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Introduction

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Many individuals experience significant stressors during childhood. These experiences vary considerably in their quality, frequency, intensity, and impact. Some of these stressors are quite common (e.g., peer conflicts, the death of elderly family members), and children usually manage such stressors adequately with no professional intervention. Childhood traumatic events, though less ubiquitous, are also common and are more likely to be psychologically overwhelming because they potentially threaten a child's sense of safety and security and lead to subjective feelings of terror, fear, shame, anger, helplessness, and/or worthlessness. Potentially traumatic childhood events include child sexual or physical abuse, exposure to domestic or community violence, the traumatic loss of a family member whether through death or other means, natural and man-made disasters, war or refugee-related experiences, severe car accidents, fires, and/or medical traumas (Cohen, Mannarino, & Deblinger, 2006).

Many children—perhaps those with stress-resistant temperaments or genetic makeups, naturally effective coping styles, and/or strong support systems—are resilient even to these very traumatic childhood events. However, research has documented that a significant proportion of those who experience childhood trauma develop maladaptive emotional and behavioral reactions that disrupt their psychosocial development and adjustment. Studies examining the significant negative effects of childhood trauma date back

many decades. Researchers from the National Institute of Mental Health conducted perhaps the first large-scale study of the impact of trauma on children with their examination of schoolchildren's psychosocial reactions to a tornado striking the movie theater where they were gathered for a matinee (Bloch, Silber, & Perry, 1956). Another seminal investigation of children's reactions to trauma was conducted in the 1970s following a school bus kidnapping in Chowchilla, California. Terr (1985) prospectively examined the unfolding traumatic responses of the kidnapped children compared with a group of nontraumatized children matched on age and sex. Children's posttrauma reactions have continued to be examined by researchers since these early investigations, with studies repeatedly demonstrating strong associations between childhood trauma and an increased risk of developing posttraumatic stress symptoms, depression, conduct problems, psychotic symptoms, substance abuse problems, as well as other emotional and behavioral difficulties (Arseneault et al., 2011; Briere & Elliott, 2003; Kendall-Tackett, Williams, & Finkelhor, 1993; Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Maercker, Michael, Fehm, Becker, & Margraf, 2004; McKay, Lynn, & Bannon, 2005; Putnam, 2003).

In addition, recent research suggests that children who have experienced one traumatic event are highly likely to have experienced traumas of a different nature (Turner, Finkelhor, & Ormrod, 2010). Moreover, the accumulation of traumatic experiences in childhood has been well established to be associated with increasingly severe adverse effects by both retrospective and prospective empirical investigations (Felitti et al., 1998; Finkelhor, Ormrod, & Turner, 2009).

Clinical descriptions of interventions designed to address the effects of childhood trauma date back many decades as well. However, empirical research examining the efficacy of these treatment methods is a more recent development. When we began our efforts to design and evaluate interventions for this population of children, there were no published scientific studies evaluating the efficacy of interventions designed to specifically address childhood posttraumatic stress disorder (PTSD). In essence, trauma-focused cognitive-behavioral therapy (TF-CBT) for children and adolescents was developed and evaluated in response to this clear gap in the scientific literature.

Beginning in the mid-1980s, at separate clinical research sites in Pittsburgh (Judith A. Cohen and Anthony P. Mannarino) and New Jersey (Esther Deblinger), we began conducting independent research studies to identify the specific problems exhibited by children who had experienced trauma, with an initial focus on sexual abuse (Cohen & Mannarino, 1988; Deblinger, McLeer, Atkins, Ralph, & Foa, 1989; Mannarino & Cohen, 1986; Mannarino, Cohen, & Gregor, 1989; Mannarino, Cohen, Smith, & Moore-Motily, 1991; McLeer, Deblinger, Atkins, Foa, & Ralph, 1988) in order to inform

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the development of evidence-based interventions for this population. We initially implemented and examined the clinical benefits of preliminary treatment protocols (Cohen & Mannarino, 1993; Deblinger, McLeer, & Henry, 1990) and conducted several independent randomized controlled trials of trauma-focused individual (Cohen & Mannarino, 1996, 1998; Deblinger, Lippmann, & Steer, 1996) as well as group therapy (Deblinger, Stauffer, & Steer, 2001) models.

TF-CBT, as described in *Treating Trauma and Traumatic Grief in Children and Adolescents* (Cohen, Mannarino, & Deblinger, 2006), TF-CBTWeb, and this book, reflects the integration of our earlier treatment models (Cohen & Mannarino, 1993; Deblinger & Heflin, 1996) as well as our ongoing collaborative efforts. Our initial large-scale multisite collaboration examined the efficacy of TF-CBT in comparison to child-centered therapy (Cohen, Deblinger, Mannarino, & Steer, 2004). The results demonstrated that, compared with children and caregivers assigned to child-centered therapy, those assigned to TF-CBT exhibited significantly greater improvements with respect to PTSD, depression, behavior problems, feelings of shame, and dysfunctional abuse-related attributions, while their parents reported significantly greater improvements in abuse-specific distress, depression, parenting skills, and parental support. Additionally, these findings were generally maintained over a 1-year follow-up period (Deblinger, Mannarino, Cohen, & Steer, 2006). The findings of our most recent multisite dismantling study documented the overall efficacy of TF-CBT for young children in both 8- and 16-session formats (ages 4–11), while highlighting the benefits of the eight-session trauma narrative condition in most efficiently and efficaciously helping children overcome abuse-related fear and generalized anxiety (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). The results also suggested that the skill-building components and the parenting component, in particular, were perhaps most critical in addressing externalizing behavior problems (Deblinger et al., 2011), replicating earlier findings (Deblinger et al., 1996). The efficacy of TF-CBT for children exposed to intimate partner violence (IPV) also has been recently evaluated in a randomized trial conducted in a community setting. The results of this investigation demonstrated that, compared with children assigned to client-centered therapy (usual care), those assigned to eight sessions of TF-CBT exhibited significantly greater reductions in IPV-related PTSD and anxiety (Cohen, Mannarino, & Iyengar, 2011). Recent studies have further documented the benefits of TF-CBT for children who have suffered traumatic grief (Cohen, Mannarino, & Staron, 2006), children traumatized by the events associated with 9/11(CATS Consortium, 2010) as well as Hurricane Katrina (Jaycox et al., 2010), and child populations with high trauma exposure rates, including children in foster care (Dorsey, Cox, Conover, & Berliner, 2011; Lyons, Weiner, & Scheider, 2006) and children exposed to

