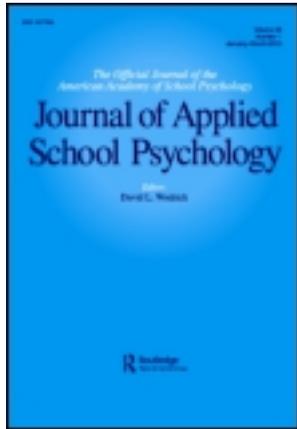


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Monica M. Fitzgerald^a & Judith A. Cohen^b

^a University of Colorado, School of Medicine, Denver, Colorado, USA

^b Pittsburgh Allegheny General Hospital, Temple University School of Medicine, Pittsburgh, Pennsylvania, USA

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Trauma-Focused Cognitive Behavior Therapy for School Psychologists

MONICA M. FITZGERALD

University of Colorado, School of Medicine, Denver, Colorado, USA

JUDITH A. COHEN

*Pittsburgh Allegheny General Hospital, Temple University School of Medicine, Pittsburgh,
Pennsylvania, USA*

Schools are ideal settings for identifying children and adolescents who have been exposed to traumatic events. They are also ideal for providing evidence-based mental health services, such as trauma-focused cognitive behavioral therapy, to students affected by childhood posttraumatic stress disorder and co-occurring mental health and behavioral problems. Educators and school psychologists are uniquely positioned to educate school staff and families about child trauma and play a crucial role identifying and treating traumatized children in schools. School psychologists can (a) implement trauma informed screening to gain an awareness of child trauma, (b) recognize reminders that trigger trauma symptoms and identify ways to manage these triggers and responses in school settings, (c) facilitate a supportive response for traumatized students and families, and (c) provide trauma-focused cognitive behavioral therapy to children and their nonoffending caregivers in the school setting.

KEYWORDS *child, family, schools, trauma, empirically based treatment*

INTRODUCTION

It is alarming that more than 65% of American children experience at least one traumatic event before adulthood (Copeland, Keeler, Angold, & Costello,

Address correspondence to Monica M. Fitzgerald, University of Colorado-Denver, Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, Anschutz Medical Campus, 13123 East 16th Avenue, B390, Aurora, CO 80045. E-mail: monica.fitzgerald@ucdenver.edu

2007). After traumatic events such as child abuse, family violence, assault, accidents, robbery, or sudden death of a loved one, children may display a wide range of emotional and behavioral problems that can affect social, academic, and physical health. It is unfortunate that children's traumatic experiences and resulting trauma symptoms are unrecognized and untreated. Besides primary healthcare settings, schools are ideal settings for identifying trauma-exposed children and providing mental health services (Costello, Pescosolido, Angold, & Burns, 1998; Farmer, Burns, Phillips, Angold, & Costello, 2003; Jaycox, Morse, Tanielian, & Stein, 2006; Storch & Crisp, 2004). However, routine screening for childhood trauma exposure and trauma symptoms and provision of empirically supported treatments in schools is not common. Challenges of standardizing these procedures include limited resources, time constraints, competing educational demands, concerns about child abuse reporting, and the need to attend to school behavioral crises (Evans & Weist, 2004; Jaycox et al., 2006). School psychologists play a critical role in overcoming such challenges to effectively identify and treat traumatized children in schools. They are uniquely positioned to educate teachers, school counselors, families, and administrators about child trauma and collaborate with these stakeholders to implement screening protocols and facilitate treatment delivery. Further, school psychologists often have primary responsibilities to conduct educational and psychological testing in the schools, but may also provide trauma focused treatment, and supervise other school counselors who provide trauma treatment to school children. Highly effective, short-term trauma-focused treatments, such as trauma-focused cognitive behavioral therapy (Cohen, Mannarino, & Deblinger, 2006; see <http://tfcbt.musc.edu>) are successfully implemented in the schools. Effectively treating children's trauma-related problems alleviates suffering for impacted children and families, and significantly improves child behavior problems and academic performance in affected children (Cohen, Mannarino, & Knudsen, 2004; Stein et al., 2003). This article describes how school psychologists can gain an awareness of child trauma and facilitate a supportive response for traumatized students and families, and provide TF-CBT to children and their nonoffending caregivers in the school setting.

Effect of Trauma on Children

Epidemiological research highlights the large prevalence of victimization and trauma exposure in childhood (Copeland et al., 2007; Finkelhor, Ormrod, Turner, & Hamby, 2005; Kilpatrick, Acierno, Resnick, Saunders, & Best, 2000), and the significant proportion of children who develop posttraumatic stress disorder (PTSD) and experience comorbid difficulties such as depression, anxiety disorders, substance use, and externalizing behavior problems (Copeland et al., 2007). Childhood trauma can result in significant

developmental disruptions, long-term serious mental and physical health problems (Felitti et al., 1998; Pynoos, Steinberg, Schreiber, & Brymer, 2006), and increased involvement in child welfare and juvenile justice systems (Ford, Chapman, Hawke, & Albert, 2007). Experiencing trauma can affect a child's school experience in a number of ways. Trauma and violence exposure in childhood is directly linked to significant deficits in attention, abstract reasoning, and long-term memory for verbal information (Beers & DeBellis, 2002), and changes in student academic performance and behavior, including decreased IQ and reading ability (Beers & DeBellis, 2002; Delaney-Black et al., 2003), lower grade point average (Hurt, Malmud, Brodsky, & Giannetta, 2001), higher absenteeism (Beers & DeBellis, 2002), and decreased rates of graduation from high school (Grogger, 1997). With learning problems, the child may have trouble with (a) concentration, memory, comprehension; (b) paying attention in class, or (c) falling asleep in class. Further, traumatized children may exhibit behavioral, emotional, and physical reactions to trauma reminders experienced in the school setting, as well as trauma reenactment behavior problems that may greatly interfere with their school functioning. These symptoms may look like daydreaming, difficulty paying attention and focusing, distractibility, irritability, and difficulty interacting with classmates. The manner in which children show their distress can vary by age and developmental level.

