Trauma-focused Cognitive Behavior Therapy for Traumatized Children and Families

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KEYWORDS

• Children • Adolescents • Trauma • PTSD • Parents • Families
• Trauma-focused CBT • Treatment

KEY POINTS

- Trauma-focused cognitive behavioral therapy (TF-CBT) is a family-focused treatment in which parents or caregivers (hereafter referred to as "parents") participate equally with their traumatized child or adolescent (hereafter referred to as "child").
- TF-CBT is a components-based and phase-based treatment that emphasizes proportionality and incorporates gradual exposure into each component.
- Parents and child receive all TF-CBT components in parallel individual sessions that allow parents and child to express their personal thoughts and feelings about the child's trauma experiences, gain skills to help the child reregulate trauma responses, and master avoidance of trauma reminders and memories.
- Families also participate in several conjoint parent-child sessions to enhance family communication about the child's trauma experiences and parental support of the child.
- Research documents that parental participation significantly enhances the beneficial impact of TF-CBT for traumatized children.

OVERVIEW: NATURE OF THE PROBLEM

Child trauma is a serious societal problem. At least 1 trauma is reported by two-thirds of American children and adolescents (hereafter referred to as "children"); 33% of children experience multiple traumas before reaching adulthood.[1] Although most children are resilient, trauma exposure is associated with increased risk for medical and mental

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Abbreviations

PTSD Posttraumatic Stress Disorder
TF-CBT Trauma-focused cognitive behavior therapy

health problems including posttraumatic stress disorder (PTSD), depression, anxiety, substance abuse, and attempted and completed suicide.[2,3] Early identification and treatment of traumatized children can prevent these potentially serious and long-term negative outcomes.

Parents can have a significant impact on children's trauma responses. For example, lower levels of parental distress about the child's trauma and greater parental support predict more positive outcomes after child trauma exposure, whereas greater parental PTSD symptoms predict more negative child outcomes.[4] Involving parents in the traumatized child's treatment can effectively address these factors and thus positively affect the child's outcome.

Nonoffending parents are typically children's primary source of safety, support, and guidance. (Note that trauma-focused cognitive behavior therapy [TF-CBT] does not include offending parents; ie, parents who perpetrated the trauma for which the child is receiving treatment, such as a parent who perpetrated the child's sexual abuse or domestic violence.) However, trauma experiences teach children that the world is dangerous and that adults may not protect them. Such children often become angry at and stop trusting their parents, leading parents to become confused and upset. Trauma-focused therapy can help parents recognize and respond appropriately to their children's trauma responses while setting appropriate behavioral limits. This approach enables parents to provide the traumatized child with ongoing opportunities to relearn (or learn for the first time) that people can be safe and trustworthy. Thus, there are many reasons to suggest that family-focused treatment that integrally includes parents significantly enhances outcomes for traumatized children.

CHILD EVALUATION OVERVIEW

Evaluating children after trauma exposure is complex and is described in detail elsewhere.[5] There are important differences between forensic and clinical evaluations, particularly after child abuse.[6] The following discussion pertains only to clinical evaluations. As with all child mental health evaluations, these evaluations should include multiple informants. At a minimum this includes interviewing the child and parent, but school reports, pediatric records, and/or other information should also be obtained as clinically indicated, and this often includes speaking to or reviewing records from the child's Child Protective Services case worker, juvenile justice parole officer, and/or past and current psychiatric treatment providers (eg, medication prescriber, in-home or wraparound services, residential treatment facility). If a forensic evaluation has been conducted by the local child advocacy center or a private evaluator, these records should also be reviewed and included in the evaluation.

To benefit from TF-CBT, children must have experienced at least 1 remembered trauma. The remembered trauma can be any type of trauma, including multiple traumas or complex trauma. Because avoidance is a hallmark of PTSD, children often initially minimize information about their trauma experiences and symptoms; in some cases they may completely deny having experienced trauma, thus contributing to underdiagnosis of trauma-related disorders. In addition, as noted earlier, trauma involves the betrayal of trust, typically by adults; meeting a new adult, such as a therapist, can therefore serve as a trauma reminder and lead to high levels of mistrust during the

initial evaluation, particularly for children with early interpersonal trauma and attachment disruption (complex trauma).

