CHAPTER 1

Overview of Preschool PTSD Treatment

Why Is Treatment Needed?

Natural Course

Exposure to life-threatening traumatic events is common. More than two-thirds of children experience at least one life-threatening traumatic event by age 16 years (Copeland, Keeler, Angold, & Costello, 2007). Of those, more than one-third experience more than one traumatic event. The good news is that approximately 70% of individuals appear to be resilient. The bad news is that the 30% of individuals who are susceptible to develop trauma-related symptoms often have a chronic course and need a specific type of therapy to help them recover.

Prospective longitudinal studies have demonstrated a need for treatments such as this manual by showing that posttraumatic stress disorder (PTSD) does not usually disappear with a tincture of time or even an extended period of time. Investigators have estimated the prevalence of PTSD in young children to be 10% 6 months after motor vehicle accidents (Meiser-Stedman, Smith, Glucksman, Yule, & Dalgleish, 2008) and burns (De Young, Kenardy, Cobham, & Kimble, 2012), 25% 6 months after a gas explosion in Japan (Ohmi et al., 2002), 17% 9–12 months post 9/11 (DeVoe, Bannon, & Klein, 2006), 13% on average 15 months after burn injury (Graf, Schiestl, & Landolt, 2011), and 23% 2 or more years after a variety of traumatic events (Scheeringa, Zeanah, Myers, & Putnam, 2005).

Prospective Studies in Young Children

There have been several well-done studies on the long-term trajectories of PTSD symptoms in young children. We conducted the first prospective follow-up of PTSD symptoms

in a cohort of 1- to 6-year-old children (Scheeringa et al., 2005). The families were non-help-seeking and experienced a variety of types of trauma, including accidents, abuse, and witnessing domestic violence. Initially, there were 62 children in the sample with a mean of 3.6 PTSD symptoms, and 26% meet the full PTSD diagnosis. After 2 years, the 35 children retained in the sample had a mean of 2.9 symptoms, and 23% still met the full PTSD diagnosis. As there was no evidence of significance natural recovery, nearly the entire sample seemed to follow the chronic–worsening trajectory.

Meiser-Stedman et al. (2008) assessed 62 2- to 6-year-old children 2–4 weeks following motor vehicle accidents and found a 7% prevalence of PTSD. When reassessed 6 months later, the prevalence had actually increased to 10%. More encouraging, De Young et al. (2012) studied 130 1- to 6-year-old children following burn injuries and found a 25% prevalence of PTSD 1 month after the trauma, which decreased to 10% after 6 months.

The long-term trajectories of PTSD symptoms have been described mostly for adult trauma victims. Long-term follow-up studies have shown several different trajectories over time (Bonanno et al., 2012). A *moderate* group shows medium severity of PTSD symptoms and some gradual natural recovery. A *high* group shows high severity of PTSD symptoms and some gradual natural recovery. A *chronic–worsening* group shows moderate to severe symptoms and does not improve or worsens over time. Relatively few of the individuals in these groups naturally improve to achieve complete absence of symptoms. Substantial improvements are possible for some individuals, but once PTSD develops, it is a quite chronic problem.

These data make it clear that PTSD does not go away on its own and that intervention is required. When should intervention begin? Treatment is indicated if symptoms persist after 1 month. The National Institute for Clinical Excellence (2005) published an expert consensus report that stated that watchful waiting is the recommendation for mild symptoms within the first month, whereas treatment within the first month ought to be considered for severe PTSD. This recommendation was based on a very substantial body of evidence that symptoms that are present after 1 month are likely to endure, impair, and not resolve without evidence-based treatment.

Thus, contrary to a widely held belief that children simply "grow out of" PTSD (Cohen & Scheeringa, 2009), these findings indicate that a substantial proportion of trauma-exposed young children have chronic PTSD symptoms and impairment and require treatment. Furthermore, in our follow-up study, we noted that although 17 children had received community treatment, they did not improve, suggesting that community treatment as usual was ineffective and that more effective treatment was needed (Scheeringa et al., 2005). This and other considerations led us to develop the following treatment protocol.

Development of Preschool PTSD Treatment

Prior to the development of Preschool PTSD Treatment (PPT), only two randomized studies had focused on trauma-related symptoms of young children, and both were limited to those exposed to sexual abuse. Cohen and Mannarino (1996a) had randomly allocated

39 3- to 6-year-old sexually abused children to either 12 individual sessions of trauma-focused cognitive-behavioral therapy (TF-CBT) or nondirective supportive therapy. The TF-CBT group improved significantly more than the supportive therapy group on Total Behavior Problems and the Internalizing scale of the Child Behavior Checklist; a PTSD measure was not employed in this study. Deblinger, Stauffer, and Steer (2001) had randomly allocated 44 2- to 8-year-old children to either 11 sessions of group TF-CBT or group supportive educational treatment. Both groups improved on PTSD symptoms; the TF-CBT group did not show greater improvement than the supportive educational group, perhaps because the TF-CBT group members were not asked to speak about their own experiences due to their young ages.

Although both of these randomized studies with young children were encouraging, several limitations needed addressing. First, only the Deblinger et al. (2001) study used an outcome measure of PTSD and found no difference between TF-CBT and supportive groups. The evidence for reducing PTSD symptoms in young children was thus slim. Second, both studies were limited to children with sexual abuse. Thus, when the first-ever federally funded programs to train clinicians to treat children for PTSD were created, following the 2001 World Trade Center attacks and the 2004 Florida hurricanes, preschool children were left out of these large and important programs because of the perception that there were no sufficient disaster protocols for this age group (Allen, Saltzman, Brymer, Oshri, & Silverman, 2006; CATS Consortium, 2007).

An additional gap was the absence of feasibility data as to whether young children could understand and cooperate with the essential techniques of cognitive-behavioral therapy (CBT). Although the Cohen and Mannarino (1996a) and Deblinger et al. (2001) studies both used rigorous methods to ensure therapist fidelity to the treatment protocols, they did not have data on the actual feasibility of the CBT techniques for the children. In other words, the therapists appropriately followed the protocols, but there were no separate ratings on whether children appeared to understand each element of the protocol. Therapist fidelity and feasibility for children may overlap quite a bit, or they may not. Another major aim of developing PPT was to create a treatment method that was proven to have tasks that young children could really do (i.e., be developmentally feasible).

The PPT protocol was first developed based on the relevant literature about the use of CBT techniques to treat PTSD, my research findings on assessments of young children, and my clinical experience of trying to treat PTSD in young children. During the process of writing the manual, I invited Judith A. Cohen and Lisa Amaya-Jackson to assist and be coauthors. Cohen and Anthony P. Mannarino had experience in developing and testing of TF-CBT in older children. In addition, they had conducted the previously mentioned study using CBT for sexually abused children ages 3–6 years (Cohen & Mannarino, 1996a), which included, among other techniques, anxiety management training (direct discussion of trauma reminders with progressive relaxation and positive imagery), detection of distorted attributions, and time spent with the mothers over a 12-session individual therapy structure. Amaya-Jackson, with John March, had written and tested a group CBT manual for older children (March, Amaya-Jackson, Murray, & Schulte, 1998), which included, among other techniques, anxiety management training with both narrative and imaginal exposures, the stress thermometer, a stimulus hierarchy

list, positive self-talk, detection of distorted thoughts, prescribed homework for *in vivo* exposure, and relapse prevention over a 14-session group therapy structure. Judy and Lisa were quite helpful in the early stages of manual development and troubleshooting with the early cases.

Based on my research (Scheeringa, Peebles, Cook, & Zeanah, 2001; Scheeringa & Zeanah, 2001; Scheeringa, Zeanah, Drell, & Larrieu, 1995) and clinical experience with this population, I modified these techniques for 3- to 6-year-old children who had experienced any type of trauma. I also included many new techniques that had not been standardized in previous trauma interventions, including psychoeducation with pictorial aids; systematic discussion of reluctance, a session for discipline plans, implementation of nearly all exercises and narrative exposures through drawings, a personalized folder to collect drawings and worksheets, systematic desensitization that started with low-anxiety-provoking exposures and worked up to high-anxiety-provoking exposures, safety plans, inclusion of parents who watched all sessions in closed-circuit TV, and planned time with parents in every session to process the protocol material.

The Evidence Base

We tested PPT in a study that included 3- to 6-year-old children who had experienced a wide range of types of traumas between 2005 and the end of 2008 (funded by the National Institute of Mental Health, R34 MH70827). Children had to be between 36 and 83 months of age at the time of the most recent trauma and at the time of enrollment. Exclusion criteria were few and included moderate mental retardation, autistic disorder, blindness, deafness, and familial inability to speak English. Also, children whose only trauma was sexual abuse were not enrolled because the two previous studies had already shown the effectiveness of CBT for treating young victims of sexual abuse (Cohen & Mannarino, 1996a; Deblinger et al., 2001).

The study was divided into two phases. In Phase 1, we treated the first six children with the manualized protocol. This phase helped us empirically discover numerous minor revisions that were helpful (e.g., the term *safe place* was not well understood, so it was changed to *happy place*). In Phase 2, we randomly assigned half of the subjects to receive treatment immediately and the other half to a 12-week wait list (WL). The duration of the 12-week WL was designed to be the same duration of time as the treatment group. Hurricane Katrina struck New Orleans soon after Phase 2 began, which interrupted the treatment of several subjects and stopped all activity for nearly 6 months as our clinic was being made habitable again. Because of this delay, we opted to allocate the next 10 subjects to immediate treatment in order to rebuild the caseloads before we resumed randomization. As a result, more children were assigned to immediate PPT treatment ($n = 51$) than to the 12-week WL period ($n = 24$). Thirty-two children completed at least one session in the PPT group, 20 completed all 12 sessions, and 11 completed the waiting period in the WL group.

The first aim of the study was to test the effectiveness of the protocol to reduce PTSD symptoms. The treatment clearly worked and the changes between these groups

were highly significant (Scheeringa, Weems, et al., 2011). The PPT group had a mean of 7.9 symptoms before treatment, which decreased to a mean of 3.6 symptoms after treatment. The WL group showed no significant improvement during the waiting period (mean 7.7 PTSD symptoms prewait vs. 7.2 symptoms postwait). Also, the qualitative use of the manual was described with two case studies (Scheeringa et al., 2007).