The prototypical disorder associated with trauma exposure is PTSD, characterized by symptoms of reexperiencing, avoidance, and arousal. School psychologists should be familiar with PTSD symptoms in order to identify children who would benefit from further evaluation. PTSD reexperiencing symptoms include frightening or otherwise distressing memories, including thoughts or dreams of the traumatic event and scary thoughts or dreams that may seem unrelated to the specific event. Children may also exhibit behaviors that suggest traumatic reexperiencing or reenactment. PTSD avoidance symptoms are characterized by children attempting to avoid memories, images, thoughts, discussions, people, places, or things that remind him or her of their traumatic experiences. Avoidance can also be manifested by emotional numbing, social withdrawal, and not wanting to engage in usual activities such as school, sports or being with friends. PTSD hyperarousal symptoms are characterized by children having difficulty sleeping, increased anger, physical symptoms, or increased jumpiness. At school, hyperarousal may take the form of frequent headaches, stomachaches, asking to go to the nurse's office, decreased ability to concentrate or pay attention, or angry outbursts. Youth may have new fears or more difficulty with anger, be more irritable, moody, bored, inattentive, or seem to go from zero to sixty in terms of escalating emotional and behavioral outbursts. With emotional or behavioral deregulation, or maladaptive cognitions, the child may have trouble modulating feelings or behaviors, especially when reminded of the trauma.

Recognizing and Managing Trauma and Trauma Reminders in School Settings

Trauma symptoms can be triggered by the presence of reminders or cues that remind the child of the traumatic event itself, and children may become very angry, upset, or physically ill when faced with trauma reminders. Trauma reminders are any person, place, situation, smell, or internal sensation that reminds the child of something present at the time of the initial trauma. Trauma reminders are idiosyncratic to the individual child and situation. In a school setting, school psychologists may provide support in a variety of ways. They can (a) increase their awareness of the potential for different types of reminders to trigger trauma symptoms; (b) collaborate with educators to identify potential reminders; (c) if feasible, develop a plan to remove reminders from school settings; and (d) if not feasible to remove the reminders, collaborate with the child, parents, and educators to implement strategies that strengthen the child's adaptive coping skills, and thus help the child to function in the presence of trauma reminders. School psychologists should be aware that it may take several weeks for children to develop the ability to cope with painful or frightening reminders. Helping a child master fear when confronted with trauma reminders is discussed further in the subsequent sections describing TF-CBT treatment components.

Schools: Ideal Settings for Treating Traumatized Children

Schools and primary healthcare settings are the main entry portals for children's access of mental health services given that schools have access to all children who need mental health services, and children spend most of their waking hours in school (Costello et al., 1998; Farmer et al., 2003; Jaycox et al., 2006). Schools provide a natural setting for identifying traumatized children who need help and providing evidence based treatments. Traumatized children demonstrate impairment through changes in academic performance, attendance patterns, behavioral problems, and social functioning, and these behaviors are often brought to the attention of school staff, typically for disciplinary action. Schools offer a naturalistic environment to closely monitor children's functioning and treatment response and facilitate easy and frequent observation by school staff (counselors, school psychologists, and teachers) in a variety of situations. In addition, school psychologists have easy access to children's academic information including grades, classroom behavior, and interactions with peers and teachers that is sometimes difficult to access for outside providers who often rely solely on parental report. Schools are typically located in the clients' community, and educators are familiar to and often trusted by families. Providing school-based treatment also eliminates common barriers to parents accessing care for mental health for a child such as transportation problems, lack of insurance, or lack of

childcare for other children. Although parental involvement in treatment is strongly encouraged, school-based treatment eliminates reliance on parents for child participation; children benefit from trauma-focused EBT even without parental involvement.

TF-CBT

TF-CBT (Cohen, Mannarino, & Deblinger, 2006; see <http://tfcbt.musc.edu>) is a structured components-based treatment for children ages three to eighteen years of age with primary trauma symptoms including affective difficulties (PTSD, fear, worry, depression, anger, and mood instability), behavioral difficulties (e.g., avoidance of trauma reminders, reduced or problematic social interactions, trauma-related behavior problems, behavioral dysregulation, or substance use), biological difficulties (e.g., physical manifestations of trauma), cognitive symptoms (maladaptive cognitions about self, others, world such as self-blame, low self-worth, shame), social difficulties (e.g., impaired attachments, affiliating with deviant peers, problematic family interactions), or school difficulties (e.g., trouble concentrating or learning, poor grades, decreased attendance, or school-related trauma reminders). A grief-focused version of TF-CBT is also available for children suffering from traumatic grief which arises after a death experienced as traumatic (<http://www.musc.edu/ctg>).

