NCTSN The National Child Traumatic Stress Network

CBITS: Cognitive Behavioral Intervention for Trauma in Schools

GENERAL INFORMATION

Treatment Description

Acronym *(abbreviation)* **for intervention:** CBITS

Average length/number of sessions: 10

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)*:
During the CBITS training and ongoing consultation with sites, we have specifically included in our training ways to implement this program to address cultural competency. We encourage sites to use culturally appropriate examples during the treatment, and we discuss the cultural issues pertinent to each trainee's site. Although there are examples for each of the exercises in the manual, clinicians are encouraged to substitute these for culturally salient ones. For example, in working with immigrant populations, we focused some of the parent sessions on separation and loss issues that so many had experienced during the migration process. When we've worked in Catholic schools, faith-based clinicians openly discussed the students' examples of coping through prayer and complementing this with CBT skills.

CBITS is an ideal trauma intervention for underserved ethnic minority students who frequently do not receive services due to a whole host of barriers to traditional mental health services. This school-based program is designed to be delivered in school settings, whether it is in an urban or midwestern public school serving a diverse student body or a religious private school providing outreach to an immigrant community. CBITS has been successfully used in a wide variety of communities because it can be flexibly implemented and addresses barriers such as transportation, language, and stigma.

In addition, CBITS has also addressed the barrier of parent and family involvement that can be so common in many communities. We have used a community-based participatory partnership model of including ethnic minority parents from the community being served along with community leaders, clinicians, and researchers to design the implementation plan so that the program is presented in a relevant and culturally congruent way.

Trauma type *(primary)*: Community violence

Trauma type *(secondary)*: Domestic violence

Additional descriptors *(not included above)*: CBITS is appropriate for a wide range of traumas including: physical abuse, disasters, accidents, witnessing death, assault, war, terrorism, immigration related trauma, and traumatic loss.

Target Population

Age range: 10 **to** 15

Gender: ❒ **Males** ❒ **Females** ☒ **Both**

Ethnic/Racial Group *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)*: CBITS has been used in a broad range of populations across the US and internationally.

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Target Population continued	Immigrant Populations: CBITS has been delivered to newly immigrated students such as Latino (primarily from Mexico and Central America), Korean, Russian, and Western Armenian students. Acculturation Levels: CBITS has been implemented and evaluated with a broad range of acculturation levels, from newly immigrated youth to highly acculturated youth, as well as multigenerations of African Americans. Ethnic/Racial Groups Served: CBITS has been successfully delivered to Latinos, African Americans, Asian American/Pacific Islanders, and Native American communities (the Navajo, Chippewa-Cree, Black Feet, and Yakima communities). **Other cultural characteristics** *(e.g., SES, religion)*: Faith-based: CBITS has been delivered in a Catholic school by clinicians with lay health promotors and parish nurses providing outreach and parenting support. We are in the process of conducting an evaluation (RCT) in this setting. SES: CBITS has been used in communities of wide ranges of SES including the very poor and middle class populations across the United States. **Language***(s)*: Spanish, Korean, Russian, Western Armenian, Japanese **Region** *(e.g., rural, urban)*: Urban, suburban, and rural **Other characteristics** *(not included above)*: High Risk Populations: CBITS has also been delivered in schools for students in Special Education, for youth at risk for HIV and for children who are war refugees.
Essential Components	**Theoretical basis:** Cognitive Behavioral **Key components:** CBITS is a program developed for use in schools for a broad array of traumas and populations. CBITS was originally developed in a community-based participatory research partnership with school-based clinicians, clinician researchers, and community members which has enhanced its relevancy for school communities. CBITS is a skills-based, child group intervention that is aimed at relieving symptoms of Posttraumatic Stress Disorder (PTSD), depression, and general anxiety among children exposed to multiple forms of trauma. CBITS Child Groups: The program consists of ten group sessions (6-8 children/group) of approximately an hour in length, usually conducted once a week in a school setting. The CBITS intervention has also been delivered in other settings, such as mental health clinics.

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Essential Components continued

One unique aspect of CBITS is the focus on trauma from the child's perspective. For those children who have multiple traumas, CBITS recommends that the child be the one to choose, with help from the clinician, which trauma will be the focus of treatment. Frequently, although a clinician will perceive one trauma to be the most salient for a child, the child will associate greater impact from another trauma.

In addition to the group sessions, participants receive 1-3 individual sessions, usually held before the exposure exercises.

CBITS also includes two parent education sessions and one teacher education session.

CBITS teaches six cognitive-behavioral techniques:

- Education about reactions to trauma
- Relaxation training
- Cognitive therapy
- Real life exposure
- Stress or trauma exposure
- Social problem-solving

Parental permission is sought for children to participate.

A screening procedure is recommended to assist in identifying children in need of the program. A brief screening instrument has been developed for this purpose and should be followed by an individual meeting with a clinician to confirm the screening results.

Clinical & Anecdotal Evidence

Are you aware of any suggestion/evidence that this treatment may be harmful?
❒ Yes ☒ No ❒ Uncertain

Extent to which cultural issues have been described in writings about this intervention *(scale of 1-5 where 1=not at all to 5=all the time)***.** 5

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ Yes ☒ No

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No**

If YES, please include citation:
Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., et al. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. Journal of the American Medical Association, 290(5), 603-611.

Has this intervention been presented at scientific meetings? ☒ Yes ❒ No

Clinical & Anecdotal Evidence continued

If YES, please include citation(s) from last five presentations:

Kataoka S, Langley AK, Jaycox LH, Stein BD, & Ebert L. Supporting Implementation and Dissemination of a School–Based Intervention: The Learning Collaborative Model in School-Based Interventions for Students with Trauma: Engagement, Implementation, and Dissemination The 56th Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Honolulu, HI: October, 2009 (Symposium: A. Langley, Chair).

Kataoka S. Making the Grade: Partnering with Schools to Support Students The 56th Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Honolulu, HI: October, 2009 (Honors Presentation).

Kataoka S. Cognitive Behavioral Intervention for Trauma in Schools. 2010 National Conference of the American Society for Adolescent Psychiatry, Los Angeles, CA: March, 2010. (Presentation).

Langley, A.K. Jaycox, L.H., Nadeem, E., Walker D. Translating Evidence-Based Trauma Interventions for the School Setting: Models for Building Multidisciplinary Workforce, Implementation Success and Sustainability. The 26th Conference of the International Society for Traumatic Stress Studies. Montréal, Québec, Canada November 4-6, 2010

Walker, D., Chehil, S., Dean, K. Building Capacity Through Collaboration: The Introduction of a Child-Focused, Evidence-Based Trauma Intervention in Guyana. The 26th Conference of the International Society for Traumatic Stress Studies. Montréal, Québec, Canada November 4-6, 2010

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:

The program has been replicated in post-hurricane New Orleans and in three separate studies of Native American groups.

