Introduction

Each year a large percentage of children are exposed to trauma. Experiencing trauma as a child is particularly devastating because of the effects the trauma has on the child’s development (Copping, Warling, Benner, & Woodside, 2001). Traumatized children, especially those showing symptoms of Posttraumatic Stress Disorder, would benefit from age-appropriate interventions that help them process and move past the trauma (Bower, 2008). Such interventions reduce the chance that the child will develop further disabling disorders later in life. Trauma-Specific Cognitive Behavioral Therapy is the evidenced-based treatment of choice for traumatized children (Bower, 2008). The multiple components of TF-CBT help a child manage stress, face their debilitating fears, and process the traumatic event through the creation of a trauma narrative (Cohen & Mannarino, 2008). TF-CBT, when done well, is a necessary and effective treatment intervention for traumatized children.

Problem and Diagnosis

Due to the multitude of experiences a child may perceive as traumatic and the unpredictability of catastrophic events, the exact percentage of children who experience trauma every year is difficult to ascertain (Fletcher, 2003). Researchers have estimated that one in every eight children experience bullying, sexual and physical abuse, neglect, and other forms of maltreatment (Bower, 2008). Additionally, researchers have conjectured that over 33% of children witness or indirectly experience violence (Bower, 2008). In 2002, Cotello, Erkanli, Fairbank, & Angold surveyed over 1400 children/adolescents and discovered that 25% of children under 16 years of age report experiencing one high-magnitude trauma (Fletcher, 2003). Traumatic events can range from abuse and neglect, traumatic death of loved ones, suicide threats, domestic violence, school shootings, kidnappings, terrorist attacks, floods, and many
more terrible events (Copping et. al, 2001; Putman, 2009; Fletcher, 2003; Brown, Pearlman, & Goodman, 2004; Davies, 2004). Children exposed to trauma are at risk for developing a host of distressing mental and behavioral problems such as Posttraumatic Stress, Anxiety Disorders, Mood Disorders, Legal Problems, etc. (Copping et. al, 2001).

Children exposed to trauma have particular vulnerability for long-lasting consequences. Copping et. al. (2001) states, “childhood trauma is particularly significant because uncontrollable, terrifying experiences may have their most profound effects when the central nervous system has not yet fully matured.” Trauma in childhood has been known to affect a child’s development of attention, cognition, personality, social skills, self-esteem, self-concept, and impulse control (Copping et. al, 2001). Additionally, evidence supports a link between childhood trauma and later juvenile delinquency, drug abuse, and criminal behavior (Fletcher, 2003). The devastating holistic impact of childhood trauma, especially if gone untreated, can lead to adult psychological conditions such as personality disorders, debilitating anxiety disorders, and depression (Fletcher, 2003; Copping et. al, 2001).

Children and adolescents exposed to trauma tend to express their distress in varying modalities. Common symptoms include nightmares, lack of concentration, anger, aggression, and somatic complaints (CATS, 2007). Many children will avoid reminders of the traumatic event; have feelings of re-living the event; and have difficulty expressing affect appropriately (Cohen & Mannarino, 2008). Children who experience a multitude of these symptoms may have a disorder known as Posttraumatic Stress Disorder\(^1\) (PTSD) (Cohen & Mannarino, 2008). It is natural for children exposed to trauma to have some change in behavior but it is important to note that not all traumatized children will develop Posttraumatic Stress Disorder (Fletcher, 2003). On average, of all children exposed to trauma, 36% are diagnosed with PTSD (Fletcher,

\(^1\) See Appendix for full DSM-IV-TR criteria for PTSD
Whether or not a child meets full criteria for PTSD, early intervention that targets any debilitating symptoms and provides a safe space for children to process their thoughts, feelings, and behaviors are necessary to prevent further complications as the child continues to grow.

**Relevant Research Interventions and Specific Treatment Approach**

Since the beginning evidence of posttraumatic stress reactions in children in the 1970-1980’s, many approaches to intervention have been utilized by mental health practitioners. Unfortunately, evidence shows that many of these interventions are not proven effective (Fletcher, 2003; Bower, 2008). Bower (2008) states, “More than three-fourths of U.S. mental health professionals who treat children and teens with PTSD report using treatments that have not been scientifically reviewed or for which effectiveness could not be determined by the task force.” According to Bower’s (2008) review, five common approaches of intervention have lacked sufficient evidence of its effectiveness; these include art therapy, play therapy, psychodynamic therapy, drug therapy, and psychological debriefing. Each of these interventions are described in brief, below.