TF-CBT Research Base

TF-CBT is currently the most rigorously tested, efficacious treatment for children and adolescents impacted by childhood PTSD and co-occurring mental health and behavioral problems and their caregivers and is the most widely disseminated trauma-specific intervention in the field (TF-CBT is effective for children suffering from exposure to a wide array of traumatic experiences, including child abuse, domestic violence, community violence, terrorism, childhood traumatic grief, natural disasters, HIV/AIDS-related traumas, and multiple traumas. To date, 10 randomized controlled trials of TF-CBT have been published (for a summary, see Fitzgerald & Cohen, 2011; Weisz & Kazdin, 2010). In addition to these randomized controlled trials, TF-CBT has been tested in quasiexperimental trials (CATS Consortium 2010; Jaycox et al., 2010; Weiner, Schneider, & Lyons, 2009) and open, noncontrolled trials (e.g., Deblinger, McLeer, & Henry, 1990), two focusing specifically on childhood traumatic grief (Cohen, Mannarino, & Knudsen, 2004; Cohen, Mannarino, & Staron, 2006).

Several TF-CBT trials included youth with an index trauma of sexual abuse and clinically significant PTSD symptoms or sexually inappropriate behaviors. A large multisite investigation of TF-CBT (Cohen, Deblinger, Mannarino, & Steer, 2004) also provided evidence that TF-CBT is efficacious

with multiply traumatized youth. The majority of TF-CBT trials have involved contact sexual abuse and a nonoffending caregiver participating in treatment. A recent community study also documented the effectiveness of TF-CBT in improving children's PTSD and anxiety symptoms when provided by community clinicians in a community domestic violence center. It is important to note that many of these children had ongoing contact with the domestic violence offender and thus were living in ongoing danger (Cohen & Mannarino, 2011). These trials demonstrate that by the end of a relatively short treatment course (8 to 16 sessions), TF-CBT is superior to comparison treatments (e.g., nondirective, supportive therapies and child-centered therapies, waitlist control) in resolving a range of trauma-related mental health outcomes and adaptive functioning, including children's PTSD symptoms and diagnosis, depression, anxiety, externalizing behavior problems, social competence, sexually reactive behavior problems, shame, and trauma-related cognitions (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996, 1998a; Deblinger, Lippmann, & Steer, 1996; Cohen, Mannarino, & Iyengar, 2011). TF-CBT is also effective in improving caregiver distress and parenting skills, which are powerful mediators of positive child outcomes (Cohen & Mannarino, 1998a).

TF-CBT: Model Description

TF-CBT incorporates elements of cognitive-behavioral, attachment, family, humanistic, and psychodynamic principles as well as research findings about the psychophysiology of childhood trauma. TF-CBT is a family-focused approach: Caregivers and children are included equally in this model and several conjoint child–parent sessions are included. However, this treatment can also be delivered as an individual intervention when there is no available caregiver, or as a group intervention. The treatment is typically implemented within 12 to 20 sessions, 60–90 min in length, and it is recommended for sessions to take place weekly. However, this format can be adjusted to optimally fit the school schedule and caregiver involvement. For example, school psychologists often have much shorter time intervals to remove children from their classes for therapy. Thus, it is even more imperative to highly structure the session time, set clear agendas with planned activity/work to accomplish TF-CBT goals in session and reward/fun time to reward children for accomplishing their work and reduce anxiety before returning to the classroom.

The primary goals and themes of TF-CBT are to (a) help the child and parent gain life skills to manage stress and regulate emotional, behavioral, and cognitive states effectively; (b) include nonoffending parents or other caretaking adults in treatment, whenever possible in order to improve parental understanding of the child's trauma experiences and responses and the parent's optimal response to these; (c) achieve mastery over

trauma-related triggers, memories, thoughts, feelings, and traumatic avoidance through the use of gradual exposure throughout the entire course of treatment; (d) help children and families make meaning and contextualize the traumatic experiences through cognitive and affective processing (focusing on the present and future vs. living in the past); and (e) enhance safety and optimize future developmental outcomes. Other important considerations are the centrality of the therapeutic relationship and the importance of culture, which are addressed elsewhere (Cohen et al., 2006). Consistent with these overarching themes, the TF-CBT model has nine core treatment components, described by the acronym, PRACTICE. The PRACTICE components include initial skills-based components (P-R-A-C) followed by more trauma-specific components (T-I-C-E), with Gradual Exposure (GE) integrated into all treatment components. The core components are introduced accordingly in a sequence which progressively builds on skills and concepts presented earlier. See Table 1 for a summary of the TF-CBT PRACTICE components.

TF-CBT components are provided individually to child and parent; each progresses in parallel with conjoint sessions occurring near the end of TF-CBT treatment. TF-CBT clinicians determine the pace of treatment and progress from one component to the next based on the unique needs of each child and family and clinical circumstances. Weekly practice of skills outside of session in real-world settings (school, home) is incorporated throughout TF-CBT. Implementing TF-CBT in school settings allows for teachers and other staff to reinforce healthy coping and practice of skills. Fidelity to the TF-CBT model is ensured through appropriate sequencing of PRACTICE components, proportional use of components (e.g., portion of sessions devoted to PRAC skills, TN and processing, and ICE), incorporation of gradual exposure, and adherence to the treatment time frame. Expert consultation, supervision and fidelity tools, such as the TF-CBT Brief Practice Checklist (Deblinger, Mannarino, Murray, & Epstein, 2008) are used to ensure effective delivery of the model. The TF-CBT model will be described below.

