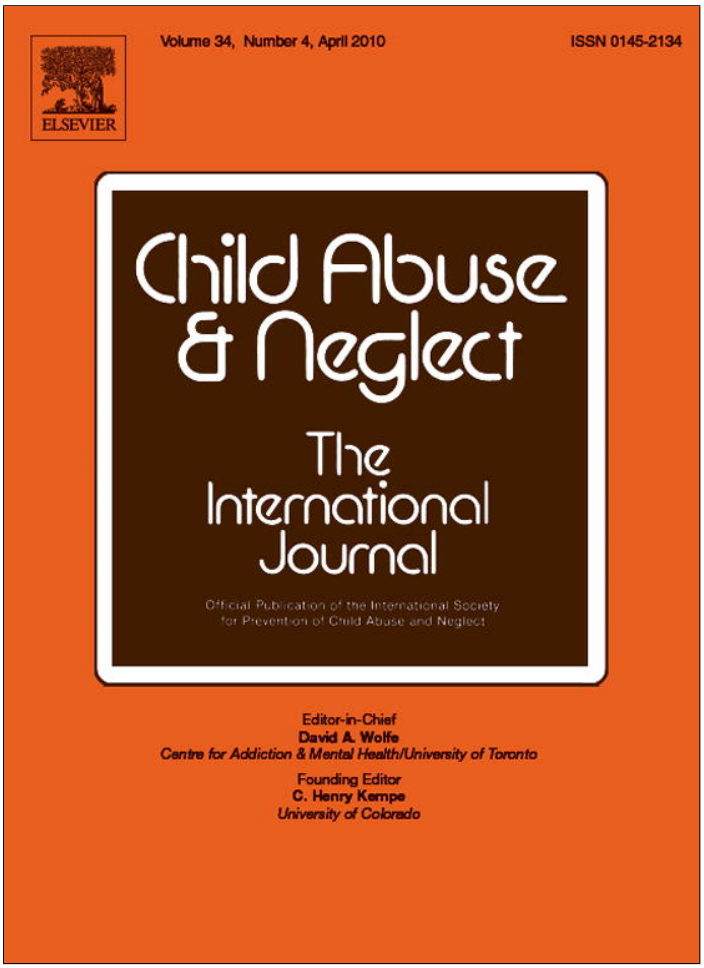

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Practical strategies

Trauma focused CBT for children with co-occurring trauma and behavior problems

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ABSTRACT

Objective: Childhood trauma impacts multiple domains of functioning including behavior. Traumatized children commonly have behavioral problems that therapists must effectively evaluate and manage in the context of providing trauma-focused treatment. This manuscript describes practical strategies for managing behavior problems in the context of trauma-focused evidence-based treatment (EBT) using a commonly implemented EBT for traumatized children.
Methods: The empirical literature is reviewed and practical strategies are described for conducting trauma- and behavioral-focused assessments; engaging families in trauma- and behavioral-focused treatment; treatment-planning that includes a balance of both trauma and behavioral foci; managing ongoing behavioral problems in the context of providing trauma-focused treatment; managing behavioral crises ("crises of the week"); addressing overwhelming family or social problems; and steps for knowledge transfer.
Results: Trauma-focused EBT that integrate behavioral management strategies can effectively manage the behavioral regulation problems that commonly occur in traumatized children.
Conclusions: Addressing trauma-related behavioral problems is an important part of trauma-focused treatment and is feasible to do in the context of using common trauma-focused EBT.
Practice implications: Integrating effective behavioral interventions into trauma-focused EBT is essential due to the common nature of behavioral regulation difficulties in traumatized children.

Introduction

More than half of the children and adolescents (hereafter referred to as "children") in the USA have experienced a potentially traumatic event such as child abuse, sexual assault, domestic violence, community violence, bullying, serious accidents, fires, disasters, medical trauma, or the traumatic death of a loved one. Approximately a quarter of exposed children develop significant symptoms of Posttraumatic Stress Disorder (PTSD) (Copeland, Keeler, Anglod, & Costello, 2007). Since PTSD places children at increased risk for other psychiatric and medical conditions and may derail normal developmental processes, it is important for these children to receive early and effective treatment (American Academy of Child and Adolescent Psychiatry, in press).

