Learning from Research and Clinical Practice Core

Child Sexual Abuse Task Force

NCTSN The National Child Traumatic Stress Network

How to Implement Trauma-Focused Cognitive Behavioral Therapy

National Child Traumatic Stress Network
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How to Implement Trauma-Focused Cognitive Behavioral Therapy

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with

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Preface

It is an unfortunate fact that many children and adolescents experience traumatic events such as child abuse, domestic violence, community violence, natural disasters, war, terrorism, and the death of loved ones under traumatic circumstances. Many children, in fact, experience multiple types of trauma. Although some children demonstrate extraordinary resilience in the aftermath of these experiences, many develop psychological difficulties, which can be serious and long-lasting. These include symptoms of Posttraumatic Stress Disorder (PTSD), depression, anxiety, shame, poor self- esteem and behavioral problems.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial component-based treatment model which has strong scientific evidence of efficacy in treating trauma symptoms in children, adolescents and their parents. This model was initially developed to address trauma associated with child sexual abuse and has more recently been adapted for use with children who have experienced a wide array of traumatic experiences (Deblinger & Heflin, 1996; Cohen, Mannarino & Deblinger, 2003).

This TF-CBT Implementation Manual is for therapists, clinical supervisors, program administrators and other stakeholders who are considering the use of TF-CBT for traumatized children in their communities. It was developed by the SAMHSA-funded National Child Traumatic Stress Network's Sexual Abuse Task Force, and is based on our experiences over many years in training community providers when, how, and with whom to use TF-CBT. Through the NCTSN we have had the opportunity to further study how community practitioners make decisions about using TF-CBT, and what types of training and consultation experiences optimally assist them in implementing this treatment in their settings.

We hope the TF-CBT Implementation Manual will assist you in weighing the pros and cons of adopting this evidence based treatment practice in your agency, offer guidance in overcoming obstacles to implementing TF-CBT by your agency's direct service providers, and, when used in conjunction with the TF-CBT Treatment Manual, related books and associated training and consultation, assist you in helping more children recover from the negative impact of trauma.

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TF-CBT Program Developers

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Colleagues in the National Child Traumatic Stress Network (NCTSN)

The NCTSN is a network of over 50 trauma treatment programs across the US that provides ongoing constructive suggestions for revising this manual so that it is more responsive to the needs of community therapists working with traumatized children. We are particularly grateful to those therapists affiliated with the:

- The Child Trauma Treatment Network-Intermountain West
- Mental Health Corporation of Denver
- Aurora Mental Health Center, and
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- Dedicated and steadfast assistance of Ann Marie Kotlik, Administrative Assistant, without whose help this treatment manual would still be a series of scribbled notes. We are grateful for her patience and skills during this endeavor.
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Why Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)?

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Why Should Agencies and Clinicians Consider Implementing TF-CBT?

The primary reason that practitioners in diverse settings are interested in implementing TF-CBT is because they wish to deliver services that are recognized to be among the most effective for children and their families who have been exposed to traumatic events.

There is substantial evidence suggesting that TF-CBT is effective in treating childhood Post-traumatic Stress Disorder (PTSD) and related difficulties, particularly among children who have experienced one or more traumatic events.

Over a dozen studies have demonstrated that TF-CBT successfully treats symptoms of PTSD, with most children overcoming the disorder at the end of TF-CBT treatment.

Many of these studies compared TF-CBT to other treatments commonly provided to traumatized children, such as supportive therapy, child centered therapy, play therapy, or usual community treatment, and showed that children receiving TF-CBT experienced significantly greater improvement.

Children receiving TF-CBT experienced significantly greater improvement.

Studies which have followed children for as long as one to two years after the end of treatment have shown that these improvements are sustained long after treatment is over. This suggests the promise of TF-CBT in ameliorating and preventing many of the long-term problems associated with childhood PTSD.

Abstracts and a list of relevant studies follow.

Study 1

19 girls 3-16 years old who experienced contact sexual abuse and met DSM III-R criteria for PTSD participated in an open study in which they received 12 sessions of TF-CBT. Results indicated:

- No significant changes were exhibited in symptoms during a 2-3 week baseline period.
- Significant improvements in terms of children's levels of PTSD, depression, anxiety and behavior problems were found from pre to post treatment.

- Participants who experienced more invasive sexual contact showed greater improvement with respect to externalizing and internalizing behavior problems.
- Neither age nor other abuse characteristics moderated treatment response.
- Demographics: 100% female; 7.79 was the mean age.

Deblinger, McLeer, & Henry, 1990

Study 2

67 sexually abused 3-7 year old children and their non-offending parent/primary caretaker were randomly assigned to 12 sessions of TF-CBT or nondirective supportive therapy (NST), consisting of play therapy for children and supportive therapy for parents. Results indicated:

- TF-CBT>NST for improving PTSD, internalizing, externalizing and sexually inappropriate behaviors
- These differences were sustained over a 12 month follow-up period
- Parental emotional distress about the child's sexual abuse strongly predicted treatment response
- Demographics: 58% female, 42% male; 54% Caucasian, 42% African American, 4% other. Only difference in treatment outcome based on race indicated that Caucasian race predicted more improvement in social competence.

Cohen & Mannarino, 1996a, 1996b, 1997

Study 3

82 sexually abused 8-14 year old children and their non-offending parent/primary caretaker were randomly assigned to 12 sessions of TF-CBT or NST. Results indicated:

- TF-CBT>NST in improving depression and social competence among treatment completers at post-treatment
- TF-CBT>NST in improving anxiety, depression, sexual problems and dissociation among treatment completers at 6 months post-treatment, and in improving PTSD and dissociation among treatment completers at 12 months post-treatment.
- In intent-to-treat analyses, TF-CBT>NST in improving depression, anxiety and sexual problems

- Parental support for the child, and children's positive abuse-related cognitions predicted better treatment response
- Demographics: 68% female, 32% male; 60% Caucasian, 37% African American, 2% biracial, 1% Hispanic. Race did not impact on treatment response.

Cohen & Mannarino, 1998, 2000; Cohen, Mannarino & Knudsen, 2004

Study 4

100 sexually abused 8-14 year old children and their non-offending parent/primary caretaker were randomly assigned to community treatment as usual (TAU) or to TF-CBT provided to a) parent alone, b) child alone, or c) parent + child. Results indicated:

Parents who received TF-CBT experienced greater improvement in parenting skills; their children experienced greater improvement in self-reported depression and in behavior problems.

