This article reviews the four major components of trauma-focused cognitive behavioral therapy (CBT) for children and adolescents: exposure, cognitive processing and reframing, stress management, and parental treatment. For each component, background, description, and the current empirical support for including each of these components in the treatment of traumatized children is presented. Although there is growing empirical support for the efficacy of trauma-focused CBT in decreasing psychological symptomatology, there are inadequate data to indicate the relative contribution of the individual CBT components. Suggestions for future clinical and research directions are also discussed.

**Trauma-Focused Cognitive Behavioral Therapy for Children and Adolescents**

*An Empirical Update*

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Unfortunately, substantial numbers of children are exposed to traumatic events such as child abuse, rape, community or domestic violence, natural disasters, vehicular accidents, war, or sudden death of a parent or sibling. Several studies (Finkelhor, 1998; Singer et al., 1995) have documented high levels of traumatic exposure in children and have demonstrated that exposure to such traumatic experiences can result in significant psychological symp-
tomatology, including posttraumatic stress disorder (PTSD) or other anxiety disorders, depressive symptoms, or a variety of behavioral problems (American Academy of Child and Adolescent Psychiatry [AACAP], 1998). If left untreated, these difficulties may become chronic, producing adverse effects that may persist into adulthood (Green et al., 1994; Sack, Clarke, & Seeley, 1995). It is therefore important to empirically evaluate strategies for treating symptomatic traumatized children, which may minimize these negative sequelae.

Most of the treatment techniques developed for treating trauma-related symptoms in children have been modified from treatments for traumatized adults or from interventions that have been useful in treating nontraumatized children who have symptoms similar to those seen in traumatized children, that is, anxiety or depressive symptoms. In particular, interventions that have been efficacious in decreasing PTSD symptoms in adults have been adapted for use in traumatized children. Because children develop a variety of difficulties after traumatic exposure, including depressive, anxiety, and behavioral symptoms (AACAP, 1998), effective child interventions for such symptoms have also been modified for use in this population.

Of all the interventions used to treat trauma-related symptoms in children, cognitive behavioral interventions have received the most empirical evaluation. Saigh (1986) described the use of behavioral treatment for children with PTSD with an emphasis on in vitro flooding techniques. Pynoos and Eth (1986) described a 90-minute clinical interview for children exposed to violence, designed to aid in cognitive mastery of anxiety and grief. Chemtob, Tomas, Law, and Creminiter (1997) described cognitive-based psychological debriefing intervention to be used in disaster situations. March, Amaya-Jackson, Murray, and Schulte (1998) developed a manualized cognitive behavioral group intervention for adolescents exposed to single-incident trauma, in which exposure is a prominent feature. Parson (1997) described an intervention for children exposed to catastrophic community violence that includes cognitive, behavioral, and psychodynamic features. Cohen and Mannarino (1993) described a cognitive behavioral treatment model for sexually abused preschoolers and their parents that focuses on direct discussion of specific aspects of the trauma and correction of cognitive distortions. Deblinger and Heflin (1996) published a detailed protocol for treating sexually abused children and their nonoffending parents that includes cognitive coping and exposure techniques. Thus, many advocate the use of cognitive, behavioral, and/or cognitive behavioral therapy (CBT) for traumatized children. This article will describe each of the components of CBT commonly used in treating traumatized children and present the current empirical support for their use.
EXPOSURE/DIRECT DISCUSSION OF THE TRAUMATIC EVENT

Overview

Exposure techniques have been successfully used to treat a variety of symptoms in traumatized adults. For example, Foa et al. (1998) demonstrated that exposure therapy was efficacious in decreasing PTSD symptoms in adult rape victims, whereas Keane, Fairbank, Caddell, and Zimering (1989) and Cooper and Clum (1989) found that flooding successfully reduced PTSD symptoms in combat veterans. Exposure has also been used to successfully treat children without a history of trauma who have anxiety disorders such as specific phobias and panic disorder (Carlson, Figueroa, & Lahey, 1986; Ollendick, 1979).