Art therapy and play therapy are interventions used to help children tangibly express their feelings in order to understand and control their emotions (Bower, 2008). Through play and drawing, children whom have difficulty verbally expressing their experiences can share them in a less threatening manner (Bower, 2008; Putman, 2009). Putman (2009) cites an article by Nader and Pynoos written in 1990 who conjecture that “visual and other perceptual experiences of the [traumatic] event become embedded and transformed in a child’s play and drawings.” Therefore, “play and drawings serve as an ongoing indicator of both the child’s processing and his or her resolution of traumatic elements” (Putman, 2009).
Psychological debriefing is an intervention carried out in a group format and involves education and discussion surrounding the trauma (Bower, 2008). Group members share and discuss their individual reactions to the trauma and are given advice on coping strategies. The group typically meets within three days of the event (Bower, 2008). Psychodynamic therapy serves to change an individual’s unconscious reactions to the traumatic event, allowing the individual to unravel his or her emotions and incorporate the trauma into his or her self-concept (Bower, 2008). Finally, medications or drug therapy do not cure PTSD; but rather, are used to ease the stress-related symptoms experienced by children (Bower, 2008). Although the five treatment approaches above may lack sufficient evidence when used individually, if incorporated into other approaches such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), success rates increase.

Numerous research articles support TF-CBT as an evidenced-based intervention for traumatized children and adolescents (Bower, 2008; Brown et. al, 2004; Putman, 2009; Foa & Meadows, 1997; Hoch-Espada, Ryan, & Deblinger, 2006). TF-CBT has been extensively researched, and in numerous reports, has been found to have the strongest empirical support of effectiveness in improving children’s PTSD symptoms (Putman, 2009; Bower, 2008; Hoch-Espada et. al, 2006). TF-CBT uses a multitude of techniques that address the child’s thoughts, feelings, and behaviors associated with trauma (Hoch-Espada et. al, 2006).

Judith Cohen and Anthony Mannarino (2008), experts in TF-CBT, describe the model as a flexible piecemeal treatment that has both joint and individual child and parent sessions. Cohen and Mannarino (2008) explain the components of TF-CBT through the acronym PRACTICE, which stands for “Psychoeducation and Parenting skills, Relaxation skills, Affective regulation skills, Cognitive coping skills; Trauma narrative and cognitive processing of
the traumatic event(s); In vivo mastery of trauma reminders; Conjoint child-parent sessions; and Enhancing safety and future developmental trajectory.” PRACTICE is a particularly relevant acronym because practicing skills is crucial to the success TF-CBT (Cohen & Mannarino, 2008).

Gradual exposure is the core principle that drives TF-CBT; thus, each component of the treatment includes some exposure to the traumatic event experienced by the child; the difficulty of the exposure increases over time (Cohen & Mannarino, 2008). Following a brief description of each component of TF-CBT, a case study is presented that demonstrates the usage of TF-CBT with Mary, age 6 and her mother.

Psychoeducation, the first component of TF-CBT, is used to help the children and their parents understand the typical impact of trauma on a child, as well as instill a sense of hope for the child’s successful recovery (Brown et. al., 2004; Cohen & Mannarino, 2008). During the initial assessment, the therapist explains the child’s diagnosis and the TF-CBT model for treatment. Throughout future sessions, the therapist continues to educate the families on common symptoms in traumatized children and normalize the feelings of the child and parents as they grapple with the trauma (Cohen & Mannarino, 2008). The parenting component provides support for the parents and coaches them on positive parenting skills to use in response to their child’s behavioral issues elicited by the trauma (Cohen & Mannarino, 2008).

Multiple relaxation skills are taught to the child as a way to help him gain control over his distressing physical sensations (Brown et. al, 2004; Cohen & Mannarino, 2008). Many techniques such as yoga, progressive muscle relaxation, sports, singing, music, praying, blowing bubbles, and deep breathing are used according to the child’s interests, so that he has multiple “tools in [his] toolkit” that can be used in any stressful situation (Cohen & Mannarino, 2008). In-between sessions, the child practices his techniques and updates the therapist on their
effectiveness at the next appointment. The therapist then “fine tunes” any problem areas and the child practices the techniques again the next week (Cohen & Mannarino, 2008).

Therapists use cognitive coping skills to help children and parents identify upsetting thoughts related to the traumatic event and recognize the feelings and behaviors that follow these thoughts (Cohen & Mannarino, 2008). The clients learn to evaluate the accuracy of their thoughts and whether they prove to be harmful or helpful to the healing process. Overtime, harmful thoughts are replaced with more appropriate thoughts (Cohen & Mannarino, 2008).