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violence and traumatic loss in low-resource countries (Dorsey, Murray, Balusubramanian, & Skavenski, 2011; Murray et al., 2011). While there are many approaches to treating childhood trauma, recent reviews of the empirical literature suggest that TF-CBT has the most extensive empirical support for its efficacy in treating children suffering from PTSD and related emotional and behavioral difficulties (Bisson et al., 2007; Saunders, Berliner, & Hanson, 2004; Silverman et al., 2008). Thus far, there have been 22 scientific investigations examining the efficacy of TF-CBT, including 12 randomized controlled trials. In addition, TF-CBT has received very positive ratings for efficacy, feasibility, and readiness for dissemination based on extensive treatment outcome reviews sponsored by the Department of Justice (Saunders et al., 2004), the California Evidence-Based Clearinghouse for Child Welfare (*www.cebc4cw.org*), and the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (*www.nrepp.samhsa.gov*).

Given the strong evidence supporting its efficacy, it is not surprising that there has been increasing demand for training in this model over the last decade. To date, there have been more than 18 statewide TF-CBT learning collaboratives designed to disseminate training to administrative, supervisory, and direct service providers in mental health agencies across the United States (Sigel & Benton, 2011). We have also created a TF-CBT "Train-the-Trainer" Program to increase the availability of face-to-face clinical trainings. Most notably, we have collaborated with colleagues from the Medical University of South Carolina to create free-of-charge introductory web-based training in TF-CBT (*www.musc.edu/tfcbt*; *www.musc.edu/ctg*) as well as a web-based TF-CBT consult site (*www.musc.edu/tfcbtconsult*) that may be utilized by TF-CBT therapists on an ongoing basis. To date, more than 100,000 therapists from across the United States and around the world have registered for training on the TF-CBT website. These web-based formats also provide data from the field that will continue to inform our efforts to enhance and expand the use of TF-CBT with appropriate populations.

The current book reflects efforts to apply what has been learned in the last two decades from TF-CBT-related research, clinical work, as well as training and dissemination efforts. While cognitive-behavioral principles provided the foundation on which TF-CBT was originally developed, other theories have also informed our efforts to enhance the efficacy of TF-CBT for children who have experienced a wide array of traumas. These theories include humanistic, attachment, family systems, and empowerment models (Cohen, Mannarino, & Deblinger, 2006).

As noted earlier, traumatic experiences have the potential to disrupt the psychosocial development of a child and undermine the well-being of an entire family. Thus, the overarching objective of TF-CBT is to circumvent

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this process by providing youngsters and their family members with understanding, knowledge, and skills to help them to confront and make meaning of traumatic experiences. At the same time, children and their caregivers learn to optimally manage trauma reminders as well as other stressors and conflicts in the present as they reclaim a sense of enthusiasm and optimism for the future. When children and caregivers successfully complete TF-CBT, they often not only achieve the just-described goals but grow stronger and more resilient as individuals and closer and more cohesive as families.

THERAPEUTIC ENGAGEMENT

Implementing treatment in the aftermath of trauma requires thoughtful consideration of the overall needs of the child and family as well as attention to potential barriers to treatment that may make therapeutic engagement challenging. In the aftermath of many traumas, other pressing issues may take precedence over engaging families in therapy. In the case of child maltreatment, these include child protection and law enforcement investigations, medical examinations, and attention to other safety concerns. Similarly, in the aftermath of widespread disasters, the need for shelter, food, safety, and medical attention usually takes priority over the need for psychological treatment. Recognizing these priorities and providing prompt referrals to needed resources is an important strategy for engaging families in subsequent therapy. After these acute issues have been addressed, the therapist can optimize engagement by discussing potential barriers to treatment such as lack of transportation, scheduling conflicts, or other competing priorities. McKay and others (2004) have demonstrated that both initiation of treatment and session attendance can be improved by utilizing empirically validated engagement strategies such as (1) establishing the need for mental health care, (2) enhancing the caregiver's motivation for treatment, (3) reviewing prior therapy experiences, (4) establishing a collaborative working relationship, and (5) providing assistance in overcoming concrete barriers (e.g., transportation, scheduling). These strategies are highly applicable to engaging families in TF-CBT and have been successfully utilized in prior TF-CBT investigations (i.e., Cohen et al., 2004; Deblinger et al., 1996, 2001; Dorsey & Feldman, 2008). At the outset of treatment, for example, TF-CBT therapists review the assessment findings and acknowledge the impact of the trauma(s) not only on the children but on the parents as well. This process not only establishes the need for trauma-focused therapy, but also normalizes and validates trauma-related feelings and reactions. It is also not uncommon for caregivers and youngsters to report negative prior experiences with mental health therapy and/or social services. Thus, differences between what has been experienced in the past and what can be anticipated

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in the structure and course of participating in TF-CBT is emphasized. With these expectations carefully outlined, a commitment to participation in an approximate number of sessions is elicited. To further motivate therapy participation and optimism, the scientific research supporting the effectiveness of this treatment approach is highlighted with a focus on the specific benefits of active caregiver participation and collaboration. TF-CBT begins with a focus on the trauma(s) that precipitated the initiation of treatment as well as the clients' related presenting concerns.

