. Allow children to tell their story uninterrupted. They will likely give a very brief account without much detail. Write down this account verbatim as the child tells the story.

Once the child has told the story for the first time, go lead the child through their narrative in a number of steps (again recording everything they say). Important domains to get information on include factual details, thoughts, feelings and sensory details as well as hotspots and worst moments. It is important to get a sense of the hotspots from the child – ask about the 'scariest' parts.

Pace the session according to the capabilities and distress level of the child. Be sure to guide the child through the narrative sensitively, reminding them to use their relaxation skills if necessary, and do not

do too much work around hotspots until some anxiety has habituated and they become more comfortable speaking about the trauma.

Some useful questions to assist include:

Factual Details

What was happening before it happened?
Who was there?
Where was everyone and what were they doing?
What were you doing before the trauma?
What were the first signs of danger?
What was your first reaction?
What happened next?
What happened afterwards?
When were you safe again?

Thoughts

What did you think was going to happen?
What did you wish you did but didn't do?
What did you think was going to happen to you/others?

Feelings

When did you feel most scared?
When did you feel most sad?
When did you feel most angry?
Were you worried you might get in trouble?
Were you worried that other people might get hurt? Who?

Sensory Details

Do you remember what you were wearing?
What was the weather like?
Do you remember any tastes or smells?
Where there any objects that stand out in your mind?
What colour was the X?

After the story has been recounted, go back through the parts of the memory that the child identified as the 'worst moments' and try to get three to five to put on the Worst Moments hierarchy. Ask the child for a scary feelings rating for each so that they can be ordered.

If the child is very distressed, relaxation and happy place imagery can be practiced as a way to help. This also has the benefit of communicating to the child that they can use these strategies as needed. Continue to take scary feelings ratings until there is a decline in distress. Tell the child that they have shown that they can tolerate thinking about these memories, and even when they become upset, they feel better a short time after.

Allow the child to draw a picture on The Story of What Happened To Me sheet. This and the Worst Moments sheet should be placed in the workbook at the end of the session.

Report to Parent

Set aside more time than usual to speak to the parent in this session. This is because the parent may not have heard about the trauma from their child's perspective, and hearing about what they have said can be a powerful experience. Revisit the model and rationale for memory work if necessary – it is important the parent really grasp the reasons for addressing the memory, and how it will aid emotional processing and symptom reduction.

Ask the parent for their writing task and review it with them. Use their experience and account of the trauma as basis for outlining the narrative provided by the child. Ask the parent what they thought of while they were listening to the narrative and normalise any distress that the parent might experience. Spend some time addressing the importance of the child feeling able to talk about what happened. Ask whether any key details have been omitted from the child's report which the child can be asked about next session and integrated into the narrative.

Conclude the session together, there is no need to set homework.

Stream 2 - The Trauma Narrative Part II

Subsequent narrative sessions are very similar to the first but are intended to enable additional details of the trauma to begin to be incorporated into the memory. This needs to happen in combination with cognitive restructuring (the following module). Providing an opportunity for elaboration and the incorporation of new information (possibly garnered from the parent at the end of the previous session) will allow for some updating to occur. The same procedures and materials are used as the previous narrative session.

Procedure

Explain to the child that they will be doing something very similar to what they did last week by continuing with their detective work in finding out what really happened. Provide encouragement and reinforcement for how brave they were last week, and inform them that this week they are going to tell the story again and you will be stopping them to ask questions throughout so that you can get the full story.

Ask the child to start telling you the story right at the very beginning. While they recount the story, stop them at various points to prompt them for additional details that their parent provided at the end of the last session. Ensure you ask about factual details, thoughts, feelings, worst moments and sensory experiences. Use gentle questioning and discussion to integrate new information into the memory. For example, if a child reports that they thought they were going to be trapped and never get out, it is valuable to ask them what they know now that they didn't know then (ie., that they ambulance was on the way and would get them out as soon as they arrived).

As new information is added to the memory, record this and note that it has been added. The discrepancy between information they didn't have then but now do have can be used to reduce the sense of current threat - that the trauma is something that happened in the past and now they are safe.

Throughout the narrative, ask for a Scary Feelings rating. The child needs to continue to discuss the narrative until their anxiety rating has reduced by at least some degree. Provide encouragement for their bravery and if they are very distressed, prompt them to use their relaxation/happy place imagery to help. Continue to take scary feelings ratings until there is a decline in distress.

Building a detailed narrative is a work in progress and will need to continue until there has been a marked decrease in memory-elicited anxiety.

Report to Parent

Describe to the parent what the session has involved and relay the narrative provided by the child. Explain the importance of ‘updating’ the trauma memory as a way to reduce sense of current threat and clearly distinguish between the past traumatic event, and the here and now. This material may have been covered with the parent in the previous session.

If time permits, speak to the parent about the child’s likely appraisals and what will be covered next session (see next module).

Conclude the session together. There is no need to set homework.

