Program Overview: Trauma-Focused Cognitive Behavioral Therapy

Please note that the accuracy of the contents of this inventory cannot be guaranteed until the program director has reviewed this summary for accuracy. Changes may be pending.

Category	**Cognitive Behavioral Therapy**	***Definitions/ Notes***
Program Name	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	TF-CBT has also been referred to as AF-CBT and CBT-SAP
History of Program	TF-CBT was developed in the 1980s and originally designed to treat children with posttraumatic stress related to sexual abuse. It integrates trauma-informed practices with cognitive-behavioral therapy, and helps children and parents gain knowledge and skills in working through traumatic events and reminders, as well as improve parent-child communication and support. Since its inception, it has been widely evaluated and used to treat children showing emotional and behavioral difficulties who have experienced multiple traumas and violence exposure types.	
Description of Program as it Relates to addressing Children's Exposure to Violence	TF-CBT is a structured, weekly conjoint child and parent psychosocial therapy for children and adolescents with emotional and behavioral difficulties associated with violence exposure and trauma. It focuses on providing a safe, trusting environment where children and parents build skills in coping, stress reduction, and management of overwhelming emotions and traumatic grief. When implemented with fidelity, 80% of children receiving TF-CBT typically show reductions in PTSD symptoms within 12-18 sessions. The core components of TF-CBT make up the acronym PRACTICE, and include providing **Psychoeducation** about childhood trauma, relevant violence, and PTSD and **Parent guidance**; **Relaxation skills** **i**ndividualized to the child and parent; **Affective modulation skills** adapted to	

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	the child, family and culture; **Cognitive coping** including connecting thoughts, feelings, and behaviors related to the trauma; completing a **Trauma narrative** to in sharing the trauma(s) and related experiences; **In-Vivo** Exposure to reduce anxiety associated with traumatic events; **Conjoint** parent-child sessions to practice skills and enhance trauma-related discussions; and **Enhancing personal safety** and optimal development through providing safety and social skills training as needed.	
Service Continuum	Tertiary/Targeted Intervention	
Primary Exposure Type	Domestic Violence Sexual Abuse Physical Abuse Community Violence School Violence (e.g., shootings; rape) Gang Violence High Risk for Exposure / Trauma	
Target Population	Individual Children/ Youth Parent/Caregivers(s)	
Target Age	Early Childhood (3-5) Middle Childhood (6 - 12) Adolescence (13-21)	For children ages 3-18
Target Gender	Both	
Appropriate for Unique Ethnic, Cultural, or Linguistic Populations?	Has this program been used or evaluated with minority, cultural, or linguistically diverse groups? Yes If yes, please indicate: Latino/Hispanic African American Caucasian	
What Adaptations have been	Have any adaptations or modifications been made with respect to specific minority, cultural, or linguistic groups?	

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made?	Yes **If yes, please describe:** TF-CBT has been evaluated with Latino, African American, and Caucasian youth and families. Two adaptations that have been systematically evaluated include a culturally adapted TF-CBT for Latino children and components that address children's Traumatic Grief. An adaptation for Indian American children is currently being developed will be evaluated. Materials have been translated into several languages and TF-CBT is being implemented in different countries (e.g., Zambia, Pakistan, Germany).	
Primary Settings	Mental Health Community Agency Residential Treatment	
Persons or Entities in charge of delivering Program	Mental Health Providers (e.g., Social Workers, Therapists)	
Primary Components	Assessment/ Triage/Screening Child Individual Therapy Conjoint Parent-Child Sessions Parent Training/Therapy **Other** (Please describe): Conjoint Sessions with caregivers and children, often towards the end of treatment	

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Resource & Capacity Planning

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Length/Duration of Program	Please Describe: TF-CBT is typically delivered in 12-18, weekly 60-90 minute sessions (30-45 minutes with the child, 30-45 minutes with the parent). Conjoint sessions are typically 30-60 minutes, and held towards the end of the treatment. However, TF-CBT is flexible enough so that duration, session length, and structure of each session (i.e., child-only, parent-only, or conjoint sessions) is determined by assessment information and needs of the child and family.	
Required Materials	Manuals/Program materials Video/Audio Equipment Fidelity Checklists/Assessments Other (Please Describe): Although not required, there are many supplemental materials available to use including a workbook to support clinician's delivery of the core PRACTICE skills.	On-line training manual with demonstration videos, scripts, and post-tests is available at: http://tfcbt.musc.edu. Provider manuals for clinicians includes a step-by-step guide, common challenges and solutions, and example handouts, and is available at: Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). TreTreating Trauma and Traumatic Grief in Children and Adolescents. New York: The Guilford Press.
Are Materials Available in Multiple Languages?	Several assessments typically used with the implementation of TF-CBT are available in Spanish. Parent materials (e.g., brochures and handouts), as well as the TF-CBT workbook for use with clinicians are available in Spanish. Materials are also being translated in Dutch and German.	
Training Requirements	Face-to-face training On-line training	Typical training sequence includes: 1. Complete the on-line, 10-hour free training at http://tfcbt.musc.edu

