

AN ALGORITHM FOR DETERMINING USE OF TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY

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The shift toward dissemination of evidence-based practices has led to many questions about who is appropriate for a particular treatment model, particularly with complex clients, in diverse community settings, and when multiple evidence-based models have overlapping target populations. Few research-based tools exist to facilitate these clinical decisions. The research on trauma-focused cognitive-behavioral therapy (TF-CBT), an evidence-based treatment for children suffering from posttraumatic stress reactions, is reviewed to inform development of an algorithm to assist clinicians in determining whether a particular client is appropriate for TF-CBT. Recommendations are made for future research that will facilitate matching TF-CBT and other evidence-based practices to particular child clients.

Keywords: trauma, evidence-based, treatment, child, TF-CBT

The rapidly growing movement toward evidence-based practice in psychology has resulted in an increasing number of identified treatment models supported by research. The availability of effective treatments, combined with pressures to reduce the length of psychotherapy, has encouraged many community agencies to begin adopting evidence-based practices. The nascent field of implementation research has seen increasing interest as the challenges of spreading a new practice to community settings have become evident (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Community clinics often serve children with complex psychopathology and family situations that make the application of a new manualized practice challenging. Many clinicians and agencies are also adopting multiple evidence-based practices that often overlap in their target populations, further complicating the selection of a particular model for a particular child. Unfortunately, evidence-based tools to assist clinicians in determining whether a particular treatment is indicated for a particular client are rare. The available research was reviewed to develop an evidence-based algorithm that would assist clinicians in determining whether to use trauma-focused cognitive-behavioral therapy (TF-CBT), a well-supported treatment for children suffering from traumatic stress symptoms.

Of children presenting for outpatient mental health treatment for any condition, estimates of psychological trauma exposure (e.g., sexual abuse, physical abuse, serious accident, community violence) range from 60% to 90% (Ford et al., 1999). Children exposed to psychological

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We would like to thank Judith Cohen and Shannon Dorsey for their feedback about this article.

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trauma, particularly chronic traumatic stressors, are at increased risk for multiple problems, including internalizing and externalizing disorders, academic problems, impaired relationships, and health problems (Bogat, Deljonghe, Levendosky, Davidson, & von Eye, 2006; Flores, Cicchetti, & Rogosch, 2005; Thompson & Massat, 2005). A number of promising and evidence-based interventions have been developed for treating traumatic stress symptoms in children, including TF-CBT, which is the most widely disseminated trauma-specific intervention for children (Saxe, MacDonald, & Ellis, 2007). TF-CBT is a manualized yet flexible treatment for children suffering from posttraumatic stress reactions (Cohen, Mannarino, & Deblinger, 2006). It is supported by five completed randomized clinical trials (RCTs) published in peer-reviewed journals and two open (nonrandomized) studies (see Table 1).

Subsequently, a number of national and statewide TF-CBT dissemination and implementation efforts have been completed (CATS Consortium & Hoagwood, 2007) or are under way, most in collaboration with the Substance Abuse and Mental Health Services Administration National Child Traumatic Stress Network (NCTSN). For example, the first and third authors have been involved in separate statewide TF-CBT dissemination efforts in collaboration with the NCTSN in Connecticut (through the Child Health and Development Institute) and South Carolina (through the Medical University of South Carolina), respectively. These projects use adapted forms of the Learning Collaborative methodology, developed by the Institute for Healthcare Improvement (2003), to improve training, implementation, and sustained use of TF-CBT by clinicians in community settings (Markiewicz, Ebert, Ling, Amaya-Jackson, & Kisiel, 2006).

Clinicians new to the model often ask about how to determine whether a client is appropriate for TF-CBT. Questions about determining appropriateness for TF-CBT most often come from clinicians (who may be learning a new practice and often have complex clinical cases), supervisors or agency administrators (who may have other evidence-based practices with overlapping target populations available), or from those who refer children for trauma-focused treatment (such as child welfare workers, school personnel, or probation officers). Many clinicians request assistance in determining how to best triage cases

when they have a high caseload, a limited number of treatment openings, and a preponderance of cases with a history of trauma or complex clinical presentations. In addition, agencies may offer multiple evidence-based practices, often with overlapping target populations, further increasing the need for evidence-based tools to facilitate clinical decision making and triage. Clinicians who do not treat traumatized children or practice TF-CBT would also benefit from a brief tool to assist them in making appropriate referrals, given the widespread dissemination of TF-CBT and its recognition as a well-supported practice in the National Registry of Evidence-Based Programs and Practices (<http://www.nrepp.samhsa.gov>).

Despite the number of national and statewide TF-CBT dissemination efforts to date, there are relatively few resources and no known formalized guidelines available to help clinicians determine appropriateness for TF-CBT. The treatment developers do include general recommendations about case selection in the treatment manual (Cohen, Mannarino, & Deblinger, 2006) and the NCTSN has also offered brief guidelines (NCTSN Child Sexual Abuse Task Force and Research and Practice Core, 2008). These recommendations suggest that clinicians should complete a thorough assessment of potential clients, including posttraumatic stress disorder (PTSD) symptoms, comorbid psychiatric and substance abuse problems (for the child and caregiver), and suicidal ideation to determine whether a child suffering from traumatic stress symptoms might need additional stabilization or other support prior to starting trauma-focused therapy. However, a comprehensive evidence-based algorithm or decision-making process that summarizes the available research for determining when TF-CBT is indicated has not been published despite the desire among clinicians to have such a tool. Thus, we reviewed the TF-CBT research to develop a preliminary evidence-based algorithm to assist clinicians, agencies, and referral sources in deciding whether or not, and when, to implement TF-CBT with children they serve.

