

**Treating adolescents with posttraumatic stress disorder (PTSD)
in a school based setting:**

An introduction to Stanford Cue Centered Treatment (CCT)

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About Trauma and Stanford CCT

Children are particularly vulnerable to developing posttraumatic stress disorder (PTSD). Trauma exposure in childhood has been shown to interfere with a child's cognitive, social, emotional, and self-esteem development. It has been associated with various psychological issues in adolescence, including anxiety, depression, dissociation, and posttraumatic symptoms such as re-experiencing and hyper-arousal. Other associated problems include academic problems, truancy and school suspension, social withdrawal, aggressive and delinquent behavior, substance use and abuse, thought problems, emotional problems, poor physical health, suicidal ideation, and suicide attempts.

Stanford Cue-Centered Treatment is founded upon the principle that trauma exposure can cause cognitive, emotional, physiological, and behavioral symptoms, all of which interact with one another. Re-exposure to traumatic reminders (cues) can cause exacerbation of these symptoms. Stanford Cue-Centered Treatment (CCT) is designed to address the four core domains impacted by trauma (cognition, behavior, emotions, and physiology) through a combination of empirically supported treatments and CCT-specific interventions.

Stanford CCT has several unique components that set it apart from standard trauma-focused cognitive-behavioral therapy (TF-CBT). The therapist works as a partner in treatment and also as a teacher. The therapy focuses strongly on helping the youth develop insight into her or his past and current patterns. Stanford CCT derives its name from its focus on the conditioning process that results in sensitivity towards trauma-related cues. A primary goal of Stanford CCT is to facilitate traumatized youth in making a connection between their past history and their current behaviors and emotions. Rather than having youth attempt to "unlearn" imbedded connections, Stanford CCT focuses on creating new connections and behavioral responses.

Stanford CCT's combination of cognitive, behavioral, expressive, psycho-educational, and family therapies aims to target these four core domains. The therapy is designed to reduce negative cognitions, allow for emotional expression, identify and change trauma-related responses, empower with knowledge and skills, and strengthen the relationship between the caretaker and his or her child. Through Stanford CCT, youth and their caretakers are taught to recognize and effectively manage maladaptive responses that occur upon exposure to traumatic reminders.

Counselors working in schools have an ethical obligation to assist with youth suffering due to trauma and its aftermath. In particular, it is important to acknowledge and assist with trauma as it occurs on a day-to-day basis in low income disadvantaged neighborhoods within our own communities. Many children do not have an option to escape from their violent community settings, and counselors need to be sensitive to their very real suffering, and the difference a well trained caring counselor can make in their lives.

Stanford CCT Therapy – four basic parts

Stanford Early Life Stress Research Program (ELSRP) has seen dramatic results with the children and their caretakers under Stanford Cue Centered Treatment (CCT) treatment. The title of this therapy is "Stanford Cue-Centered Treatment: A multi-modal approach for youth experiencing posttraumatic symptoms." It was featured as the front cover lead article in the San Francisco Chronicle newspaper by Jill Tucker entitled "Children who survive urban warfare suffer from PTSD, too" (August 26, 2007).

This therapy draws from trauma-focused cognitive behavioral therapy (TF-CBT), narrative therapy, psychodynamic and art therapies with a heavy emphasis on psycho-education. It was done in schools in the San Francisco Bay Area in low-income, high crime areas. The therapist went to the school to deliver treatment to the child/family. CCT has four basic parts:

Part I: Introduction/Psychoeducation/Coping Skills (Sessions A, 1, 2 & 3)

Treatment starts with a very in-depth assessment with the caretaker and child asking detailed questions about the trauma. Often times this is the first open conversation the family has had about the trauma (Session A). The child is invited to do a Body Map (Kara Grief Support) drawing at the end of the first session. A full discussion of posttraumatic stress disorder and its symptoms helps the family to normalize what may be happening (Session 1). Psycho-education handouts on trauma are sent home with the caretaker.

In Sessions 2 & 3 the youth and therapist work together to help the child develop a coping "tool box" – things that help the child calm down when s/he is feeling anxious, scared, sad, angry, etc. The therapist teaches the child to do slow breathing techniques, progressive muscle relaxation and guided imagery, explaining why these techniques help the child gain body mastery. The Feelings Thermometer (Aureen Wagner, Ph.D.) helps children quantify their stress level.