Morsette, A., Swaney, G., Stolle, D., Schuldberg, D., van den Pol, R., & Young, M. (2009). Cognitive Behavioral Intervention for Trauma in Schools (CBITS): School-based treatment on a rural American Indian reservation. Journal of Behavior Therapy and Experimental Psychiatry, 40(1), 169-178

Goodkind, J.R., LaNoue, M.D. & Milford, J. (2010). Adapation and implementation of Cognitive Behavioral Intervention for Trauma in Schools with American Indian youth. Journal of Clinical Child and Adolescent Psychology, 39(6): 858-872.

Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., et al. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. Journal of Traumatic Stress, 23(2), 223-231.

Morsette, A., van den Pol, R., Schuldberg, D., Swaney, G. & Stolle, D. (2012). Cognitive behavioral treatment for trauma symptoms in American Indian youth: preliminary findings and issues in evidence-based practice and reservation culture. Advances in School Mental Health Promotion, DOI:10.1080/1754730X.2012.664865

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Has the intervention been replicated anywhere? ☒ **Yes** ❒ **No**

Other countries? *(please list)* Australia, Japan

Other clinical and/or anecdotal evidence *(not included above)*:

Adaptation and Community

Kataoka, S. H., Fuentes, S., O'Donoghue, V. P., Castillo-Campos, P., Bonilla, A., Halsey, K., et al. (2006). A community participatory research partnership: the development of a faith-based intervention for children exposed to violence. Ethn Dis, 16(1 Suppl 1), S89-97.

Screening

Dean, K. L., Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Pincus, H. A., et al. (2004). Acceptability of asking parents about their children's traumatic symptoms. Psychiatric Services, 55(8), 866.

Jaycox, L. H., Stein, B. D., Kataoka, S. H., Wong, M., Fink, A., Escudero, P., et al. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. Journal of the American Academy of Child & Adolescent Psychiatry, 41(9), 1104-1110.

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Clinical Trials *(w/control groups)*	**N=**199 **By gender:** 50% females **By ethnicity:** Mexico: 57% El Salvador: 18% Guatemala: 11% Other: 13%	Kataoka, Stein, Jaycox, Wong, Escudero, Tu, et al., 2003
Clinical Trials *(w/control groups* **continued**	**By other cultural factors:** All participants had immigrated to the US in the past 3 years. The intervention was conducted in Spanish by bilingual, bicultural clinicians.	
Randomized Controlled Trials	**N=**126 **By gender:** 54% females	Stein, Jaycox, Kataoka, Wong, Tu, Elliott & Fink, 2003.

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Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

Screening Measures:

- Modified Life Events Scale (Singer, 1995) to assess the level of exposure to violence
- Child PTSD Symptom Scale (Foa, 2001)

Outcome measures:

- Child PTSD Symptom Scale (Foa, 2001)
- Children's Depression Inventory (Kovacs, 1983)
- Pediatric Symptom Checklist

If research studies have been conducted, what were the outcomes?
In a randomized controlled study, children in the CBITS intervention group had significantly greater improvement in PTSD and depressive symptoms compared to those on the waitlist at a three-month follow-up. Parents of children in the CBITS intervention group also reported significantly improved child functioning compared with children in the wait list group. The improvements in symptoms and functioning in the CBITS group continued to be seen at a subsequent follow-up at 6 months. Results from another study showed that those in the CBITS intervention group had significantly fewer self-reported symptoms of PTSD and depression at post-test, adjusting for relevant covariates, as did children in a comparison group.

Training Materials & Requirements

List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.
Copies of the treatment manual can downloaded or purchased at https://www.rand.org/pubs/tools/TL272.html.

How/where is training obtained? Online training is available at www.cbitsprogram.org, virtual or in-person live trainings with certified trainers can be arranged by contacting Pamela Vona at pamela@safeandresilient.org.

What is the cost of training?
Costs vary, contact Pamela Vona at pamela@safeandresilient.org

Are intervention materials *(handouts)* **available in other languages?**
☒ **Yes** ❒ **No**

If YES, what languages? Manual and materials are available in Spanish and Arabic at https://www.rand.org/pubs/tools/TL272.html

Other training materials &/or requirements *(not included above)***:**
Implementation materials and support (access to experts, discussion board, collaborative workspace) are available at www.cbitsprogram.org

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Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** • CBITS is specifically designed and evaluated in multicultural and multilingual populations. • CBITS has been used in mulitple languages including: Spanish, Korean, Western Armenian, Russian, and Japanese. • CBITS has been adapted for use on a variety of Native American reservations. • CBITS has been used successfully in a faith-based private school. • CBITS has been used throughout the U.S. and internationally (Japan and Australia). • CBITS treatment materials have been translated into other languages. • CBITS is a flexible, manualized intervention that can be easily adapted for different populations. • CBITS is specifically designed for use in schools and by school-based clinicians with training that specifically focuses on implementation of trauma services in the school setting. • CBITS' school-based format alleviates common obstacles to treatment such as transportation barriers, stigma of seeking "mental health" care, and dependence on parents and families to seek and find care. • CBITS includes training on important factors involved in delivering a program in the schools successfully such as integrating the program into the school calendar, using a brief assessment tool to detect eligible students, and understanding and supporting the roles of school staff. • CBITS is an intervention that can be readily accessible to all eligible students, regardless of parent ability to be involved in treatment. • CBITS has had significant involvement of multiple stakeholders in the development and implementation of the program. • CBITS is the only trauma intervention that has been found to be effective in a RCT for multiply traumatized youth.
Pros & Cons/ Qualitative Impressions continued	**What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** CBITS is not yet adapted for early elementary school students (K-2) and for older adolescents/young adults. **Other qualitative impressions:** The CBITS team has conducted multiple focus groups across the Los Angeles area in private and public schools and has found an overwhelming need identified by communities for an intervention in schools. These focus group participants have also described the school and faith-based settings to be, not only appropriate, but ideal for delivering CBITS for traumatized youth.

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References

Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., et al. (2003). A school-based mental health program for traumatized Latino immigrant children. Journal of the American Academy of Child & Adolescent Psychiatry, 42(3), 311-318.

Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., et al. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. JAMA: Journal of the American Medical Association, 290(5), 603-611.

Stein, B, Jaycox, L., Kataoka, S., Wong, M., Wenli, T., Elliot, M., and Fink, A.(2003) School- based interventions for children exposed to violence. JAMA, 290, 2541.

Jaycox, L. H., Stein, B. D., Kataoka, S. H., Wong, M., Fink, A., Escudero, P., et al. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. Journal of the American Academy of Child & Adolescent Psychiatry, 41(9), 1104-1110.

Stein, B. D., Kataoka, S., Jaycox, L. H., Wong, M., Fink, A., Escudero, P., et al. (2002). Theoretical basis and program design of a school-based mental health intervention for traumatized immigrant children: A collaborative research partnership. Journal of Behavioral Health Services & Research, 29(3), 318-326.

Stein, B. D., Jaycox, L. H., Kataoka, S., Rhodes, H. J., & Vestal, K. D. (2003). Prevalence of child and adolescent exposure to community violence. Clinical Child & Family Psychology Review, 6(4), 247-264.

Stein, B. D., Kataoka, S., Jaycox, L., Steiger, E. M., Wong, M., Fink, A., et al. (2003). The mental health for immigrants program: Program design and participatory research in the real world. In M. D. Weist (Ed.), Handbook of school mental health: Advancing practice and research. Issues in clinical child psychology. (pp. pp. 179-190). New York, NY: Kluwer Academic/Plenum Publishers.

Dean, K. L., Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Pincus, H. A., et al. (2004). Acceptability of asking parents about their children's traumatic symptoms. Psychiatric Services, 55(8), 866.

Jaycox, L. H., Kataoka, S. H., Stein, B. D., Wong, M., & Langley, A. (2005). Responding to the needs of the community: A stepped care approach to implementing trauma-focused interventions in schools. Report on Emotional and Behavioral Disorders in Youth, 5(4), 100-103.

Wong, M. (2006). Commentary: building partnerships between schools and academic partners to achieve a health-related research agenda. Ethn Dis, 16(1 Suppl 1), S149-153.

Kataoka, S. H., Fuentes, S., O'Donoghue, V. P., Castillo-Campos, P., Bonilla, A., Halsey, K., et al. (2006). A community participatory research partnership: the development of a faith-based intervention for children exposed to violence. Ethn Dis, 16(1 Suppl 1), S89-97.

Stein, B. D., Jaycox, L. H., Langley, A., Kataoka, S. H., Wilkins, W. S., & Wong, M. (2007). Active parental consent for a school-based community violence screening: comparing distribution methods. Journal of School Health, 77(3), 116-120

Jaycox, L.H., Stein, B.D., Amaya-Jackson, L.M. & Morse, L.K. (2007). School-based interventions for child traumatic stress. In: Evans, S. W., Weist, M., & Serpell, Z. (Eds). Advances in School-Based Mental Health Interventions, Volume 2 (pp.16-1–16-19). Kingston, NJ: Civic Research Institute.

References continued

Jaycox, L.H., Stein, B., and Amaya-Jackson, L. (2008) School-based treatment in children and adolescents. In E.B. Foa, T.M. Keane, M.J. Friedman & J.A. Cohen (Eds), Effective Treatments for PTSD: Practice Guidelines for the International Society for Traumatic Stress Studies. (pp. 327-345) New York, NY: Gilford Press.

Wong, M., Rosemond, M., Stein, B.D., Langley, A.K., Kataoka, S., & Nadeem, E. (2007). School-based intervention for adolescents exposed to violence. The Prevention Researcher, 14(1), 17-20.

Dean, K., Langley, A., Kataoka, S., Jaycox, L. H., Wong, M. & Stein, B.D. (2008). School-based disaster mental health services: Clinical, policy, and community challenges. Professional Psychology: Research and Practice, 39(1), 51-57

Jaycox, L.H., Stein, B.D., Amaya-Jackson, L. (2008). School-based treatment for children and adolescents. In: E.B. Foa, T.M. Keane, M.J. Friedman & J.A. Cohen (Eds). Effective Treatment for PTSD: Practice Guidelines from the International Society of Traumatic Stress Studies. New York; Guildford Publications.

Ngo, V., Langley, A., Kataoka, S., Nadeem, E., Escudero, P., & Stein, B.S. (2008). Providing evidence based practice to ethnically diverse youth: Examples from the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program. Journal of the American Academy of Child & Adolescent Psychiatry 47(8), 858-862.

Wong, M. (2008). Interventions to reduce psychological harm from traumatic events among children and adolescents: A commentary on the application of findings to the real world of schools. American Journal of Preventive Medicine 35(4), 398-400.

Kataoka, S.H., Langley, A Stein, B.D., Jaycox, L, Zhang, L, Sanchez, N, Wong, M (2009). Violence exposure and PTSD: The role of English language Fluency in Latino children. Journal of Child and Family Studies 18, 334-341.

Morsette, A., Swaney, G., Stolle, D., Schuldberg, D., van den Pol, R., & Young, M. (2009). Cognitive Behavioral Intervention for Trauma in Schools (CBITS): School-based treatment on a rural American Indian reservation. Journal of Behavior Therapy and Experimental Psychiatry 40, 169-178.

Jaycox L.H, Langley A.K., Stein B.D., Wong, M., Sharma, P., Scott, M., Schonlau, M. (2009). Support for Students Exposed to Trauma: A pilot study. School Mental Health, 1(2), 49-60.

Kataoka, S., Nadeem, E., Wong, M., Langley, A., Jaycox, L., Stein, B. & Young, P. (2009). Improving disaster mental health care in schools: a community-partnered approach. Am J of Prev Med; 37(6S1): 225-229.

Cohen, J.A., Jaycox, L.H., Mannarino, A.P., Walker, D.W., Langley, A. K. & DuClos, J. (2009). Treating traumatized children after Hurricane Katrina: Project Fleur-de Lis™. Clinical Child and Family Psychology Review, 12(1): 55-64

Jaycox, L., Cohen, J., Mannarino, A., Walker, D., Langley, A., Gegenheimer, K., Scott, M., and Schonlau, M. (2010).

Children's mental health care following Hurricane Katrina: a field trial of trauma focused psychotherapies. Journal of Traumatic Stress, 23(2) 223-231.