Children should have prominent trauma-related symptoms. A PTSD diagnosis is not necessary, although some PTSD symptoms are typically present. The use of a validated screening instrument, such as the University of California, Los Angeles PTSD Reaction Index for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition[7] or the Children's Posttraumatic Symptom Scale,[8] may be useful for following these symptoms but is not a replacement for a thorough clinical interview. Evaluators must develop competence at interviewing children across the developmental spectrum for the range of trauma symptoms with which children may present. Other common diagnoses are depressive, anxiety, behavioral, or adjustment disorders. Therapists should clearly understand the manifestations of complex trauma and the multiple domains of trauma impact (ie, affective, behavioral, biological, cognitive, interpersonal, perceptual), rather than depending solely on diagnosis to determine appropriateness for trauma-focused treatment. At the same time, therapists must distinguish between complex trauma and other comorbidities. For example, children whose behavioral problems occur within a constellation of affective, biological, cognitive, and interpersonal dysregulation that is triggered by trauma reminders are likely to respond to TF-CBT, and must be differentiated from children with severe primary externalizing behavior problems (eg, conduct disorder) who are likely to benefit more from another evidence-based treatment that addresses these difficulties before embarking on trauma-focused treatment.

MANAGEMENT GOALS

As the description given earlier suggests, the goals of TF-CBT are to address and reregulate the individual child's domains of trauma impact, which may be summarized by, but are not limited to, the following:

(A) Affective, such as anxiety, sadness, anger, affective dysregulation
(B) Behavioral, such as avoidance of trauma reminders, self-injurious behaviors, maladaptive behaviors modeled during trauma (eg, sexual behaviors, bullying, aggression), noncompliance, severe behavioral dysregulation
(B) Biological, such as hypervigilance, poor sleep, increased startle, stomach aches, headaches, other somatic problems that interfere with functioning
(C) Cognitive/perceptual, such as intrusive trauma-related thoughts and memories, maladaptive trauma-related beliefs, dissociation, psychotic symptoms, cognitive dysregulation
(S) Social/school, such as impaired relationships with family, friends, peers; social withdrawal; decline in school concentration, performance, and/or attendance; impaired attachment and/or trust

DESCRIPTION OF TREATMENT

Core Trauma-focused Cognitive Behavior Therapy Principles

Core TF-CBT principles are (1) phase-based and components-based treatment, (2) component order and proportionality of phases, (3) the use of gradual exposure in TF-CBT, and (4) the importance of integrally including parents or other primary caregivers into TF-CBT treatment. The first 3 are briefly described here. More details about these principles are described on our free Web-based training site, TF-CBT*Web*, available at www.musc.edu/tfcbt and elsewhere.[9,10] The remainder of this article addresses how parents are incorporated into TF-CBT treatment.

TF-CBT is a phase-based and components-based treatment, as shown in **Box 1**.

The 3 phases of TF-CBT are stabilization, trauma narration and processing, and integration and consolidation. The components of TF-CBT are summarized by the acronym PRACTICE: Psychoeducation, Parenting Skills, Relaxation Skills, Affect Modulation Skills, Cognitive Processing Skills, Trauma narrative and processing, In vivo mastery, Conjoint child-parent sessions; and Enhancing Safety and future development. These components are described in detail later.

Box 1
TF-CBT components and phases

Psychoeducation	Stabilization phase
Parenting skills	
Relaxation	
Affect modulation	
Cognitive processing	
Trauma narration and processing	Trauma narrative phase
In vivo mastery	Integration/consolidation phase
Conjoint child-parent sessions	
Enhancing safety (traumatic grief components; optional)	

Fidelity to the TF-CBT model is important to ensure positive outcomes. Fidelity to the TF-CBT model includes the following: (1) the PRACTICE components are provided in sequential order (with some flexibility within the stabilization skills as clinically indicated and addressing Enhancing Safety first when clinically appropriate); (2) all PRACTICE components are provided (with the exception of In Vivo Mastery when this is not clinically indicated), and (3) the 3 TF-CBT phases are provided in appropriate proportion and duration. For typical trauma treatment cases, TF-CBT duration is 12 to 15 sessions and each treatment phase receives about an equal number of treatment sessions (ie, 4–5 sessions/phase). For complex trauma cases, treatment duration is longer (16–25 sessions) and the proportionality is altered slightly with about half of the treatment (8–12 sessions) dedicated to stabilization skills and a quarter of the treatment (4–6 sessions) spent on trauma narrative and integration/consolidation phases, respectively, as described elsewhere.[11]

