



# Trauma-Focused Cognitive Behavioral Therapy: Addressing the Mental Health of Sexually Abused Children

## What's Inside:

- What makes TF-CBT unique
- Key components
- Target population
- Effectiveness of TF-CBT
- What to look for in a therapist
- Resources for further information

## Promising Practices in Child Welfare

This issue brief was developed by Child Welfare Information Gateway, in partnership with the Chadwick Center for Children and Families at Rady Children's Hospital San Diego. Contributing authors include Judith Cohen, M.D., Esther Deblinger, Ph.D., Anthony P. Mannarino, Ph.D., Charles Wilson, M.S.S.W., Nicole Taylor, Ph.D., and Robyn Igelman, Ph.D.

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Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based treatment approach shown to help children, adolescents, and their caretakers overcome trauma-related difficulties. It is designed to reduce negative emotional and behavioral responses following child sexual abuse and other traumatic events.<sup>1</sup> 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.

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 programs. 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 other childhood traumas.

<sup>1</sup> 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 focus of this issue brief is the treatment of sexual abuse. Another issue brief in this series addresses abuse-focused cognitive behavioral therapy (AF-CBT) for the treatment of physical child abuse.

## What Makes TF-CBT Unique

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

### Addresses the Effects of Sexual Abuse and Trauma

In the immediate as well as long-term aftermath of sexual abuse, children are at risk of developing significant emotional and behavioral difficulties (see, for example, Briere & Elliott, 2003; Berliner & Elliott, 2002; 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)**. PTSD symptoms 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 abuse and similar traumatic experiences (e.g., Deblinger, Lippman, & Steer, 1996; Cohen & Mannarino, 1996a, 1996b, 1998a, 1998b; Deblinger, Stauffer, & Steer, 2001; Cohen, Deblinger, Mannarino, & Steer, 2004). The program helps children to process the traumatic memories, overcome problematic thoughts and behaviors, and develop effective coping and interpersonal skills. (See also Effectiveness of TF-CBT, below.)

### **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. Children and parents first participate separately in therapy and then attend several joint child-parent sessions. The parent component teaches stress management, parenting, 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.

### **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 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 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.

### **Successful in Various Environments and Appropriate for Multiple Traumas**

TF-CBT has been implemented successfully in urban, suburban, and rural environments and has demonstrated success with Caucasian, African-American, and Hispanic children from all socioeconomic environments. It has been adapted for Latino and hearing-impaired populations. In addition, recent research findings suggest that TF-CBT may be preferable to less directive 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, in press). 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, in press).

### **Key Components**

TF-CBT is a short-term treatment typically provided in 12 to 18 sessions of 60 to 90 minutes or longer, depending on treatment needs. The intervention is typically provided in outpatient mental health facilities, but it has been used in hospital, group home, school, community, 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, 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 sexual abuse
- Correct maladaptive or unhelpful beliefs and attributions related to the abusive 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 thought stopping.
- **A - Affective expression and regulation**—Helping the child and parent manage their emotional reactions to reminders of the abuse, improve their ability to express emotions, and participate in self-soothing activities.
- **C - Cognitive coping and processing**—Exploration and correction of inaccurate attributions about the cause of, responsibility for, and results of the abusive experience(s).
- **T - Trauma narrative**—Gradual exposure exercises, including verbal, written, or symbolic recounting of abusive events.
- **I - In vivo exposure**—Gradual exposure to nonthreatening 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.
- **E - Enhancing personal safety and future growth**—Education and training on personal safety skills, interpersonal relationships, and healthy sexuality; encouragement in the use of new skills in managing future stressors and trauma reminders.