Langley, A.K., Nadeem, E., Kataoka, S.H., Stein, B.D., Jaycox, L.H. (2010). HYPERLINK "http://springer.r.delivery.net/r/r?2.1.Ee.2Tp.1je6Ef.B%5fMryU..H.KsSO.3QT2.bW89MQ%5f%5fDERSFQb0" \o "http://springer.r.delivery.net/r/r?2.1.Ee.2Tp.1je6Ef.B%5fMryU..H.KsSO.3QT2.bW89MQ%5f%5fDERSFQb0" \t "_blank" Evidence-based mental health programs in schools: barriers and facilitators of successful implementation. School Mental Health, 2(3) 105-113.

Kataoka, S., Jaycox, L.H., Wong, M., Nadeem, E., Langley, A., Tang, L., Stein, B.D. (2011). Effects on school outcomes in low-income minority youth: preliminary findings from a community-partnered study of a school trauma intervention. Ethnicity & Disease; 21(3 Suppl 1):S1-71-7.

Morsette, A., van den Pol, R., Schuldberg, D., Swaney, G., Stolle, D. (2012). Cognitive behavioral treatment for trauma symptoms in American Indian youth: preliminary findings and issues in evidence-based practice and reservation culture. Advances in School Mental Health Promotion; 5(1): 51-62.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Training Guidelines

Field	*May include requirements, recommendations, minimum standards, variations, ratios, and other considerations*
Treatment/Product Description	**Description:** The CBITS Program is an early intervention group program for students who have experienced trauma and have symptoms of posttraumatic stress disorder (PTSD). Designed with and for school personnel, it has been implemented widely for a variety of different students and systems. Adaptations for nonclinical personnel, younger children, and special populations are available. **NCTSN Fact Sheet Available:** http://nctsn.org/sites/default/files/assets/pdfs/cbits_general.pdf **Culturally Specific Information Available:** http://nctsn.org/sites/default/files/assets/pdfs/cbits_cultural.pdf **Goals:** The goals of CBITS are to reduce symptoms of distress related to trauma (PTSD and depressive symptoms), improve coping skills related to stress and trauma, and build peer, school staff, and parent support. **Target Population:** Late elementary school through high-school students. Students are usually identified through screening for trauma and related symptoms but can also be identified through counselor, teacher, or other referrals. **Essential Components:** CBITS consists of 10 group sessions and 1-3 individual sessions, as well as parent and teacher informational sessions. **Other considerations:** CBITS is ideal for reaching underserved students who experience high levels of trauma but who often don't have access to services outside of the school setting. CBITS has also been effectively delivered in schools following a crisis (natural or man-made) that has affected many students.
Training	Training in the early intervention CBITS program has historically been flexible and tailored to the needs of individuals and organizations. Although we have developed a Web-based, free training course, we do not recommend it as a stand-alone training. We work with sites and individuals prior to training to determine the most appropriate type of training and ongoing supervision/consultation. In this section we present a minimally acceptable training option and the most comprehensive option. The most comprehensive option is typically only possible with dedicated funding. Most typically, CBITS training falls somewhere between these two options. **Minimally Acceptable Training** This level of training is only appropriate for individuals or organizations that have prior experience in all of the following: • Delivery of mental health services in the school setting • Delivery of evidence-based practices (using manual or similar) • Delivery of cognitive behavioral, trauma-focused therapies • Delivery of therapeutic groups with children **Mode of Training:** Combined virtual/manual/live training.

Training (*continued*)	
	Content: All trainees must complete the following: • Read CBITS manual • Complete five-hour Web-based course • Review Web site quick-tips and role-plays • Attend one-day condensed live training with certified trainer, after completion of Web-based course Site must have a local supervisor who can provide clinical supervision to trainees and who participates in all the training activities above, along with CBITS trainees. **Number of Days/Hours Total/Minimum:** 16 hours (8 virtual, 8 live) **Options for Make-up:** N/A **Training Cost:** Cost to clinician is the CBITS manual (approx. $45); all other Web-based materials and virtual training are free. Trainings are usually arranged on-site for a group of school-based clinicians. Costs in 2015 for 1 certified CBITS trainer were $2000 plus travel expenses (1 trainer suggested per maximum of 15 trainees). **Training Contact Information:** www.cbitsprogram.org **Most Comprehensive Training** This level of training is appropriate for any school-based clinician. Experience with the following is helpful: • Delivery of mental health services in the school setting • Delivery of evidence-based practices (using manual or similar) • Delivery of cognitive behavioral, trauma-focused therapies • Delivery of therapeutic groups with children **Mode of Training:** Face-to-face, virtual, manual, telephone. **Content:** All trainees must complete the following: • Read CBITS manual • Take five-hour Web-based course • Attend two-day face-to-face training • Use five-hour Web-based course for review and brush-up following training • Review Web site quick-tips and role-plays Clinicians collect ongoing fidelity of implementation and outcomes measures for quality assurance and improvement. Supervisor takes part in all training activities along with CBITS trainees. Certified CBITS trainer provides weekly case consultation with new trainees. Approved supervisor obtains ongoing consultation from certified CBITS trainer on overall implementation. Certified CBITS trainer reviews fidelity of implementation and outcomes monitoring for quality assurance and improvement.

Training (*continued*)	**Number of Days/Hours Total/Minimum:** Three days initially; two hours monthly **Options for Make-up:** N/A **Training Cost:** Cost to clinician is the CBITS manual (approx. $45); all other Web-based materials and virtual training are free. Trainings are usually arranged on-site for a group of school-based clinicians. Costs in 2015 for 1 certified CBITS trainer were $4000 plus travel expenses (1 trainer suggested per maximum of 15 trainees). Ongoing consultation and fidelity monitoring by a certified CBITS trainer in 2015 cost $200 per hour. **Training Contact Information:** www.cbitsprogram.org
Selection	**Typical trainees for this Treatment/Product:** Mental health clinicians working in a school or school-like setting where running closed groups is feasible. **Minimum Education Level:** Master's degree that includes clinical training in child mental health. **Licensure/Certification:** Licensure/certification requirements vary by school and region. We suggest that those working towards licensure co-lead groups with a licensed individual or work closely with their supervisor of record who is also trained in CBITS. **Experience:** Experience in the following areas is helpful and can be grounds for more flexible/minimal training: • Delivery of mental health services in the school setting • Delivery of evidence-based practices (using manual or similar) • Delivery of cognitive behavioral, trauma-focused therapies • Delivery of therapeutic groups with children **Match/Fit:** This intervention is designed for use in schools but has also been used successfully in school-like settings (e.g., after-school programs, summer programs).
Preparation for Training and Implementation	**Clinician Readiness Assessment Available?** In development. **Agency Readiness Assessment Available?** Yes. Example items: To what extent have you obtained school or clinic administration support for implementing CBITS? How many schools/clinics have been identified for implementation of CBITS? **Typical Prerequisites for Training:** Purchase of manual, completion of five-hour Web course. We work closely with sites and individuals to ensure that the training occurs close to proposed CBITS implementation and that the school system is ready for the program. There is typically a pre-work phase that assesses readiness for training and implementation and specific needs of the agency or organization. **Prereading/Other:** The CBITS manual is available at Voyager Sopris: http://www.voyagersopris.com/curriculum/subject/school-climate/cognitive-behavioral-intervention-for-trauma-in-schools
Consultation	Ongoing consultation is highly recommended but can be flexibly implemented depending on resources and goals for the program. Consultation and fidelity monitoring are required to become a certified CBITS implementer. **Type/Mode/Ratio:** Flexible consultation with a certified CBITS trainer is recommended. This consultation is typically by telephone and supported by audiotapes from group sessions. Live monitoring of sessions is also possible. Reflective learning groups, or ongoing group training/consultation, offer another mode. Supervisors should participate in ongoing consultation.

