Trauma-focused Cognitive Behavior Therapy (TF-CBT) for Child Abuse
Marianne Celano, PhD, ABPP
Uma Dorn, PhD
Marissa Petersen-Coleman, PsyD
Lindsay Pate, PhD
TF-CBT for Child Abuse

• A comprehensive, empirically supported treatment model for 3 to 21 year olds and their parents in the aftermath of traumatic experience
  - Sexual abuse
  - Exposure to intimate partner violence
  - Disasters

• Developed by Cohen, Mannarino & Deblinger

• Addresses multiple domains of trauma impact:
  - PTSD
  - Depression
  - Anxiety
  - Externalizing behavior problems
  - Relationship and attachment problems
TF-CBT for Child Abuse

• Integrative in theory (hybrid approach):
  – Trauma sensitive interventions (exposure)
  – CBT principles
  – Attachment theory
  – Family therapy (parent-child joint sessions)

• Components-based
  – Skill-building progression
  – Flexibly applied and sequenced

• Time limited
  – 12 to 25 sessions (60 – 90 minutes)
  – Divided approximately equally between child and parent

• Single therapist

• Homework
TF-CBT for Child Abuse: Goals

• **Goals for children:**
  - To alleviate child’s abuse-related symptoms
  - To correct child’s inaccurate or unhelpful thoughts about the abuse/trauma
  - To reduce the child’s behavior problems

• **Goals for parents/caregivers:**
  - To alleviate parent’s abuse-related symptoms
  - To correct parent’s inaccurate or unhelpful thoughts about the abuse/trauma
  - To restore the parent-child relationship
  - To teach behavior management techniques
• Parental support is critical to recovery
• Some parental reactions to child trauma contribute to child symptoms or behavior problems
  – Inappropriate self-blame and guilt
  – Inappropriate child blame
  – Overly strict or overly permissive discipline
  – Minimization and denial
• Evidence base: child depression, aggression and sexual acting out improved only when parents were directly treated
TF-CBT: Goals of Joint Parent-Child Sessions

• Share information about child’s experience

• Address inaccurate or unhelpful thoughts
  – Child’s thoughts
  – Parent’s thoughts

• Encourage optimal parent-child communication

• Model appropriate child support and redirection

• Prepare for future trauma reminders
TF-CBT Components: PRACTICE

- Psychoeducation about child trauma & Parenting
- Relaxation skills
- Affective modulation skills
- Cognitive coping: thoughts, feelings, behavior
- Trauma narrative and processing
- In vivo mastery of trauma reminders
- Conjoint child-parent sessions
- Enhancing safety and future developmental trajectory
TF-CBT Assessment

- Safety (IPV, neglect, weapons)
- Child history of traumatic experience
  - Single versus multiple traumas
- Child PTSD symptoms
- Child and caregiver psychiatric history
- Child and caregiver functioning before trauma
- Baseline narrative
  - Positive life experience
  - Some aspect of traumatic experience
- Caregiver interview
  - History of traumatic experience
  - Reactions to child’s abuse
TF-CBT: Psychoeducation

• General education about child trauma
  – Psychological and physiological reactions to stress

• Information about specific trauma experienced by child (e.g., sexual abuse)
  – Why do perpetrators abuse children?
  – How do children react to sexual abuse?
  – Why don’t children tell about the abuse right away?

• Normalize responses to the traumatic event

• Instill hope for recovery
• Establish reasonable developmental expectations

• Teach effective discipline techniques
  – Labeled praises for compliance
  – Planned ignoring
  – Clear, direct commands (not too many)
  – Consistent consequences

• Encourage mastery of skills through role play and practice

• Reduce child sexual behavior problems
TF-CBT: Relaxation

- Techniques to reduce physiological manifestation of stress and PTSD:
  - Controlled breathing
  - Relaxation training
  - Guided imagery

- Children demonstrate mastery by teaching parents the technique in session

- Homework: practice when not upset
TF-CBT: Affect Modulation

• Help children and parents identify their emotions accurately
  – Name a range of emotions
  – Identify trauma-related emotions
  – Rate the intensity level of emotions (SUDS)
  – Normalize trauma-related emotions

• Discuss appropriate expression & modulation of emotions

• Homework: practice feelings identification and appropriate feelings expression
TF-CBT: Cognitive Coping

- Teach child and family about relationships between thoughts, feelings and behaviors

- Help child practice skill of thinking about a given situation in several ways:
  - Accurate versus inaccurate cognitions
  - Helpful versus unhelpful cognitions
  - Change a feeling by changing the thought
TF-CBT: Trauma Narrative