Part II: Trauma Narrative/Cognitive Distortions (Sessions 4, 5, 6 & 7)

In Sessions 4 & 5 the child begins to tell their life story. The therapist acts like a reporter, recording everything on a lifeline, rating the events as positive, negative or neutral. The therapist is listening for cognitive distortions as the child tells the story and will address those in Session 6 & 7. As the child talks, the therapist monitors the child's stress and encourages the child to use "tools" as needed to bring down their "temperature".

Cognitive distortions can be the root for altered world views, and the therapist works to undo them in the next two sessions (6 & 7). During all four sessions the therapist helps the child name the feelings they may have felt during the traumatic incidents. The therapist and child complete Feelings Sheets with statements such as “If I were afraid, I would...., I am sad because...., Because I am angry I...” to help the child begin to recognize how their behavior in the here and now is related to the past traumatic incidents.

Part III: Parent Meeting (Session 8), Identification of Trauma Cues/Triggers (Session 9), Systematic Desensitization (Sessions 10, 11 and 12)

In Session 8 the caretaker, youth and therapist meet to discuss the progress thus far, and to get the caretaker’s input on cues that cause the youth stress. Cues are neither positive nor negative – they are neutral objects that were present in the environment during the trauma, and could be serving as traumatic reminders, or even causing flashbacks and re-experiencing. In Session 9 the child and therapist decide on a few cues that cause the child’s “temperature” to rise. They look at what the current reaction to these stressors are, and explore possible new reactions. Cues are assessed for the child’s reaction to them cognitively, physically, emotionally and behaviorally.

Sessions 10 starts with hypothetical cue exposure, monitoring the child’s anxiety level. The “temperature” is expected to rise, while the child has the experience of being safe with the therapist, promoting fear extinction. Tools are used as needed if anxiety rises too high. In Session 11 the therapist role plays the cue exposure and the following week the child is expected to expose themselves in-vivo to their cues. In Session 12, the cue exposure is evaluated, assessing what tools the child used to tolerate cue exposure.

Part IV: Revisiting the Trauma Narrative (Session 13), Closure (Session 14 & 15)

The trauma narrative is revisited in Session 13, with emphasis on the youth being a survivor rather than a victim. The therapist notes changes in the cognitions as the youth tells the story again. Session 14 is a closing session with both caretaker and child with the therapist making recommendations for further work if needed, and doing psycho-education around therapeutic gains being a succession of steps up, and occasional set backs. Session 15 is the closing with just the child and therapist. Another Body Map is completed and compared. Both brainstorm how the child will handle future situations.

Results

At every session the child completed a UCLA PTSD Reaction Index – child version (symptoms only after the first one is completed). At the beginning, middle, and end of treatment, along with three months post-treatment, both caretaker and child complete a variety of assessments such as the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Child Depression Inventory (CDI), Child Trauma Questionnaire (CTQ), Revised Children’s Manifest Anxiety Scale (RCMAS) and UCLA PTSD Index for Parents. Demographic and medical questionnaires were given to the parents at the beginning.

The study timeline was from April 2009 until November 2011. 155 children were referred, 65 children participated, 38 in the treatment group, 27 in the control/waitlist group. We had 13 treatment group and 11 waitlist/controls drop resulting in 41 children who received treatment. The control group received treatment afterwards. Results were statistically significant in all child measures with highest decreases seen in PTSD symptoms.

Plans are underway to disseminate Stanford Cue Centered Treatment to other groups and organizations that wish to use it. It is currently being tested in Spain where it has been translated into Spanish, and in Brazil, Hawaii, Australia, and San Diego. To receive training and to use Stanford CCT in an organization, please see the Stanford Early Life Stress Research Program website: <http://elsrp.stanford.edu>.

