

Trauma-Focused Cognitive Behavioural Therapy for Children and Parents

Judith A. Cohen & Anthony P. Mannarino

Allegheny General Hospital, Center for Traumatic Stress in Children and Adolescents, 4 Allegheny Center, 8th Floor, Pittsburgh, PA 15217, USA. E-mail: jcohen1@wpahs.org

Trauma-focused cognitive behavioural therapy (TF-CBT) for children and parents is an evidence based treatment approach for traumatised children. Evaluation of TF-CBT includes several randomised controlled trials, effectiveness studies and ongoing studies for children experiencing sexual abuse, domestic violence, traumatic grief, terrorism, disasters and multiple traumas. The model of TF-CBT described here is a flexible, components-based model that provides children and parents with stress management skills prior to encouraging direct discussion and processing of children's traumatic experiences. TF-CBT components are summarised by the acronym PRACTICE: Psychoeducation, Parenting skills, Relaxation skills, Affective modulation skills, Cognitive coping skills, Trauma narrative and cognitive processing of the traumatic event(s), *In vivo* mastery of trauma reminders, Conjoint child-parent sessions, and Enhancing safety and future developmental trajectory. Currently this model of TF-CBT is being adapted and implemented both within the USA and internationally.

Keywords: Trauma; posttraumatic stress; children; adolescents; cognitive behavioural therapy; parents

Introduction

All too often children experience traumatic events before reaching adulthood. International studies document that child sexual abuse, physical abuse or domestic violence affect up to 25% of children around the world, with potentially serious and negative effects lasting into adolescence and adulthood if left untreated (Ammar, 2006; Chen, Dunne, & Han, 2004; Nelson et al., 2002; Xu, Campbell, & Xhu, 2001). Natural disasters, motor vehicle accidents, community and school violence are also common, with many children being negatively impacted by such exposure. Although some children never experience war, terrorist acts or refugee status, many others do. These events are also potentially traumatic and can result in long lasting negative emotional sequelae.

While most children are resilient following trauma exposure, some are not. Recent research suggests that genetic makeup influences how children respond to traumatic events (Caspi et al., 2002). Several other factors can serve as risk or protective factors following children's exposure to trauma. These include the degree of exposure to the index trauma, including threat to the child's life and threat to or loss of life of family members; the availability of social support; past history of other traumas; the child's preexisting history of anxiety disorder; parent's history of psychiatric disorder; the presence of parental posttraumatic stress disorder (PTSD) in response to the index trauma; and the amount of time the child spends viewing television coverage of the index traumatic event (reviewed in Pine & Cohen, 2002).

The impact of trauma exposure

Children may develop different types of emotional or behavioural problems in response to traumatic

exposure. These can be divided into problems of affect, behaviour, and cognition.

Affective problems may include sadness, fear, anxiety or anger. Some children may develop excessive moodiness, or develop difficulty in controlling or regulating their moods and emotional states (affective dysregulation). Affective dysregulation can arise from a variety of causes, and it is important for the therapist to critically analyse the source of the child's problems. For example, a child may feel sad because she is overly responsive to negative stimuli (her feelings are easily hurt), is underresponsive to positive stimuli or does not have adequate skills to access positive stimuli (she 'doesn't know how to take a compliment', 'she's too shy to approach new peers', etc.). These sound like similar problems but may require somewhat different interventions. Perhaps this child is happy sometimes but later reinterprets that experience more negatively (i.e. has fun at a friend's house but later says she hated it). In the above instances, the child's negative feelings were partly related to negative cognitions that are amenable to therapeutic interventions.

Behavioural problems may take the form of avoidance of trauma reminders (any person, place, thing or situation that reminds the child of the original trauma). Avoidance is a hallmark of PTSD, but it is also normal for children to want to avoid talking about painful or difficult subjects. Thus, it may be hard to distinguish PTSD avoidance from a child's normal reticence to discuss an upsetting topic, the irritability associated with depression, or another underlying difficulty. Following traumatic exposure children may also develop new oppositional behaviours (which may result from anger or feelings of betrayal in reaction to the unfairness of the traumatic event). Children may develop new difficulty in separating from adults (school refusal, wanting

to sleep with parents), regressive behaviours, or other manifestations of anxiety. Adolescents may use substances as a way of coping with emotional distress or avoiding trauma reminders. Another symptom of PTSD is re-experiencing the original trauma. In some cases this may lead to sexualised behaviour, bullying, or abuse of others.