Next, 10 of the 11 children who completed the WL period still met the study inclusion criteria, so they were treated with PPT. Six of these 10 children completed all 12 sessions, and they were then combined with the PPT group to form a single group to estimate effect sizes of the treatment. The effect size for reducing PTSD symptoms was large by conventional standards: $d = 1.01$. The number of symptoms also significantly decreased for major depressive disorder (MDD), oppositional defiant disorder (ODD), and separation anxiety disorder (SAD), but not for attention-deficit/hyperactivity disorder (ADHD). The effect sizes for MDD, SAD, and ODD were also large: $d = 0.92$, 0.72, and 0.89, respectively.

When treatment completers were followed up after 6 months ($n = 16$), the effect sizes were again moderate to large for all disorders except ADHD, indicating excellent stability of treatment gains.

The second main aim of the study was to examine the feasibility of every one of the CBT techniques we used with the young children. Forty-six children participated in at least one treatment session and were rated for feasibility on the TF-CBT techniques. Overall, children were judged to understand and complete 83.5% of the items rated (out of 1,793 possible from a total of 388 treatment sessions). An independent rater scored 30.7% of the treatment sessions from video ($n = 116$ sessions, 530 items), and this rater agreed with the therapists' ratings 96.2% of the time. The rater and therapists' interrater agreement (kappa) was substantial at 0.86. The feasibility data on specific techniques are presented later, after the techniques are described.

Since then, PPT has been used in my clinic by trainees whom I supervise, and by colleagues at Tulane and around the world. Feedback over the past 5 years has led to minor refinements. PPT has been disseminated to over 800 clinicians in 27 trainings around the world, including England and Australia, and distributed to hundreds of other clinicians via the Internet.

Who Is Appropriate for Treatment?

In our randomized trial, inclusion criteria stated that children had experienced a life-threatening traumatic event and had four or more PTSD symptoms, with at least one of them a reexperiencing symptom from DSM criterion B or an avoidance symptom from DSM-IV criterion C. A reexperiencing or avoidance symptom was required for the exposure exercises to be salient in TF-CBT. The children did not need to meet criteria for the full disorder.

The lower age limit for children was determined by the age at which they have developed autobiographical narrative memory of events and adequate verbal language. This is typically around 36 months of age (Fivush, 1993; Terr, 1988), but may be earlier

in special circumstances. The upper age limit for using this protocol is more flexible. In our randomized trial, children's ages were between 3 years, 0 months, and 6 years, 11 months, at the time of the most recent trauma and at the time of enrollment, but we have used the protocol on older children outside of that trial.

A relative contraindication to attempting this treatment is children with untreated ADHD. In my experience, it is usually more helpful to treat ADHD with medication first and then start this protocol. For equivocal cases in which the ADHD is mild or it is suspected that the ADHD symptoms are PTSD-related, then it makes sense to start the protocol and see if children can cooperate.

How Is the Treatment Theorized to Work?

A review of studies on treatment for PTSD identified three factors that were involved across types of trauma treatments:

1. Emotional engagement with the trauma memory.
2. Organization and articulation of a trauma narrative.
3. Modification of basic core beliefs about the world and oneself (Zoellner, Fitzgibbons, & Foa, 2001).

PPT addresses all three of these in a CBT structure. The challenge in working with younger children is how to apply these techniques in a developmentally sensitive fashion that both the child and parent can utilize.

CBT for PTSD

CBT appears to be an effective treatment modality for PTSD because of the focus on learning theories and cognitive distortions (Foa, Keane, & Friedman, 2009; Silverman et al., 2008; Zoellner et al., 2001). Although it is not clear what causes PTSD at a neurocircuitry level, it is evident that these are new behaviors, thoughts, and feelings that were not present prior to a traumatic event and that seem to be associated with magnified and automatic cognitive processes.

Behavior therapy rests on a primary assumption that most behavior develops and is sustained through the principles of learning (Rimm & Masters, 1979). One type of learning, operant conditioning (Skinner, 1953), is particularly useful for treatment because it works by voluntary behaviors (operants) being reinforced by consequences (response). In theory, change in behavior is linked to the strength and frequency of the responses. These characteristics can be manipulated in treatment protocols.

Cognitive therapy rests on the primary assumption that individuals interpret the world through cognitive structures (schemas) that have secondary impacts on altered feelings and behaviors (Beck, 1967). Cognitions and behaviors are, of course, not independent, and theorists have sought a more realistic amalgam of the two, such as in social learning theory (Bandura, 1969).

CBT is the rational blending of both modalities, which over the past 30 years has evolved into a diverse group of interventions (Thase & Wright, 1997). The empirically driven theory and practice of CBT lend it well to systematic and structured treatment protocols.

CBT techniques can be simplified into two components: exposures (systematic desensitization and prolonged or imaginal exposure) and anxiety management training (relaxation, cognitive restructuring, and biofeedback). Empirical support exists for both categories, plus for combined treatment packages (reviewed in Rothbaum & Foa, 1996). PPT uses both techniques in a combined treatment package. Although exposures and anxiety management training are the primary techniques that are thought to decrease PTSD, there are many other aspects of PPT that go into a successful treatment package; these are described next.

Components of PPT

The main framework of the 12 sessions of PPT is presented in the following list. The sessions build on each other in the philosophy of graded exposure therapy. The skills needed before Session 2 are taught in Session 1, and so on. Regarding the exposures in Sessions 6–10, the earlier exposures are intended to be less anxiety-provoking than later exposures in order to gradually build the child's skills to cope with the most feared exposures.

- Session 1: Psychoeducation, overview.
- Session 2: Behavior management for defiance module.
- Session 3: Learn CBT tools—identify feelings.
- Session 4: Learn CBT tools—relaxation exercises.
- Session 5: Tell the story.
- Session 6: Easy narrative exposure.
- Session 7: Medium narrative exposure.
- Session 8: Medium narrative exposure.
- Session 9: Worst-moment narrative exposure.
- Session 10: Worst-moment narrative exposure.
- Session 11: Relapse prevention.
- Session 12: Review and graduation.

The titles of these sessions only describe the main focus of each session. Multiple activities take place in each session; these are described in detail in the manual in Part II. Approaches that are constants throughout the treatment and techniques that are repetitive are described next to avoid repeating them every time in Part II.

The Office

Do not keep toys and snacks in your therapy room (we use snacks during sessions but we do not store the snack supplies in the therapy room). Avoidance is part and parcel of

PTSD. Two of the PTSD symptoms include avoidance of internal and external cues that remind individuals of their traumatic events. If toys and snacks are in your room, even if they are out of sight behind cabinet doors, children will use these distractions to avoid exposures. In addition, the main job in life for young children is to play, and they will try to play if given half the chance. Perhaps most importantly, children are brought to therapy by their parents as unwilling participants, and they do not yet have the abstract understanding that therapy is a place to come and discuss emotional and behavioral problems. The way you set up the therapy room is instructional to them about how to behave. Toys and snacks in the room are a recipe for inviting unnecessary control battles.

A Straightforward Approach

Throughout every session, and especially at the very beginning, it is important to adopt a "matter-of-fact" attitude toward discussing the trauma, especially with younger children. If the child is reticent to discuss the trauma, the therapist may feel uncomfortable "pressing the issue" because the power differential of age, size, and verbal abilities are magnified relative to working with older children and adults. This need to stay focused on the issue may also feel uncomfortable to the therapist because a caregiver observes every session. If a caregiver has made clear that he or she has avoided talking about the trauma with the child, the therapist now has two patients to worry about upsetting. Humor can be used to lighten the mood. Despite these potential challenges, the success of treatment depends on the child, and perhaps the caregiver, ultimately being able to confront these memories without disabling fears and anxiety.

The Therapeutic Alliance

In my opinion, the so-called therapeutic alliance has been a bit oversold. The therapeutic alliance is of course important. In an activity that is essentially interpersonal, how could it not be important? Where it is oversold is in the sense that the alliance has to be affectively expressed or is inappropriately and artificially created. A warm and fuzzy therapeutic alliance certainly makes therapy more pleasurable. All individuals, however, are neither inherently affectively expressive nor terribly interested in interpersonal interaction (e.g., those with Asperger syndrome and its variants). Treatment can be just as successful with more affectively aloof alliances that have a solid underpinning of cooperation. When the alliance does not come so easily, the therapist must be able to adapt his or her interaction style to the temperament and personality level of each individual (not the other way around). Cooperation is the only essential aspect without which therapy cannot succeed.

Reluctance

Based on research data that showed that caregivers of children with PTSD have enormous symptomatic burdens of their own (reviewed in Scheeringa & Zeanah, 2001) and on the clinical experience that mothers are often reluctant to recollect their children's

traumatic experiences, we built in motivation and compliance sections for the mothers in every session. The therapist is directed to preemptively anticipate with the mother that she will feel reluctant to come to subsequent sessions. This feeling is validated, systematically rated on a weekly basis, and addressed in more depth when needed.

Emphasis is placed on the importance of the therapist preparing parents for the possibility that they will not want to come back for subsequent sessions. This common reluctance arises for several reasons. For one, parents do not want to confront painful memories, and they do not want to put their children through painful memories. In some cases the children improve a bit and the parents use that improvement as an excuse to stop coming. Another possibility is that parents have started to dredge up traumatic memories from their own pasts. If one of these reasons stops a family from coming back for treatment, it is already too late to address it. In this protocol, the reluctance to return is anticipated and discussed in the first session and in every session thereafter. This preemptive validation of the parents' experiences has the added benefit of building their trust in the therapist's competence. It shows that the therapist has experience and even expertise in this area and knows what's coming down the road.

Parents are given directive advice to report how they ignored their reluctance and came back anyway. They are asked to report "what tricks you used to make yourself come back." Some of the "tricks" that parents have reported to us include:

- "I just come because my child needs it."
- "I took a Xanax."
- "I prayed."
- "I don't want my girl to go through what I went through" (the mother had been sexually molested as a child, as her daughter was, but the mother never received any counseling or support).
- More than one mother of boys who witnessed severe domestic violence perpetrated by their fathers said, "I don't want him to turn out like his father."