- Children who received TF-CBT (alone or in combination with parents) experienced greater improvement in PTSD
- Parents who received TF-CBT (alone or in combination with children) experienced greater improvement in parenting skills; their children experienced greater improvement in self-reported depression and in behavior problems
- Demographics: 83% female, 17% male; 72% Caucasian, 20% African American, 6% Hispanic, 2% other. Impact of demographics not evaluated.

Deblinger, Lippmann & Steer, 1996

Study 5

44 maternal caregivers and 44 children 2-8 years old were randomly assigned to participate in a TF-CBT group program or a supportive counseling group program. Results indicated:

- Children who had participated in the TF-CBT group showed significantly greater improvements in the body safety skill and knowledge than children assigned to the supportive groups.
- Maternal caregivers who had participated in the TF-CBT groups reported significantly greater reductions in their abuse-related

intrusive thoughts and negative parental emotional reactions than caregivers who had participated in the support groups.

Demographics: 61% girls; 39% boys; 64% Caucasian; 21% African American; 14% Hispanic; 14% children representing other ethnic origins.

Deblinger, Stauffer & Steer, 2001

Study 6

229 8-14 year old children with sexual abuse-related PTSD symptoms and their non-offending parent/primary caretaker were randomly assigned to receive TF-CBT or child centered supportive therapy (CCT) at one of two treatment sites. Results indicated:

- TF-CBT > CCT in improving children's PTSD, depression, behavior problems, shame and abuse-related cognitions
- TF-CBT> CCT in improving parents' depression, abuse-specific distress, support of the child and effective parenting practices
- Demographics: >90% experienced multiple traumas, mean types of traumatic events experienced = 3.6; 79% female, 21% male; 60% Caucasian, 28% African American, 4% Hispanic, 7% biracial, 1% other. Demographic variables did not influence treatment response.

CTG improve[es] during both the trauma-and grief-focused components of treatment

Cohen, Deblinger, Mannarino & Steer, 2004

Study 7

Adaptation of TF-CBT for children experiencing Childhood Traumatic Grief (CTG).

22 children 6-17 years old with CTG, and their parent/primary caretaker received phased trauma-and grief-focused TF-CBT components in an open study. Results indicated:

- Children experienced significant improvement in PTSD, CTG, depressive, anxiety and behavioral problems, with PTSD symptoms improving only during the trauma-focused phase of treatment, and CTG improving during both the trauma-and grief-focused components of treatment
- Parents experienced significant improvements in PTSD and depressive symptoms

- Demographics: 50% female, 50% male; 68% Caucasian, 32% African American. Neither race nor gender was correlated with treatment response, but older age was correlated with greater improvement in behavior problems in children and in depressive symptoms in parents.

Cohen, Mannarino & Knudsen, 2004

Bibliography

Cohen, JA, Deblinger E, Mannarino, AP, Steer R (2004). A multisite randomized controlled trial for children with sexual abuse-related PTSD symptoms. Journal of the American Academy of Child & Adolescent Psychiatry, 43, 393-402

Cohen, JA, Mannarino AP (1996a). A treatment outcome study for sexually abused preschool children: Initial findings. Journal of the American Academy of Child & Adolescent Psychiatry, 35, 42-50

Cohen, JA , Mannarino, AP (1996b). Factors that mediate treatment outcome in sexually abused preschool children. Journal of the American Academy of Child & Adolescent Psychiatry, 35, 1402-1410.

Cohen, JA, Mannarino, AP (1997). A treatment study of sexually abused preschoolers: Outcome during one year follow-up. Journal of the American Academy of Child & Adolescent Psychiatry, 26, 1228-1235

Cohen, JA, Mannarino, AP, (1998). Interventions for sexually abused children: Initial treatment findings. Child Maltreatment, 3, 17-26.

Cohen, JA, Mannarino, AP (2000). Predictors of treatment outcome in sexually abused children. Child Abuse & Neglect, 24, 983-994.

Cohen, JA, Mannarino, AP, Deblinger, E (2003). Trauma-Focused Cognitive Behavioral Therapy for Children and Parents. Unpublished treatment manual, Drexel U. College of Medicine, Allegheny General Hospital, Pittsburgh, PA (available at jcohen1@wpahs.org)

Cohen, JA, Mannarino, AP, Knudsen, K (2004). Treating sexually abused children: One year follow-up of a randomized controlled trial. Child Abuse & Neglect. Child Maltreatment,43, 1225-1233.

Cohen, JA, Mannarino, AP, Knudsen, K (in press-b). Treating childhood traumatic grief: A pilot study. Journal of the American Academy of Child & Adolescent Psychiatry

Deblinger, E, McLeer, SV & Henry, DE (1990) Cognitive/Behavioral Treatment for Sexually Abused Children Suffering Post-traumatic Stress: Preliminary Findings: Journal of the American Academy of Child and Adolescent Psychiatry, 29(5), 747-752.

Deblinger E, Lippmann, J, Steer, R (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. Child Maltreatment, 1, 310-321

Deblinger, E , Heflin, AH (1996). Treating sexually abused children and their non-offending parents: A cognitive-behavioral approach. Thousand oaks, CA: Sage Publications.

Deblinger, E., Steer, R., & Lippmann, J. (1999). Maternal factors associated with sexually abused children's psychosocial adjustment. Child Maltreatment, 4(1), 13-20.

Deblinger, E., Steer, R., & Lippmann, J. (1999). Two-year follow-Up study of cognitive behavioral therapy for sexually abused children suffering posttraumatic stress symptoms. Child Abuse and Neglect, 23(12), 1371-1378.

Deblinger, E., Stauffer, L. & Steer, R. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for children who were sexually abused and their nonoffending mothers. Child Maltreatment, 6(4),332-343.

Stauffer, L. & Deblinger, E. (1996). Cognitive Behavioral Groups for Nonoffending Mothers and Their Young Sexually Abused Children: A Preliminary Treatment Outcome Study, Child Maltreatment, 1(1), 65-76.

Stauffer, L. & Deblinger, E. (2003). Let's talk about taking care of you: an educational book about body safety. Hatfield, PA: Hope for Families, Inc

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An Overview of TF-CBT

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What is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)?

Trauma-focused CBT (TF-CBT) is a component-based model of psychotherapy which combines trauma-sensitive interventions with cognitive behavioral therapy strategies. This treatment addresses the unique needs of children with Posttraumatic Stress Disorder (PTSD), depression, behavior problems or other difficulties related to traumatic life experiences.

How is the Treatment Structured?

TF-CBT is a short term treatment approach, which may work in as few as 12 treatment sessions, and which may be provided for longer periods of time.

TF-CBT addresses the unique needs of children with PTSD, depression, behavior problems, or other difficulties related to traumatic life experiences.