TABLE 1 Trauma-Focused Cognitive Behavioral Therapy Components: PRACTICE

P:	Psychoeducation (information about trauma and trauma reactions)
P:	Parenting skills (behavior management skills)
R:	Relaxation skills (managing physiologic reactions to trauma)
A:	Affective modulation skills (managing affective responses to trauma)
C:	Cognitive coping skills (connections between thoughts, feelings, behaviors)
T:	Trauma narration and cognitive processing (correcting cognitive distortions related to trauma)
I:	In-vivo mastery of trauma reminders (overcoming generalized fear related to trauma)
C:	Conjoint child–caregiver sessions (variety of joint child–caregiver activities)
E:	Enhancing safety and future developmental trajectory (safety planning for future)

TF-CBT Model Components

The PRACTICE components are the core of the TF-CBT model. More detailed descriptions are available elsewhere (Cohen et al., 2006). Parents are included in every component. Although assessment is not part of the formal PRACTICE skills, it is a critical aspect of TF-CBT. Routinely assessing children for exposure to traumatic events, posttraumatic stress symptoms, and other common co-occurring trauma sequelae (e.g., depressive or anxiety symptoms, externalizing behavior symptoms) is essential to guide initial treatment planning and to track children's symptoms and response to treatment. Information about free or low-cost measures assessing trauma exposure and symptom, such as the UCLA Posttraumatic Stress Disorder Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004) and the Child PTSD Symptom Scale (Foa, Johnson, Feeny, & Treadwell, 2001), is provided by the National Child Traumatic Stress Network. This resource also has information about measures assessing other trauma-related symptoms such as depressive symptoms (e.g., Child Depression Inventory [Kovacs, 1992]; Moods and Feelings Questionnaire [Angold et al., 1995]), internal and externalizing problems (e.g., Child Behavior Checklist [Achenbach, 1991]; Behavioral Assessment System for Children [Reynolds & Kamphaus, 2004]; Pediatric Symptom Checklist [Gardner, Lucas, Kolko & Campo, 2007]); and strengths (e.g., Strengths and Difficulties Questionnaire [Goodman, 1997]). Standardized assessment tools are also emerging for use with younger students, including preschoolers, to learn about violence exposure and trauma symptoms in young children (Stover & Berkowitz, 2005).

PPRACTICE

Psychoeducation begins at the initial assessment and continues throughout the treatment process. Families often feel alone, fearful, confused, guilty and unsure of how the trauma will affect their child and family. The clinician normalizes the child's and parent's responses to the traumatic event and clarifies misconceptions about the trauma, with the aim of supportively communicating to the child and caregiver several key themes: (a) that they are not alone in their experience of trauma or the only ones who feel this way; (b) that they are not weird, strange, or crazy to feel this way or think these things, given their experience; and (c) that there is hope and children and families recover with therapy (i.e., TF-CBT works). Clinicians also provide information about common emotional, behavioral, and physiological reactions after abuse and trauma. Specific information about the child's diagnosis is also provided, if appropriate. It is important to note that, from the start, TF-CBT clinicians begin to identify children's trauma reminders ("triggers"), educate children, parents, and teachers about the role of these reminders in eliciting trauma-related emotions, behaviors, physical problems or other difficulties and that TF-CBT will develop positive coping strategies for these.

Gradual exposure is incorporated into psychoeducation by using the names of trauma experiences (e.g., sexual abuse, domestic violence, death) and educating parents and children about trauma triggers and their connection to children's trauma symptoms. Consistent with the approach, the clinician often first provides information about trauma from a more general perspective to introduce relevant topics and then gradually focuses in on the child's reactions to his or her personal experience of the trauma. The clinician chooses creative therapy activities (card games, board games, brochures/handouts) that match the child's interests to provide psychoeducation and to answer common questions about the trauma. The specific kind of information provided to the child and caregiver varies according the type of abuse or traumatic events that were experienced and is matched to the child's developmental level. When children have experienced more than one type of traumatic event, such as sexual abuse and domestic violence, the clinician will gradually provide information about all types of trauma, but introduces only one type of trauma first (sometimes the child chooses), in order to not overwhelm the child/parent and make the content digestible. For children who have experienced multiple or complex traumas, clinicians must understand the underlying theme of the child's trauma experience; this should be a focus of GE rather than only focusing on a series of trauma types.

PPRACTICE: PARENTING COMPONENT

The parenting component of TF-CBT provides caregivers with effective strategies to optimally understand and support their child following trauma. Clinicians help caregivers to recognize and address their children's trauma-related difficulties *as well* as their personal response to the child's trauma experience and its impact on parenting and maintenance of child trauma reactions. The caregiver's ability to address personal traumatic reactions and become a primary source of support and security facilitates the child's positive treatment response. In the parenting component, clinicians teach caregivers safe and effective ways to manage child behavioral problems, such as disruptive, aggressive, or noncompliant behavior or fears, sleep problems, and inappropriate sexual behaviors. Providing parents with parenting skills is important because child abuse and trauma often results in behavior problems, and parents of children who experience trauma and/or abuse often lack effective parenting strategies and/or feel guilty about disciplining their children who have experienced trauma. The parent management skills taught in TF-CBT overlap with those taught in other evidence-based parenting programs (Eyberg, Nelson, & Boggs, 2008; <http://www.triplep.net>). These focus on increasing positive parent-child encounters and teaching reinforcement of positive child behaviors. These skills may include praise, compliment exchange, selective attention and active ignoring, rewards, contingency management plans, giving effective instructions, and use of logical

and appropriate consequences for misbehavior (e.g., time-out, withdrawal of privileges). Clinicians actively teach, coach, and reinforce parent's use of parenting skills. GE is incorporated into the parenting component by helping parents understand the connection between the child's behavior problems and the child's traumatic experiences.