Stream 2 - Cognitive Restructuring Session

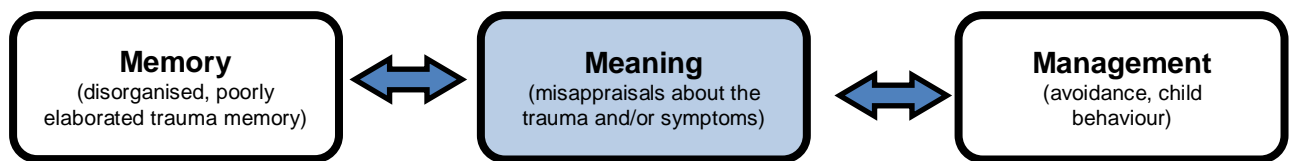
Aims

- To identify misappraisals of the trauma and/or PTSD symptoms
- To modify misappraisals and reduce sense of current threat

Rationale

Children may show maladaptive cognitions about the trauma itself, and/or about symptoms of PTSD. Appraisals about the trauma are likely to do with responsibility, guilt, or shame and some children may show magical thinking or omen formation. For traumatic symptoms, appraisals are often related with going crazy and having an unrealistically heightened sense of danger. The goal here is to identify and modify maladaptive appraisals in order to reduce perceived threat. Sensitive interviewing and attention to common themes is needed as children of this age may be unable to verbalise their concerns. The Child Post-Traumatic Cognitions Inventory (CPTCI) is used to prompt for common cognitions held by children about the traumatic event and their symptoms.

This module addresses the ‘meaning’ component of the model. In doing so, the memory is also addressed.



Materials

Scary Moments sheet
Updating My Memory sheet
Testing Things Out For Myself sheet
CPTCI

Meeting Structure

This session is a joint session.

Procedure

Although cognitive restructuring takes place as a joint session, the parent needs to be seen individually before the session so that they can be prepared for some of the concerns that their child may have. This should occur at the start of the session, or at the conclusion of the previous session.

Parents need to know that many of their child’s misappraisals may be to do with them and could be guilt driven. For example, their child may have thought that their parent was going to die during the

trauma; they may be concerned that their parent blames them for the accident; that awful things happened to their parent if they were separated; that their parent is now at risk of dying because they had to go to hospital in the aftermath and so on. It is useful for parents to know this prior to the session so they can be prepared. Once the parent understands that nature of what their child's concerns are likely to be, the joint session can commence.

It can often be very helpful for the child to tell their parent of their worst fear. Depending on the nature of the trauma and the verbal stage of the child, when children tell parents of their fears – for instance, that they thought that mum or dad was going to die, most parents will respond with great warmth and care. This can have the effect of freeing the child and parent to talk to one another outside the session about the trauma.

If the child and parent were separated during the trauma, it can be very helpful for children to hear about what happened from the parent's point of view (e.g., what happened to the parent in the hospital while separated). Take care that the parent is able to do this without becoming too overwhelmed or upset.

a) Identifying Maladaptive Appraisals

Maladaptive appraisals need to be elicited and assessed, although it may be fairly obvious from narrative and reliving exercises what key cognitions and misappraisals are. In addition to these, use the CPTCI to enquire about further misappraisals. It asks about self-blame (e.g., I am a coward), interpretation of PTSD symptoms (e.g., not being able to get over all my fears means I am a failure), over-generalised sense of danger (e.g., I have to watch out for danger all the time), and omen formation (e.g., something terrible will happen if I do not try to control my thoughts about the frightening event). Any themes that emerge from the measure should be asked about and assessed further.

b) Modifying Appraisals

Some thoughts may be altered simply via the provision of information. Information about the facts of the traumatic event can be obtained from parents and may help in changing cognitions to do with guilt, self-blame and perceive blamed.

Other ways of cognitive restructuring are via behavioural experiments and incorporating new information which contradicts the appraisal. With behavioural experiments, keep them simple and concrete. For example, if a child who has been in a car accident thinks that all adults run through red

lights, do a survey at an intersection to see how many cars go through red lights. To update the memory in a structured way, use the Updating My Memory sheet and integrate new information that directly counters the appraisal. This new information can then be incorporated into the narrative.

Develop new cognitions in response to behavioural experiments and structured cognitive work to update the memory. Appraisal modification and memory updating should occur together in this way. That is, cognitive restructuring and updating of the narrative take place concurrently. It is necessary to continually be thinking about how information which is now available (but was not available at the time) can be used to develop the trauma memory and really distinguish between the time that the trauma occurred, and now when the child is safe.

At the end of the session, provide encouragement and reinforcement for the child's bravery. Really emphasise how well they are doing in being able to overcome the scary memory.

Homework

Homework is to test out a belief by conducting a behavioural experiment. Agree on what this will be during the session by filling in the first part of the Testing Things Out For Myself sheet. The help of the parent should be enlisted to assist with the task.