TF-CBT Overview

TF-CBT was initially developed for children suffering from sexual abuse, and has since been adapted for children suffering from exposure to a variety of traumatic events, including domestic violence, community violence, terrorism, child-

TABLE 1. Characteristics of Samples Represented in Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) Studies

Study	Sample	Recruitment	Trauma types	Inclusion criteria	Exclusion criteria	Comorbidity
Cohen, Deblinger, Mannarino, & Steer, 2004 (RCT)	<i>N</i> = 229; ages 8–14; 60% White, 28% AA, 4% Latino, 8% other	Sexually abused children from various sources	Primary: 100% had history of confirmed sexual abuse; 90% had other trauma exposure	At least 1 PTSD symptom per cluster; 89% met DSM-IV PTSD criteria; caregiver participates	Psychosis; substance abuse; developmental disorder (MR/PDD); non-English speaker	Mean CBCL <i>t</i> score of 64; 35% had <i>t</i> > 70 on CBCL
Cohen & Mannarino, 1998b ^a (RCT)	<i>N</i> = 49; ages 7–15; 59% White, 37% AA, 2% Latino, 2% other	Children sexually abused in the past 6 months, referred from various sources	100% had been sexually abused by someone 5 years older	Contact sexual abuse within past 6 months; caretaker participates	Psychosis; substance abuse; developmental disorder (MR/PDD); caregiver with current psychosis or substance abuse; serious medical illness; lack of long term caretaker	Not described
Deblinger, Lippman, & Steer, 1996 (RCT)	<i>N</i> = 100; ages 7–13; 72% White, 20% AA, 6% Latino, 2% other	Sexually abused children referred following a forensic evaluation	100% had been sexually abused	Substantiated contact sexual abuse; 3 PTSD symptoms; 1 re-experiencing or avoidance symptom; caregiver participates	Psychosis; severe developmental delay; suicidal/dangerous; ongoing contact with perpetrator	29% MDD; 30% ODD; 20% ADHD; 24% SAD; 20% GAD; 12% CD
Cohen & Mannarino, 1996b (RCT)	<i>N</i> = 67; ages 3–6; 54% White, 42% AA, 4% other	Sexually abused children referred for forensic evaluation	100% had been sexually abused by someone 5 years older	Substantiated contact sexual abuse; WBR Total Behavior score > 7 or sexually inappropriate behavior	Developmental disorder (MR/PDD); psychosis; serious illness; participating caregiver with psychosis or substance abuse	Mean CBCL internalizing <i>t</i> = 63; mean CBCL externalizing <i>t</i> = 63; mean CSBI total = 25
King et al., 2000 (RCT)	<i>N</i> = 36; ages 5–17; ethnicity not reported	Sexually abused children referred from various sources	100% had been sexually abused; nearly all had multiple abuse episodes	Substantiated contact sexual abuse; 3 PTSD symptoms; 1 re-experiencing or avoidance symptom; English speaking	Unsupervised perpetrator contact; severe intellectual disability; psychosis; suicidal behavior; on antidepressant or anti-anxiety medications; child or caregiver unwilling to participate	69% PTSD; 19% DYS; 19% ODD; 17% SAD; 14% GAD; 8% CD; 6% MDD; 6% ADHD; 6% SP
CATS Consortium & Hoagwood, 2007 (non-RCT)	<i>N</i> = 445; ages 6–21; 10% White, 15% AA, 61% Latino, 14% other	Children with PTSD symptoms after 9/11 attacks	Experienced terrorist attacks or aftermath; 75% had other trauma exposure	Moderate/severe PTSD symptoms	Psychosis; suicidal ideation; substance abuse	Not reported

TABLE 1. (continued)

Study	Sample	Recruitment	Trauma types	Inclusion criteria	Exclusion criteria	Comorbidity
Lyons et al., 2008 (non-RCT)	N = 69; ages 3–18; 39% White, 48% AA, 7% Latino, 6% other	Discrete traumatic event	Various trauma types; mean of 10 traumas; 75% had “complex trauma”	Moderate/severe PTSD symptoms	Not reported	Various

Note. RCT = randomized clinical trial; AA = African American; DSM-IV = *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.); PTSD = posttraumatic stress disorder; CBCL = Child Behavior Checklist; MR = mental retardation; PDD = pervasive developmental disorder; MDD = major depressive disorder; ODD = oppositional defiant disorder; ADHD = attention deficit/hyperactivity disorder; SAD = separation anxiety disorder; GAD = generalized anxiety disorder; CD = conduct disorder; CSBI = Child Sexual Behavior Inventory; WBR = Weekly Behavior Record; DYS = dysthymia; SP = specific phobia.

^aTreatment described was similar to TF-CBT but not called TF-CBT.

hood traumatic grief, and natural disasters (Hanson & Sawyer, 2008; Lang & Ford, 2008). The TF-CBT model, described in detail elsewhere (Cohen, Mannarino, & Deblinger, 2006), is a flexible, short-term intervention for children and adolescents from 3 to 17 years old who are suffering from posttraumatic stress reactions, including PTSD and depression, and their caregiver(s). TF-CBT was developed to decrease posttraumatic stress reactions through cognitive-behavioral skill building and gradual exposure to feared trauma memories and reminders.

TF-CBT is a components-based psychotherapy that incorporates trauma-sensitive interventions with cognitive-behavioral, family, and humanistic principles. The core components of TF-CBT are described by the PRACTICE acronym: Psychoeducation and Parenting skills, Relaxation, Affective expression and modulation, Cognitive coping and processing, Trauma narrative, In-vivo exposure, Conjoint sessions, and Enhancing future safety and development (Cohen, Mannarino, & Deblinger, 2006). A phase-based approach is used, beginning with initial preparatory components (psychoeducation, parenting skills, relaxation, affective expression, cognitive coping) focused on building child and parent coping skills; continuing with the use of gradual exposure techniques to develop, process, and share the details of the traumatic event through trauma narratives; and ending with work to enhance future positive adaptation and safety. Treatment length is described as being from 12 to 16 sessions of 90 min each (Cohen, Deblinger, Mannarino, & Steer, 2004), although in community settings session length may be shorter and treatment duration may be longer. A core feature of TF-CBT is the inclusion of parents or caregivers throughout treatment whenever possible. The child and caregiver generally participate in separate but parallel sessions during the initial components (e.g., each has his or her own 45-min session), but caregivers and children regularly come together in family sessions to reinforce concepts, enhance positive communication, build a sense of mutual trust and cohesion, and practice skills learned in individual sessions. When the child and therapist have fully developed and processed the trauma narrative, the caregiver and child meet with the therapist for conjoint sessions where the child shares his or her trauma narrative with the caregiver.