Exposure, whether intense and prolonged (such as in vivo or imaginal flooding) or graduated (such as gradual exposure), involves ongoing exposure to stimuli that produce fear or anxiety—typically, for traumatized individuals, these stimuli represent specific aspects of the traumatic event. The mechanisms by which exposure techniques are hypothesized to work are detailed elsewhere (Wolpe, 1990) and include extinction, reciprocal inhibition, and habituation. Specifically, through the process of repeated exposure, remembering the trauma and reminders of the trauma typically become less emotion-laden over time. This usually results in an unpairing of thoughts about the trauma and overwhelming negative emotions (fear, anger, etc.). This in turn decreases the intensity of intrusive traumatic recollections and decreases the need to use avoidant behavior, which is a typical symptom of PTSD.

Description

Imaginal Flooding

Because exposure techniques were helpful in decreasing symptomatology in traumatized adults, some researchers have more recently adapted them for use in children exposed to traumatic events. In a series of case reports, Saigh (1987a, 1987b, 1989, 1998) and Saigh, Yule, and Inamdar (1996) used imaginal flooding to treat children and adolescents exposed to a variety of traumatic experiences. This technique involves the identification of specific anxiety-provoking scenes through clinical interviews, and several subsequent sessions during which the therapist instructs the child to imagine the specific details of the anxiety-provoking scenes. During this procedure,
the child rates the degree of emotional distress he or she experiences (Saigh, 1998, p. 405).

Gradual Exposure

Deblinger and Heflin (1996), Cohen and Mannarino (1993), and March et al. (1998) developed gradual exposure models that encourage children to first describe a relatively less upsetting episode or aspect of the trauma and to gradually progress to describing more traumatic events that are more emotionally difficult to verbalize and cope with. In this approach, the therapist begins by simply asking the child to tell something about the traumatic event. Typically, the child will provide a very brief description. Initial exposure exercises may involve discussions about the trauma in the abstract (i.e., educational information) or less anxiety-provoking aspects of the experience (i.e., telling an investigator about the experience). Subsequent exercises then attempt to elicit more specific descriptions of what happened. Once the child has described the event(s) in detail, the therapist may ask what the child was feeling or thinking during the event. At the conclusion of the exposure portion of the session, the therapist asks the child how it felt to talk about the traumatic event to assess how stressful it was and to gauge the child’s ability to tolerate increased levels of exposure in the next session. This process occurs over several sessions and is typically accomplished through the use of drawings, descriptions written in book form or typed on a computer, conducting mock interviews into a tape recorder, and so forth. These are saved and reviewed at successive sessions as part of the gradual exposure process.

EMPIRICAL SUPPORT

Saigh (1987a, 1987b, 1989, 1998) and Saigh et al. (1996) used single-case designs to demonstrate that imaginal flooding resulted in decreased PTSD symptoms. This series of case studies provides the only empirical evidence to date that specifically supports the efficacy of using exposure techniques per se to reduce symptomatology in traumatized children.

Other studies have provided some indirect evidence in this regard. Berliner and Saunders (1996) evaluated two similar forms of group CBT for sexually abused children. In the index treatment, exposure therapy was used in addition to stress inoculation therapy (SIT). Specifically, each child was required to describe details of the sexual abuse experience at least once during the therapy. In the comparison group, the SIT that was provided was iden-
tical, but this exposure technique was not used. However, vicarious exposure occurred for many children in the control condition because some children in that condition spontaneously described their abuse experiences in group sessions. This may account in part for why no differential treatment effects were found for the two types of treatment, that is, the treatments were too similar to detect differences. Another study that used explicit exposure techniques was conducted by Deblinger, Steer, and Lippmann (1996, 1999b). This study used gradual exposure as described above and provided CBT treatment to either the child, the parent, or the child and parent. A community treatment control condition was also used. Providing treatment directly to the child (i.e., child only or child and parent CBT conditions) resulted in greater improvement in PTSD symptoms, which would suggest that the use of exposure techniques provided directly to the child was superior in decreasing these symptoms. However, the CBT used (Deblinger & Heflin, 1996) also contained other CBT elements (cognitive processing, stress management, and, in the child and parent condition, a parental treatment component). Thus, this study does not specifically document the efficacy of gradual exposure, as it cannot separate the effects of this component from cognitive and stress management interventions.