Stream 2 - Reliving and Imaginal Exposure

Aims

- To elaborate and integrate the updated traumatic memory into autobiographical memory
- To modify misappraisals during the trauma to reduce current sense of threat

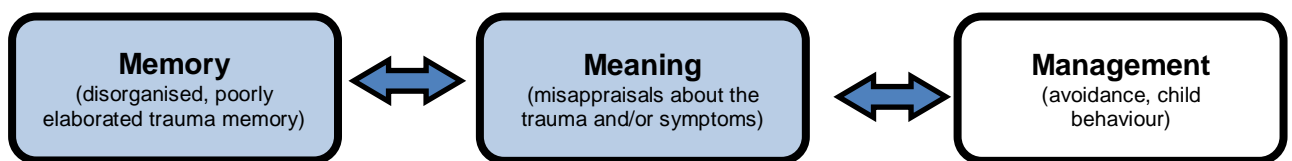
Rationale

Along with developing an elaborated narrative, reliving is at the core of treatment. Worst moments from the trauma are the key targets for reliving, with a focus on incorporating new, safety information that the child has identified in the previous sessions. The objective of reliving is for the child to be able to really engage with the frightening emotions associated with the trauma, and to talk through the events in detail, including new safety information, to the point that there is a reduction in anxiety.

As with recounting the narrative, reliving exercises can be a powerful demonstration that the child can think about the trauma without going crazy or losing control.

There will be substantial variation in the structure and number of reliving sessions required and needs to be set at the child's pace. Before moving on, the aim is for the child to be able to imagine worst parts from the trauma scene, be able to talk through the events in detail from multiple modalities (ie., what they could see, hear, smell) until there has been a reduction in fear.

Reliving (with updated material) is concerned with aiding the integration of the trauma memory into autobiographical memory, as well as updating the meaning and appraisals of the memory.



Meeting Structure

The session is to commence together, then the child is to be seen alone, then the parent alone, before finishing together.

Materials

Feelings Thermometer
Scary Feelings Scoresheet
Worst Moments Hierarchy
Worst Moment Picture

Procedure

a) Preparation

Prior to commencing the reliving, explain and demonstrate the procedure. This can be framed as similar to what they did when they told the trauma story, but the difference is that today, you want them to really imagine that they are back at the scene of what happened. You will ask them to say what they can see, smell, hear, and what they are thinking and feeling. You will ask them to do this in first person, present tense. This will be beyond some children although it may be helpful to demonstrate what you mean. It might be helpful for the child to use an aid that represents an ‘updated’ version of the trauma memory to facilitate the ‘time-tagging’ of the event. For example, a family photograph that was taken after the event might act as a reminder to the child that what they thought was going to happen didn’t happen. For example, if a child was concerned that their parents were going to die, having photo of the family from after the trauma can act as a reminder that their parents did not die. Holding a photograph or something that represents the updated memory might assist the child in completing the reliving.

Children may tend to rush through quickly at first, so ask them to take it slowly, or be prepared for the first reliving to be quite quick, and then repeat it more slowly.

Provide encouragement and an appropriate reward (options include a sticker, some colouring in time, a game of the child’s choice) for agreeing to be brave and talk about what happened.

b) Reliving

Ask the child to sit comfortably, and allow themselves to relax. Get a scary feelings score. When they are ready, they can close their eyes if they feel comfortable doing so. Ask the child to begin telling you what happened and to include all the new information they have discovered. An example of this would be ‘even though I thought no one was ever going to find me, I now know that help was on its way’ or ‘I was sure my sister was dead, but now I know she just hit her head and woke up later.

Prompt the child to include updated information if they do not do so spontaneously. Ask the child what they know now that they didn’t know then.

Prompting for different sensory details is useful at hotspots or points where the child seems to rush through parts. At these hotspots, use the ‘rewind and hold’ analogy: ask the child to ‘stop the tape’

and describe what they can see, feel, think. Use the Worst Moments hierarchy to make sure all key moments are included.

A lot of the work, especially at the beginning, is in encouraging the child to slow down so that the event can be remembered in detail. Ask for scary feelings ratings periodically and record them on the Scary Feelings Scoresheet.

Continue in the reliving until the child is at the point at which they felt safe again. Get them to really imagine this safe feeling and to stay with this feeling until their scary feelings score has lowered.

Following the reliving, ask the child to rate their scary feelings. Continue to do so until distress reduces. Demonstrate what happens with anxiety over time – drawing a line from the very scary to less scary anchor points over time can be a powerful demonstration that the child can tolerate the memory and that scary feelings associated with remembering will decline.

After the reliving, praise the child for having done it despite it being hard. Allow plenty of time for anxiety levels to return to normal. Ask what it was like to do it and what the worst part of the event was. Encourage discussion of the event, in a non-reliving way.

Reliving exercises will need to be practiced until the memory has been sufficiently elaborated and processed, resulting in consistently lower levels of ‘scary feelings’ ratings.

Key worst moments need to be worked through and appraisals from these worst moments addressed. Key cognitions of children tend to surround themes of harm (to the self or the parent/s) and perceived blame from others (e.g., mum getting angry that I ran onto the road). To elicit these appraisals, ask about worst moments and associated feelings. For each of the difficult moments, assess emotions including fear/sadness/anger/relief, and ask whether they were worried they might get in trouble or be hurt, or whether anyone else would be hurt. Getting at these most troublesome appraisals and enabling their modification through the incorporation of new material is essential.

