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 (TF-CBT)

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How to Implement Trauma-Focused Cognitive Behavioral Therapy

From the National Child Traumatic Stress Network

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Preface

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I. Preface

It is an unfortunate fact that many children and adolescents experience traumatic events such as child abuse, domestic violence, rape, violent crime, community violence, natural disasters, war, terrorism, and the death of loved ones under traumatic circumstances. Many experience multiple types of trauma. Although some children demonstrate extraordinary resilience in the aftermath of these experiences, many have significant distress or develop psychological difficulties that can be serious or long lasting. These experiences also increase the risk of adult physical and psychological problems, criminal behavior, and impaired functioning.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based psychosocial treatment model that incorporates elements of cognitive-behavioral, attachment, humanistic, empowerment, and family therapy models. It includes several core treatment components designed to be provided in a flexible manner to address the unique needs of each child and family. There is strong scientific evidence that this therapy works 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, including multiple traumas.

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 (NCTSN) Sexual Abuse Task Force and is based on our experiences over many years in training community providers as to 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 this TF-CBT Implementation Manual will assist agencies in weighing the pros and cons of adopting this treatment model, offer direct service providers guidance in overcoming obstacles to implementing TF-CBT, and, when used in conjunction with our book, *Treating Trauma and Traumatic Grief in Children and Adolescents* (J.A. Cohen, A.P. Mannarino,and E. Deblinger; NY: Guilford Press, 2006), an online training course (http://www.musc.edu/tfcbt), and associated training and consultation, assist more children recover from the negative impact of trauma.

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Why Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)?

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II. Why TF-CBT?

Why Should Agencies and Clinicians Consider Implementing TF-CBT?

Agencies and clinicians consider implementing a new treatment out of a wish to deliver services that have been proven to be effective. TF-CBT is recognized as being one of the most effective interventions for children who have significant psychological symptoms related to trauma exposures.

More than a dozen scientifically rigorous studies have demonstrated that TF-CBT helps children and families recover from the negative effects of traumatic experiences, including PTSD symptoms, depression, and related difficulties. Many of the 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 improved faster and more completely than the children who received other treatments.

Studies that followed children for as long as one to two years after the end of treatment found that these improvements were sustained. This supports the promise of TF-CBT to potentially prevent the long-term problems associated with childhood trauma.

Children receiving TF-CBT had better outcomes compared to other treatments.

A list of relevant studies, and seminal facts about them, can be found in Appendix 1.

Here are some important facts. TF-CBT:

- works for children who have experienced any trauma, including multiple traumas.
- is effective with children from diverse backgrounds.
- works in as few as 12 treatment sessions.
- has been used successfully in clinics, schools, homes, residential treatment facilities, and inpatient settings.
- works even if there is no parent or caregiver to participate in treatment.
- works for children in foster care.
- has been used effectively in a variety of languages and countries.

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An Overview of TF-CBT

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III. An Overview of TF-CBT

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

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based model of psychotherapy that addresses the unique needs of children with PTSD symptoms, depression, behavior problems, and other difficulties related to traumatic life experiences.

What Are the Components of TF-CBT?

TF-CBT is a short-term treatment approach that can work in as few as 12 sessions. It also may be provided for longer periods of time depending on the child's and family's needs.

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 or caregivers, as well as joint parent-child sessions, are part of the treatment. As with any therapy, forming a therapeutic relationship with the child and parent is critical to TF-CBT. The specific components of TF-CBT are summarized by the acronym PRACTICE:

- Psychoeducation is provided to children and their caregivers about the impact of trauma and common childhood reactions.
- Parenting skills are provided to optimize children's emotional and behavioral adjustment.
- Relaxation and stress management skills are individualized for each child and parent.
- Affective expression and modulation are taught to help children and parents identify and cope with a range of emotions.
- Cognitive coping and processing are enhanced by illustrating the relationships among thoughts, feelings and behaviors. This helps children and parents modify inaccurate or unhelpful thoughts about the trauma.
- Trauma narration, in which children describe their personal traumatic experiences, is an important component of the treatment.

- *In vivo* mastery of trauma reminders is used to help children overcome their avoidance of situations that are no longer dangerous, but which remind them of the original trauma.
- Conjoint child-parent sessions help the child and parent talk to each other about the child's trauma.
- The final phase of the treatment, Enhancing future safety and development, addresses safety, helps the child to regain developmental momentum, and covers any other skills the child needs to end treatment.

What Symptoms Does TF-CBT Reduce?

TF-CBT primarily reduces symptoms of Posttraumatic Stress Disorder (PTSD). PTSD is characterized by problems with managing trauma-related negative emotions and physical reactions caused by memories or reminders of the trauma that may lead to maladaptive coping such as avoidance of reminders. These reactions often interfere with functioning at home, in school, and in interpersonal relationships. Typical PTSD symptoms are:

- Intrusive and upsetting memories, thoughts, or dreams about the trauma
- Avoidance of things, situations, or people which are trauma reminders
- Emotional numbing
- Physical reactions of hyperarousal, trouble concentrating, or irritability

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 PTSD symptoms, TF-CBT results in improvements in:

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

When children experience serious traumas, other family members are affected as well. This is why TF-CBT typically includes parents or caregivers in treatment. In the aftermath of trauma, TF-CBT is effective in helping parents to:

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

However, it is important to remember that TF-CBT can work for children who do not have a parent available to participate in treatment, and children should not be excluded from receiving TF-CBT for this reason.

When Is TF-CBT Not the First-Line Treatment of Choice?

Many children in clinical settings have a trauma history. The trauma experience may very well have contributed to their problems, but TF-CBT may not be the first or most important therapy they need.

When children are referred to therapy because their predominant problems are disruptive behaviors such as defiance, disobedience, aggression, or rule- or law-breaking, the first order of business is to directly address these behaviors. The positive parenting components of TF-CBT, parent behavior management therapies, or other interventions designed specifically for these behaviors should be provided.

Similarly, children who are severely depressed or suicidal, or who have active substance abuse, should first receive treatments specific to those conditions.

TF-CBT will often be an appropriate intervention for these children once the above presenting problems have been addressed.

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Implementing TF-CBT

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IV. Implementing TF-CBT

Agency Stakeholders: Buy-In Within and Outside Agencies

Successfully implementing TF-CBT in any agency requires the support of a variety of individuals and groups. Developing buy-in and commitment from all these critical players makes implementation easier and more effective.

In addition to the clinicians who will be asked to provide TF-CBT, other key stakeholders in agencies who will directly affect how successfully TF-CBT is implemented include administrative decision makers, clinical supervisors, other direct service providers, staff from finance and medical information, parents and consumers, and persons who might be called upon to provide child care while parents attend sessions.

Many community agencies that are linked with community systems and settings, consider their community partners key stakeholders in their success. These partners may provide referrals, as well as social, and fiscal, support. Community partners can include:

- Law enforcement professionals
- Child Protective Services (CPS)
- Victim-witness advocates and community organizations
- School counselors and teachers
- Pediatric and family medical practitioners
- Clergy

Internal agency stakeholders, particularly agency administrators, clinical supervisors, and clinicians, will need to come together around the necessary steps of adopting a new practice. Implementing TF-CBT usually involves four steps: organizational readiness, pre-implementation training, implementation, and sustaining the practice.

Steps in Implementing TF-CBT: What does it take?

- *Organizational readiness* includes the process an organization goes through in identifying a new model for adoption. Any agency that is considering adopting a new model or practice obviously has some interest in change, or would not be exploring new options. However, adopting and maintaining a new practice requires making a number of changes that are not necessarily intuitive. Organizational readiness refers to how ready an organization is to make the changes required at various organizational levels to successfully implement and sustain a new practice

  For more information about assessing organizational readiness, refer to Appendix 2.

- *Pre-implementation training* refers to the multi-step process required to prepare agencies for implementing a new practice such as TF-CBT. The most obvious recipients of training are therapists, but others in an organization also need to know about the new practice. In the case of TF-CBT, administrators, supervisors, receptionists, intake coordinators, data managers, assessors, insurers, consumers, referring agencies and many others may have a stake in a new practice. Therefore, it is crucial to consider who needs to be included in the pre-implementation training phase and how to provide training to all appropriate stakeholders before attempting implementation. For therapists, three phases of training are provided: Web-based training; live training; and ongoing expert consultation. For supervisors, additional consultation is also available, as is training for community stakeholders.

- *Implementation* refers to actually putting into play the coordinated efforts of staff, clinicians, supervisors, and administrators so that TF-CBT is provided effectively in an organization. From providing the treatment sessions and obtaining model-specific supervision, to documentation and billing practices, different staff and resources will play different roles in fully installing a model program like TF-CBT. Implementing TF-CBT effectively also includes a plan for evaluating how the treatment is being used to ensure that therapists are using TF-CBT correctly. A recommended way of doing this is through the use of fidelity instruments. These allow therapists and supervisors to follow the course of each case to see which components are being implemented in a systematic and transparent manner. Fidelity instruments also track the course of implementation for the entire agency and yoke implementation to outcomes for individual children.

- *Sustaining the practice* refers to having a plan in place to ensure that the agency will continue using TF-CBT in a self-sustainable way after the training and consultation calls have ended without the support of expert consultants, ongoing training, or even supervisors who may leave to take other jobs. How can an agency sustain the practice of TF-CBT after the support phase is over? This is a question to consider from the moment adoption begins.

Information for Program Administrators

There are several important considerations that program administrators must take into account when considering adopting TF-CBT. These include:

- Will TF-CBT improve agency performance?
- How much will it cost to achieve the desired improvements?
- What agency-level adjustments will be required to support successful adoption and use of TF-CBT by clinicians?

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

Here are some key reasons to adopt and implement TF-CBT:

- Many policy-making entities and funders are adopting standards that favor the use of evidence-based interventions.
- There are increasing expectations that services must prove effective.
- Results that can be achieved with short-term intervention are more cost-effective.

Two key requirements for TF-CBT implementation are:

- Organizational leadership that supports the use of evidence-based interventions. This support promotes acceptance by clinicians.
- Training and specific ongoing supervision

The cost of initial training depends on the type of training preferred and the number of staff to be trained. Many TF-CBT training options are available at a range of prices.