Consultation (*continued*)	**Frequency:** Weekly with first CBITS group, tapering down to monthly as the implementer gains experience. **Participation:** Presentation and audio submission. **General/Expected Duration of Consultation:** Varies depending on experience and skills. **Demonstrated Proficiency/Mastery/Competence:** Use of a fidelity measure that assesses both content and quality of implementation is recommended.
Case Completion Requirements	Successful case completion, as determined by consultation and/or fidelity monitoring, is a requirement for certification as a CBITS implementer. **Case Selection Criteria:** N/A **Case Completion:** Typically, running two groups with high fidelity is sufficient for certification as a CBITS implementer. Successful completion of at least one CBITS group is required before participation in train-the-trainer activities. **Fidelity:** Fidelity ratings by a certified CBITS trainer are recommended. Self-assessment tools are also available. **Mode of Review (e.g., Video/Audio/Test):** Audiotape or live monitoring.
Maintenance	**Booster:** Booster trainings for implementers are suggested on a yearly basis. **Advanced:** Advanced options include certification as a CBITS implementer and certification as a CBITS trainer. **Maintenance Plan/Continuing Education:** N/A
To Supervise Providers of the Treatment/ Product	**Prerequisites needed to supervise use of the Treatment/Product** CBITS supervisors can be of two types: 1. Onsite trauma specialists who have participated in training. These individuals are expected to participate in consultation, if applicable, but there are no other special requirements for supervisors. Supervisors are not expected or certified to train others in CBITS. 2. Certified CBITS trainers. See below for details.
To Train Providers in the Treatment/ Product	**Prerequisites needed to train providers in the Treatment/Product:** Trainers have experience implementing at least one CBITS group successfully with fidelity. They are required to be approved by the CBITS Faculty to initiate the training to become a CBITS Trainer. They are required to co-train with CBITS faculty. Adherence and quality of training are monitored during these co-training sessions until an acceptable level is reached across all training content as determined by the CBITS faculty. **Levels:** 1. CBITS Trainer in Training 2. Certified CBITS Trainer 3. CBITS Faculty **# of Cases Completed in Treatment/Product:** Trainers must have run at least one CBITS group prior to beginning the train-the-trainer process. **# of Years Practiced:** N/A

Endorsement or Certification Options	**For Clinician:** Many CBITS implementers are not certified. However, certification is available and involves ongoing consultation and fidelity monitoring until a certified CBITS trainer judges that an acceptable level of fidelity has been reached. **For Supervisor:** N/A **For Trainer:** Trainers are certified through the train-the-trainer process specified above. **Decision-making process/body:** Judgment from certified CBITS trainer and CBITS faculty. **Roster of Trainers:** Yes, we maintain a list of certified trainers. We match trainers to sites requesting training based on location and availability. Contact our team through www.cbitsprogram.org to inquire about training. All approved trainings are coordinated or registered through this system.
Additional Resources	All information on CBITS and adaptations are available on the CBITS Web site at www.cbitsprogram.org. You must register on the Web site (at no cost) to access these resources.

NCTSN The National Child Traumatic Stress Network

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

GENERAL INFORMATION

Treatment Description

Acronym *(abbreviation)* **for intervention:** TF-CBT

Average length/number of sessions: 12-25 sessions (60-90 minute sessions, divided approximately equally between youth and parent/caregiver)

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:** TF-CBT has been modified to address the needs of Latino, Native American, deaf and hearing impaired, military and many international populations. It has been provided in group formats and in multiple settings(e.g., homes, foster homes, schools, residential treatment facilities) to address transportation barriers

Trauma type *(primary)*: Sexual abuse, domestic violence, traumatic grief, disaster, terrorism, multiple or complex traumas

Trauma type *(secondary)*: Other trauma types

Additional descriptors *(not included above)***:** TF-CBT addresses the multiple domains of trauma impact including but not limited to Posttraumatic Stress Disorder (PTSD), depression, anxiety, externalizing behavior problems, relationship and attachment problems, school problems and cognitive problems. TF-CBT includes skills for regulating affect, behavior, thoughts and relationships, trauma processing, and enhancing safety, trust, parenting skills and family communication.

Target Population

Age range: 3 **to** 21

Gender: ❒ **Males** ❒ **Females** ☒ **Both**

Ethnic/Racial Group *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** TF-CBT has been tested in U.S. Caucasian, African American and Latino populations as well as in European, Australian and African youth with positive outcomes in multiple domains. Applications for childhood traumatic grief (CTG) have also been used for multiple populations with positive outcomes.

Other cultural characteristics *(e.g., SES, religion):*
TF-CBT has been used with families of diverse SES and religions.

Language*(s)***:** The TF-CBT treatment book has been translated into Chinese (Mandarin), German, Dutch, Polish, Japanese and Korean. French and Russian translations are underway. Instruments to assess TF-CBT outcomes are available in multiple languages including all of the above as well as Spanish and a variety of African tribal languages.

Region *(e.g., rural, urban)***:** TF-CBT has been used in urban, suburban and rural regions.

Other characteristics *(not included above)***:** TF-CBT has been modified for use in military settings as well as for residential treatment facilities (e.g., additional training materials are available for training direct care staff to support the use of TF-CBT skills in the residential setting); in schools; and for youth with developmental challenges.

