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Trauma-Focused Cognitive Behavioral Therapy for traumatized children and adolescents

ABSTRACT

While most children who have experienced some sort of trauma are resilient, others develop negative psychological effects which may include posttraumatic stress disorder, depression, anxiety, behavioral problems, cognitive problems, and loss of investment in the future. The TF-CBT model provides children and parents with stress management skills and encourages direct discussion and processing of children's traumatic experiences. The model is comprised of eight components, each of which is provided to both the child and parents in parallel sessions. This article will focus on this treatment model.

Key words: trauma, posttraumatic stress; children; adolescents; cognitive behavioral therapy

Introduction

Trauma affects children and adolescents (hereafter referred to as "children") commonly. Sexual abuse, physical abuse or domestic violence affect up to a quarter of the world's children (ALYAHRI & GOODMAN, 2008; AMMAR, 2006; CHEN, DUNNE & HAN, 2004; FANSLAW, ROBINSON, CREngle, & PERESE, 2007; NELSON, ET AL., 2002; XU, CAMPBELL & XHU, 2001). Many children experience community or school violence as well (e.g., LEA, SHIELDS, NADESEN & PIERCE, 2008). In many parts of the world natural disasters, motor vehicle accidents, war, terrorist acts and/or refugee experiences are also common.

While most children are resilient, many others experience serious and potentially long lasting negative psychological effects from traumatic experiences. These may include the development of posttraumatic stress disorder (PTSD), depression, anxiety or other affective dysregulation problems; behavioral problems such as anger, substance abuse, sexualized or violent behaviors that reenact the child's own traumatic experiences; or cognitive problems such as self-blame, shame, loss of trust, hopelessness, loss of investment in future plans, goals, or association with deviant peers due to poor self-esteem and worthlessness (COHEN, MANNARINO & DEBLINGER, 2006, pp 3-19).

To some extent the way children respond to trauma may be determined by genetic factors (e.g., CASPI ET AL., 2002). Other determinants may be the severity of exposure to the trauma, including the degree to which the child or adolescent subjectively believed his or her life or another close person's life was in danger (or whether someone actually died); the availability of social support during and after the traumatic event(s); past history of other traumas; the child's or youth's preexisting history of anxiety disorder and the parental psychiatric history including presence of PTSD; and the amount of time the child or adolescent spent watching television coverage of the traumatic event if applicable (PINE & COHEN, 2002).

In addition to these factors, children's long term response to trauma may be determined by whether or not they receive effective treatment. Fortunately evidence-based treatments (EBT) are now available for children who have significant psychological problems following traumatic exposure. This paper describes a prototypical EBT, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for traumatized children.

Which Children and Adolescents Should Receive TF-CBT?

TF-CBT is designed for children whose primary presenting problems are related to their traumatic life experiences. These problems are typically PTSD, depression, or anxiety symptoms (whether or not the child meets full criteria for any of these disorder); or shame, negative self-esteem, or behaviors that are clearly related to the traumatic experience(s). TF-CBT has been tested with children ages 3-17 years old and has anecdotally been used with children as young as 2 years old and with young adults (i.e., in their 20's). This treatment model has been used with families of many diverse cultures including North America, South American, Africa, Asia and the Middle East. The TF-CBT treatment manual is translated into several languages (Dutch, German, and Chinese, with Spanish content available and Japanese and Korean translations in progress and an Arabic translation being negotiated). TF-CBT has been used in diverse settings including clinics, homes, residential treatment facilities and foster homes. It has good evidence of effectiveness in ethnic minority youth (HUEY & POLO, 2008).

TF-CBT was initially developed for children who experienced sexual abuse. It has been shown in randomized controlled trials (RCT) to improve PTSD and other symptoms in children who experienced sexual abuse, multiple traumas and domestic violence and has been also been shown in quasi-controlled and effectiveness studies to improve PTSD for children exposed to natural disasters, terrorism, and traumatic grief. These studies are described below.