Another study used group CBT children exposed to a variety of single-episode traumatic events (March et al., 1998). In this treatment model, breakout individual sessions were used for exposure interventions. The 15 children who completed this treatment experienced significant improvement in PTSD symptoms. Although there was not a control treatment condition in this study, a variable delay in the time between initial assessment and the start of treatment controlled for improvement due to the simple passage of time. However, similar to the Deblinger and Heflin (1996) treatment approach, this treatment model also included other CBT elements (stress management, cognitive processing), so the efficacy of the exposure component per se could not be independently assessed.

There is no empirical evidence that successful treatment of traumatized children, with or without PTSD symptoms, always requires repeated retelling of the details of the traumatic event. Some children may feel that such repetition is beating a dead horse and therefore unnecessary; other children may not have anxiety related to memories of the event per se. Normal embarrassment, rather than pathological anxiety and avoidance, may explain a child’s reluctance to repeatedly discuss certain events (such as sexually abusive acts). Unless more compelling evidence for the efficacy of exposure techniques becomes available, clinicians should carefully evaluate these issues and use repeated exposure techniques primarily for clear PTSD-like symptoms.
COGNITIVE INTERVENTIONS

Overview

There is significant evidence that cognitive therapy is efficacious in decreasing trauma-related symptomatology in adults, particularly sexual assault victims (Foa, Rothbaum, Riggs, & Murdock, 1991; Frank et al., 1988; Resick & Schnicke, 1992). There is also substantial evidence that cognitive interventions are efficacious in decreasing child and adolescent depressive (Brent et al., 1997; Clarke et al., 1995) and anxiety symptoms (March, 1995).

Cognitive distortions may occur as part of children’s attempts to understand or explain why a traumatic event occurred. Such cognitions may be derived in part from thoughts the child has regarding what he or she did or didn’t do related to the event, and also from the process of trying to make meaning out of what happened. The latter component is particularly associated with cognitive developmental level, capacity for abstract thought, and perspective taking, and may contribute to older children developing more complex and disturbing cognitive distortions than young children. To regain a sense of control over their lives, children might look for something they did to “cause” the original trauma, with the hope that if they do not do that again trauma will not occur in the future. Alternatively, in an effort to protect themselves from the fear, shock, or emotional pain they experienced during the original trauma, children may try to “prepare” for future traumatic events by believing that the world is generally unfair or dangerous and therefore develop an expectation that bad things are going to happen. Cognitive distortions may also derive from the social environment of the child and family, which may reinforce self-blame when specific forms of victimization occur. Examples of cognitive distortions following trauma include self-blame for the traumatic event, survivor guilt (feeling that “it should have been me” who the bad thing happened to, in cases where someone else was more seriously hurt than the child), and a changed view of life in which the world no longer seems safe and the child develops distortions about life’s injustices or over-estimation of danger in nontraumatic situations (Janoff-Bulman, 1992). Other distortions may include a negative view of self or a view of others as untrustworthy.

According to cognitive theory, such distorted cognitions can lead to negative emotional states and negative behaviors, including depression, anxiety, PTSD symptoms, and self-destructive or aggressive acts (Beck, 1976). Cognitive therapy aims to prevent the development of these difficulties through correcting cognitive errors and enhancing cognitive coping mechanisms.
Description

Cognitive Processing Therapy

Cognitive processing therapy was developed by Resick and Schnicke (1992) specifically for adult sexual assault victims. Its focus is to provide training in challenging problematic cognitions. Cohen and Mannarino (1993) and March et al. (1998) have adapted the intervention for use in traumatized children. The idiosyncratic cognitive distortions a child has internalized may become evident as the child shares descriptions of the trauma during the use of exposure techniques. In some cases, the therapist may have to directly inquire about the child’s thoughts and attributions about the event. Specific attention is given to self-blame, survivor guilt, and changed worldview related to the trauma. Other cognitive distortions may include confusion between responsibility for the traumatic event and regret about doing something that may have contributed to but did not cause the event, or errors regarding the intention of the perpetrator (e.g., in a drunken rage a child’s father shoots and kills the mother).