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

Target Population continued	TF-CBT should be provided to youth who have significant emotional or behavioral difficulties related to one or more traumatic life events (including complex trauma); youth do not have to meet PTSD criteria to receive TF-CBT. TF-CBT treatment has been shown to result in improvement in PTSD symptoms, depression, anxiety symptoms, externalizing behavioral problems, sexualized behavior problems, shame, trauma-related cognitions, interpersonal trust, and social competence.
Essential Components	**Theoretical basis:** Cognitive-behavioral, family, empowerment **Key components:** • Establishing a therapeutic relationship with youth and parent • Use of gradual exposure throughout treatment **PRACTICE components:** • Psychoeducation about child trauma and trauma reminders • Parenting component including parenting skills • Relaxation skills individualized to youth and parent • Affective modulation skills tailored to youth, family and culture • Cognitive coping: connecting thoughts, feelings and behaviors • Trauma narrative and processing • In vivo mastery of trauma reminders • Conjoint youth-parent sessions • Enhancing safety and future developmental trajectory • Traumatic grief components
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 3 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No** **If YES, please include citation:** All of our treatment outcome studies (cited below) include dropout statistics. **Has this intervention been presented at scientific meetings? ☒ Yes ❒ No**

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GENERAL INFORMATION

Clinical & Anecdotal Evidence continued	**If YES, please include citation***(s)* **from last five presentations:** Numerous citations available upon request. **Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No** **If YES, please include citation:** Cohen, JA, Mannarino, AP & Deblinger, E (2006). Treating trauma and traumatic grief in children and adolescents. New York: Guilford Press Free online training course: TF-CBT Web: www.musc.edu/tfcbt **Has the intervention been replicated anywhere? ☒ Yes ❒ No** **Other countries?** *(please list)* Zambia; Cambodia; Norway; Germany; Holland; Japan **Other clinical and/or anecdotal evidence** *(not included above)***:** Multiple replication studies	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)* TF-CBT has the strongest research evidence of any treatment model for traumatized children. Multiple randomized controlled trials (RCT) and replication studies including international studies have been conducted documenting the effectiveness of TF-CBT for improving a range of problems for these children.	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**19 Gender: female=19, male=0	Deblinger et al, 1990
Clinical Trials *(w/control groups)*	Foster care: TF-CBT=69, Usual care **N=**2218 Disaster: **N=**306	Weiner et al, 2009 CATS Consortium, 2010

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Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Randomized Controlled Trials	921 total youth; 743 treatment completers **By gender:** 507 female; 236 male **By self-identified ethnicity:** 447 Caucasian 176 African American 29 Latino 42 Biracial 13 Other 36 Australian children Democratic Republic of Congo: Former child soldiers: **N=**52 Sex trafficked girls: **N=**52	Cohen & Mannarino, 1996 Cohen, Mannarino & Knudsen, 2005 Cohen, et al, 2004 Cohen, et al, 2011 Deblinger, et al, 1996 Deblinger et al, 2001 Deblinger et al, 2011 King et al, 2000 O'Callaghan & McMullen,2012 McMullen & O'Callaghan, 2012
Studies Describing Modifications	Childhood traumatic grief: 61 **By gender:** 38 female, 23 male **By ethnicity:** 43 Caucasian 15 African American 3 Biracial	Cohen, Mannarino & Knudsen, 2004 Cohen, Mannarino & Staron, 2006

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

- PTSD: UCLA PTSD Reaction Index; CPSS and/or KSADS
- Depression: Children's Depression Index; TSCC
- Anxiety: SCARED; STAIC; TSCC
- Externalizing and Internalizing behavior problems: CBCL
- Sexual behavior problems: CSBI or TSCC
- Trauma-related cognitions: Children's Attribution and Perception Scale (CAPS)
- Parental support: PSQ
- Parental distress: PERQ
- Parental depression: BDI
- Parenting practices: Parenting Practices Questionnaire
- Parental conflict/violence: Conflict Tactics Questionnaire

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

Outcomes continued	**If research studies have been conducted, what were the outcomes?** TF-CBT superior to Child Centered Therapy, wait list and usual treatment on multiple outcomes listed above
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Private office or other meeting room for therapy sessions **Supervision requirements** *(e.g., review of taped sessions)***?** Approved TF-CBT training and expert consultation (web-based; 2 days of face to face training; at least 6 months of twice monthly consultation with expert trainer) OR participation in approved learning collaborative use of fidelity monitoring using fidelity checklist and use of at least one standardized instrument to assess progress pre-post treatment **To ensure successful implementation, support should be obtained from:** An approved TF-CBT trainer
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** TF-CBT Implementation Manual **How/where is training obtained?** TF-CBT Web (www.musc.edu/tfcbt) followed by 2 day training from approved TF-CBT trainer and at least 6 months of consultation calls OR participation in approved learning collaborative **What is the cost of training?** Approximately $10,000/10 clinicians **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** German, Dutch, Japanese, Chinese, Polish, Spanish **Other training materials &/or requirements** *(not included above)***:** • Free web-based TF-CBT for Childhood Traumatic Grief training available at CTGWeb: www.musc.edu/ctg • Free web-based TF-CBT consultation program (Funded by the Annie E. Casey Foundation) available at www.musc.edu/tfcbtconsult • National TF-CBT Certification Program will be available in spring 2012
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** TF-CBT is a flexible model that includes many components that are already familiar to many community therapists. It is relatively easy to learn in a short time and is acceptable to most families and therapists.