The skills taught in the parenting component also largely apply to the educators who serve as supportive adults in the school environment (e.g., teachers, teacher's assistant, counselors or other educational aids that have regular contact with the child). School staff have many roles and demands placed upon them as well, such as meeting educational learning standards, managing the classroom environment and attending to different learning abilities, and facilitating social/community functioning which sometimes makes it difficult to provide a higher level of assistance or support to an individual child who is having difficulties. A complicated behavioral plan in the school will not be feasible to implement in TF-CBT or another other EBT, and therefore, psychologists work closely with teachers to target limited top priority behaviors (viewed as important to the teacher and psychologist) and implement a behavioral modification plan or positive coping reinforcement plan in a manner that is simple and truly feasible to implement in a busy classroom.

A psychologist's willingness to observe and coach new skills live in the classroom, will communicate their commitment to understanding the competing demands of the teacher and providing real assistance and plan refinement on the spot, versus two weeks later at an Individualized Education Program meeting. Thus, the psychologist is viewed as a support to the teacher rather than as a burden. Providing simple knowledge about child trauma, its effect, and the symptoms the particular child is struggling with is the role of the psychologists and incorporation of the teacher's input in case conceptualization and treatment planning. The psychologist asks the teacher for their preferred times for the child to leave the class for sessions to minimize class disruption and interruption in important learning activities. Learning about teachers' concerns/fears about trauma therapy is also important given that many teachers share concerns that children discussing trauma during their school day will lead to additional difficulties that the teacher will be left to manage. Thus, explaining the treatment process, enlisting the teacher's buy-in, providing brief weekly check-ins/updates, and determining a priori the ways to best integrate the child into school activity after TF-CBT sessions are helpful TF-CBT implementation strategies in school settings.

Ongoing supportive presence for teachers is optimal to implement TF-CBT effectively, versus only having teacher contact when something is needed or required of the teacher to implement. A parallel process of positive, open communication and collaboration is beneficial between psychologists and teachers, and similar to adult caregivers, teachers respond well to clear acknowledgement and praise of their efforts and acknowledgement of the struggles they face. The teacher is thus identified as playing a key

supportive role on the team (child, caregiver, teacher, psychologist, other relevant adult).

PPRACTICE: RELAXATION COMPONENT

Relaxation skills provide children and parents individualized skills to manage physiological arousal and symptoms of fear and anxiety (e.g., increased heart rate, rapid, shallow breathing, muscle tension). Teaching the body to physiologically relax reduces the child's perceptions of fear and anxiety and encourages a sense of empowerment and mastery over symptoms. These skills can also be helpful to distract children/caregivers from upsetting and traumatic thoughts and refocus on pleasurable activities and self-soothing.

Clinicians typically begin with identifying skills the child already uses for coping with stress, releasing tension, self-soothing, and relaxing their body. Clinicians aim to build upon the healthy, positive coping skills in the child's repertoire and reduce and replace any maladaptive, harmful coping behaviors (e.g., aggression, running away, substance use). Clinicians explain the difference between normal fear and anxiety responses and traumatic stress reactions. Clinicians provide specific methods of stress management skills such as controlled diaphragmatic breathing, progressive muscle relaxation, quick tension and relaxation (e.g., Raggedy Ann/Tin Soldier), and pleasant imagery. Relaxation strategies also include listening to calming music, creating calming words/mantras, relaxation songs, prayer, yoga, physical exercise, dance, meditation, visualization, and arts. The methods of teaching and practicing these skills in session are tailored to the developmental level and interests of the child (use of props, stuffed animals, figurines, puppets, bubbles, books, CDs/iPod). Children often teach their caregivers the skill so that their caregivers can help them practice using relaxation strategies outside of session (first within nonstressful situations, and then in response to trauma triggers). Caregivers become more attuned to their child's stress states and help the child differentiate when they are truly in danger versus when they are having a trauma trigger (and feeling unsafe and experiencing physical symptoms of stress), and provide prompts to use relaxation skills.

PPRACTICE: AFFECTIVE MODULATION COMPONENT

Affective modulation helps children learn the skills necessary to accurately identify, express, and regulate positive and negative emotions and to help children and caregivers understand healthy versus unhealthy or maladaptive forms of emotional expression. First, the clinician helps the child and caregiver understand and learn the basic skills of emotional regulation, and then these skills are applied to emotions associated with the abuse and trauma. Individual affective modulation strategies are developed according to the needs, developmental level and interests of each child and often include seeking social support, self-soothing, positive self-talk, distraction and

thought stopping, positive imagery, problem solving, and interrupting inappropriate behavior (e.g., hitting) as a way of expressing negative emotion (fear, irritability, frustration). Caregivers are also taught how to model these skills (labeling feelings and effective coping) and reinforce the child's use of healthy affective regulation skills. GE is implemented in this component by helping children identify and practice strategies for coping with negative affective states associated with trauma reminders.