Gradual exposure is included in all of the TF-CBT components. During each session the therapist carefully calibrates and includes increasing exposure to trauma reminders while encouraging the child and parent to use skills learned in previous sessions in order to master the fear, anxiety, or other negative emotions evoked on exposure to these trauma memories. Through this process the child and parent learn new cognitions (eg, “I can talk about sexual abuse without crying”; “Maybe my child is not damaged by what happened”). With time and ongoing practice, these cognitions become stronger and generalize to other situations, gradually replacing the maladaptive ones they initially had about the child’s traumatic experience. Current evidence suggests that this may be the underlying process through which trauma-related fear is diminished.[12]

Parental Involvement in Trauma-focused Cognitive Behavior Therapy

Parent involvement is an integral part of the TF-CBT model and parents receive as much time in the treatment as children. During most TF-CBT sessions, the therapist

spends about 30 minutes individually with the child and 30 minutes individually with the parent. Conjoint child-parent sessions are included later in the TF-CBT model to optimize open children-parent communication, both generally and related to the child's trauma experiences, as described in detail later. This structure was selected rather than family sessions based on the rationale that child trauma significantly affects parents and children and thus both benefit from individual opportunities to process personal trauma responses before meeting together to do so.

The therapist meets with the parent each session to provide the parent with each PRACTICE component as the child is receiving that component. In this manner, the parent is able to help the child to practice using the appropriate TF-CBT skills during the week when the child is not in therapy. Many parents report that the TF-CBT skills are personally helpful to them, and that encouraging their children to use these is helpful in reminding the parent to use the skills as well. Often parents practice the skills together with their children at home and this encourages the development of family resilience rituals that continue long after the end of therapy. Another reason for individual parent sessions is to facilitate open therapist-parent communication about difficult topics. For example, parents may use demeaning language to describe the child's behaviors, use ineffective discipline strategies, or say hurtful things to the child about the trauma. In such situations individual parent sessions allow the therapist to provide more appropriate parenting skills, as described later.

Most children in foster care have experienced trauma. As described later, including foster parents in treatment can enhance engagement and treatment completion for these children. In these cases, the therapist can also include the birth parent in TF-CBT if the therapist considers this to be clinically appropriate (eg, if the child is having regular visits with this parent and/or reunification is anticipated in the near future). Typically the therapist sees the birth parent in individual sessions at a separate time from the child and foster parent, and provides the birth parent with the same information as the foster parent. If the visits with the birth parent are going well and both foster parent and birth parent desire this, the therapist may consider having some sessions that include the birth and foster parents together at some points during the treatment, if clinical judgment suggests that this would be beneficial. Whether or not the birth parent participates, it is important that whenever possible at least 1 consistent parenting figure participates with the child throughout the course of TF-CBT.

Orienting the Family to Trauma-focused Cognitive Behavior Therapy

From the beginning of treatment it is important for the therapist to help the family understand that TF-CBT is a collaborative child-parent, trauma-focused treatment. The therapist may find it useful to review the information from the child's assessment that led the therapist to conclude that trauma-focused treatment was appropriate. Collaborative child-parent treatment means that the child and parent both receive about equal time each session and that the treatment includes 2-way open communication about important issues. The parent and child may express discomfort about this (eg, lack of confidentiality in therapy). The therapist can often address this by asking each what their concerns are about sharing information and making appropriate adjustments to the extent to which this occurs when indicated. For example, youth with complex trauma who are attending TF-CBT with new foster parents often have understandable issues with trusting these new caregivers or even in trusting the therapist; the therapist needs to attend to this appropriately or the therapy may be derailed.[11]

The therapist also explains what trauma-focused treatment entails in TF-CBT; namely that (1) the therapist thinks that the following problems (the therapist specifies

what these are here) are related to the child's trauma experiences; (2) these problems and their relationship to the child's trauma experiences are the focus of this treatment; and (3) this is the focus of TF-CBT and what the treatment will be addressing every session, even if other issues arise during the course of treatment. By clarifying the nature of trauma-focused treatment, the therapist helps the family to understand what to expect and also differentiates TF-CBT from other treatments (eg, usual care) that they may have received in the past.