CORE VALUES OF TF-CBT

The acronym CRAFTS summarizes the core values of the TF-CBT model. These values apply to all cases regardless of the specific population, community, or setting. This reflects the universality of the human condition in terms of the essential therapy ingredients that contribute to the overall healing of children and their families. The values outlined next highlight that the TF-CBT model is components based; respectful of community, cultural, and religious traditions; adaptable to individualized needs and circumstances; family focused; based on a strong therapeutic relationship; and strongly encouraging of self-efficacy. More specifically, the model is:

Components-based, such that it incorporates knowledge, skills, and processes that build on one another and are integrated in a way that best suits the needs of the particular client and family.

Respectful of individual, family, community, culture, and religious practices, in terms of understanding the impact of the traumatic experience(s) and optimally supporting the child's and family's healing in the context of their family, culture, and community.

Adaptable, as highlighted in this volume by the numerous examples of the importance of the flexible and creative ways that therapists optimally motivate clients and implement the treatment components for diverse populations and settings while maintaining fidelity to the model.

Family focused, in that every effort is made to include supportive family members. Thus, therapists are strongly encouraged to make active efforts to engage parents and/or other caregivers in the treatment process whenever possible. It should be noted that siblings and/or other family members (e.g., a grandparent or a special aunt) are also involved when feasible and clinically appropriate.

Therapeutic relationship centered, such that much attention should be given to creating a therapeutic relationship that allows parents and children to feel safe, accepted, and validated. Such relationships help clients to feel trusting and confident to share their trau-

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matic experiences as well as their most distressing fears, thoughts, and developing beliefs, while also taking the risks necessary to learn and utilize new skills that will produce significant positive change in their lives.

Self-efficacy focused, in that TF-CBT is a short-term, strengths-based model designed to have long-term benefits. In the context of TF-CBT, therapists encourage self-efficacy and feelings of mastery by actively collaborating with clients in planning therapy, motivating clients to follow through on assignments between sessions, acknowledging therapy successes, encouraging and recognizing the ongoing use of TF-CBT skills, and enhancing clients' feelings of preparedness for trauma reminders and other life stressors that they may encounter long after therapy has ended.

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ASSESSMENT STRATEGIES

Prior to initiating TF-CBT, it is critical to assess the impact of the traumatic exposures on various domains of functioning. CRAFTS is also used to summarize the potential areas of maladjustment targeted by TF-CBT. These include:

Cognitive problems, such as dysfunctional thought patterns, school learning problems, or concentration difficulties.

Relationship problems, such as increased conflicts at home, in school, or at work and impaired trust or expectations of betrayal in interpersonal interactions.

Affective problems, such as difficulties effectively expressing and/or managing feelings of anxiety, depression, and/or anger.

Family problems, including parenting difficulties, parent–child conflicts, extended family disruptions that may more frequently occur in the context of intrafamilial abuse disclosures, and frequent out-of-home placements (e.g., foster, residential treatment) that arise from early severe interpersonal violence or abuse.

Traumatic behavior problems, including behavioral avoidance of innocuous trauma reminders, sexual behavior problems, aggressive behaviors, and/or noncompliant behaviors.

Somatic problems, including sleeping difficulties, hyperarousal symptoms, headaches, stomachaches, and other physiological reactions to traumatic memories, reminders, and cues.

Assessment of these domains for treatment planning purposes can be accomplished via structured interviews, observations, and standardized measures administered to the children as well as the parents. The use of

standardized measures undoubtedly enhances the effective implementation of TF-CBT because they provide objective information that forms the basis for the individual tailoring of the treatment plan for the specific needs of the child and his or her family while also allowing for the assessment of treatment progress.

Given the focus of TF-CBT, the assessment of PTSD and related symptoms is particularly pertinent. A variety of well-validated and reliable PTSD measures are designed for this purpose, including semistructured PTSD interviews such as the Schedule for Affective Disorders and Schizophrenia for School-Age Children—Present and Lifetime Version (Kaufman, Birmaher, & Brent, 1996) and/or child and parent PTSD measures such as the UCLA PTSD Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004). Additional measures that may be used to assess other areas of functioning include (1) the Children's Depression Inventory (Kovacs, 1985) to evaluate depression, (2) the Child Behavior Checklist (Achenbach, 1991) or the Strengths and Difficulties Questionnaire (Goodman, 1997) to assess behavior problems, (3) the Multidimensional Anxiety Scale for Children (March, 1997) or the State–Trait Anxiety Inventory for Children (Spielberger, 1973) to assess generalized anxiety, and (4) the Shame Scale (Feiring, Taska, & Lewis, 1996) to measure feelings of shame related to experiences of abuse.

It is critically important to assess parents' overall functioning as well given that they are often directly or indirectly affected by the trauma(s) their children have experienced. This assessment may also help determine the need for a separate therapy referral if the parents' emotional difficulties are of an individual nature, require immediate attention, or are likely to interfere with their ability to participate in treatment on behalf of their child. To assess parental reactions to the child's traumatic exposures, one can utilize measures such as the Impact of Event Scale—Revised (Weiss, 2004) or the Parent Emotional Reaction Questionnaire (Mannarino & Cohen, 1996). Other standardized measures that are useful in terms of assessing parental functioning and planning treatment include the Beck Depression Inventory (Beck, Steer, & Brown, 1996) and the Parenting Practices Questionnaire (Strayhorn & Weidman, 1988) or Alabama Parenting Questionnaire (Frick, 1991) to assess parenting skills.

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TF-CBT STRUCTURE AND TREATMENT COMPONENTS

TF-CBT sessions are structured such that the therapist meets with the child and parent(s) for separate individual sessions, with time increasingly devoted to conjoint sessions over the course of the middle and latter stages of therapy. In cases in which the child is demonstrating behavior problems,

however, conjoint sessions may begin early in treatment to allow for the consistent practicing of parenting and coping skills with parents and children together.