Correcting cognitive errors include three steps. The first step is to identify the child’s current cognitions. For example, with regard to self-blame, the therapist explores the child’s belief about why the trauma occurred, who made it happen, could anyone have prevented it, could/should the child have done anything differently, and, if he or she had, what would have changed. The second step is for the therapist and child together to evaluate the child’s reasoning for any distorted cognitions. The third and final step is to replace the cognitive distortion with an accurate cognition. This often follows naturally from carefully exploring the child’s reasoning.

Cognitive Coping

Related forms of cognitive therapy (Beck, 1976; Seligman, 1998) focus on correcting dysfunctional automatic thoughts, which can lead to negative emotional states such as depression and anxiety. Deblinger and Heflin (1996) have described this intervention for use in abused children, in which children identify the relationships between negative automatic thoughts, negative affective states, and dysfunctional behaviors. By learning to challenge the original negative thought and replacing it with more positive alternative thoughts, children learn to better modulate their affective and behavioral states. For example, a child who was a passenger in a motor vehicle accident may think that cars are dangerous, and as a result may be fearful of cars (negative affect) and refuse to ride in cars at all (avoidant behavior). By replacing
the original thought with a more functional thought, such as “usually cars are safe—I’ve ridden in cars thousands of times when there wasn’t an accident,” this child may feel more confident and be able to ride in cars again. Such behavior (riding in cars without an accident) will then further reinforce the positive thought and tend to extinguish the automatic negative one.

**EMPIRICAL SUPPORT**

Many studies have demonstrated that specific attributions and perceptions affect the psychological symptoms that traumatized children develop. In particular, trauma-specific internal causal attributions (self-blame) for the trauma have been found to correlate with emotional difficulties in sexually abused children (Brown & Kolko, 1999; Fiering, Taska, & Lewis, 1998; Joseph, Brewin, Yule, & Williams, 1993; Kress & Vandenberg, 1998; Morrow & Sorrell, 1989; Spaccarelli, 1995; Wolfe, Gentile, & Wolfe, 1989). Trauma-related but not necessarily trauma-specific attributions have also been correlated with child distress. Fiering et al. (1998) found that higher levels of shame predicted depression, low self-esteem, and posttraumatic stress symptoms in a group of sexually abused children. Mannarino and Cohen (1996a, 1996b) demonstrated that certain abuse-related cognitions (such as thinking you are different from peers, self-blame, and thinking others do not believe you) strongly predicted psychological symptom formation, both at the time of abuse disclosure and 12 months postdisclosure. In addition, a general negative attributional style is associated with greater internalizing symptoms in abused children (Brown & Kolko, 1999; Kress & Vandenberg, 1998; Mannarino & Cohen, 1996a; Wolfe et al., 1989), and sexually abused children’s locus of control (i.e., cognitive construct about general causality) has been found to correlate with anxiety symptoms (Mannarino & Cohen, 1996a). Thus, there is strong empirical support for the theory behind including cognitive interventions in the treatment of traumatized children, particularly those who have experienced sexual abuse.

Several treatment studies have been conducted using cognitive therapy to treat traumatized children. As noted above, the Deblinger et al. (1996) and March et al. (1998) interventions included cognitive processing and cognitive coping interventions, and both demonstrated efficacy in decreasing PTSD and depressive symptoms in traumatized children. Cohen and Mannarino compared predominantly cognitive interventions to nondirective supportive therapy (NST) in two studies of sexually abused children, ages 3 to 7 years old (Cohen & Mannarino, 1996b) and 8 to 14 years old (Cohen & Mannarino, 1998). In the former study, preschool children receiving CBT
experienced significantly greater improvement in PTSD, sexualized behaviors, and a variety of other psychological symptoms than those receiving NST. In the latter study, CBT was superior to NST in improving depressive symptoms and social competence. Both of the CBT treatment models included indirect exposure techniques and stress management and parental treatment, so it is not possible to determine whether the cognitive interventions per se accounted for the improvement. However, in the 8- to 14-year-old study (Cohen & Mannarino, 1998), the strongest predictor of treatment outcome was the children’s abuse-related cognitions, as measured by the Children’s Attributions and Perceptions Scale (Cohen & Mannarino, 2000; Mannarino et al., 1994). This finding suggests the importance of providing cognitive therapy to address trauma-related symptomatology, at least in children exposed to sexual abuse.