As an initial step, free Web-based training (http://www.musc.edu/tfcbt) is recommended for all therapists. At the minimum, a terminal master's level degree is required. Live training is recommended for optimal implementation. A full-day training for one staff member can be obtained for as little as $100-$300 at annual regional

and national conferences (see resources at http://www.musc.edu/tfcbt) while having a TF-CBT trainer provide a full-day's training at an agency may cost as much as $3000. (All TF-CBT trainers are trained in the TF-CBT Train the Trainers Program.)

The TF-CBT manual, *Treating Trauma and Traumatic Grief in Children and Adolescents* (J.A. Cohen, A.P. Mannarino, and E. Deblinger; NY: Guilford Press, 2006) is available for approximately $30. Ongoing consultation calls cost approximately $200 per hour and are recommended for 6 to 12 months.

TF-CBT's developers are partnering with the National Center for Child Traumatic Stress (NCCTS) to conduct a series of Learning Collaboratives on the Adoption and Implementation of TF-CBT. These are intended to help agencies gain the necessary clinical and implementation competence to embed TF-CBT into their practices. (For more information or to schedule a training, contact Anthony Mannarino, PhD, at amannari@wpahs.org. For more information on Learning Collaboratives, contact Jan Markiewicz at jan.markiewicz@duke.edu).

Depending on how extensively an agency expects its therapists to change their current practices, agency-level adjustments may be required to implement TF-CBT. As with learning any other new skill, adopting and adapting a new model of psychotherapy will take time and energy. Program administrators should expect that therapists will need some time to gain these new skills. They may need extra supervision time and expert consultation time, and it may take more than 12 sessions to implement the TF-CBT model in the beginning. Administrative support in the early stages of this process often results in more efficient use of therapist time and greater therapist competence in using TF-CBT later on.

Information for Clinical Supervisors

Clinical supervisors are critical to the successful implementation of TF-CBT or any evidence-based intervention. They are usually responsible for managing service delivery, providing training and supervision to therapists, and ensuring that therapists meet programmatic and accountability expectations. As with other stakeholders, clinical supervisors who are convinced of the effectiveness of TF-CBT for children treated in their programs will support implementation. But if they are not convinced that there is value in this model, it is unlikely that therapists in the agency will use it correctly or effectively.

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

Here are some key reasons why clinical supervisors should support the implementation of TF-CBT:

- Clinical supervisors are committed to providing the best services to clients.
- TF-CBT works for the kinds of traumatized children and problems typically seen in community agencies.
- TF-CBT shares commonalities with the treatments most therapists currently use for traumatized children and does not require a radical change in practice.
- The TF-CBT manual is a very helpful guide that provides therapists with specific information about strategies that work.

The requirements that are key for clinical supervisors if TF-CBT implementation is to be effective include:

- All clinical supervisors in a program should be trained in TF-CBT and ideally have some opportunity to deliver it to traumatized children.
- Clinical supervisors will have access to ongoing supervisory expert consultation either within the program or through outside consultants.
- Clinical supervisors will make use of a variety of supervisory mechanisms, including regular supervision of individual or group cases, observation or recording of sessions, and development of forms to help maintain treatment focus.

Information for Therapists

Therapists are deeply committed to helping their clients, but they may not have received training in evidence-based interventions, and their past experience with treatment manuals may cause them to see such interventions as restrictive and inflexible. Thus, they may view the move toward evidence-based interventions as criticism of their current practice. Also, therapists often have heavy caseloads and must deal with numerous requirements and expectations that are already burdensome and time-consuming. So, for therapists to be willing to try TF-CBT or any other evidence-based therapy, they must believe that it really works for the population(s) they treat, and that it will not reduce therapy to a “cookbook” approach.

Here are some key considerations for therapists to keep in mind when considering TF-CBT:

- Therapists are committed to providing the best service to their clients.
- TF-CBT provides specific, proven strategies that can help traumatized children.
- TF-CBT is not a radical departure from current trauma therapies. Rather, it offers specific strategies to accomplish treatment goals.
- Many therapists are already using and including many TF-CBT components and activities but may not have labeled or conceptualized them as such.

Therapists will be more apt to implement TF-CBT when they recognize that the developers of TF-CBT developed the treatment with respect for the centrality of the therapeutic relationship. The clinician's relationship with the child and with the parent or caregiver is an essential ingredient of TF-CBT. These values are embodied in TF-CBT's:

- Emphasis on clinical sensitivity, flexibility, and creativity.
- Provision of training and ongoing supervision in applying TF-CBT to individual cases.
- Description of the treatment manual as a "guide," not a prescription, as expressed in the phrase "treatment guided by a manual."
- Presentation of TF-CBT as a collection of core treatment components that can be delivered in a flexible manner and sequence.
- Acknowledgment that real-life cases may require temporary deviations from ideal TF-CBT protocols or that other issues in treatment may take temporary precedence.

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

Information for Families and Children

Parents, caregivers, and other family members want the children in their care to receive help to recover from the effects of trauma. These family members need information about the treatment process and what they can expect. They also need to know what is expected of them and of their trauma-affected child or adolescent.

It is important to communicate these key points about TF-CBT to families and children:

- It has been proven to work.
- It is often successful in 12-16 sessions.
- Talking about the trauma, even though it may be hard, is an important ingredient in successful therapy. This aspect of therapy will be done gradually and in collaboration with families. Children will not be forced to talk about what happened.
- Sometimes during the early phases of therapy, children will be more upset than before therapy began. They may complain of not liking therapy. But, over time, remembering and talking will become easier and they will begin to feel better.

Information for Community Referral Sources

When implementing TF-CBT, an agency will want to reach out to other agencies, professionals, and potential clients. Agencies implementing TF-CBT should focus especially on communicating with those people who come into contact with families where trauma has occurred, and should explain that TF-CBT has been shown to be effective and that it can augment other services currently being provided. The agency should generate a list of these agencies and individuals to be informed, and should ask staff to contribute to these lists.

Information for Third-Party Payors

Third-party payors are interested in supporting services that restore enrollees to effective functioning in a timely and cost-effective manner.

Given these priorities, key points regarding TF-CBT include:

Third-party payors need to know that with TF-CBT, client improvement occurs in as few as 12-16 sessions.

- With TF-CBT's structured, components-based approach, client improvement is trackable and time-limited.
- TF-CBT generates highly observable results.
- TF-CBT's effectiveness, compared to other therapies, has been well documented in numerous studies across a variety of client populations who have experienced sexual abuse, physical abuse, multiple traumas, traumatic loss, and PTSD.

Other Issues Related to Implementing TF-CBT

Staffing Levels and Skills

TF-CBT is a treatment model for the specific aftereffects of traumatic experiences. The model assumes that clinicians already have basic training and experience in child development, developmental psychopathology, engaging clients and establishing a therapeutic alliance.

Clinicians who treat traumatized children and their families also need to be comfortable hearing about and dealing with traumatic events. For example, a crucial principle of TF-CBT is *gradual exposure to the trauma*. Thus, the therapist talks about the child's traumatic experiences in almost every session. Also, every TF-CBT component introduces the child's traumatic experiences in a different way, with gradually increasing intensity, until during the *trauma narrative* children are encouraged to talk about the details of their traumatic experiences. These techniques are designed to help the therapist respond to, or prevent, maladaptive avoidance on the part of the child. Clinicians who find these techniques difficult may inadvertently reinforce a child's avoidance.

Clinicians and supervisors will need time and support to do this intensive work. Agencies must also be capable of delivering an intervention that may last 12-25 sessions. Although not all children need the full protocol, some components may require more time with some clients if they are to be effective. Teaching new skills or altering maladaptive cognitions often takes repeated sessions as well as practice between sessions. Also the trauma narrative component should not be delivered if the setting cannot offer regular sessions or if children remain in a dangerous environment because this component is based on the principle that repeated exposure to upsetting memories gradually decreases negative emotional responses or maladaptive avoidance coping.

Supervisors as well as clinicians should complete the TF-CBT training. If supervisors are not familiar with the approach, they will have difficulty assisting therapists in delivering it. Incorporating model-specific supervision into both clinicians' and supervisors' schedules is essential to helping therapists carry out the components of the approach.

TF-CBT and Reimbursement

TF-CBT will usually be a reimbursable service. Medicaid and private insurers will approve TF-CBT for enrolled clients who meet eligibility requirements. Crime Victims Compensation (CVC) programs will also support TF-CBT for eligible victims because it focuses on crime-related impacts.

Programs should always explore whether children are eligible for CVC since all states have a CVC program that includes coverage for crime-specific mental health services for at least some crime victims. Agencies and treatment programs that wish to learn more about their state's CVC program should contact the US Department of Justice Office for Victims of Crime at http://www.ojp.usdoj.gov/ovc.

One important potential complication regarding reimbursement is that TF-CBT includes direct services to parents or the family. Although Medicaid generally reimburses "family therapy," many private insurers make a distinction between individual and family therapy and provide limited, if any, coverage for family therapy. CVC programs may also limit coverage for family therapy. Because billing is ordinarily done using Current Procedural Terminology (CPT) codes, programs may have to address this consideration directly with insurance companies.

One strategy for dealing with this issue is to explain that all proven interventions for children's disorders/conditions involve parents, which means that they will either be present during some sessions or will receive direct services as part of the intervention. In some cases, insurance companies or CVC programs will agree to permit the use of individual therapy CPT codes because the child is the identified patient and the services are intended to address child conditions. There are individual CPT codes for therapy with and without child in some states.

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. Although not ideal, this may be the best available approach.

TF-CBT and Managed Care

The intent of managed medical care is to contain the cost of providing 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 time-efficient and components-based sessions, managed care companies should view TF-CBT as a highly focused, clinically effective, and cost-effective treatment for significant symptoms following trauma.