If conducting this exposure exercise is too difficult for the child, ask them to draw pictures of the worst moments from the trauma but including updated information. There is more detailed information about this in the stream 1 version of reliving.

Report To Parent

Explain the rationale and purpose of reliving to the parents. It may be useful to revisit the model to explain how exposure aids the emotional processing of the memory and facilitates a reduction in symptoms.

If the parent is still reluctant to speak openly about the trauma to their child, or if they are worried about upsetting them, it might be helpful to have some time with both child and parent and encourage the child to tell the parents about their memory of what happened.

Over the week, the parent will have to encourage their child to complete their homework by drawing one of their difficult moments from the trauma, making sure updated information is incorporated into the picture.

Homework

With the assistance of the parent, the child is asked to draw a picture of one of their worst moments and record it on the Scary Moment Exposure sheet. Parents need to ensure that their child continues with the exercise until scary feelings reduce.

Stream 2 - In Vivo Exposure

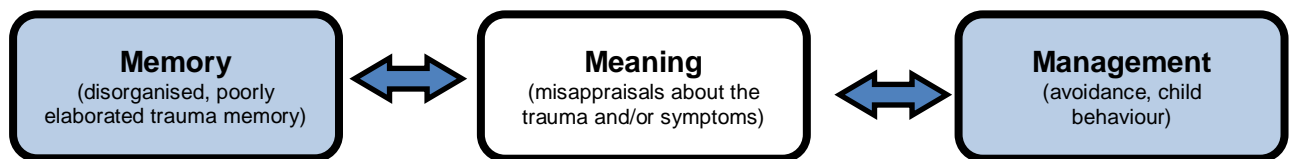
Aims

- To extinguish anxiety in response to trauma cues
- To reduce behavioural avoidance
- To provide a context to the trauma as being in the past

Rationale

Children will often avoid the site of the accident or reminders of it. According to cognitive models of PTSD, this avoidance plays a key role in the maintenance of the disorder. Exposure to the trauma site and related cues allows for the anxiety response to extinguish and for the trauma memory to be compared to how the scene is in reality. This enables the temporal processing of the event and for it to be recognised as something that occurred firmly in the past.

The site visit aids with the processing of the trauma memory and targets behavioural avoidance.



Materials

Feelings Thermometer
Scary Feelings Scoresheet
Scary Reminders Chart
Testing Things Out For Myself Sheet

Procedure

In vivo exposure will typically involve a site visit with the family, as well as a series of graded exposures to reminders (for the child to practice for homework). It is useful for the parent to see how to conduct exposure, as parents will need to assist their child with in-vivo exposure that is set for homework. A caveat to this is if the parent is also experiencing significant PTSD symptoms and is unwilling to do so. In this case, the child should be accompanied by two therapists to do the site visit.

a) Provide a Rationale

Enquire why the child is avoiding reminders, and what might happen if they confront them. If they are unable to verbalise their fears, provide sensible options (ie., ‘Are you worried that if you go back it may happen again?’). Then, setup the visit as a behavioural experiment to test out their fear.

Conceptualise the site visit as a demonstration that they are fighting back against the trauma. Provide encouragement and recognition that the task at hand will be scary, but will help them to get better. Remind the child of how well they have done in the past in facing up to the memory and being brave during their previous work.

c) Exposure

Visit the site with the family and monitor ‘scary feelings’ throughout. Remain in the situation until anxiety has declined. After the exposure, check the child’s predictions. Spontaneous intrusive memories are likely: ask them what is different about the scene now. One of the main objectives is to really draw out the discrepancy in time between the here and now compared to when the trauma occurred. Use any differences such as in the weather, the angle the scene is approached from, buildings that may have been painted and so on to emphasise that the trauma is in the past and visiting now is very different. This will aid with the temporal processing of the memory and to give it a clear context in the past.

d) After Exposure

Give the child lots of praise for being brave. Ask what they have learnt. Key take home messages are that the child can confront reminders and tolerate scary feelings. Highlight differences between the memory and the actual scene, and emphasise that the traumatic event is in the past and that things have moved on since then. This is known as “time-tagging” – the purpose of which is to really give the child a sense that the trauma is firmly rooted in the past and things now are different, which reduces sense of current threat.

Plot the scary feelings rating on the Scary Feelings Scoresheet to demonstrate to the child what happens to their scary feelings over time. Use this as a rationale for setting up exposure to reminders as homework.

d) After Exposure

Give the child lots of praise for being brave. Ask what they have learnt. Key take home messages are that the child can confront reminders and tolerate scary feelings. Highlight differences between the memory and the actual scene, and emphasise that the traumatic event is in the past and that things have moved on since then. This is known as “time-tagging” – the purpose of which is to really give the child a sense that the trauma is firmly rooted in the past and things now are different, which reduces sense of current threat.

Plot the scary feelings rating on the Scary Feelings Scoresheet to demonstrate to the child what happens to their scary feelings over time. Use this as a rationale for setting up exposure to reminders as homework.