As one can see from most of these comments, the parents sacrificed their own discomfort so that their children could get help.

Candy and Snacks

The use of food is a technique to help children enjoy the otherwise unpleasant activity of talking about their traumatic experiences. Food helps break the ice and make children feel more comfortable. One piece of chewy candy (e.g., Tootsie Roll, Starburst, caramel chewies, Hershey's Kiss) is offered from a candy bowl at the beginning of each session. A snack, such as a bag of chips and a juice pouch, is offered about halfway through each session.

These treats are offered unconditionally. They are never to be used as rewards or withheld as enticements to influence participation in therapy sessions. If parents spontaneously attempt to use the food for contingent purposes, the therapists must gently intercede.

Offering snacks and drinks to parents must be a more flexible option. Routinely offering a cold drink or snack to the parent at every session is not recommended. However, if the absence of such an offering becomes an issue for needy parents, it is not expected that offering minimal snacks would pose a serious threat to the integrity of the treatment protocol.

Roadway Book

The Roadway Book is simply an inexpensive folder with three clasps to collect all of the worksheets. This book is one of several methods used to help the child develop a coherent narrative of the trauma, free of cognitive and memory distortions. Over the course of the treatment, this book, which is organized session by session in chronological order, is filled with projects and homework. Children are asked to individualize their books by decorating their covers and naming them.

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

Discipline Plan

ODD is common in preschool children following trauma. For example, in our study of 62 trauma-exposed preschool children, ODD was present in 75% of those with PTSD and was the most common comorbid disorder (Scheeringa, Zeanah, Myers, & Putnam, 2003). In our experience, disruptive behavior is the single most common reason parents bring their young children for treatment following traumas (as opposed to PTSD symptoms). Therefore, Session 2 is devoted to this problem at the beginning and followed up in subsequent sessions. If defiance is not a problematic issue for a child, skip this session and go on to Session 3.

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

When determining target behaviors for discipline plans, it is *critical to narrow each behavior down* to a measurable, clear action that you (and more importantly, the mother) can tell, unambiguously, when it is occurring. For example, if the mother says, "He's mean," in response to being asked for a target behavior, "mean" is not a measurable or

clearly identified action. Other unacceptable target behaviors include "He's aggressive," "He hits," and "He doesn't listen." Clear and measurable target behaviors include:

- "He chokes his sister."
- "He throws objects at the walls and/or people."
- "He doesn't pick up his toys after I tell him three times."

Once the target behaviors have been identified, set a goal that is easily achievable over the following week. It is much more important for children to achieve success for the first week of a discipline plan that it is to "fix" the whole problem. For example, set a goal of picking up toys after one reminder for only 2 out of the next 7 days. After this goal is met, the goal can be increased in the subsequent weeks. More often than not, given the inherently oppositional nature of many children with ODD problems, they will exceed these low goals simply because they are not supposed to exceed them.

Lastly, pick a reward through a negotiation with the children and parents. These ought to be quite small rewards, inexpensive, and therefore imminently doable. For example, children often choose to pick a movie, order pizza, or have Mom take them to the playground.

In the following weeks in which discipline plans were implemented at home, you will need to vigorously follow up on these during sessions. There are generally three possible outcomes at this point:

1. The plan was successful. —You will either need to negotiate how to modify it for the upcoming week or just leave it in place, unmodified.
2. The parent followed the plan, but the child's behavior did not improve. —You will need to decide whether to stick with the same plan another week, "ratchet it up a notch" with more potent rewards or consequences, or choose a different target behavior.
3. The parent did not follow the plan. —You will need to assertively address this issue now, rather than later. That is, put the issue of the parent's noncompliance on the table straightforwardly, as opposed to glossing over it. It is highly probable at this point that it was not an accident that the parent did not follow the plan, and it will not be followed in the future if it is not enforced. The counselor is the enforcer. You must sensitively "hold the parent's feet to the fire" and remind him or her that there are consequences—that is, the child's defiant behavior—if the parent does not follow the behavior plan.

How many weeks should discipline plans be used? As few as possible, and until the parent appears satisfied with the outcome. The typical range is one to five sessions. We do not try to keep repeating discipline for too many weeks because by Session 6 we really want the homework-related attention focused on the *in vivo* exposures.

Note on time-out: There tends to be widespread misunderstandings among both clinicians and parents about time-out. The erroneous view of time-out is that it is a

therapeutic technique that has efficacy in producing long-lasting changes in behavior. Time-out may work that way in your average child who has no clinical-level disturbances, but that is not our clinical population.

The proper use of time-out with a clinical population most of the time is as a last resort measure to temporarily interrupt disobedience or to stop children from harming themselves, others, or property. *Temporarily interrupt* is the key phrase. When time-out temporarily stops a child from doing something unsuitable, by definition, it has worked. We do not use time-out to extinguish bad behavior or instill morality. If a parent says, "I tried time-out and it didn't work," then reeducate him or her on the true usefulness of time-out. We generally do not use time-outs in discipline homework, but you may still want to address it as an aside.

Grief

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

What is the difference between normal and abnormal forms of grief? The *normal* grief response includes feelings of loneliness and preoccupation with thoughts and memories of the lost person. The responses can be grouped in the usual four categories of human responses: (1) feelings (sad and angry), (2) somatic symptoms/sensations (headaches, stomachaches, trembling, sweaty, and heart racing), (3) thoughts (missing the person and thoughts about how the person died), and (4) behaviors (crying, withdrawal, and temper tantrums).

Grief is considered *abnormal* when it has lasted abnormally long or is abnormally severe. Abnormal grief may be considered if, after 6 months, the child continues to feel persistent longing for the deceased; intense sorrow, anger, and/or self-blame; excessive avoidance of reminders of the loss; a desire to die to be with the deceased; persistently feeling alone and detached; and a loss of interest in usual activities.

Some basic tips on how to handle grief are provided in Session 2. For more extensive suggestions or guidance on complicated cases, therapists ought to consult grief-specific manuals (e.g., Salloum, 1998).

Parents Watch Sessions on TV

Sessions 3–11 begin with children, parents, and therapists checking in for 5 minutes or less. Then the parents go to a separate room and watch the therapy sessions in real time on a monitor. After the work with the children is finished, the parents come back into the room with the therapists while, ideally, the children can be in a separate room supervised by another adult. This is an unusual amount of changing rooms that requires extra effort, so why do it?

With children this young, you *must* have parents involved in some aspects of the treatment and it is ideal to have parents involved in all aspects of the treatment. So what is the best way to get parents involved? The parents need to *see* everything that you are doing with their children and learn all the same things that the children are learning. You cannot have the parents in the room with you and the children because children act and talk differently with their parents in the room. Also, you want the children involved with you during the therapy session, not the parents, so it becomes a little awkward to have the parents sitting on the side like third wheels.

We have found this method of having parents watch the sessions on TV to be helpful in multiple ways. First, young children are still developing verbal expression skills to communicate their thoughts and feelings to others. By default, you have to rely on reading their body language to know if they are anxious or avoidant. You do not know the children well enough to read their body language with that level of subtlety, but parents are experts at it. Parents know if something is wrong with their children just by a look that they probably cannot even explain. Therapists benefit by receiving this feedback from parents when the parents rejoin the therapists at the end of each session. Therapists can then use this feedback in subsequent sessions with the children.

Second, the children will need to do homework, and parents are essential to this treatment component. Parents have to understand the rationale for the homework and the steps involved because they will have to initiate the homework, transport their children to the *in vivo* exposure sties, and help guide them through the homework steps.

Third, two of the most useful ways that parents can help their children improve is by helping them avoid trauma reminders in the environment that trigger their distress, and by patiently soothing their children after they become distressed by triggers. To be able to provide these two sources of help, parents need to be better attuned to their children's internal lives. Most, if not all, parents that we have worked with have told us that they never asked their children to tell their stories of what happened to them in their traumatic events. Or, when parents thought they knew what their children remembered of witnessing traumatic events, they were then surprised to learn the details of what the children truly remember after watching the session on TV. Distressing reactions of their children to seemingly mysterious triggers were rendered no longer mysterious.

Fourth, parents learn to change their behavior by *seeing* someone else work with their children in a different way than they know how to do. It is not uncommon for therapists to think that working with parents directly to change their parenting behaviors will improve the children. However, there is very little randomized, controlled evidence that therapists can change fundamental parenting behaviors that have an impact on children's psychopathology. We shall talk later about parent–child relationship issues, but for now the main point is that the only times that I have seen parents fundamentally alter their parenting in this type of treatment is by watching live interactions of others with their children. Telling parents what to do doesn't seem to work. Explaining the importance of doing something doesn't seem to work. Parents don't know what they don't know about how to parent differently, and they can't know how to make something work with their unique children until they see someone else interact more effectively with those children.

You don't have a camera and monitor? A camcorder costs about $100 and a monitor about another $100. Including cables, discs, and accessories that may be needed, a setup costs less than $300. Therapists spend more than that on new sofas. There are other barriers? There is no way to string a cable from the camera to the monitor? There is no extra room in your clinic for the mother to watch? There is always a workaround. A hole can be drilled through a wall for a cable, or wireless signals can be used. Wireless baby monitors can be used to transmit sound and sometimes pictures. You can Skype over the Internet or use a FaceTime-enabled iPhone to connect one room to another. You can record the session on your smartphone or tablet and play back selected portions for the parents. These days there is almost no excuse to prevent showing the sessions to parents.

Scary Feelings Score (a.k.a. Stress Thermometer)

When children are called upon to do exposures during the office sessions and *in vivo* homework assignments, they need to be able to identify and communicate when their emotional distress increases from not distressed to more distressed. Conversely, after performing their relaxation exercises, they need to be able to identify and communicate when their emotional distress decreases from distressed to less distressed. Children in this age group have usually never been asked to communicate this degree of detail about their emotions, so they need to be taught the skill.

