

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. The acronym PRACTICE reflects the components of the treatment model: Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development. Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process or in a group therapy format.

Descriptive Information

Areas of Interest	Mental health treatment
Outcomes	<p>Review Date: June 2008</p> <ul style="list-style-type: none"> 1: Child behavior problems 2: Child symptoms of posttraumatic stress disorder (PTSD) 3: Child depression 4: Child feelings of shame 5: Parental emotional reaction to child's experience of sexual abuse
Outcome Categories	<ul style="list-style-type: none"> Family/relationships Mental health Social functioning Trauma/injuries
Ages	<ul style="list-style-type: none"> 0-5 (Early childhood) 6-12 (Childhood) 13-17 (Adolescent) 26-55 (Adult)
Genders	<ul style="list-style-type: none"> Male Female
Races/Ethnicities	<ul style="list-style-type: none"> Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	Outpatient
Geographic Locations	<ul style="list-style-type: none"> Urban Suburban
Implementation History	<p>Since its development in the late 1980s, TF-CBT has been adapted by therapists across the United States and in Australia, Cambodia, Canada, China, Denmark, Germany, Japan, the Netherlands, Norway, Pakistan, Sweden, and Zambia. It has been used with children in foster care and with those who have suffered multiple and diverse traumas, including the September 11 terrorist attacks and Hurricane Katrina. More than 60,000 mental health professionals have completed the free training that was made available on the TF-CBT Web site in 2005.</p>
NIH Funding/CER	Partially/fully funded by National Institutes of Health: Yes

Studies	Evaluated in comparative effectiveness research studies: Yes
Adaptations	Adaptations of this program have been developed for use with diverse cultures, including Latino and tribal populations. In addition, the 2006 treatment book by Cohen, Mannarino, & Deblinger (see Readiness for Dissemination Materials) has been translated into Dutch and is currently under contract through Guilford Press to be translated into German, Japanese, Korean, and Mandarin.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	IOM prevention categories are not applicable.

Quality of Research

Review Date: June 2008

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

[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.](#) 

Study 2

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, 1(4), 310-321.

Study 3

[Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. \(2004\). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43\(4\), 393-402.](#) 

[Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. \(2006\). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45\(12\), 1474-1484.](#) 

Supplementary Materials

[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. J., 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*, 39\(11\), 1347-1355.](#) 

Mental Health Services & Policy Program, Northwestern University. (n.d.). Evaluation of the implementation of three evidence-based practices to address trauma for children and youth who are wards of the State of Illinois. Evanston, IL: Author.

Outcomes

Outcome 1: Child behavior problems

Description of Measures

Child behavior problems were measured using two instruments completed by parents:

- Child Behavior Checklist-Parent Version, a descriptive rating measure used to assess both adaptive competencies and behavior problems. It includes areas of child activities and functioning related to family, social, and school behaviors.
- Weekly Behavior Report, which documents the frequency of 21 PTSD-like behaviors in sexually abused preschool children, such as reexperiencing symptoms (e.g., nightmares, sexualized behaviors), avoidance of trauma reminders, and hyperarousal symptoms (e.g., new fears, aggression).

Key Findings

In one study, children were randomly assigned to the intervention group or a group receiving

nondirective supportive therapy. Children in the intervention group had a statistically significant decrease in behavior problems from pre- to posttreatment relative to those in the comparison group (all p values < .05).

In another study, children and their female guardian were randomly assigned to one of three intervention groups--child only, guardian only, or guardian and child--or to a comparison group receiving standard community care. Guardians receiving the intervention (i.e., those in the guardian-only group and guardian and child group) rated their child as exhibiting significantly fewer behavior problems at posttreatment than did those assigned to the child-only group or the comparison group ($p < .05$).

In a third study, children and their female or male guardian were randomly assigned to the intervention group or a group receiving child-centered therapy. Children in the intervention group demonstrated significantly greater reductions in behavior problems from pre- to posttreatment relative to those in the comparison group ($p < .05$).

Studies Measuring Outcome Study 1, Study 2, Study 3

Study Designs Experimental

Quality of Research Rating 3.8 (0.0-4.0 scale)

Outcome 2: Child symptoms of posttraumatic stress disorder (PTSD)

Description of Measures Symptoms of PTSD were measured using the PTSD section of the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-PL). The K-SADS-PL is a structured diagnostic interview administered by therapists to the child and parent separately, with a consensus response obtained for each item as a summary score. The interview includes a selection of screening questions used to identify traumatic events that the child has experienced. Items assess behaviors related to reexperiencing symptoms, hyperarousal, and avoidance of the trauma.