Once back at the clinic, construct a hierarchy of feared situations and scary reminders using the Scary Reminders Chart. This can be developed in a very straightforward way – by now it should be clear the kinds of reminders that trigger fear. Ask the child to rate these in terms of scary feeling level, and they can then be put onto the reminders chart hierarchically. Spend some time with the parent discussing how to assist their child to completing exposures for homework. These should not be as difficult as the site visit, but needs to elicit at least some anxiety. It is important that the ensures their child remain in the situation until fear decreases. They will also need to measure anxiety before and after the exposure.

Lead the parent through the Testing Things Out For Myself sheet in detail, explaining their role to support their child and to remind their child of their anxiety management skills if necessary.

Homework

Homework is to do an exposure to a trauma reminder (as per the hierarchy). Assigning exposure for homework ensures that the child does not become dependent on the therapist to confront avoided reminders. The task should be set up at the end of the session by completing the Testing Things Out For Myself sheet and parental assistance needs to be enlisted for logistics and support (ie., to take the child to the site, to drive them in a car, to monitor anxiety ratings). Ensure that anticipated outcomes are specific so that success can be measured.

Further Exposure Work

Commence the next session by carefully reviewing the homework assignment with both the child and parent. Depending on level of progress, additional exposure sessions may be necessary. If the child still experiences significant distress in response to reminders, continue working up the exposure hierarchy until there is a notable reduction in cue-elicited fear.

Stream 2 - Relapse Prevention

Aims

- To consolidate what has been learnt
- To provide a sense of achievement
- To review skills that can be used to manage future symptoms

Rationale

By the time the child reaches the end of the program, there will hopefully have been a marked reduction in symptoms. However, the periodic return of some symptoms is common, and families need to know how to respond when this happens. Much of the relapse prevention work is intended to educate the parent as to how they can support and remind their child of the skills they have developed which can be used to cope with future difficulties. Accordingly, this final session is a joint session.

This session is also designed to give the child a sense of accomplishment by reviewing all that they have learnt. The presentation of their completed workbook and certificate represents what they have achieved in therapy. They have the option of keeping their book.

Meeting Structure

This session is a joint session.

Materials

Workbook
Things I Have Learnt Sheet
Achievement Certificate
Updated Narrative

Procedure

Commence the session with a review of all the child has learnt. Go through the workbook page by page and ask the child to recall each skill they learnt. Have the parent write these out on the Things I Have Learnt sheet. Prompt as necessary and be sure to include relaxation, happy place imagery, imagining 'worst moments' from the scary story, being a detective to test things out, visiting the site and tolerating scary reminders. Include any additional skills that may have developed during treatment (i.e., imagery techniques, rehearsal of nightmares).

Spend some time discussing the updated trauma narrative (clearly distinguishable from their initial narrative) and emphasise their success in gathering clues about what really happened.

Provide encouragement and praise for all the child has achieved. Really emphasise the new tools that they now have for dealing with their scary feelings and getting back to their life. Return to the cupboard metaphor and explain that now they have done some detective work, organised the memory and put everything piece back together in an ordered way it isn't scary anymore. Remind the child that while many of their scary feelings have reduced and no longer bother them, sometimes, scary memories might jump and scare them when they're not expecting it – kind of like when a t-shirt or dress might just fall out of the cupboard. Explain that this is normal and happens to everyone and what they need to do is just fold it up and put it away.

Ask the child if they can think of something they might do tomorrow or the next day that would bring back a scary memory. If the child can't think of something, provide an example. Hopefully the child will be able to recognise that coming across a scary reminder may inadvertently scare them. Ask the child how they might respond to this. Use this as an opportunity to go through the list of skills and see if they can identify what might be helpful. Use a few examples to get the child to identify appropriate strategies. You may need to use drawings or cartoons to demonstrate this.

Conclude the session with a final review of the child's accomplishments. Present them with a certificate recognising all their hard work and ask them to colour and decorate it. This should be placed in the workbook which is for them to keep.