We recognize that a variety of caregivers may participate in TF-CBT and in many cases these are not the child's legal parents and/or may be a single parent or caregiver. For consistency and simplicity, the term "parents" is used throughout the following description of TF-CBT components except where specifically noted.

STABILIZATION PHASE (4–12 SESSIONS)

Psychoeducation

During psychoeducation the therapist provides information about common trauma responses and trauma reminders, and connects these to the child's trauma experiences. The therapist also normalizes and validates these as trauma responses, because many children and parents view traumatic behavioral and affective dysregulation as the child having become a bad kid. Helping children and parents understand these as children's response to the bad things that have happened in their lives, and recognizing trauma reminders that may trigger these responses, is often extremely helpful in changing the child's and parent's perspective on the problem. Importantly, this gives them hope that the child can recover and return to more positive functioning, even if the child has a long history of complex trauma and long-standing dysregulation. As with all TF-CBT components, the therapist individually tailors how to provide psychoeducation, taking into consideration the developmental level, culture, and interests of the child and family. This approach may include playing interactive psychoeducational games such as the What Do You Know game,[13] or, for teens, discussing psychoeducational information such as that available at www.nctsn.org.

During psychoeducation for parents, the therapist provides information about the child's trauma experiences and common responses, as described earlier. Important information related to the child's trauma experience may be provided during the psychoeducation component; for example, children who have experienced sexual abuse begin to receive developmentally appropriate information about sexual abuse, including proper names for private parts. Some safety information may be incorporated during the psychoeducation component (eg, doctor's names for private body parts and information about okay and not okay touches for young children who have experienced sexual abuse). However, for children with complex trauma or those at very high risk of experiencing ongoing trauma, the Enhancing Safety component may be provided as the initial TF-CBT component before psychoeducation, as described in detail elsewhere.[11,14,15]

Importantly, the therapist helps the parents begin to identify potential trauma reminders. Trauma reminders are any cue (eg, people, places, situations, sights, smells, memories, internal sensations) that remind the child of an earlier trauma; this initiates a cascade of psychological, physical, and neurobiological responses similar to those the child experienced at the time of the original trauma. When parents understand this process, they can make more sense of children's trauma responses and intervene earlier in the process to support the children's use of TF-CBT skills to interrupt, reverse, or mitigate the process. For example, a child in foster care who had experienced previous domestic violence and physical abuse

from his father became angry and aggressive when yelled at by an older foster brother, leading him to hit younger children in the home. For this child, loud or angry voices were trauma reminders of his father (perpetrator), who often screamed before becoming physically abusive. The foster mother yelled at this child when he became aggressive to the younger children, causing him to become even more dysregulated. Psychoeducation about the child's trauma reminders and responses was the first step in changing this pattern.

Parenting Skills

During the parent skills component, parents gain effective strategies for responding to children's behavioral and emotional dysregulation. The therapist typically provides specific instruction, practice, and role plays in parenting skills, which the therapist clinically determines according to the child's presentation and the parents' current knowledge and skills. The therapist always encourages parents to use these skills while remembering that the child's behavioral problems occur in the context of trauma reminders. More detailed information about implementing these skills is available elsewhere.[9,10]

Time in and time out Time out involves placing the child in a quiet place that lacks child-family interaction or other positive stimulation in order to encourage the child to reregulate his or her own emotions and/or behavior. When the larger family context is that the child has frequent positive, nurturing, and enjoyable interactions with parents (time in), the child typically finds time out to be very negative and wants to return to time in as soon as possible. Thus, time out is most effective when the family provides high-quality time in.

Praise, positive attention, selective attention In order to create time in, therapists instruct parents in using praise, positive attention, and selective attention. Elements of effective praise include identifying specific behaviors the parents want the child to continue, labeling these for the child immediately after they occur, and enthusiastically praising these behaviors without taking back the praise with negative statements or qualifications.