Individual sessions for the child and for the parents as well as parent-child joint sessions are part of the treatment. The focus of all sessions is to:

- Form a therapeutic relationship with children and parents
- Provide psychoeducation to children and their caregivers about the impact of trauma on children and common childhood reactions to trauma
- Help children and parents identify and cope with a range of emotions (affective modulation)
- Develop personalized stress management skills for children and parents
- Teach children and parents how to recognize the connections between thoughts, feelings and behaviors
- Encourage children to share verbally or in the form of a written narrative their traumatic experiences
- Modify children's and parents' inaccurate or unhelpful trauma-related thoughts (cognitive distortions)

- Help parents develop skills for optimizing their children's emotional and behavioral adjustment
- Help children and parents talk with each other about the traumatic experiences, and
- Teach the family safety skills and ways to cope with trauma reminders in the future.

What Does the Treatment Require?

Clean, pleasant, private treatment rooms equipped with the games, books and toys required by TF-CBT utilized with storage for those toys so that they do not distract the child when they are not being used.

Scores on specific assessments prior to and after treatment provide measures of improvement and local evidence of effectiveness..

If possible, a separate supervised waiting room for the children while their parents are with the clinician helps provide children with a sense of safety and reduces parental distraction during the adults' time with the clinician.

Addition of the identified or necessary assessments to your agency's intake and assessment process. Scores prior to the treatment inform as to the child's and parent's current status and scores after the treatment provide measures of improvement to the family, clinician, and agency. Use of the pre- and post-measures preserves TF-CBT as an EBT. A list of assessments is provided in the section "Delivering TF-CBT."

Which Children Should Receive TF-CBT?

Children ages 3-18 years old with significant symptoms of Post Traumatic Stress and their parents or primary caregivers, and children with significant trauma-related symptoms, including depression, anxiety, and behavioral problems that appear to be related to traumatic life events can benefit from TF-CBT even if they do not meet the full diagnostic criteria for PTSD.

Additionally, they must be able to remember at least some aspect of their past trauma, which excludes children without the ability to convey

memory due to cognitive impairment, developmental level, or significant dissociative process.

Directly addressing problems with severe aggression, substance abuse or self-injury take precedence over the treatment of PTSD and related difficulties. Stabilization of these acute problems is required before embarking on any trauma-related treatment such as TF-CBT.

What Symptoms Does TF-CBT Reduce?

TF-CBT reduces symptoms of Post-Traumatic Stress, which is characterized by problems with affect regulation, behavioral functioning, relationships, attention and consciousness, self-perception, somatization, and systems of meaning. These symptoms are evidenced by:

- Intrusive memories, thoughts or dreams about the trauma
- Avoidance of trauma reminders
- Emotional numbing
- Physical and psychological hyperarousal, and
- Significant impairments in daily living.

Children with problems from traumatic experiences may benefit from TF-CBT even if they do not meet the full criteria for PTSD..

In addition to improving symptoms of PTSD, studies of children and adolescents who have experienced sexual abuse have shown that TF-CBT results in improvements in:

- Depression
- Anxiety
- Behavior problems
- Sexualized behaviors
- Trauma-related shame
- Interpersonal trust, and
- Social competence.

When children experience serious traumas such as sexual abuse, other family members are affected. This is one reason why TF-CBT typically includes parents in treatment. In the aftermath of trauma, TF-CBT is effective in helping parents:

- Overcome general feelings of depression
- Overcome PTSD symptoms
- overcome emotional distress about the child's trauma
- Improve their parenting practices, and
- Enhance their ability to support their children.

These positive effects of TF-CBT have been found in children and parents of diverse cultural backgrounds, and for children as young as 3 years old.

Stakeholder Identification

Successful implementation of TF-CBT generally requires the support of a variety of individuals. Key stakeholders impacted by the implementation include people within your setting as well as people from other sectors of the service delivery system. Working to develop buy-in and commitment from key stakeholders makes implementation easier and more effective.

For example, within your setting, this would be key administrative decision makers, clinical supervisors, direct service providers, people from finance and medical information, and persons who might be called upon to provide child care while parents are being seen.

Outside of your setting, the list would include community leaders such as those listed below:

- Law enforcement professionals
- Child Protective Services
- Victim-witness advocates
- School counselors
- Medical social workers

- Private practitioners in mental health
- Police
- Forensic evaluators
- Pediatricians
- Judges
- Attorneys
- Legal advocates
- Probation officers
- Teachers, and
- Spiritual leaders such as pastors, rabbis, and imams.

Each of these groups has a stake in the wellbeing of children, and each would derive specific benefits from the effects of TF-CBT as children and their families practice and apply it to everyday situations.

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Creating Partnerships and Preparing to Deliver the Treatment

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Creating Partnerships with Key Stakeholders

A vital part of preparation is creating partnerships with key stakeholders. A partnership means thinking about what key stakeholders bring to the implementation of TF-CBT and what might be needed to strengthen their support. Partnership creation begins with information sharing followed by genuine dialogue with key stakeholders about the benefits and risks the implementing TF-CBT.

Stakeholder Information

The content below provides information critical to and strategies for creating buy-in among key stakeholders for adoption and use of TF-CBT.

Information for Therapists

As early as possible, ensure that the following points become a regular part of your conversations with clinicians about implementing TF-CBT. TF-CBT trainers also do this during the training, but agency focus helps set the tone as leaders:

- Acknowledges the centrality of the therapeutic relationship with the child and parents prior to implementation and throughout
- Point out that establishing a trusting therapeutic relationship with the child and parents takes precedence over specific treatment interventions, and
- Emphasize clinical sensitivity, flexibility and creativity.

How you present a treatment guided by a manual influences acceptance and resistance. If you talk about "manualized treatment" or imply a "cookbook approach" or "algorithms" some therapists may feel that their judgment and creativity are devalued. We recommend the phrase "treatment guided by a manual."

We recommend the phrase "treatment guided by a manual."

TF-CBT should be presented as a collection of core treatment components that do require some successive learning, so that there is a highly recommended order of presentation.

Most community therapists are already utilizing some components of TF-CBT in their usual treatment because they were a part of other treatments. TF-CBT advocates should solicit information about these and point out that these favored methods are totally consistent with TF-CBT as a treatment, and that therapists are learning novel ways to utilize these.

Most therapists already utilize some components of TF-CBT .. and are simply going to learn some novel ways to use these favored practices.

This encourages therapists to view TF-CBT training as a collaborative learning experience rather than as a series of didactic directives telling them how to change their practices.

It is also important for therapists to remember that the presentation and methods used to help children master information and skills can and should be flexible, sensitive to the individual child's developmental level, culture, community and family values.