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P:	Psychoeducation (information about trauma and trauma reactions)
P:	Parenting skills (behavior management skills)
R:	Relaxation skills (managing physiologic reactions to trauma)
A:	Affective modulation skills (managing affective responses to trauma)
C:	Cognitive coping skills (connections between thoughts, feelings, behaviors)
T:	Trauma narrative and processing (correcting cognitive distortions related to trauma)
I:	In vivo mastery of trauma reminders (overcoming generalized fear related to trauma)
C:	Conjoint child-parent sessions (variety of joint child-parent activities)
E:	Enhancing safety and future development (safety planning for future)

Fig. 1. TF-CBT components: PRACTICE.

Effective treatments for PTSD symptoms and co-occurring psychiatric problems are available. One evidence-based treatment (EBT) for PTSD is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is a structured individual and parent trauma-focused model that includes initial skills-based components followed by more trauma-specific components with gradual exposure integrated into each component (Cohen, Mannarino, & Deblinger, 2006; www.musc.edu/tfcbt). TF-CBT components are summarized in Fig. 1. Optimally TF-CBT is provided to children and parents or primary caretakers in parallel individual sessions with additional conjoint child-parent sessions included later in treatment. Flexible application of TF-CBT with early and specific focus on the positive parenting component can accommodate complex trauma presentations including significant behavior problems.

TF-CBT was initially tested in specialty trauma treatment clinics in which referred children primarily presented with PTSD symptoms. Inclusion criteria for these studies required the participation of a supportive parent or caregiver. However many of these children had histories of multiple trauma exposure and co-morbid conditions such as depression or behavior problems (Cohen, Deblinger, Mannarino, & Steer, 2004) TF-CBT worked well for children exposed to a variety of traumas, multiple traumas, both genders, and various ethnic and racial backgrounds.

There is considerable interest in transporting TF-CBT to routine clinical settings in which most children receive mental health care. In the USA, public mental health centers are a primary setting for child mental health service delivery. Many children exposed to trauma also initially present in domestic violence shelters, multi-service centers for refugee and immigrant children, or substance abuse programs. TF-CBT has recently been used with positive outcomes in usual care settings such as community mental health centers, for children living in foster care (Amaya-Jackson, Gerrity, Wison, & Widdoes, 2009; Northwestern University, 2008) and in National Child Traumatic Stress Network Learning Collaboratives (NCTSN, www.nctsn.org) conducted in non-specialty settings.

Many traumatized children presenting for care in community settings are not seeking treatment for trauma-specific psychological impact. Sometimes the trauma history is known (e.g., domestic violence programs) but the focus is on other considerations such as establishing safety and stability. In other instances, the trauma history and related symptoms may not be known at the time of referral but be disclosed during the assessment.

In addition to trauma exposure, many of these children have experienced other significant adversities that affect emotional and behavioral adjustment. Children may have been neglected, unsupervised, or exposed to harsh or inconsistent parenting practices; many have problematic attachments. For example, approximately 50% of children seen in public mental health settings have had an open child welfare case within 2 years and many of these children are brought to treatment by their abusive or neglectful parent (Lau & Weisz, 2003).

Beyond their clinical conditions, a substantial proportion of these children continue to live in compromised circumstances. Many families are poor and disadvantaged and struggle with a whole array of difficulties in simply managing to meet basic survival needs. The parents often have their own psychiatric conditions. Others are involved with the criminal justice system. Of particular importance for helping children with trauma-related psychological impacts is that many children are still exposed to the sources of trauma impact. This may mean that they live with their abuser or an offender as is common

in cases of child physical abuse and domestic violence, or they still live in the dangerous and violent communities that produced their traumatic stress symptoms. Thus most children exposed to potentially traumatic events who are referred for clinical care in public mental health have multiple problems, often including significant externalizing behavior problems (e.g., oppositional, noncompliant, physically aggressive, intrusive, destructive, or sexually inappropriate behaviors). These are often the problems for which their parents initially bring them for therapy, rather than PTSD or other trauma-related problems. If during assessment the clinician identifies the child's trauma impact as a clinically significant concern and offers trauma-focused therapy as an option, the behavior problems and other relevant considerations for the family must be a focus of treatment or the family will likely not be motivated to engage in treatment, since the behavior problems will likely persist or escalate if the clinician does not address them and effectively manage behavioral crises that arise during the course of trauma-focused treatment.