Cognitive problems may include distorted ideas about why the traumatic event happened, who was responsible (including self-blame), shame or worthlessness, and/or a loss of trust. Children who blame themselves for what happened and feel that they are unworthy of being loved or of having good things happen to them may begin to behave in self-defeating ways. For example, they may begin to associate with peers who get into trouble, truant from school, or use drugs, and may start to engage in these behaviours themselves as they believe this is 'the kind of person I am now'. As will be discussed below, TF-CBT is largely based on the idea that affect, behaviours and cognitions are interrelated.

It should be clear from the brief discussion above that traumatic exposure can result in a wide variety of emotional and/or behavioural symptoms in children and adolescents. Some children will develop significant disorders such as PTSD, depression, or substance use disorders, while others will not. The potential impact of trauma on children is discussed in greater detail elsewhere (Cohen, Mannarino, & Deblinger, 2006a, pp 3–19).

Trauma Focused Cognitive Behavioural Therapy (TF-CBT)

The model of TF-CBT described here is a flexible components-based treatment model that consists of individual child-and-parent treatment sessions, as well as joint child-parent sessions. Each component is provided to both the child and parent in parallel sessions; parents additionally receive interventions to optimise effective parenting. The components of TF-CBT are summarised by the acronym PRACTICE. This is particularly appropriate since we hope that children and parents will practise what they learn in therapy between treatment sessions. A core principle of the TF-CBT model is the use of 'gradual exposure'. Each TF-CBT component includes graded exposure to the child's traumatic experience; the intensity of the exposure incrementally increases as the child and parent systematically move through the hierarchy. PRACTICE stands for Psychoeducation and Parenting skills; Relaxation skills; Affective regulation skills; Cognitive coping skills; Trauma narrative and cognitive processing of the traumatic event(s); *In vivo* mastery of trauma reminders; Conjoint child-parent sessions; and Enhancing safety and future developmental trajectory. Each of these components is described below.

TF-CBT is not for every child who has experienced a trauma

We developed this model of Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) for children whose primary presenting problems were related to their traumatic life experiences, that is, PTSD, depression, anxiety, or behavioural problems that clearly emerged

secondary to the traumatic event or events children experienced. No treatment is optimal for everyone, and this treatment is not optimal for children whose primary problems are not trauma-related. Traumatic events happen to children who have other serious psychiatric problems, and children with longstanding behavioural problems may have experienced traumatic events, either in their distant past or recently. For these children it is critical to determine whether their trauma symptoms are primary, or their other psychiatric problems will take precedent in their treatment. If the latter is true, it will be important to provide conjoint treatment for the co-existing condition so the TF-CBT therapist can focus on the trauma treatment without being constantly sidetracked by comorbidity issues, or to address and stabilise the comorbid problems before the child can adequately address trauma issues through TF-CBT interventions. Some of these children may not have significant trauma symptoms, in which case a thorough assessment would indicate that TF-CBT would not be appropriate. This highlights the importance of providing a complete trauma-focused assessment prior to starting TF-CBT, which should evaluate not only whether the child experienced trauma exposure, but to what extent these events are currently impacting upon the child. Children for whom TF-CBT is not appropriate should be referred for an alternative evidence supported treatment model.

Treatment components

Psychoeducation

Once the therapist, child and parent agree that TF-CBT is the right treatment, it is important to educate the family about this approach. Psychoeducation should start from the first contact with the family. When a child has experienced a traumatic event, parents are understandably distressed, worried, or even overwhelmed about what this means for the child's long term prognosis. Providing information in this regard (e.g. that many children have mostly transient symptoms and recover well following trauma exposure) can provide an important message of hope before the family even comes to the initial assessment. At the initial assessment, information about the child's diagnosis and the treatment plan (e.g. the TF-CBT treatment model) should be introduced. Psychoeducation continues throughout treatment by providing information about the impact of trauma on children and family members, the nature of PTSD or other diagnoses/symptoms the child is exhibiting, and information to normalise the child's and parent's situation. For example, providing statistics about how many children have experienced the same type of traumatic event as the child (one out of every four girls experience sexual abuse) may help to decrease the child's and parent's sense of stigmatisation. Education about the criminal justice system and where to apply for victim's assistance may also be important means of engaging families in the early stages of treatment.