Key Findings In one study, children and their female guardian were randomly assigned to one of three intervention groups--child only, guardian only, or guardian and child--or to a comparison group receiving standard community care. Children receiving the intervention (i.e., those in the child-only group and guardian and child group) exhibited significantly fewer PTSD symptoms at posttreatment than did those assigned to the guardian-only group or the comparison group ($p < .01$).

In another study, children and their female or male guardian were randomly assigned to the intervention group or a group receiving child-centered therapy. Children in the intervention group demonstrated significantly greater reductions in PTSD symptoms from pre- to posttreatment relative to those in the comparison group (all p values < .01). Children in the intervention group continued to have fewer PTSD symptoms than those in the comparison group at 6- and 12-month follow-up (all p values < .01).

Studies Measuring Outcome Study 2, Study 3

Study Designs Experimental

Quality of Research Rating 3.6 (0.0-4.0 scale)

Outcome 3: Child depression

Description of Measures Child depression was measured using the Child Depression Inventory, a 27-item self-report scale of depressive symptoms for children 7 to 17 years old. Children are asked to respond based on how they have been feeling over the past 2 weeks.

Key Findings In one study, children and their female guardian were randomly assigned to one of three intervention groups--child only, guardian only, or guardian and child--or to a comparison group receiving standard community care. Children receiving the intervention (i.e., those in the child-only group and guardian and child group) were significantly less depressed at posttreatment than were those assigned to the guardian-only group or comparison group ($p < .05$).

In another study, children and their female or male guardian were randomly assigned to the

intervention group or a group receiving child-centered therapy. Children in the intervention group had greater decreases in depression symptoms from pre- to posttreatment than those in the comparison group (all p values < .05).

Studies Measuring Outcome	Study 2, Study 3
Study Designs	Experimental
Quality of Research Rating	3.8 (0.0-4.0 scale)

Outcome 4: Child feelings of shame

Description of Measures	Feelings of shame were measured using the Shame Questionnaire, a self-report instrument for children ages 7 years and older used to measure feelings of shame related to sexual abuse.
Key Findings	In one study, children and their female or male guardian were randomly assigned to the intervention group or a group receiving child-centered therapy. Children in the intervention group had significantly greater improvement with regard to feelings of shame from pre- to posttreatment than those in the comparison group (all p values < .01). At 6- and 12-month follow-up, children in the intervention group continued to report less shame than those in the comparison group (all p values < .01).
Studies Measuring Outcome	Study 3
Study Designs	Experimental
Quality of Research Rating	3.7 (0.0-4.0 scale)

Outcome 5: Parental emotional reaction to child's experience of sexual abuse

Description of Measures	<p>Parental reaction was measured using three instruments:</p> <ul style="list-style-type: none"> • Parent Emotional Reaction Questionnaire, a 15-item self-report measure used to describe specific parental emotional reactions to the child's experience of sexual abuse (e.g., fear, guilt, anger, embarrassment, feeling upset). • Parenting Practices Questionnaire (PPQ), a paper-and-pencil self-report measure of parents' parenting skills and interactions with their children. Three items about general parenting practices from the original PPQ were modified to address interactions with children specific to sexual abuse. • Parent Support Questionnaire, a 19-item self-report measure of parental support to the sexually abused child and attributions about responsibility for the abuse.
Key Findings	<p>In one study, children and their female guardian were randomly assigned to one of three intervention groups--child only, guardian only, or guardian and child--or to a comparison group receiving standard community care. Guardians receiving the intervention (i.e., those in the guardian-only group and guardian and child group) reported significantly greater use of effective parenting skills at posttreatment than did those assigned to the child-only group or the comparison group (p < .01).</p> <p>In another study, children and their female or male guardian were randomly assigned to the intervention group or a group receiving child-centered therapy. Guardians assigned to the intervention group showed greater improvement in support of the child victim and in effective parenting practices from pre- to posttreatment than those in the comparison group (all p values < .01). At 6- and 12-month follow-up, guardians in the intervention group continued to report less abuse-specific distress than those in the comparison group (all p values < .05).</p>
Studies Measuring Outcome	Study 2, Study 3
Study Designs	Experimental
Quality of Research Rating	3.7 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	0-5 (Early childhood) 6-12 (Childhood)	58% Female 42% Male	54% White 42% Black or African American 4% Race/ethnicity unspecified
Study 2	6-12 (Childhood) 13-17 (Adolescent) 26-55 (Adult)	83% Female 17% Male	72% White 20% Black or African American 6% Hispanic or Latino 2% Race/ethnicity unspecified
Study 3	6-12 (Childhood) 13-17 (Adolescent) 26-55 (Adult)	79% Female 21% Male	60% White 28% Black or African American 8% Race/ethnicity unspecified 4% Hispanic or Latino

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see [Quality of Research](#).