Finally, remind therapists that their professional judgment dictates when immediate concerns require a focus on something other than the TF-CBT materials for that session, and that their exercise of this judgment is paramount to success.

Information for Clinical Supervisors

Clinical supervisors are critical to the successful implementation of TF-CBT. Determining ways to help supervisors plan and participate in the change is important.

All TF-CBT clinical supervisors should receive TF-CBT training, and should have access to ongoing supervisory expert consultation, to foster fidelity and usage.

Clinical supervisors convinced of the effectiveness and applicability of TF-CBT for children treated in their programs will support implementation. Fostering this conviction is the key task in creating buy-in, which is done by providing information that TF-CBT:

- Is applicable to populations their program treats
- Works with those populations

- Shares commonalities with treatments they currently use for traumatized children
- and also providing guidelines for recommending TF-CBT as a treatment for children seen.

All TF-CBT clinical supervisors should receive TF-CBT training, and should have access to ongoing supervisory expert consultation, to foster fidelity and usage.

By allowing supervisors the covered time to participate in these consultative activities, program directors also communicate to supervisors that they value the use of TF-CBT.

Information for Program Administrators

Program administrators need to know first and foremost that TF-CBT will improve agency performance, at what cost will improvement occur, and contact information related to agencies similar to their own who have successfully implemented TF-CBT.

Program administrators need to know first and foremost that TF-CBT will improve agency performance

At the same time they need a brief introduction to TF-CBT and agency level adjustments that may be required to support successful adoption and use of TF-CBT by clinicians. For example, an adjustment might be the reallocation of resources to support therapist training and additional clinical supervision time.

Information for Families and Children

Families and children need to know why TF-CBT is the treatment of choice for their child's or adolescent's problem. They also need to know what is expected of them and their child or adolescent as well as what they can expect from the therapist during the course of treatment.

With TF-CBT, therapists can tell families that treatment is often successful in about 12 sessions, and that at the end of that time the therapist, child and parents will review how the child is doing to make decisions about whether additional treatment is needed. This gives the family hope that significant progress will occur in the near future, while also leaving open the possibility that longer therapy will be needed.

The TF-CBT developers have found that almost all families are receptive to receiving TF-CBT when therapists explain the model to them.

Caregivers and children are often especially concerned about how direct information about the trauma is handled during therapy. It may be helpful to tell families that several studies have shown: that by the end of TF-CBT treatment, most children and parents say that talking about the trauma or developing a written trauma narrative was the most helpful part of their therapy.

Therapists should emphasize that the trauma-focused work is approached gradually over several treatment sessions, only after children have learned and practiced skills that help them tolerate the process. The children are also able to stop the process anytime if it is too disturbing.

most children and parents say that talking about the trauma or developing a written trauma narrative was the most helpful part

Parents may be forewarned that therapy is hard work and that sometimes children complain about having to talk about the trauma. If this occurs, they are encouraged to share this with the therapist while maintaining their commitment to treatment and encouraging their child's continued participation.

Information for Community Referral Sources

In your implementation, your agency will want to reach out to other agencies, professionals and potential clients with whom it interacts. Generate—and plan for staff to do the same—a list of these individuals. Let it be known that you are offering a tested, effective treatment, especially to persons who may come in contact with families where trauma has occurred and how this treatment can augment services currently provided by their own agency..

Information for Third Party Payors

Third-party payors need to know that clients for whose services they are paying will be restored to effective functioning in a timely and cost-effective manner. With TF-CBT, client improvement occurs in as few as 12 sessions, and TF-CBT generates highly observable results.

Third-party payers need to know.. with TF-CBT client improvement occurs in as few as 12 sessions..

Evidence of Effectiveness

TF-CBT's effectiveness compared to other therapies is well documented in numerous studies across a variety of client populations who have experienced sexual abuse, physical abuse, traumatic loss, and PTSD. The following studies attest to TF-CBT's effectiveness.

Cohen JA, Deblinger E, Mannarino AP, Steer R (2004). A multisite randomized controlled trial for children with sexual abuse-related PTSD symptoms. J American Academy of Child & Adolescent Psychiatry, 43, 393-402.

Deblinger E, Lippmann J, Steer R (1996) Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. Child Maltreatment, 1, 310-321.

Deblinger, E., Steer, R. and Lippmann, J. (1999). Two-Year Follow-Up study of Cognitive Behavioral Therapy for Sexually Abused Children Suffering Posttraumatic Stress Symptoms. Child Abuse and Neglect, 23(12), 1371-1378.

Cohen JA, Mannarino AP (1996) A treatment outcome study for sexually abused preschool children: Initial findings. J American Academy of Child & Adolescent Psychiatry, 35, 42-50.

Deblinger E, Stauffer LB, Steer RA (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their non-offending mothers. Child Maltreatment,6, 332-343.

Cohen JA, Mannarino AP, Knudsen K (in press). Treating sexually abused children: One year follow-up of a randomized controlled trial. Child Abuse & Neglect

Treatment guidelines that may be of interest to insurers are contained in the following articles:

American Academy of Child & Adolescent Psychiatry (1998) Practice Parameters for the Diagnosis and Treatment of PTSD in Children and Adolescents. Journal for the American Academy of Child & Adolescent Psychiatry, 37 (10, supplement) 4s-26s

Cohen, JA, Berliner, L, March JS (2000). Guidelines for the treatment of PTSD: treatment of Children and Adolescents, Journal of Traumatic Stress, 13, 566-568 (summary of ISTSS guidelines)

Other Issues related to Preparation for Delivery of TF-CBT

Staffing Levels and Skill

Clinicians who become providers of TF-CBT must have significant experience in child development, and in working with trauma.

Clinical staffing levels must accommodate 12-15 sessions of treatment for each client for whom TF-CBT is appropriate. These sessions are generally divided equally between the child and the parents or caregivers. Reimbursement issues may dictate some aspects of the structure of how treatment is delivered for individual clients.

Supervisors should complete the TF-CBT treatment training as well as clinicians. Participation by providing weekly clinical supervision and participating in once monthly expert consultation for one hour is critical to long-term success.

Therapeutic Materials Required

The TF-CBT treatment manual includes ideas about therapeutic games, toys and books used for implementing TF-CBT. Therapists may substitute other books and games that reinforce specific TF-CBT skills and concepts, or design their own or make these with children during treatment sessions as a therapeutic activity. To reduce distraction, most play materials should be put away when providing TF-CBT.

Although TF-CBT research studies have sometimes allowed 90 minutes for TF-CBT sessions, TF-CBT may also be provided in 60 minute sessions

TF-CBT and Reimbursement

Although TF-CBT research studies have sometimes allowed 90 minutes for TF-CBT sessions, TF-CBT may also be provided in 60 minute sessions.