No treatment model is appropriate for all children, and TF-CBT is no exception. This model is probably not optimal for children whose primary problems are serious and longstanding behavioral problems or other serious psychiatric symptoms (e.g., psychotic symptoms; substance abuse; serious self-injury) even if the clinician suspects that these may have their origin in early traumatic experiences. For these children or adolescents it is critical to determine whether the

trauma symptoms are primary or their other psychiatric problems take precedence. Usually the other problems need to be stabilized before the trauma issues can be effectively resolved. Some of these children may not have a primary trauma problem, but instead may have had a historical trauma which is not the primary cause of the underlying current problem. This emphasizes the importance of conducting a thorough initial evaluation prior to starting TF-CBT. To emphasize: TF-CBT is not the optimal model to use for children or adolescents who need initial stabilization of self-injury or other serious psychiatric instability, nor for primarily addressing serious behavioral problems. Other evidence-based models are available and should be used for children and adolescents who are in need of these services. TF-CBT is designed for children and adolescents who have trauma-specific symptoms such as PTSD, depression, anxiety or mild to moderate behavioral problems clearly linked to their traumatic experiences e.g., sexualized behaviors related to sexual abuse).

TF-CBT Overview

TF-CBT is a components-based treatment model. Its components are provided in individual child sessions. Parents are also included in therapy whenever feasible; parents receive parallel individual sessions. The components are summarized by the acronym PRACTICE. A core principle of TF-CBT is gradual exposure (GE). The TF-CBT therapist carefully calibrates and increases the intensity and duration of exposure to the child's trauma experience during each progressive component. In this way the child and parent are able to gradually increase their ability to tolerate exposure to trauma memories and reminders and thus to master avoidance. The PRACTICE components are Psychoeducation and Parenting skills; Relaxation skills; Affect expression and modulation skills; Cognitive Coping skills; Trauma narrative and processing; in vivo mastery of trauma reminders; Conjoint parent-child sessions; and Enhancing safety and developmental trajectory. Each component is described below.

More detailed information about this model is available in our free web-based training course. This can be accessed at www.musc.edu/tfcbt. Our treatment manual also describes more details about the treatment model. This book, *Treating Trauma and Traumatic Grief in Children and Adolescents* is available from www.guilford.com or www.amazon.com; German, Dutch and Chinese translations are available as described above.

TF-CBT Components

Psychoeducation

Psychoeducation is introduced during the first phone contact with the family and continues throughout TF-CBT treatment. Psychoeducation typically provides information to the child or

adolescent and parent about the nature of the child's trauma experience and current symptoms, and hope for recovery. Many parents and children feel less isolated by learning some facts about the child's type of trauma. For example, children who experienced sexual abuse may feel less alone if they learn that a quarter of all girls and a sixth of all boys experience this kind of trauma. Information about the child's symptoms may reassure children and parents that the child is responding in an expected fashion to stress. Providing written information such as handouts or brochures to parents may be especially helpful since families may refer to this at home when they are feeling stressed. Encouraging families to believe that their children will recover may in itself be a critically important factor in healing. Therapists who exude optimism about treatment are likely to have more positive outcomes than those who shed doubt on the prospects of recovery. Telling parents that 80% of children experience remission from symptoms after 12 sessions of TF-CBT provides hope.

GE is used at a very low level in the psychoeducation component. For example, the child and parent are not asked to talk at all about the child's personal trauma experiences at this point, but rather during this component the therapist typically shares general information about the type of trauma the child has experienced without reference to the child's own experiences. The therapist uses the correct terms for the type of trauma the child experienced (e.g., "sexual abuse," "physical abuse," "domestic violence," "car accident," "death") and thus helps the child and parent to begin to grow comfortable with talking about this type of trauma in general. TF-CBT therapists are also trained not to lower their voices, look away or otherwise to inadvertently convey shame or discomfort about talking about the trauma that the child experienced. Through these nonverbal techniques the therapist also models that the family does not have to avoid talking about the child's traumatic experience, and that the therapist is confident that the child will master this experience and recovery from its negative impact.

Parenting Skills

As noted previously, under usual circumstances parents participate in TF-CBT during parallel individual sessions with their children. TF-CBT views parents as active members of the treatment team. Therapists only see children 1 hour a week; parents are with children much of the rest of the week. TF-CBT therapists count on parents to implement what they have learned in therapy with their children during the subsequent week at home. It is therefore critically important to engage and involve parents in the therapy process, including parents' opinions about the best way of implementing TF-CBT components for their individual children. TF-CBT provide parents with effective parenting skills but parents guide therapists in optimal ways for using these skills with the specific child – what will work for this child's problems, given his or her interests, the family's history of trying different behavioral strategies in the past, the child's particular strengths and vulnerabilities and the parent's ability or interest in using different strategies. The therapist needs to take all of these into consideration when implementing proven

parenting strategies such as praise, selective attention, and/or contingency behavioral programs and so forth. Helping parents to better manage children's behavioral regulation problems that have occurred as a result of traumatic experience improves the parent-child relationship and also empowers parents to feel capable as good, protective and effective parents who can guide their children on the path towards recovery.