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Delivering TF-CBT

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V. Delivering TF-CBT

Fostering Attitudes of Acceptance

Attitudes and expectations in the setting where services are delivered influence clients', clinicians', and other staff members' experience of the treatment. When clinicians come from markedly different socioeconomic and/or cultural backgrounds than those of the client population they serve, they may project their frames of reference onto their clients. Clients may also assume that they are being judged negatively because of these differences. The terms "stigma" and "stigmatization" refer to negative judgments – conscious or unconscious, of another person based on perceived or actual differences in their race, ethnicity, socioeconomic background, character, or physical appearance. *Cultural competence* is an important tool for preventing and reducing stigma.

How TF-CBT Fosters Cultural Competence

Cultural competence refers not only to adapting TF-CBT for specific populations or settings but also to a broader set of attitudes that translates to interpersonal sensitivity and skills. For example, the choice to suspend one's judgments about another's experience or choices prevents stigmatization and leaves an "open space" for disclosure.

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

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

TF-CBT supports cultural competency in these ways:

- TF-CBT's collaborative approach is inherently respectful of cultural, community, and familial 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, so they prepare and encourage parents to take a leadership role in joint sessions.

- TF-CBT therapists realize the crucial importance of understanding the family's cultural background.
- TF-CBT therapists understand that cultural beliefs or expectations may influence parents' views of reporting child abuse to legal authorities, the meaning of sexual experiences, and parents' beliefs as to whether children should receive education about sexual matters.

It is therefore important that TF-CBT therapists work actively to improve their knowledge and understanding of different cultural groups served. When implementing treatment components, TF-CBT therapists should always try to work within the family's cultural framework, as is illustrated in the following case:

TF-CBT includes education about healthy sexuality for children who have been sexually abused. However, a father of Middle Eastern descent objected to the therapist's talking about sex to his daughter because, he said his culture prohibited female children from hearing about sexual matters.

The therapist pointed out that his daughter had already learned that 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 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 to differentiate between values that are commonly held by a particular cultural group and idiosyncratic practices or beliefs.

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

Cultural views often have a significant positive impact on behavior that can be congruent with clinicians' attitudes and expectations about how treatment can work. However, in some cases, family members may knowingly or unknowingly misinterpret the context of cultural teachings, as in these three cases:

CASE 1. *A North African boy had witnessed many episodes of his father's 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 his mother or punish his sister through sexual means whenever he chose to, and that 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 distorted belief that their culture encouraged or tolerated family violence.

CASE 2. *A young Jehovah's Witness rape victim was told by her father that because she had "had sex" before marriage, she was unclean.*

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 later met with the family to clarify that their religion did not endorse this view but rather saw the child as a completely innocent victim of a crime. This helped the father to view his daughter more positively and to become more supportive of her in subsequent sessions.

CASE 3. *In the case of a Hispanic family touched by the sexual abuse of their daughter, the psychoeducation component was especially important because the family had to be oriented to the concept of therapy and all that it entails. Stigmas about mental health treatment had to be addressed, and the roles of the clinician and the family, as well as expectations for both, also needed to be clearly outlined. Cultural beliefs regarding sexuality and virginity also had to be addressed so the clinician could identify thoughts and beliefs that could be detrimental to the child's healing.*

For example, the family was worried that no "decent" boy would want a "used" girl and was concerned that she would not be able to marry in a traditional Catholic ceremony because she was no longer "pure." There was also much self-blame on the part of the mother, who felt that she was being punished for failing to protect her child from harm. These cognitive

distortions were identified and challenged prior to working on a trauma narrative so that the mother's guilt would not interfere with her being able to participate in conjoint sessions and to provide support for her child.

During this time, religion was identified as a coping mechanism for both the child and her mother. Each session began with a prayer, and prayer was used as a relaxation technique during difficult times at home. When work on the trauma narrative began, the clinician was careful to identify unhealthy thoughts expressed by the child, and by the mother as well when the clinician shared the narrative with her in preparation for conjoint sessions. The child was adamant about not sharing the trauma narrative with her father because speaking to him about a sexual issue was considered disrespectful in their family. Therefore, the decision was made to share the trauma narrative only with the mother.

Following the conjoint sessions, cognitive processing again addressed any lingering distortions. When developing a plan for future safety, cultural beliefs were again incorporated and beliefs about sexuality and sexual behaviors were also addressed. With a few modifications to incorporate cultural beliefs relevant to this family, TF-CBT was successfully implemented.

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

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

Fostering the Ability to Talk About Traumatic Events

A key requirement of TF-CBT is the therapist's ability to tolerate hearing and talking about children's trauma experiences. But this may be difficult because these stories are often very graphic and distressing. This is why avoidance is such a common and often maladaptive response among both child trauma victims and therapists. However, there is evidence that becoming able to remember and talk about the trauma without extreme distress is central to resolving trauma's impact. Therefore, it is crucial for children to see that their TF-CBT therapists can tolerate hearing about their traumatic experiences, as well as their accompanying emotional reactions. Therapists' comfort with and commitment to the positive value of openly addressing the trauma encourages both children and parents to follow their lead. Therapists need to balance the importance of addressing the trauma experience with the need

for adequate preparation, a strong therapeutic relationship, and the child's proceeding at a pace he or she can tolerate.

Therapeutic Materials and Activities

TF-CBT encourages the therapist's creativity and the use of games, toys, and books to facilitate treatment components.

The TF-CBT treatment manual, *Treating Trauma and Traumatic Grief in Children and Adolescents*, includes suggestions for therapeutic games, toys, and books that can be used to implement TF-CBT. Therapists are encouraged to include other children's books, such as *Please Tell: A Child's Story About Sexual Abuse* by Jessie Ottenweller; *A Place for Starr: A Story of Hope for Children Experiencing Family Violence*, by Howard Schor and Mary Kilpatrick; and *A Terrible Thing Happened: A Story for Children Who Have Witnessed Violence or Trauma*, by Margaret M. Holmes, Sasha J. Mudlaff, and Cary Pillo. Therapists may find games that reinforce specific TF-CBT skills and concepts, design their own games, and make up games with children during treatment sessions as a therapeutic activity. (To reduce distraction, most other play materials should be put away when providing TF-CBT.)

Client Selection Criteria

TF-CBT will not be necessary, or the first-line treatment, for all children with a trauma history. Sometimes children are referred to a specialty program simply because the traumatic event happened rather than because they have specific symptoms. In other cases, they are referred to a more general mental health setting because they have emotional and behavioral problems that may or may not be the result of the trauma.

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 specialty settings such as Child Advocacy Centers or trauma-specific programs, many children are seen simply because parents have become aware of the trauma experience and are seeking other services such as investigative interviews, or are wanting information, advocacy, and support. In many cases, these programs are serving children and families shortly after the trauma but before there is clear information that the children are suffering from significant post-trauma impacts. For these families, the psychoeducation component of TF-CBT, anticipatory guidance, or abbreviated versions of TF-CBT components may be all that is needed. Not all children exposed to trauma require a full course of TF-CBT. By the same token, children with long-standing histories of interpersonal abuse

and violence, especially when accompanied by major neglect, may need more than TF-CBT alone.

In general mental health settings, when children are referred or families seek mental health services, it is typically because the children 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.

Although many of these children have multiple trauma histories, and these histories may be related to the children's presenting problems, other adverse circumstances may be the primary contributing factor. For example, harsh and inconsistent parenting is a primary cause of defiance and aggression in children.

TF-CBT is intended for children with a trauma history whose primary symptoms or behavioral reactions are related to the trauma. Traumatic stress reactions can be more than simply symptoms of PTSD and often present as difficulties with affect regulation, relationships, attention and consciousness, somatization, self-perception, and systems of meaning. These effects can also interfere with adaptive functioning.

Children with significant disruptive behavior problems should initially receive treatment that directly addresses these problems. Neither children nor parents are likely to make the best use of TF-CBT when behavior is out of control, destructive, or dangerous to others. Interventions can be sequenced so that therapies designed to address disruptive behaviors are instituted first. Once behaviors are stabilized, TF-CBT can be provided. If the trauma history includes allegations of child abuse, these should be reported to the appropriate authorities and investigated before TF-CBT is initiated. This approach to treatment is predicated on confirmation that the abuse occurred either through clinical assessment or substantiation by a child protective services (CPS) agency or law enforcement. In cases where there is an active CPS or law enforcement investigation, it is appropriate to defer some components of TF-CBT (e.g., the trauma narrative) until investigative interviews have been completed so treatment does not compromise the legal process. In cases where children are at risk, the first priority is that the proper legal authorities ensure the child's safety.

When children remain in high-risk situations with a continuing possibility of harm, such as many cases of physical abuse or exposure to domestic violence, some aspects of TF-CBT may not be appropriate. For example, attempting to desensitize children to trauma memories is contraindicated when real danger is present.

Screening and Assessment

Intake procedures in mental health settings that serve children should include some form of trauma-focused screening. Many children have been exposed to trauma, and

this exposure may be the source of, or a contributing factor to, their difficulties. In addition, there is substantial evidence that without direct screening, many children or parents will not reveal trauma histories. However, when asked directly, many will.

Screening can be as simple as adding a one-page checklist that directly inquires about trauma history to the usual intake process. Alternatively, therapists routinely may include inquiry about trauma exposure in assessment interviews. Trauma screening ideally should include the full array of possible traumas, including child abuse, rape, domestic violence, accidents, injuries, medical procedures and illnesses, and natural and human disasters. When the screening process identifies a trauma history, a more in-depth assessment of trauma-focused impacts can be carried out. At this point, there are a number of key domains to consider, including depressive symptoms, anxiety, behavior, PTSD, parental symptom inventories, and parental support. However, these must be tailored to the existing intake and assessment battery of the agency.

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 the measures and/or interpret results.

The UCLA PTSD Index for DSM-IV (Pynoos RS, Rodriguez N, Steinberg A, Stuber M, Fredrick C, 1998) and its scoring worksheets which are being used in the NCTSN can be found in Appendix 3.

To evaluate the treatment effects of TF-CBT, so that clinicians can report and document progress objectively to the family and to the agency or practice, the same clinical assessment questions or measures used before treatment began should be employed at its conclusion.