Example of ineffective praise Mother (several hours after son takes out garbage when asked): "Thanks for doing your chores. I wish you were always good like that." (Errors: did not label the specific desired behavior; did not provide praise immediately after the behavior occurred; took back the praise with a negative qualifying statement.)

Example of effective praise Mother (immediately after son takes out garbage when asked): "I like how you took out the garbage as soon as I asked you to do it. Thank you so much for doing that!"

Often parents expect, take for granted, and/or ignore children when they are behaving well, and only give attention to negative or problematic behaviors. Because all children crave parental attention, this paradigm tends to reinforce children's negative behaviors; the opposite of what parents intend. In order to reverse this, positive attention requires parents to look for, attend to, and promptly provide positive attention (hugs, high fives, verbal praise, and/or other positive attention) in response to children's positive behaviors. The therapist helps parents to selectively attend to these positive behaviors while paying less attention to minor negative behaviors that, although annoying or irritating, are not dangerous (eg, pestering or intrusive behaviors, rolling eyes) By reinforcing desired behaviors with high levels of attention and not attending to undesired behaviors, parents often see marked improvements in behavioral problems.

For more significant behavioral problems, the therapist helps the parents and child to collaboratively develop an individualized contingency reinforcement program. Such programs address specific behaviors (eg, aggression, sleep problems, sexually inappropriate behaviors), and provide specific contingencies (rewards such as stars; punishments such as loss of access to electronics) if the child does or does not meet the expectations for the number of times the behavior occurs within a given time period (typically 1 day or part of a day). Critical to the success of these programs are to: (1) include the child and parents in developing the program and prizes associated with rewards; (2) chose only 1 behavior to address at a time rather than attempting to resolve multiple behaviors simultaneously; (3) have parents provide praise for any successes and provide contingencies and rewards promptly and consistently.

Relaxation Skills

As noted earlier, traumatized children experience multiple neurobiological changes that tend to maintain trauma responses. Parents may experience their own personal biological hyperarousal responses. Relaxation skills can help children and parents to reregulate these stress systems, both in resting states and in response to trauma reminders. The therapist provides personalized relaxation strategies to the child and encourages them to practice these on a regular basis at home. These strategies may include focused (yoga) breathing, progressive muscle relaxation, and visualization, skills that have been shown to produce physiologic relaxation responses, but therapists may also encourage children to use a variety of other relaxation strategies based on the child's own interests and developmental level. For example, young children often like to relax through blowing bubbles, dance (eg, Hokey Pokey, Chicken Song), and song (Row, Row, Row Your Boat), whereas teens often prefer to relax using their favorite music, physical activities, or crafts, such as crochet or knitting. Other children find reading or prayer relaxing. It is important for children to develop a variety of different relaxation strategies because a particular strategy (eg, exercise) may be effective in some settings (eg, after school or with peers) but not in others (eg, when going to sleep at night).

After the child has identified and practiced several acceptable relaxation strategies, the therapist meets with the parents and teaches them the relaxation skills preferred by the child. The therapist helps the parents to recognize situations in which the child may be experiencing physiologic arousal in response to trauma reminders and encourages the parents to support the child in using the relaxation skills in these situations. Parents often find relaxation skills to help with their personal anxiety or hyperarousal responses and the therapist may encourage parents to use relaxation in this regard as well. As noted earlier, younger children may enjoy demonstrating the newly practiced relaxation skills directly to the parents in a brief joint meeting with the parents at the end of this session.

Affect Modulation Skills

During trauma experiences many children learn to not express, develop distance from, or even deny negative feelings as a self-protective mechanism. During this component the therapist helps children to become comfortable with expressing a variety of different feelings and to develop skills for managing negative affective states. These skills may include strategies such as problem solving, seeking social support, positive distraction techniques (eg, humor, journaling, helping others, perspective taking, reading, taking a walk, playing with a pet), focusing on the present, and a variety of anger management techniques. The therapist encourages the child to develop a tool kit of skills that work in different settings and for different negative feelings.[9] These skills are familiar to most child therapists; however, in contrast with other child

treatments, in TF-CBT the therapist encourages the child to implement the affective modulation skills in response to trauma reminders.

After identifying the child's preferred affective modulation strategies, the therapist then educates, practices, and role plays with the parents about how they can support the child in implementing these skills. This process often requires substantial parental tolerance and forbearance.