GE is used in the parenting component by directly addressing with the parent the behavioral impacts of the child's trauma experience and encouraging the parent to believe that the above techniques will be successful in overcoming these problems. By connecting these problems to the child's traumatic experience the therapist helps the parent to understand that the child is not being "bad" but is having behavioral effects related to the trauma, and that these will resolve with positive interventions. This is also helpful in overcoming parental avoidance about talking about the child's traumatic experiences.

Relaxation

Physiological changes also occur following child trauma (DeBellis et al., 1999), including increased resting and reactive heart rate, blood pressure, adrenaline output, and many other central nervous system changes that tend to maintain high fear and hyper-responsiveness to danger. Many different forms of relaxation can effectively reverse these changes. Having a number of "tools in the toolkit" for self-soothing or relaxation for child and parent can help children when physiological or psychological fear occurs. It is best for therapists to tailor these skills to individual children's and parents' interests rather than using the same ones for everyone. For example, focused deep breathing such as the type that is commonly used in yoga has good evidence of reversing physiological changes associated with PTSD, but few children and teens are naturally drawn to the use of this technique. Most children prefer "fun" activities such as sports and recreation (e.g., soccer, basketball, hockey for teens; singing songs and dance for younger children) so therapists may ask children or teens what types of activities they enjoy doing and encourage them to engage in these activities when the setting is appropriate (e.g., after school). However, it is also important to develop effective relaxation strategies for settings in which recreation or sports are not feasible, for example, in school or at bedtime. These might include the use of progressive muscle relaxation (gradually tensing and relaxing each set of muscles starting at the feet and progressing to the head) or progressive visualization exercises (visualizing a specified series of views, for example, the ocean, a butterfly, and the sunset). Either of these can be done quietly when seated or lying down. Parents learn these skills and encourage children to use them at times of stress.

GE is used during relaxation to help children address trauma reminders. Trauma reminders may be any person, place, situation, a smell, song, an internal memory, or anything that triggers a memory about the child's traumatic experiences. When these occur the child often experiences physiological and/or psychological fear, anxiety or avoidance. The therapist and parent encourage the child to tailor the use of relaxation skills as described above, to the specific situation

and reminder, e.g., which skill will work best for which type of reminder in which situation? Over time more strategies may need to be developed as new reminders arise in novel situations.

Affect Expression and Modulation

Children who have experienced chronic trauma such as child abuse or ongoing violence may avoid expressing feelings, be affectively constricted (i.e., say that they “feel nothing”), have difficulty distinguishing different feelings (e.g., say that they feel “angry” regardless of the situation) or be overly responsive to negative affective cues from others (e.g., inaccurately perceive anger in others with neutral, sad, concerned or preoccupied facial expressions). These and other traumatized children often also have difficulty modulating negative emotions. Some may have learned to suppress these feelings until they can no longer hold them in, leading to explosive outbursts; whereas others may successfully suppress feelings leading to severe emotional constriction. Helping children learn to accurately identify, express and modulate feelings is critically important. This can be achieved through a variety of techniques, for example, feeling expression games or the use of drawing (using different colors to denote different feelings) can help children learn to express a variety of different feelings. Learning how to seek social support, the use problem solving skills, negotiating, and the use of humor, optimism and faith are some other techniques that are useful in this regard. These are described in greater detail elsewhere (COHEN ET AL., 2006; www.musc.edu/tfcbt)

GE is used in affect expression and modulation in helping children cope with trauma reminders. Therapists and parents should work with children to identify which affective modulation strategies work best when have affective modulation problems occur in given situations (e.g., when visiting the perpetrator of domestic violence; when going to school where bullying occurred; in other settings where trauma reminders occur). Helping children recognize trauma reminders is an important step in this process.

Cognitive Coping

Once children are able to modulate feelings, they learn connections between thoughts, feelings and behaviors through the use of cognitive coping as they relate to everyday situations. Therapists encourage children and parents to recognize situations in which they have upsetting feelings related to everyday events (e.g., the child was not invited to a party) and to examine thoughts and feelings related to that event: are these thoughts accurate and helpful, and if not, can the child develop more accurate and/or helpful thoughts that will help him or her feel better?