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

Pros & Cons/ Qualitative Impressions continued	**What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Some therapists do not like to use structured therapy approaches nor to talk directly about children's traumatic experiences. These therapists may prefer a different treatment model.
Contact Information	**Name:** Judith Cohen, M.D.; Anthony Mannarino, Ph.D. or Esther Deblinger, Ph.D. **Address:** 4 Allegheny Center, 8th Floor **Email:** jcohen1@wpahs.org; amannari@wpahs.org; deblines@umdnj.edu **Website:** www.pittsburghchildtrauma.net; www.musc.edu/tfcbt
References	CATS Consortium (2010). Implementation of CBT for youth affected by the World Trade Center disaster: Matching need to treatment intensity and reducing trauma symptoms. *JTS, 23*, 699-707. Cohen, JA, Mannarino, AP & Deblinger, E (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*. New York: Guilford Press. Cohen, JA, Mannarino AP & Iyengar, S (2011). Community treatment of PTSD for children exposed to intimate partner violence: A randomized controlled trial. *Arch Ped Adol Med*, 165, 16-21. Cohen, JA, Deblinger, E, Mannarino, AP & Steer, R (2004). A multisite randomized controlled trial for children with sexual abuse-related PTSD symptoms. *JAACAP, 43*, 393-402 Cohen, JA, Mannarino, AP (1996). Treating sexually abused preschool children: Initial treatment outcome findings. *JAACAP, 35*, 42-50. Cohen, JA, Mannarino AP & Knudsen K (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse Neglect, 29*, 135-145. Cohen, JA, Mannarino, AP & Knudsen, K (2004). Treating childhood traumatic grief: A pilot study. JAACAP, 43, 1225-1233. Cohen, JA, Mannarino, AP & Staron, V (2006). JAACAP. A pilot study of modified cognitive behavioral therapy for childhood traumatic grief. *JAACAP, 45*, 1465-1473. Deblinger, E, Lippmann, J & Steer, R (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*, 310-321. Deblinger, E, McLeer, SV & Henry, DE (1990). Cognitive, behavioral treatment for sexually abused children suffering posttraumatic stress: preliminary findings. JAACAP, 29, 747-752. Deblinger, E, Mannarino, AP, Cohen, JA, Runyon, M & Steer, R (2011). Trauma-focused CBT for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety, 28*, 67-75. Deblinger, E, Stauffer, L & Steer, RA (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their non-offending mothers. *Child maltreatment, 6*, 332-343. King, NJ, Tonge, BJ, Mullen, P, Myerson, N, Heyne, D, Rollings, S, Martin, R & Ollendick, TH (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *JAACAP, 39*, 1347-1355.

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

References continued

McMullen, J & O'Callaghan, P (2012). *Delivering and evaluating a group intervention with former child soldiers and other war-affected children: A randomised controlled trial*. Paper presented at the Division of Educational and Child Psychology, British Psychological Society Annual Meeting, Stratford Upon Avon, January 2012.

O'Callaghan, P & McMullen, J (2012). *Psychological and psychosocial interventions with war affected children*. Clinical trials ID NCT01509872

Weiner, D, Schneider, S & Lyons, JS (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review, 31*,1199-1205

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Training Guidelines

Field	*May include requirements, recommendations, minimum standards, variations, ratios, and other considerations*
Treatment/Product Description	**Description:** TF-CBT addresses the multiple domains of trauma impact including but not limited to posttraumatic stress disorder (PTSD), depression, anxiety, externalizing behavior problems, relationship and attachment problems, school problems, and cognitive problems. TF-CBT includes skills for regulating affect, behavior, thoughts and relationships, and trauma processing; and enhancing safety, trust, parenting skills, and family communication. **NCTSN Fact Sheet Available:** http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/TFCBT_General.pdf **Culturally Specific Information Available:** http://nctsn.org/sites/default/files/assets/pdfs/tfcbt_cultural.pdf TF-CBT has been shown to be effective with culturally diverse populations, including Caucasian, African-American, and Latino families as well as African and Asian families. There are cultural applications of TF-CBT for Latino and Native American families. **Goals:** To reduce traumatic stress symptoms and improve overall functioning and development of children and adolescents with a history of exposure to traumatic life events. **Target Population:** Children and adolescents ages 3-18 and their caretakers. **Essential Components:** PRACTICE components which include stabilization components, trauma narration and processing, and treatment integration. **Other considerations:** Can be implemented in outpatient, residential, in-home, and school settings.
Training	**Minimally Acceptable Training** **Mode of Training:** Completion of TF-CBT Web; 2-day, in-person clinical training; 12 follow-up consultation calls. **Content:** TF-CBT implementation **Number of Days/Hours Total/Minimum:** 10 hours for TF-CBT Web; 14 hours for live clinical training; 12 hours for consultation calls. **Options for Make-up:** Clinicians can join other consultation calls if they are not able to complete the calls. **Training Cost:** Cost for agency is typically $4000-6000 for the 2-day training; the cost of each consultation call is $150-200. **Training Contact Information:** Anthony P. Mannarino, PhD (amannari@wpahs.org) **Most Comprehensive/Highest Recommended Training** **Mode of Training:** Completion of TF-CBT Web; 2-day, in-person clinical training; 12 follow-up consultation calls; advanced TF-CBT training. **Content:** TF-CBT Implementation

Training (*continued*)	**Number of Days/Hours Total/Minimum:** 10 hours for TF-CBT Web; 14 hours for live clinical training; 12 hours for consultation calls; 7 hours for advanced training. **Options for Make-up:** Clinicians can join other consultation calls. **Training Cost:** Cost for agency is typically $4000-6000 for the 2-day training; the cost of each consultation call is $150-200; advanced training is $2000-3000. **Training Contact Information:** Anthony P. Mannarino, PhD (amannari@wpahs.org)
Selection	**Minimum Education Level:** Currently in graduate school or having a Master's degree in a mental health related discipline. **Licensure/Certification:** No **Experience:** No **Match/Fit:** The theoretical foundation for this treatment approach is CBT. It is intended for children and adolescents exposed to single incident or multiple traumas who present with traumatic stress symptoms or complex trauma. Clinicians who pursue TF-CBT training should have basic knowledge with respect to childhood traumatic stress and the impact of trauma on children and families. Also, it is important that clinicians have general, basic clinical competencies in treating children and families exposed to traumatic life events. This intervention is contraindicated for children and adolescents who are acutely suicidal or acutely psychotic and require immediate stabilization; who have a primary drug or alcohol problem that requires stabilization; or who have serious cognitive impairments that preclude participation in CBT intervention.
Preparation for Training and Implementation	**Clinician Readiness Assessment Available?** No **Agency Readiness Assessment Available?** Yes, NCTSN BSC Learning Collaborative **Typical Prerequisites for Training:** TF-CBT Web **Pre-reading/Other:** Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York, NY: Guilford Press.
Consultation	**Type/Mode/Ratio:** 12 consultation calls; maximum of 12 clinicians/set of calls. **Frequency:** Either 2X/month for 6 months or 1X/month for 12 months. **Participation:** Case presentations, including behavioral rehearsal and feedback on TF-CBT components. **General/Expected Duration of Consultation:** One-hour calls. **Demonstrated Proficiency/Mastery/Competence:** Successful case presentations based on the use of the TF-CBT Case Presentation Template. **Other Parameters of Consultation:** None
Case Completion Requirements	**Case Completion:** One during course of consultation calls; three for TF-CBT therapist certification. **Fidelity:** TF-CBT Brief Practice Checklist **Mode of Review:** Trainer/consultant oversees case completion.