Parenting component

As noted above, parents receive parallel sessions that address each of the PRACTICE components. In addition, they receive interventions to optimise parenting

skills, since parenting practices may change following children's exposure to traumatic events. For example, parents may become overly protective or more permissive about maintaining routines. Alternatively, parents may never have had adequate parenting skills to address behavioural difficulties and now may have even more problems as children develop trauma-related behaviours such as enuresis, aggression or noncompliance. In any of these cases parents can benefit from learning basic parenting skills such as the use of praise, selective attention (selectively attending to children's positive behaviours), the appropriate use of time out, and contingency reinforcement programs (behaviour charts). Therapists collaborate with parents to individualise each of these interventions for the particular child and parent, keeping in mind that one might work more optimally for a given child, family or culture.

Relaxation skills

Relaxation skills are also individualised for each child and parent. These skills aim to both reverse any physiologic changes that may have resulted from their traumatic experiences (DeBellis et al., 1999) and to help children gain mastery over their subjectively stressful experiences. Having a number of options, or 'tools in the toolkit' to select from when stressful situations arise allows children to try an array of different methods to self-soothe when they feel either physically or psychologically stressed. This provides a sense of control, which children (and often parents as well) were deprived of during the original traumatic experiences. These relaxation skills may include deep breathing and progressive muscle relaxation, blowing bubbles (for younger children), yoga and mindfulness exercises (for older children and teens), listening to music, sports, knitting, singing, reading funny stories, praying, or listening to relaxation tapes. Therapists work with each family to create several options that will work for the child in each of several settings (school, home, on the playground, at friends' homes). Children practise these and report back on how they worked between treatment sessions. If they didn't work, therapists work with the family to 'fine tune' the relaxation skills and the child and parent practise them again the following week until they are working well.

Affective modulation skills

Affective modulation skills are similarly tailored for each individual family. Some severely traumatised children are affectively constricted so therapists may initially work with such children to expand their range of affective expression by playing a variety of feeling games. Therapists then work with children and parents to develop individualised affective modulation skills, by first identifying areas in which the child has difficulties (e.g. is the child overly responsive to negative affective cues, or under responsive to positive ones? Does she/he need help with social skills or problem solving skills in order to improve affective modulation?) Therapists assist children and parents in strengthening these skills to add to children's 'toolkits' and encourage them to practise these skills between sessions.

Cognitive coping skills

Therapists also assist children and parents in gaining cognitive coping skills, that is, recognising connections among thoughts, feelings and behaviours as they relate to everyday situations. Therapists encourage children and parents to identify thoughts related to upsetting events, to determine the feelings and behaviours they had associated with those thoughts, and to evaluate whether these thoughts are accurate and helpful. Alternatively, children and parents can be encouraged to generate alternative thoughts for each situation, and then to explore what feelings and behaviours would be associated with these thoughts and whether these would be more soothing/prosocial than the original ones they experienced. In this manner, children and parents learn that they have control over their own thoughts, and consequently over their feelings and behaviours and thus have another 'tool for the toolbox' for self-soothing of negative affective states, upsetting situations and trauma reminders.

The trauma narrative and cognitive processing trauma experiences

After completion of the skill-building components of TF-CBT, therapists move to the trauma-specific components. Children develop a trauma narrative by gradually telling the story of what occurred during their traumatic experience(s), most often through the writing of a book, poem, song or other written narrative. The reasons for creating a trauma narrative include the following: 1) overcoming avoidance of traumatic memories; 2) identifying cognitive distortions through the child's telling of the story in his or her own words; 3) contextualising the child's traumatic experiences into the larger framework of the child's whole life: through telling the story in context (before, when, since this happened to me...), the child is able to see that he or she is more than just a victim of trauma. Some children choose to create the narrative on a computer while others prefer to write their stories or dictate them to the therapist. Occasionally, children will want to tell their stories through art, dance, song or other creative techniques. If possible it is helpful to preserve the child's narrative in a permanent manner so that it can be reviewed from one session to the next. As the child is writing the narrative, it is shared with the parent in separate parent sessions (with the child's permission) so that the parent has the opportunity to prepare for later conjoint child-parent sessions. Once the child has created the narrative (including the child's thoughts, feelings, body sensations and the worst moments of the traumatic experience), the therapist assists the child in cognitively processing any cognitive distortions that are contributing to negative affective states (such as self-blame, shame, feeling damaged, low self-esteem, related to the traumatic event). Cognitive processing utilises the techniques mastered earlier during the cognitive coping components (learning to change thoughts to more accurate and helpful ones as described above). It is not uncommon for parents to hear some aspects of the child's traumatic experience for the first time through the child's narrative, and to experience difficult emotions (such as self-blame) that need to be worked through. Therefore parents may need to cognitively process some parts of the child's narrative

during individual parent sessions prior to the later conjoint child-parent sessions.