For example, the child’s thought in this situation may be, “no one likes me” (thought) and this may lead the child to feel sad and lonely (feeling) and to stay at home and not do anything for the rest of the week (behavior). In examining the above thought the therapist helps the child to see that it is likely not accurate (most children have at least one person who likes them) and it is certainly not helpful, i.e. it does not make the child feel good. What could be a

different thought in this situation? If the child is not able to come up with one (a common scenario), the therapist might suggest, "Perhaps the parents only allowed a certain number of children to be invited, and you are not one of his closest friends, so the reason you weren't invited is only because it was a small party, not because he doesn't like you." How would this thought make the child feel? The child may feel somewhat better, especially if he knows someone else who was not invited. His behavior may be to call another child who wasn't invited to the party and plan to do something with that child during the week. In this manner children and parents learn that they have control over their thoughts and feelings, rather than that their feelings and thoughts control them. Cognitive coping thus becomes another tool in the toolbox for soothing negative affective states.

GE is used during cognitive coping for parents but not for children, i.e., the therapist does apply cognitive coping directly to the child's trauma experiences just yet. This is delayed until the next component.

Trauma Narration and Processing

Once children and parents have mastered the skills components of TF-CBT (which typically takes 4-8 sessions), therapists move to the trauma-specific components. In these sessions children talk more specifically about their personal trauma experiences. If the earlier components have correctly used GE this will not be a significant increase in exposure since each previous component gradually increased the intensity and duration with which exposure was used to address trauma reminders.

During this component children develop a narrative about their personal trauma experiences, typically through writing a book, poem, song or other written narrative. For young children the therapist writes what the child dictates, plays or talks about. It is important to have some written record of what the child describes in order to review it with the child and parent during subsequent "tellings" of the narrative, during which exposure and mastery occurs. The reasons for creating a narrative include 1) overcoming avoidance of traumatic memories; 2) identifying and processing maladaptive cognitions about the trauma through the child telling about it in his or her own words; 3) contextualizing the child's trauma experiences into the larger perspective of the child's life through telling the story in context (i.e., by telling the story of before the trauma started; when it was happening; since it has stopped, the child is able to see that he or she is more than simply a trauma victim).

The trauma narrative typically occurs over 3-5 sessions. It usually starts with "who I am," then describes the child's relationship to the perpetrator or the child's life before the trauma started or happened; then describes in detail at least one episode of trauma, and concludes with a section on "how I have changed, what I would like to tell other children who have gone through this." Once the child has created the narrative of "what happened," the therapist reviews it with the child to fill in additional thoughts, feelings and body sensations, and worst moments of the traumatic experience. Then the therapist cognitively processes maladaptive cognitions that may

be contributing to negative affective states. For example, the child may have expressed self-doubt, self-blame, shame, or other thoughts or feelings during the narrative that suggest maladaptive cognitions that need to be addressed.

As the narrative is developed it is shared (with the child's permission) with the parent during parallel parent sessions. This enables the parent to prepare for later conjoint child-parent sessions. It is important to understand that often these narratives are at least as upsetting to parents as to children, since the children have lived through and know the details of the narrative whereas often the information is new and possibly shocking to the parents. Parents may also benefit from cognitive processing of the narrative.

In vivo Mastery

This component uses graduated exposure for children who have developed generalized avoidance of innocuous cues (e.g., children who were sexually abused in the family's bathroom and are now afraid of using any bathroom; children who were bullied in school and now are afraid of attending school; children who were in a car accident and now avoid riding in any cars, etc). Such avoidance can lead to impairment in social, academic, physical and/or psychological domains and therefore needs to be addressed promptly. In order to do in vivo exposure it is important to develop a hierarchy of feared cues, and to gradually help the child to master these feared stimuli through graduated exposure. This requires that the child, parents, therapist and (if appropriate) school personnel be committed to sticking with the exposure program and to keeping the settings safe from true danger. In vivo exposure should not be initiated if perpetrators or other dangers are still present (e.g., if the perpetrator of abuse is still in the home or the bullies are still in the school) since this will serve to reinforce the child's learned and generalized fear and the exposure plan will most likely be unsuccessful.