The components of TF-CBT are summarized by the acronym PRACTICE: **P**sychoeducation and **P**arenting; **R**elaxation; **A**ffective expression and modulation; **C**ognitive coping; **T**rauma narrative development and processing; ***I****n vivo* exposure; **C**onjoint parent–child sessions; and **E**nhancing safety and future development. These components generally remain the same regardless of trauma types, community environments, or setting differences; however, some additional components are included when working with children suffering traumatic grief reactions. Additionally, if potential trauma exposure is ongoing, some revisions to the order and implementation of these components may be necessary, as described elsewhere (Cohen, Mannarino, & Iyengar 2011; Cohen, Mannarino, & Murray, 2011). It is also worth noting the appropriateness of PRACTICE as an acronym in that the model itself emphasizes the importance of clients *practicing* the TF-CBT skills at home in order to optimize benefits. Moreover, when therapists *practice* what they preach, in relation to using the TF-CBT skills, not only do they more effectively model these skills for their clients, but their experiences using the skills personally may help to inspire their ability to motivate clients to engage in treatment and make the changes necessary to support optimal healing and adjustment.

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Theoretical Rationale for Gradual Exposure

As noted earlier, ideas from several theories of psychology have influenced our thinking in terms of the development and refinement of TF-CBT. Cognitive-behavioral principles, however, provide the overarching theoretical rationale for the implementation of this treatment model. TF-CBT includes a variety of strategies that emphasize learning by means of associations, consequences, and observations of others. Based on classical conditioning theory, traumatic events may be conceptualized as unconditioned stimuli that elicit unconditioned or reflexive responses including fear, terror, helplessness, and/or anger. These automatic emotional reactions to trauma are natural and adaptive as they signal the need for protective reactions to real danger such as flight-or-fight response. However, PTSD symptoms may develop when innocuous stimuli (e.g., sounds, sights, smells, images, people, places, or other trauma-related stimuli) present at the time the trauma begin to elicit the same negative unconditioned emotional responses due to their association with the original traumatic threat. Children suffering from PTSD as a result of abuse, for example, may respond to nonabusive people in authority as potential threats as opposed to resources for support. Instrumental conditioning occurs through experience, when children learn

to reduce their anxiety by avoiding innocuous people, places, or things associated with the original trauma(s). Through the process of stimulus generalization, PTSD sufferers avoid a widening circle of innocuous trauma-related cues that trigger traumatic memories and/or symptoms despite the lack of real danger.

Observational learning may also play an important role in determining how children respond to trauma reminders or misperceived threats. Many children respond to misperceived threats in the environment with progressively more withdrawn, isolative, and/or submissive behaviors. Other children, particularly those exposed to violent traumas, may respond to innocuous reminders or misperceived threats with anger or aggressive behaviors similar to those exhibited by others in their environment. While aggression and withdrawal are common manifestations of fear in traumatized children, caregivers may view these behaviors as disobedience and inadvertently respond in ways that exacerbate them. Moreover, as these children have increasingly problematic interactions with parents as well as others, unhealthy beliefs about themselves, relationships, and the world develop. Through these mechanisms of learning, traumatic experiences negatively impact on children's physiological, emotional, behavioral, and cognitive functioning. The PRACTICE components of TF-CBT are therefore designed to enhance coping in each of these domains of functioning.

Gradual exposure (GE) is critical to implementing TF-CBT and is incorporated into *all* of the TF-CBT components. During each subsequent PRACTICE component, the therapist carefully calibrates and increases exposure to trauma reminders while encouraging the child and parent to use skills learned in previous sessions and praising demonstrated mastery. In an effort to counter tendencies toward posttraumatic avoidance, gradual exposure is initiated at the outset of TF-CBT with the direct acknowledgment of the trauma(s) endured and psychoeducation about traumatic stress reactions. In addition, during psychoeducation, GE might consist of simply using the words "sexual abuse" rather than referring to "the bad thing that happened." As the child progresses through the model, the therapist encourages the child and parent to implement the skills with increasing specificity to reminders of the sexual abuse until, during the trauma narrative, the child is encouraged to recount his or her traumatic experiences and to share this with the parent during conjoint sessions when clinically appropriate.

Engaging the child in the trauma narrative and processing component not only helps to extinguish the intense negative emotions associated with traumatic memories and reminders, but perhaps more importantly creates new associations such that traumatic memories may elicit feelings of strength and pride. Moreover, trauma processing and corrective feedback provided by therapists help children to develop adaptive and contextualized interpretations of past events such that healthier self, family, and wordviews

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may develop. The final skill-building component encourages the development of safety skills. Through discussions and role plays, this component provides additional opportunities for youngsters to differentiate between real dangers in the present and innocuous triggers or reminders. Gradual exposure, as incorporated into each of the practice components outlined below, demonstrates to children and their caregivers that they not only have the strength to confront trauma reminders, but they can also learn and grow by acknowledging and processing traumatic memories.

Psychoeducation

Psychoeducation is provided to the child and parents throughout the course of treatment, but is critical from the start in terms of enhancing therapeutic engagement immediately modeling nonavoidance. After obtaining intake information about the trauma(s) experienced and assessing the child's and parent's trauma reactions, the therapist can offer reassuring educational information that normalizes these trauma responses and outlines the general procedures for treatment. The therapist provides specific feedback regarding the assessment findings as well as the child's strengths and difficulties, particularly in terms of how that information informs the planning of treatment. In addition, the therapist should emphasize the important role of parents in treatment, highlighting how their involvement and support may be the single most important influence on their child's healing. To inspire confidence in the treatment approach and optimism about the child's prognosis, it is important to emphasize the effectiveness of the treatment model both in terms of prior clinical experience as well as the extensive research findings.

