NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

Treatment Description

Acronym *(abbreviation)* **for intervention:** TF-CBT

Average length/number of sessions: Over 80% of traumatized children will show significant improvement with 12-to-16 weeks of treatment (once a week; 60-to-90 minute sessions).

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:** TF-CBT has been adapted to address the needs unique to Latino and hearing-impaired/deaf populations, and for children who are experiencing traumatic grief. It is also being adapted for Native American families.

Trauma type *(primary)*: Sexual abuse, traumatic grief, domestic violence, disasters, terrorism, multiple traumatic events

Trauma type *(secondary)*: Other types of traumatic events

Additional descriptors *(not included above)***:** The goal of TF-CBT is to help address the biopsychosocial needs of children, with Posttraumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers. TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.

Target Population

Age range: 3 **to** 18

Gender: ❒ **Males** ❒ **Females** ☒ **Both**

Ethnic/Racial Group *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** TF-CBT has been tested in Caucasian and African American children as well as Latino children. The modifications of TF-CBT which have been specifically tested for Latino children and for Childhood Traumatic Grief are described under different treatment model descriptions. TF-CBT is currently being adapted for Native American children and for children in other countries (e.g., Zambia, Pakistan, the Netherlands, Germany, etc.).

Language*(s)***:**
The TF-CBT manual is being translated into Dutch and German and being adapted for children of diverse cultural backgrounds as described above. Some of the instruments used to test TF-CBT's efficacy are currently available in Spanish.

Region *(e.g., rural, urban)***:**
TF-CBT has been implemented and tested for children in urban, suburban and rural areas.

Other characteristics *(not included above)***:** TF-CBT is a clinic-based, individual, short-term treatment that involves individual sessions with the child and parent as well as joint parent-child sessions.

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Target Population continued	TF-CBT should be provided to those children who have significant behavioral or emotional problems that are related to traumatic life events, even if they do not meet full diagnostic criteria for PTSD. Treatment results in improvements in PTSD symptoms as well as in depression, anxiety, behavior problems, sexualized behaviors, trauma-related shame, interpersonal trust, and social competence.
Essential Components	**Theoretical basis:** Cognitive-behavioral, family, empowerment **Key components:** PRACTICE Establishing and maintaining therapeutic relationship with child and parent • **P**sycho-education about childhood trauma and PTSD • **P**arenting component including parent management skills • **R**elaxation skills individualized to the child and parent • **A**ffective modulation skills adapted to the child, family and culture • **C**ognitive coping: connecting thoughts, feelings, and behaviors related to the trauma • **T**rauma narrative: assisting the child in sharing a verbal, written, or artistic narrative about the trauma(s) and related experiences, and cognitive and affective processing of the trauma experiences; in vivo exposure and mastery of trauma reminders if appropriate • **C**onjoint parent-child sessions to practice skills and enhance trauma-related discussions • **E**nhancing future personal safety and enhancing optimal developmental trajectory through providing safety and social skills training as needed
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 3 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ❒ Yes ☒ No** **If YES, please include citation:** All of our treatment studies include drop out statistics (Cohen & Mannarino, 1996; Cohen & Mannarino, 1998; Cohen, Deblinger, Mannarino & Steer, 2004; Deblinger, Lippmann & Steer, 1996). We also have data on client satisfaction for our treatment studies. See below for these publications.

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Clinical & Anecdotal Evidence continued

Has this intervention been presented at scientific meetings? ☒ Yes ❒ No

If YES, please include citation(s) from last five presentations:
Numerous citations available upon request.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:

Cohen, Mannarino & Deblinger, 2006

Cohen & Mannarino, 1996

Cohen & Mannarino, 1997

Cohen & Mannarino, 1998

Cohen, Mannarino & Knudsen, 2005

Cohen, Deblinger, Mannarino & Steer, 2004

Deblinger, McLeer & Henry, 1990

Deblinger, Lippmann & Steer, 1996

Deblinger, Steer & Lippman, 1999

Deblinger, Stauffer & Steer, 2001

Deblinger & Heflin, 1996

King, Tonge, Mullen, Myerson, Heyne, Rollings, et al., 2000

Stauffer & Deblinger, 1999

Has the intervention been replicated anywhere? ☒ Yes ❒ No

Other countries? *(please list)* King et al., 2000

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Randomized Controlled Trials	**N=**551 original participants, 453 treatment completers Treatment completers **By gender:** 335 female, 118 male **By ethnicity:** 280 Caucasian, 129 African American, 16 Hispanic American, 15 Biracial, 13 other ethnic background	Cohen & Mannarino, 1996; Cohen & Mannarino, 1998; Cohen et al., 2004, Deblinger et al., 1996, Deblinger et al., 2001