• Goals:
  – Desensitize child to trauma-related feelings/images
  – Recognize and prepare for trauma reminders
  – Identify unhelpful/inaccurate thoughts and beliefs for later processing
• Flexible format (book, poem, song, drawing)
• Multiple sessions
• Rate distress at key junctures, use affect regulation and mindfulness skills
• Separate sessions for child and caregiver during TN development and processing
TF-CBT: Trauma Narrative: Child

• **Structure of Narrative**
  – Starts with general information about child/family
  – Proceeds forward from first incident or backwards from disclosure or medical exam
  – If multiple episodes, includes some (first, last, worst)
  – Includes worst moment/memory/part
  – Ends with impact statement

• **Review, adding thoughts and feelings:**
  – *What did you think about when you were feeling mad?*
  – *Are there any thoughts that pop into your head when you remember him touching you?*

• **Prepare child for sharing narrative with parent**
TF-CBT: Trauma Narrative: Parents

- Explain rationale for trauma narrative
- Emphasize slow pace

- Share parts of narrative with parent
  - Prepare parent for child distress, parent distress
  - Support parent in “bearing witness,” using coping skills
  - Cognitive processing as appropriate
  - Ensure that parent will respond supportively

- Prepare for joint child-parent session
TF-CBT: In Vivo Processing

• Gently challenge children’s and parent’s thoughts related to the abuse:
  – Differentiate accurate vs. inaccurate cognitions
  – Challenge negative “core beliefs”
  – Encourage more healthy thought processes

• Replace distorted cognitions with more accurate, realistic, or helpful ones:
  – Progressive logical questioning
  – Best friend role play
  – Alternative cognitions

• Teach parents how to effectively challenge the child’s cognitive errors related to the abuse
TF-CBT: Common Distortions in TN

• Self-blame
  “I did nothing to stop him”
  “I didn’t tell right away”

• Overestimating danger
  “I can’t trust anyone now”
  “All men are dangerous”

• Negative world view
  “Bad things will always happen to me”
  “Abused children will never be the same”
TF-CBT: Sharing the Narrative

• Content
  – Child shares trauma narrative
  – Child and parent ask and answer questions of each other, facilitated by therapist
  – Therapist praises family for progress made

• Format choices
  – Individual meeting with child and parent prior to joint part of session
  – Joint session followed by individual meeting with child and parent
  – Joint session only (assumes prior preparation)
TF-CBT: Enhancing Safety

• Education and training in safety skills
  – Praise productive response to traumatic event
  – Focus on risk reduction versus prevention
  – Skill building: verbal and nonverbal behavior

• Key concepts
  – Communicate feelings clearly and openly
  – Attend to “gut feelings”
  – Identify safe people and places
  – Body ownership rules (OK and not OK touches)
  – Secrets vs. surprises
  – Ask for help until someone provides it
• Principles of healthy sexual behavior
  – Clear consent for sex from both partners
  – Sex should not be exchanged for money/gifts
  – Sex partners should be close in age
  – Sexual behavior should not involve family members
  – Sex should occur in private
  – Risks of internet sex

• Healthy and unhealthy boundaries
  – Who should you tell about intimate details of your life?
  – What content is appropriate for online social media?
TF-CBT: Contraindications

• For child:
  – Suicidal ideation or self-destructive behavior
  – Substance abuse
  – Psychosis or severe dissociative symptoms
  – Severe and persistent conduct problems

• For caregiver:
  – Severe psychiatric conditions (e.g., psychosis)
  – Ongoing substance abuse
  – Ongoing abuse/neglect of child, IPV
  – Unresolved child abuse/trauma history
• Implement other evidence-based intervention **before** starting TF-CBT
  – DBT for self-injurious behavior
  – PCIT or other relationship-based therapy
  – Supportive therapy for child or parent

• Provide crisis stabilization and managing everyday life while continuing TF-CBT
  – Save for last 20 minutes of session
  – Extend session or length of treatment
TF-CBT: Empirical Support

• The most rigorously tested treatment for abused children and adolescents

• 4 randomized clinical trials with sexually abused children, 1 with children exposed to IPV

• Identified as “efficacious” for abuse-related symptoms
  – U.S. Office for Victims of Crime
  – SAMHSA’s National Registry of Evidence-based Programs & Practices

• Meets “well-established criteria” threshold (Silverman et al., 2008)
• Clinical trials demonstrate improved child PTSD, depression, anxiety, shame, & behavior problems