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General information about the trauma(s) may be provided in a variety of different ways. Even clients who demonstrate extreme avoidance in terms of discussing their personal traumatic experiences are often receptive to general informational discussions about the trauma endured. During the early stages, it is helpful to provide some of the basic facts about the types of traumas experienced in terms of its characteristics, prevalence, impact, common misconceptions, and so on. Educational handouts, books, and games are frequently utilized with children as well as their parents. These activities represent an important early step in the GE process because they undoubtedly trigger memories of the trauma but rarely elicit negative emotions. Rather, during these educational activities, new associations are being created such that trauma memories may begin to be associated with feelings of safety and pride, as knowledge often encourages feelings of empowerment. In general, TF-CBT should not feel like a mysterious process, as clients are educated in a very practical way throughout the treatment concerning the overall therapy objectives and components.

Parenting Skills Training

Parenting skills training is also provided throughout the course of treatment because it is well documented that the parental support and effective parenting skills positively influence trauma recovery in children (Deblinger et al., 1996, 2011; Mannarino & Cohen, 1996). Therapists may initially collaborate with parents in developing family rituals, routines, and structure that will enhance children's feelings of safety and security, while also promoting positive parent–child communication skills such as active listening and the mutual exchange of praise. In order to support the use of effective parenting skills, it is important to conduct functional behavioral analyses, reviewing problematic as well as positive parent–child interactions, on a weekly basis. In the aftermath of trauma, many well-meaning parents inadvertently reinforce problematic behaviors in their children. In the course of conducting functional analyses with respect to parent–child interactions, it is helpful to elicit as much detail as possible, including underlying parental thoughts and feelings that may be driving overindulgent, overprotective, overly harsh, and/or other problematic parenting practices. In the early sessions, the therapist may identify specific problematic child behaviors as well as positive adaptive behaviors that can replace and effectively serve the functions of the problem behaviors (i.e., gaining attention, escaping anxiety, achieving feelings of control). This is particularly important given the natural tendency for parents, in the aftermath of a trauma, to focus on children's difficulties and symptoms, inadvertently reinforcing them. By identifying adaptive behaviors that can replace the maladaptive behaviors, parents can be encouraged to refocus their attention on these positive behaviors by utilizing praise, positive attention, active listening, and tangible rewards when appropriate. Learning to minimize parental attention given to problem behaviors is equally important and often requires very active efforts to dramatically reduce the use of lectures, yelling, and empty threats, which inadvertently increase negative behaviors. Parents and children may also collaborate with the therapist on the development of house rules as well as consequences when the rules are broken. The consequences generally take the form of time-outs, house chores, loss of privileges, and so on, and parents are taught how to optimally administer these consequences in a warm but firm and consistent manner.

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Parents are often significantly affected by the traumas their children have personally suffered. GE during the parenting component includes helping parents understand the traumatic impact on both the children and themselves, for example, framing the children's response as due to the trauma that happened to the children rather than the children "being bad." Helping parents to understand that they are their children's most important role models for coping is critical. Thus, parents also are encouraged to learn the

coping skills described in the components presented next so that they can both model and reinforce their children's efforts to practice those skills.

Relaxation Training

Relaxation training is introduced early in treatment and provides children and parents with skills they can use to manage daily stressors as well as any distress they may experience in the context of facing traumatic memories in treatment. Focused breathing is a particularly important relaxation skill because it can be mastered easily and used in any context. Other relaxation activities that are commonly utilized in the context of TF-CBT include progressive muscle relaxation exercises and guided imagery, which may be particularly useful with young children. When young children are encouraged to imagine themselves as a tin soldier and then a rag doll, they not only learn the difference between muscular tension and relaxation but, most importantly, learn that they can control muscle tension in their own bodies. Relaxation skills can be particularly valuable for clients with sleeping difficulties and those who experience distress physiologically, such as muscular tension in the form of backaches and headaches.

Mindfulness practices may also be utilized to help TF-CBT clients relax or quiet their minds. This practice encourages the focusing of one's full attention on the present moment through the nonjudgmental observation and acceptance of one's thoughts, feelings, sensations, and surroundings. This disciplined but gentle process of refocusing the mind on moment-to-moment experiences in the present may be very healing for those who have suffered a great deal of trauma in the past and are fearful of the future. Moreover, recent research suggests that this form of meditation not only may decrease feelings of distress but also appears to be instrumental in reducing distractive and ruminative thoughts and behaviors common among PTSD sufferers (Jain et al., 2007). GE during the relaxation component includes encouraging children to implement the techniques just discussed or other relaxation strategies when they experience trauma reminders.

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Affective Expression and Modulation Training

Affective expression and modulation training highlights skills that help children and parents communicate and manage feelings more effectively. With young children, this component often begins with exercises designed to identify and review experiences associated with the primary emotions (e.g., happy, sad, mad, scared). Traumatic events often lead to a wide range of other emotions, some of which children may have never experienced before. Thus, it is important to help clients expand their emotional vocabulary beyond the primary emotions just listed to include those frequently

associated with trauma (e.g., terror, shame, grief, rage, embarrassment, helplessness). Moreover, by identifying feeling states and labeling them, clients are taking the first steps toward increasing their awareness of their own distressing emotions and managing them more successfully. Part of GE during this component includes helping children and parents to recognize the connection between these negative affective states and children's trauma reminders. In addition, parents and children are encouraged to practice both verbally expressing their own feelings and inquiring about each others' feelings. These skills can help reduce parent–child conflict and are particularly important for children who tend to express negative emotions through aggressive and/or other problematic behaviors. Parents may be encouraged to utilize active listening skills at home when children share their feelings in words as opposed to dysfunctional behaviors. This type of homework greatly contributes to improving parent–child communication and interactions overall.