Helping parents to tolerate children's verbal expressions of negative emotions as a positive step toward improved affective regulation is often challenging for the therapist and parents, especially when the parents' cultural perspective views verbalizations of negative emotions (eg, using cuss words, or saying "I hate you") as disrespectful. Some parents have limited tolerance for their child's demands for parental support, especially when these come at inconvenient times or are viewed as whining or manipulative. The therapist may address this by having the parents keep a chart of the child's negative behaviors and requests for support; such parents often find that negative behaviors occur soon after the child unsuccessfully asks for support, and that if/when the parents begin to respond more consistently to the child's requests for support, the problematic behaviors begin to decrease.

Cognitive Processing Skills

During this component the therapist helps children recognize connections among thoughts, feelings, and behaviors (the cognitive triangle) and replace maladaptive cognitions (inaccurate or unhelpful thoughts) related to everyday events with more accurate or helpful cognitions. At this point in TF-CBT the therapist is not focusing on trauma-related thoughts with the child, because it is more effective to process these during the trauma narrative component. The therapist may use a variety of techniques to assist children with cognitive processing, including progressive logical (Socratic) questioning, responsibility pie, and best friend role play.[9,10]

The therapist meets with the parent to introduce the cognitive triangle and to begin processing the parents' maladaptive cognitions. Initially the therapist identifies parents' maladaptive cognitions related to everyday events and helps the parents use cognitive processing in this regard. Many parents have maladaptive cognitions related to the child's trauma (eg, "I should have protected my child"; "I should have known sooner that this was happening to my child"; "My child is forever damaged because of what happened"). The therapist uses clinical judgment to decide whether to begin processing the parents' trauma-related maladaptive cognitions (ie, before or during the child's trauma narrative). Cognitive processing techniques are described in a free Web-based training site, CPT*Web*, available at www.musc.edu/cpt.

TRAUMA NARRATIVE AND PROCESSING PHASE (4–6 SESSIONS)

Trauma Narrative and Processing

During the trauma narrative and processing phase, the therapist and child engage in an interactive process during which the child describes increasingly difficult details about personal trauma experiences, including thoughts, feelings, and body sensations that occurred during these traumas. Through this process the child speaks about even the most horrific and feared traumatic memories, thus speaking the unspeakable, which enables the child to learn a mastery rather than avoidance response to these memories. Through the process of retelling the story as it is being developed further, the child has multiple opportunities for repeated practice of learning this mastery over traumatic memories; this also enables the child to gain perspective about the trauma experiences and thereby to identify potential errors in beliefs that the child previously

assumed to be set in stone (maladaptive cognitions; eg, "I deserved to be abused"). Through the cognitive processing strategies learned previously the therapist helps the child to process trauma-related maladaptive cognitions. The child develops a written summary of the trauma narrative process, usually in the form of a book, poem, or song. However, it is critical to emphasize that this written document is only a small fraction of the trauma narrative, which is an interactive process that occurs between the child and therapist, typically over the course of several sessions. The written narrative often is organized into chapters (eg, "About me"; "How it all began"; "Sexual abuse through the years"; "Domestic violence sucks"; Death"; "Escape"; "How I've changed"). Children who have experienced complex trauma often develop a life narrative rather than a chapter narrative, organized around a central trauma theme.[11] However, like other TF-CBT trauma narratives, these also describe specific trauma episodes in detail.

As the child meets with the therapist weekly to develop the narrative, the therapist meets in parallel sessions with the parents to share the content of the child's narrative. This sharing serves multiple purposes. Few parents have heard all of the details about the child's trauma experiences, and this process allows the parents to understand the child's trauma experiences more fully. Even when the parent coexperienced the trauma, such as a mother who was the direct victim of domestic violence that the child witnessed, it is common for these perspectives to differ considerably and a primary goal of the TF-CBT process is for nonoffending parents to hear and support the child's personal perspective. Another goal is to help parents to identify and process their personal trauma-related maladaptive cognitions; for example, hearing the child's trauma narrative may cause parents to question why their child did not tell them about the abuse sooner, and this provides an opportunity for the parents to thoroughly process this maladaptive cognition. In addition, hearing the child's trauma narrative in separate sessions with the therapist as the child is developing the narrative provides the parents with adequate time to prepare emotionally and cognitively for the conjoint child-parent sessions, during which the child typically shares the narrative directly with the parents. Through repeated exposure to the child's narrative the parents, like the child, gain new mastery related to hearing about their child's trauma experiences, and thus more ability to model adaptive coping in the child's presence during the conjoint sessions.