References

- Body Map of Feelings. (n.d.). *Kara Grief Support*, www.kara-grief.org, Palo Alto, CA.
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About Victor Carrion, MD

Dr. Victor G. Carrion is an Associate Professor at the Stanford University School of Medicine and Director of the Stanford Early Life Stress Research Program. He is in the faculty at the Lucile Packard Children's Hospital at Stanford and Associate Editor for the Journal of Traumatic Stress. After completing medical school training at Mount Sinai School of Medicine, Dr. Carrion completed his residency at University of Pennsylvania and his fellowship in Child Psychiatry and Research at Stanford University. Since joining the faculty at Stanford, Dr. Carrion's research has concentrated in understanding how early life stress, such as traumatic experiences, alter behavior and emotion and the role of brain structure and function in these findings. He is also interested in the development of new treatment modalities that are focused and targeted. He has been awarded Young Investigator Awards by the American Foundation for Suicide Prevention, the National Association for Research in Schizophrenia and Affective Disorders, the American Academy of Child and Adolescent Psychiatry and the National Institute of Mental Health. Dr. Carrion can be reached through email: vcarrion@stanford.edu or on the web at <http://elsrp.stanford.edu>.

About Laura C. Strom, MS, LMFT

Laura Strom worked three years as a Stanford child trauma therapist in a ground breaking 15 session intervention treating adolescents with posttraumatic symptoms in schools. This trauma work was done in low income San Francisco Bay Area neighborhood schools that experience high rates of community violence and gang-related crime. This was part of a research project through the Stanford Early Life Stress Research Program (Stanford ELSRP).

Laura Strom holds an MS Counseling (MFCC) from San Francisco State University. She also completed the Pupil Personnel School Counseling (PPSC) Credential program through SFSU's school counseling department. Laura is a Licensed Marriage and Family Therapist (MFC 49174). Laura has had extensive child and adolescent trauma focused training through the Stanford Early Life Stress Research Program with Victor Carrion, M.D. an internationally recognized child trauma psychiatrist, researcher, educator and this study's principal investigator.

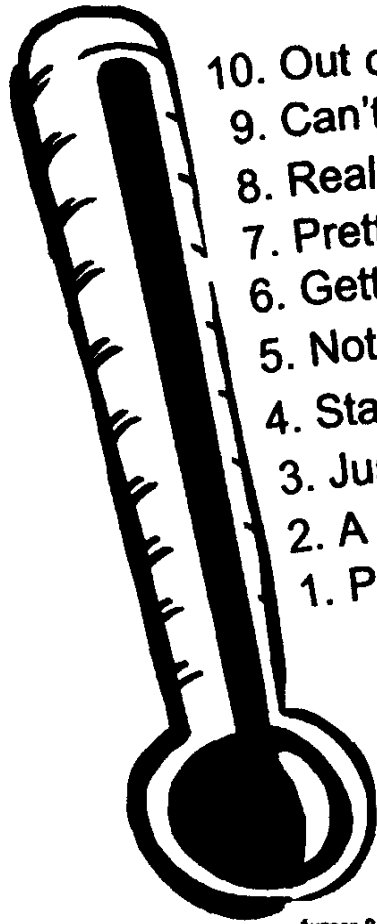
Laura can be reached via email (LCStrom@gmail.com) or on the web at <http://LauraCStrom.com>.

About the Stanford Early Life Stress Research Program

The Stanford Early Life Stress Research Program, under the direction of Victor Carrion, MD, is part of the Stanford School of Medicine, Department of Psychiatry and Behavioral Sciences, Child and Adolescent Psychiatry Division. This research team investigates the role of early adversity during development, including natural disasters (flooding, fires, earthquakes, etc.) and also those that are man-made (assaults, motor-vehicle accidents, physical and sexual abuse, witnessing violence, etc.). Stanford ELSRP can be contacted at: Stanford Early Life Stress Research Program, Department of Psychiatry & Behavioral Sciences, Stanford University School of Medicine, 401 Quarry Road, MC: 5795, Stanford, CA 94305-5795, Phone: 650-724-3377, Toll free: 1-888-411-2672, Fax: 650-724-4794. More information is available on the web at: <http://elsrp.stanford.edu>.

The Feeling Thermometer

The _____ Thermometer



10. Out of Control! **Ballistic!**
9. Can't Handle It.
8. Really Tough.
7. Pretty Tough.
6. Getting Tough.
5. Not too Good.
4. Starting to Bother.
3. Just a Little Uneasy.
2. A Little Twinge.
1. Piece of Cake!