In older populations, this tool is a 10-point rating scale known as the Subjective Units of Distress Scale or more simply as a stress thermometer. We've found empirically that young children cannot grasp a 10-point scale, so we use a 3-point scale. They don't understand the word *stress*, but they usually do understand *scary feelings*. They don't understand thermometers yet.

In Session 4, therapists teach children how to rate their scary feelings, and this 3-point scale is thereafter used in a variety of in-office and homework exposures.

Relaxation Exercises

I recommend that you teach three relaxation exercises: slow breathing, muscle relaxation, and an imaginary "happy thought." All of the relaxation exercises may not work for some children, so a range of exercises is taught. It is hoped that each child finds at least one of these techniques useful.

A child may dislike all of the relaxation exercises for an idiosyncratic reason, or it may become apparent that another exercise works much better. For example, a child may get a better result from his mother rubbing his belly when he's upset. One boy created a way to interweave his fingers together that calmed him during his *in vivo* exposures. Feel free to ask caregivers for other options and substitute exercises that work. If children refuse any sort of relaxation exercise, they may still be able to cooperate with the simpler and less involved task of paying attention to the feelings in their bodies.

Start with *muscle relaxation* since this one tends to be accepted more easily by this age group than the others. See the exercise description in Therapist Form 3 in Part III for an example. This description uses counting by 2's to make it rhythmic and concrete.

We've found that it is engaging to describe this process as "making your muscles tight, *tight*" (demonstrate by squeezing your arm muscles) and then "go loose like noodles" (shake your arms around like noodles to demonstrate). You may use your own favorite method too. The point is to try to make the exercise fun and engaging.

Next, teach children about slow, controlled *breathing*. Children typically show the most resistance to this exercise. Try to make it an engaging contest about breathing in through the nose, and then out through the mouth. Show the child how to do it and use exaggerated facial expressions such as a crinkled nose and puckered mouth. Another way to make it a contest is to have them blow hard and long on something like a pinwheel or a piece of paper. Counting and tapping out beats can also make it rhythmic and easier to remember (e.g., "Breathe in, one, two, breathe out, one, two, three"). Or, suggest that the child lie down to make it more relaxing.

There is some empirical evidence (Ancoli & Kamiya, 1979; Ancoli, Kamiya, & Ekman, 1980) that recruitment of the parasympathetic branch of the autonomic nervous system, as opposed to the sympathetic branch, for breathing has a more calming effect (although that evidence does not come from work with trauma-exposed youth). The parasympathetic branch may be recruited by using the diaphragm muscle to breathe rather than the muscles in the chest wall. Diaphragmatic breathing expands the stomach during inhalation. Children can feel this expansion by simply placing their hands on their stomachs and feeling them rise and fall with each breath. However, based on experience, diaphragmatic breathing is difficult to learn and has not been shown to have a superior effect. Still, it may be worthwhile to teach.

Next, explain *happy-place imagery*. Children can learn to self-soothe when they get too scared by replacing scary feelings with an image/picture of something that makes them happy. You could call it "happy place" or "happy thought," or you may need a different term that they understand better (we initially tried "safe place," but children did not feel that *safe* was better than *happy*). A happy thought can be about some event that was fun, such as a party; or someplace calm, like the beach; or someplace familiar, like their mother's lap; or someplace private, such as a favorite window seat in their home. Young children do not associate thoughts of being alone as happy thoughts because they are so rarely alone at this age, and many are still concerned, to some degree, by separations. Younger children's happy thoughts will tend to focus on exciting events with other people. When one young girl picked the toy aisle at Walmart as her happy place, her mother protested to the therapist that the girl was not taking this seriously and was trying to get some toys out of this somehow. The therapist reassured the mother that her daughter's choice was developmentally appropriate.

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

These exercises are initially introduced to children as "relaxation exercises" because *relax* is a term that children this age can understand fairly easily. A proviso, however, is that *relaxation* may not be a realistic concept for this population. Children with PTSD

feel genuine fear from their triggered reminders of the traumatic events they experienced. Although the exposure exercises are not intended to trigger that degree of distress, the exposures nonetheless trigger substantial amounts of anxiety. Children can decrease the amount of anxiety they feel with these exercises, but they *never* achieve a state of true relaxation. If you find that certain children resist using the exercises, consider reframing them as "body control" or "body power" activities and avoid using the term *relax*.

Stimulus Hierarchy

The "stimulus hierarchy" is simply a list of reminders/triggers arranged from the least scary to the most frightening. This list will be used to select items for office exposures and for *in vivo* homework exposures. Examples of items that work well in stimulus hierarchies can be gleaned from the real examples of office and homework exposures in the next section on exposures.

You need to take notes during Session 4 when caregivers give you their version of the trauma (see the section on getting the "bird's-eye view" in Session 4, p. 83) and during Session 5 when children tell their version of the story for the first time. The items for the stimulus hierarchy will be pulled from your notes.

What if children had more than one traumatic event in their lives? Can you mix and match events on the stimulus hierarchy? The stimulus hierarchy can include reminders from more than one event. Discuss with the children (and/or the caregivers) which single event was the scariest or most memorable, and start with that one. If children spontaneously start talking about additional events, allow them to do this freely. A rule of thumb that has worked for us is that if parents are organized enough to return phone calls and show up for appointments, they can handle multiple *in vivo* homework assignments for two different types of traumas. If parents are not able to return phone calls and show up for appointments, you ought to stick to working on one type of traumatic event at a time; if you get through the protocol for one traumatic event, the number of sessions can always be extended to work on a second traumatic event.

A common question is whether the items on the stimulus hierarchy should reflect the events that happened in the past or situations in the present that trigger reminders of the past. That is a difficult question to answer in the abstract. The answer depends on the specific details of each situation. In general, we have found from experience that the hierarchy works best as a tool in psychotherapy if it includes events from the past, not memories of the past or reminders of the past in the present day. Let's take the example of a child who had been in a motor vehicle accident. An exposure to that event from the past would be an exposure to the actual place where the accident occurred. An exposure to a reminder in the present would be an exposure to riding in a car that is not the car in which the actual accident occurred. Both types of exposures can be effective, but the exposure to the event from the past tends to have more salience.

Also keep in mind which types of situations can be turned into homework exposures and which types might be physically impossible. For example, if an event occurred in a different state, it may be impossible to do an *in vivo* exposure around many aspects of that event.

For a vertical stimulus hierarchy, list moments from the least scary to the scariest. This sheet is put in the Roadway Book and used in later sessions. It is quite important that the reminders are listed in the correct order so that sessions are focused efficiently on the most anxiety-provoking situations.

What if the child rates all reminders the same? We've found that some children rate everything as the scariest. One possible solution is to ask the caregiver to decide which are really the least and the most distressing. Another solution is to create a horizontal hierarchy instead of a vertical one.

Regardless of whether a vertical or horizontal hierarchy is created, the determination that you are on the right track is always a bit of trial and error. Using all available information from the caregivers and children, make your best guess about which events on the hierarchy to focus and then reevaluate after each session to determine if these are provoking sufficient anxiety to be effective. In a case that we published (Scheeringa et al., 2007), we initially thought that a boy's worst moment had been separation from his mother when he was put in a boat with his grandparents to leave their flooded house during the Hurricane Katrina disaster. We had chosen the separation event as a best guess based on information provided mainly by his mother. As the therapy proceeded, however, the boy spontaneously turned the lights off in the therapy room a couple of times, which cued the therapist to ask if he was afraid of the dark, to which he agreed. This also led his mother to reconsider the past events and realize that it had been extremely frightening when the family had lived in their attic in the dark for 2 days and nights to escape the floodwater. They shifted the experience of being in the attic to the top of his stimulus hierarchy, and his symptoms subsequently improved dramatically.

Exposures/Narratives/Drawings

Nearly all of the tasks for children to complete in the PPT manual involve drawing. Drawing is a common technique used to assist younger children with recall of past memories, to help express internalized thoughts and feelings (Gross & Hayne, 1998), and in particular to facilitate the expression of painful traumatic memories (Malchiodi, 1997; Steele, 2012).

Drawing is also a highly developmentally appropriate way to interact with young children. Having something on the table that is between the children and therapists, which gives the children something to focus on, is a great facilitator for communication. It is developmentally inappropriate to expect young children to sit in a chair and make eye contact with an adult and hold a back-and-forth conversation. Young children do not yet have the capacities or practice to do that. The easiest communications will always occur when there is something between the therapists and children such as drawings or worksheets.

Easy items that the child can already tolerate fairly well are picked first in Session 6. You will work together over Sessions 6–10, moving up the list toward the "worst moment." Do not let overly eager children pick their worst moment for their first exposure practice because they do not have the capacity yet to understand for what they are volunteering. There will be plenty of repetition in later sessions to get to the worst moment. Conversely, you may need to encourage anxious children to move more quickly up the list.

Producing the ideas for the children's exposures often requires creativity. To help with that, the drawing/narrative exposures conducted in the office and the homework exposures that we've done with actual patients are listed for various types of traumatic events in the section titled "Tips on Creating Drawings/Narratives and Homework for Different Types of Traumatic Events."

When starting the first exposure, *explain* that children are going to start making their scary feelings (PTSD) go away. They will need to pick an easy item from their list, draw it, then imagine it, and tolerate the anxiety until their fear goes down. For this easy task, this may not take long.

Ask the child to *draw* a picture of this item. Give the child the worksheet for the Roadway Book with empty space for drawing (Child Worksheet 6.1). This is titled the Not-Too-Scary Reminder. The purpose is for the child to stay mentally in the situation until he or she is not scared at all and may even get bored. Overall, this activity ought to last several minutes, or the amount of time it takes to draw the picture. The child can use the relaxation exercise to help him or her stay with the scene until the scary feelings go away. This sounds simple, but it can be a rather long affair for children who have difficulty and need guidance on what and how to draw. For children who simply can't or won't do the drawing, you can do the drawing and narrate out loud as you go. Other children may take a long time because they want to spend a lot of time on the drawing. Have patience.