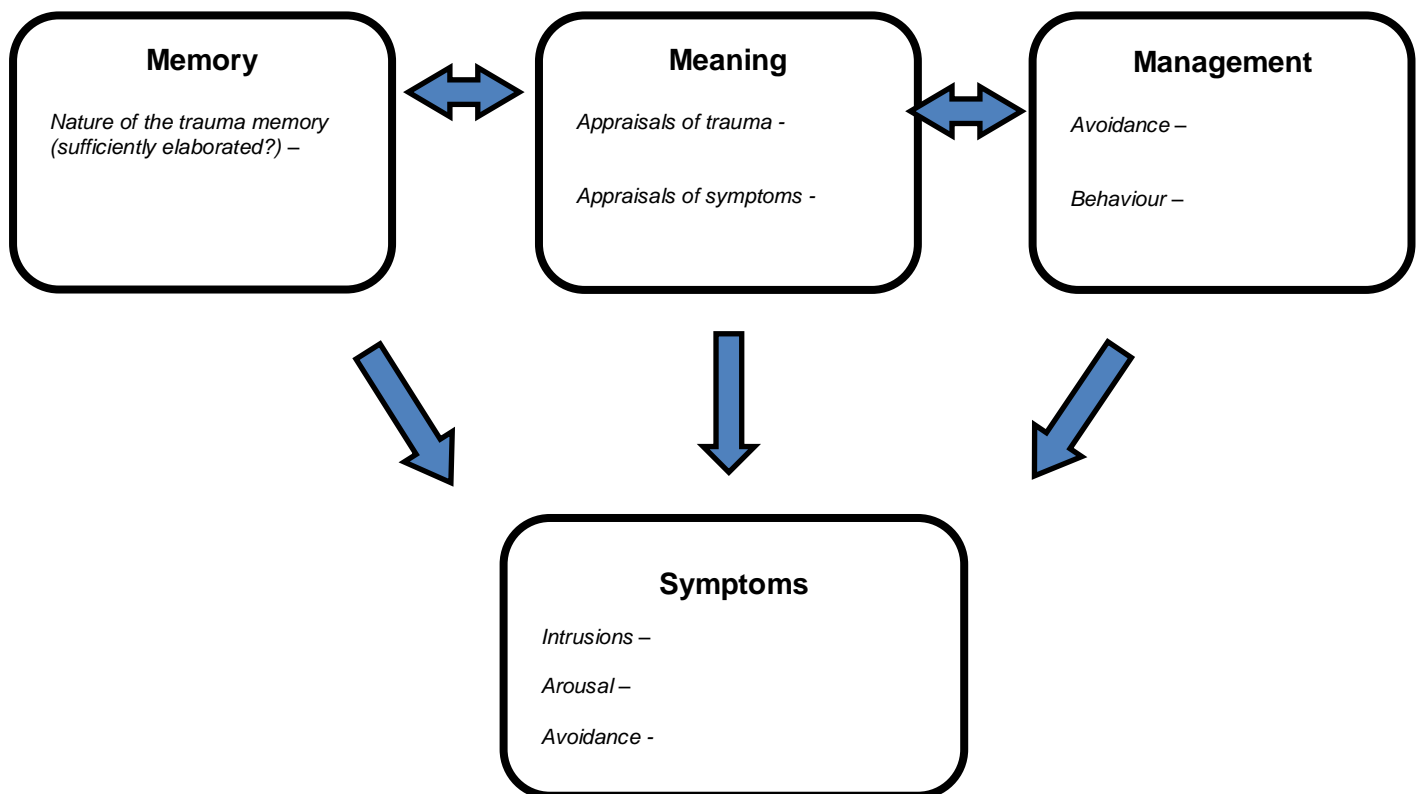
Supplementary Materials

Therapist Guide for Non-Responders

If you have come to the end of treatment and the child has not improved, further sessions will be required.

At the core of treatment is the processing of the trauma memory. If for some reason this does not happen, symptoms are unlikely improve. It is the role of the therapist to uncover what might be going on that is preventing the memory from being processed. In these cases, there are usually a myriad of complex, secondary issues that may need to be addressed in order for memory work to take place.

Enter case details into the blank formulation below. This may help identify which target/s have not yet shifted and warrant further attention.



Below are some common barriers to successful treatment.

1. Lack of parental support – This is likely to be the case if the parents is experiencing a profound posttraumatic stress reaction themselves, or are depressed to the point of being unable to support their child effectively through treatment. In such instances, they will need to be referred to appropriate services. Work with the child will need to take place to a greater extent within the sessions (rather

than between the sessions in the form of homework). If the child has another caregiver with whom they spend considerable time and might be better suited to support them through therapy, this could be another option.

2. Threat – If there are on-going genuine threats to the safety or needs of the child, this is likely to prevent successful treatment. For example, if a child has a parent in hospital, or if they need to undergo a medical procedure as a result of the trauma, this is problematic because the sense of current threat is valid. This should be carefully assessed prior to the commencement of treatment and a decision made about the appropriateness of treatment at this time given the circumstances.

3. Depression - Depression is a major obstacle for treatment because children may refuse to engage with the trauma memory or may not have the cognitive resources to do so. When this seems to be an issue, activity scheduling and behavioural activation strategies might improve mood to a point where trauma-focused work can commence.

4. Grief – If someone died during or after the trauma, some grief-focused work will need to take place. That nature of the death and their relationship to the child will dictate how this work is approached. However, psychoeducation about death and funerals might be indicated, as might a visit to the cemetery. Assessment of cognitions surrounding death and responsibility will be necessary to inform subsequent work.

5. Age – This is the first trial in children of such a young age with PTSD. Based on the developmental stage of the child, treatment will need to move more slowly than for older, more advanced children, hence the division of the treatment into two age distinct streams. Nevertheless, the pace will still need to be set according to the level of the child.

Managing Defiant Behaviour

To be used early in treatment around sessions 1-3 and as required thereafter

Children may be defiant simply as a result of being afraid and not wishing to have to think about what has happened to them. Ensure that they know that this is a safe place, and try to develop rapport, particularly in the first few sessions. If the child consistently refuses to do what they are asked and displays oppositional behaviour to the point that it prevents treatment progressing, the following suggestions can be used to assist with behavioural management.

