

# Trauma-Focused Cognitive Behavioral Therapy

Brief Description | Recognition | Program IOM | Intervention Type | Content Focus | Protective Factors  
Risk Factors | Interventions by Domain | Key Program Approaches | Outcomes | Evaluation Design  
Delivery Specifications | Intended Setting | Fidelity | Barriers and Problems | Personnel | Education  
Personnel Training | Cost | Intended Age Group | Intended Population | Gender Focus  
Replication Information | Contact Information

*Program developers or their agents provided the Model Program information below.*

## BRIEF DESCRIPTION

Trauma-Focused Cognitive Behavioral (TF-CBT) is a psychotherapeutic intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It was developed by integrating cognitive and behavioral interventions with traditional child abuse therapies that focus on enhancement of interpersonal trust and empowerment. The program can be provided to children 3 to 18 years of age and their parents by trained mental health professionals in individual, family, and group sessions in outpatient settings. It targets symptoms of posttraumatic stress disorder (PTSD), which often co-occurs with depression and behavior problems. The intervention also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use.

## PROGRAM BACKGROUND

TF-CBT was originally developed and tested for sexually abused boys and girls, ages 3 to 14, and their nonabusive parents. Many of these children had sexualized behaviors as well as other behavioral problems, anxiety, depression, and problematic attributions about the abuse. Although these children were from diverse socioeconomic backgrounds, most were from poor or working-class urban or rural families and primarily White and African American.

TF-CBT was developed and tested at the Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents, in Pittsburgh, PA, with grants from the U.S. Department of Health and Human Services' National Institute of Mental Health and National Center for Child Abuse and Neglect, and the Department of Justice Office for Victims of Crime, the Allegheny-Singer Research Institute, and the Jewish Healthcare Foundation of Pittsburgh. TF-CBT is currently being modified and disseminated for use in broader community settings through the National Child Traumatic Stress Initiative network, which is funded by the Center



for Mental Health Services of the Substance Abuse and Mental Health Services Administration. Numerous therapy and treatment elements have been incorporated into the design of the TF-CBT model, in hopes of avoiding some of the long-term negative effects of child traumatic stress such as increased risk of substance abuse, suicide attempts, relationship difficulties, smaller brains, and lower IQs.

---

## **RECOGNITION**

Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services: Model Program

---

## **INSTITUTE OF MEDICINE CLASSIFICATION (IOM)**

SELECTIVE, INDICATED

The program was developed for selective and indicated audiences. It was particularly developed for children with emotional or behavioral symptoms related to traumatic exposure.

---

## **INTERVENTION TYPE**

TREATMENT

---

## **CONTENT FOCUS**

PSYCHOLOGICAL TRAUMA, DOES NOT SPECIFICALLY ADDRESS ANY SUBSTANCES

The program targets risk factors for substance use/abuse, such as traumatic stress and traumatic bereavement.

### **Parent involvement as an adjunct strategy:**

A parent treatment component is an integral part of this treatment model. It parallels the interventions used with the child so that parents are aware of the content covered with the child and are prepared to reinforce or discuss this material with the child between treatment sessions and after treatment has ended.

---

## **PROTECTIVE FACTORS**

INDIVIDUAL, FAMILY

### **INDIVIDUAL**

- Stress management skills
- Affective regulation
- Problem-solving and safety skills
- Communication skills
- Self-esteem
- Interpersonal trust

## FAMILY

- Effective parenting skills
  - Parental support of the child
  - Stress management skills
- 

## RISK FACTORS

### INDIVIDUAL, FAMILY

#### INDIVIDUAL

- Poor self-esteem
- Impaired interpersonal trust
- Self-injury
- Aggression toward others

#### FAMILY

- Parental trauma-related emotional distress
  - Inappropriate parenting practices
  - Inadequate parental support of the child
  - Lack of safety in the home setting
- 

## INTERVENTIONS BY DOMAIN

### INDIVIDUAL, FAMILY

#### INDIVIDUAL

- Therapeutic interventions combined with social skills education and artistic engagement

#### FAMILY

- Individual and parent-child counseling, parent education, play therapy, skill-building for children
  - Parent education/family therapy
  - Parent education/parent skills training
- 

## KEY PROGRAM APPROACHES

PARENT-CHILD INTERACTIONS, PARENT TRAINING, SKILL DEVELOPMENT, THERAPY, OTHER: PARENT SUPPORT

### PARENT-CHILD INTERACTIONS

Parents learn how to provide optimal support to their children.