In the early stages of therapy, the sessions are typically divided equally between the child and parent individual sessions. Later in treatment, the therapist's individual time with the child and parent is reduced to allow for joint parent-child session time.

Most insurance companies provide coverage of ancillary parent sessions as well as family sessions when the child is the identified patient.

TF-CBT providers whose insurance programs do not allow this type of reimbursement may elect to spend most of the session with the child in order to receive reimbursement for a full session of individual psychotherapy.

Treatment programs using TF-CBT may approach funding sources to request that TF-CBT be covered as a highly cost-effective, focused treatment for children whose primary treatment issues are trauma-related.

The TF-CBT developers will provide such programs with written information documenting the effectiveness and efficiency of TF-CBT relative to other treatments for children who have experienced sexual abuse and/or other trauma.

These programs should specify that insurance coverage of TF-CBT should not preclude these children from receiving medication management, case management or other services not included in the TF-CBT treatment model.

Children who traumatized by criminal acts such as sexual abuse may be eligible to receive Victim's Compensation funds, which can be used to pay for mental health treatment, such as TF-CBT. Each state has different requirements and procedures for accessing these funds.

Treatment programs wishing to learn more about accessing Victim's Compensations funds for their patients should contact the US Department of Justice Office for Victims of Crime at http://www.ojp.usdoj.gov/ovc

TF-CBT and Managed Care

The intent of managing medical care is to contain the cost of providing such services and to enhance the quality of services. Given the many serious long-term problems associated with childhood trauma and PTSD, and the evidence that TF-CBT successfully treats these problems in 12-16 sessions, managed care companies should view TF-CBT as a highly focused, clinically effective and cost-effective treatment for significant symptoms following an acute or chronic trauma.

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Knowledge Requirements

Client Selection Criteria

Typically when children are referred or families seek mental health services, it is because they have significant emotional and behavioral problems. Most often the presenting concerns are externalizing behavior problems. Many children also exhibit symptoms of depression, anxiety, substance abuse and other psychiatric disorders.

Children often have multiple trauma histories and this history may be related to the children's presenting problems. The broadest and most general selection criteria are that a child be between the ages of three and eighteen, and have a history of trauma. However, a history of trauma alone does not indicate TF-CBT without corroboration that presenting symptoms appear to be centrally related to the traumatic experience.

a history of trauma alone does not indicate TF-CBT without corroboration that presenting symptoms appear to be centrally related to the traumatic experience

In addition, if the trauma history includes child abuse allegations, before TF-CBT is initiated, such allegations should be reported to the appropriate authorities and investigated. This approach to treatment is predicated on the substantiation of the abuse allegations a child protection services agency, law enforcement investigation and/or an independent forensic evaluation that ensures the safety of the child and prompts medical and mental health evaluations to be completed to the largest extent possible prior to the initiation of treatment.

Traumatic stress often presents as problems in adaptive functioning, affect regulation, relationships, attention and consciousness, somatization, self-perception, and systems of meaning.

Screening and Assessment

Train intake workers to screen for trauma history. Intake procedures can (and should) be modified to include a trauma-focused screening. Changes may be as simple as adding a one-page checklist to the usual intake process, asking directly about trauma history, and any trauma symptoms identified. Remember that such a checklist must be inclusive of trauma such as domestic violence, motor vehicle accident, injuries, and medical processes as well as natural disaster, maltreatment, and terrorism. When the checklist indicates trauma has occurred, children are referred for a more in-depth trauma-focused assessment.

A trauma-focused clinical assessment usually occurs prior to treatment initiation. Sometimes, however, it may occur after treatment has begun, for example, with a client in treatment before implementation of TF-CBT, or when trauma is not disclosed during intake.

A trauma-focused clinical assessment usually occurs prior to treatment initiation. Sometimes, however, it may occur after treatment has begun, for example, with a client in treatment before implementation of TF-CBT, or when trauma is not disclosed during intake.

Standardized trauma-screening and trauma impact measures are available and can be used as part of the clinical assessment process. Some are commercially available, while others can be obtained at no cost. Most commercially available measures require a qualified professional to administer and/or interpret results.

A chart of recommended assessments follows:

Parent Assessments	PERQ: Parent's Emotional Reaction Questionnaire (Mannarino and Cohen, 1996) PSQ: Parental Support Questionnaire (Mannarino and Cohen, 1996) PPQ: Parenting Practices Questionnaire (Strayhorn JM, Weidman CS, 1988) BDI-II: Beck Depression Inventory (Beck AT, Steer RA, Brown GK, 1996) **Parental PTSD**
Child PTSD Assessments	**UCLA PTSD Index for DSM-IV PTSD**, Parent Version (Pynoos RS, Rodriguez N, Steinberg A, Stuber M, Fredrick C, 1998) **Child PTSD Symptom Scale** (Foa EB, Treadwell K, Johnson K, Feeny NC, 2001)--includes adaptive functioning **Trauma Symptom Checklist for Children** (Briere) **PTSD Checklist** (A-J) **K-SADS- PL**: Kaufman Schedule for Affective Disorders and Schizophrenia for School-Aged Children-Present and Lifetime version (Kaufman J, Birmaher B, Brent DA et al., 1996) **ADIS-C**: Anxiety Disorder Interview Schedule for Children (Silverman, et al, 1988)

Child Depression Assessments	**CDI**: Children's Depression Inventory (Kovacs M, 1985) **MFQ**: Mood and Feeling Questionnaire (Angold et al) **CAPS**: Children's Attributions and Perceptions Questionnaire/Scale (Mannarino AP, Cohen JA, Berman SR,994)
Child Anxiety Assessments	**SCARED**: Screen for Child Anxiety Related Emotional Disorders (Birmaher B, Khetarpal S, Brent D et al., 1997) **STAIC**: State-Trait Anxiety Inventory for Children (Spielberger CD, 1973) **MASC**: Multidimensional Anxiety Scale for Children (March, 1994)
Child Behavior Assessments	**CBCL**: Child Behavior Checklist (Achenbach TM, 1991) **CSBI**: Child Sexual Behavior Inventory (Friedrich WN, Grambsch P, Damon L et al., 1992) **PTSD Diagnostic Scale** (Foa EB, 2001)

TF-CBT should not be initiated for children with:

- Severe aggression
- Severe substance abuse
- Severe self-injury
- Severe cognitive impairment, or
- Inability to remember any of the traumatic event (may be because of the child's age at the time the trauma occurred, developmental level, or dissociation).