• Clinical trials show improved parental distress, support & depression

• Gains are maintained over time (1 to 2 years)

• Control groups include child-focused supportive treatment, nondirective play therapy, wait-list, and “usual treatment.”
TF-CBT: Empirical Support, Trial 3

- 8 to 15 year old males and females
- 41 TF-CBT, 41 nondirective supportive therapy
- Both treatments: 12 weekly sessions of 90 minutes
- 49 treatment completers (30 TF-CBT, 19 NST)
- ITT analyses showed differential treatment effects for PTSD and depression at post, and for PTSD at 1 year f/u
- No differential treatment effects for behavior problems
TF-CBT: Empirical Support, Trial 4

- 8 to 14 year old males and females
- 114 TF-CBT, 115 child centered therapy
- Both treatments: 12 weekly sessions of 90 minutes
- 149 (73%) treatment completers; analyses for 92 and 91 who attended at least 3 sessions and had post data
- At post, differential treatment effects for PTSD, depression, & behavior problems. At 1 year f/u, differential effects for PTSD and depression only.
- At post, differential treatment effects for parent abuse-related distress, support of child, and effective parenting. 1 year f/u: differential effect for abuse-related distress only.
TF-CBT: Empirical Support: Samples

• Tested with African American, Caucasian, and Latino families in the U.S.

• Tested with rural, suburban and urban families

• Tested with varying SES groups

• Modified to address needs of Latino, Native American, deaf and hearing impaired, military and international populations

• Modifications for use in military settings, schools, residential treatment facilities
TF-CBT: Systematic Review

- Cary & McMillen, 2012
- 12 articles representing 10 unique studies (RCTs)
- Three types of TF-CBT evaluated
  - Branded version (3 studies)
  - Similar version (5 of 5 key components)
  - Similar version (4 of 5 key components)

- Pooled estimates suggest that TF-CBT is more effective than attention control, standard community care & waitlist control conditions at:
  - reducing **PTSD symptoms** at post & 12 months after intervention
  - reducing the symptoms of **depression** and **problem behaviors** at immediate post but **not** at 12 months after intervention
TF-CBT: Essential Components

- 210 children (age 4 to 11) with sex abuse & PTSD:
  - 8 sessions with TN (3 sessions for TN)
  - 8 sessions without TN
  - 16 sessions with TN (11 sessions for TN)
  - 16 sessions without TN

- All conditions yielded clinical gains on 14 outcome measures with moderate to large effect sizes

- Some differential treatment responses ($n=179$)
  - TN more effective than no TN in reducing abuse-related fear
  - 16 session conditions more effective in reducing PTSD symptoms than 8 session conditions*
  - Both No TN conditions more effective in reducing behavior problems than TN conditions.
  - 16 sessions No TN condition best for improvement in in parenting
TF-CBT: Essential Components

• 72% assigned to 8 sessions completed treatment, as compared to 54% assigned to 16 sessions

• 158 children (age 4 to 11) with 6m & 12m f/u data:
  – Treatment gains sustained or improved for families in all 4 conditions
  – Differences between 4 conditions found at post were not sustained at 6 and 12 month f/u
  – Children’s internalizing behavior problems & self-reported depressive symptoms at baseline predicted 12m PTSD status
TF-CBT: Research Caveats

• TF-CBT has not been compared to an alternative abuse-specific treatment

• There is limited support for the efficacy of TF-CBT for very young children (ages 2 to 5) and their families
  – TF-CBT yielded significant improvements in PTSD symptoms compared to waitlist control for 3 to 6 year olds experiencing a variety of traumas, not sex abuse (Scheeringa et al., 2011)

• Evidence is strongest for symptoms and problems directly related to the abuse

• Modified versions of TF-CBT (e.g., for residential treatment facilities) have not been empirically tested
TF-CBT: Dissemination

• Widely disseminated via the National Child Traumatic Stress Network (NCTSN)

• Training requirements:
  − 10 hour free web-based training at http://tfcbt.musc.edu/
  − 2-day basic training taught by national trainer
  − 12 consultation calls with national trainer
  − 3 cases to completion
TF-CBT: Conclusions

• There is strong evidence for the efficacy of TF-CBT in reducing abuse related PTSD and distress for 5 to 18 year old children who have been sexually abused and their caregivers

• The model offers sufficient flexibility to support tailoring to individual families while maintaining treatment fidelity

• Research into essential components of the model is underway, but the model has not been compared to abuse-focused alternative treatment

• The model is widely disseminated
For more information, contact Marianne Celano at mcelano@emory.edu