

Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma

Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based treatment approach shown to help children, adolescents, and their caregivers overcome trauma-related difficulties. It is designed to reduce negative emotional and behavioral responses following child sexual abuse, domestic violence, traumatic loss, and other traumatic events.¹ The treatment—based on learning and cognitive theories—addresses distorted beliefs and attributions related to the abuse and provides a supportive environment in which children are encouraged to talk about their traumatic experience. TF-CBT also helps parents who were not abusive to cope effectively with their own emotional distress and develop skills that support their children.

What's Inside:

- Features of TF-CBT
- Key components
- Target population
- Effectiveness of TF-CBT
- What to look for in a therapist
- Considerations for child welfare agency administrators
- Resources for further information

¹ While TF-CBT is effective in addressing the effects of traumatic events (e.g., the loss of a loved one, domestic or community violence, accidents, hurricanes, terrorist attacks, etc.), the main focus of this issue brief is the treatment of child sexual abuse and exposure to other trauma.



Use your smartphone to access this issue brief online.



Child Welfare Information Gateway
Children's Bureau/ACYF
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
800.394.3366
Email: info@childwelfare.gov
<http://www.childwelfare.gov>

This issue brief is intended to build a better understanding of the characteristics and benefits of TF-CBT. It was written primarily to help child welfare caseworkers and other professionals who work with at-risk families make more informed decisions about when to refer children and their parents and caregivers to TF-CBT therapists. This information also may help biological parents, foster parents, and other caregivers understand what they and their children can gain from TF-CBT and what to expect during treatment. In addition, this issue brief may be useful to others with an interest in implementing or participating in effective strategies for the treatment of children who have suffered from sexual abuse or multiple traumatic events.

Researchers and providers continue to develop and refine trauma treatment approaches and determine how to incorporate them into child welfare services. In September 2011, the Children's Bureau awarded 5-year cooperative agreements to five organizations to focus on integrating trauma-informed and trauma-focused practice in child protective service (CPS) delivery. The grantees will implement TF-CBT and several other therapies demonstrating some evidence of effectiveness with children and families who have experienced trauma.²

² The Children's Bureau does not endorse any specific treatment or therapy. Before implementing a specific type of therapy in your community, consider its appropriateness based on families' needs, resource availability, and fit within the current service delivery system. Read the section Considerations for Child Welfare Agency Administrators to determine if TF-CBT is right for your agency, and consult the section Resources for Further Information to identify and select therapies for the families you serve.

Features of TF-CBT

TF-CBT addresses the negative effects of sexual abuse, exposure to domestic violence and other traumatic events by integrating several therapeutic approaches and treating both child and parent in a comprehensive manner.

TF-CBT Addresses the Effects of Sexual Abuse and Trauma

In the immediate as well as long-term aftermath of exposure to trauma, children are at risk of developing significant emotional and behavioral difficulties (see, for example, Berliner & Elliott, 2002; Briere & Elliott, 2003; Chadwick Center, 2004). For example, victims of sexual abuse often experience:

- **Maladaptive or unhelpful beliefs and attributions** related to the abusive events, including:
 - A sense of guilt for their role in the abuse
 - Anger at parents for not knowing about the abuse
 - Feelings of powerlessness
 - A sense that they are in some way "damaged goods"
 - A fear that people will treat them differently because of the abuse
- **Acting out behaviors**, such as engaging in age-inappropriate sexual behaviors
- **Mental health disorders**, including major depression
- **Posttraumatic stress disorder (PTSD)** symptoms, which are characterized by:

- Intrusive and reoccurring thoughts of the traumatic experience
- Avoidance of reminders of the trauma (often places, people, sounds, smells, and other sensory triggers)
- Emotional numbing
- Irritability
- Trouble sleeping or concentrating
- Physical and emotional hyperarousal (often characterized by emotional swings or rapidly accelerating anger or crying that is out of proportion to the apparent stimulus)

These symptoms can impact the child's daily life and affect behavior, school performance, attention, self-perception, and emotional regulation.