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 and Adjusting the Length of TF-CBT Treatment

One benefit of TF-CBT is that it has been shown to improve children's trauma symptoms in a relatively short period of time. Research studies suggest that by the end of 12-16 treatment sessions, TF-CBT can resolve PTSD, depression, anxiety, behavioral difficulties, shame, and other problems in about 80 percent of children who have been sexually abused, including those who have

TF-CBT often improves children's trauma symptoms within 12-16 treatment sessions.

experienced multiple traumas, those whose parents have a personal history of abuse, and those whose parents have substance abuse problems. This suggests that many children with trauma-specific impacts such as PTSD symptoms can be treated successfully 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 children who have been sexually abused or who have experienced other significant trauma.

However, studies have documented that TF-CBT 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.

Still, clinicians may elect to provide TF-CBT over a longer time course for the following indications:

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

When children need more extended TF-CBT treatment, it can be adjusted for delivery over a longer period of time by:

- Spending more time on each TF-CBT component
- Devoting more sessions to those TF-CBT components that the child is having trouble mastering
- Revisiting previously addressed TF-CBT components at later points during treatment
- Selectively using other evidence-based treatments (EBTs) before or after TF-CBT

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

Children who have many emotional or behavioral problems in addition to those related to trauma may also benefit from receiving TF-CBT interventions. For these 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.

Skill Acquisition

It is recommended that therapists who wish to learn how to deliver TF-CBT follow the sequence outlined below.

First, they should take the Web-based course, TF-CBT Web, available at http://www.usc.edu/tfcbt. This free online course includes streaming video demonstrations of core TF-CBT components, printable scripts, cultural considerations, links to resources, and pre- and post- self-assessment tests. Those who complete the course receive a printable certificate of completion worth 10 Continuing Education Unit (CEU) credits.

Second, they should read the TF-CBT treatment manual, *Treating Trauma and Traumatic Grief in Children and Adolescents* (Cohen, Mannarino, & Deblinger, 2006, NY: Guilford Press, available from http://www.guilford.com or http://www.amazon.com).

This treatment 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
- Includes recommended rating forms to monitor children's progress in treatment

Third, they should attend 1-2 days of intensive skills-based training in the TF-CBT model that include:

- Interactive learning exercises to practice TF-CBT skills
- Examples from actual treatment sessions
- Multiple opportunities for therapists to ask questions

Fourth, and perhaps most important, they should secure ongoing consultation with a clinical supervisor or other expert in TF-CBT who can help apply the components of the model with fidelity in real-life cases.

Fifth, they should address the barriers and challenges around implementing TF-CBT. This means working collectively with supervisors, senior leaders, and clinicians in an ongoing manner during the adoption and implementation phase. Implementing TF-CBT often requires collective buy-in and phased strategizing to facilitate the critical ongoing supervision/consultation. This process helps clinicians to achieve fidelity and to address barriers to client engagement, appropriate billing, and resource allocations.

Learning from Research and Clinical Practice Core

Child Sexual Abuse Task Force

Maintaining TF-CBT

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VI. Maintaining TF-CBT

Sustaining Fidelity and Avoiding "Drift"

Fidelity means that the therapist is using TF-CBT as it was tested, in a consistent and clearly defined way. If therapists diverge or "drift" too much from how the treatment was originally designed and 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 by asking specific TF-CBT–focused questions related to the core components of the treatment will reduce drift.

Creativity and flexibility are necessary when 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

TF-CBT fidelity measures focus on the core TF-CBT components and the sequence in which they are provided to the child and family. As described previously, here are TF-CBT's specific "PRACTICE" components:

- Psychoeducation is provided to children and their caregivers about the impact of trauma and common childhood reactions.
- Parenting skills are provided to optimize children's emotional and behavioral adjustment.
- Relaxation and stress management skills are individualized for each child and parent.
- Affective expression and modulation are taught to help children and parents identify and cope with a range of emotions.
- Cognitive coping and processing are enhanced by illustrating the relationships among thoughts, feelings and behaviors. This helps children and parents modify inaccurate or unhelpful thoughts about the trauma.
- Trauma narration, in which children describe their personal traumatic experiences, is an important component of the treatment.

- *In vivo* mastery of trauma reminders is used to help children overcome avoidance of situations that are no longer dangerous, but remind them of the original trauma.
- Conjoint child-parent sessions help the child and parent talk to each other about the child's trauma.
- The final phase of treatment, Enhancing future safety and development, addresses safety, helps the child regain developmental momentum, and covers other skills the child needs to end treatment.

Therapists should deliver TF-CBT treatment in the sequence in which the components are described in the treatment manual and in training. The learning is sequential in that later sessions build on skills learned in earlier sessions. However, treatment is fluid, and components may overlap and be repeated.

Because the TF-CBT treatment model focuses on the core components and sequential learning without limiting manner or approach, or the number of sessions per core component, it 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 to practice these skills. Reviewing components later in the therapy, or in response to external stressors, provides additional opportunities to internalize what has been learned. It also preserves fidelity and supports clinical decision making.

However, it is important that therapists not spend excessive time on early components in order to avoid the more difficult trauma-related components of the treatment.

The developers of TF-CBT have found that, in many cases, it has been the therapist's own 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 six-year-old boy was referred to one of the TF-CBT developers after receiving nine months of treatment elsewhere. The therapist asked the child whether he had talked about his sexual abuse with his previous therapist. The little boy said, "No, we never talked about it." When the therapist asked him why, the boy replied, "My therapist wasn't ready."*

Addressing Fidelity Issues with Novice vs. Experienced Therapists

Both 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 ones that are clearly defined and provide specific guidance in how to implement each of their components.

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 also find it difficult to differentiate between true crises and the normal difficulties that arise during the course of treatment. Although novice therapists are usually more compliant with the TF-CBT model, they may abandon it if something unanticipated occurs. Or, or more typically, they may seek advice about to proceed. If skilled TF-CBT supervision or consultation is available, these difficulties can become important learning experiences that can help novice therapists stay on course.

But 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, providing ongoing access to expert consultation or experienced TF-CBT supervision is key to maintaining fidelity in novice therapists.

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

A nondirective supportive approach is known to be less effective than TF-CBT.

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

Experienced therapists do encounter other barriers in maintaining allegiance to the TF-CBT approach. These can include:

- Unfamiliarity or discomfort with short-term treatment approaches and/or the trauma narrative component of TF-CBT
- Commitment to a different treatment approach or a lack of conviction that the TF-CBT model is appropriate for the type of children they normally treat.

Ongoing consultation is one way to encourage experienced therapists to try a new approach. Persuading them to try the model with a single child is often key. Once therapists have successfully implemented the TF-CBT model with one child, they are more likely to use it with others.

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

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

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

Another way to overcome barriers with experienced therapists is to present cases of successful TF-CBT treatment of children who had problems or trauma histories similar to those of the children a therapist is seeing. This emphasizes the commonalities between a therapist's usual patients and those who have responded well to TF-CBT.

To address these issues of fidelity, the developers of TF-CBT and two experienced trainers have developed a TF-CBT Fidelity Instrument that tracks the timing and implementation of specific TF-CBT components in a manner that helps therapists and supervisors to determine whether fidelity is being adequately maintained.

This fidelity instrument is included in Appendix 4.

Meeting Fidelity Standards

The following criteria are used when evaluating whether fidelity standards are being met:

- Each TF-CBT component must be implemented for each child unless there are clinical reasons for deleting a component (for example, there are no trauma reminders the child is avoiding, so *in vivo* mastery is not needed).

- The TF-CBT components must be implemented in the "PRACTICE" order unless there is a compelling reason to change the sequencing. (However, returning to a previously provided component to reinforce its use is permitted.)

- Progression from one component to the next must occur within a reasonable time period (i.e., treatment is completed within 12 to 16 sessions for usual cases, and 16 to 20 sessions for complex cases).

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Additional Clinical Considerations

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VII. Additional Clinical Considerations

Service Needs in Addition to Treatment

A majority of traumatized children are identified as having other service needs in addition to therapy for trauma. Children and/or families often need assistance with safety planning, placement, housing, and transportation. Many children have problems at school or with the legal system. 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. According to practitioners and programs, the unavailability of resources in the community and lack of case coordination are common barriers to delivering TF-CBT.

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

Addressing Comorbidity

Clinicians should recognize that intermittent suicidal thoughts are experienced by many children with a history of trauma and should not preclude the provision of TF-CBT or other trauma-focused treatments. For many traumatized children, the most effective way to stop these thoughts is to address the trauma in therapy.

However, *acute* suicidality and serious substance abuse are issues that usually require the involvement of other providers, and appropriate levels and types of services must be offered.

As mentioned earlier, TF-CBT should be suspended until emergencies related to acute suicidality or serious self-harm subside. During the emergency, clinicians will typically increase the frequency of sessions, make "no-harm contracts," offer telephone availability, or use other strategies indicated by the clinical situation to provide help, support, and stabilize the client. 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, and so forth. Practitioners therefore need to be familiar with procedures and resources in their community.

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

Children's externalized behavior problems, whether resulting from trauma or from a lack of parenting skills, are often difficult for parents or caregivers to cope with. However, when the parent becomes involved in learning more effective behavioral parenting strategies, the positive effect of TF-CBT is only strengthened. Also, if the primary concern becomes the child's oppositional behavior, aggression, or rule-breaking, the treatment focus should shift in response. Because caregivers may or may not know what kinds of responses are age-appropriate, or may lack effective parenting skills for the situation, treatment of caregivers is often appropriate and the TF-CBT therapist may emphasize 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 comorbid conditions including ADD, ADHD, ODD, OCD, RAD, as well as for conduct disorder, bipolar disorder, and other conditions typified by disturbances in mood, attention, and behavior.

These cases require careful attention to multiple symptom clusters and multiple diagnoses. Effective differential diagnosis and the management of multiple treatment modalities is critical for the purpose of optimizing the child's ultimate well-being.

Multiple diagnoses are an indication of multidomain problems and should raise questions about whether trauma is causal and whether TF-CBT is the treatment of choice.