TF-CBT Training

Training in TF-CBT is being provided nationally and internationally through multiple mechanisms, including online training (<http://tfcbt.musc.edu>), single or multiday trainings, and learning collaboratives (Cohen & Mannarino, 2008). Therapists new to TF-CBT are typically advised that they should minimally complete the online TF-CBT course, attend a multiday in-person training by a TF-CBT trainer, and receive ongoing consultation or supervision for at least 6–9 months from an experienced TF-CBT supervisor or outside TF-CBT trainer/consultant while learning and practicing the model with children and families.

TF-CBT Research

The existing TF-CBT research was reviewed to guide development of the evidence-based algorithm for determining appropriateness for TF-CBT. Table 1 includes summaries of the five published RCTs comparing individual TF-CBT, or very similar protocols on which TF-CBT is based (Cohen et al., 2004; Cohen & Mannarino, 1996b, 1998b; Deblinger, Lippman, & Steer, 1996; King et al., 2000), and two nonrandomized implementation studies of TF-CBT (CATS Consortium & Hoagwood, 2007; Lyons, Weiner, Schneider, Martinovich, & McClelland, 2008). Recommendations about case selection are primarily based on the five RCTs, and findings from the other studies are used only when they provide information lacking in the RCTs. The five completed RCTs in Table 1 include a total of 563 children primarily 5 to 17 years of age and mostly Caucasian or African American. However, the majority of participants in one implementation study were Latino (CATS Consortium & Hoagwood, 2007).

Inclusion and Exclusion Criteria

As shown in Table 1, contact sexual abuse, usually within the previous 12 months, and a caregiver who was willing and able to participate in treatment were inclusion criteria for participants in each RCT. The implementation studies included children suffering from child traumatic stress symptoms following a wider range of traumatic stressors, including terrorist attacks (CATS Consortium & Hoagwood, 2007) and diverse

forms of violence, abuse, and other traumas (Lyons et al., 2008). Participants in the RCTs also were required to have clinically significant PTSD symptoms or sexually inappropriate behaviors (or in the case of preschool children, clinically significant behavior problems). Most or all studies excluded children with active psychotic symptoms, suicidal ideation, active substance abuse, serious medical illnesses such as cancer, and those who were severely developmentally or cognitively delayed. Exclusions for the participating parent in most or all of the studies included those with active psychosis or substance abuse.

Trauma History, PTSD Status, and Comorbidity

As shown in Table 1, none of the studies required a full PTSD diagnosis for inclusion; typically from three to five PTSD symptoms were required. Data from a large, recent multisite study indicated that over 90% of participants had experienced at least one other traumatic event, with participants experiencing an average of 3.7 different types of traumatic events, including the sexual abuse for which they were referred for treatment (Cohen et al., 2004). One study with 36 participants provided comorbidity data, with 84% of the children who were diagnosed with PTSD also meeting criteria for another psychiatric diagnosis, including dysthymia, oppositional defiant disorder, separation anxiety disorder, generalized anxiety disorder, and conduct disorder (King et al., 2000). Two additional studies showed that participating children's average broadband Child Behavior Checklist internalizing and externalizing behavior problem scores were in the subclinical range (Cohen et al., 2004; Cohen & Mannarino, 1996b). Results from the largest RCT suggested that TF-CBT was more effective than child-centered therapy for children with multiple traumas and higher levels of depression comorbid with PTSD symptoms (Cohen et al., 2004). Finally, some participants in an RCT comparing TF-CBT to pharmacological treatment (sertraline) had comorbid diagnoses, including major depression, generalized anxiety disorder, substance use disorder, oppositional defiant disorder, panic disorder, and anorexia nervosa (Cohen, Mannarino, Perel, & Staron, 2007).

Treatment Outcome

Table 2 summarizes the results of the five TF-CBT clinical trials (including follow-up stud-

TABLE 2. Evidence of Statistically Significant Change on Outcome Measures From Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) Clinical Trials and Implementation Studies

Study	Re-experiencing	Avoidance	Hypervigilance	All PTSD	CBCL Internalizing	CBCL Externalizing	CBCL Total	State anxiety	Trait anxiety	Sexual behaviors	Parenting practices
Cohen, Deblinger, Mannarino, & Steer, 2004 ^a	Y	Y	Y	—	N	N	Y	N	N	N	Y
1-year follow-up: Deblinger, Mannarino, Cohen, & Steer, 2006	Y	Y	Y	—	N	N	N	N	N	—	N
Cohen & Mannarino, 1998b	—	—	—	—	N	N	—	N	N	N	—
1-year follow-up: Cohen, Mannarino, & Knudsen, 2004	—	—	—	N	N	N	N	Y	Y	N	—
Deblinger, Lippmann, & Steer, 1996	—	—	—	Y	N	Y	—	N	N	—	Y
2-year follow-up: Deblinger, Steer, & Lippmann, 1999	—	—	—	Y	—	Y	—	—	—	—	N
Cohen & Mannarino, 1996b	—	—	—	—	Y	Y	—	—	—	Y	—
1-year follow-up: Cohen & Mannarino, 1997	—	—	—	—	Y	Y	—	—	—	N	—
King et al., 2000 ^b	Y	Y	Y	Y	N	N	—	N	—	—	—
12-week follow-up	N	Y	N	Y	N	N	—	Y	—	—	—
CATS Consortium & Hoagwood, 2007	—	—	—	Y	—	—	Y ²	—	Y	—	—
Lyons et al., 2008	Y	N	—	Y	—	—	—	—	—	—	—

Note. PTSD = posttraumatic stress disorder; CDI = Children's Depression Inventory; CBCL = Child Behavior Checklist; Y = statistically significant improvement for TF-CBT group; N = no significant difference between groups.