PPRACTICE: COGNITIVE COPING

Cognitive coping helps children and caregivers understand the connections among thoughts, feelings, and behaviors and provide techniques for identifying and changing inaccurate, distorted, or unhelpful thoughts that are causing negative feelings and behaviors. Clinicians teach the interrelationship among thoughts, feelings, behaviors, and include healthy cognitive coping by using examples from daily life (not related to trauma) such as school, bus, sports, work scenarios in which thoughts may not be accurate or helpful. Clinicians help children and caregivers recognize that how you think about events influences how you feel and behave. Techniques include using the cognitive triangle, cartoons, thinking bubbles, scenarios, and books illustrating examples of thinking styles, cued videos, acting out scenarios with puppets and dolls that generate discussion about the feelings in different scenarios (Cohen et al., 2006). All techniques are adapted to the age and developmental skills of the child.

Children and parents learn to examine their own patterns of negative thinking (“Am I falling into a thinking trap?” “Is my thought accurate?” “Is it helpful, does it make me feel better?”), and to change dysfunctional thoughts about everyday events, which often extends to thinking about the traumatic events that the child experienced. When children spontaneously discuss trauma-related thoughts and accompanying distress (e.g., “I shouldn’t have told, now we are all apart,” “I didn’t fight back”), clinicians ask clarifying questions, review psychoeducation, ask children what others have told them or discussed already about the topic, and help children identify affective regulation and coping skills to reduce distress related to these thoughts. However, clinicians do not focus on challenging these thoughts through formal cognitive restructuring with children until after the trauma narrative is created when cognitive and emotional processing occurs. In the parallel parent component of cognitive coping, caregivers benefit from gaining personalized coping skills and are introduced to more formalized cognitive restructuring to address their patterns of distorted or unhelpful thoughts related to their child’s trauma, often focused on themes of safety, responsibility, blame, shame, self-worth, and stigma (e.g., “This has ruined our lives . . . it will never be the same! My child’s innocence is lost! No one is to be trusted!”). Thus, GE is implemented in this component by helping caregivers

to identify their distorted and unhelpful cognitions and practice cognitive restructuring strategies for coping with negative affective states associated with their children's trauma exposure and/or their own trauma reminders.

PPRACTICE: TRAUMA NARRATIVE AND COGNITIVE PROCESSING

The trauma narrative (TN) is created by helping the child develop a narrative (often, but not always in the form of a written book) about his or her traumatic experiences. The goal of the TN is to encourage children to directly describe their personal trauma experiences and organize their narratives in some preserved format that the psychologist and child can review during subsequent sessions to process maladaptive cognitions (in future components) and share the narrative with the caregiver. Over several sessions, the clinician helps the child to describe the details of what happened before, during and after the traumatic experiences, and helps the child include increasing details, thoughts, feelings, and physiological reactions in the narrative. Developing the TN involves gradual exposure, which allows the child to experience the negative feelings (fear, panic, shame, sadness, disgust) and physiological reactions associated with the trauma in small doses in a safe, controlled environment. The goal is for the clinician is to help the child describe traumatic memories and the difficult feelings associated with the trauma until these are no longer so frightening or painful that the child must avoid them. Through this process the TN provides an opportunity for "making the unspeakable speakable," which provides mastery of these feared memories and diminishes the power and control of these memories. The TN offers an opportunity for children to discuss the meaning the trauma has in the past, present, and future and to contextualize it into their life. Thus, another goal of the trauma narration and processing component is for children to gain a better understanding of the effect that their trauma experiences on their lives, and through this process, to alter this effect in the present and future.

School psychologists and other school counselors implementing TF-CBT may use a variety of therapeutic devices and structured activities to complete the TN, depending on the age, developmental abilities, and interests of the child. These may include writing a book, drawing a set of pictures, or using other creative arts (writing poems or songs, acting it out, making a PowerPoint presentation) to describe the traumatic events and the child's reactions. Narratives are often organized according to the temporal sequence of the child's life, but rarely include all of the child's adverse experiences. Chapters often focus on the strengths/personality of the child; what life was like before the traumas started (or for youth who have experienced early chronic traumas, describing some remembered early good times); describing the youth's relationship with the person/people who perpetrated the traumas including positive aspects of the relationship if any; the first or different types

of traumatic events experienced; the worst time or hot spots (i.e., trauma reminders or triggers); and a final chapter addressing how the child has changed, what has been learned/accomplished, advice for other children who have experienced trauma, and their hopeful future. As such, the TN is not only about traumatic events, but also designed to help the child put the traumatic events in the larger context of their life.

The back and forth, supportive interchange, and discussion between the child and clinician about the child's traumatic experiences and current thoughts/feelings related to the trauma is an essential part of the TN in helping the child process and organize the experience and tolerate negative feelings associated with the trauma. If GE has been properly integrated into earlier components, developing the narrative should not be a sudden leap in exposure, but only a gradual, incremental increase from previous sessions. It is sometimes helpful to use analogies when reviewing the rationale for TN, such as describing how cleaning out a wound or removing a splinter (it really stings at first, but is essential for reducing distress, preventing infection, and allowing healing to occur, to get on with their fun life activities). Some children may be interested in reading a children's book about the type of trauma they experienced and how other kids feel about it and recover. The clinician offers praise for any progress (small and big) mastering avoidance, confronting scary memories, and paces the exposure process accordingly. Fun rewards are built in for being brave, such as playing games or special time on the computer after the TN work is accomplished in session.