TF-CBT and Multiple Trauma Events

The TF-CBT components that address symptoms resulting from multiple traumas produce benefits without necessarily being tied to a particular traumatic event. In addition, children who have suffered multiple traumas may have differing levels of willingness to talk about the various traumas they have experienced. For example, because some traumas may carry much more shame than others, children will often chose not to discuss their most distressing experiences until much later in treatment.

Eventually, however, multiply traumatized children may benefit from the therapist's help in putting together a chronological lifeline narrative that incorporates all the

traumas they experienced, as well as positive experiences, and thus creates a hopeful ending.

Managing Parents/Caregivers with Complex Needs

Engaging parents/caregivers is necessary for the effective delivery of TF-CBT. They must be partners with therapists in helping their children, or the treatment will not work. Although most parents want to do their best by their children, many possible barriers or obstacles may interfere with their full participation in the treatment process. One of the first steps in delivering TF-CBT is to identify and constructively address these barriers in ways that are respectful and that engage parents and caregivers. Working with parents with complex needs, particularly when doing so requires working with the service systems involved in the child's life – is one of the reasons cited most often by clinicians as a reason for extending the duration of treatment.

Potential barriers and obstacles to effectively managing parents/caregivers may include the following:

- The parent/caregiver does not agree that the trauma occurred (most common in cases of physical or sexual abuse).
- The parent/caregiver agrees that the trauma occurred but believes that it has not affected the child significantly or that addressing it directly will make matters worse.
- The parent/caregiver is overwhelmed or highly distressed by his or her own emotional reactions and is not available or able to attend to the child's experience.
- The parent/caregiver is suspicious, distrustful, or does not believe in the value of therapy.
- The parent/caregiver is facing many concrete problems such as housing, finances, or legal concerns that consume a great deal of energy.
- The parent/caregiver is not willing or prepared to change parenting practices even though this may be important for treatment to succeed.

Before initiating treatment with any child, therapists must first engage parents/caregivers and address any potential barriers or obstacles. Specific strategies that can be undertaken include:

- Perseverance in establishing a therapeutic alliance
- Exploring past negative interactions with social service agencies or therapy (including the potential role of the parent/caretaker's personal history of trauma)
- Exploring the parent/caretaker's potential concerns related to differences of culture, gender, class, religion, or other cultural-competency factors that may make them feel as if they are not being understood, accepted, believed, listened to, or respected by the clinician
- Exploring and helping to overcome practical barriers to participating in treatment
- Communicating and emphasizing the centrality of the parent/caregiver role in the child's recovery
- Using parent-focused sessions to reduce parent/caregiver distress and to guide them through structured activities that empower them in interactions with the child
- Delaying or using caution in selecting the content of joint sessions until the parent/caregiver can offer the child the support necessary
- Providing assistance with concrete needs or facilitating connection to appropriate services
- Giving psychoeducation about how therapy works and the components of the therapy process
- Instilling optimism in the parent/caregiver about the child's potential for recovery with successful therapy

Learning from Research and Clinical Practice Core

Child Sexual Abuse Task Force

Conclusions

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VIII. Conclusions

TF-CBT is an effective treatment for children and adolescents with a variety of trauma-related difficulties. It also offers 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 a particular practice setting.

In this manual, we have attempted to address some of the questions that may arise for agencies and programs that are considering whether and how to attempt to implement TF-CBT. We hope that this information will enhance understanding of this treatment model and encourage agencies and programs to consider its use with children in their communities who have experienced traumatic stress.

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Child Sexual Abuse Task Force

Appendices

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Appendix 1

TF-CBT Research Summary

TF-CBT is the most researched and most supported of all current treatments for childhood Posttraumatic Stress Disorder (PTSD) and child trauma, with seven completed randomized controlled trials (RCT), three open (non-controlled) studies, and four ongoing RCTs.

The ongoing RCTs include (a) a study of children with PTSD symptoms related to domestic violence (DV) being conducted in a community DV center; (b) a study of children exposed to Hurricane Katrina; (c) a study of children with traumatic grief; and (d) a multi-site study of young sexually abused children with PTSD symptoms. The most important completed studies are briefly summarized below.

Study 1: Deblinger, E., Lippmann, J., Steer, R (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*(4), 310-321.

- 100 sexually abused (SA) children, 8-14 years old, and parents randomized to TF-CBT for child only, parent only, child plus parent, or treatment as usual (TAU)
- Children receiving TF-CBT experienced significantly greater improvement in PTSD symptoms.
- Children of parents receiving TF-CBT experienced significantly greater improvement in depressive and behavioral symptoms; parents experienced significantly greater improvement in positive parenting practices.
- Differences sustained at 2-year follow-up.

Study 2: Cohen, J. A., Mannarino, A. P. (1997). A treatment study for sexually abused preschool children: Outcome during a one-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*(9), 1228-1235.

- 86 SA children, 3-6 years old, and parents randomized to TF-CBT or nondirective supportive therapy (NST), followed for one year post-treatment.
- Children receiving TF-CBT experienced significantly greater improvement in total behavior problems, internalizing, externalizing, and PTSD symptoms characteristic of young sexually abused children at one year follow-up.
- Parental support and emotional distress mediated preschool children's symptoms.

Study 3: Cohen, J. A., Mannarino, A. P., Knudsen, K. (2005). Treating sexually abused children: One year follow-up of a randomized controlled trial. *Child Abuse and Neglect, 29*(2), 135-145.

- 82 SA children, 8-15 years old, representative of a community SA sample, and parents randomized to TF-CBT or NST, followed one year post-treatment.
- Study did not require minimum symptoms for entry, only elevation on at least one of the study instruments (e.g., behavior or sexual behavior problems, depression, etc.).
- Intent-to-treat analysis indicated greater improvement in TF-CBT group for depression, anxiety, and sexual problems.
- Of treatment completers: children receiving TF-CBT experienced significantly greater improvement in depression and social competence post-treatment; in anxiety, depression, sexual problems, and dissociation, at 6 months post-treatment; and in PTSD and dissociation at one year post-treatment.

Study 4: Cohen, J. A., Deblinger, E., Mannarino, A. P., Steer, R. A. (2004). A multi-site, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43* (4), 393-402.

- 229 SA children, 8-14 years old, and parents randomized to TF-CBT or Child Centered Therapy (CCT) at two sites, followed for one year post-treatment.
- More than 90% experienced multiple traumas.
- Children receiving TF-CBT experienced significantly greater improvement in PTSD, depression, behavior problems, shame, and abuse-related attributions.
- Parents in TF-CBT experienced significantly greater improvement in depression, abuse-specific distress, support of the child, and effective parenting practices.
- At one-year follow-up, children with multiple traumas and initial high levels of depression did worse in CCT group only, suggesting that TF-CBT is more effective than CCT for these children.

Study 5: King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., Ollendick, T. H. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(11), 1347-1355.

- 36 SA Australian children, 5-17 years old, randomly assigned to TF-CBT for child only, child plus family, or wait list control (WL), followed for 3 months post-treatment.
- TF-CBT for child and family superior to WL in improving PTSD, anxiety, and depression.

Study 6: CATS Consortium & Hoagwood, K. (2007). Implementing CBT for traumatized children and adolescents after September 11: Lessons learned from the Child and Adolescent Trauma Treatments and Services (CATS) Project. *Journal of Clinical Child and Adolescent Psychology, 36,* 581-592.

- 589 largely Latino youth from low-income households with mild-to-severe trauma symptoms following terrorist attacks of September 11.
- 445 received TF-CBT or Trauma Grief Components Therapy for moderate-to-severe PTSD symptoms; 144 received enhanced services or TAU for low-to-mild PTSD symptoms.
- 173 community therapists (diverse in ethnicity and in theoretical orientation) delivered the treatment after being trained by the trauma treatments' developers; also received ongoing consultation.
- Regression discontinuity analysis conducted to correct for non-random assignment.
- Both groups experienced significant improvement; children receiving CBT experienced significantly greater rate of improvement over 6 months despite the CBT group's having more trauma and greater family adversity.
- Demonstrated feasibility of disseminating TF-CBT by diverse community therapists for multiply traumatized children.

Study 7: Mental Health Services & Policy Program, Northwestern University (2008). Evaluation of the implementation of three evidence-based practices to address trauma for children and youth who are wards of the State of Illinois, Final Report.

- TF-CBT and two other evidence-based practices, Child Parent Psychotherapy, and Structured Psychotherapy for Adolescents Recovering from Chronic Stress, compared to TAU for children in Systems of Care (SOC) foster care.
- TF-CBT was the EBP used for children ages 6-12 years old.
- Results demonstrated that EBP can be implemented with high fidelity (TF-CBT at 87%) by SOC mental health providers for highly traumatized and highly symptomatic children.
- TF-CBT achieved gains that were significantly greater than comparable youth in SOC on traumatic stress symptoms and child behavioral/emotional needs.
- Children participating in TF-CBT were one-tenth as likely as same-age children in SOC to run away from a placement and half as likely to have any placement interruption (both statistically significant findings).

Study 8: National Crime Victims Research and Treatment Center (2007). TF-CBT*Web* First Year Report. Charleston, SC: Medical University of South Carolina (Available at http://www.musc.edu/cvc).

- In first 16 months of TF-CBT*Web*, 12,481 professionals registered; 74.6% were master's level (social work or counseling) professionals; 40% of US registrants completed the entire course (high for free online learning).
- Learners experienced significant knowledge gain in all modules of the course.
- Virtually all learners who completed the course expressed high levels of satisfaction with the course.