Evidence-based treatments exist for behavior problems. There is a substantial literature documenting the effectiveness of a variety of parent behavior management approaches (Eyeberg, Nelson, & Boggs, 2008). These interventions are primarily behavioral, target parenting skills, and are often fully parent-mediated. They do not address emotional problems that children with behavior problems may have. There is also a highly effective cognitive behavioral treatment for children with sexual behavior problems regardless of the cause of the behaviors (Carpentier, Silovsky, & Chaffin, 2006).

In contrast, TF-CBT addresses both trauma-related emotional and behavior problems. However, it is not clear that clinicians in routine practice settings are familiar with or skilled at delivering the parenting behavioral interventions that are the essential ingredients of this component of TF-CBT, especially in cases where the behavior problems are prominent. In order for TF-CBT to be effective with trauma-affected children who also have behavior problems, the parenting component will likely require a specific and sustained focus in therapy.

The parenting component of TF-CBT consists of the application of standard behavior management and skills training applied within the context of trauma-focused therapy. The parent management components include increasing positive parent-child encounters, reinforcement of positive behavior, ignoring minor irritating behavior, giving effective instructions and meting out consequences for misbehavior (e.g., time out, withdrawal of privileges). These strategies involve behavior monitoring and explicit behavior management plans. Core skills training for both children and parents involve teaching problem solving and communication. These are specific skills that require behavioral rehearsal and practice between sessions. The purpose of this paper is to describe how TF-CBT can be successfully implemented for children with coexisting trauma symptoms and significant behavioral problems, including frequent "crises of the week" ("COW").

Assessment: Is trauma-focused treatment appropriate?

Assess for trauma exposure and trauma symptoms

Conducting a thorough assessment is critical to determining what problems to focus on during treatment. The first step in determining whether trauma-focused treatment is indicated is ascertaining the child's exposure and responses to trauma. Given the prevalence of exposure and the possibility of chronic PTSD, routine assessment of exposure and responses to trauma should become the standard of care in mental health settings. Although some clinicians have concerns about bringing up trauma exposure early in treatment, the evidence shows that asking about trauma exposure typically results in children identifying traumatic life events. In contrast, children ordinarily do not spontaneously identify such experiences during an assessment or therapy.

The clinician should evaluate whether the child has significant symptoms that are clearly related to the child's exposure to trauma (such as PTSD, depression, anxiety, etc.). Standardized instruments are available to assess these symptoms and use of such instruments is especially helpful for identifying children who would benefit by a trauma-focused intervention. Although semi-structured standardized interviews are considered the "gold standard" evaluation method, these are time consuming and not feasible in most community settings. Self-report instruments for children >7 years old, and parent report instruments for younger children are valid ways of assessing PTSD and depression symptoms. These are fast and easy to administer (for example, the child can complete the instrument while the therapist is interviewing the parent or vice versa). The most widely used assessment instruments for identifying trauma exposure and PTSD symptoms are the UCLA PTSD Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004) and the Child PTSD Symptom Scale (Foa, Treadwell, Johnson, & Feeny, 2001). Child and parent report versions are available; recently a parent screening version was developed for children <7 years old (available in Cohen, Kelleher, & Mannarino, 2008).

- If the child has not experienced a trauma or does not have significant trauma-related symptoms (e.g., PTSD including avoidance; depressive symptoms; self-blame; maladaptive coping strategies; attachment or relationship problems, etc.), trauma-focused treatment is not appropriate. An EBT for the child's other problems is likely indicated.