Ask for the *scary feelings score* at the beginning for a baseline rating and then every 3–5 minutes thereafter. "How scared are you now—none, a little, or a lot?" Keep a copy of the scary feelings score in view on the table for the child to reference. We've found that we need to be a bit leading with young children because they do not have fully developed skills yet for the metacognitive task of self-monitoring their internal states and then reporting these states to another person. They need some scaffolding to understand this exercise. It is useful to remember that in the early sessions you are probably *educating* the child on how to do this exercise as much as anything. We approach it in a two- or three-step ritual:

1. Before asking the child for his or her rating, ask, "Did that make you feel more nervous? Did your scary feeling score go up?"
2. Then ask the child to point on the rating sheet to the face that matches how he or she feels. The child can also hold up the number of fingers: one, two, or three.
3. If the child has finished the drawing and the score is still "a lot scared," or the child seems particularly anxious before the drawing is finished, say, "Now, we're going to do one of our tools to make the scary feelings go away."

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

Record the child's scores on the Scary Feelings Scores form (Therapist Form 1: Reluctance Checklist). These systematic data will help you judge whether the exposure task is having its intended purpose (to create some anxiety that rises and then falls).

Watch out for some children, particularly boys, who don't want to admit to being scared. If you suspect this is happening, change *your* wording from "How scared are

you?" to "How *hard* was that—none, a little, or a lot?" Some children feel relatively more anger than fear from these exposures. If you only use the words *scared*, *nervous*, or *anxious* with them, the task may not have the needed salience, and it will look like it is not working for them. If this appears to be the case, consider using an emotion word that more accurately reflects the feelings stirred up by the reminders. If it's not fear or nervousness, it is usually anger, but it could be sadness or some other negative emotion. Older children can adapt on their own if you are using the wrong emotion words, but preschool children tend to follow your directions more literally.

After completing this drawing, ask children to close their eyes and think about it for 30 seconds for an *imaginal exposure*. This may seem redundant, and it is. It is meant to create more exposures while changing things up a bit. In addition, imaginal exposures may be easier or more productive for some children.

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

The following descriptions of cases, drawings, and homework assignments are derived from work with actual patients. Identifying details have been changed in all examples to protect the personal information of the individuals.

Sexual Abuse

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

Session	Drawing/narrative	Homework
6	Sitting in the room in the house where the abuse occurred, just before it happened.	Mom and child drive past the house where it happened but do not stop.
7	Driving in Mom's car to the house where it happened.	Mom and child drive to the house where it happened and stop to sit in the car outside.
8	Picture of the perpetrator.	Sit in car outside the house where it happened. Make it more intense by sitting there longer.
9	Room where abuse occurred.	Drive to house where abuse occurred and get out of car briefly.
10	Child lying down, perpetrator standing next to her.	Get out of car at house again. Do it for a little longer than last time.
11	Near future: Next week, going to a new house. Distant future: Next month, going to a new house.	Get out of car at house again. Do it for a little longer than last time.

Domestic Violence

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

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

Domestic Violence and Motor Vehicle Accident

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

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

Motor Vehicle Accident

This child was a passenger in his mom's car when the car stalled at a stoplight and was rear-ended by a white pickup truck. He was 4 years old at the time of the accident and the treatment.

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

MVA Plus Medical Treatments

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

Session	Drawing/narrative	Homework
6	The restaurant that he and his mom stopped at before the accident.	Drive to a restaurant that resembles the real one and visualize being at the restaurant before the accident.
7	Mom's car on the highway.	Drive through the scene of accident.
8	Their cars plus several other cars on the highway.	Drive by the actual restaurant at which they stopped, and then drive by the scene of accident. Look at the tire skid marks on the pavement.
9	Multiple scenes: Receiving emergency medical treatment at the scene, the ambulance, getting stuck by a needle in the emergency room, and wearing the neck brace.	Use an actual doctor visit that was planned the next week.
10	Lying in the car right after the accident.	Use actual doctor visit that was planned the next week.
11	Near future: Next week, going to the doctor. Distant future: As a teenager, riding in a car that swerves on the highway.	Go to actual doctor's office.

MVA Pedestrian

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

Session	Drawing/narrative	Homework
6	Playing football in the front yard.	Go into the front yard.
7	Playing football in the front yard with more detail.	Walk around the front yard with parent and toss the football several times.

8	The front yard, the street, and the row of bushes.	Play football in the front yard; have Mom talk to child about the bushes.
9	Added the car to the scene and how he got hit.	Stand into the bushes where he was found.
10	Car hitting him and knocking him into the bushes.	Go to the bushes, play football in the front yard, talk about the accident.
11	Near future: Standing close to the curb and car whizzes past. Distant future: As a teenager, crossing a busy street.	Go to the bushes, play football in the front yard, talk about the accident.

Crime Scene Where Father Was Murdered

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

Session	Drawing/narrative	Homework
6	Driving over the Mississippi River bridge to the crime scene.	Redrive part of the route to get to the crime scene. Drive over the bridge, but don't go to crime scene yet.
7	Mom getting out of the car at the crime scene and blood on the street at the scene.	Drive on street near the scene and talk about what happened.
8	Father's funeral.	Visit father's grave.
9	Sitting in the car in front of the police station.	Park in front of police station. Have them talk about the incident to heighten the focus.
10	Father's funeral; crime scene again.	Visit father's grave.
11	Near future: Next week, seeing a crime scene. Distant future: As a teenager, attending a funeral.	Drive close as possible to the old crime scene and get out of car, talk about what happened.

Frightening Story Overheard and Anxiety Sensitivity (Afraid of Becoming Afraid)

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

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

Hostage

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

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

Rode Out Hurricane; Trapped in Floodwater; Airlifted from Roof of School Shelter by Helicopter; Overwhelmed in Evacuation Crowd Waiting for Buses; Scared in Mass Evacuation Shelter

This 5-year-old child experienced numerous scary events during the weeklong Hurricane Katrina event. She saw snakes and dead animals in the floodwater. This example illustrates how complex disasters can be.

Session	Drawing/narrative	Homework
6	Mass evacuation shelter.	View picture of mass shelter.
7	School shelter.	Drive to the school shelter.
8	Crowd waiting for the buses.	Drive to the school shelter again.
9	First boat they took through the floodwater.	Drive by the site where they waited for the buses.
10	Helicopter ride.	The assigned homework was to go see a boat, but a thunderstorm happened by chance which provided a sufficient homework exposure.
11	Near future: Next week, rain. Distant future: As a 16-year-old, hurricane.	Go see the boat at a neighboring house that was used to rescue them.

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

One of the important findings of our work after Hurricane Katrina was that young children whose families had evacuated prior to the storm and had never been in harm's way developed PTSD after they returned and witnessed their devastated homes (Scheeringa & Zeanah, 2008). The appearance of PTSD symptoms in children who had escaped the hurricane happened so many times that it did not appear to be a fluke of a few children. The onset of their symptoms was carefully tracked to the day they returned and stood on the curb outside their old homes or stepped inside their gutted homes and witnessed the loss of everything they had known there.

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

Evacuated and Then Returned to See Destroyed Home

This child was evacuated with his family before Hurricane Katrina. Their home was flooded by over 4 feet of water and completely destroyed with mud on the floor, mold on everything, and broken furniture. He was 6 years old at the time of the flood and the treatment.

Session	Drawing/narrative	Homework
6	Stuffed animal covered with mold.	Look through the window of a house that was damaged by Katrina.
7	Child's toys that were destroyed by the flood.	Go to a store and look at toys similar to those that he had lost in the storm.
8	Decorations on wall inside house that were destroyed.	Walk through the house that has been cleaned and gutted to the studs.
9	Child's broken and moldy bed.	Look at pictures of his house when it was damaged.
10	Living room with mold and furniture tossed around and broken.	Because home exposures seemed to have worked but then lost their intensity, exposure target switched to water. Drive to the lake, look at the water, and talk about the hurricane.

11	Near future: Next week, rainstorm. Distant future: As a teenager, hurricane evacuation.	Go to the lakefront where homes were destroyed and go to the water's edge.

What If a Child Dissociates in Session?

Among the dozens of children whom we have treated with this protocol, we have seen a child appear to dissociate during a session only once. This child froze in place and stared at the wall for approximately 10 seconds during an in-office exposure. He had been doing this at home for months, so this was not a new symptom. As treatment progressed, these freezing spells gradually disappeared.

There is little written about what works best with young children who dissociate. My advice is to gently talk to the child to try to orient him or her back to the present. The sound of your voice should make the child realize that he or she is in an office with another person, and not actually reliving the traumatic event. You might say things such as, "Andrew, why don't you do your breathing?" and "Alice, are you thinking about what happened?"

When the child has stopped the freezing spell, ask what he or she was thinking about to see if the child can verbalize what just happened. Also, provide praise for using newly acquired skills to cope with it by calming him- or herself. That ought to be the last in-office exposure for the session.

When the child returns for the next session, be sure to check in with the caregiver to see if the freezing spells had increased, decreased, or did not change over the week. If the spells increased, you probably want to slow down the intensity of the in-office exposures and build in more feelings of safety in the session. Otherwise, stick to the protocol and plow ahead.

What If a Child Appears to Fabricate or Have Distorted Memories?

Shawna was a 5-year-old girl who had lived through a series of life-threatening experiences in New Orleans during the Hurricane Katrina disaster. She and her mother had nearly drowned as their house was flooded on the first day of the disaster, then they were shuttled to dry ground on two different boats through the floodwaters during which she saw dead bodies and people screaming for help. They sheltered in a school, from which they were eventually air-lifted from the roof by a rope-seat into a helicopter, only to be deposited amidst a frightening crowd amassed along a highway to wait for evacuation buses. During therapy sessions Shawna claimed that she saw her grandmother dead and floating in the water, and that an alligator grabbed the body. Her mother confirmed that the grandmother had drowned in the flood but in a completely different neighborhood. How vigorously should one address these false recollections?

The image of her grandmother's body could certainly qualify as a traumatic image, and one that could create disturbing symptoms, one of which appeared to be a serious distortion of reality. As noted earlier, the review by Zoellner et al. (2001) identified three factors that were involved across successful treatments of PTSD; one of them was the organization and articulation of a trauma narrative. One might infer from this review

that this distortion in Shawna's narrative ought to be countered and corrected. There are, however, few empirical data available to make generalizations about distorted memories of young children. It was possible that Shawna's image of her grandmother was more comforting to her than the alternative of not knowing what had happened to her. Imagining that she saw her body at least allowed a lesser degree of uncertainty.