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Research Evidence continued	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Studies Describing Modifications		See TF-CBT for Childhood Traumatic Grief and Culturally Modified TF-CBT for details
Other Research Evidence: Randomized trial replicating findings by treatment developers	**N=**36 **By gender:** 25 female, 11 male **By ethnicity:** English speaking Australian children	King et al., 2000

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

- An initial clinical interview with parent and child
- Kiddie-SADS structured interview
- Children's Depression Inventory
- State-Trait Anxiety Inventory for Children
- Child Behavior Checklist
- Child Sexual Behavior Inventory
- Children's Attributions and Perceptions Questionnaire
- Parent's Emotional Reaction Questionnaire
- Parental Support Questionnaire
- Parenting Practices Questionnaire
- Beck Depression Inventory (for parental depression)
- UCLA PTSD Index

If research studies have been conducted, what were the outcomes?

A series of randomized controlled trials have demonstrated the superiority of TF-CBT over nondirective play therapy and supportive therapies in children (ages 3 to 14) who have experienced multiple traumas, and those positive results were maintained over time. TF-CBT has proven to be effective in improving PTSD, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. The parental component of TF-CBT increases the positive effects of TF-CBT for children by improving parents' own levels of depression, emotional distress about their children's abuse, support of the child, and parenting practices.

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Outcomes continued	TF-CBT was evaluated by Northwestern University for children in foster care receiving Systems of Care (SOC) interventions (the highest level of services available prior to requiring placement in residential treatment facility). Children at two agencies received TF-CBT; comparable foster children receiving SOC at other agencies received SOC treatment as usual (TAU). Children receiving TF-CBT experienced significantly less placement disruption and less running away than those receiving SOC TAU. Children receiving TF-CBT also experienced significantly greater improvement in PTSD symptoms on the UCLA PTSD Reaction Index, and significantly greater improvement in emotional and behavioral needs on the CANS (Child and Adolescent Needs and Strengths instrument) than those receiving SOC TAU (Mental Health Services and Policy Program, 2008).
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Private treatment rooms conducive to child comfort and safety **Supervision requirements** *(e.g., review of taped sessions)***?** Clinical supervisors trained and experienced in TF-CBT. **To ensure successful implementation, support should be obtained from:** • Crime-victims' compensation funds in some states • Licensed practitioners/programs for Medicaid reimbursement • Insurance companies that provide coverage of ancillary parent sessions for the child who is the identified patient
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Cohen, Mannarino & Deblinger, 2006 **How/where is training obtained?** Through the NCTSN TF-CBT Learning Collaborative, TF-CBT Train the Trainer Program, AACAP, APSAC, ISTSS, or other privately arranged trainings. **What is the cost of training?** Training through the NCTSN Learning Collaborative is at cost of travel only. Other trainings depend on registration costs of individual conferences. Private trainings cost approximately $2000-3000/day per trainer plus expenses. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ☐ **No** **If YES, what languages?** The TF-CBT treatment manual is being translated into Dutch and German. **Other training materials &/or requirements** *(not included above)***:** Training sessions are appropriate for supervisors and therapists with a master's degree or higher.

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Training Materials & Requirements continued	Therapists and clinical supervisors benefit the most from receiving several sequential types of training, which include: • Reading this fact sheet • Completing TF-CBT*Web* online training course • Reading the program developers' treatment book(s) and related materials • Readiness assessment • Intensive skills based training, one to two days • Ongoing expert consultation from trainers for six months • Advanced TF-CBT training, one to two days
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** TF-CBT currently has strong evidence of efficacy and is flexible in terms of how clinicians can adapt it for different families. It can be provided over a relatively short period of time and can be provided in a variety of different settings (home, school, clinic, hospital, residential setting, etc.). Although ideally parents or caretakers should be included in treatment, we have provided it to children only when parents have been unable or unwilling to participate. Most community therapists have been positive about adopting TF-CBT with ongoing consultation. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Some therapists are not amenable to using a structured approach to treatment such as TF-CBT which requires the therapist to encourage children to talk about their traumatic experiences, or to a short-term treatment model which encourages the parent rather than the therapist to be the primary agent of change for the child. Such therapists will likely prefer a different approach.
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