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		2. Read through the provider manual 3. Attend a 2-3 day training 4. Receive on-going consultation (bi-weekly or monthly) based upon need and as structured with program representatives
Provider Certification/ Training/ Requirements	Program Specific Certification/Training Required Special Service Area Required (e.g., Social Worker, Doctor)	Qualified providers must have a minimum of a master's degree and have completed the program on-line training and read the manual.
System or Agency Recommendations for Serving CEV Populations	**With-in Agency Support & Infrastructure:** Organizational Readiness assessments are recommended and available through contacting program representatives. In addition, agencies should have age-appropriate waiting areas, private space for seeing children and parents, and books, play materials and treatment materials ready.	
Costs of Implementation	Training & Consultation: Web-based training (http:tfctb.musc.edu) is free Materials/Manuals: Approximately $35/ manual	

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Evidence for CEV

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Evidence for Preventing or Addressing Violence Exposure	In general, when implemented with a high degree of fidelity (effectiveness), this program demonstrates *robust empirical findings* in preventing children's exposure to violence or ameliorating the effects of exposure, using a *reputable conceptual framework* and an evaluation *design of the highest quality*, and has been used with populations known to be at risk for violence exposure (e.g., children in residential settings).	
Evaluation Design of Studies with Children Exposed to Violence	Randomized, control experimental design Quasi-experimental design	
Violence Exposure-Related Outcomes	**Child** (Briefly Describe) Significant improvements have been found on behavioral and emotional symptomatology, including reductions in internalizing and externalizing difficulties, as well as sexualized behaviors among sexually abused preschoolers (compared to children receiving non-directive supportive therapy) immediately after treatment. Improvements in emotional and behavioral symptoms, as well as serious sexualized behaviors, were maintained over a one-year period. Twice the percentage of children in the control group exhibited clinical levels of symptomatology compared to those receiving trauma-focused CBT for Preschoolers at the 6-month and 1 year follow-up Children receiving TF-CBT show significant improvement in posttraumatic stress and depression symptoms, and display fewer externalizing difficulties after 12 sessions of TF-CBT compared to control groups. These findings were maintained over a two-year period.	

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	Compared to Child-Centered therapy, children with multiple types of violence exposure in addition to sexual abuse receiving TF-CBT not only showed lower rates of PTSD, but also showed lower rates of shame that were maintained over a 1 period. **Parent** (Briefly Describe): Parents of sexually abused children who received TF-CBT (either individual sessions or combined with child- and parent-participation) reported significantly more effective parenting practices compared to parents in the control group. These findings were generally maintained over a two-year period, with a slight drop a year after treatment. Such findings have been found across multiple sites with parents whose children were exposed to multiple traumas. These parents, compared to control groups, reported decreases in their own emotional distress related to their children's sexual abuse, as well as gains in their ability to provide abuse-related support and appropriate abuse-related parenting practices. Decreased parental emotional distress was maintained over a 1 year period.	
Additional Research Information	Studies 1 & 2: **Design, Setting, Participants:** 100 children ages 7-13 with histories of sexual abuse and their non-offending caregivers were invited to participate. Referrals were obtained from the Division of Youth and Family Services, prosecutor's office, and community agencies. Participants were randomly assigned to three treatment conditions: individual or child-only (N = 25), parent-only participation (N = 25), parent and child participation (N = 25), or a control condition of a community standard intervention (N=25). All participants received 12 sessions of either 45 minutes (child- or parent-only) or 90 minutes (child- and parent-sessions). Approximate 21 children and their caregivers in each condition continued to participate in 3-month, 6-month, 1-year, and 2-year follow-up assessments (greater	Studies 1 & 2: Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*(4), 310-321 Deblinger, E., Steer, R. A., & Lippmann, J. (1999). Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering from post-traumatic stress symptoms. *Child Abuse & Neglect, 23*(12), 1371-1378.