^a Significant improvement in child's shame, child's trust, child's credibility, parental support of the child, parents' emotional reaction to the abuse, and parents' depression at posttreatment. Significant improvement in child's shame and parents' emotional reaction to the abuse at follow-up. ^b The Behavior Assessment System for Children was used instead of CBCL.

ies) and the two implementation studies, which used a variety of outcome measures. Virtually all of the results (11 of 12 comparisons) indicated that TF-CBT reduced symptoms of PTSD at post-treatment significantly more than control conditions, and that these reductions were usually maintained at follow-up between 12 weeks and 2 years posttreatment (nine of 13 follow-up comparisons were significant). Similar results were found for depression symptoms at posttreatment (four of five comparisons were significant), whereas only two of four comparisons of depression symptoms at follow-up remained significant. Results related to state and trait anxiety were mixed, with only three of 12 tests of symptom reduction in these variables showing significant differences between TF-CBT and control participants. With the exception of preschool children (Cohen & Mannarino, 1996b, 1997), most participants did not show significant group differences in posttherapy improvement on broadband internalizing or externalizing behaviors or on measures of sexual behaviors. Thus, TF-CBT appears to have primary benefit in reducing the severity of PTSD and depression symptoms, rather than more generalized emotional distress or behavior problems.

However, the largest RCT (Cohen et al., 2004) warrants some additional attention. TF-CBT had broader benefits, including significantly reducing children's self-reported shame and improving trust and the sense that their reports of abuse were believed, as well as caregivers' self-reported depression symptoms, emotional distress related to the child's abuse, parenting practices, and parental support. However, with the exception of children's shame symptoms, none of these differences between TF-CBT and the comparison treatment remained significant at the 1-year follow-up (Deblinger, Mannarino, Cohen, & Steer, 2006). These results indicate that TF-CBT may yield more rapid improvement in children's and parents' overall emotional state than supportive child-centered therapy, as well as reducing children's sense of shame, which otherwise may persist as a serious problem into adulthood.

Furthermore, nationwide dissemination efforts show that TF-CBT implemented outside of formal research settings by clinicians in diverse community practice settings can also yield positive child outcomes. For example, an implementation project in New York City showed that, when disseminated to dozens of therapists, TF-CBT was

associated with improvements in children's PTSD, depression, and anxiety symptoms over a 6-month period (CATS Consortium & Hoagwood, 2007; Hoagwood et al., 2006). Similarly, a large-scale implementation project in Illinois supported the effectiveness of TF-CBT by demonstrating that it was associated with statistically significant reductions in traumatic stress symptoms in traumatized children receiving services in the child welfare system setting (Lyons et al., 2008). Lyons et al. (2008) reported that TF-CBT was also associated with improvements in youths' psychosocial strengths and anger control, ability to meet their behavioral/emotional needs, and overall life functioning, and in reductions in their involvement in risky behaviors.

Treatment Moderators and Predictors

One of the five TF-CBT outcome studies directly reported analyses of potential treatment moderators. However, none of the tested variables—age, gender, ethnicity, and number of treatment sessions—moderated treatment response to TF-CBT (Cohen et al., 2004). That is, TF-CBT was equally effective across a range of ages, for both genders, and for children of primarily Caucasian and African American ethnocultural backgrounds.

Cohen and Mannarino (2000) published data from an RCT (Cohen & Mannarino, 1998b) showing that children who felt others did not believe their disclosures of abuse were more likely to have a poorer treatment response (i.e., higher levels of trauma-related anxiety and PTSD symptoms posttreatment). Children who felt that they were not believed and who felt blamed for the sexual abuse also were more likely to have higher levels of depression symptoms posttreatment. Finally, higher levels of parental support of their child (per the parent's report) and higher socioeconomic status predicted lower levels of state anxiety among children posttreatment. However, for all of these analyses, children who received TF-CBT and the child-centered therapy were analyzed together, so the results cannot be interpreted as showing that these moderators specifically apply to TF-CBT.

The findings suggest that feeling disbelieved or blamed for sexual abuse, or having parents who are less supportive or more socioeconomically disadvantaged, are associated with less benefit from TF-CBT or supportive therapy. This is not

surprising given that TF-CBT was designed to be performed with a supportive caregiver and a key component of the intervention is helping caregivers adopt an open, validating communication style with their children. Thus, either approach to therapy may need to be modified to address specific factors related to caregiver support levels or socioeconomic hardship, which pose barriers to family engagement and response to treatment (e.g., parental psychopathology and emotion dysregulation; harsh, coercive discipline or communication style; poverty and unemployment). On the other hand, there is no evidence that children or families with these potential negative prognostic factors had worsened symptoms of PTSD, anxiety, or depression following TF-CBT (or child-centered therapy), so it does not appear that either therapy is contraindicated for such children and families.

In a sample of preschool children (Cohen & Mannarino, 1996b), several variables predicted fewer internalizing and externalizing behavior problems at posttreatment: older age of the child, better communication skills, and parents with less emotional distress related to their child's abuse (Cohen & Mannarino, 1996a). At 6- and 12-month follow-ups, mothers' reports of their own social support and of the support they provided to their child were the most significant predictors of treatment outcome, including both internalizing and externalizing behaviors (Cohen & Mannarino, 1998a). This is consistent with research showing that a parent's ability to support their child and obtain their own social support are among the key factors in promoting resiliency and psychosocial health in children exposed to adversity (Laor, Wolmer, & Cohen, 2001; Masten & Coatsworth, 1998; McGloin & Widom, 2001).