Maintenance	**Booster:** Not yet determined. **Advanced:** Not yet determined. **Maintenance Plan/Continuing Education:** Not yet determined.
To Supervise Providers of the Treatment/ Product	Prerequisites needed to supervise use of the Treatment/Product **# of Cases Completed in Treatment/Product:** 10 **# of Years Practiced:** 2 **# of Year Providing Supervision:** 2 in model; 3 overall **# of Supervisees:** Not Specified
To Train Providers in the Treatment/ Product	**Prerequisites needed to train providers in the Treatment/Product:** Completion of TF-CBT train-the-trainer program which requires that candidates be certified in TF-CBT, have substantial experience in supervising with the TF-CBT model, and have excellent general training experience.
Endorsement or Certification Options	**For Clinician:** TF-CBT Therapist Certification (https://tfcbt.org) **For Supervisor:** TF-CBT Train-the-Supervisor Program **For Trainer:** TF-CBT Train-the-Trainer Program **Decision-making process/body:** TF-CBT Developers **Roster of Trainers:** There is a listing of certified TF-CBT therapists which can be found at https://tfcbt.org
Additional Resources	TF-CBT Workbooks: *"Your Very Own TF-CBT Workbook"* https://tfcbt.org/wp-content/uploads/2014/07/Your-Very-Own-TF-CBT-Workbook-Final.pdf *"Dealing with Trauma: A TF-CBT Workbook for Teens"* http://tfcbt.thebrewroom.com/wp-content/uploads/2014/07/Dealing_with_Trauma_-_A_Workbook_for_Teens.pdf TF-CBT Online Course: https://tfcbt.musc.edu/

About *Seeking Safety*

Seeking Safety (SS) is a coping skills approach to help people attain safety from trauma and/or addiction. It is present-focused and designed to be safe, optimistic, and engaging. The treatment is highly flexible. It can be conducted in group or individual format; open or closed groups; with any gender; adults and adolescents; any length of time available (using all 25 topics or fewer); any treatment setting (e.g., outpatient, inpatient, residential); and any type of trauma and/or addiction. It can be used from the start of treatment as it is stabilization-oriented. It can be used with clients who have trauma and/or addiction problems (they do not have to have both). Seeking Safety has been implemented for over 25 years in diverse types of programs, including community-based, mental health, addiction, criminal justice, veteran/military, adolescent, school, and medical settings. The Seeking Safety book has been translated into 14 languages.

Seeking Safety topics

Seeking Safety offers 25 topics, each representing a safe coping skill relevant to trauma and substance problems. Topics can be done in any order, in any session length, and as few or many as desired (not all 25 have to be done). They address cognitive, behavioral, interpersonal, and case management domains:

- Interpersonal topics: *Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources*
- Cognitive topics: *PTSD: Taking Back Your Power, Compassion, When Substances Control You, Creating Meaning, Discovery, Integrating the Split Self, Recovery Thinking*
- Behavioral topics: *Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding)*
- Combination topics: *Introduction/Case Management, Safety, Life Choices, Termination*

Five key principles of Seeking Safety

(1) *Safety as the overarching goal*-- helping clients attain safety in their relationships, thinking, behavior, and emotions);
(2) *Integrated treatment* that addresses trauma and addiction at the same time if clients have both;
(3) *A focus on ideals* to inspire hope;
(4) *Four content areas*: cognitive, behavioral, interpersonal, and case management; and
(5) *Attention to clinician processes* (helping clinicians work on self-care, emotional responses, and other issues).

Additional features:

- *Traumas are not described in detail*. Clients do not have to tell or listen to intense trauma details. We focus on trauma as it impacts the client in the present.
- *Allows for harm reduction or abstinence* approaches.
- *Encourages but does not require 12-step* and other self-help groups
- *Focuses on empowerment* and choice
- *Is written in everyday language* to be accessible to all
- *"Meets clients where they are at" in terms of addiction*, not requiring abstinence or motivation to quit; these often develop as they do Seeking Safety over time.
- *Anyone can participate*. No one is excluded from Seeking Safety. Anyone receiving services of any kind can participate in Seeking Safety. It has been successfully conducted with people who are psychotic, illiterate, homeless, severely mentally ill, suicidal, and have histories of violence.
- *Anyone can conduct it.* It has been implemented by all types of professionals and also be peers and paraprofessionals. No specific license, degree, or education is required. Training is available and recommended but only required only if a formal publishable clinical trials is being conducted for research purposes.

Evidence base

Seeking Safety is an *evidence-based model, with over 45 published research articles* and consistently positive results and high satisfaction. It has been studied in a broad range of populations in terms of ethnic diversity, setting, and severity of trauma history and addiction.

Seeking Safety is *one of the most cost-effective models*, especially for addiction. A government-based analysis, for example, indicates that it has 88% likelihood of benefit relevant to cost, which was the third highest of all 23 SUD models (higher than motivational interviewing, 63%; motivational enhancement therapy, 61%, and relapse prevention, 56%) (Washington State Institute for Public Policy, 2018).

For all studies, go to www.seekingsafety.org, section *Evidence*. Studies include numerous pilots, randomized controlled trials, and multi-site trials.

Learn more

See www.seekingsafety.org.

Citations

Lenz, A. S., Henesy, R., & Callender, K. (2016). Effectiveness of Seeking Safety for Co-Occurring Posttraumatic Stress Disorder and Substance Use. *Journal of Counseling & Development*, *94*(1), 51-61.

Najavits, L. M., Clark, H. W., DiClemente, C. C., Potenza, M. N., Shaffer, H. J., Sorensen, J. L., Tull, M. T., Zweben, A., Zweben, J. E. (2020). PTSD / substance use disorder comorbidity: Treatment options and public health needs. *Current Treatment Options in Psychiatry*, 1-15.

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

Najavits, L. M., Hyman, S. M., Ruglass, L. M., Hien, D. A., & Read, J. P. (2017). *Substance use disorder and trauma*. In S. Gold, J. Cook, & C. Dalenberg (Eds.), Handbook of Trauma Psychology (pp. 195-214): American Psychological Association.

Najavits, L.M. (2013). *Seeking Safety HIV guide*. Treatment Innovations, Newton Centre, MA.

Najavits, LM (2009). *Seeking Safety: An implementation guide*. In A. Rubin & DW Springer (Eds). The Clinician's Guide to Evidence-Based Practice. Hoboken, NJ: John Wiley.

Washington State Institute for Public Policy (downloaded 4/28/2018). *Benefit-Cost Results: Substance Use Disorders—Seeking Safety*. http://www.wsipp.wa.gov/BenefitCost/Program/307

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