In a school setting, it is typical for more concerns to be raised about doing focused exposure work with children who have to return to the classroom and perform in the learning environment. It is particularly important to schedule TN sessions with some flexibility to have a buffer and set a child up for success in transitioning into the classroom and avoiding an intense learning activity with high attentional demands (e.g., math quiz, chemistry lab). It is possible children's minds are still focused on the narrative and they need a time buffer immediately after their trauma processing session. Further, it is imperative to build in enough time for relaxation procedures to be implemented to reduce anxiety to a minimal level before the child returns to class. Clinicians explicitly let children and their caregivers know that they may anticipate increased memories of trauma or thoughts given that they have activated memory and shared details. It is important to normalize that this may be part of their experience, but all children are different. Developing a plan to cope with any increased distress in between TN sessions is of utmost importance. It is fortunate that, within the school environment, psychologists/clinicians have the opportunity to check in with the child and teacher later in the day to assess functioning/regulation and any concerns and difficulties with reintegration.

Another component of GE involves rereading their trauma narratives in subsequent sessions and including more details about what happened, as

well as how they were feeling, what they were thinking, and their body sensations at the time the traumatic experiences occurred. This allows clinicians to identify dysfunctional cognitions that children would not necessarily share during direct questioning. Cognitive processing of the narrative includes addressing these inaccurate and unhelpful cognitions and replacing them with more optimal thoughts, which can be added to the narrative. In a case example of the 7-year-old girl who was sexually abused by her male babysitter, the school psychologist used information gained in the TN to identify unhelpful thought patterns related to themes of anger and self-blame that continued to distress the young girl ("I didn't say no or stop. I am mad at him for tricking me. I am mad at myself"). To address these types of thoughts, the clinician uses a variety of cognitive restructuring strategies (Socratic Questioning, Responsibility Pie, Best Friend Role Play, or thought experiments) to process and challenge these beliefs to gain a more balanced, healthy perspective.

As the child develops the TN in individual child sessions, the clinician typically shares it with the caregivers (with the child's permission) during parallel caregiver sessions. The goals include helping the parents gain understanding and empathy of their child's experience, become desensitized themselves to the details, thoughts and feelings and to prepare to support the child during the Conjoint Parent-Child Sessions when the child shares the narrative with the parent.

PPRACTICE: IN VIVO MASTERY

Children and adolescents who have experienced traumatic events may consequently develop generalized fears that interfere with their ability to function. Children may avoid people, places, or objects that, in and of themselves are inherently innocuous but now serve as trauma reminders (cues/triggers) of the traumatic event. Trauma triggers may include smells, sights, and sounds (e.g., cologne, clothing, hair of perpetrator). In the child's mind these cues are dangerous given they are associated with the traumatic event. For example, children who have been sexually abused at night often develop fears of the dark, of their room, and/or of sleeping alone, and will become highly distressed if they encounter these situations. Another example of generalized avoidance of trauma reminders is an adolescent's school refusal resulting from being assaulted in the school gym.

In vivo ("living") mastery is a form of GE that involves gradually facing trauma cues and reminders in person in real settings in which the fear stimulus initially occurred to overcome avoidance and to regain optimal functioning. This is different from imaginal exposure where the child remembers, thinks about, and talks about a feared object or activity, but it is not really there. Before implementing in vivo interventions, it is first necessary to confirm that the feared stimulus (e.g., darkness, sleeping in room alone) is truly innocuous and safe (i.e., has the perpetrator been removed from the home,

the school is safe and has precautions in place). Typically, the clinician develops an in vivo exposure plan with the child and caregiver by first gaining as much information about the feared situation/object as possible, collaboratively setting up a hierarchy (listing least feared to most feared according to the child) and assisting with pacing the exposure (e.g., set up a way for the child to let you and supportive adult/caregiver know their level of distress throughout the process), and building in praise, encouragement, and other rewards for successes. Once the exposure plan is developed, the child is gradually and repeatedly placed in closer and closer contact with a feared object/situation in real life until the child can tolerate gradually increasing duration and intensity of exposure. The child uses the PRAC skills learned earlier in treatment to process and tolerate fear. The clinician collaborates closely with others needed to support the in vivo exposure plan (e.g., teachers, school, caregiver) to ensure that they provide praise/rewards when the child is successful with each step of the plan, that they reinforce coping, and do not inadvertently promote avoidance. When successfully implemented, in vivo procedures help children reduce their fears by mastering trauma reminders so that they are able to function optimally across various settings and meet developmental milestones. Sometimes in vivo exposure is implemented earlier in treatment when avoidance of trauma triggers seriously impairs children's functioning.

PPRACTICE: CONJOINT CHILD–PARENT SESSIONS

Conjoint child–parent sessions involve meeting together with child and caregiver for the therapeutic activities. When children have completed trauma narratives and processing, and are ready to share their narratives with caregivers, the psychologist uses clinical judgment to evaluate the child's and the caregiver's readiness to participate in conjoint sessions. At this point in treatment, caregivers ideally have participated in parallel parent sessions focused on preparing them to encourage, hear, and praise their children for talking openly about their traumatic experiences. GE involves the child sharing the trauma narrative directly with the parent, the clinician referring directly to the types of trauma the child experienced when preparing the child, and directive psychoeducation about trauma and other safety topics (developing a plan for safety and/or coping with reminders in the future). When caregivers and their children come together to share the narrative, the clinician serves as a coach and provides any redirection, prompts, or scaffolding, if needed.