With Shawna we adopted a strategy of gently questioning her for details but not implying that her memory was incorrect. We explored rather than argued. By Session 10, Shawna's exposure narrative had become noticeably more orderly and accurate. Her mother, after watching on TV, remarked, "She's thinking today." Her symptoms, not coincidentally, had also markedly improved. It was as if, according to Zoellner et al. (2001), the trauma narrative had become more organized in the child's mind.

Homework

Homework involves *in vivo* exposure, which is probably the most effective aspect of the whole therapy because exposure to anxiety-provoking situations in real life tends to give children the best experience of managing their fears. *In vivo* exposures work just like in-office exposures, except the anxiety-provoking stimuli are out in the community. Children are expected to expose themselves to the stimuli, think about the traumatic events, rate the severity of their feelings, and then use their relaxation exercises to calm down. The whole process does not need to take more than a minute but often lasts several minutes.

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

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

Whether the homework is accomplished or not depends largely on the caregivers when working with children in this age group. We've had excellent success at getting homework completed; however, there is a subset of caregivers who either forget or avoid it. The best strategy for coaxing caregivers to be more cooperative with homework has

been to troubleshoot and revise assignments coupled with persistent reminders that the homework is important if their children are to get better. Some caregivers seem to respond better if the homework is presented more formally as a "contract" or "deal."

Child Cooperation

I tell therapists that 50% of the battle is to get cooperation from the children. That is true for psychotherapy for all ages because psychotherapy is a voluntary activity, but it has unique challenges with very young children.

Many young children are relatively unfocused, uncooperative, and energetic in the office for the first two to three sessions. They often settle down quickly as they learn the routine. They also settle down in Session 3 and beyond because that is when the caregivers start going into the next room and the children are alone with the therapists. In most cases, no special plan is needed to manage this behavior if it can be waited out. Have patience.

What if you've got an oppositional child who won't cooperate with the exercise? Try the following tricks.

Tell, Don't Ask

Don't *ask* the child to do the exercise. *Tell* the child (politely). The "tell, don't ask" strategy is actually appropriate for all children. And think of your alternative—what if you ask and the child says, "No"? What would be your move after that?

Ashton was a 4-year-old who had been kicked and thrown against walls by a day care assistant on several occasions when he disobeyed her and had tantrums. During Sessions 3, 4, and 5, the therapist had tried asking him questions to do a variety of tasks.

The therapist asked, "Ashton, can you think of a happy place?"

"No."

After several minutes of negotiation, she obtained some semi-agreement about a potential happy place. "Can you draw you in your happy place?"

"No."

By Session 6, the therapist had learned to "tell, don't ask" to get better cooperation. When it came time for him to draw his exposure, she stated, "Ashton, it's time for you to draw the front of your old school."

Not being quite so easy to say no to that, he sat and looked at her.

"Here's brown. I think that's a good color. Show me how you make a building."

He picked up the brown marker and started drawing a square building.

The Time Limit

This method can work for highly anxious children who believe that when you tell them to do exposures, they will be stuck doing exposures for long stretches of time. This kind of thinking is a form of catastrophizing. Before telling them to start an exposure, strike a

deal with them that they have to do the exposure for only, say, 2 minutes. Usually, they do the exposure for 2 minutes, realize that they are not overwhelmed, and are then willing to keep going. Also, young children do not have the ability to tell time on a wall clock and cannot tell when 2 minutes have passed. Do not, however, renege on the deal. If children ask you if 2 minutes have passed, you must honor the deal and preserve their trust for the next session.

The exposure component can also be turned into a sort of fun and cooperative task. Use a clock with a second hand and teach them how to tell when a minute has passed. They can do the exposure while they watch the second hand spin around, and they can be in charge of telling you when the time is up.

The Tom Sawyer Method

This method is well suited for children who are very controlling. In Mark Twain's book *Tom Sawyer*, Tom faced "deep melancholy" at the prospect of having to whitewash the picket fence. To avoid this fate, he pretended to enjoy the work in order to trick his friends to take over the job from him. Therapists can employ this tactic by acting indifferent about children's participation. Make no eye contact, start doing the drawing exposure alone, and act like you're having fun. Provide a running commentary of what you're doing. The idea is that if you act like you don't want the child to cooperate, the controlling nature of the child will do the opposite of what you appear to want.

> Four-year-old Lucy had suffered physical abuse and also witnessed her mother's boyfriend, Bobby, beating her mother and then getting arrested by the police. She became emotionally dysregulated at the mention of doing exposures in the office. She would become loud and talkative and wander around the room. The therapist could not make her physically come to the table to work on drawing the exposure. Instead, the therapist started doing the exposure drawing herself and talked out loud about what she was drawing.
>
> "Here is the police car. Here is the policeman coming to arrest Bobby," the therapist said as she drew the car and the policeman. The girl wandered over to peer at the drawing, which now appeared to be the most fun thing in the room.
>
> The girl said, "It's not a policeman. It's a policewoman."
>
> "Oh. Um, well, let's see then, she needs. . . ."
>
> "She needs a button on her shirt," said the girl, who had now sat down on the chair next to the therapist and watched intently what was being drawn.
>
> At this point, even though the therapist was doing the drawing, the child was clearly participating in an exposure.

Betcha Can't

This method is well suited for competitive children. When children refuse to cooperate and act as if they already know this and already know that and don't need to do the silly things you're telling them do, then use their competitive nature to your advantage. Turn the task into a competition. As with the Tom Sawyer tactic, it helps to act indifferent

about his or her participation and make little eye contact. Oppositional children are typically competitive.

Bryce was a 5-year-old boy who had witnessed many episodes of domestic violence between his mother and father. The worst episode occurred when his father punched his mother in the face and she fell unconscious on the floor. She had a grotesque black eye for days afterward. He refused to participate in either the drawing exposure or relaxation exercises for Sessions 6 and 7, although he admitted that talking about it made him upset. For Session 8 the therapist tried the "betcha can't" tactic.

"Today, we need to draw your mom's face after the fight with dad. I don't think you'll like this." Bryce was sitting on the sofa as usual, instead of seated at the table. Whereas Bryce would have typically argued with the therapist over the activity, this time he was caught off guard and sat silently looking at her. You could almost see the wheels turning his head, trying to figure out this new challenge.

As the therapist began to draw, paying little attention to Bryce, she said, "I want the orange pencil. Orange is my favorite color. You probably don't have a favorite color."

"My favorite color is blue," Bryce said reflexively with his usual argumentative voice. The trick had worked. He was providing the information the therapist wanted even though he didn't want to provide it. The therapist just needed to keep the format intact.

"Mmmm," she replied. She worked on drawing Bryce's mother's face for 15 seconds, and then said in a low, casual voice, "Wow, this is harder than I thought. Kinda good I didn't ask you to do this one."

With that, Bryce's competitive nature simply could not resist walking over to look at this apparently impossible drawing. "That's not how she looked," he argued.

"Well, sure. Here's the black eye," she shot back.

"It's too small," he said with as much sneering tone as a 5-year-old can muster.

"There," she said, enlarging the black eye slightly. "But the hair. Hair is hard. I better do the hair too."

At this point, Bryce could resist showing her up no longer. "Let me do it," he said with exasperation. "You don't know what her hair looks like."

This strategy worked well enough so that Bryce cooperated for a couple of minutes on the drawing. One would prefer that the exposure be longer than a couple of minutes, but a couple of minutes were better than nothing. The same strategy was used to get Bryce to use the relaxation exercises.

Less Is More

This strategy is useful for nearly all types of uncooperative children, but it is usually the last strategy tried because it is so counterintuitive for therapists. The strategy is incredibly simple: Therapists use less volume, less words, and less eye contact. This works on controlling and competitive children because when therapists whisper, it sounds like they are talking about a super special secret. This also works well on children with poor social interaction skills because it reduces the overall load of social interaction stimuli—verbal and body language—that they have to process. For most people, when they perceive that the other person does not understand them, their intuition is to increase the

volume of their voice, use more words to explain themselves, and be more expressive to grab their attention. Those increases can work for people who are hard of hearing or inattentive, but they are counterproductive in our therapy situations.

Teddy was a 6-year-old boy who had been physically assaulted numerous times by his father. His parents were divorced and his mother was not available to be a caregiver because of her drug abuse. He was being cared for by his grandmother. Teddy was resistant to even come into the therapy room, so the therapist had negotiated to let him bring a few toys with him. When the therapist tried to direct his attention to the drawing exposure, he would deny that the event ever happened or argue about the first detail she brought up and involve himself with the toys. After several sessions of trying the time limit and the Tom Sawyer strategies, the therapist was out of tricks to try and finally attempted the "less is more" strategy. As Teddy was walking around the room, bouncing a rubber ball against the wall and trying to loudly convince the therapist to play with him, the therapist started to draw on the paper and whispered to herself.

"I'm going to draw the time that Dad hit Teddy in the back seat of the car."

Teddy continued to bounce the ball but he stopped talking.

"These are the wheels. Teddy is sitting in the back seat," she whispered as she drew the wheels and Teddy.

Teddy stopped bouncing the ball and walked over to look. "Hey," he said. "What's that?"

"That's Teddy sitting in the back of the yellow car. And here is Dad. He was angry." The therapist kept drawing without looking up at Teddy or offering to let him draw.

"Hey, I can do that," Teddy nearly demanded.

"Pick a crayon," the therapist whispered without stopping her drawing.

Teddy sat in the chair next to her and began drawing. The therapist continued to narrate in a whisper, "Teddy is in the back seat before that time Dad hit him. Dad is mad." At the same time she discreetly gathered up the toys off the table, collected them in a box, and slid them under the table.

Teddy drew details of the car rather than the actions of the physical assault, but he received the exposure through the visual reminder of the drawing and the therapist's narration of the event.