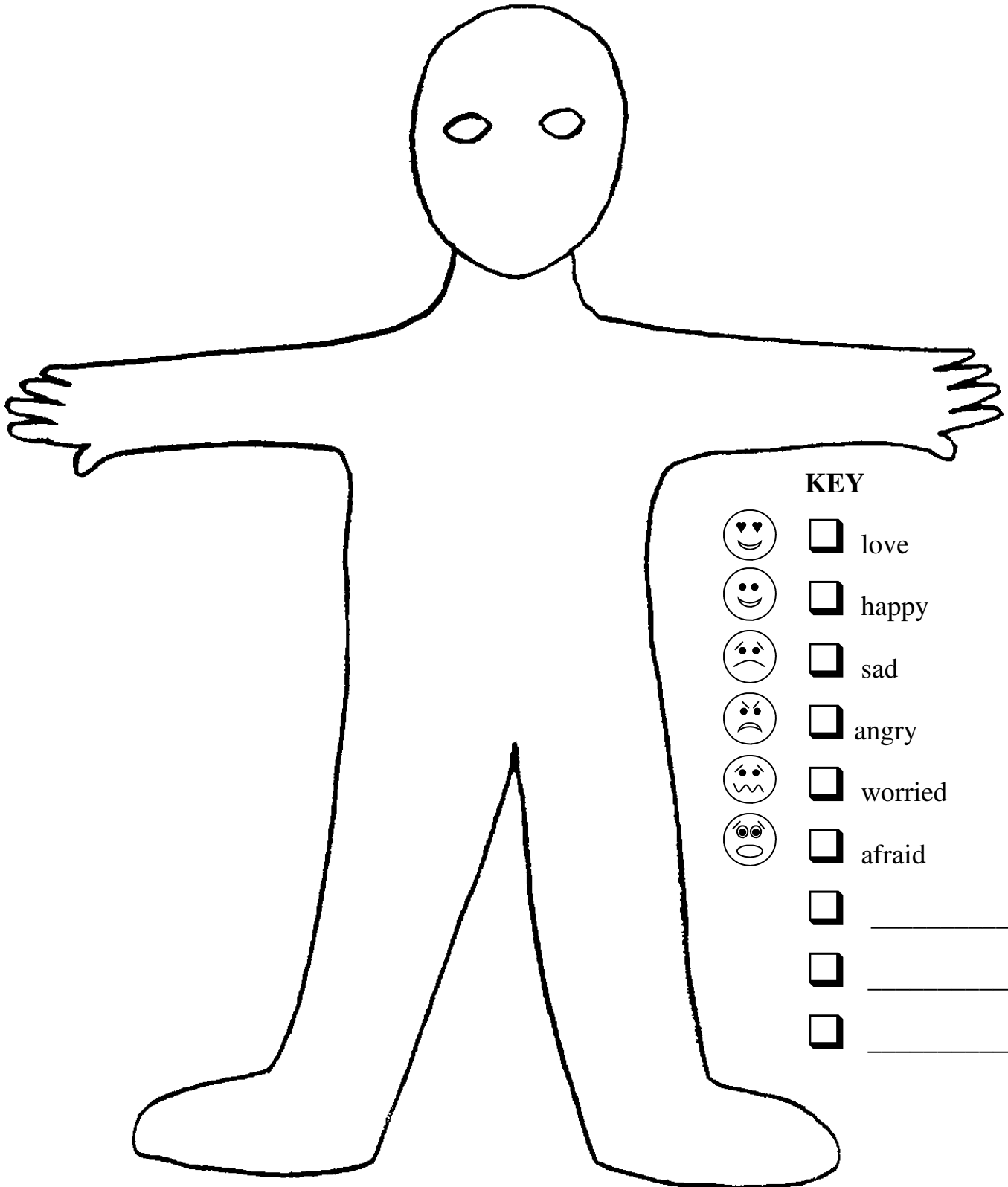
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Body Map of Feelings—Where do your feelings live?

Choose a different color for each feeling, and color the Key first. Feel free to add extra feelings to the key. Then color the body with where and how much of each feeling is there.

Name: _____

Date: _____



KEY



love



happy



sad



angry



worried



afraid