INTEGRATION AND CONSOLIDATION PHASE (4–6 SESSIONS)

In Vivo Mastery

In vivo mastery is the only optional TF-CBT component. Some children develop ongoing fears and avoidance of situations that are inherently innocuous. When this avoidance significantly interferes with children's adaptive functioning, it becomes an important issue to address in treatment; TF-CBT therapists use clinical judgment to determine which children require this component. For example, a child who was sexually abused in her bedroom by a perpetrator who is no longer in the home was still afraid to sleep in her own bed, and eventually afraid to sleep at night at all, and was disrupting other family members' sleep. Another child who witnessed his sibling's sudden death at home avoided attending school for fear that his mother or another younger sibling would also die when he was not home. In vivo mastery would be appropriate for these children. In distinction to the trauma narrative, which involves imaginal exposure to children's trauma experiences, in vivo (in real life) mastery involves exposure to the innocuous situation (eg, sleeping in one's own bed; returning to school) that the child fears and avoids. Through gradually facing the feared situation

and learning that the feared outcome does not happen, the child learns mastery rather than avoidance.

In order to implement in vivo mastery, the therapist, child, and parents develop a fear hierarchy (sometimes referred to as a fear ladder), ascending from the least feared (1) to most feared (10) scenarios, with 10 being the desired end point (eg, the child sleeping in her own bed or attending full days of school). In vivo mastery involves gradually building up to or mastering the end point through mastering a series of smaller steps. Because in vivo mastery typically takes several weeks to complete and also because the child's adaptive functioning is significantly affected, the therapist usually begins in vivo mastery during the TF-CBT stabilization skills phase. Because relaxation and other TF-CBT stabilization skills are needed to help the child (and often the parent) to tolerate the intermediate steps in the fear hierarchy, the therapist often provides psychoeducation, parenting skills, and relaxation skills before initiating the in vivo mastery plan.

The parents are critical to the success of in vivo mastery. Children are often reluctant to surrender the fears that they believe are keeping bad things from happening and parents provide confidence and reassurance that helps the child to get through the difficult early stages of the mastery process. Parents and (if applicable) school personnel must understand why in vivo mastery is important to the child's improved adaptive functioning and must join in with the plan for it to be successful. The therapist must address the parents' concerns or fears about the child gaining mastery over the feared situation, as well as any potential secondary gain that parents may derive from the child continuing the avoidant behavior. The therapist also encourages the parents to use ongoing praise, patience, and persistence in encouraging the child to use relaxation and other TF-CBT skills during the in vivo mastery plan. These skills increasingly reap rewards for the child and parents as the child gains increasing pride in mastering previously feared situations. If the parents do not perform the in vivo plan consistently, the child's fear and avoidance often get even worse, because of the power of intermittent reinforcement. The therapist should not embark on an in vivo plan unless the parents are fully invested in seeing the plan through to completion.

Conjoint Child-Parent Sessions

The therapist provides several conjoint child-parent sessions during the integration and consolidation phase. These sessions provide opportunities for modeling and optimizing direct communication among family members about the child's traumatic experiences and other important topics before treatment closure. During conjoint sessions the therapist typically meets briefly with the parents alone (5–10 minutes) and the child alone (5–10 minutes) to prepare each for the rest of the session (conjoint child-parent session, 40–50 minutes).

The first conjoint session is usually devoted to the child sharing the trauma narrative. If this occurs, the parents have already heard and cognitively processed the child's narrative during their individual parent sessions with the therapist (described earlier). In addition to the child sharing the narrative, the child and parents may ask each other several questions that they prepared during their respective preparation time. For example, one child asked his parents "How were you feeling when I disclosed the sexual abuse"; a parent asked her son, "Did you ever blame me for your sister's death?" These questions often facilitate open discussion of deeper feelings and cognitions related to the child's trauma experiences and many families report that these sessions were the most valuable part of their TF-CBT treatment.