Goenjian et al. (1997) provided group CBT interventions that had a strong cognitive focus to adolescents exposed to an earthquake in Armenia, and compared those receiving treatment with adolescents in nearby schools who received no therapy. Although the treated group showed improvement in PTSD symptoms, the untreated group worsened with regard to both PTSD and depressive symptoms. Because the index treatment contained other CBT elements, including desensitization and stress management, the specific impact of the cognitive interventions cannot be measured.

In summary, there is strong evidence in sexually abused children that trauma-related cognitions mediate the development and resolution of psychiatric symptomatology. There is also suggestive evidence that cognitive interventions are efficacious in resolving trauma-related symptoms in children exposed to a variety of stressors. However, because cognitive-focused treatment models have also contained other CBT elements, it is not yet possible to ascertain the specific impact of cognitive components in symptom resolution.

Stress Management

Stress management strategies, such as SIT, have been found to be efficacious in decreasing a variety of symptoms in adult assault victims, including PTSD, depression, and anxiety (Echeburua, deCorral, Zubizaretta, & Sarasua, 1997; Foa et al., 1991, 1998). In adults exposed to other stressors, some studies have found relaxation therapies alone to provide some benefits, although they were less effective than cognitive therapy in decreasing PTSD symptoms (Marks, Lovell, Noshiruani, Livanou, & Thrasher, 1998; Silver et al., 1995). There is evidence that relaxation interventions alone are efficacious in decreasing anxiety symptoms in non-traumatized children.
Muscle Relaxation and Breathing Techniques

Children who have been traumatized are often hypervigilant and anxious and thus find it difficult to relax either physically or emotionally. As there is evidence that physical relaxation contributes to stress reduction, children are often taught muscle relaxation and controlled breathing techniques. The former consists of a series of muscle tensing and relaxation cycles, beginning with the toes and progressing up to the head. Children may practice this technique during treatment sessions and use it when they are feeling physical or emotional tension or to fall asleep at night. Focused breathing, such as that used during yoga-type meditation, may also be taught. Children are instructed in the use of abdominal breathing (i.e., abdomen rises during inhalation, falls during exhalation) and focused concentration on the sensations related to breathing. These techniques may be used before or in combination with gradual exposure components of CBT (Cohen & Mannarino, 1993; Saigh, 1995).

Thought Stopping and Thought Replacement

Thought stopping and thought replacement are taught to enhance the child’s sense of control over negative thoughts and resultant negative emotions. It is also used to help the child manage disturbing thoughts that occur outside of treatment.

Thought stopping is taught by having the child interrupt the upsetting thought (e.g., by snapping a rubber band around his or her wrist) and then using a verbal interruption (such as saying, “Snap out of it”). Thought replacement is then taught by instructing the child to think about a positive experience or memory and to mentally describe details of that experience (e.g., describing the people who were at the child’s last birthday party, what the cake looked like, the presents received, etc.). With younger children, it is often helpful to have the child draw a detailed picture of this positive event. The child can practice doing this until he or she feels in charge of his or her thoughts. This gives the child a method to not think about the trauma at certain times, such as bedtime or during school, when doing so would interfere with the child’s normal activities. In CBT treatments that include a cognitive component, the child may be instructed to only use this method when
thoughts about the trauma are intruding on normal activities; at other times, the child is encouraged to process thoughts about the trauma by correcting cognitive distortions and by writing these thoughts down and bringing this writing to discuss at the next therapy session. Typically, once children believe that they have the power to replace thoughts that produce overwhelming negative emotions, they are more able to tolerate those thoughts and therefore become less likely to use avoidant techniques. Deblinger and Heflin (1996) describe the use of positive self-talk and coping statements (e.g., “I’m brave, I can do this”). This is particularly useful for young children for whom repetition of self-empowering statements can be quite effective.