Conjoint Sessions

As TF-CBT treatment draws toward a close it is very important to include conjoint child-parent sessions. The goals are to improve direct child-parent communication about the child's trauma as well as other important issues, and to shift the child's and parent's expectations from needing the therapist to achieve their goals of improving the child's outcomes, to being able to do this by talking directly with each other. During conjoint sessions children typically share their trauma narratives directly with their parents (parents will have already heard the narrative from the therapist and have been well prepared for the conjoint sessions by the therapist). In addition, children and parents talk about other important issues such as safety, preparing for future trauma reminders, and moving forward in the future after therapy has ended. Children and parents may want to ask each other questions about the child's traumatic experience (e.g., "How are you feeling about what happened?" "Do you think I should have been able to stop it?" "Are you mad at me for what happened?"), in order to address any lingering issues before the end of treatment. This is the benefit of the therapist treating both the child and the parent: this ther-

apist will be in an ideal situation during conjoint sessions to identify and encourage discussion of any such lingering issues that have not yet been addressed. Although TF-CBT can be effective when provided to children without parental involvement, optimal benefits occur when children and parents participate together (DEBLINGER, LIPPMAN & STEER, 1996; KING ET AL., 2000).

Enhancing Safety and Developmental Trajectory

Optimizing safety and helping the child regain his or her optimal developmental trajectory are the final PRACTICE components. Traumatized children may develop risk seeking behaviors (PYNOOS, STEINBERG, LAYNE, BRIGGS, OSTROWSKI & FAIRBANK, 2009). Helping children realistically assess danger, learn safety skills and health-promoting decisions is important for ensuring that children will not experience future victimization nor victimize others. As described above, therapists may decide to include safety skills in conjoint sessions for some children and adolescents but may determine that this topic is best addressed in individual sessions for others. Additional skills may be addressed as needed prior to termination in order to enhance the child's developmental trajectory and return to normal functioning. If referral to ancillary or additional psychiatric services is needed this should be done either during or at the end of TF-CBT treatment.

Research Studies

TF-CBT currently is the most thoroughly tested of any psychotherapy for traumatized children and adolescents. It has been evaluated in 8 randomized controlled trials, three quasi controlled trials, two open studies and one cross site evaluation conducted among many sites of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)-funded National Child Traumatic Stress Network (www.nctsn.org). These studies have documented that TF-CBT was 1) superior to a variety of comparison conditions including non-directive therapy, child centered therapy and community treatment as usual for improving a variety of symptoms including PTSD, depression, social competence, behavior problems, fear, sexual safety knowledge and dissociation in children ages 3-17 years old who had experienced sexual abuse, as well as improving parental symptoms in parents participating in TF-CBT (COHEN & MANNARINO, 1996; COHEN, MANNARINO & KNUDSEN, 2005; DEBLINGER, LIPPMAN & STEER, 1996; DEBLINGER, STAUFFER & STEER, 1999; COHEN, DEBLINGER, MANNARINO & STEER, 2004; DEBLINGER, MANNARINO, COHEN, RUNYON & STEER, 2009; KING ET AL., 2000); 2) superior to usual community treatment for improving PTSD and other symptoms among multiply traumatized children (COHEN ET AL., 2004) and for improving PTSD, behavior problems and placement disruption among foster children with high levels of initial behavior problems (NORTHWESTERN UNIVERSITY, 2008); 3) superior to child centered therapy for improving domestic violence-related PTSD and other symptoms when treatment was provided in community domestic violence treatment settings

(COHEN, MANNARINO & IYENGAR, 2009); 4) effective in improving children's PTSD symptoms after community disasters and terrorist attacks (JAYCOX ET AL., 2009; HOAGWOOD, in press); and 5) effective in improving child and adolescent (ages 6-17 years old) PTSD and traumatic grief symptoms (COHEN, MANNARINO & KNUDSEN, 2004; COHEN, MANNARINO & STARON, 2006). These studies suggest that TF-CBT has broad applicability for child and adolescent trauma symptoms across multiple types of trauma.

International Implementation

TF-CBT research is also beginning to occur internationally. As noted earlier the TF-CBT treatment manual has been translated into several other languages and TF-CBT studies are ongoing in Norway, the Netherlands, Germany, Zambia and Cambodia. TF-CBT implementation is occurring in China, Indonesia, Japan, Tanzania, American Samoa, Pakistan, and a variety of other settings. The free web-based course *TF-CBTWeb* (www.musc.edu/tfcbt) has been accessed by more than 50,000 mental health professionals in more than 60 countries supporting its cross-cultural acceptability. As more international practitioners become aware of this model we look forward to hearing how it works for children of increasingly diverse backgrounds in different countries.

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This paper explores children's trauma symptoms related to parental incarceration and lays the groundwork for the implementation of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) within a... Children Traumatized by Parental Incarceration and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Arditti's (2005) ecological approach to incarceration aims to holistically understand the effects of incarceration on the interrelationships between the family members, environments, and society, and asserts that incarceration may produce multiplicative harms on children and families.