After the children and parents have completed the necessary skill building portions of TF-CBT, the therapist begins the trauma-specific components that aid the child in the development of her trauma narrative (Cohen & Mannarino, 2008; Davies, 2004). Cohen and Mannarino (2008) explain the three therapeutic benefits a trauma narrative has for a child. Through the child voicing her story, whether it be through poetry, song, writing, etc., she is:

“overcoming avoidance of traumatic memories; (2) identifying cognitive distortions through the…telling of the story in [her] own words; (3) contextualising [sic]…her traumatic experiences into the larger framework of [her] whole life: through telling the story in context…, [she] is able to see that…she is more than just a victim of trauma.”

For further exposure, the child reads and re-reads her trauma narrative as it is being written and upon completion (Hoch-Espada et. al., 2006). Often times, the child will read her trauma narrative to her parent once it has been finished, which paves the way for positive communication between the child and parent (Naubauer, Deblinger, & Sieger, 2007).

Overall, TF-CBT is a flexible, individualized, evidence-based treatment, highly effective for children, adolescents, and their families who have been traumatized (Cohen & Mannarino, 2008). The following case example brings to light the various elements of TF-CBT in the treatment of Mary, a six year old girl, who has been sexually abused by her father and has
witness numerous accounts of severe domestic violence (Naubauer et. al, 2007). The case study comes from a chapter focused on TF-CBT is an anthology titled *Play Therapy with Children in Crisis: Individual, Group, and Family Therapy* (Naubauer, Deblinger, & Sieger, 2007)².

**Case Study: Mary, Age 6**

*Background Information and History:* Mary (6-year-old, Caucasian, female), was referred for treatment after she disclosed to her grandmother that she had been sexually abused by her father, Joe. Joe was abusive not only to Mary but to her mother, Linda, as well. Mary witnessed many episodes of domestic violence, the latest of which landed her mother in the hospital for a week. Mary attends a local elementary school and is in first grade. Recently, she has been exhibiting behavioral problems in school, such as refusal to do schoolwork or follow her teacher’s directions. Mary was also beginning to show physical aggression towards her brother and fellow schoolmates. Currently, Mary is living in her Grandma Jackie’s house with her mother and brother. One night, while Jackie was tucking Mary into bed, Mary disclosed that her father would touch her “chest and her private areas” when he tucked her into bed at night (p.110). Mary reported her dad would also watch her take baths and insist that she let him wash her private parts. Jackie relayed all that Mary said to Linda and the family’s CPS worker.

Mary’s CPS worker referred Mary for counseling to help her work through the effect of the sexual abuse and exposure to domestic violence. Linda agreed to be an active participant in Mary’s treatment so that she could learn how best to address Mary’s behavior problems while providing support for her daughter. TF-CBT was determined to be the treatment of choice.

In the initial meeting, the therapist explained the components of TF-CBT and reviewed Mary’s treatment plan. The therapist explained that she would have parallel individual sessions

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² Although the book is titled “Play Therapy,” the case study presented focuses exclusively on TF-CBT as an intervention.
with Linda and Mary during the first part of treatment and joint parent-child sessions towards the middle and end sessions of treatment.

**Session One:** While meeting individually with Linda, the therapist normalized the frustration Linda expressed over Mary’s defiant behaviors. Together, they spent time exploring areas in which Mary was showing healthy, positive behaviors. Linda was given the homework of noticing these positive behaviors in Mary throughout the week.

Once Linda had finished her session, the therapist met with Mary. She asked Mary to tell her about an experience she had in the last day (a neutral narrative). The therapist did so in order to ascertain Mary’s ability for recalling and relaying information. This gave her a picture of Mary’s baseline skills of verbal and expressive communication. Mary told the therapist about going to the park, swinging high on the swings, and being angry when her mom made her stop swinging so high. The therapist recognized that Mary was able to use feeling words and explain the event in adequate detail. Next, the therapist explored the trauma. She began by asking Mary why she had come to talk to a therapist. Mary responded with, “I don’t know,” but after the therapist explained that she helps girls talk about bad things that happened to them; Mary stated, “Yes. My dad did bad stuff to me and to my mom.” The therapist continued to explore Mary’s response and was able to get Mary to share that her dad touched her private parts and hurt her mom, and that she didn’t like it. The therapist praised her for telling what happened and asked how she felt now. Mary acknowledged that it was hard to talk about but she felt a little better having it off her chest.

**Session Two:** The second session with Linda involved reviewing the assigned homework and providing psychoeducation around positive behavior support and modification for traumatized children. The therapist also explored Linda’s negative thoughts and feelings about her daughter
and how these influenced the way she responded to Mary’s defiant behaviors. The therapist provided Linda with articles to read about domestic violence and child sexual abuse and asked her to write down any questions she had and bring them in the following week.