Within school settings, it is often challenging to get consistent participation from caregivers, and a TF-CBT clinician works hard to overcome logistical and perceptual barriers so that caregivers can receive ample preparation for the trauma narrative sharing. When in-person sessions are difficult to achieve, clinicians capitalize on using the phone to help prepare for conjoint

sharing and periodic in-home visits. Sometimes a clinician prepares the child and parent to share a specific part of the narrative, if clinically indicated.

PPRACTICE: ENHANCING SAFETY AND DEVELOPMENT

Enhancing safety and development focuses on providing safety skills to help the child and family to maintain safety in the present and future and optimize the child's normal development, and regain a sense of security. GE is implemented in this component through talking about prevention of future traumatic events and the content covered varies depending on the child's trauma exposure history and current safety needs. Safety planning is addressed earlier in TF-CBT if there are acute safety concerns. For example, a sexually abused child who exhibits high levels of sexualized behaviors at intake will benefit immediately from psychoeducation about healthy sexuality, individualized safety skill training (learning the sexual behavior rules), provided in collaboration with the parent, reduction of sexually stimulating activities, and safety monitoring to reduce these inappropriate behaviors. If these behaviors were occurring at school, school personnel would need to have an immediate response plan to support the child and reduce risk for others. Parents and clinicians carefully consider the child's developmental level and the child's current living situation in practicing body safety skills and/or developing a safety plan. For example, many children are still living with ongoing threats to their safety and it is critical that safety planning take into consideration how children, parents, and others in the community can contribute to the child's optimal sense and reality of safety. The clinician is careful not to communicate that the child could or should have done something differently in the past that might have prevented their previous victimization. GE is implemented in this component through talking about and practicing safety skills, and developing plans for coping with trauma reminders, and preventing future traumatic events. Clinicians use varied materials (brochures, books, videos) and techniques (behavioral rehearsal/role-play, no-go-tell for young children) to teach knowledge and skills related to relevant topics (e.g., bullying, assertiveness).

Completing Treatment

TF-CBT is considered complete when all components have been provided and when the information gained through assessment (self-report measures, child/caregiver report, and observation) indicates adequate reduction of trauma-related symptoms and optimal adaptive functioning. In general, this occurs within 8 to 20 sessions. However, children who have experienced multiple traumas may have other problems and family stresses, such as impending divorce, illness, and ongoing legal involvement that require additional interventions or ongoing providing of TF-CBT components to

consolidate these skills. Assessment may also elucidate additional treatment goals that go beyond the scope of the TF-CBT model and require a different, evidence-based intervention. When children and their families do end treatment, their accomplishments and successes are celebrated, often with a graduation ceremony or party planned by the child.

Overcoming Barriers to Implementing TF-CBT in Schools

A common challenge to implementing TF-CBT in school settings involves the disruption of services and scheduling problems that clinicians encounter. Students are sometimes absent because of illness or are truant from school, and some students are abruptly withdrawn or transferred to another school in the middle of therapy. Gaps in treatment often occur because of holidays, testing periods, unanticipated drills, or other school events that conflict with scheduled session times. Further, the long summer break may prevent a child from receiving treatment, and school clinicians often struggle to transfer treatment to another provider who will continue this specific type of trauma focused treatment to help the youth continue progressing. In addition, it is often challenging to gain regular access to and participation by family members when services are provided to children in the schools. Psychologists do their best to engage caregivers and overcome obstacles to them participating, even if minimally, and they exercise any flexibility they are afforded by their school, such as making a periodic home visit and gaining permission from teachers to reschedule sessions, if they are disrupted by an unanticipated school event. The school team approach to serving the youth facilitates coordination and collaboration on all fronts, including the senior leadership placing value on care for mental health and building a trauma informed staff and granting permission for staff to make alterations in school routine when indicated to facilitate mental health treatment.

SUMMARY

School psychologists and educators play a critical role in identifying, referring, supporting, and treating children affected by traumatic events and their families in the school setting. TF-CBT is currently best supported mental health treatment currently available for treating trauma-exposed youth and their nonoffending caregivers and it can be successfully implemented in school settings. TF-CBT is also effective for students who experience the traumatic death of a parent, sibling, or other loved one and develop a condition known as childhood traumatic grief (Cohen & Mannarino, 2011; Cohen et al., 2006). There are many advantages to integrating trauma screening and TF-CBT into the school setting (e.g., access and retention in treatment, support by school staff, tracking of behavior and progress) as well as challenges (e.g., limited time, resources, and caregiver involvement, school crises) that

will require creativity and team work to overcome. School psychologists can help children and their families recover from traumatic experiences by educating school staff about child trauma, implementing screening protocols to recognize and refer children with trauma symptoms, and implementing effective treatment while maintaining child and family confidentiality. School psychologists are critical in facilitating a team approach at the school and ensuring that communication with parents, teachers, and professionals is open and collaborative throughout the treatment process.

Psychologists who are interested in learning more about integrating TF-CBT in the schools will benefit from the free, web-based training resources available through the National Child Traumatic Stress Network and the Medical University of South Carolina, as well as treatment manual (Cohen et al., 2006), and school toolkits (e.g., Jaycox et al., 2006). Further, Cohen and Mannarino (2011) described various ways that educators can provide collaborative support to children suffering from childhood traumatic grief in classroom settings. In sum, educators and psychologists have an important and unique opportunity to integrate trauma informed assessment and treatment services into their schools, and these professionals play an invaluable role in supporting traumatized children's health, well-being, and recovery.

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