Evaluate for behavior problems

Assuming the child does have trauma symptoms, before making a decision to provide trauma-focused treatment it is also critical to assess for other problems. For the purposes of this paper we are interested specifically in behavior problems. Although children are likely the most accurate reporters of their internalizing symptoms, behavior problems must be assessed

by gathering information from others such as parent(s) or other primary caretakers (hereafter referred to as "parents") teachers, child care providers, pediatricians, and Child Protective Services (CPS). Standardized measures exist for behavior problems in the public domain and many of these can be readily accessed in the public domain (reviewed in Leary, Collett, & Myers, 2009). In some instances the child will have such serious behavior problems (e.g., acutely suicidal or homicidal behaviors) that these will require the clinician's entire focus in treatment.

- If the behavior problems are so severe that it is clear that the clinician will not be able to focus on trauma issues until these are resolved, an EBP for behavior problems rather than trauma should be used until the child's behaviors have stabilized.

Conduct functional behavioral analysis (FBA)

Assuming the child has both trauma symptoms and behavior problems but the behaviors are not overwhelming, it is important to conduct a FBA of the behaviors. Behavior generally has the function of either achieving a desired goal (e.g., obtaining a reward such as attention, privileges, influence) or avoiding a negative consequence (e.g., distress, unpleasant activity, punishment). The basic principle of FBA is that behavior that is rewarded (e.g., gaining something good, avoiding something bad) tends to persist even if the behavior itself is not desirable. Problematic trauma-related behaviors, for example, tend to involve avoidance of memories and reminders that produce distress. Even such extreme behaviors as self-harm, substance abuse or risky sexual behaviors may have the immediate function of reducing trauma-related distress although they have obvious negative consequences as well. In the case of other externalizing behaviors such as disobedience, aggression, and delinquency, the child may achieve immediate gain by avoiding an unpleasant activity, getting one's way, or achieving status with delinquent peers. Regardless of the initial cause of a behavior, it can persist because it is reinforcing.

In order to conduct a FBA, the clinician should evaluate in what settings and in what contexts the child's behavior problems occur, their severity, what the antecedents are, what consequences have been implemented to respond to these behaviors, whether they have been provided consistently, what the child's response has been to these consequences, whether prior treatment has been received for the behavior problems and if so, what this treatment consisted of and how the child responded to this treatment. It is also helpful to assess the relationship between the behavior problems and the trauma, for instance, did these problems start only after the child's trauma experiences, or did they predate the trauma? Did the nature or severity of the child's behavior problems noticeably change after the start of the trauma?

Determine the relationship between behavior problems and the child's trauma, if any

Establishing the extent to which the behavior problems are trauma-related is an important assessment activity prior to the initiation of TF-CBT. There are a number of ways in which this can be ascertained. The behavior may be connected to avoidance of trauma-related distress (e.g., serves an anxiety reduction function). Such behaviors may be relatively manageable (e.g., not wanting to be separated from a parent, school avoidance, restricting activities, trouble falling asleep). Other behaviors are more concerning because of their consequences to the child or others. Examples include sexual behavior problems, aggression, or self-harming behaviors. These behaviors can all be conceptualized as trauma-related. Sexual behavior problems may have the benefit of self-soothing, power over others, or gaining attention. Aggression may be the result of ineffectively managed anger about the trauma or a strategy to prevent re-victimization. Self-harm may serve to reduce immediate high levels of internal distress. It is important to be aware that behavior that may have started as trauma-related may persist because of more proximal rewards and punishments.

- It may be difficult to accurately ascertain connection between the child's traumatic experiences and every behavior problem but it's helpful for therapists to make these connections when feasible. Helping parents understand these connections often facilitates their ability to optimally implement effective parenting strategies.

These behaviors may have other causes as well. For example, children exposed to domestic violence may be aggressive not as a manifestation of trauma but rather because violence has been modeled or because parents are ineffective, inconsistent or harsh. Ascertaining the factors influencing the behavior is essential for determining treatment targets and strategies.