Managing In-Session Defiance

If a child won't co-operate, some ways to manage this are:

- Be firm and instruct them to complete the relevant activity rather than ask them to
- Act indifferently towards their participation and complete the relevant exercise alone and act as though it is fun while providing a commentary as to what you are doing
- Act indifferently towards the child and make the exercise into a competition as the child may be competitive and wish to join
- A basic rule and reward system may need to be implemented if the above strategies do not work and defiance is interfering with progress. Agree upon a plan with the parent/s.

Helping Parents Manage their Defiant Child

Assess how much of a problem defiant behaviour is and ask whether it has emerged or worsened following the trauma. In the case that the child has always been defiant, explain basic principles of reinforcement and positive parental attention, and assist the parent to develop a reward and punishment plan.

If defiant behaviour has developed since the trauma, discuss the role of parental guilt and the effects of this on subsequent leniency with discipline. Explain that it is very common for parents to experience overwhelming guilt that their child has experienced a trauma. As a result, they will often compensate by becoming lenient with discipline because they feel that their child has been through enough and they want to make things easier for them.

Illustrate how this is not actually helping their child and that discipline needs to be enforced in the same way as it was before the trauma. Be careful not to assign any blame, and normalise leniency it as a natural reaction to caring about their child. However, explain why it is not helpful. Use the PTSD model to demonstrate how parental leniency enables avoidance, which is linked to the maintenance of the disorder. Once the parent understands the reasons they need to reduce their leniency, negotiate an agreement which involves working towards ignoring the guilt and implementing discipline in the same way as they did prior to the traumatic event.

Make a list of common defiant behaviours that the child engages in, and find out which behaviour is most troubling. This will be the first target behaviour for the discipline plan. Ensure the behaviour is measurable and obvious. For example, instead of 'being aggressive' redefine this in terms more amenable to measurement such as 'hitting his sister' or 'throwing his toys'. Develop a plan that includes time out and rewards (if this is acceptable to the family). For example, it might be the case that a child is first asked to stop the behaviour and if they do so, they are rewarded. If they continue the behaviour then they are then given a warning. If they comply after the warning, they receive a reward. However, if they still do not stop they have a choice: stop the behaviour, or continue and receive a minute of time out.

Of course, this is only a suggestion and the plan that is devised will have to be appropriate for the family and in collaboration with their existing reward and punishment system (if they have one).

Write out the plan for the parent to take home. Once a plan has been agreed upon with the parent, it is beneficial to have a discussion with the child present. The child can be involved and may wish to suggest appropriate rewards. It is useful for them to see the therapist backing up their parent with respect to discipline.

Make sure you follow-up on the discipline plan over subsequent sessions, and discuss how it went. Ask for specific examples of failure and success. If there were obstacles and the plan wasn't carried out, address why this was. Be directive and emphasise that their child needs them to enforce discipline. If the plan resulted in an improvement in defiant behaviour, congratulate the parent.

If the parent is very resistant and unable to continue with the discipline plan, this is ultimately their decision. However, provide gentle encouragement that while it is difficult now, it will become easier with repeated practice. Once the child learns that there are consequences to their actions, behaviour is likely to improve. Revisit this issue with the family as needed and continue with weekly reviews of the discipline plan where appropriate.

Improving the Child/Parent Relationship

The experience of a trauma will invariably have some impact on the relationship between the parent and child. This will be particularly evident if the child becomes oppositional or defiant. One way to approach this issue is to develop ways to improve the relationship between the child and parent. This can be facilitated by demarcating some 'special' time to be spent between the parent and child involving soothing and enjoyable activities. Enquire about how the child is comforted and use this as a starting point. Suggestions for other activities might include listening to calming music together, going for a walk to somewhere special, rocking the child to sleep, and reading stories together. The activity scheduling module can be used to do this in a more structured way. This 'special time' can also be used as a reward for improved behaviour and where possible, the child should be involved in choosing what some of these activities are.

Dealing With Poor Engagement or Motivation

To be used early in treatment around sessions 1-3 and as required thereafter

If the parent does not seem engaged in therapy raise the possibility that they may not wish to carry on with treatment. Normalise this reaction and address their apprehension.

It is useful to give some reasons as to why parents, at some point or another during therapy may not wish to return. These include:

- They don't want to think about the trauma anymore
- They don't want to expose their child to trauma memories anymore

Validate these feelings and then emphasise that for therapy to be effective, these short-term difficulties need to be overcome and there will be longer term benefits. This reluctance is likely to reduce over the course of treatment.

It is important that the parent feels comfortable and able to raise these issues with you as they arise. It is useful to explicitly inform them of this so that they do not feel concerned to disclose reluctance to attend at a future time when it may be relevant.