If severe aggression, self-injury, substance abuse, or other significant pathology is present, stabilize these conditions prior to TF-CBT

Generally speaking, children with elevated scores on measures of Post-Traumatic Stress or Post-Traumatic Stress Disorder are candidates for TF-CBT. Note that scores that are markedly high may be an indication of trauma related symptoms. In some cases, children with extreme avoidance may show almost no symptoms on these measures. Thus extremely low scores may also indicate trauma-related symptoms. Clinical interviewing and judgment should be used to further evaluate whether such children have severe avoidant symptoms and thus are in need of trauma-focused treatment such as TF-CBT. If severe aggression, self-injury, substance abuse, or other significant pathology is present, stabilize these conditions prior to TF-CBT.

To evaluate the treatment effects of TF-CBT, it is recommended that the same clinical assessment measures used prior to the initiation of treatment be used at the conclusion of treatment.

Client satisfaction surveys can also serve to bolster clinician confidence in clients' comfort and appreciation of the trauma-focused and structured nature of TF-CBT.

Time Requirements; Adjusting the Length of TF-CBT Treatment

One of the benefits of TF-CBT is that it improves children's trauma symptoms in a short period of time (typically within 12-16 weeks).

This is especially important in managed care environments where treatment sessions are limited, and also for families who are unable or unwilling to participate in long tem therapy.

By the end of 12 treatment sessions TF-CBT has successfully resolved PTSD, depression, anxiety, behavioral difficulties, shame and other problems in about 80% of children who have been sexually abused, including those who have experienced multiple traumas, those whose parents have a personal history of abuse, and those whose parents have substance use problems. This suggests that most children with PTSD can be successfully treated with short term TF-CBT treatment

Many therapists who are used to providing longer term therapy may doubt that short term therapy can successfully treat most children who have been sexually abused or who have experienced other significant trauma.

TF-CBT…improves children's trauma symptoms… (typically within 12-16 weeks)

Research has documented that TFCBT is effective for children who have experienced more severe and chronic sexual abuse as well as multiple traumas. Moreover, follow-up assessments have documented that the symptom improvements demonstrated at post treatment appear to maintain over time.

In some cases they may elect to provide TF-CBT over a longer time course for the following reasons:

- The child has particular difficulty establishing a therapeutic relationship;
- The child is emotionally unstable and needs many sessions to learn to tolerate trauma-related feelings

- The child experienced so many episodes of abuse or different types of trauma that it takes longer to develop that child's trauma narrative, or
- The child has repeated crisis situations during therapy which prolongs the course of treatment.

The TF-CBT developers have successfully treated many children with these problems within a short term TF-CBT framework, and encourage therapists to try this short term approach initially.

Some children may need more extended treatment. TF-CBT can be adjusted for delivery over a longer period of time

However, some children may need more extended TF-CBT treatment. TF-CBT can be adjusted for delivery over a longer period of time by:

- Spending more time on each TF-CBT component
- Devoting more sessions only to those TF-CBT components that the child has trouble mastering or
- Returning to previously addressed TF-CBT components at later points during treatment.

Children who have many emotional or behavioral problems in addition to those related to trauma may also benefit from receiving TF-CBT interventions. For those children, more time may be devoted to skill building, especially with regard to parenting and communication skills. These may be provided within the context of ongoing long term psychotherapy, or alternatively may be provided by a TF-CBT therapist concurrent with the child receiving other services such as medication management, in-home therapy or family based treatments. In these situations it is important to prioritize the child's problems in order to address the most serious concerns immediately.

For almost all children, treating severe substance dependence, aggression or suicidal behaviors should take precedence over providing TF-CBT. Once acute problems are stabilized, therapists may address ongoing trauma-related problems including PTSD.

Skill Acquisition

TF-CBT training is sequential with the prescribed sequence shown.

First, read the TF-CBT manual accompanying this toolkit and/or books listed below.

The manual:

- Describes specific TF-CBT components
- Provides multiple examples of how to implement each component
- Emphasizes the value of therapist creativity and flexibility
- Includes ideas for therapeutic games, books and tapes to use with TF-CBT, and
- Includes recommended rating forms to monitor children's progress in treatment.

The books:

- Cohen, JA, Mannarino, AP, & Deblinger, E (2001) Child and parent trauma-focused cognitive behavioral therapy treatment manual. Drexel University College of Medicine, unpublished.
- Deblinger, E, Heflin AH (1996) Treating Sexually Abused Children and Their Nonoffending Parents: A Cognitive-behavioral Approach. Thousand Oaks, CA: Sage.

Second, attend 1-2 days of intensive skills-based training in the TF-CBT model with:

- Interactive learning exercises to practice TF-CBT skills
- Tapes of actual treatment sessions as examples
- Multiple opportunities for therapists to ask questions and
- Presentation of diverse case examples.

Also, watch videotapes of the TF-CBT training, which are also available to therapists who have received the initial training, to reinforce and review the skills taught during the training.

Finally, engage in ongoing consultation with TF-CBT experts.

TF-CBT expert consultation:

- Occurs monthly for at least 6 months
- Focuses on problems therapists are encountering in TF-CBT treatment
- Provides alternative methods for implementing TF-CBT and
- Encourages therapist adoption, adaptation and fidelity to TF-CBT.

Regular on-site meetings with well-trained supervisors skilled in TF-CBT may take the place of expert consultation

Attend 1-2 day training in advanced TF-CBT techniques for supervisors and therapists who have been using TF-CBT to further learn about:

- Advanced TF-CBT training provides advanced TF-CBT skills to supervisors and therapists who have been using the TF-CBT
- Treating children whose perpetrator was an older sibling
- Interfacing with the criminal and juvenile justice systems
- Developing therapeutic alliances with unsupportive parents
- Treating children with multiple problems besides PTSD, and
- Adapting TF-CBT for children with developmental or other disabilities.

Fostering Attitudes

The attitudes and expectations in the service delivery setting impact the client and the caregivers' experience of the treatment. When clinicians come from markedly different socioeconomic and cultural backgrounds than the client population they serve, it is easy for their frames of reference to be projected onto the clients, or for the clients to assume that the difference leaves them somehow judged "defective." The unconscious judging of another person as defective because of perceived or actual differences in origin, character or physiology is the foundation of stigma. One way to prevent and reduce stigma—resulting from any of these causal attributes—is cultural competence.

While cultural competence refers to the adaptation of TF-CBT for specific populations or settings, it refers to a broader set of attitudes that translate to interpersonal sensitivity and skills. For example, the choice to suspend one's judgments about another's experience or their choices prevents stigmatization and leaves an "open space" for disclosure.

Cultural competence

TF-CBT has been successful in reducing PTSD and other difficulties in children from many different cultural backgrounds. TF-CBT is a highly collaborative therapy approach, with the therapist, parents and children all working together to identify common goals and how to attain them.

