NCTSN The National Child Traumatic Stress Network

# Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

| | |
|---|---|
| **Treatment Description** | The goal of TF-CBT is to help address the unique biopsychosocial needs of children with Post Traumatic 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** | 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. TF-CBT should be provided to those children (ages 4 to 18) 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. |
| **Intensity** | Over 80 percent of traumatized children will show significant improvement with 12-to-16 weeks of treatment (once a week; 60-to-90 minute sessions). |
| **Essential Components** | • Establishing and maintaining therapeutic relationship with child and parent<br>• Psycho-education about childhood trauma and PTSD<br>• Emotional regulation skills<br>• Individualized stress management skills<br>• Connecting thoughts, feelings, and behaviors related to the trauma<br>• Assisting the child in sharing a verbal, written, or artistic narrative about the trauma(s) and related experiences<br>• Cognitive and affective processing of the trauma experiences<br>• Education about healthy interpersonal relationships<br>• Parental treatment components including parenting skills<br>• Joint parent-child sessions to practice skills and enhance trauma-related discussions<br>• Personal safety skills training<br>• Coping with future trauma reminders |

| | |
|---|---|
| **Assessment/ Outcome Measures Used** | • An initial clinical interview with parent and child<br>• Kiddie-SADS structured interview<br>• Children's Depression Inventory<br>• State-Trait Anxiety Inventory for Children<br>• Child Behavior Checklist<br>• Child Sexual Behavior Inventory<br>• Children's Attributions and Perceptions Questionnaire<br>• Parent's Emotional Reaction Questionnaire<br>• Parental Support Questionnaire<br>• Parenting Practices Questionnaire<br>• Beck Depression Inventory (for parental depression)<br>• UCLA PTSD Index |
| **Training Requirements** | Training sessions are appropriate for supervisors and therapists with a master's degree or higher. Therapists and clinical supervisors benefit the most from receiving several sequential types of training, which include:<br>• Reading this fact sheet<br>• Reading the TF-CBT treatment manual<br>• Readiness assessment<br>• Intensive skills based training, one to two days<br>• Ongoing expert consultation from trainers for six months<br>• Advanced TF-CBT training, one to two days |
| **Fidelity Monitoring Procedures** | The effectiveness of TF-CBT depends on all of the essential components being provided in a manner and order generally consistent with the TF-CBT treatment manual.<br><br>TF-CBT Fidelity Measure |
| **Implementation Requirements, Readiness, and Reimbursement** | • Clinical supervisors trained and experienced in TF-CBT<br>• Private treatment rooms conducive to child comfort and safety<br>• Insurance companies that provide coverage of ancillary parent sessions for the child who is the identified patient<br>• Licensed practitioners/programs for Medicaid reimbursement<br>• Crime-victims' compensation funds in some states |
| **Outcomes/ Evaluation** | 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. |

| | |
|---|---|
| **Adaptations for Special Populations or Settings** | 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. |
| **Recent Publications** | Cohen JA. Mannarino AP (1996a) A treatment study for sexually abused preschool children: Initial findings. J Amer Acad Child & Adol Psychiatry, 35, 42-50.<br><br>Cohen JA. Mannarino AP (1997) A treatment study of sexually abused preschool children: Outcome during one year follow-up. J Amer Acad Child & Adol Psychiatry, 36, 1228-1235.<br><br>Cohen JA. Mannarino AP (1998b) Interventions for sexually abused children: Initial treatment findings. Child Maltreatment, 3, 17-26.<br><br>Cohen JA, Mannarino AP, Knudsen K (in press) Treating sexually abused children: One year follow-up of a randomized controlled trial. Child Abuse & Neglect.<br><br>Cohen JA, Deblinger E, Mannarino AP, Steer R (2004). A multisite randomized controlled trial for multiply traumatized children with sexual abuse-related PTSD. J Amer Acad Child & Adolescent Psychiatry, 43, (4), 393-402.<br><br>Cohen JA, Mannarino AP, Deblinger E Child and Parent Trauma-focused Cognitive Behavioral Therapy Treatment Manual. Drexel University College of Medicine (available from the authors at jcohen1@wpahs.org).<br><br>Deblinger, E., McLeer, S.V. & Henry, D.E. (1990). Cognitive/Behavioral Treatment for Sexually Abused Children Suffering Post-traumatic Stress: Preliminary Findings: Journal of the American Academy of Child and Adolescent Psychiatry, 29 (5), 747-752.<br><br>Deblinger E, Lippmann J, Steer R (1996) Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. Child maltreatment, 1, 310-321.<br><br>Deblinger E, Steer R, Lippman J (1999) Two year follow-up study of cognitive behavioral therapy for sexually abused children suffering posttraumatic stress symptoms. Child Abuse & neglect, 23, 1371-1378.<br><br>Deblinger E, Stauffer LB, Steer RA (2001) Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their non-offending mothers. Child Maltreatment,6, 332-343<br><br>Deblinger E, Heflin AH (1996) Treating sexually abused children and their non-offending parents: A cognitive behavioral approach. Thousand Oaks, CA: Sage<br><br>Stauffer, L.B., & Deblinger, E. (1999). Let's talk about taking care of you: An educational book about body safety. Hatfield, PA: Hope for Families, Inc. (Available from http://www.hope4families.com) |

| | |
|---|---|
| **Treatment Developers** | Allegheny General Hospital Center for Child Abuse & Traumatic Loss, Drexel University College of Medicine, Pittsburgh, PA<br><br>New Jersey CARES Institute, School of Osteopathic Medicine, University of Medicine and Dentistry of New Jersey, Stratford, NJ. |
| **Contact Information** | For more information on the CBITS model, contact Judy Cohen, MD, Allegheny General Hospital (jcohen1@wpahs.org), Anthony Mannarino, PhD (amannari@wpahs.org), Allegheny General Hospital, or Esther Deblinger, PhD (deblines@umdnj.edu),New Jersey CARES.<br><br>For consultation regarding training opportunities and implementation procedures for this model within the Network, contact Charlene Allred (callred@psych.duhs.duke.edu) at Duke or Cassie Kisiel at UCLA (ckisiel@mednet.ucla.edu). |