To date, numerous studies have documented the effectiveness of TF-CBT in helping children overcome these and other symptoms following child sexual, domestic violence, and similar traumatic experiences (see Empirical Studies at end of paper). This treatment helps children to process their traumatic memories, overcome problematic thoughts and behaviors, and develop effective coping and interpersonal skills (see Effectiveness of TF-CBT, below).

TF-CBT Treats Nonoffending Parents in Addition to the Child

Recognizing the importance of parental support in the child's recovery process, TF-CBT includes a treatment component for parents (or caregivers) who were not abusive. Treatment sessions are divided into individual meetings for the children and parents, with about equal amounts of time

for both. The parent component teaches stress management, parenting and behavior management skills, and communication skills. As a result, parents are better able to address their own emotional distress associated with the child's trauma, while also supporting their children more effectively.

TF-CBT Integrates Several Established Treatment Approaches

TF-CBT combines elements drawn from:

- **Cognitive therapy**, which aims to change behavior by addressing a person's thoughts or perceptions, particularly those thinking patterns that create distorted or unhelpful views
- **Behavioral therapy**, which focuses on modifying habitual responses (e.g., anger, fear) to identified situations or stimuli
- **Family therapy**, which examines patterns of interactions among family members to identify and alleviate problems

TF-CBT uses well-established cognitive-behavioral therapy and stress management procedures originally developed for the treatment of fear, anxiety, and depression in adults (Wolpe, 1969; Beck, 1976). These procedures have been used with adult rape victims with symptoms of PTSD (Foa, Rothbaum, Riggs, & Murdock, 1991) and have been applied to children with problems with excessive fear and anxiety (Beidel & Turner, 1998). The TF-CBT protocol has adapted and refined these procedures to target the specific difficulties exhibited by children who are experiencing PTSD symptoms in response to sexual abuse, domestic violence, or other childhood traumas. In addition, well-established parenting approaches (e.g.,

Patterson, 2005; Forehand & Kotchick, 2002) also are incorporated into treatment to guide parents in addressing their children's behavioral difficulties.

TF-CBT Shows Results in Various Environments and Cultural Backgrounds

TF-CBT has been implemented in urban, suburban, and rural environments and in clinics, schools, homes, residential treatment facilities, and inpatient settings. TF-CBT has demonstrated effectiveness with children and families of different cultural backgrounds (including Caucasian, African-American, and Hispanic children from all socioeconomic backgrounds) (e.g., Weiner, Schneider, & Lyons, 2009). Therapy has been adapted for Latino, Native American, and hearing-impaired populations. It is a highly collaborative therapy approach in which the therapist, parents, and child all work together to identify common goals and attain them.

TF-CBT Is Appropriate for Multiple Traumas

Recent research findings suggest that TF-CBT is more effective than nondirective or client-centered treatment approaches for children who have a history of multiple traumas (e.g., sexual abuse, exposure to domestic violence, physical abuse, as well as other traumas) and those with high levels of depression prior to treatment (Deblinger, Mannarino, Cohen, & Steer, 2006). The model also has been tested with children who are experiencing traumatic grief after the death of a loved one (Cohen, Mannarino, & Knudsen, 2004; Cohen, Mannarino, & Staron, 2006).

Key Components

TF-CBT is a short-term treatment typically provided in 12 to 18 sessions of 50 to 90 minutes, depending on treatment needs. The intervention is usually provided in outpatient mental health facilities, but it has been used in hospital, group home, school, community, residential, and in-home settings.

The treatment involves individual sessions with the child and parent (or caregiver) separately and joint sessions with the child and parent together. Each individual session is designed to build the therapeutic relationship while providing education, skills, and a safe environment in which to address and process traumatic memories. Joint parent-child sessions are designed to help parents and children practice and use the skills they learned and for the child to share his/her trauma narrative while also fostering more effective parent-child communication about the abuse and related issues.