**EMPIRICAL SUPPORT**

Several trauma-focused CBT interventions for children have included a relaxation component. Saigh (1998) used 10 minutes of relaxation prior to each 60-minute exposure session; Cohen and Mannarino (1993) included a specific relaxation module in their treatment model for sexually abused preschoolers. Berliner and Saunders (1996) taught a child-modified version of SIT. However, only one study has been designed to specifically evaluate the specific efficacy of relaxation techniques for reducing symptoms in traumatized children. Field, Seligman, Scafedi, and Schanberg (1996) compared massage therapy to a video psychoeducational control condition in children exposed to a hurricane, and found that the massage therapy resulted in significantly greater improvement in depressive and anxiety symptoms. Salivary cortisol (a measure of a stress-responsive hormone) also decreased in the group receiving massage therapy. This study thus provides support for the use of relaxation interventions in children experiencing a natural disaster. However, until more empirical support is available for relaxation interventions alone, relaxation techniques should probably be used in combination with other CBT components in treating traumatized children.

**PARENTAL TREATMENT**

Parents are typically included in mental health treatment for their children for a variety of reasons. First, obtaining multiple sources of information about the child’s functioning is considered essential in child psychiatric practice (AACAP, 1997). Second, parental and/or familial dysfunction is often a factor in child psychiatric difficulties; addressing such dysfunction in therapy is often required to resolve the child’s symptoms. Third, parental rein-
forcement of therapeutic interventions at home and general parental support of the child are often essential factors in the child’s recovery from behavioral or emotional problems.

All of these factors are salient in working with traumatized children. PTSD is notoriously difficult to diagnose in young children, and parental information about symptomatology may be critical in identifying this disorder (AACAP, 1998). Parents are often negatively affected by their children’s exposure to traumatic life events; such parents may be either directly or vicariously traumatized themselves (AACAP, 1998). As will be discussed below, there is significant empirical evidence that trauma-related parental distress is correlated with higher levels of child symptomatology, and that parental support of the traumatized child is a significant factor in the child’s symptom resolution. The primary goals of including parents in CBT treatment of traumatized children are to resolve the parents’ own emotional upset about the child’s traumatic exposure, correct cognitive distortions the parents’ may have, and enhance effective parenting and appropriate parental support for these children.

Description

Parental components of trauma-focused CBT typically parallel the child interventions, that is, they include exposure, cognitive, and stress management interventions. Each of these are briefly described below.

Exposure

Parents are encouraged to describe their thoughts and feelings about the traumatic event in a manner similar to that used with the children. Parents are told that this is not only to resolve their own emotional distress, but also to provide the child with a model for openly discussing the trauma and associated difficult emotions. In individual sessions with the parents, the therapist nonjudgmentally encourages the parents to express their genuine emotions about the traumatic event and its impact on the child and family. It is important for parents to have an opportunity to share emotions that may be socially undesirable (like anger at the child or love for the offender in cases of sexual abuse). During this stage of therapy, the therapist is encouraged to express acceptance while exploring thoughts and beliefs that may underlie the parents’ emotional reactions. Once the parents have made significant progress in their individual work with the therapist, joint sessions may be used for the child to talk directly to the parents about the traumatic event and for the child to see that the parents can tolerate this, encourage it, and respond
supportively to the child without experiencing excessively upsetting emotions (Deblinger & Heflin, 1996). As part of the parents’ exposure, the therapist may directly share with the parents the child’s artwork, writing, and verbal descriptions of the trauma. (The therapist should obtain the child’s permission prior to doing this.) Developmental issues may also be relevant with regard to sharing details of the trauma with the parents. Adolescents have legitimate concerns about privacy that should be considered when deciding whether sharing details of the trauma with parents would be beneficial.

COGNITIVE INTERVENTIONS

Self-blame is a common parental reaction to learning one’s child has been exposed to a traumatic event. Usually the parents had no way of knowing that there was danger in the situation or they would not have allowed the child to be there. In these cases, the therapist may explore with parents, “How do you think you should have known that was dangerous?” It is often helpful for the therapist to reframe parental behavior as an example of encouraging normal independence that was appropriate for the child’s developmental level and what the parents knew about the situation.