## Target Population

TF-CBT is most appropriate for use with sexually abused children 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 who:
  - Experience PTSD
  - Show clinically significant levels of depression, anxiety, shame, or other dysfunctional abuse-related feelings, thoughts, or developing beliefs
  - Demonstrate behavioral problems, especially age-inappropriate sexual behaviors
- Children and adolescents who have been exposed to other childhood traumas (e.g., exposure to domestic violence, traumatic loss of a loved one)
- Nonoffending parents (or caregivers) of the victims of sexual abuse or trauma

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, 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 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, cutting themselves, or engaging in other parasuicidal behavior. For these teens, a stabilizing therapy approach such as dialectical behavior therapy (Linehan, 1993) 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 eight empirical investigations have been conducted evaluating the impact of TF-CBT (Cohen & Mannarino 1996a; Deblinger et al., 1996; Stauffer & Deblinger, 1996; Cohen & Mannarino 1997; Deblinger, Steer, & Lippmann, 1999; King et al., 2000; Deblinger et al., 2001; Cohen, Deblinger, et al., 2004). 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 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.

Studies reveal that more than 80 percent of children show marked improvement in symptoms within 12 to 16 sessions (using one 60- to 90-minute session per week). The children 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 et al., 2004)

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

### 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) [www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf](http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf)
- The National Child Traumatic Stress Network (*Empirically Supported Treatments and Promising Practices*, supported by The Substance Abuse and Mental Health Services Administration (SAMHSA), 2005) [www.nctsnet.org/nccts/nav.do?pid=ctr\\_top\\_trmnt\\_prom](http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom)
- *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders, Berliner, & Hanson, Eds., National Crime Victims Research and Treatment Center and The Center for Sexual Assault and

Traumatic Stress; Office for Victims of Crime, U.S. Department of Justice, 2004) [www.musc.edu/ncvc/resources\\_prof/OVC\\_guidelines04-26-04.pdf](http://www.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf)

- The California Evidence-Based Clearinghouse for Child Welfare (2006) [www.cachildwelfareclearinghouse.org/](http://www.cachildwelfareclearinghouse.org/)
- *SAMHSA Model Programs: National Registry of Evidence-based Programs and Practices* [www.modelprograms.samhsa.gov](http://www.modelprograms.samhsa.gov)

### 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.

### 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:

- Reading the program developer's treatment book(s) and related materials
- Participating in intensive skills-based training for 1 to 2 days
- Receiving ongoing expert consultation from trainers for 6 months
- Participating in advanced TF-CBT training for 1 to 2 days

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

### 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.)? Are they clinically supervised by (or did they 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?

### Conclusion

TF-CBT is an evidence-based treatment approach for children who have experienced sexual abuse 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

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## Internet Resources

Center for Traumatic Stress in Children & Adolescents  
[www.pittsburghchildtrauma.com](http://www.pittsburghchildtrauma.com)

Medical University of South Carolina  
*Guidelines for Treatment of Physical and Sexual Abuse of Children*  
[www.musc.edu/ncvc/resources\\_prof/OVC\\_guidelines04-26-04.pdf](http://www.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*  
[www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTA brochure.pdf](http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTA brochure.pdf)

National Child Traumatic Stress Network  
Empirically Supported Treatments and Promising Practices  
[www.nctsnet.org/nccts/nav.do?pid=ctr\\_top\\_trmnt\\_prom](http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom)

University of Medicine & Dentistry of New Jersey, School of Osteopathic Medicine  
CARES Institute  
[www.caresinstitute.org](http://www.caresinstitute.org)

SAMHSA Model Programs  
National Registry of Evidence-Based Programs and Practices  
[www.modelprograms.samhsa.gov](http://www.modelprograms.samhsa.gov)

The California Evidence-Based Clearinghouse for Child Welfare  
[www.cachildwelfareclearinghouse.org/](http://www.cachildwelfareclearinghouse.org/)

## Training and Consultation Resources

### Web-Based Training

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

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 1- to 3-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.

### 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](mailto:JCohen1@wpahs.org)

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

## Practitioner's Guides

Clinicians are encouraged to read one or both of the practitioners' guides below.

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.

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.

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