Goals

Generally, the goals of TF-CBT are to:

- Reduce children's negative emotional and behavioral responses to the trauma
- Correct maladaptive or unhelpful beliefs and attributions related to the traumatic experience (e.g., a belief that the child is responsible for the abuse)
- Provide support and skills to help nonoffending parents cope effectively with their own emotional distress
- Provide nonoffending parents with skills to respond optimally to and support their children

Protocol Components

Components of the TF-CBT protocol can be summarized by the word "PRACTICE":

- **P - Psychoeducation and parenting skills**—Discussion and education about child abuse in general and the typical emotional and behavioral reactions to sexual abuse; training for parents in child behavior management strategies and effective communication
- **R - Relaxation techniques**—Teaching relaxation methods, such as focused breathing, progressive muscle relaxation, and visual imagery
- **A - Affective expression and regulation**—Helping the child and parent manage their emotional reactions to reminders of the abuse, improve their ability to identify and express emotions, and participate in self-soothing activities
- **C - Cognitive coping and processing**—Helping the child and parent understand the connection between thoughts, feelings, and behaviors; exploring and correcting of inaccurate attributions related to everyday events
- **T - Trauma narrative and processing**—Gradual exposure exercises, including verbal, written, or symbolic recounting of abusive events, and processing of inaccurate and/or unhelpful thoughts about the abuse
- **I - In vivo exposure**—Gradual exposure to trauma reminders in the child's environment (for example, basement, darkness, school), so the child learns to control his or her own emotional reactions

- **C - Conjoint parent/child sessions**—Family work to enhance communication and create opportunities for therapeutic discussion regarding the abuse and for the child to share his/her trauma narrative
- **E - Enhancing personal safety and future growth**—Education and training on personal safety skills, interpersonal relationships, and healthy sexuality and encouragement in the use of new skills in managing future stressors and trauma reminders

Target Population

TF-CBT is appropriate for use with sexually abused children or children exposed to trauma ages 3 to 18 and parents or caregivers who did not participate in the abuse.

Appropriate Populations for Use of TF-CBT

Appropriate candidates for this program include:

- Children and adolescents with a history of sexual abuse and/or exposure to trauma who:
 - Experience PTSD
 - Show elevated levels of depression, anxiety, shame, or other dysfunctional abuse-related feelings, thoughts, or developing beliefs
 - Demonstrate behavioral problems, including age-inappropriate sexual behaviors

- Children and adolescents who have been exposed to other childhood traumas (e.g., exposure to community violence, traumatic loss of a loved one) and show symptoms of depression, anxiety, or PTSD
- Nonoffending parents (or caregivers)

Meaningful assessment is important in selecting which children may benefit from TF-CBT and to inform the focus of the intervention. The assessment should specifically address PTSD, depressive and anxiety symptoms, and sexually inappropriate behaviors and other behavior problems, as these have been found to be most responsive to TF-CBT in multiple studies.

Limitations for Use of TF-CBT

TF-CBT may not be appropriate or may need to be modified for:

- Children and adolescents whose primary problems include serious conduct problems or other significant behavioral problems that existed prior to the trauma and who may respond better to an approach that focuses on overcoming these problems first.
- Children who are acutely suicidal or who actively abuse substances. The gradual exposure component of TF-CBT may temporarily worsen symptoms. However, other components of TF-CBT have been used successfully to address these problems. It may be that, for these children, the pace or order of TF-CBT interventions needs to be modified (as has been done in the Seeking Safety model; Najavits, 2002), rather than that TF-CBT is contraindicated for these populations.

- Adolescents who have a history of running away, serious cutting behaviors, or engaging in other parasuicidal behavior. For these teens, a stabilizing therapy approach such as dialectical behavior therapy (Miller, Rathus, & Linehan, 2007) may be useful prior to integrating TF-CBT into treatment.

Effectiveness of TF-CBT

The effectiveness of TF-CBT is supported by outcome studies and recognized on inventories of model and promising treatment programs.