### PARENT TRAINING

Parents learn effective parenting.

## SKILL DEVELOPMENT

Children learn skills in stress management, cognitive processing, communication, problem solving, and safety.

Parents learn parenting skills that relate to and support the skills the children are learning.

## THERAPY

Children participate in a series of therapy sessions (approximately 12 to 16) that address feeling identification, introduction of Cognitive Triangle, Stress Inoculation Therapy, gradual exposure (creating a narrative of the traumatic events the child experienced), cognitive processing, three joint parent-child sessions, and a graduation. Although this is a child-focused intervention, if possible, parents or caretakers participate in parallel sessions.

## OTHER: PARENT SUPPORT

Parents are assisted in exploring their own thoughts and feelings about the child's experience and resolving their personal trauma-related distress. They are also assisted with learning effective parenting skills.

## HOW IT WORKS

Traumatized children may develop extreme fear of anything that reminds them of the traumatic event. This can lead to avoidance of traumatic reminders and extreme emotional and physiological guardedness. Whether or not children have PTSD, these symptoms can significantly interfere with their ability to function and develop optimally. TF-CBT helps children talk directly about their traumatic experiences in a supportive environment where they can become less fearful, less avoidant, and more able to tolerate trauma-related thoughts and feelings. This treatment model also teaches children how to examine their thoughts, feelings, and behaviors and how to change these in order to feel better. It also provides children with tools such as relaxation and deep-breathing techniques, problem solving, and safety education to help them manage stressful situations in the future. A parental treatment component is an important element of TF-CBT. With it, parents are assisted in—

- Exploring their own thoughts and feelings about the child's experience and resolving their personal trauma-related distress
- Learning effective parenting skills
- Providing optimal support to their children

Several child-parent sessions are included in the TF-CBT intervention, during which the child is encouraged to discuss the traumatic experience directly with the parent, and both parent and child learn to communicate questions, concerns, and feelings more openly. This intervention is typically provided in outpatient mental health facilities but has been used in hospital, group home, school, community, and in-home settings.

For successful replication of TF-CBT, it is highly desirable that the child's parent or primary caretaker is available to participate in treatment. TF-CBT-trained supervisors may audio tape treatment sessions to review and provide helpful feedback to staff. Private therapy rooms are required for this intervention, along with drawing and writing supplies, psychoeducational books (a reference list can be provided and site staff can order books appropriate to their clients), and handouts provided with the *TF-CBT Treatment Manual*. Use of pre and posttreatment assessment instruments to monitor treatment outcome also is important.

## Client Identification

Childhood PTSD is underrecognized and undertreated, and most outpatient facilities already see traumatized children without recognizing this should be an important treatment focus. It is the implementer's responsibility to develop methods to identify and recruit children with significant trauma related difficulties who can attend 12 to 16 weekly treatment sessions. The *Cognitive Behavioral Therapy Training Guide* includes a component on how to identify and screen children in general clinical populations for trauma exposure and PTSD symptoms.

---

## OUTCOMES

### REDUCTIONS IN BEHAVIORS RELATED TO RISK FACTORS, IMPROVEMENTS IN BEHAVIORS RELATED TO PROTECTIVE FACTORS, OTHER TYPES OF OUTCOMES

#### REDUCTIONS IN BEHAVIORS RELATED TO RISK FACTORS

Significantly fewer behavior problems and significantly fewer posttraumatic stress disorder symptoms.