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	attrition was observed in control group). **Outcome Measures:** Children's levels of PTSD, anxiety, and depression at baseline, 3- and 6-month, as well as 1- and 2-year follow-ups were measured using the Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS-E) the State Trait Anxiety Inventory of Children (STAIC), and the Children's Depression Inventory (CDI). Parents completed the Child Behavior Checklist (CBCL) to provide information on children's externalizing problems and the Parenting Practices Questionnaire (PPQ) **Studies 3 & 4:** Design, Setting, Participants: 67 (out of 86 eligible) sexually abused preschoolers (ages 3-7) and their non-offending parent were randomly assigned to either trauma-focused CBT for Sexually Abused Preschoolers (CBT SAP, N = 39) or Non-directive supportive therapy (N = 28) and completed treatment (12 sessions). Sexual abuse was substantiated in all cases. 28 of the children in the trauma-focused CBT SAP and 15 children in the NST participated in the post-intervention evaluation during the 6-month and 1-year follow-up evaluation. **Outcome Measures:** Baseline and post-intervention measures of children's sexualized behavior and emotional and behavioral difficulties (e.g., affective dysregulation) symptoms were measured by interviewing children using the Pre-School Symptom Self-Report (PRESS), a pictorial instrument for young children. Parents completed the Child Behavior Checklist (CBCL), Child Sexual Behavior Inventory (CSBI), and a Weekly Behavior Report (a measure developed by the researchers) at baseline, post-intervention, and again at 6-month and 1-year follow up. **Studies 5 & 6:** **Design, Setting, Participants:** 229 children (8-14 years) from different	Studies 3 & 4: Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(1), 42-50. Cohen, J. A., & Mannarino, A. P. (1997). A treatment study for sexually abused preschool children: outcome during a one-year follow up. *Journal of American Academy of Child and Adolescent Psychiatry, 36(9)*, 1228-1235. Study 5 & 6: Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized

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	community settings (inner-city, suburban, and rural) with confirmed cases of sexual abuse and their caregivers participated baseline measures. Most children had multiple types of violence exposure, including 58% had witnessed domestic violence, 26% had been victims of physical abuse, 17% had witnessed or been involved in community violence. Children and caregivers were randomly assigned to and completed an average of 10 sessions (75% completed all 12) of TF-CBT (N= 89) or Child Center Therapy (N = 91). Children and parents were then evaluated at 6- and 12-months post treatment (80 and 82 children in the TF-CBT group, respectively and 71 and 73 in the CCT group, respectively). **Outcome Measures:** Children's levels of PTSD (avoidance, re-experiencing, and arousal) were assessed using a semi-structured interview with children and parents (K SADS-PL). Children also completed measures of depression (CDI), anxiety (STAIC), and negative, challenging attributions, levels of trust and shame (Children's Attributions & Perceptions Scale and Shame Questionnaire). Parents completed measured to assess their own levels of depression (Beck Depression Inventory), their emotional distress related to the abuse and perceived abuse-related support and parenting practices (Parent's Emotional Reaction Questionnaire, PERQ, Parental Support Questionnaire, PSQ, & modified Parenting Practices Questionnaire). All measures were administered at baseline, post treatment, 6-month and 1-year follow-up.	controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(4), 393-402. Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related symptoms. *Journal of American Academy of Child and Adolescent Psychiatry, 45 (12)*, 1474-1484.
Is this Program an Evidence-Based Practice in *other* Family/ Youth Development Areas?	No	

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Sources	Empirical Studies (peer-reviewed journal) Evaluation Conducted by Program OJJDP Model Programs Find Youth Info NREPP California Clearing House Other (describe): NCTSN (www.nctsNet.org)	

Contact Information

Web site: http://tfcbt.musc.edu/

For information about program implementation, training and technical asstance: Esther Deblinger, Ph.D.
Professor of Psychiatry
School of Osteopathic Medicine
University of Medicine and Dentistry of New Jersey
42 East Laurel Road, Suite 1100
Stratford, NJ 08084
Phone: (856) 566-7036
Fax: (856) 566-2778
E-mail: deblines@umdnj.edu

Anthony Mannarino, Ph.D.
Department of Psychiatry
Allegheny General Hospital
Pittsburgh, PA 15212
Phone: (412) 330-4312
E-mail: amannari@wpahs.org

For additional information about the program:
Judith Cohen, M.D.
Professor
Department of Psychiatry
Allegheny General Hospital
4 Allegheny Center, Room 864
Pittsburgh, PA 15212-4772
Phone: (412) 330-4321
Fax: (412) 330-4377
E-mail: jcohen@wpahs.org

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