Demonstrated Effectiveness in Outcome Studies

To date, at least 11 empirical investigations have been conducted evaluating the impact of TF-CBT on children who have been victims of sexual abuse or other traumas (see Empirical Studies at end of paper). In addition, there have been studies specifically showing the effectiveness of TF-CBT with children exposed to domestic violence (Cohen, Mannarino, & Iyengar, 2011; Weiner, Schneider, & Lyons, 2009). The findings consistently demonstrate TF-CBT to be useful in reducing symptoms of PTSD as well as symptoms of depression and behavioral difficulties in children who have experienced sexual abuse and other traumas. In randomized clinical trials comparing TF-CBT to other tested models and services as usual (such as supportive therapy, nondirective play therapy, child-centered therapy), TF-CBT resulted in significantly greater gains in fewer clinical sessions. Follow-up studies (up to 2 years following the conclusion of therapy) have shown that these gains are sustained over time.

Children showing improvement typically:

- Experience significantly fewer intrusive thoughts and avoidance behaviors
- Are able to cope with reminders and associated emotions
- Show reductions in depression, anxiety, disassociation, behavior problems, sexualized behavior, and trauma-related shame
- Demonstrate improved interpersonal trust and social competence
- Develop improved personal safety skills
- Become better prepared to cope with future trauma reminders (Cohen, Deblinger, Mannarino, & Steer, 2004)

Research also demonstrates a positive treatment response for parents (Cohen, Berliner, & Mannarino, 2000; Deblinger, Lippmann, & Steer, 1996). In TF-CBT studies, parents often report reductions in depression, emotional distress associated with the child's trauma, and PTSD symptoms. They also report an enhanced ability to support their children (Deblinger, Stauffer, & Steer, 2001; Cohen, Deblinger, et al., 2004; Mannarino, Cohen, Deblinger, Runyon, & Steer, in press).

Recognition as an Evidence-Based Practice

Based on systematic reviews of available research and evaluation studies, several groups of experts and Federal agencies have highlighted TF-CBT as a model program or promising treatment practice. This program is featured in the following sources:

- *Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices* (Chadwick Center, 2004) at <http://www.chadwickcenter.org/kauffman/kauffman.htm>

- The National Child Traumatic Stress Network's (2005) *Empirically Supported Treatments and Promising Practices*, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), at <http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>
- *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders et al., 2004) at http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf
- The California Evidence-Based Clearinghouse for Child Welfare (2011) at <http://www.cebc4cw.org>
- *SAMHSA Model Programs: National Registry of Evidence-Based Programs and Practices* at <http://nrepp.samhsa.gov>
- *Journal of Clinical Child and Adolescent Psychology* (Silverman et al., 2008).

What to Look for in a Therapist

Caseworkers should become knowledgeable about commonly used treatments before recommending a treatment provider to families. Parents or caregivers should receive as much information as possible about the treatment options available to them. If TF-CBT appears to be an appropriate treatment model for a family, the caseworker should look for a provider who has received adequate training, supervision, and consultation in the TF-CBT model. If feasible, both the caseworker and the family should have an opportunity to interview potential TF-CBT therapists prior to beginning treatment.

Questions to Ask Treatment Providers

In addition to appropriate training and thorough knowledge of the TF-CBT model, it is important to select a treatment provider who is sensitive to the particular needs of the child, caregiver, and family. Caseworkers recommending a TF-CBT therapist should ask the treatment provider to explain the course of treatment, the role of each family member in treatment, and how the family's specific cultural considerations will be addressed. The child, caregiver, and family should feel comfortable with and have confidence in the therapist with whom they will work.

Some specific questions to ask regarding TF-CBT include:

- What is the nature of the therapist's TF-CBT training (when trained, by whom, length of training, access to follow-up consultation, etc.)? Is this person clinically supervised by (or did he or she participate in a peer supervision group for private practice therapists with) others who are TF-CBT trained?
- Is there a standard assessment process used to gather baseline information on the functioning of the child and family and to monitor their progress in treatment over time?
- What techniques will the therapist use to help the child manage his or her emotions and related behaviors?
- How and when will the therapist ask the child to describe the trauma?
- Will the therapist use a combination of individual and joint child-parent sessions?