If they bring it up at any stage during treatment, point out that even though they felt reluctant to attend, they came anyway. Ask as to what it was that brought them in. This can be used as a justification for future sessions to continue. If necessary, revisit the formulation and PTSD model and discuss how it will be difficult in the short-term, but the long term success of therapy requires the processing of the trauma memory. Provide encouragement around the fact that they have already overcome the most challenging part – which was deciding to make a change and come in for treatment in the first place. They just need to be persistent.

Sleep Hygiene & Nightmares

To be used early in treatment if nightmares are highly distressing and problematic

Aims

To reduce symptoms of over-arousal

To elaborate and change the meaning of traumatic dreams

Rationale

Children's sleep may be disrupted because of nightmares, and they may have trouble falling asleep due to high levels of physiological arousal. Children may also deliberately delay going to sleep for fear of nightmares. This can result in irritability, poor concentration and fatigue.

In the case that the child experiences quite distressing nightmares, these should be addressed in therapy relatively early on. Sleep difficulties should be targeted in a joint session with both the child and parent – the involvement of the parent is critical because they will enforce the evening routine.

Materials

Sleeping Chart

Procedure

a) Provide basic psycho-education about sleep hygiene

Key points to cover include:

- A regular bedtime with a precursory wind down time
- Remind the child that they can practice their relaxation/happy place imagery before bed
- Stories – once in bed, the child can have stories read to them, or can read to themselves
- Children may like to listen to music to help them drop off to sleep. Having the volume very low on the radio means that children need to concentrate hard to listen, and are less likely to be distracted by intrusive memories or anxious thoughts

Younger children might benefit from keeping a sleeping chart – recording their bed times and sticking to agreed times in return for stickers which eventually lead to a reward. This may be particularly useful for non-compliant children who have difficulty going to bed or staying in bed

b) Nightmares

Where nightmares are a distressing symptom, two main techniques (rehearsal and changing endings) can be used to deal with them. Bad dreams should be normalised as common reactions to trauma which happen to lots of children and adults. Acknowledge that dreams are frightening and seem real at the time, but that they cannot come true or really hurt you.

Rehearsal

Ask the child to tell you about their dream, in detail, from beginning to end. Younger children may like to draw some part of the dream. Older children can be asked to write it down, in detail and from beginning to end, for homework. Children may like to record their nightmare onto a tape recorder. As with reliving, engage all senses and include as much detail as possible. Children should then be asked to read their description of their nightmare, or listen to it on tape, repeatedly, until it becomes boring rather than frightening.

Changing Endings

Rehearsal alone may result in a decrease in nightmare frequency. If this does not happen, children can be helped to directly change the content of their nightmare. Ask the child to imagine a positive ending to their nightmare. Be creative. Encourage younger children to think about imaginary helpers or superheroes who might help in their dream. Older children may like to imagine a friend or film star helping. Start rehearsing the dream as usual. Introduce the imaginary helper, or change the ending to a positive one. This positive ending should be imagined in as much detail as the real dream. Ask children to say out loud the dream with a positive ending, from beginning to end. As above, ask them to draw or write the new dream for homework. Rehearse it before bed.

Homework

As noted, homework involves completing the Sleeping Chart, rehearsing the nightmare and discussing it with family members.

Working With Imagery

To be used late in treatment if images do not become less vivid following reliving

Aims

To reduce avoidance

To elaborate and change the meaning of the trauma image/memory

Rationale

Children's intrusive images, usually of worst moments, may have a frozen quality: the same image intrudes and it is extremely vivid and accompanied by a feeling of 'nowness'. Children often report that these qualities change following reliving in that the image becomes less vivid.

For some children, this change does not occur through reliving alone and may need to be addressed through direct attempts to modify it. This approach has the advantage that it can reduce avoidance by asking children deliberately to hold into an intrusive image before manipulating it. It can also reduce the sense of uncontrollability that children report when experiencing intrusive images.

Materials

Paper and pencils

Procedure

A variety of techniques can be used so it is necessary to try each out until it is clear which works best for the child.

Ask the child to deliberately recall their intrusive image in their mind, and to project it onto a wall and stare at it. Frame it like a picture or imagine that it is a picture on a TV screen. Describe it. Is it in black and white or colour? Is it still or moving like a film? Hold onto the image and move it around the wall. Imagine taking a remote control and slowly turning the brightness control or the colour. If there are sounds associated with it, imagine turning down the volume. Imagine the picture becoming blurry or fuzzy as if the reception is bad. Imagine the picture fading away.

For younger children for whom this is too advanced, ask them to draw a picture of their image. It can then be manipulated. Drawing it from another angle such as a bird's eye view or different perspective may help change the qualities of the imagery. Using colour to modify it may also be helpful.

Explore different techniques to play around with the image. This can have an effect on the child's sense of being out of control and helpless. Take care that you encourage engaging with the traumatic image, rather than avoiding it. This is best achieved by doing the exercises slowly. Some children report that with repeated practice, images will fade if they just hold onto them and project them without doing much to alter them. Provide encouragement for bravery in doing this exercise.

Report To Parents

Cover the material from the session and ask the parent to support the child's homework task.

Homework

Set imagery homework. Ask the child to practice what they did during the session at home.