Children receiving TF-CBT experience significantly greater improvement in:

- PTSD symptoms
- Depression
- Negative attributions (such as self-blame) about the traumatic event
- Defiant and oppositional behaviors
- Anxiety

#### IMPROVEMENTS IN BEHAVIORS RELATED TO PROTECTIVE FACTORS

Children receiving TF-CBT experienced significantly greater improvement in depressive symptoms, significantly greater improvement in social competence, and maintained these differential improvements over the year after treatment ended.

#### OTHER TYPES OF OUTCOMES

Develops adaptive skills for dealing with stress

Decreases children's anxiety about thinking or talking about the event

Enhances accurate and helpful cognitions

Enhances children's personal safety skills

Resolves parental distress about the child's experience

Enhances parental support for their children

Prepares children to anticipate and cope with traumatic loss reminders

## EVALUATION DESIGN

Evaluation of TF-CBT has included both open treatment studies, which evaluated pre- to posttreatment improvement, and randomized controlled trials where children were randomly assigned to receive either TF-CBT or nondirective play therapy, where the child or parent is empowered to direct the treatment process and content (children 3 to 7 years old), or supportive therapy (children 8 to 14 years old). The latter studies have treated over 500 sexually abused children, including a multisite study that has been conducted in conjunction with Dr. Esther Deblinger of the Center for Children's Support, University of Medicine and Dentistry of New Jersey. TF-CBT is currently being evaluated in a randomized clinical trial for children who experienced traumatic loss as a result of terrorism. Drs. Elissa Brown and Robin Goodman at the New York University Child Study Center are conducting this trial. Evaluation in both open and randomized treatment trials has included multiple domains (PTSD, depression, anxiety, behavioral problems; school, family, and social functioning), multiple reporters (child, parent, teacher, therapist, independent evaluator ratings), and assessment of moderating and mediating factors in treatment response.

---

## DELIVERY SPECIFICATIONS

### 5–54 WEEKS

Amount of time required to deliver the program to obtain documented outcomes:

There are approximately 12 to 16 sessions for children and for parents, three of which are joint sessions.

The sessions typically last 60 to 90 minutes (30 to 45 minutes each with child and parent) and typically are provided on a weekly basis.

---

## INTENDED SETTING

### RURAL, URBAN, SUBURBAN

The program was developed for urban, suburban, and rural settings.

---

## FIDELITY

Components that must be included in order to achieve the same outcomes cited by the developer:

Staff experienced in evaluating and treating a variety of child and adolescent mental health problems;

Specific 1- to 3-day training for therapists in the use of the *Cognitive Behavior Treatment Manuals*;

Private therapy rooms with appropriate supplies, books, and handouts provided with the treatment manual;

Identification and recruitment of traumatized children who can attend 12 to 16 weekly treatment sessions; and

Use of pre- and posttreatment assessment instruments to monitor treatment outcomes.

**Optional components or strategies, and how they were determined to be optional:**

Audiotaping treatment sessions with monitoring and feedback provided by trained supervisors; ongoing consultation with CBT trainers; and availability of a parent or primary caretaker to participate in treatment.

---

**BARRIERS AND PROBLEMS**

NO INFORMATION PROVIDED

---

**PERSONNEL**

Therapists experienced in evaluating and treating a variety of child and adolescent mental health problems, and who receive training in the CBT program. Status is determined by the administering entity.

Supervisors should be trained in the CBT program.

---

**EDUCATION**

GRADUATE, SPECIAL SKILLS

Providers and supervisors can be Ph.D., M.D., or M.S.W./master's-level therapists.

**Personnel problems encountered by users when implementing this Model Program and potential solutions:**

A Ph.D. is not required; however, personnel should have training in providing child and family therapy. This is subjective and something that is determined by the developers before they agree to train persons to administer this program.

---

**PERSONNEL TRAINING**

Type: SEMINAR/WORKSHOP, Location: ONSITE (user)/OFFSITE (developer or trainer location), Length: BASIC

Therapists are required to take 1 to 3 days of training in trauma-focused cognitive behavioral therapy. training is provided by TF-CBT therapists skilled and experienced in using and teaching this treatment modality and who have participated in previous clinical trials in which its efficacy was established.

Training may be provided in Pittsburgh, at the developer's site, or user's site.