In vivo mastery of trauma reminders

In vivo mastery of trauma reminders involves developing a graduated exposure program for children who have developed generalised avoidance of innocuous cues. For example, a child who was sexually abused in a bathroom might now be afraid of all bathrooms, and be unable to use bathrooms at school. This might eventually lead to school refusal, which may impair the child's functioning. In order to help this child return to school, the child needs to learn that not all bathrooms are dangerous, and that school is a safe place. *In vivo* mastery of generalised trauma reminders follows the same general principles as other graduated exposure programs, which are described elsewhere (Kendall, 1990).

Conjoint child-parent sessions

Conjoint child-parent sessions are an important component of our model of TF-CBT for families where a parent is available to participate in treatment. TF-CBT has been provided for children alone, but children experience added benefits when parents participate (Deblinger, Lippmann, & Steer, 1996; King et al., 2000). During the joint sessions, the communication shifts from children talking directly about their traumatic experiences with the therapist, to sharing this information with the parent while the therapist moves to the background. During these sessions children typically share their trauma narratives directly with parents (parents have already heard these in individual sessions with therapists and accommodated to the emotional content adequately to be supportive and praising of children during the retelling of the narrative). Children and parents also build on their ability to talk about other aspects of the children's traumatic experience; for example, by asking each other questions they may not have felt able to ask previously ('Are you mad at me for what happened?' 'Do you think I should have been able to stop it from happening?'). This allows parents to provide reassurance and praise to children for discussing any ongoing fears and cognitive distortions, with appropriate modeling/guidance from therapists. These sessions may also be used to enhance parents' roles as a reliable resource for trauma-related information through enjoyable joint activities. For example, the child and parent might work together to develop a Public Service Announcement about domestic violence, or a child who had experienced sexual abuse might quiz the parent about healthy sexuality (the therapist will have previously prepared the parent for these projects during individual parent sessions).

Enhancing safety and future developmental trajectory

Many traumatised children need additional skills in order to remain safe in the future. Safety skills are individualised to each child's and family's particular situation, and provided and practised either during individual or joint child-parent sessions. Some examples of safety skills we provide include: healthy sexuality for sexually abused children, including prevention of sexually inappropriate behaviours; 'no, go, tell'

(sexual abuse safety skills for younger children); domestic violence safety plan development (individualised for each child's developmental level and the family's specific circumstances); bullying safety skills; and drug refusal skills. We encourage children and parents to apply the skills learned during TF-CBT treatment to other difficult situations they may encounter after therapy ends, as these do not only apply to traumatic circumstances.

Evidence of efficacy and effectiveness

The TF-CBT model described here has been tested in several randomised controlled treatment trials (RCTs) for sexually abused and multiply traumatised children. All of these have supported the efficacy of this model for improving PTSD, depression and other emotional and behavioural difficulties in children from 3–17 years of age (Cohen, Deblinger, Mannarino, & Steer, 2004a; Cohen & Mannarino, 1996; Cohen, Mannarino, & Knudsen, 2005; Deblinger et al., 1996; King et al., 2000). Another RCT is currently underway for children with domestic violence-related PTSD symptoms. Two pilot effectiveness studies have demonstrated the promise of TF-CBT for treating Childhood Traumatic Grief (Cohen, Mannarino, & Knudsen, 2004b; Cohen, Mannarino, & Staron, 2006b). Children receiving TF-CBT or another CBT model following the 2001 terrorist attacks in New York City were matched to receive either the full treatment model or only the skills portion (enhanced services) depending on their level of PTSD symptoms. Matching children to the required level of care was successful in decreasing all children's PTSD symptoms; the children receiving CBT experienced greater rate of improvement over 6 months than those receiving enhanced services or usual treatment (Hoagwood et al., 2006). A TF-CBT Learning Collaborative approach is being used in New Orleans to provide treatment to children affected by Hurricane Katrina. Several state-wide initiatives are currently being conducted to disseminate and implement TF-CBT in the US, including in New York, Washington, Massachusetts, Illinois, Delaware, Mississippi and New Hampshire. Each state is attempting to collect different types of data with regard to adoption and implementation of this TF-CBT model.