Other Trauma-Focused Interventions for Children

TF-CBT is not the only evidence-based or promising treatment for children experiencing posttraumatic impairment. The NCTSN (<http://www.nctsn.org>) and National Registry of Evidence-Based Programs and Practices (<http://www.nrepp.samhsa.gov>) provide descriptions of other psychotherapies for child traumatic stress symptoms and PTSD that have shown promise in one or more studies. These include child-parent psychotherapy (Lieberman & Van Horn, 2008),

cognitive-behavioral intervention for trauma in schools (Stein et al., 2003), parent-child interaction therapy (Chaffin et al., 2004), Seeking Safety (Najavits, Gallop, & Weiss, 2006), eye movement desensitization and processing (Chemtob, Nakashima, & Carlson, 2002), abuse-focused cognitive-behavior therapy (AF-CBT, recently renamed alternatives for families-CBT; Kolko & Swenson, 2002), Real Life Heroes (Kagan, 2008), structured psychotherapy for adolescents responding to chronic stress (SPARCS; DeRosa & Pelcovitz, 2008), and trauma affect regulation: guide for education and therapy (TARGET; Ford & Saltzman, 2009). The role that these other therapies may play in addressing special clinical cases and issues are discussed below.

Evidence-Based Answers to Questions About Using TF-CBT

With complex clinical cases and the availability of an increasing number of promising or evidence-based interventions for treating child traumatic stress symptoms, clinicians and agencies often face difficult decisions about who is appropriate for TF-CBT. The following recommendations are based on data from the published TF-CBT clinical trials, effectiveness studies and implementation projects, and subsequent follow-up studies. In addition, research-supported recommendations about alternative trauma-focused interventions are included when possible.

For What Age Range Is TF-CBT Effective?

Children from 3 to 17 years old have participated in TF-CBT clinical trials. With schoolage children and adolescents, there is ample evidence that TF-CBT is generally efficacious. Developmental differences may require some modifications to the treatment model for very young children. For example, with younger children, caregiver involvement and an emphasis on teaching behavior management skills to parents are typically important (Bouchard, Mendlowitz, Coles, & Franklin, 2004). A treatment manual for adapting TF-CBT for preschool children is currently being developed and tested (Scheeringa et al., 2007). Child-parent psychotherapy (Lieberman & Van Horn, 2008) is an efficacious alternative approach for preschool children. Finally, parent-child interaction therapy is an efficacious

alternative for preschool and schoolage children, particularly when the child presents with high levels of externalizing behavior and parent–child relationship problems. Adaptations are also available for emotionally and physically abusive parents with children ages 4–12.

For What Types of Trauma Exposure Is TF-CBT Effective?

In addition to showing evidence of efficacy for posttraumatic reactions and depression symptoms secondary to sexual abuse, a modified form of TF-CBT called cognitive–behavioral therapy for child traumatic grief has been shown to be associated with improvement in symptoms of PTSD and traumatic grief in children following the traumatic death of a loved one, although no RCTs have been completed (Cohen et al., 2004; Cohen, Mannarino, & Staron, 2006). TF-CBT also has shown promise with children who had experienced severe traumatic exposure (including physical abuse, domestic or community violence, and painful medical procedures) and high levels of family adversity when the focal trauma was sexual abuse (Cohen et al., 2004) or terrorism (CATS Consortium & Hoagwood, 2007).

Is TF-CBT Effective Without Caregiver Participation?

Even though TF-CBT has been found to be effective when completed with the child alone, there is ample evidence to support caregiver involvement in trauma-focused treatment whenever possible. For example, parental support is predictive of better child outcomes (Cohen & Mannarino, 1998a, 2000), as are lower levels of parental distress (Cohen & Mannarino, 1996a; Laor et al., 2001). TF-CBT also may improve parents' own depression symptoms, emotional reactions, and parenting practices (Cohen et al., 2004).

Two studies randomly assigned children to TF-CBT with or without caregiver involvement, but both were limited by small samples and low statistical power and by the confounding variable of session length (children whose caregivers were involved had sessions that were twice as long as those of the participants whose parents were not involved). Deblinger et al. (1996) compared four treatment conditions (child only, parent only, child and parent combined, and community care), but did not directly compare outcomes for the

child-only and combined groups. King et al. (2000) found no significant differences on PTSD symptoms, depression, anxiety, or behavior problems between children receiving treatment for sexual abuse with or without a parent's participation. However, parent participation was related to greater reductions in the child's abuse-related emotional distress (King et al.). Thus, although the indirect evidence supports caregiver involvement whenever possible, the limited data available suggest that TF-CBT may be nearly as effective when completed with the child alone.

The existing evidence also does not directly examine the efficacy of TF-CBT in three other special cases involving caregivers. The first is with children who have no current primary caregiver or who have multiple temporary adult caregivers (e.g., children placed in residential treatment or foster care; children with an incarcerated primary caregiver). However, there is some evidence of the effectiveness of TF-CBT with children in foster care (Lyons et al., 2008) and without a caregiver's involvement in treatment (e.g., King et al., 2000).