**COST (estimated in U.S. dollars)**

\$1,001–5,000

Cost considerations for implementing this Model Program as recommended by the developer:

**TRAINING**

The cost would vary according to a number of variables.

For example . . . . . \$1,000 per day, per  
trainer per training day,  
plus travel and costs

Typically, training involves two to three trainers.

**Staff costs:** (i.e., how much the program would have to compensate for time lost during training) would depend on the program.

After training is completed, costs for implementing the program would not typically exceed the regular cost of providing therapy and supervision and should not add to the cost of the program unless the user wanted ongoing consultation or to use standardized instruments that would have to be purchased from the publishers. Trauma-Focused Cognitive Behavioral Therapy instruments are offered free of charge.

**MATERIALS**

Replication fees for manuals and materials are  
standard copying rates for 100 pages  
per treatment manual, approximately . . . . . \$50 per trainee

**Available products:**

*Child and Parent Trauma-Focused Cognitive Behavioral Therapy Treatment Manual.*

*Cognitive Behavioral Therapy for Traumatic Bereavement in Children Treatment Manual.*

*Cognitive Behavioral Therapy for Traumatic Bereavement in Children Group Treatment Manual.*

Audiotape: "Treating Trauma in Children and Adolescents", by Judith A. Cohen, M.D.  
(Available through Sage Publications, Thousand Oaks, CA.)

Videotapes: "Treating Multiply Traumatized Children after 9/11".

The TF-CBT program offers treatment manuals that address specific types of trauma events including *CBT Treatment Manual for Traumatic Bereavement*; *CBT Treatment Manual for Children* (individual treatment); *Traumatic Bereavement CBT Group Treatment Manual for Children*. A "Treatment of Trauma in Children" audiotape is also available.

**INTENDED AGE GROUP**

EARLY CHILDHOOD (0–4), CHILDHOOD (5–11), EARLY ADOLESCENT (12–14),  
TEENAGER (15–17)

It was developed for children and youth 3 to 18 years old.

## **INTENDED POPULATION**

AFRICAN AMERICAN, HISPANIC/LATINO, WHITE

The program has been delivered to White and African American participants and adapted for Hispanic/Latino children, with some assessment instruments available in Spanish.

---

## **GENDER FOCUS**

BOTH GENDERS

The program was developed for use with male and female children and youth.

---

## **REPLICATION INFORMATION**

This program has been implemented at the NYU Child Study Center in New York City, Pittsburgh, and New Jersey. These providers have not given permission for contact information to be published. Currently it is being replicated in New York City, Denver, Utah, and California.

Additional populations include Native Americans, Hispanics/Latinos, and the deaf.

No substantive alterations were needed for adaptations to additional populations or settings.

---

## **CONTACT INFORMATION**

### **ABOUT THE DEVELOPER**

Judith A. Cohen, M.D.

Anthony P. Mannarino, Ph.D.

Dr. Cohen and Dr. Mannarino have served as principal investigators on 12 grants resulting in the development, testing, and dissemination of the TF-CBT treatment model. Together they direct the Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents in Pittsburgh, PA. Dr. Cohen is a board-certified child and adolescent psychiatrist and professor of psychiatry at Drexel University College of Medicine. She is the principal author of the Practice Parameters for the Assessment and Treatment of Children with PTSD published by the American Academy of Child and Adolescent Psychiatry.

Dr. Mannarino is a clinical child psychologist, professor of psychiatry at Drexel University College of Medicine, and chairman of the Department of Psychiatry at Allegheny General Hospital. Drs. Cohen and Mannarino have both served on the board of directors of the American Professional Society on the Abuse of Children and have published and taught extensively regarding the assessment and treatment of traumatized children.

**FOR INFORMATION, CONTACT**

The Center for Traumatic Stress in Children and Adolescents

Department of Psychiatry

Allegheny General Hospital

4 Allegheny Center, 8th Floor

Pittsburgh, PA 15212

Phone: (412) 330-4312

Fax: (412) 330-4377

E-mail: [jcohen1@wpahs.org](mailto:jcohen1@wpahs.org)