In some situations, the parents may have contributed to the child’s traumatization, as in the case where a child was injured while a parent was not providing adequate supervision due to drug or alcohol intoxication. In many cases, however, neglectful parenting was not the cause of the child’s traumatization (e.g., a child molested by mother’s paramour), but the parent’s action (having a relationship with the perpetrator) inadvertently exposed the child to danger. It is important in these situations to help the parents realistically assess the appropriate responsibility for the child’s traumatic event and to accept self-responsibility only to the degree that is realistically warranted. Positive parenting behaviors in the present should be recognized by the parents and therapist as offsetting past parental deficits.

Parents appear to blame their children much less frequently than they blame themselves when traumatic events have occurred. However, when parents do blame the child, this can be a significant barrier to the child’s optimal functioning. In some cases, the child may have contributed to his or her own exposure to trauma but is not responsible for the traumatic event itself (e.g., if a child is hit by a speeding car while being truant from school). In these situations, cognitive reframing of who is responsible for what acts (as described
above) may be helpful in clarifying for the parents how much responsibility rests with the child.

It is often helpful to explore with parents the distinction between actions that inadvertently contribute to victimization and those that make one morally responsible for what occurred. In this manner, an unhelpful all-or-nothing approach can be avoided. The concept of regret is useful in this regard. People may do something that they later regret because it in some way allowed a trauma to occur (e.g., leaving a door unlocked or accepting a ride with a slight acquaintance). However, such actions do not make them morally responsible for being robbed or sexually assaulted; the responsibility for such behaviors still rests with the perpetrator of the act. Therapy may also focus on the fact that humans are not perfectly able to foresee the future or predict the safest decisions; in many threatening situations, there is simply no way to tell what the best action may be to avoid harm. These issues should be addressed and explored with parents who have attributional errors regarding responsibility.

**Stress Management**

Relaxation techniques as described for children earlier are often taught to parents, both for their own use and to instruct their children to use during periods of increased stress. Parents are typically encouraged to make supportive verbal statements to their children, both related to the traumatic event and more generally during therapy sessions and at home. In addition to encouraging the parents to offer verbal support, an important form of support parents can offer traumatized children is an enhanced sense of safety and security. Problem-solving techniques are typically used in sessions with parents to maximize children’s safety from future traumatic events while maintaining age-appropriate independence. Parents are encouraged to maintain normal familial roles and rules, including the expectation that the child behave in an age-appropriate manner. Rather than being seen by the child as being unsympathetic or mean, this reinforces the child’s perception that he or she is still normal and not irreversibly damaged from the trauma, and that the parents see him or her as being as “normal” as before the trauma occurred. Maintenance of normal family functioning also reassures the child that the family is unchanged or at least can emerge undamaged from the trauma. Teaching the parent basic behavior management techniques may be helpful in this regard, and the use of these techniques should be encouraged for any children in the family who are not following the usual family rules.
EMPIRICAL SUPPORT

There is strong evidence demonstrating the impact of familial support and parental emotional distress about the child’s traumatic exposure on the development of child PTSD symptoms. These studies include children exposed to a variety of traumatic events, including disasters (McFarland, 1987), community violence (Breslau et al., 1991), serious medical illnesses such as cancer (Niv, 1985) and burns (Armstrong et al., 1994; Stoddard, 1996), and war (Garbarino & Kostelny, 1996). In addition to the relationship between general parental distress and child trauma-related symptomatology, studies of sexually abused children have further elucidated relationships between parental functioning and child symptoms.