The second scenario with limited data about TF-CBT efficacy is with children whose primary caregiver is significantly psychologically or emotionally impaired (e.g., due to mental illness or substance use disorders). The third case is with children living in situations where ongoing trauma exposure is extremely likely (e.g., ongoing domestic violence in the home). In these cases, a clinical decision should be made about whether any caregiver is supportive enough and available to participate in trauma-focused treatment in a supportive manner, even if minimally. For example, an unsupportive, hostile, or extremely emotionally labile caregiver, whose participation in sessions with the child is deemed by the clinician to be contraindicated, might be included by providing separate individual sessions to the parent and child. TF-CBT with the child alone will include psychoeducation, coping, and safety skills components that can help the child cope with the parent's psychological problems or stressful home environment. Providing similar education and guidance separately to the caregiver may be more effective than excluding caregivers who appear unwilling or unable to support their child. Individual TF-CBT sessions with the caregiver, which focus on parental cognitive and emotional difficulties, barriers related to support, and healthy parent–child communication skills,

might improve caregiver support and allow for conjoint sessions later in treatment. In these complex cases, decisions about whether and how best to include such caregivers in TF-CBT should be made on a case-by-case basis and remain a key question for further research.

If no caregiver is available to participate, TF-CBT may still be used with children. In such cases, a therapist can help children identify other supportive adults in their life who might help to reinforce skills they are learning or participate in treatment in some way. This could entail participating throughout treatment in the same way that a caregiver would, or less intensively (e.g., without conjoint trauma narrative sessions). When there is no adult available to participate in treatment, TF-CBT has been found to be effective with the child alone.

For children in settings where there is ongoing conflict, the child's safety is of course the primary concern. Little is empirically known about using TF-CBT (specifically the trauma narrative component) in situations where a child continues to be at high risk of experiencing ongoing trauma exposure. However, the goal of the trauma narrative in this situation would presumably not just be to master past trauma reminders, but to also allow the child and caregiver to identify potentially dangerous situations and take appropriate steps to optimize safety. These additional features of trauma narrative work draw on skills from TF-CBT's cognitive coping, cognitive processing, and enhancing safety components. Engaging parents in treatment in a parallel manner is also crucial in these situations given that the child's narrative work may help the parent gain insight into the negative impact of trauma on their child and family and make critical changes (e.g., realizing the impact of the domestic violence on the child may lead a parent to end an abusive relationship).

Parents who are seriously psychologically or behaviorally impaired, or who have limited initial ability or willingness to support their child in therapy, may also benefit from participating with their child in one of several alternative trauma-focused psychotherapies. With young children, child-parent psychotherapy (Lieberman & Van Horn, 2008), parent-child interaction therapy (Chaffin et al., 2004), and AF-CBT (Kolko & Swenson, 2002) are explicitly designed to enhance caregiver empathy, responsiveness, consistency, and communication with their child.

When caregiver substance abuse may seriously compromise placement stability or caregiver support of the child, promising practices that combine substance abuse treatment for the caregiver and substance abuse recovery education and affect regulation skills for the child, such as Seeking Safety (Najavits et al., 2006) or TARGET (Ford, 2009) may be helpful alone or in combination with TF-CBT components.

Is TF-CBT Effective Without Trauma Narrative Development and Processing?

The trauma narrative component, a form of gradual exposure therapy that allows the child to experience and process the negative feelings and cognitions associated with the trauma, has been included in all of the published TF-CBT clinical trials. There is evidence that other cognitive and behavioral components of TF-CBT may be beneficial to children suffering from PTSD symptoms (Feeny, Foa, Treadwell, & March, 2004), and that providing only the initial TF-CBT components (psychoeducation, parenting skills, relaxation, affective expression, cognitive coping) without the trauma narrative can be effective for children with mild PTSD symptoms (CATS Consortium & Hoagwood, 2007). However, the bulk of evidence indicates that the trauma narrative should be included whenever possible. Perhaps the clearest potential contraindication for trauma narrative work is when the child's current living situation is extremely unsafe or unstable.

Is TF-CBT Effective for Children With "Complex Traumatic Stress Disorders" or Those With Comorbid Psychiatric Conditions?

Several studies have indicated that TF-CBT is effective for children who have experienced multiple traumas or who have comorbid psychiatric disorders. However, there have been no direct comparisons of TF-CBT efficacy with children exposed to a single traumatic event (e.g., sexual abuse) or multiple traumatic events over time. In addition, there have not been comparisons of TF-CBT with other interventions designed specifically for children suffering from complex traumatic stress symptoms (Ford & Cloitre, 2009). However, large-scale implementation efforts have shown that TF-CBT is effective with multi-need children with "complex" trauma histories in the child welfare system (Lyons et al.,

2008). Thus, TF-CBT is a reasonable clinical choice for multiply traumatized children and those with comorbid psychiatric conditions.

Can TF-CBT Be Provided in Combination With Other Trauma-Focused Therapies?

Research is also needed to identify if, when, and for whom integrating components of different therapies leads to enhanced outcomes (Chorpita, Daleiden, & Weisz, 2005), and more specifically when and for whom the initial treatment components of TF-CBT prior to trauma narrative work are sufficient to address complex traumatic stress symptoms. There is growing interest and ongoing research in identifying “common components” and modular treatment protocols, which provide clinicians with increased flexibility in the use of empirically guided intervention strategies (Chorpita, Becker, & Daleiden, 2007). While there is considerable overlap between evidence-based practices for children suffering from traumatic stress, including exposure, relaxation, cognitive work, modeling, and psychoeducation (Chorpita & Daleiden, 2009), integration of other treatment models could be indicated in specific circumstances. For example, components of dialectical behavior therapy, Seeking Safety, or TARGET that address extreme affect dysregulation could be particularly useful for emotionally and behaviorally labile adolescents prior to or in combination with TF-CBT, and evidence-based models for treating conduct problems could be integrated with TF-CBT for children with comorbid externalizing disorders.