The Snack

The drawing exposure must be done on the table in the room. Uncooperative children are usually anywhere in the room except sitting at the table with the therapists. The snack is a simple trick to bring them to the table. Announce ever so casually that you think that now might be a good time for the snack. Leave the room briefly to retrieve the bag of chips and juice box and set them on the table. This intervention has the added advantage that while they eat the snack, their hands are tied up with the food and they stop talking while they chew.

All of these tricks, particularly the Tom Sawyer and "betcha can't" methods, work better if you do not oversell them. Children are inherently wired to detect trickery from adults. All of the strategies work best with a bit of "less is more" theatrics.

Safety Plans

The purpose of creating a safety plan is to give children a simple, memorized set of steps to follow if they are caught in a similar potentially traumatic situation again. The idea of a safety plan comes from the domestic violence field. Women who have been victims of domestic violence develop plans to escape to safety in the event that they feel threatened again; such a plan would include a hidden fund of cash and car keys and a friend to call. In the domestic violence field, safety plans are for the women, whereas in our treatment the safety plans are for the children.

The safety plan has two parts: (1) recognizing the danger signals and (2) enacting the action plan. Each plan ought to be individualized to the type of interpersonal trauma a child has experienced (e.g., domestic violence, physical abuse, community violence, natural disaster, dog attack).

Danger signals are cues that something bad is about to happen. For example, in cases of domestic violence, there is typically a build-up phase before Dads hit Moms, during which the perpetrator acts angry and mean. A lot of times both people yell, slam doors, and throw things before they get really, really mad. Following is a list of danger cues for different types of traumas:

Event	*Danger Signals*	*Safety Plans*
• Domestic violence	Door slammed; reddened face; things banged and thrown; yelling.	Tell Mom, "Daddy's angry." Older children may call 9-1-1.
• Sexual abuse	Left alone with older male.	Leave the room; find a safe adult.
• Community violence	Yelling, pushing, fighting.	Ask Mom to leave.
• MVA	No seat belt; going too fast; swerving; busy street.	Tell driver you are scared; ask driver to slow down; check seat belt.
• Dog attack	Growling; pulling at leash.	Tell Mom you're scared; keep away from dog.
• Natural disaster	Weather reports; warnings from the TV.	Pack special belongings in a suitcase; make plans for pets; store toys safely.

The ideal elements of an action plan for older children are to remove themselves from the danger and call for help if someone else (e.g., their mother) is in danger. This is not always possible for younger children who are more dependent on their caregivers.

The safety plan will be developed in Sessions 6–9. In Session 6, write out the tentative safety plan on the worksheet (Child Worksheet 6.2: My Safety Plan). In Session 7, use two puppets, one on each hand, to rehearse the safety plan. The purpose of the puppets is

to make it more fun and to eventually engage the children more actively in rehearsing the plans. One puppet represents a child and the other represents a therapist. The therapist puppet narrates the occurrence of danger signals and asks the child puppet to recognize the danger signals and walk through the safety plan. Next, the children take over the child puppet and they walk through the plan again. In Session 8, the children take more responsibility for the puppets, either by taking control of both puppets or being the therapist puppet. After Session 8, the children and parents have a homework assignment to walk through the safety plan at home to work out any kinks. In Session 9, talk with the children about how the rehearsal of the safety plans went at home the previous week. If they found kinks in the plan, talk about how to troubleshoot and modify the plans.

Boundary Issues

Some caregivers are inappropriately intrusive of their children's personal boundaries for privacy and confidentiality. You will probably know fairly readily if a caregiver has that issue. For example, a caregiver may tell family members inappropriate things about what the child is doing in therapy. Or, the caregiver may try to get the child to do his or her homework and relaxation in front of other family members, even though the child is obviously embarrassed to do so. But even if the caregiver does not appear to have a boundary issue, we advocate to give all caregivers a preemptive spiel in Session 4 to prevent awkward moments in the future. This issue is repeated over the next several sessions, as needed.

Review Roadway Book

The two aims of this review are to provide one more iterative process for instilling the CBT techniques in the child, and to solidify the coherent narrative of the trauma experience.

The review is accomplished in steps over the final three sessions. In Session 10, review Sessions 1–6 in the Roadway Book. In Session 11, review Sessions 7–11. In Session 12, review Sessions 1–11. This gradual reiterative practice will give you and the family time to process any new distortions or difficulties that arise from the review process.

Conduct this review with the child and parent together. The goal is to reconsider the importance of every single page. It is a tall order for a child to be in charge of that task, and reading some of the words will be impossible for the younger children. Therefore, the therapist is ultimately in charge of exploring the pages and turning to the next one at an appropriate pace. Try to have the child remember what each page was about and what he or she learned. If the child can't, or won't, recall, the therapist must verbalize the material. Use lots of praise for children's accomplishments. This component should take 5–15 minutes per session.

Feasibility of Using CBT Techniques with Young Children

As noted earlier, using a 141-item treatment fidelity checklist, therapists' self-reports of fidelity to the protocol were excellent at 96.3%, and were corroborated by raters who independently scored nearly one-third of the sessions (Scheeringa, Weems, et al., 2011). Therapist fidelity to a protocol is the traditional method of substantiating that a standardized treatment was actually delivered. *However, fidelity only tracks what the therapists did*. Fidelity does not demonstrate the *feasibility* that the patients could actually comprehend, cooperate, and make effective use of the techniques. There is overlap between fidelity and feasibility, however. To some degree, patient cooperation is an implicit part of therapist fidelity, and effectiveness is an implicit part of treatment outcome measures, but it misses a dimension of how well the techniques were suited to the patients.

To capture this additional dimension of feasibility, we used another checklist to measure how well the children cooperated. We separately calculated the percentage of time that each task was accomplished, and these data were published with the original outcome data (Scheeringa, Weems, et al., 2011). The children were rated on the ability to complete 60 items over the 12 PPT sessions. The overall frequency of cooperation among children was 83.5%. The therapists made these ratings; an independent rater, who scored 30.7% of the treatment sessions, agreed with the therapists' ratings 96.2% of the time. The rater–therapists' interrater agreement kappa was substantial at 0.86.

The feasibility of the tasks was also calculated separately for 3-, 4-, 5-, and 6-year-old children. For example, the capacity to understand the concept of PTSD from verbal discussion in Session 1 for 3-year-old children was 0%. But when the concept was taught to them with the pictorial aid cartoons, 63% of them appeared to understand. In contrast, 92% of 6-year-old children appeared to understand the concept of PTSD from verbal discussion, and 100% grasped the concept with the pictorial aid cartoons. This pattern was typical for nearly all of the tasks. The 5- and 6-year-old children had an easier time grasping the concepts and performing the tasks, whereas the 3- and 4-year-old children had relatively more difficulty. It is worth noting that the difficulty was only relative. The 3- and 4-year-old children were able to eventually perform the key tasks in 100% of the cases.

A special note is made here about homework assignments. Prior to creating this manual, my experience with homework had been to assign it rather nonsystematically—that is, on an ad hoc, as-needed basis—and homework assignments were completed sporadically, at best. When we started testing this manual, we were quite uncertain as to whether parents would do these homework exposures with their children. It was enormously encouraging to see an overall completion percentage of 82%. These empirical data ought to give great confidence to therapists who have not used systematic homework assignments in their practices previously. Furthermore, our clinical experience with this manual indicated that the homework exposures were the more therapeutic compared to the in-office exposures. My speculation about this is that when children are in the office, the exposure is not quite real, and they can more easily avoid the intensity by distracting themselves or the therapists. With *in vivo* homework exposure, however, the exposure

stimuli are quite real and unavoidable. It is during the *in vivo* exposures that all the elements of the therapy seem to come together: Children realize that they have fear reactions due to specific reminders, and that they have new relaxation skills that they can use.

Can Young Children Do Cognitive Therapy?

Doubts have been expressed as to whether young children can really do cognitive therapy. Grave and Blisset (2004) published a theoretical review that questioned whether CBT was developmentally appropriate for "young children" (Grave & Blissett, 2004). Interestingly, Grave and Blisset's definition of "young children" was 5–8 years; so we can infer that they would consider 3- and 4-year-old children even more inappropriate for CBT. Specifically, they questioned whether young children had the mature skills in causal reasoning, perspective taking, self-reflection, linguistic ability, and memory that were needed for the cognitive aspects of CBT.

Besides the empirical evidence we have gathered that this CBT is effective and the specific CBT techniques were feasible in 3- to 6-year-old children, we present additional conceptual considerations as to how cognitive therapy appears to be quite feasible with young children in this protocol:

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

Parent–Child Relational Considerations

Parents are heavily involved in this protocol because of logistical reasons. The parents are facilitators of the CBT techniques in that they provide history, interpret the children's body language, and help accomplish the homework tasks. Parents are viewed as complements that can make the CBT work better. It is tempting to view the parents as more than that, so it is important to make a distinction about what is empirically supported and what is not in regard to the impact of parenting behaviors. In short, parents are *not* viewed as causes of their children's symptoms, and they are not to be blamed for the symptoms.

We reviewed all of the studies that assessed the parent–child associations of problems following traumas that happened to the children (Scheeringa & Zeanah, 2001). Seventeen studies met our inclusion criteria that (1) the children had suffered DSM-IV-level life-threatening events, (2) the measures used in the study had to be standardized and replicable, and (3) the children and parents were assessed concurrently. A wide variety of constructs were measured and cannot all be reviewed in this space. In summary, all but one study found a significant association between worse parent outcome and worse child outcome. Many of the studies focused on PTSD symptoms and found that children with more symptoms or higher diagnosis rates of PTSD had parents with more symptoms or higher diagnosis rates of PTSD.

These data do not automatically imply that we need to treat the parent or the parent–child relationship. There are at least four theories to interpret this association.

1. The shared genetic history of parents and children may equally predispose them to developing symptoms following traumatic events. Moderate associations between specific genes and PTSD are gradually emerging, and it has been shown repeatedly in adults that the highly heritable pretrauma personality trait of neuroticism is a predisposing factor for PTSD (Fauerbach, Lawrence, Schmidt, Munster, & Costa, 2000). This research suggests that the genes that make parents vulnerable to develop PTSD are passed down to their children and make the children vulnerable to develop PTSD. In a prospective longitudinal assessment study of 1- to 6-year-old trauma-exposed children, we found a strong, positive correlation between children's and parents' PTSD, just like almost all prior studies, but parenting factors, measured in half a dozen different ways, explained very little of the variance in that relationship (Scheeringa, Myers, Putnam, & Zeanah, 2015). This finding suggests, by default, that shared genetic vulnerabilities may be a more likely explanation.