Lynskey and Ferguson (1997) found in a longitudinal study that both peer and family relationships (particularly paternal support) predicted psychological symptomatology in 18-year-olds who had been sexually abused during childhood. Oates et al. (1994) demonstrated that familial dysfunction and poor maternal problem-solving abilities correlated significantly with behavioral problems in sexually abused children at an 18-month follow-up. Hanson et al. (1992) found a significant association between maternal distress and self-reported fear in sexually abused children. Lack of maternal support (Everson et al., 1989; Friedrich et al., 1992; Leifer et al., 1993) and maternal depression (Deblinger, Steer, & Lippmann, 1999a; Kinard, 1995) have also been correlated with greater behavioral and emotional symptoms in sexually abused children. Deblinger et al. (1999a) also found that the use of guilt and anxiety-provoking parenting methods (e.g., “Mom says if I loved her, I’d do what she wants me to do”) were associated with increased levels of PTSD symptoms and acting out behavior in children who have been sexually abused. In a study of sexually abused preschool children (3 to 7 years old), the impact of demographic, developmental, and familial factors on treatment outcome was examined. The strongest predictor of outcome at the time of treatment completion was the child’s parent or primary caretaker’s level of emotional distress related to the sexual abuse disclosure as measured by the Parent’s Emotional Reaction Questionnaire (PERQ) (Cohen & Mannarino, 1996a). This was found to be true across two distinct treatment interventions. In a similar study for 8- to 14-year-old sexually abused children, parental support was shown to be a strong factor in predicting the child’s symptom resolution. Thus, there is clear evidence that parental functioning affects children’s trauma-related symptomatology.

There is limited empirical evidence with regard to the impact on child outcome of including parents in treatment. The best study in this regard compared standard community treatment to CBT offered to the child only, the
parent only, or the parent and child (Deblinger et al., 1996). Inclusion of the parent in treatment (in either the parent only or parent and child condition) resulted in a significantly greater improvement in appropriate parenting practices and children’s acting out behavior problems and children’s depressive symptoms. These findings highlight the importance of including a parent treatment component, particularly for sexually abused children exhibiting depressive symptoms or behavior difficulties.

Kolko (1996) demonstrated that family therapy and individual CBT with children and parents were equally efficacious in treating physically abused children; both were found to be superior to standard community care. It should be noted that trauma-focused CBT interventions without parental treatment components were found to be efficacious in decreasing PTSD symptoms in children exposed to single-episode traumas (March et al., 1998) and in adolescents exposed to an earthquake (Goenjian et al., 1997). It is thus possible that exposure to sexual abuse may require more parental treatment for child symptom resolution than do other types of stressors, despite the fact that many participants in the studies noted experienced a single sexual abuse episode rather than ongoing traumatic exposure (Cohen & Mannarino, 1996b, 1998; Deblinger et al., 1996). Additional research is needed to elucidate whether inclusion of a parental treatment component results in added benefit to children exposed to stressors other than child sexual abuse.

FUTURE CLINICAL AND RESEARCH DIRECTIONS

The above discussion suggests that although there is growing evidence for the efficacy of trauma-focused CBT in decreasing a variety of trauma-related symptoms in children, there are insufficient data to clarify which CBT components are most helpful in producing this clinical improvement. We also know little about which components are most efficacious for treating specific symptoms or specific populations of traumatized children. This should be considered in the context that there is almost no empirical support for any other treatment modality for traumatized children. Most studies lack a control treatment condition, random treatment assignment, and/or manualized treatments that can be closely replicated. In addition, only a few such studies include the use of psychometrically sound assessment instruments (e.g., Lanktree & Briere, 1995). In this light, the scientific support for trauma-focused CBT is relatively strong. This suggests that clinicians treating this population should become familiar with CBT treatment components and consider using them when other treatment modalities are unsuccessful in producing symptom resolution. Clinicians should also consider the fact that
trauma-focused CBT has typically been evaluated in a time-limited context, that is, significant improvement has been attained in 8 to 15 sessions, whereas other treatment modalities may need to be provided over a longer period of time to be efficacious. This is particularly relevant in the current era of managed care when time limits on mental health treatment are the rule. Thus, based on the available evidence, trauma-focused CBT should be considered a first-line treatment modality for children and adolescents who develop trauma-related symptoms (AACAP, 1998; International Society on Traumatic Stress Studies [ISTSS], in press).

With regard to future research directions, there is clearly a need for deconstructive studies, that is, research that evaluates the efficacy of specific CBT treatment components both when offered separately and when provided in combination with other components. There is also a need to determine whether specific symptoms, types of traumatic exposure, and patients with specific demographics (i.e., gender, ethnicity, age of patient) respond better to a specific CBT component or combination of components.

Finally, it is important to identify which children do not respond well to trauma-focused CBT interventions and to empirically evaluate alternative psychosocial, pharmacologic, or combination treatments that may help such children recover from traumatic exposure.

REFERENCES


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