- Is the practitioner sensitive to the cultural background of the child and family?
- Is there any potential for harm associated with treatment?

TF-CBT Training

TF-CBT training sessions are appropriate for therapists and clinical supervisors with a master's degree or higher in a mental health discipline, experience working with children and families, and knowledge of child sexual abuse dynamics and child protection. Therapists may benefit from sequential exposure to different types of training:

- Completing the 10-hour web-based training on TF-CBT on the Medical University of South Carolina website (<http://tfcbt.musc.edu>)
- Reading the program developer's treatment book(s) and related materials
- Participating in intensive skills-based training (2 days)
- Receiving ongoing expert consultation from trainers for 6 to 12 months
- Participating in advanced TF-CBT training for 1 to 2 days

See Training and Consultation Resources, below, for contact information.

Considerations for Child Welfare Agency Administrators

Agency administrators considering promoting the use of TF-CBT with children who have suffered trauma and their families will want to research several variables:

- Agency-level adjustments to support successful TF-CBT with families, such as modifications in policy, practice, and data collection
- Identification of therapists or mental health agencies with experience offering TF-CBT and who can work with children from child welfare populations (see above)
- Projected costs

When introducing TF-CBT as a referral option that child welfare workers may consider for children and families in their caseload, administrators will want to ensure that workers have a clear understanding of how TF-CBT works, the values that drive it, and its efficacy. Training for child welfare staff on the basics of TF-CBT, how to screen for trauma, and how to make appropriate referrals can expedite parent and child's access to effective treatment options (see the National Child Traumatic Stress Network's Child Welfare Trauma Training toolkit at <http://www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008>).

Research has shown that TF-CBT works best under the following organizational conditions:

- Organizational leadership that supports the use of evidence-based interventions, which, in turn, promote acceptance by workers and supervisors
- Provision of ongoing supervision to help child welfare workers make informed referrals to trauma-informed services and supervision for trained clinicians providing treatment

Conclusion

TF-CBT is an evidence-based treatment approach for children who have experienced sexual abuse, exposure to domestic violence, or similar traumas. Despite the impressive level of empirical support for TF-CBT and an established publication track record, many professionals remain unaware of its advantages, and many children and parents who could benefit do not receive such treatment. Further, in many communities around the nation, there may not yet be any TF-CBT trained therapists. The current demand for such evidence-based treatments, however, will encourage other professionals to acquire the needed training and to implement the TF-CBT model. Increased availability of TF-CBT, along with increased awareness among those making treatment referrals, can offer significant results in helping children to process their trauma and overcome emotional and behavioral problems following sexual abuse and other childhood traumas.

Resources for Further Information

References Cited

- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. Oxford, England: International Universities Press.
- Beidel, D. C., & Turner, S. M. (1998). *Shy children, phobic adults: Nature and treatment of social phobia*. Washington, DC: American Psychological Association.
- Berliner, L., & Elliott, D. M. (2002). Sexual abuse of children. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (pp.55-78). Thousand Oaks, CA: Sage Publications.
- Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect*, 27, 1205-1222.
- Chadwick Center. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices*. San Diego, CA: Author.
- Cohen, J. A., Berliner, L., & Mannarino, A. P. (2000). Treatment of traumatized children: A review and synthesis. *Journal of Trauma, Violence and Abuse*, 1(1), 29-46.
- Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 393-402.
- Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence. *Archives of Pediatrics & Adolescent Medicine*, 165(1), 16-21.
- Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2004) Treating childhood traumatic grief: A pilot study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 1225-1233.
- Cohen, J. A., Mannarino, A. P., & Staron ,V. (2006). A pilot study of modified cognitive behavioral therapy for childhood traumatic grief (CBT-CTG). *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(12), 1465-1473.

- Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*(4), 310-321.
- Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms: Examining predictors of treatment response. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 1474-1484.
- Foa, E., Rothbaum, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting & Clinical Psychology, 59*(5), 715-723.
- Forehand, R., & Kotchick, B. A. (2002). Behavioral parent training: Current challenges and potential solutions. *Journal of Child & Family Studies, 11*(4), 377-384.
- Mannarino, A. P., Cohen, J. A., Deblinger, E., Runyon, M., & Steer, R. (in press). Trauma-focused cognitive-behavioral therapy for children: Sustained impact 6 and 12 months later. *Child Maltreatment*.
- Miller, A. L., Rathus, J. H., & Linehan, M. M. (2007). *Dialectical behavior with suicidal adolescents*. New York: The Guildford Press.
- Najavits, L. M. (2002). Treatment of posttraumatic stress disorder and substance abuse: Clinical guidelines for implementing Seeking Safety therapy. *Alcoholism Treatment Quarterly, 22*(1), 43-62.
- Patterson, G. R. (2005). The next generation of PMTO models. *Behavior Therapist, 28*(2), 27-33.
- Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.) (2003). *Child physical and sexual abuse: Guidelines for treatment* (Final Report: January 15, 2003). Charleston, SC: National Crime Victims Research and Treatment Center.
- Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Amaya-Jackson, L. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 156-183.
- Weiner, D. A., Schneider, A., & Lyons, J. S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review, 31*(11), 1199-1205.
- Wolpe, J. (1969). Basic principles and practices of behavior therapy of neuroses. *American Journal of Psychiatry, 125*(9), 1242-1247.

Empirical Studies

- Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*, 393-402.
- Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(1), 42-50.
- Cohen, J. A., & Mannarino, A. P. (1997). A treatment study of sexually abused preschool children: Outcome during one year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry 36*(9), 1228-1235.
- Cohen, J. A., Mannarino, A. P., & Knudsen K. (2005). Treating sexually abused children: One year follow-up of a randomized controlled trial. *Child Abuse & Neglect, 29*, 135-146.
- Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*(4), 310-321.
- Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-Focused Cognitive Behavioral Therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety, 28*, 67-75.
- Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms: Examining predictors of treatment response. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 1474-1484.
- Deblinger, E., Stauffer, L., & Steer, R. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for children who were sexually abused and their nonoffending mothers. *Child Maltreatment 6*(4), 332-343.
- Deblinger, E., Steer, R. A., & Lippmann, J. (1999). Two year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. *Child Abuse and Neglect, 23*(12), 1371-1378.
- King, N., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., et al. (2000). Treating sexually abused children with post-traumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 59*(11), 1347-1355.
- Stauffer, L., & Deblinger, E. (1996). Cognitive behavioral groups for nonoffending mothers and their young sexually abused children: A preliminary treatment outcome study. *Child Maltreatment, 1*(1), 65-76.

Online Resources

Center for Traumatic Stress in Children & Adolescents

<http://www.pittsburghchildtrauma.net>

Medical University of South Carolina

Guidelines for Treatment of Physical and Sexual Abuse of Children

http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf

Chadwick Center for Children and Families

Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices

<http://www.chadwickcenter.org/Kauffman/kauffman.htm>

National Child Traumatic Stress Network

Empirically Supported Treatments and Promising Practices

<http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>

University of Medicine & Dentistry of New Jersey, School of Osteopathic Medicine

CARES Institute

<http://www.caresinstitute.org>

SAMHSA Model Programs

National Registry of Evidence-Based Programs and Practices

<http://nrepp.samhsa.gov>

The California Evidence-Based Clearinghouse for Child Welfare

<http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy>

Interventions Addressing Child Exposure to Trauma: Part 1 – Child Maltreatment and Family
Violence Agency for Healthcare Research and Quality, U.S. Department of Health and Human
Services

<http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?mode=&pageaction=displayproduct&productid=846>