Appendix 2

Organizational Readiness and Capacity Assessment[1,2] This assessment is intended to help your agency identify issues that are known to impact readiness for adoption of a new practice. Please circle the number that corresponds to how true each statement is with respect to current conditions and practices at your agency.	Not at all	To a slight extent	To a moderate extent	To a large extent	Consistently
Clients					
1. Clients are currently able to be screened for trauma-related symptoms that could qualify them for the new practice.	1	2	3	4	5
2. We already have many clients who will benefit from the new practice based on their clinical presentation, diagnosis, and histories.	1	2	3	4	5
Leadership/Clinicians/Staff					
3. Clinicians in our agency agree with the rationale for using the new practice.	1	2	3	4	5
4. Agency and clinical leadership actively support the adoption of the new practice for reasons clinicians can share.	1	2	3	4	5
5. We have on staff seasoned professionals to whom clinicians look for support, consultation, and guidance.	1	2	3	4	5
6. All staff who will be affected by the new practice know that changes are coming and are prepared to offer feedback for its success.	1	2	3	4	5
7. Our agency has a tradition of learning and changing so we do not become entrenched in the status quo.	1	2	3	4	5
8. The clinical orientation of the new practice is not inconsistent with that of the existing staff and leadership.	1	2	3	4	5
9. Staff at all levels perceives the advantage of implementing the new practice.	1	2	3	4	5
10. Our staff has opportunities for interaction with others in our community or around the nation who have implemented or are currently implementing the new practice.	1	2	3	4	5
Supervision					
11. Our supervisors are clear about how the new practice will benefit clients.	1	2	3	4	5
12. Our agency currently provides case-specific clinical supervision (as opposed to administrative supervision) to our clinicians.	1	2	3	4	5
13. Supervisors are prepared to learn about the new practice through training.	1	2	3	4	5
14. Weekly one-hour clinical supervision is the norm for new treatments implemented in our agency.	1	2	3	4	5
15. Clinician direct care hours can be adjusted to allow for supervision in the new practice.	1	2	3	4	5

Circle the number that corresponds to how true each statement is with respect to current conditions and practices at your agency.	Not at all	To a slight extent	To a moderate extent	To a large extent	Consistently
Internal and External Stakeholders					
16. We have collected information about key stakeholders within our agency (e.g. intake, records, and billing personnel) that might be affected by the new practice.	1	2	3	4	5
17. Internal and external "champions" or "cheerleaders" are in place to support implementation of the new practice.	1	2	3	4	5
18. We have developed or are developing targeted information for our identified stakeholders that answers their specific questions about the new practice.	1	2	3	4	5
Program/Culture/Services					
19. Our supervisors, clinicians, and staff are generally positive about changes in practice, especially when they can see how it will benefit the clients.	1	2	3	4	5
20. There are components of the new practice that are consistent with ongoing practice in our agency.	1	2	3	4	5
21. Case load and direct-care hours can be adjusted in response to the requirements of the new practice.	1	2	3	4	5
22. We have measurement systems that will provide feedback on our progress in adoption of the new practice.	1	2	3	4	5
Finance and Administration					
23. Current reimbursement mechanisms cover the new practice.	1	2	3	4	5
24. Current service definitions, units, provider qualifications, or financing mechanisms can accommodate the new practice.	1	2	3	4	5
25. Funds are available to pay for the added cost of implementing and delivering the service, even if they must be shifted from other areas.	1	2	3	4	5
Education					
26. Therapists have adequate time to formally learn about the new practice.	1	2	3	4	5
27. We traditionally provide ongoing learning opportunities and consultation to clinicians learning a new practice.	1	2	3	4	5
28. We can provide financial support and time to clinicians wishing to learn a new practice.	1	2	3	4	5
Technology					
29. Our clinicians and supervisors have high-speed broadband access to the Internet, intranet, e-mail, and learning and feedback about the new practice.	1	2	3	4	5

[1] Allred, C., Markiewicz, J., Amaya-Jackson, L., Putnam, F., Saunders, B., Wilson, C., Kelly, A., Kolko, D., Berliner, L., & Rosch, J. (2005). *The Organizational Readiness and Capacity Assessment.* Durham NC: UCLA-Duke National Center for Child Traumatic Stress.

[2] This project was funded in part by the US Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of HHS, SAMHSA, or CMHS.

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Appendix 3

Name _____ Age _____ Sex (Circle): Girl Boy
Today's Date (**write month, day and year**) _____ Grade in School _____
School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences, some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION: **Check "Yes"** if this scary thing **HAPPENED TO YOU**
Check "No" if it **DID *NOT* HAPPEN TO YOU**

1)	Being in a big earthquake that badly damaged the building you were in.	Yes [ ]	No [ ]
2)	Being in another kind of **disaster**, like a fire, tornado, flood or hurricane.	Yes [ ]	No [ ]
3)	Being in a bad **accident**, like a **very serious** car accident.	Yes [ ]	No [ ]
4)	Being in place where a **war** was going on around you.	Yes [ ]	No [ ]
5)	Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
6)	Seeing a family member being **hit, punched or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
7)	Being **beaten up, shot at or threatened to be hurt badly** in your town.	Yes [ ]	No [ ]
8)	Seeing someone in your town being **beaten up, shot at or killed.**	Yes [ ]	No [ ]
9)	Seeing a **dead body** in your town (do not include funerals).	Yes [ ]	No [ ]
10)	Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.	Yes [ ]	No [ ]
11)	Hearing about the **violent death or serious injury** of a loved one.	Yes [ ]	No [ ]
12)	Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.	Yes [ ]	No [ ]

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300 UCLA Medical Plaza, Ste 2232
Los Angeles, CA 90095-6968 (310) 206-8973
EMAIL: rpynoos@mednet.ucla.edu

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS, OR VIOLENT?** Yes [ ] No [ ]

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank: # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank: #_____

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? _____

d) Please write what happened: _____

_____

_____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.

15) Were you scared that you would die?	Yes [ ]	No [ ]
16) Were you scared that you would be hurt badly?	Yes [ ]	No [ ]
17) Were you hurt badly?	Yes [ ]	No [ ]
18) Were you scared that someone else would die?	Yes [ ]	No [ ]
19) Were you scared that someone else would be hurt badly?	Yes [ ]	No [ ]
20) Was someone else hurt badly?	Yes [ ]	No [ ]
21) Did someone die?	Yes [ ]	No [ ]

22) Did you feel very scared, like this was one of your most scary experiences ever?	Yes [ ]	No [ ]
23) Did you feel that you could not stop what was happening or that you needed someone to help?	Yes [ ]	No [ ]
24) Did you feel that what you saw was disgusting or gross?	Yes [ ]	No [ ]
25) Did you run around or act like you were very upset?	Yes [ ]	No [ ]
26) Did you feel very confused?	Yes [ ]	No [ ]
27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on the page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 5 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid, or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4

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HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
8$_{C5}$ I feel alone inside and not close to other people.	0	1	2	3	4
9$_{C1}$ I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10$_{C6}$ I have trouble feeling happiness or love.	0	1	2	3	4
11$_{C6}$ I have trouble feeling sadness or anger.	0	1	2	3	4
12$_{D5}$ I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13$_{D1}$ I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14$_{AF}$ I think that some part of what happened is my fault.	0	1	2	3	4
15$_{C3}$ I have trouble remembering important parts of what happened.	0	1	2	3	4
16$_{D3}$ I have trouble concentrating or paying attention.	0	1	2	3	4
17$_{C2}$ I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18$_{B5}$ When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19$_{C7}$ I think that I will not live a long life.	0	1	2	3	4
20$_{AF}$ I am afraid that the bad thing will happen again.	0	1	2	3	4

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH, THAT IS SINCE _____, DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	LITTLE	SOME	MUCH	MOST

S	M	T	W	H	F	S

S	M	T	W	H	F	S
	X					
					X	

S	M	T	W	H	F	S
		X			X	
		X				
			X			
		X		X		

S	M	T	W	H	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

S	M	T	W	H	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

NEVER	TWO TIMES A MONTH	1-2 TIMES A WEEK	2-3 TIMES EACH WEEK	ALMOST EVERY DAY

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Name _____ Age _____ Sex (Circle): Girl Boy
Today's Date (**write month, day and year**) _____ Grade in School _____
School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences; some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION: **Check "Yes"** if this scary thing **HAPPENED TO YOU**
Check "No" if it **DID *NOT* HAPPEN TO YOU**

1)	Being in a big earthquake that badly damaged the building you were in.	Yes [ ]	No [ ]
2)	Being in another kind of **disaster**, like a fire, tornado, flood or hurricane.	Yes [ ]	No [ ]
3)	Being in a bad **accident**, like a **very serious** car accident.	Yes [ ]	No [ ]
4)	Being in place where a **war** was going on around you.	Yes [ ]	No [ ]
6)	Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
6)	Seeing a family member being **hit, punched or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
7)	Being **beaten up, shot at or threatened to be hurt badly** in your town.	Yes [ ]	No [ ]
8)	Seeing someone in your town being **beaten up, shot at or killed.**	Yes [ ]	No [ ]
9)	Seeing a **dead body** in your town (do not include funerals).	Yes [ ]	No [ ]
10)	Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.	Yes [ ]	No [ ]
11)	Hearing about the **violent death or serious injury** of a loved one.	Yes [ ]	No [ ]
12)	Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.	Yes [ ]	No [ ]

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EMAIL: rpynoos@mednet.ucla.edu

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS OR VIOLENT?** Yes [ ] No [ ]

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank: # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank: #_____

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? _____

d) Please write what happened: _____

_____

_____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.

15) Were you scared that you would die?	Yes [ ]	No [ ]
16) Were you scared that you would be hurt badly?	Yes [ ]	No [ ]
17) Were you hurt badly?	Yes [ ]	No [ ]
18) Were you scared that someone else would die?	Yes [ ]	No [ ]
19) Were you scared that someone else would be hurt badly?	Yes [ ]	No [ ]
20) Was someone else hurt badly?	Yes [ ]	No [ ]
21) Did someone die?	Yes [ ]	No [ ]

22) Did you feel very scared, like this was one of your most scary experiences ever?	Yes [ ]	No [ ]
23) Did you feel that you could not stop what was happening or that you needed someone to help?	Yes [ ]	No [ ]
24) Did you feel that what you saw was disgusting or gross?	Yes [ ]	No [ ]
25) Did you run around or act like you were very upset?	Yes [ ]	No [ ]
26) Did you feel very confused?	Yes [ ]	No [ ]
27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on the page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 5 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4