Subsequent conjoint child-parent sessions may address healthy sexuality, bullying prevention, substance use refusal skills, making good peer or dating decisions,

enhancing family communication, enhancing safety, or other topics according to the therapist's clinical judgment. For children who have experienced sexual abuse it is particularly important for therapists to address healthy sexuality, and parents often prefer to be included in this process. Whatever the topic the therapist selects, it is helpful to make the process fun and interactive rather than didactic. For example, most children enjoy competing with their parents in quiz or other games in which they can display their increasing knowledge and understanding about trauma and its impact. During the conjoint sessions the therapist may reintroduce What Do You Know or other therapeutic games used earlier in TF-CBT to use in this regard.

Enhancing Safety

Because traumatic experiences involve the loss of safety and betrayal of trust, it is important for children and parents to acknowledge this openly during treatment and to develop practical strategies for enhancing children's physical safety as well as emotional and interactive means for enhancing the child's internal sense of security and trust. In cases in which there is ongoing risk of trauma exposure, the safety component is addressed at the beginning and often throughout TF-CBT.[11,14,15] Whether or not there is risk of repeated trauma exposure, it is usually helpful to develop a systematic family safety plan that applies to all family members, which might include no violence, no substance abuse, no secrets (ie, everyone tells and no one keeps secrets related to breaking the family safety rules), and other mutually agreed-on rules that help all family members to feel safe within the home. Communicating these to all family members and practicing their implementation at home enhances the child's belief that everyone in the family will adhere to the safety plan.

EVALUATION OF OUTCOME

TF-CBT has been evaluated in 15 randomized controlled trials in which it was compared with other active treatments/usual community care (in clinical settings) or wait-list control conditions (in refugee or war conditions). Among the currently evidence-based child trauma treatments, TF-CBT alone has been evaluated across the child and adolescent developmental spectrum (3–18 years), for multiple index trauma types (eg, sexual abuse, commercial sexual exploitation, domestic violence, disaster, war, traumatic grief, multiple and complex trauma), in different settings (eg, clinic, foster care, community domestic violence center, refugee nongovernmental organization, human immunodeficiency virus treatment centers), and in multiple countries and cultures (eg, United States, Africa, Europe, Australia) and with both mental health and non–mental health providers. In all of these studies TF-CBT has been found to be superior to the comparison conditions for improving PTSD symptoms/diagnosis, as well as other related mental health difficulties, such as depressive, anxiety, behavioral, cognitive, relationship, and other problems.

In many of these studies the impact of including parents in treatment has been examined. One study compared TF-CBT provided to child only, parent only, or child plus parent, with usual community treatment.[16] The TF-CBT conditions that included the parent led to significantly greater improvement in positive parenting practices as well as in the child's behavioral problems and child-reported depressive problems. A study of preschoolers who had experienced sexual abuse documented that TF-CBT led to greater improvement in child outcomes as well as in parental support and parental emotional distress than nondirective supportive therapy. Improvement in parental support significantly mediated improvement in children's PTSD symptoms after treatment and improvement in parental support and emotional distress

significantly mediated improvement in children's behavioral problems at 6-month and 12-month follow-ups.[17,18] A study of children aged 8 to 14 years who experienced sexual abuse showed that TF-CBT led to significantly greater improvement in parental support and this improvement significantly mediated improvement in children's depressive and anxiety symptoms.[19] Recent research has shown that including foster parents in TF-CBT enhanced the foster parent's engagement in treatment and the family's retention in treatment.[20,21] A recent community treatment study in Norway comparing TF-CBT with usual care found that, in addition to children in the TF-CBT group experiencing significantly greater improvement in PTSD, general mental health symptoms, and functional impairment,[22] parents in the TF-CBT condition experienced significantly greater improvement in their personal depressive symptoms and this mediated significantly greater improvement in children's depressive symptoms in the TF-CBT condition only.[23]

SUMMARY

TF-CBT is a family-based treatment of traumatized children with strong empirical support for improving PTSD, depressive, anxiety, behavioral, cognitive, relationship, and other problems. Parents or caregivers participate in all components of TF-CBT during initial parallel individual parent sessions and later conjoint parent-child sessions. Several studies document that parental inclusion significantly contributes to positive child outcomes.

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