In the context of TF-CBT, therapists collaborate with clients in identifying coping strategies that will help them tolerate or manage distressing emotions. TF-CBT therapists may review clients' emotional coping repertoire with the objective of reinforcing effective strategies while discouraging the use of less productive coping strategies. Ultimately, parents and children can create a tool kit that includes old and new skills that can be used effectively to manage distressing emotions (e.g. talking to a supportive adult, listening to soothing music, exercising, problem solving); GE is also implemented by helping clients to identify common trauma triggers that lead to distressing emotions so that the coping strategies just presented can be individually tailored to fit the most common circumstances. Thus, for example, when children experience triggers and distress in school, they can be encouraged to engage in coping strategies that allow them to remain in the classroom when possible. Children often find it helpful to create lists or other tools that serve as reminders of what they can do when they are feeling distressed.

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Cognitive Coping

Cognitive coping is the component that lays the groundwork for helping children and parents understand the connections between their thoughts, feelings, and behaviors. Even very young children can learn to understand that what they say to themselves (i.e., thoughts) influences how they feel and behave. However, the first step in teaching cognitive coping skills involves helping clients to capture and share internal dialogues that may be fleeting, automatic, and not necessarily in their immediate awareness. Therapists are encouraged to use non-trauma-related examples initially to help clients learn to retrieve everyday thoughts. Asking clients, for example, to share what they said to themselves when they heard their alarm clock

ring in the morning is a simple way to begin to elicit internal dialogues. Therapists can introduce a cognitive triangle to demonstrate—using non-trauma-related examples—how different thoughts about the same event can lead to very different feelings and behaviors. Through this process, therapists help children and parents recognize that negative feelings and behaviors are sometimes driven by thoughts that are inaccurate, distorted, or simply unhelpful. Through the process of therapy, clients are encouraged to examine thoughts underlying distressing feelings about everyday events for their accuracy and helpfulness. Ultimately, clients are encouraged to identify inaccurate thoughts that can be corrected and unhelpful thoughts that can be replaced with more helpful, productive thoughts.

Relatively early in treatment, parents are encouraged to share trauma-related feelings and thoughts and, with the help of their therapist, identify inaccurate and dysfunctional thoughts. After devoting some time to eliciting, acknowledging, and simply validating parents' feelings in relation to the trauma, the TF-CBT therapist encourages the examination of thoughts that may be underlying their most distressing feelings. The TF-CBT therapist may then use educational information, Socratic questioning, and role plays to help parents dispute those problematic thoughts. GE is implemented in this manner with parents during the cognitive coping component.

On the other hand, while the TF-CBT therapist may help children examine how their thoughts influence feelings and behaviors on an everyday basis, he or she does not typically challenge the children's trauma-related thoughts until these thoughts and feelings have been expressed, accepted, and validated through the trauma narrative process. When the narrative is almost complete, the therapist can begin to identify problematic thoughts that can be explored and processed, as described next.

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Trauma Narrative Development and Processing

Trauma narrative development and processing refers to the middle third of treatment, when therapy focuses increasingly on the specific traumas endured. The trauma narrative is an exposure and processing exercise that typically takes the form of a written book, with an introductory "about me" chapter as well as chapters in which children describe the circumstances of the trauma and associated thoughts, feelings, and sensations experienced. However, some children may prefer to do this work through trauma-specific discussions or other trauma-specific creative work, including poetry, songs, news shows, plays, and art, that reflects the traumatic experiences. The process is designed to help children gradually face increasingly anxiety-provoking trauma-related memories until they can tolerate those memories without significant emotional distress or avoidant responses. In the context of a trusting therapeutic relationship, children learn that recalling and writ-

ing about the traumatic experiences does not lead to the overwhelming emotions they suffered at the time of the trauma. This frees children up to share their innermost feelings and thoughts about the traumatic experiences in the context of a validating therapeutic relationship. Moreover, with the help of their therapist, children can begin to process trauma-related thoughts, with a particular focus on identifying and correcting dysfunctional thoughts and developing beliefs. GE is implemented by reviewing the narrative several times during its creation, thus helping the children to gain increasing mastery over these memories. The final narrative chapter often reflects the children's integration of what they have learned and experienced over the course of treatment in terms of its implications for their self-image, relationships with others, worldviews, and expectations for the future. The following are examples of questions therapists often pose to assist children in exploring what they have learned so that they can review and internalize healthy beliefs and incorporate them into the final narrative chapter: What have you learned in therapy? What have you learned about the trauma(s) experienced? What have you learned about yourself, your parents, your family, and/or your world? What are you looking forward to in the future? What are you most proud of? Who could you talk to about past traumatic experiences or other problems faced in the future? What would you tell other children who have had similar traumatic experiences?

In Vivo Exposure

In vivo exposure is a powerful treatment component that is highly effective in helping children overcome problematic avoidant behaviors that develop in the aftermath of trauma. Some trauma-related avoidant behaviors, however, are functional and, therefore, should not be discouraged (e.g., avoiding a sexually abusive individual or a drug-infested street corner where an assault occurred). In contrast, dysfunctional avoidant behaviors develop when the intense negative emotions that were experienced in response to the original trauma generalize to innocuous stimuli associated with it. When this occurs, traumatized individuals work hard to avoid people, places, things, and memories that reflexively elicit these intense negative emotions even though these stimuli in and of themselves may no longer be objectively dangerous. Depending on the circumstances of the trauma, children experiencing PTSD-related avoidance may, for example, begin to object to going to school, sleeping alone, being in dark environments, engaging in social activities, or using certain forms of transportation. The reduced anxiety that children experience when they engage in these behaviors reinforces their avoidance, which can lead to increasingly isolative and withdrawn behaviors. Thus, for these children, the use of the *in vivo* treatment component should be carefully considered in collaboration with parents because it requires a

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well-developed treatment plan and a full commitment. Certain highly disruptive avoidant behaviors that impact education like school refusal, may be best addressed early in treatment in collaboration with school personnel after a careful assessment of the factors driving the behavior. For many children, missing a great deal of school not only will inadvertently reinforce avoidant behaviors but may significantly undermine their ability to keep up academically, making the return to school increasingly difficult from both an academic and a social perspective. *In vivo* exposure may also be indicated when less disruptive avoidant behaviors do not diminish naturally over the course of the trauma narrative and processing components. In such circumstances, TF-CBT therapists may begin to create *in vivo* plans that gradually encourage participation in anxiety-provoking activities of increasingly greater intensity with simultaneous use of the coping skills learned earlier in treatment to manage the associated distress.