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HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
8$_{C5}$ I feel alone inside and not close to other people.	0	1	2	3	4
9$_{C1}$ I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10$_{C6}$ I have trouble feeling happiness or love.	0	1	2	3	4
11$_{C6}$ I have trouble feeling sadness or anger.	0	1	2	3	4
12$_{D5}$ I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13$_{D1}$ I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14$_{AF}$ I think that some part of what happened is my fault.	0	1	2	3	4
15$_{C3}$ I have trouble remembering important parts of what happened.	0	1	2	3	4
16$_{D3}$ I have trouble concentrating or paying attention.	0	1	2	3	4
17$_{C2}$ I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18$_{B5}$ When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19$_{C7}$ I think that I will not live a long life.	0	1	2	3	4
20$_{D2}$ I have arguments or physical fights.	0	1	2	3	4
21$_{C7}$ I feel pessimistic or negative about my future.	0	1	2	3	4
22$_{AF}$ I am afraid that the bad thing will happen again.	0	1	2	3	4

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FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME
DURING THE PAST MONTH, THAT IS SINCE _____,
DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	LITTLE	SOME	MUCH	MOST

S	M	T	W	H	F	S

S	M	T	W	H	F	S
	X					
					X	

S	M	T	W	H	F	S
		X			X	
		X				
			X			
		X		X		

S	M	T	W	H	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

S	M	T	W	H	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

NEVER TWO TIMES A MONTH 1-2 TIMES A WEEK 2-3 TIMES EACH WEEK ALMOST EVERY DAY

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Child's Name _____ Age _____ Sex (Circle): Girl Boy
Person Completing this Form _____ Relationship to Child _____
Today's Date (**write month, day and year**) _____ Grade in School _____
School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to children. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some children have had these experiences, some children have not had these experiences.

FOR EACH QUESTION: Check "Yes" if this scary thing **HAPPENED TO YOUR CHILD**
Check "No" if it **DID *NOT* HAPPEN TO YOUR CHILD**

1) Being in a big earthquake that badly damaged the building your child was in. Yes [ ] No [ ]

2) Being in another kind of **disaster**, like a fire, tornado, flood or hurricane. Yes [ ] No [ ]

3) Being in a bad **accident**, like a **very serious** car accident. Yes [ ] No [ ]

4) Being in place where a **war** was going on around your child. Yes [ ] No [ ]

5) Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

6) Seeing a family member being **hit, punched or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

7) Being **beaten up, shot at or threatened to be hurt badly** in your town. Yes [ ] No [ ]

8) Seeing someone in your town being **beaten up, shot at or killed.** Yes [ ] No [ ]

9) Seeing a **dead body** in your town (do not include funerals). Yes [ ] No [ ]

10) Having an adult or someone much older touch your child's **private sexual body parts** when your child did not want them to. Yes [ ] No [ ]

11) Hearing about the **violent death or serious injury** of a loved one. Yes [ ] No [ ]

12) Having **painful and scary medical treatment in a hospital** when your child was very sick or badly injured. Yes [ ] No [ ]

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to your child that was **REALLY SCARY, DANGEROUS, OR VIOLENT?** Yes [ ] No [ ]
Please write what happened:
_____

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Los Angeles, CA 90095 -6968
(310) 206-8973/ EMAIL: rpynoos@mednet.ucla.edu

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14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank. # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOUR CHILD THE MOST NOW** in this blank. #_____

c) About how long ago did this bad thing (your answer to a or b) happen to your child? _____

d) Please write what happened: _____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK "Yes, No, or Don't know"** to answer **HOW YOUR CHILD FELT during or right after** the experience happened that you just wrote about in Question 14. Only check "Don't Know" if you absolutely cannot give an answer.

15) Was your child afraid that he/she would die?	Yes [ ]	No [ ]	Don't know [ ]
16) Was your child afraid that he/she would be seriously injured?	Yes [ ]	No [ ]	Don't know [ ]
17) Was your child seriously injured?	Yes [ ]	No [ ]	
18) Was your child afraid that someone else would die?	Yes [ ]	No [ ]	Don't know [ ]
19) Was your child afraid that someone else would be seriously injured?	Yes [ ]	No [ ]	Don't know [ ]
20) Was someone else seriously injured?	Yes [ ]	No [ ]	
21) Did someone die?	Yes [ ]	No [ ]	
22) Did your child feel terrified?	Yes [ ]	No [ ]	Don't know [ ]
23) Did your child feel intense helplessness?	Yes [ ]	No [ ]	Don't know [ ]
24) Did your child feel horrified; was what he/she saw disgusting or gross?	Yes [ ]	No [ ]	Don't know [ ]
25) Did your child get hysterical or run around?	Yes [ ]	No [ ]	Don't know [ ]
26) Did your child feel very confused?	Yes [ ]	No [ ]	Don't know [ ]
27) Did your child feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]	Don't know [ ]

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Here is a list of problems children sometimes have after very stressful experiences. Please think about your child's stressful experience that you wrote about in Question #14. Then, read each problem on the list carefully. CIRCLE one of the numbers (0, 1, 2, 3, 4 or 5) that tells how often the problem has happened to your child **in the past month**. Refer to the **Rating Sheet** (on page 5) to help you decide how often the problem has happened. Note: If you are unsure about how often your child has experienced a particular problem, then try to make your best estimation. **Only** circle "**Don't Know**" if you absolutely **cannot** give an answer. **PLEASE BE SURE TO ANSWER ALL QUESTIONS**

	None	Little	Some	Much	Most	Don't Know
1[D4] My child watches out for danger or things that he/she is afraid of.	0	1	2	3	4	5
2[B4] When something reminds my child of what happened he/she gets very upset, scared or sad.	0	1	2	3	4	5
3[B1] My child has upsetting thoughts, pictures or sounds of what happened come into his/her mind when he/she does not want them to.	0	1	2	3	4	5
4[D2] My child feels grouchy, angry or mad.	0	1	2	3	4	5
5[B2] My child has dreams about what happened or other bad dreams	0	1	2	3	4	5
6[B3] My child has flashbacks of what happened; he/she feels like he/she is back at the time when the bad thing happened living through it again.	0	1	2	3	4	5
7[C4] My child feels like staying by him/her self and not being with his/her friends.	0	1	2	3	4	5
8[C5] My child feels alone inside and not close to other people.	0	1	2	3	4	5
9[C1] My child tries not to talk about, think about, or have feelings about what happened.	0	1	2	3	4	5
10[C6] My child has trouble feeling happiness or love.	0	1	2	3	4	5
11 [C6] My child has trouble feeling sadness or anger.	0	1	2	3	4	5
12[D5] My child feels jumpy or startles easily, for example, when he/she hears a loud noise or when something surprises him/her.	0	1	2	3	4	5
13[D1] My child has trouble going to sleep or wakes up often during the night.	0	1	2	3	4	5
14[AF] My child feels that some part of what happened is his/her fault.	0	1	2	3	4	5

UCLA PTSD INDEX FOR DSM-IV (Parent Version, Revision 1) ©

	None	Little	Some	Much	Most	Don't Know
15[C3] My child has trouble remembering important parts of what happened.	0	1	2	3	4	5
16[D3] My child has trouble concentrating or paying attention.	0	1	2	3	4	5
17[C2] My child tries to stay away from people, places, or things that make him/her remember what happened.	0	1	2	3	4	5
18[B5] When something reminds my child of what happened, he/she has strong feelings in his/her body like heart beating fast, head aches, or stomach aches.	0	1	2	3	4	5
19[C7] My child thinks that he/she will not live a long life.	0	1	2	3	4	5
20[AF] My child is afraid that the bad thing will happen again.	0	1	2	3	4	5
21[B1] My child plays games or draws pictures that are like some part of what happened.	0	1	2	3	4	5

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME
DURING THE PAST MONTH, THAT IS SINCE _____,
DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	LITTLE	SOME	MUCH	MOST

S	M	T	W	H	F	S

S	M	T	W	H	F	S
	X					
					X	

S	M	T	W	H	F	S
		X			X	
		X				
			X			
		X		X		

S	M	T	W	H	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

S	M	T	W	H	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

NEVER | TWO TIMES A MONTH | 1-2 TIMES A WEEK | 2-3 TIMES EACH WEEK | ALMOST EVERY DAY

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: ADOLESCENT VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT

Exposure to Traumatic Event
Questions 1-13: at least 1 "Yes" answer **YES NO**

Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____

Criterion A1 met
Questions 15-21: at least 1 "Yes" answer **YES NO**

Criterion A2 met
Questions 22-26: at least 1 "Yes" answer **YES NO**

Criterion A met **YES NO**

Peritraumatic Dissociation **YES NO**
Question 27: answer "Yes"

PTSD SEVERITY: OVERALL SCORE

Question # /Score	Question # /Score
1. _____	12._____
2. _____	13._____
3. _____	[Omit 14].
*4. *or*	15._____
20. _____	16._____
5. _____	17._____
6. _____	18._____
7. _____	***19. or
8. _____	21._____
9. _____	[Omit 22].
**10. *or*	**(Sum total** **PTSD SEVERITY**
11._____	**of scores) = _____** **SCORE**

*Place the highest Score from either Question 4 *or* 20 in the blank above: Score Question 4.____/Score Question 20.____
**Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____
***Place the highest Score from either Question 19 *or* 21 in the blank above: Score Question 19.____/Score Question 21.____

CRITERION B (REEXPERIENCING) SX.

Question #/DSM-IV Symptom	Score	
3. (B1) Intrusive recollections	_____	
5. (B2) Trauma/bad dreams	_____	
6. (B3) Flashbacks	_____	# of Criterion B
2. (B4) Cues: Psychological reactivity	_____	Questions with Score ≥ Symptom
18. (B5) Cues: Physiological reactivity	_____	Cutoff: _____

CRITERION B SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:
(Diagnosis requires at least 1 "B" Symptom): **YES NO**

CRITERION C (AVOIDANCE) SX.

