GUIDELINE 5

Cognitive-Behavioral Therapy for Children and Adolescents

Description

A number of effective trauma-specific cognitive-behavioral therapy (CBT) models are currently available. These models share common components, summarized by the acronym PRACTICE, whose components are as follows: *Parental* treatment, including parenting skills; *Psychoeducation* about common child and parent reactions to trauma; *Relaxation* and stress management skills; *Affective* expression and modulation skills; *Cognitive* coping skills; *Trauma narrative* and cognitive processing of the child's traumatic experiences; *In vivo desensitization* to trauma reminders; *Conjoint* child–parent sessions; and *Enhancing safety* and future development. Some CBT models for traumatized children only include some of these components; others add additional components and/or include ancillary services, such as case management. Additional tenets of these treatments include the following: (1) skills development (e.g., affective regulation and addressing safety needs) is provided prior to exposure components; (2) parental inclusion in therapy is optimal when possible; (3) recognition that trauma impacts multiple facets of children's lives; therefore, interfacing with schools, medical providers, justice system, child protection, child welfare, and other systems of care is often necessary to provide optimal interventions for traumatized children.

General Strength of the Evidence

Several individual posttraumatic stress disorder (PTSD)–targeted CBT models for children or adolescents have evidence of efficacy in Level A or B studies.

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Trauma-focused CBT (TF-CBT) is the most thoroughly tested of these models, with six Level A studies completed for children between 3 and 17 years of age by three independent research teams in the United States and Australia. These studies demonstrated that TF-CBT is superior to comparison conditions for improving a variety of child symptoms, including PTSD, depression, internalizing symptoms, general behavioral symptoms, and shame. All of these studies were conducted with sexually abused children. The largest study included over 200 children, most of whom had experienced multiple-trauma histories in addition to sexual abuse. TF-CBT was also used in three Level B studies for children who had experienced terrorism and traumatic grief; these studies also demonstrated significant improvement in PTSD symptoms. TF-CBT has been culturally adapted and evaluated for Latino children and is currently being used and evaluated with Dutch, German, Norwegian, African, Pakistani, and other international populations of children.

Cognitive-based CBT has been compared to a wait-list control in a pilot Level A study for U.K. children exposed to single-incident traumatic events and has shown positive findings for PTSD, anxiety, and depression.

Seeking Safety (SS) is an integrated treatment model for comorbid PTSD and substance use disorder (SUD). Direct exposure techniques are not typically included (but can be done adjunctively). A Level A study of U.S. adolescents showed significantly better outcomes for SS than for treatment as usual (TAU) in various domains at posttreatment, including substance use and associated problems, trauma-related symptoms, cognitions related to PTSD and SUD, psychiatric functioning, and several additional areas of pathology not targeted in the treatment (e.g., anorexia, somatization, generalized anxiety). Some gains were sustained at 3-month follow-up.

KIDNET, a child-friendly form of narrative exposure therapy (NET), was developed in Germany specifically to treat survivors of multiple and severe trauma. NET includes psychoeducation, narration, and cognitive processing, with a focus on children's and human rights to help regain dignity. One KIDNET study described as Level A was published in German in a book chapter and presented at a peer-reviewed conference shortly before publication of these guidelines.

Trauma systems therapy (TST) combines individual therapy, such as TF-CBT with a systematic approach for children who have experienced complex trauma or challenging family situations, or who need medication management, residential or inpatient placement, and/or other complex clinical needs. TST was found to be superior to usual care in a Level B study of U.S. children and adolescents.

Promising practices for complex trauma are currently being tested. Two such models, Structured Psychotherapy for Adolescents Recovering from Chronic Stress (SPARCS) and Life Skills/Life Story are being tested in residential, as well as outpatient, settings for U.S. teens with complex trauma histories.

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Course of Treatment

The CBT models for childhood PTSD described earlier are provided over the course of 8–24 sessions, but they are intended to be implemented with flexibility, so that each component can be adjusted to the needs of the individual child.

Recommendations

Several trauma-focused cognitive-behavioral child and adolescent interventions effectively decrease PTSD symptoms. Additionally, these interventions provide traumatized children and teens with skills that generalize beyond PTSD symptoms to include a variety of other domains, such as depression, anxiety, behavioral problems, shame, grief, and adaptive functioning. Therapists working in community or nonclinic settings often see multiply traumatized children: those with comorbid psychiatric conditions; those with challenging family situations, including children living in foster care, residential settings, and domestic violence shelters or refugee camps, or other unsafe settings; those who are taking a variety of psychotropic medications; and/or those with significant behavioral problems. TF-CBT, SS, TST, and KIDNET have been used and tested with some of these populations; SPARCS, Life Skills/Life Stories, and KIDNET were developed specifically for these youth. Some of the interventions described earlier have been used internationally and have been culturally adapted for diverse child populations.

Growing numbers of community therapists are using these interventions, particularly TF-CBT, through the Substance Abuse and Mental Health Services Administration (SAMHSA)–funded National Child Traumatic Stress Network (*www.nctsn.org*) and other state or nationally funded efforts. These include a free Web-based training (*www.musc.edu/tfcbt*), the use of learning collaboratives (*www.ihi.org*), and the adaptation of these treatments for children of different cultural groups.

Summary

Several models of non-school-based CBT have efficacy for treating child or adolescent PTSD in Level A or B studies. All of these models share basic principles and components described by the PRACTICE acronym. SS adds interventions for SUD prevention, and TST adds components for complex trauma management. Additional promising practices are being testing for complex trauma. Some of these models have been adapted and are being evaluated for children in diverse cultures. Thus, several effective forms of CBT are available for clinicians' use with traumatized children and teens, and preliminary

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information suggests that these interventions are acceptable and appropriate for children of diverse cultures.

Suggested Readings

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

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York: Guilford Press.

Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2006). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach.* New York: Guilford Press.

Schauer, E., Neuner, F., Elbert, T., Ertl, V., Onyut, P. L., Odnenwald, M., et al. (2004). Narrative exposure therapy in children: A case study in a Somali refugee. *Intervention, 2*, 18–32.

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