2. It may be that when both children and parents are more symptomatic, it is because the children suffered relatively more severe traumas, which vicariously traumatized the parents. Conversely, the children and parents who are both less symptomatic may have suffered less severe traumas. In other words, both children and parents reacted similarly to the severity of the traumas. The main drawback to that theory is that studies on PTSD have consistently shown that individual factors tend to be more important predictors of symptoms than degree of exposure (McFarlane, 1989), and the severity of exposure does not predict the majority of the variance in PTSD symptoms.

3. More disturbed parents may influence their children's symptoms. This theory suggests a directional relationship effect and has been the traditional "go-to" view for mental health professionals. That is, parent factors, acting through the parent–child relationship, have a causal impact on children's symptoms, at least for a subset of children. If the parent factors predated the traumatic events (e.g., harsh parenting), the parent factors may be called a *moderating*, or interaction, effect. If the parent factors were caused by the traumatic events (e.g., hostility toward their children as a result of the traumas), the parent factor may be called a *mediating* effect. At least one case study has suggested that parent–child relationship dynamics can hinder the successful adaptation of the child (MacLean, 1977, 1980). Case studies have also made it evident that caregivers do not have to be involved in the children's traumas at all to be symptomatic themselves and to appear important to treatment success (Pruett, 1979).

4. More disturbed children may influence their parents' symptoms. This is also a directional relationship effect but in the opposite direction from what professionals typically think. Parents may develop or maintain their own symptoms because they are distressed by their children's situations. In the Scheeringa et al. (2015) study, we also found that children with the most severe PTSD symptoms over time had parents who were more, not less, emotionally available and sensitive. This finding suggests that parents may have been reacting to their children's symptoms by becoming (appropriately) warmer and more sensitive to try to help their children cope. In addition, in the study that tested the PPT manual, we assessed the symptoms of the primary maternal caregivers with diagnostic interviews. The maternal symptoms of MDD significantly decreased from 4.2 (*SD* = 3.4) to 2.6 (*SD* = 2.7), but maternal PTSD symptoms, which were 9.3 (*SD* = 4.8) before PPT, remained high at 8.0 (*SD* = 4.8) after and did not significantly decrease. This finding suggests that the depression symptoms of mothers decreased as their children's PTSD symptoms decreased, and that mothers needed their own evidence-based treatment for their PTSD symptoms. When we asked mothers near the end of treatment whether they thought that they improved before their children improved or their children improved before they improved, nearly all of the mothers responded that their children improved first, and when they saw their children improve, that is when they could relax.

These are not mutually exclusive interpretations. All four interpretations may be true for one case, or each interpretation may be true for different subsets of dyads. The main point is to recognize the different possibilities, to not automatically blame the relationship, and to evaluate each patient on a case-by-case basis. The theories that appear to have the most traction, in my opinion, in the literature and in our experience are the first (shared genetic vulnerabilities) and the fourth (children influence parents) theories.

In a separate paper from that study that was published on the maternal symptoms, higher maternal depression did not have any impact on treatment gains immediately after the conclusion of therapy, but was associated with worsened children's PTSD symptoms when followed after 6 months (Weems & Scheeringa, 2013).

So how should the therapist best allocate time with the parents? The PPT protocol dictates that therapists spend at least part of every therapy session with the caregivers. The manual instructs therapists to be nondirective and to ask caregivers to reflect on the

interactions they observed between their children and the therapists on the TV monitor. These reflections are viewed mainly as ways for caregivers to articulate what they have just been thinking about. Sometimes, although not usually, it is appropriate to steer these reflections to the caregivers' past individual experiences (i.e., past traumas); in that case, see the next section ("What If Parents Need Their Own Treatment?"). At other times, the manual instructs therapists to be directive and give advice.

The chief outcome for which we aim with parents is to facilitate the CBT tasks for the children. In some cases, caregivers have exceeded that aim and learned to alter their actual parenting behaviors. The mechanism by which this occurs appears to be from watching their children on the TV monitors and then reflecting about what they viewed with therapists. The parents who could engage in that level of reflection seem to be primed to do so, with minimal pressure needed from therapists. That is, the caregivers appeared to do the reflecting and mental processing alone while they were watching the sessions. They may have been provoked by therapists to think about salient issues, but they made changes in their perceptions, attitudes, and behaviors toward their children largely on their own. We have seen more than one "Aha!" moment occur when caregivers, because they were watching the sessions on TV, made a new connection to explain their children's behaviors. This is important to note because it runs contrary, for the most part, to traditional therapeutic wisdom that parents need coaching and/or psychodynamic interpretations of the meaning of their behaviors to make changes in their parenting.

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

What If Parents Need Their Own Treatment?

In uncomplicated cases, caregivers are focused on the needs of their children. Complications do arise sometimes when the time spent with the caregivers is the most energy-consuming for therapists. If a caregiver is compelled to talk about his or her own intense symptoms and/or horrific childhood experiences, it may feel to the therapist as if the work with the child is being overshadowed. Remember that the child is not being shortchanged because you always have individual time with the child.

The model of this manual is that the time reserved to spend alone with caregivers can be viewed as psychotherapy for them. Rather than refer caregivers out for their own therapies, you can attempt to treat caregivers in a limited fashion. This should be a supportive psychotherapy model, which includes active listening and advice giving. In my experience, this is easier said than done because child therapists seem to have an inherent bias to want to focus on the children and feel like they "off mission" if they are spending lots of time on the caregivers' issues. Bear in mind that many of these caregivers do not have anyone else to whom they can tell their stories, so I encourage you to listen and not cut them off, however tangentially related the conversation appears to their children.

Practical Matters

Each session lasts approximately 45–60 minutes. In Sessions 1, 2, and 12, the children and parents are together the entire sessions. In Sessions 3–11, half of that time is spent focused on the child and the second half with the mother. As noted, we have the mother watch the child's portion on TV in an adjacent room.

Take notes during sessions on specific words, phrases, or body language from the children that you do not understand. It is quite normal with this age group *not* to understand what the children are talking about. So, rather than "interrogate" them too much, which tends to be irritating because the children don't know how to express themselves more clearly, it is sometimes best to act as if you understand. Refer to your notes later in the session with the parents alone and *have the parents interpret* what the children were saying.

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

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

What If New Traumas Occur during Treatment?

Unfortunately, bad things do not happen at random. Children who have suffered traumatic events often live in families that disproportionately experience trauma and adversity (Nilsson, Gustafsson, & Svedin, 2012). We've developed the following guidelines to help structure a therapeutic response if a new trauma occurs in the middle of treatment. All of these may or may not be salient.

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

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

The treatment plan for each situation can vary greatly depending on the unique circumstances. In general, a wait-and-watch approach for about 1 month is advocated to determine if new PTSD symptoms will endure from this new trauma (National Institute for Clinical Excellence, 2005). If symptoms endure after 1 month, then new events can be treated like old events and sessions used to tell the narrative, incorporate events into the old stimulus hierarchy or create a separate one, and conduct office and homework exposures.

The question may arise as to whether treatment for PTSD should stop when there are ongoing threats in the environment. The logic would be that when children are stressed by ongoing threats in their environments, the additional stress of exposure therapy could push the children beyond their emotional limits. The principle for managing this additional stress, however, is the same as the principle for determining how aggressively to pursue exposures. Each step taken is a consensual, negotiated, incremental action, and the stress on the children is constantly reevaluated. In that sense, there is no known absolute contraindication to conducting therapy during ongoing stress. Certainly, exposure-type therapy adds to one's overall stress level, at least temporarily, but the treatment is also quite likely to be the main means of relieving the stress. Furthermore, one must ask, if exposure-type therapy is not conducted, then what does one do? Does one simply not provide a known evidence-based therapy for an undetermined period of time for an ongoing life circumstance that may never change?

Therapist Prerequisites

Therapist prerequisites are few and of minimal difficulty to achieve. The only prerequisite for a therapist is that he or she is a licensed psychiatrist, psychologist, social worker, or other type of counselor who must be willing to follow a structured protocol.

Optional background that can be helpful includes prior didactics and experience in the implementation of these techniques:

- CBT in children.
- Treatment of PTSD in children.
- Treatment of PTSD in adults.
- Knowledge of parent–child relational issues in preschool children.

How Closely Should You Follow the Manual?: Some Thoughts on Implementation of Evidence-Based Treatments in Community Clinics

I personally believe that one of the factors that prevents clinicians from adopting evidence-based treatments is that they are too hard on themselves. They have concerns that they will not be able to perform the treatment techniques as well and as cleanly as the techniques are described in manuals. Because they do not want to do something poorly, they do not attempt it all and find other rationalizations for why a structured or manual-based therapy will not work.

I think it is useful to think of *high fidelity* and *medium fidelity*. In high fidelity, therapists follow the manual closely—very closely. In medium fidelity, therapists commit themselves more to making the attempts, expecting imperfection and mistakes, rather than hold expectations of perfect execution.

A fidelity measure—the Fidelity and Achievement ChecklisT (FACT)—is provided in Appendix 2. Therapists should fill out this measure after each session. Therapists rate themselves on whether or not they followed the manual with high fidelity or medium fidelity. In addition, therapists rate the achievements of the children—that is, whether children were able to cooperate and/or complete their tasks.

Cheat Sheets

Therapists cannot memorize all of the manual tasks, so they ought to refer to the manual frequently during sessions. An alternative to the manual is to have *cheat sheets* on the table in the therapy room during sessions to which they can frequently refer. Sample cheat sheets for each session are provided in Appendix 3. In my experience, I have found that individual therapists prefer their own personalized cheat sheets, and it is anticipated that the cheat sheets provided in Appendix 3 will serve as templates for others to create their own.

Guilford Publications
370 Seventh Avenue
New York, NY 10001
212-431-9800
800-365-7006
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