TF-CBT has been successful in reducing PTSD and other difficulties in children from many different cultural backgrounds

How cultural competency is supported by TF-CBT:

- TF-CBT's collaborative approach is inherently respectful of cultural, community and individual family differences and preferences.
- Parents are actively engaged in decision making about how the therapy should proceed within the guidelines of the TF-CBT model.
- TF-CBT therapists consider parents as experts regarding their own children and prepare and encourage parents to take a leadership role in joint sessions.
- It is particularly important for TF-CBT therapists treating children to understand the family's cultural background.
- Cultural beliefs or expectations may influence parents' views of reporting child abuse to legal authorities, the meaning of sexual experiences, or whether children should receive education about sexual matters.

It is therefore important for TF-CBT therapists to actively work to improve their knowledge and understanding about different cultural groups to whom they provide services. TF-CBT therapists should always try to work within the family's cultural framework while implementing treatment components as illustrated in the following case.

TF-CBT includes education about healthy sexuality for children who have been sexually abused, but a Middle Eastern father objected to the therapist talking about sex to his daughter, saying that his culture prohibited female children from hearing about sexual matters.

The therapist pointed out that his daughter had already learned that sexual body parts could be used to perpetrate abuse, and asked whether this was the only information he wanted her to have about sexuality.

The therapist clearly stated that this was up to the parents rather than the therapist to decide.

Once the father understood that the therapist respected his cultural views about sex education, he agreed that it would be helpful for his child to learn that sexual acts were not always abusive.

The parents and therapist together decided how to provide this information to the child, and in a joint session the parents took the lead in sharing this information with their daughter.

Knowledge about different cultures helps therapists differentiate between commonly held values among a particular cultural group and idiosyncratic practices or beliefs

Knowledge about different cultures can also help therapists differentiate between commonly held values among a particular cultural group and idiosyncratic practices or beliefs unique to one family.

In some cases family members may misrepresent cultural views to justify their own inappropriate behavior. In other cases family members may unknowingly misinterpret the context of cultural teachings.

A North African boy witnessed many episodes of his father severely beating his mother and sexually assaulting his sister. He was very angry when his mother separated from his father. He told his therapist that in his country the father is the boss, that his father therefore had a right to beat mother or punish his sister through sexual means whenever he chose to, and the mother had no right to leave the father.

The therapist used her own knowledge of the boy's culture to discuss this view with the mother and her extended family. In subsequent sessions, the mother and the boy's uncle together challenged the boy's distortion that their culture encouraged or tolerated family violence.

A young Jehovah's Witness rape victim was told by her father that, having "had sex" before marriage, she was unclean according to their religion.

The therapist had no personal knowledge of this denomination's teachings about rape. With the permission of the family she consulted with an Elder in their congregation, who met with the family to clarify that their religion did not endorse this view but rather saw this child as a completely innocent victim ofa crime. This helped the father to view his daughter more positively, and to become more supportive of her in subsequent sessions.

The TF-CBT model encourages therapists to respect parents as the experts on their own children, rather than viewing the therapist as the expert whose job it is to "correct" the parent's faulty parenting.

The TF-CBT therapist is just one element in the child's life, who works together with the child's family, community and culture to help the child recover from abuse and other traumatic life events.

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Maintaining TF-CBT

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Sustaining Fidelity

Fidelity means that the therapist is using TF-CBT as it was tested, in a consistent and clearly defined way. If therapists change the treatment too much from how it was originally used when tested, it may no longer be effective.

Regular training, supervision, consistent organizational expectations and follow-up all support fidelity and reduce "drift." Also, supervisory reflection of TF-CBT in language and assessing clinician use through asking specific TF-CBT focused questions related to the core components of the treatment supports the reduction of "drift."

Creativity and flexibility are necessary in adapting the TF-CBT model to best serve the needs of each individual child and family, while maintaining fidelity to the core TF-CBT components.

Balancing Fidelity and Flexibility in TF-CBT

The core TF-CBT components and the progression in which they are provided to the child and family are the focus of the TF-CBT fidelity measures. These are the core components:

- Establishing and maintaining a therapeutic relationship
- Psycho-education about childhood trauma and PTSD
- Emotional expression and regulation skills
- Stress management skills
- Cognitive triad (connections between thoughts, feelings, behaviors)
- Talking about and/or creating artwork, poems and/or a written trauma narrative
- Cognitively processing the trauma experiences
- Parental treatment components including parenting skills
- Joint parent-child sessions, and
- Safety planning and coping with future trauma reminders.

TF-CBT therapists should deliver the treatment in the order the components are described in the TF-CBT treatment manual and in training. The learning is successive, where later sessions build on skills learned in earlier sessions. However, treatment is fluid and components may overlap and be repeated.

By focusing on the core components and successive learning in TF-CBT without limiting manner or approach and number of sessions per core component, the treatment model balances consistency with creativity and flexibility.

Treatment is fluid and components may overlap and be repeated

For example, some children and adolescents may need to review previously presented TF-CBT components to further consolidate what they have processed and/or practice these skills. Review of components later in the therapy, or in response to external stressors provide additional opportunities for internalization of what has been learned, preserves fidelity and supports clinical decision making.

However, it is important that therapists not spend excessive time on early components as a way of avoiding more difficult trauma-related components.

The TF-CBT developers have found that in many cases, it has been the therapist's discomfort with directly discussing the child's abuse experience, rather than the child's fear, that has delayed the start of the trauma focused work.

For example, a 6 year old boy was referred to one of the TF-CBT developers after receiving nine months of treatment elsewhere. The therapist asked this child whether he had talked about his sexual abuse with the previous therapist. The little boy said "No, we never talked about it". The therapist asked the child why this was, and the boy replied, "My therapist wasn't ready".

Addressing Fidelity Issues with Novice vs. Experienced Therapists

Novice and experienced therapists face unique challenges in trying to maintain fidelity to TF-CBT. Novice therapists are often enthusiastic about

learning new treatment approaches, particularly those that are clearly defined and provide specific guidance in how to implement each part of treatment.

However, they may be less experienced in forming therapeutic alliances with "difficult" families, or in addressing aberrations from the expected course of treatment response.

Novice therapists may have some difficulty differentiating between true crises and the normal difficulties that arise during the course of treatment. While novice therapists are usually more compliant with the TF-CBT model, they may abandon the treatment plan when something unanticipated occurs or more typically seek advice regarding how to proceed. If skilled TF-CBT supervision or consultation is available, these can become important learning experiences that can help novice therapists stay on course.