International uses and adaptations of TF-CBT

The TF-CBT treatment manual described here was used in Sri Lanka, Indonesia and Thailand following the 2004 tsunami and was provided to therapists following the Beslan terrorist attacks in 2004. To our knowledge, no TF-CBT data were collected related to either of those events. TF-CBT is being used in Pakistan for children affected by the 2005 earthquakes following taped and live TF-CBT trainings; we are in communication with mental health officials to explore options regarding data collection. The TF-CBT manual is being translated into Dutch and German and we are collaborating with groups in Holland, Norway and Germany to conduct training, develop appropriate cultural adaptations and conduct clinical research in these countries. One of our colleagues (Murray, 2006) has received funding from the National Institute of Mental Health to adapt

TF-CBT for HIV affected sexually abused children in Zambia. This culturally adapted model of TF-CBT (TF-CBT-AZ) will then be pilot tested in anticipation of conducting a larger randomised controlled trial for this population.

Summary

The TF-CBT model described here is a flexible, evidence-based treatment for traumatised children. It has been tested in several completed and ongoing studies for children aged 3–17 years old who have experienced sexual abuse, traumatic grief, domestic violence, terrorism, disasters, and multiple traumatic events, and is currently being adapted and tested for use internationally.

References

- Ammar, N.H. (2006). Beyond the shadows: Domestic spousal violence in a 'democratizing' Egypt. *Trauma, Violence and Abuse*, 7, 244–259.
- Caspi, A., McClay, J., Moffit, T.E., Mill, J., Martin, J., Craig, W., Taylor, A., & Poulton, R. (2002). Role of genotype in the cycle of violence in maltreated children. *Science*, 297, 851–854.
- Chen, J., Dunne, M.P., & Han, P. (2004). Child sexual abuse in China: A study of adolescents in four provinces. *Child Abuse and Neglect*, 28, 1171–1186.
- Cohen, J.A., Deblinger, E., Mannarino, A.P., & Steer, R. (2004a). A multi-site randomized controlled trial for sexually abused children with PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 393–402.
- Cohen, J.A., & Mannarino, A.P. (1996). A treatment outcome study for sexually abused preschooler children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 42–50.
- Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006a). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.
- Cohen, J.A., Mannarino, A.P., & Knudsen, K. (2004b). Treating childhood traumatic grief: A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 1225–1233.
- 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, 135–145.
- Cohen, J.A., Mannarino, A.P., & Staron, V. (2006b). Modified cognitive behavioral therapy for childhood traumatic grief (CBT-CTG): A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45, 1465–1473.
- DeBellis, M.D., Baum, A.S., Birmaher, B., Keshavan, M.S., Eccard, C.H., Tobing, A.M., Jenkins, F.J., & Ryan, N.D. (1999). Developmental traumatology Part I: Biological stress systems. *Biological Psychiatry*, 45, 1259–1270.
- Deblinger, E., Lippmann, J., & Steer, R.A. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, 1, 310–321.
- Hoagwood, K.E., Radigan, M., Rodriguez, J., Levitt, J.M., Fernandez, D., Foster, J., & with NY State Office of Mental Health (2006). *Final Report on the Child and Adolescent Trauma Treatment Consortium (CATS) Project*. SAMHSA, Unpublished report.
- Kendall, P.C. (1990). *Coping cat manual*. Ardmore, PA: Workbook Publishing.
- 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, 1347–1355.
- Murray, L.K. (2006). *HIV and child sexual abuse in Zambia: An intervention feasibility study*. Grant Number 1 K23 MH 077532. National Institute of Mental Health (US).
- Nelson, E. C., Heath, A.C., Maden, P.A.F., Cooper, M.L., Dinwiddie, S.H., Bucholz, K.K., Glowinski, A., McLaughlin, T., Dunne, M.P., Statham, D.J., & Martin, N.G. (2002). Association between self-reported childhood sexual abuse and adverse psychosocial outcomes. *Archives of General Psychiatry*, 59, 139–145.
- Pine, D.C., & Cohen, J.A. (2002). Trauma in children: Risk and treatment of psychiatric sequelae. *Biological Psychiatry*, 51, 519–531.
- Xu, X., Campbell, J.C., & Xhu, F. (2001). Intimate partner violence against Chinese women. *Trauma, Violence and Abuse*, 2, 296–315.

Copyright of *Child & Adolescent Mental Health* is the property of Blackwell Publishing Limited and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.