An Evidence-Based Algorithm for Deciding Whether To Use TF-CBT

Based on data from the published TF-CBT studies, an algorithm is presented in Figure 1 to assist clinicians in determining when and whether TF-CBT is indicated for a particular case. This algorithm incorporates inclusion and exclusion criteria, outcome data, and treatment moderators from the clinical trials to provide preliminary clinical treatment guidelines. Of course, each case is unique and requires clinical judgment in combination with these guidelines. In a setting where TF-CBT is the only evidence-based treatment available, the algorithm can assist clinicians in deciding whether a given child is appropriate. In settings where other evidence-based treat-

ments are available, the algorithm can be used to inform triage decisions about which treatment to use. An algorithm encompassing other treatments is beyond the scope of this article, but when making determinations about whether a child is appropriate for TF-CBT, particularly with potential contraindications, clinicians must also consider the availability and evidence base of potential alternative interventions, including the following question: What available intervention has the best evidence for improving outcomes among similar children?

Unanswered Questions

One of the primary questions as yet unanswered by research is about the effectiveness of TF-CBT when the index trauma is not sexual abuse or child traumatic grief. For example, is TF-CBT just as effective for children who have not been sexually abused but are suffering from PTSD symptoms following a serious accident, domestic violence, or community violence? There is some evidence to suggest that it is, and additional clinical trials of TF-CBT with other child trauma victims will help validate these findings.

Second, additional studies that compare the effectiveness of TF-CBT for children with or without comorbid psychiatric diagnoses and with different degrees of severity of PTSD and other psychiatric symptoms are needed to confirm the limited results currently available. Specifically, the high comorbidity between PTSD and substance abuse (Jaycox, Ebener, Damesek, & Becker, 2004) among adolescents suggests a need to determine whether TF-CBT can be implemented with this population, and whether such treatment is indicated concurrently with or following substance abuse treatment. It is also unknown whether TF-CBT can be effective for adolescents who have both severe externalizing behaviors and PTSD symptoms. This is especially important given the high comorbidity between externalizing problems and PTSD and evidence that conduct disorder puts adolescents at risk for exposure to traumatic stressors and PTSD (Koenen et al., 2005). Of course, early trauma-focused intervention with children prior to the development of severe externalizing behaviors is preferable to treating these behaviors in later childhood or adolescence. However, for youth who have not received prior effective interven-

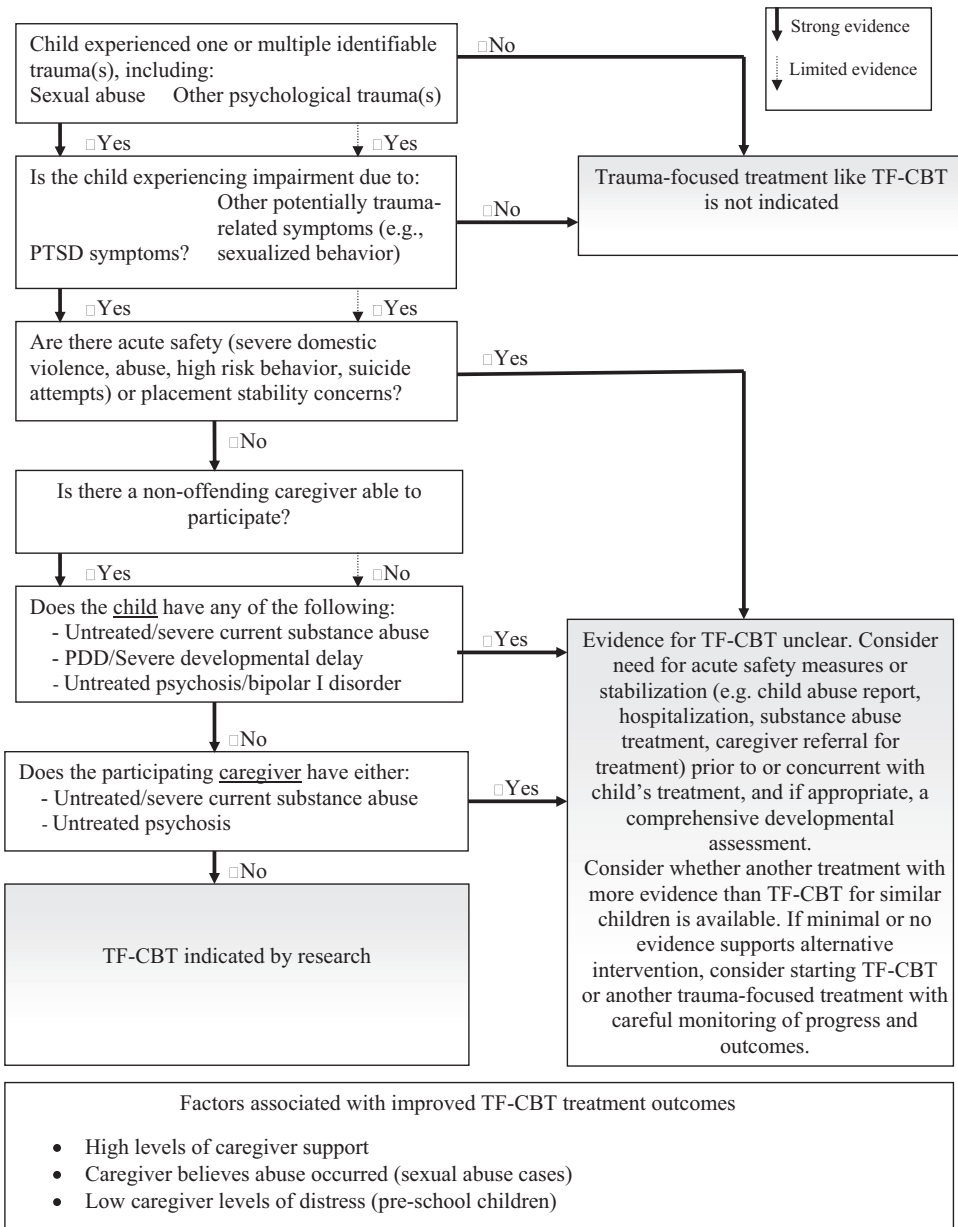


FIGURE 1. An evidence-based algorithm for determining appropriateness of trauma-focused cognitive-behavioral therapy (TF-CBT). PDD = pervasive developmental disorder.

tion, little is known about whether TF-CBT can be helpful for treating youth presenting with a full range of externalizing behaviors and traumatic stress symptoms.