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Child behavior problems	4.0	4.0	4.0	3.5	3.5	3.5	3.8
2: Child symptoms of posttraumatic stress disorder (PTSD)	3.5	3.5	4.0	3.5	3.5	3.5	3.6
3: Child depression	4.0	4.0	4.0	3.5	3.5	3.5	3.8
4: Child feelings of shame	3.0	4.0	4.0	3.5	4.0	3.5	3.7
5: Parental emotional reaction to child's experience of sexual abuse	4.0	3.5	4.0	3.5	3.5	3.5	3.7

Study Strengths

The authors used mostly well-known and well-documented outcome measures with good psychometric properties. All the studies used random assignment to treatment conditions. Researchers paid careful attention to ensuring treatment fidelity and examined the possible differences between children assigned to different treatment conditions and between treatment completers and noncompleters. Appropriate statistical analyses were conducted.

Study Weaknesses

Two of the studies had small sample sizes.

Readiness for Dissemination

Review Date: June 2008

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network. (2004). How to implement Trauma-Focused Cognitive Behavioral Therapy. Durham, NC, and Los Angeles: Author.

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

Deblinger, E., & Heflin, A. H. (1996). Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach. Thousand Oaks, CA: SAGE.

Hendricks, A., Cohen, J. A., Mannarino, A. P., & Deblinger, E. (n.d.). Your very own TF-CBT workbook.

National Child Traumatic Stress Network. (2005). The courage to remember: Childhood traumatic grief curriculum guide with CD-ROM. Durham, NC, and Los Angeles: Author.

National Child Traumatic Stress Network. (n.d.). The promise of trauma-focused therapy for childhood sexual abuse [CD-ROM]. Durham, NC, and Los Angeles: Author.

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

Stauffer, L., & Deblinger, E. (2004). Let's talk about taking care of you: An educational book about body safety for young children. Boyertown, PA: Hope for Families.

Stauffer, L., & Deblinger, E. (2005). A workbook about taking care of me. Boyertown, PA: Hope for Families.

TF-CBT handouts and homework sheets

TF-CBT Web site, <http://tfcbt.musc.edu/>

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see [Readiness for Dissemination](#).

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	4.0	3.0	3.7

Dissemination Strengths

Implementation materials are thorough, practical, logically organized, and easy to understand. Clinician qualifications are clearly described. Therapeutic scripts suggest multiple options for cultural adaptations. The developers provide several levels of online training as well as supplementary coaching for clinicians and supervisors. An extensive searchable knowledge bank for further resources on childhood trauma is also provided. Fidelity measures and a searchable database of childhood trauma outcome measures are available to support quality assurance.

Dissemination Weaknesses

The materials include little guidance on how to select appropriate outcome measures from those provided or how to use data derived from these measures to improve program delivery.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Intervention manual (Treating Trauma and Traumatic Grief in Children and Adolescents)	\$31 each	No

10-hour, online introductory training	Free	Yes
2- to 3-day, on-site full clinical training (introductory and advanced training)	Varies depending on site needs	Yes
Learning collaborative	Varies depending on site needs	No
Consultation call twice a month for at least 6 months	\$200-\$260 per hour	Yes, unless organization is involved in a learning collaborative
TF-CBT brief practice checklist	Free	Yes

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

* Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(4), 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., & Knudsen, K. (2004). Treating childhood traumatic grief: A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(10), 1225-1233. 

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse and Neglect*, 29(2), 135-145. 

Cohen, J. A., Mannarino, A. P., Perel, J. M., & Staron, V. (2007). A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(7), 811-819. 

* 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., Stauffer, L. B., & Steer, R. A. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. *Child Maltreatment*, 6(4), 332-343. 

Hoagwood, K. E., & the CATS Consortium. (2008). Impact of CBT for traumatized children and adolescents affected by the World Trade Center disaster. Manuscript submitted for publication.

King, N. J., 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*, 39(11), 1347-1355. 

Contact Information

To learn more about implementation, contact:

Esther Deblinger, Ph.D.
(856) 566-7036
deblines@umdnj.edu

Anthony Mannarino, Ph.D.
(412) 330-4312
amannari@wpahs.org

To learn more about research, contact:

Judith Cohen, M.D.
(412) 330-4321
jcohen1@wpahs.org

Consider these [Questions to Ask](#) (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- <http://tfcbt.musc.edu/>