Question #/DSM-IV Symptom	Score	
9. (C1) Avoiding thoughts/feelings	_____	
17. (C2) Avoiding activities/people	_____	
15. (C3) Forgetting	_____	# of Criterion C
7. (C4) Diminished interest etc.	_____	Questions with
8. (C5) Detachment/estrangement	_____	Scores ≥ Symptom
*10. *or* 11. (C6) Affect restricted	_____	Cutoff: _____
**19. *or* 21. (C7) Foreshortened future	_____	

[*Place the highest Score from either Question 10 *or* 11 in the blank above; **Place the highest Score from either Question 19 *or* 21 in the blank above.]

CRITERION C SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:
(Diagnosis requires at least 3 "C" Symptoms): **YES NO**

CRITERION D (INCREASED AROUSAL) SX.

Question #/DSM-IV Symptom	Score	
13. (D1) Sleep problems	_____	
*4. *or* 20. (D2) Irritability/anger	_____	
16. (D3) Concentration problems	_____	# of Criterion D
1. (D4) Hypervigilance	_____	Questions with
12. (D5) Exaggerated startle	_____	Score ≥ Symptom Cutoff: _____

[*Place the highest Score from either Question 4 *or* 20 in the blank above.]

CRITERION D SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:
(Diagnosis requires at least 2 "D" Symptoms): **YES NO**

DSM-IV PTSD DIAGNOSTIC INFO.

DSM-IV FULL PTSD DIAGNOSIS LIKELY
(Criteria A, B, C, D all met) **YES NO**

PARTIAL PTSD LIKELY
(Criterion A met and:
Criteria B + C or B + D or C + D) **YES NO**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: PARENT VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT

Exposure to Traumatic Event
Questions 1-13: at least 1 "Yes" answer **YES** **NO**

Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____

Criterion A1 met
Questions 15-26: at least 1 "Yes" answer **YES** **NO**

Criterion A2 met
Questions 22-26: at least 1 "Yes" answer **YES** **NO**

Criterion A met **YES** **NO**

PTSD SEVERITY: OVERALL SCORE

Question # /Score	Question # /Score
1. _____	**10 or
2. _____	11._____
* 3 or	12._____
21. _____	13._____
4. _____	[Omit 14].
5. _____	15._____
6. _____	16._____
7. _____	17._____
8. _____	18._____
9. _____	19._____ [Omit 20].

(Sum the items from the above 2 columns, write sum below)

(Sum total of scores) = _____ **PTSD SEVERITY SCORE**

*Place the highest Score from either Question 3 *or* 21 in the blank above: Score Question 3. ____/Score Question 21._____

**Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION B (REEXPERIENCING) SX.

Question #/DSM-IV Symptom	Score
3. (B1) Intrusive recollections or	____*
21. (B1)Repetitive Traumatic Play	
5. (B2) Trauma/bad dreams	_____
6. (B3) Flashbacks	_____
2. (B4) Cues: Psychological reactivity	_____
18. (B5) Cues: Physiological reactivity	_____

# of Criterion B Questions with Score ≥ Symptom Cutoff: _____

*Place the highest Score from either Question 3 or 21 in the blank above: Score Question 3 (Intrusive recollections) _____
Score Question 21(Repetitive play) _____

CRITERION B SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:
(Diagnosis requires at least 1 "B" Symptom): **YES** **NO**

CRITERION C (AVOIDANCE) SX.

Question #/DSM-IV Symptom	Score
9. (C1) Avoiding thoughts/feelings	_____
17. (C2) Avoiding activities/people	_____
15. (C3) Forgetting	_____
7. (C4) Diminished interest etc.	_____
8. (C5) Detachment/estrangement	_____
*10. *or* 11. (C6) Affect restricted	_____
19. (C7) Foreshortened future	_____

# of Criterion C Questions with Scores ≥ Symptom Cutoff: _____

CRITERION C SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:
(Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

*Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION D (INCREASED AROUSAL) SX.

Question #/DSM-IV Symptom	Score
13. (D1) Sleep problems	_____
4. (D2) Irritability/anger	_____
16. (D3) Concentration problems	_____
1. (D4) Hypervigilance	_____
12. (D5) Exaggerated startle	_____

# of Criterion D Questions with Score ≥ Symptom Cutoff: _____

CRITERION D SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:
(Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**

DSM-IV PTSD DIAGNOSTIC INFO.

DSM-IV FULL PTSD DIAGNOSIS LIKELY
(Criteria A, B, C, D all met) **YES** **NO**

PARTIAL PTSD LIKELY
(Criterion A met and:
Criteria B + C or B + D or C + D) **YES** **NO**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: CHILD VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT

Exposure to Traumatic Event
Questions 1-13: at least 1 "Yes" answer **YES** **NO**

Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____

Criterion A1 met
Questions 15-21: at least 1 "Yes" answer **YES** **NO**

Criterion A2 met
Questions 22-26: at least 1 "Yes" answer **YES** **NO**

Criterion A met **YES** **NO**

Peritraumatic Dissociation **YES** **NO**
Question 27: answer "Yes"

PTSD SEVERITY: OVERALL SCORE

Question # /Score	Question # /Score
1._____	12._____
2._____	13._____
3._____	[Omit 14].
4. _____	15._____
5._____	16._____
6._____	17._____
7. _____	18._____
8. _____	19._____
9. _____	[Omit 20].
* 10. *or*	
11._____	

(Sum the items from the above 2 columns, write sum below)

(Sum total of scores) = _____ PTSD SEVERITY SCORE

*Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION B (REEXPERIENCING) SX.

Question #/DSM-IV Symptom	Score	
3. (B1) Intrusive recollections	_____	
5. (B2) Trauma/bad dreams	_____	
6. (B3) Flashbacks	_____	# of Criterion B
2. (B4) Cues: Psychological reactivity	_____	Questions with Score ≥ Symptom
18. (B5) Cues: Physiological reactivity	_____	Cutoff: _____

CRITERION B SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:
(Diagnosis requires at least 1 "B" Symptom): **YES** **NO**

CRITERION C (AVOIDANCE) SX.

Question #/DSM-IV Symptom	Score	
9. (C1) Avoiding thoughts/feelings	_____	
17. (C2) Avoiding activities/people	_____	
15. (C3) Forgetting	_____	# of Criterion C
7. (C4) Diminished interest etc.	_____	Questions with
8. (C5) Detachment/estrangement	_____	Scores ≥ Symptom
*10. *or* 11. (C6) Affect restricted	_____	Cutoff: _____
19. (C7) Foreshort. future	_____	

[*Place the highest Score from either Question 10 *or* 11 in the blank above.]

CRITERION C SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:
(Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

CRITERION D (INCREASED AROUSAL) SX.

Question #/DSM-IV Symptom	Score	
13. (D1) Sleep problems	_____	
4. (D2) Irritability/anger	_____	
16. (D3) Concentration problems	_____	# of Criterion D
1. (D4) Hypervigilance	_____	Questions with
12. (D5) Exaggerated startle	_____	Score ≥ Symptom Cutoff: _____

CRITERION D SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:
(Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**

DSM-IV PTSD DIAGNOSTIC INFO.

DSM-IV FULL PTSD DIAGNOSIS LIKELY
(Criteria A, B, C, D all met) **YES** **NO**

PARTIAL PTSD LIKELY
[Criterion A met and:
Criteria (B + C) or (B + D) or (C + D)] **YES** **NO**

Appendix 4

TF-CBT Brief Practice Checklist

Client Identifier (e.g., initials):_____ **Therapist Identifier:**_____

TF-CBT Treatment Component	Session #:	1	2	3	4	5	6	7	8	9	10
	Date:	/	/	/	/	/	/	/	/	/	/
Caregiver participation: Therapist met (face-to-face or via telephone) with caregiver for 15 minutes or longer.											
P: Therapist provided psycho-education (e.g., directive education about the traumatic event, normal reactions to trauma, and instills hope).											
P: Therapist provided parenting skills (e.g., time out, selective attention, praise, reinforcement plans).											
R: Therapist explained the physiology of relaxation and instructed on methods of relaxation.											
A: Therapist assisted the child in accurately identifying their feelings, and various ways of regulating their emotions (e.g., imagery, thought stopping, positive self-talk).											
C: Therapist reviewed the cognitive triangle, educating the child on the connection among thoughts, feelings, and behaviors and helping the child generate alternative thoughts that are more accurate or helpful, in order to feel differently.											
T: Therapist developed a trauma narrative with the child, and worked to modify cognitive distortions throughout the narrative.											
I: Therapist developed an in-vivo desensitization plan to resolve avoidant behaviors.											
C: Conjoint child-parent session: sharing trauma narrative with parents or other joint parent-child activity.											
E: Therapist addressed the child's sense of safety and developed a safety plan (if needed).											
E: Therapist taught problem-solving skills and/or social skills as needed by the child.											

TF-CBT Treatment Component	Session #:	11	12	13	14	15	16	17	18	19	20
	Date:	/	/	/	/	/	/	/	/	/	/
Caregiver participation: Therapist met (face-to-face or via telephone) with caregiver for 15 minutes or longer.											
P: Therapist provided psycho-education (e.g., directive education about the traumatic event, normal reactions to trauma, and instills hope).											
P: Therapist provided parenting skills (e.g., time out, selective attention, praise, reinforcement plans).											
R: Therapist explained the physiology of relaxation and instructed on methods of relaxation.											
A: Therapist assisted the child in accurately identifying their feelings, and various ways of regulating their emotions (e.g., imagery, thought stopping, positive self-talk).											
C: Therapist reviewed the cognitive triangle, educating the child on the connection between thoughts, feelings, and behaviors and helping the child generate alternative thoughts that are more accurate or helpful, in order to feel differently.											
T: Therapist developed a trauma narrative with the child, and worked to modify cognitive distortions throughout the narrative.											
I: Therapist developed an in-vivo desensitization plan to resolve avoidant behaviors.											
C: Conjoint child-parent session: sharing trauma narrative with parents or other joint parent-child activity.											
E: Therapist addressed the child's sense of safety and developed a safety plan (if needed).											
E: Therapist taught problem-solving skills and/or social skills as needed by the child.											

Citation: Deblinger, E, Cohen, J, Mannarino, A, Murray, L, and Epstein,C. (2007). TF-CBT Brief Practice Checklist.