In the absence of these resources, novice therapists may try a variety of different interventions, often simply responding to whatever problems the family presents each week. This nondirective supportive approach is known to be less effective than TF-CBT. Therefore the key to maintaining fidelity in novice therapists is to assure ongoing access to expert consultation or experienced TF-CBT supervision.

[a} nondirective supportive approach is known to be less effective than TF-CBT.

Experienced therapists are usually quite skilled in forming therapeutic relationships, and in differentiating true crises from treatment resistance. They are more prone to continue on with the TF-CBT treatment, adjusting only minimally to accommodate the unexpected.

The barriers experienced therapists encounter in maintaining allegiance to the TF-CBT approach include: unfamiliarity or discomfort with short term treatment approaches and/or the trauma narrative component of TF-CBT; commitment to a different treatment approach for traumatized children; or lack of conviction that the TF-CBT model is appropriate for the type of children they normally treat.

Pointing out the similarities between TF-CBT and what they are already providing encourages experienced therapists to implement specific TF-CBT components.

Ongoing consultation is one way to encourage experienced therapists to try a new approach; and the key is often convincing them to try to use the

model with a single child. Once they have successfully implemented the TF-CBT model with one child they are more likely to use it with other children.

Pointing out the similarities between TF-CBT and what they are already providing to traumatized children is one way to encourage experienced therapists to implement specific TF-CBT components.

Encouraging the use of TF-CBT components in day to day interactions among staff can help clinicians to practice, internalize, and benefit from the skill we are encouraging families to utilize (e.g., praise, active listening, cognitive coping, relaxation, etc.).

Presenting successful TF-CBT treatment cases of children who had similar problems or trauma histories to the children they are seeing also emphasizes the commonalities between therapists' usual patients and those who have responded well to TF-CBT.

Experienced therapists are particularly adept at guiding children through conversations and expressions of their trauma narrative, offering critical support, and supporting the delicate balance between approaching and avoiding difficult issues.

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Additional Clinical Considerations

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Service Needs in addition to Treatment

A majority of traumatized children are identified as having service needs in addition to therapy for trauma. Children/families often need assistance with safety planning, placement, housing, and transportation. Many children have problems at school or with the legal systems. In some communities there are significant populations of non-English speakers, recent immigrants, and refugees with special needs.

Families are frequently involved with multiple systems (e.g., child welfare) and therapists may be expected to provide reports, attend staffings or testify in legal proceedings. Practitioners/programs identify unavailability of resources in the community and lack of case coordination as common barriers to delivering TF-CBT.

Supervision is useful to assist therapists in staying focused on the specific task of delivering a specific psychosocial intervention even when child and family circumstances are not optimal. Of course triage should occur when safety or basic needs are unmet.

Addressing Co-Morbidity

Suicidality and substance abuse are issues that usually require the involvement of other providers and appropriate levels and types of services must be offered.

TF-CBT should be suspended until emergencies related to suicidality or serious self harm subside. During the emergency, experienced clinicians increase session frequency, make "no-harm contracts," offer telephone availability or use other strategies available to increase client support. At risk children should be referred for evaluation for medication and more intensive levels of treatment such as hospitalization, partial programs, more intensive outpatient services, etc.. Practitioners need to be familiar with procedures and resources in the community

The fact of past substance abuse or occasional current substance abuse does not interrupt TF-CBT for either the child or parent. Substance abuse may be an avoidance coping strategy that will dissipate when the TF-CBT skills are learned. The presence of substance abuse at a level that impairs the child's ability to incorporate the benefits of the treatment into their life, or at a level that prevents their caregiver from providing a consistent, safe environment is the marker for additional intervention.

Externalized behavior problems resulting from trauma or lack of parenting skills are often difficult for caregivers. When the parent is involved in learning more effective behavioral parenting strategies, the positive effect of TF-CBT is only strengthened. If the primary concern becomes oppositional behavior, aggression or rule breaking, the treatment focus should shift in response. Because caregivers may or may not know age-appropriate responses, or have effective parenting skills for the situation, caregiver treatment is often appropriate. The TF-CBT therapist may place greater emphasis on teaching effective parenting strategies.

Environments at risk for trauma or where chronic traumatization is the norm predispose children to multiple diagnoses. TF-CBT can be highly effective for children with co-morbid conditions including ADD, ADHD, ODD, OCD, RAD. Conduct Disorder, Bi-Polar Disorder, and others typified disturbance in mood, attention, and behavior.

Recognition that multiple diagnoses are an indication of multi-domain problems should raise the flag about trauma as causal, and TF-CBT as the treatment of choice.

In theses cases, careful attention to multiple symptom clusters, and multiple diagnoses is required. The goal of effective differential diagnosis and the management of multiple treatment modalities is critical for the purpose of optimizing well being.

TF-CBT and Multiple Traumatic Events

TF-CBT components that address symptoms resulting from multiple targets produce benefits without necessarily being tied to a particular traumatic event. In addition, multiply traumatized children may have differing levels of willingness to talk about various traumas. Some traumas may carry with them much more shame than others, thus children will often chose not to discuss the distressing experiences until much later in treatment.

Eventually, however, multiply traumatized children may benefit from the therapist's assistance in putting together a chronological life line narrative that incorporates various traumas as well as positive experiences and creates a hopeful ending.

Fostering the Ability to Talk about Traumatic Events

As TF-CBT therapists demonstrate availability to be present while traumatic occurrences are discussed, perceived resistance to trauma exposure often diminishes. Clinician comfort and commitment to the positive value of openly addressing the trauma encourages children and parents to follow their lead. Therapists need to balance addressing the trauma experience with adequate preparation, maintaining the treatment alliance, and the risk of turning therapy into an adversarial process.

Managing Difficult Parents

Engaging parents is a necessary ingredient to reduce their distress, provide them with psychoeducation, help put the child's experience into perspective, increase optimism about recovery, and enhance their effectiveness in responding to their child's behavioral and emotional needs.

Parents who experience themselves as valued by the clinician, and whose own pain at the trauma their child has experienced is met with acceptance are more likely to cooperate.

Providing immediate assistance in reducing parental distress will increase parents' positive view of therapy and promote compliance. Developing skills becomes a reward in itself as the quality of relationships with others is enhanced and coping ability is increased.

Conclusion

TF-CBT is an effective treatment for children and adolescents with a variety of trauma-related difficulties. It also has demonstrated benefits for the parents of these children. However, just because a treatment is known to be effective does not mean it is right for your practice setting. In this manual we have attempted to address some of the questions that may arise as you consider whether you should attempt to implement TF-CBT. We hope that this information has assisted you in understanding more about this treatment model and that it has encouraged you to consider its use with children who have experienced traumatic stress in your community.