Blueprints for Violence Prevention

University of Colorado Boulder's Center for the Study and Prevention of Violence

<http://www.colorado.edu/cspv/blueprints>

Training and Consultation Resources

Web-Based Training

Medical University of South Carolina (MUSC). Distance learning course on TF-CBT
<http://tfcbt.musc.edu>

Web-based training in TF-CBT is available as an adjunct or precursor to attending training workshops. The website training may be accessed free of charge. Therapists typically benefit from a 2-day intensive initial training course, as well as advanced training seminars after some experience implementing the model. Access to written resources such as books and treatment manuals (listed below), ongoing consultation or clinical mentoring, and regular clinical supervision are important complements to any web-based training.

Medical University of South Carolina (MUSC). Distance Learning course on Child Traumatic Grief
<http://ctg.musc.edu>

Web-based training is available on the application of TF-CBT principles and interventions to child traumatic grief along with presentation of grief-related interventions.

National Child Traumatic Stress Network. Child Welfare Trauma Training Toolkit
<http://www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008>

This course is designed to teach basic knowledge, skills, and values about working with children in the child welfare system who have experienced traumatic stress. It also teaches how to use this knowledge to support children's safety, permanency, and well-being through case analysis and corresponding interventions tailored for them and their biological and resource families.

Web-Based Consultation

Medical University of South Carolina (MUSC). Distance Learning Consultation on TF-CBT
<http://etl2.library.musc.edu/tf-cbt-consult/index.php>

This web-based consultation tool provides information about frequently asked questions by providers implementing TF-CBT.

Implementation Guide

Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network. (2008). *How to implement trauma-focused cognitive behavioral therapy*.
[http://www.nctsn.org/nctsn_assets/pdfs/TF-CBT Implementation Manual.pdf](http://www.nctsn.org/nctsn_assets/pdfs/TF-CBT%20Implementation%20Manual.pdf)

Onsite Training Contacts

Judith Cohen, M.D.
Center for Traumatic Stress in Children & Adolescents
Allegheny General Hospital
Pittsburgh, PA
Phone: 412.330.4321
Email: JCohen1@wpahs.org

Anthony P. Mannarino, Ph.D.
Center for Traumatic Stress in Children & Adolescents
Allegheny General Hospital
Pittsburgh, PA
Phone: 412.330.4312
Email: amannari@wpahs.org

Esther Deblinger, Ph.D.
CARES Institute
University of Medicine & Dentistry of NJ - School of Osteopathic Medicine
Stratford, NJ
Phone: 856.566.7036
Email: deblines@umdnj.edu

Practitioner's Guides

Cohen, J. A., Mannarino A. P. & Deblinger, E. (2006). *Treating trauma and traumatic grief in children & adolescents*. New York: Guilford Press.

Deblinger, E. & Heflin, A. H. (1996). *Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach*. Newbury Park, CA: Sage Publications.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2012). *Trauma-focused CBT for children and adolescents: Treatment applications*. New York: Guilford Press.

The following children's books by Stauffer & Deblinger also may be useful in teaching personal safety and other coping skills:

Stauffer, L. B., & Deblinger, E. (2003). *Let's talk about taking care of you: An educational book about body safety*. Hatfield, PA: Hope for Families, Inc.

Stauffer, L., & Deblinger, E. (2005). *Let's talk about coping and safety skills: A workbook about taking care of you*. Hatfield, PA: Hope for Families, Inc.

Acknowledgments:

The original (2007) and current versions of this issue brief were developed by Child Welfare Information Gateway, in partnership with the Chadwick Center for Children and Families at Rady Children's Hospital San Diego. Contributing Chadwick authors include Cambria Rose Walsh, Anthony P. Mannarino, and Charles Wilson.

The conclusions discussed here are solely the responsibility of the authors and do not represent the official views or policies of the funding agency. The Children's Bureau does not endorse any specific treatment or therapy.

Suggested Citation:

Child Welfare Information Gateway. (2012). *Trauma-focused cognitive behavioral therapy for children affected by sexual abuse or trauma*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.



U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