During Mary’s second session, the therapist helped her develop a long list of feeling words such as “happy,” “sad,” “mad,” “embarrassed,” “shy,” that she could use when talking about the trauma. Mary was asked to give examples of situations in which she felt each feeling. In order to focus on feelings related to the trauma, Mary was asked to put a mark by every feeling she felt when she and her mom were being hurt. While Mary talked about each feeling, the therapist assessed the accuracy of the information relayed as well as any irrational thoughts or feelings Mary was experiencing. Finally, using the list, the therapist offered age-appropriate psychoeducation about domestic violence and child sexual abuse.

*Session Three:* The third session focused on the CBT triangle of thoughts, feelings, and behaviors. The therapist used cognitive techniques to help Linda and Mary identify any distorted thinking such as, “it’s my fault.” Mary was taught specific relaxation techniques such as “tin soldier verses rag doll” to use when she felt tense, nervous, or afraid (p.121).

*Sessions 4-10:* The next seven sessions focused on trauma-specific work—the making of Mary’s trauma narrative. The therapist explained the process to Mary who chose to use drawings to tell her story. As the narrative was being completed, the therapist showed sections to Linda in her individual sessions and encouraged her to share her own experiences of abuse. Once the narrative was complete, the therapist began exploring how Mary would feel about sharing the narrative personally with her mother and how Linda would feel about hearing the story from her daughter.
During the first parent-child joint session, the therapist used a fun question/answer game about domestic violence and sexual abuse to help Mary and Linda communicate about the difficult topics in general. Linda was able to praise Mary for all that she knew and the two were able to relax. During the next parent-child session, Mary was able to show her narrative to her mother, who praised and complimented her on the confidence she was showing through sharing her story. The therapist ended each joint session on a positive note by having Mary and Linda praise each other in a specific, uplifting way. In the final parent-child session, Linda and Mary talked about a safety plan to be used if a crisis was to arise and reviewed the safe people and places Mary could go to if she needed help. Finally, the therapist offered some final psychoeducation on good/bad secrets and healthy/unhealthy touch. She then presented Linda and Mary with scenarios that required them to use the skills they had learned in therapy to respond to each scenario.

**Termination Session:** To acknowledge and celebrate all the hard work Linda and Mary did in therapy, a graduation party was planned. Mary’s grandma and little brother were present for the graduation and surprised Mary with a bunch of balloons. The therapist presented Mary with a graduation hat and certificate and assured both Linda and Mary that she would be here if the need for future therapy would arise.

**Case Study Summary:** The therapist used the PRACTICE acronym for TF-CBT explained earlier as a guide to her sessions. The beginning of treatment focused on psychoeducation and skill building around sexual abuse and stress management techniques. The therapist encouraged Mary to share her feelings and thoughts related to the traumas. These thoughts and feelings were put into Mary’s trauma narrative she made during the middle stages of therapy. Mary’s mother was given education about sexual abuse and its effect on children; as well as parenting tips on
how to recognize her child’s symptoms, learn effective parenting techniques, and notice the strengths within her child. The end of treatment focused on appropriate safety skills building.

**Conclusion**

It is a sad reality that many children will witness at least one major trauma before their 16th birthday (Fletcher, 2003). Even more devastating is the fact that symptoms of PTSD in traumatized children, when left untreated, can develop into further disabling disorders (Copping et. al, 2001). However, the extensive research on TF-CBT has proven it to be the evidenced-based treatment of choice for traumatized children (Bower, 2008). TF-CBT has multiple components, explained throughout the paper, which can be remembered by the acronym: PRACTICE (Cohen & Mannarino, 2008). The case study of Mary demonstrated each component of TF-CBT and its positive effects on Mary and Linda’s healing process. There is and always will be a need for continued research on the effectiveness of TF-CBT in traumatized children; but it is undeniable that TF-CBT, when done well, helps children overcome the devastating impacts of trauma.
References


APPENDIX

DSM-IV-TR Criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   1) the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2) the person’s response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
   1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   2. recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
   3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
   4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. efforts to avoid activities, places, or people that arouse recollections of the trauma
   3. inability to recall an important aspect of the trauma
   4. markedly diminished interest or participation in significant activities
   5. feeling of detachment or estrangement from others
   6. restricted range of affect (e.g., unable to have loving feelings)
   7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   1. difficulty falling or staying asleep
2. irritability or outbursts of anger  
3. difficulty concentrating  
4. hyper vigilance  
5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.