Third, there is little research about the effects of implementing TF-CBT with children who are in unstable placements. Data about treatment ef-

fectiveness with this population are especially important given the instability in many child trauma victims' lives, particularly those with complex trauma histories or those in the foster care system. For example, a child who is in an unstable living situation, a relatively short-term placement, or a particularly chaotic home might

benefit from TF-CBT, but there is a risk that change in placement or dropping out of treatment might prematurely end or interrupt trauma narrative work. Extrapolating from an implementation study (CATS Consortium & Hoagwood, 2007), the TF-CBT psychoeducation and skill building components may be beneficial for youth in short-term placements, given that these components equip youth with useful knowledge about traumatic stress symptoms and teach youth skills to identify and manage emotions, develop adaptive coping skills, and bolster safety skills in potentially unsafe situations.

Even if the treatment course cannot be completed in the available timeframe, these early phases of TF-CBT may be an important “clinical opportunity” to help youth reduce significant symptoms and bolster resiliency and perhaps complete abbreviated trauma-processing work. However, it is also possible that children in such placements would benefit more from other evidence-based interventions focusing on skill acquisition that do not include trauma memory processing and that avoid the possible risks of interrupted and incomplete processing. For example, the TARGET intervention has been successfully implemented in large juvenile justice systems with evidence of benefits (Ford, Chapman, Hawke, & Albert, 2007). In the meantime, clinicians should consider on a case-by-case basis whether to use TF-CBT in situations based on the estimated likelihood of disrupted trauma processing and the availability of alternative evidence-based models.

Fourth, TF-CBT may be enhanced through adaptation for children and families of different ethnoracial backgrounds (Pole, Gone, & Kulkarni, 2008). TF-CBT RCT and field studies have been conducted with children from a variety of ethnocultural backgrounds with no indication clinically or in research tests of ethnicity as a potential moderator. However, there may be important differences within and across ethnocultural groups as to the acceptability and meaning of doing trauma narrative work, as well as the optimal timing, form or medium (e.g., using culturally specific rituals for healing or storytelling), and therapist (e.g., of the same or different ethnocultural background) who facilitates the construction of the trauma narrative (Pole et al., 2008). There has been little or no research on children who are not Caucasian, African American, or Latino, so the generalizability of the TF-

CBT research to those from other ethnic backgrounds is speculative.

Finally, additional research is needed about the relative effectiveness of TF-CBT without a caregiver, particularly in situations when the caregiver’s emotional stability or support of the child is questionable. Although few would doubt the value of a caregiver participating in a child’s treatment whenever possible, some children with traumatic stress symptoms do not have a caregiver who is willing or able to participate effectively. This is especially true of children with complex trauma histories, who might have been traumatized by abuse, neglect, or separations at the hands of their caregivers. In these cases, research is needed about whether inclusion of another trusted adult (e.g., relative, foster parent, child protective services worker) can improve outcomes compared with treatment with the child alone.

Future Directions

Research is needed to determine whether use of this or other evidence-based algorithms improves clinicians’ ability to identify and treat children who are suffering from traumatic stress symptoms. A first step would be to ask clinicians using the algorithm to determine whether or not they find it helpful to their practice. It will also be important to determine whether use of the algorithm improves identification of appropriate cases by comparing clinicians who are and are not using it. Finally, research comparing outcomes of children seen by therapists or agencies using or not using the algorithm would provide the best evaluation of its effectiveness.

Ultimately, clinicians want to know what is the most effective treatment for a particular child. The state of the field is such that we have several promising or effective manualized treatments for children suffering from traumatic stress symptoms, and these treatments are making their way into practice through dissemination programs. Research can identify the evidence-based models that are most likely to prove effective for the majority of children. Clinicians with extensive experience providing treatment to children and adolescents can draw on more general psychotherapy research (e.g., Chorpita et al., 2007) and clinical experience to identify core elements in treatment that appear to be important across a range of therapeutic modalities and conditions.

However, we know virtually nothing about which treatment to use, or how to integrate multiple treatments, when there is evidence to support more than one model.

Clinicians would also benefit from research about which specific components of a prescribed treatment are important or essential for improvement. Finally, we hope to learn how individual characteristics can be used to inform decisions about which treatment or treatment components would be most effective for a particular child so that adaptive interventions can be individually tailored (Collins, Murphy, & Bierman, 2004). As Chorpita et al. (2007) noted, identifying the core components of effective treatments allows clinicians to better tailor treatment to individual clients and eliminates the redundancy of multiple overlapping evidence-based treatments. A better understanding of the essential core components in trauma-focused therapy would provide greater flexibility in treatment (e.g., clinicians might not have to adhere as closely to a particular model, but could incorporate components from various models based on the client's needs).

Thus, research is needed to identify moderators of outcome in TF-CBT and other trauma-focused child psychotherapies that could be used to predict which approach is likely to work best, and for whom, and to what extent different treatment components are necessary. Subsequently, more sophisticated evidence-based algorithms could be developed that would assist clinicians and agencies in selecting the most appropriate trauma-specific intervention(s) or components for each child. Finally, as clinical researchers, we must not become overly focused on all that is "unknown" about certain evidence-based practices and efficacy research limitations, which can paralyze us when asked to make specific recommendations about interventions. Thus, in the many cases where the research for an evidence-based practice does not fit exactly for a particular client, clinicians should use the best evidence and available treatments that most closely approximate the client's characteristics and needs.

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