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Conjoint Parent–Child Sessions

Conjoint parent–child sessions are designed to help parents and children practice the skills learned and begin to communicate more openly about the traumas experienced. Early in treatment, the TF-CBT therapist spends more time with the children and parents in individual sessions; the amount of time devoted to conjoint sessions over the course of treatment is based on clients' specific needs. When children have significant behavior problems, it is often very useful to begin engaging in brief conjoint parent–child sessions early on to provide opportunities for parents to practice praise, selective attention, and the other coping and behavior management skills they are learning.

The content and timing of initiating the trauma-focused conjoint sessions are based on parents' and children's emotional states and levels of skill development. Ideally, conjoint sessions with respect to trauma-related communication should be initiated when parents have developed sufficient emotional composure to serve as effective coping role models for their children and when children have engaged in enough skills and trauma-focused work to demonstrate pride in sharing their newfound trauma-related knowledge and skills. These conjoint sessions usually begin with more general discussions about the relevant traumas. It is helpful to utilize books and games to create a fun, relaxed atmosphere during the initial trauma-focused conjoint sessions, such as Survivor's Journey (for sexual abuse trauma) (Burke, 1994) or What Do You Know?, a simple question-and-answer game about sexual abuse, physical abuse, and domestic violence (Deblinger, Neubauer, Runyon, & Baker, 2006). These activities help parents and children gain greater confidence and comfort in talking together about the traumas in the abstract prior to reading and discussing the personal trauma narrative.

It is also extremely important to prepare parents for hearing their child

read his or her narrative by reviewing the complete narrative with them during individual parent sessions. During individual sessions, parents often greatly benefit from participating in role plays, with the therapist in the role of the child reading the narrative. Role plays help parents become comfortable hearing the narrative while they practice responding to the narrative with active listening, praise, and support for the child. In separate preparation sessions, the therapist may also assist the parents and child individually to identify their trauma-related questions so they can be responded to in therapeutically optimal ways. It should be noted that in a minority of cases it may become apparent early in treatment or during the preparatory individual parent sessions that it is not in the child's best interest to share the narrative because of parental emotional instability or inability to be optimally supportive. The child can still greatly benefit from TF-CBT even if he or she is unable to share the narrative. Often other conjoint activities can take the place of sharing the narrative and can be similarly beneficial (e.g., reviewing general information and/or parents acknowledging how proud they are of their child's work). GE is implemented in this component by sharing the child's narrative together with the parents and/or reviewing trauma-related educational information.

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Enhancing Safety and Future Development

Enhancing safety and future development is a component that also may be incorporated into treatment at different stages depending on the traumas being addressed and the family's circumstances (Cohen, Mannarino & Murray, 2011). For children who have experienced domestic or community violence and may have some ongoing exposure despite efforts to minimize such, safety skills may be introduced and practiced early in the course of treatment to enhance safety in high-risk environments and ensure that everyone is in agreement with respect to the safety plan. For children who are less vulnerable to ongoing trauma, it is advisable to delay the focus on safety skills until after much of the narrative is complete. This may minimize children's tendencies to feel compelled to report what they "should" have done in the narrative (as per the safety training) rather than how they actually responded to the trauma. Moreover, focusing on safety skills too early in treatment may inadvertently reinforce feelings of self-blame.

In general, children who have experienced significant trauma are likely to feel an increased sense of vulnerability. Thus, although children cannot and should not be reasssured that they will be completely protected from future traumas—as many parents would like to do—TF-CBT encourages the development of relevant safety skills to enhance children's sense of mastery and self-efficacy when faced with future stressors or traumas. The learning of personal safety skills may be normalized by likening them to other standard safety skills the children may have learned in school or at home

(e.g., "stop, drop, and roll" for fire safety; use of seat belts while riding in a car; wearing a helmet while riding a bike). Prior to initiating personal safety skills training, however, it is critical to emphasize to children that the way they responded to the trauma was the best way they could have given their age, knowledge, emotions, and experience at that time. Moreover, children participating in TF-CBT may be reminded that they have already engaged in the most important safety skill—telling a trusted adult about the trauma—and they should be congratulated for doing so given how difficult this step can be. The primary objectives of the safety skills component include (1) assessing children's skills and knowledge regarding potential dangers in their environment; (2) providing and reviewing information about relevant risks, such as child sexual abuse, family violence, community violence, bullying, and Internet danger; (3) developing and practicing communication, assertiveness, problem-solving, body safety, and other safety skills relevant to the trauma endured (e.g., fire safety, pool safety); and (4) involving parents in reviewing the skills and developing safety plans that can be practiced during conjoint and/or family sessions.

Children who have experienced significant losses and traumatic grief may require additional grief-focused components beyond the practice components.

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Grief-Focused Components

Grief requires remembering the person who died. Children with traumatic grief avoid thinking about or remembering the deceased person or reminiscing about the deceased person because even happy thoughts segue into traumatic memories about how the person died, and these are too distressing to tolerate. Children with traumatic grief may benefit from additional grief-related treatment components after completing the TF-CBT components as related to the traumatic death. We very briefly summarize them here; interested readers may obtain more detailed information elsewhere in this volume and at *www.musc.edu/ctg*.

Grief psychoeducation: Providing information to the child and parent about the wide range of child grief responses and information about bereavement and mourning. This builds on and supplements earlier psychoeducation provided about death and traumatic symptoms. In so doing, the therapist helps to further establish the importance of maintaining open communication about the traumatic loss of loved ones that for many children and parents might seem easier to avoid.

Grieving the loss; resolving ambivalent feelings: Concretizing the death (e.g., through a balloon exercise that describes what the child has lost and what can still be held onto in the relationship with the

deceased); addressing ambivalent feelings toward the deceased helps the child accept the totality of the deceased and address unresolved issues. It is not unusual for lost loved ones to be remembered in only positive terms, as reflected in the widely accepted practice of "speaking no ill of the dead." However, remembering their lost loved one more realistically as a beloved but naturally flawed individual may reduce bereaved children's vulnerability to having unrealistically high expectations for themselves and others. Thus, during this component it is helpful for children to express both what they miss as well as what they don't miss about the lost loved one, while also processing ambivalent feelings and conflicts they may have experienced with that individual in the past.

Preserving positive memories: Encouraging the child and parent to memorialize the deceased and internalize positive aspects of the deceased into self-concept. While the focus on positive and cherished memories of the deceased can be painful, it also provides children with the experience of knowing that they can manage these feelings and need not avoid positive memories. Finding ways to celebrate the lost loved one's life can create new associations such that trauma-related memories may come to be associated with feelings of pride as opposed to intense grief.

Redefining the relationship; committing to present relationships: Accepting that the relationship lives on but is one of memory and the child must commit to relationships with living people. At this stage of therapy, when PTSD symptoms have greatly subsided, with therapeutic support children are typically more able to internalize the love and wisdom shared by lost loved ones in ways that do not interfere with their ability to establish, deepen, and learn from relationships in the present.

Closure issues: Children and parents respond very well to TF-CBT and the related grief components in terms of overcoming highly disruptive PTSD, depression, anxiety, and traumatic grief symptoms (Cohen, Mannarino, & Staron, 2006). However, grieving is a natural process that often extends beyond the end of therapy and thus it is important to prepare parents and children for this in the final phase of treatment. Such preparation may include normalizing the ongoing grieving process; addressing trauma, loss, and change reminders in the future; and encouraging full engagement in life as it is in the present.

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Graduating Therapy

Graduating therapy is an important goal that is often discussed at the start of TF-CBT given the time-limited nature of this treatment approach. Estab-

lishing the expectation that the children will graduate from TF-CBT encourages confidence and an optimistic view regarding their recovery from the start. For many children and parents, it is reassuring to know that there is a beginning, middle, and end of treatment that they can plan for and look forward to. While confronting and processing trauma experienced in the past is a major objective of treatment, equally important is the focus on the skills learned to be used in the present and the development of optimistic expectations for the future. Thus, setting high expectations for what clients will accomplish and complete over the course of therapy is consistent with the core value of encouraging client self-efficacy in the context of TF-CBT.

TF-CBT is often provided to children who have experienced numerous unexpected traumas and losses. Therefore, as treatment termination nears, a reminder of the number of sessions remaining is especially helpful to children and their parents. In the final phase of treatment, it is also important to readminister standardized measures to review progress and confirm the appropriateness of the clients' therapy graduation. Children who are receiving longer term care at agencies or institutions may graduate from the TF-CBT portion of their treatment and continue on with other forms of treatment (e.g., supportive counseling, mentoring, skill building). Still, these children can benefit from taking time to celebrate their TF-CBT graduation. On the basis of assessment, the therapist may make referrals, if appropriate, for other services and provide guidelines for reconnecting if booster sessions are needed in the future. This is an important time to acknowledge the feelings of loss that termination may elicit while simultaneously highlighting the positive factors associated with the ending of the weekly therapy sessions. For example, therapy graduation reflects the children's success in treatment, the parents' ability to provide the support needed, and the opportunity to utilize this time for other positive activities (e.g., after-school activities, clubs, and sports).

After completing the trauma-focused conjoint sessions, the final individual sessions provide clients opportunities to share their thoughts and feelings about those sessions, while also reviewing overall progress and what they have learned in terms of their self-view, their relationships with others, as well as their worldview. These ideas may already be incorporated into the final chapter of their trauma narrative and thus may be read and/or reviewed one last time. In addition, it is important to discuss and plan for future trauma reminders and steps that can be taken to prevent emotional and behavioral relapses. The therapist should collaborate with clients to create a relaxed, fun celebration, incorporating, when possible, the clients' favorite activities and/or graduation mementos, such as certificates, graduation hats, balloons, and cake. This celebration provides another opportunity to reinforce feelings of strength, pride, and family togetherness in the aftermath of the trauma rather than the distressing trauma-related thoughts and feelings that originally brought the family to treatment.

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CONCLUSION

The concept for this book grew out of the dramatic growth in the utilization of TF-CBT with children of all ages and from diverse cultures and settings. While this introduction outlines the basic principles, values, and treatment components associated with TF-CBT, the chapters that follow highlight the individual tailoring of TF-CBT to optimally serve children's and adolescents' specialized needs. Outstanding authors were invited to contribute chapters based on their extensive experience utilizing TF-CBT in the special contexts described. Thus, the chapters to follow offer specific recommendations for maintaining overall fidelity to the model while simultaneously creatively applying TF-CBT to optimally address applications across different settings, developmental issues, and special populations. Two chapters highlight the value of play in creatively engaging children of different ages in the educational, skill-building, as well as exposure and processing components. Other chapters demonstrate how to adjust TF-CBT to overcome the barriers to treatment or accommodate the special circumstances in which traumatized children are receiving treatment (e.g., residential settings, foster placements, low-resource countries). A unifying theme throughout this book is the importance of building and maintaining a positive, trusting, and collaborative therapeutic relationship. The chapters and the many case examples bring to life the unique aspects of utilizing TF-CBT with children at different developmental stages, from different cultural backgrounds, and in diverse settings in the United States and around the world. Although we recognize that there is still much to be learned to enhance the resiliency of children and families, we hope that the ideas offered here support the many professionals around the world working to help children and their families build more hopeful futures.

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