Finally, a key clinical issue is what plans are in place to address the child's safety or sense of safety. It is important in cases of child abuse to ascertain whether or not CPS or other agencies that assure child safety are actively involved with the family and if there are restrictions on the contact with the person who perpetrated the violence. In domestic violence cases, it may be important to know if there is a protection order or what are the visitation arrangements. Some children continue to live in high violence neighborhoods or communities. If children are still in danger this has very important implications for understanding and responding to their behavior. Some behaviors may be necessary and legitimate responses to the environment and would not be expected to resolve without a change in the environment. The goal of exposure in treatment would not be to desensitize the child to trauma reminders in such situations, but rather to assist children in "fine tuning" their vigilance to danger, learning to differentiate between dangerous and innocuous situations and use skills to problem solve about how to cope with both types of situations. Thus, TF-CBT would need to be adapted for such children but could still be a valuable intervention to reduce symptoms and enhance adaptive coping.

Developing a workable treatment plan

Present the assessment data and treatment options

The clinician can use the above information to decide whether trauma-focused therapy is appropriate for the child. Assuming the clinician has determined that TF-CBT may be appropriate for children with trauma impact and significant behavior problems, a first step would be for the clinician to present to the parent the information gathered during the assessment that supports the need to treat both trauma symptoms and behavior problems:

"From everything I have learned today it seems that your child has both trauma impact and a significant behavior problem. As you can see on this instrument your child completed, he is reporting moderately severe PTSD symptoms. You have reported significant behavioral problems as well. There are two different ways we can go. One is to try behavior management treatment for the behavior problems. I would be happy to provide this treatment if it is your choice, but this would not really address the PTSD symptoms your child is reporting. The other possibility is to try a trauma-focused treatment that would also address your child's behavior problems. I believe his behavior problems may be related to the trauma and this treatment works for behavior problems as well. In the trauma-focused treatment we would be addressing both the behaviors and the trauma-related problems in each session. This is your choice. If you need more information about this trauma-focused treatment I would be happy to answer your questions or give you some information in writing."

Explain TF-CBT and determine whether parents agree to it

In order for parents to agree to TF-CBT treatment it is crucial for the clinician to explain what this treatment is comprised of, specifically, that during each session the therapist will address both the child's behavior problems *and* trauma issues. Do the parents agree to trauma-focused treatment or do they only want therapy to address the child's behavior problems? If parents do not buy in to the idea of addressing the child's trauma impact as well as the behaviors, it is likely that problems will arise in trying to implement trauma-focused treatment. The clinician will likely find that explaining connections between the child's trauma experiences and current behavior problems will help the parent to understand why trauma-focused treatment may be relevant to addressing the behavior problems:

"From what I have learned from you and your son today, I believe that your child's angry outbursts and oppositional behavior are related to his having experienced sexual abuse by his older brother (recently removed from the home following the child's disclosure). Here is why. You and he have told me that his behavior got much worse when his brother returned from the residential treatment facility 2 years ago. This is when his brother started sexually abusing him. Since then he has become increasingly angry and oppositional with you and at school. He told me that he gets really mad when he thinks about the abuse. He said that since the abuse started right around the time that school started, school reminds him of the sexual abuse and now he hates school. This is a very typical picture of a child who has experienced trauma and develops behavior problems. Many kids who receive trauma-focused treatment then have significant improvement in their behaviors and are back to normal by the end of treatment. There are two important things for you to consider. One is that we would be directly talking about the trauma during every session as part of the treatment. The other is that I will need your help and active participation in addressing the behavior problems. If this is okay with you, I think it would be a great treatment for your family. But if this is not what you want, please feel free to tell me."

After this discussion has occurred and if the parent agrees to proceed with TF-CBT, the therapist can proceed with the standard element of therapy including developing a treatment plan and beginning the engagement and motivational process. The therapist needs to be mindful that even with agreement to a trauma-focused treatment it may be necessary to review this agreement during the course of therapy.

Motivation and engagement strategies

The essence of therapy is that it is a change process. Two key components for successful behavior change have been identified. These processes are in addition to the availability of effective interventions. One is motivation. Motivation can be defined as problem recognition and readiness to change (Miller & Rollnick, 2002). In some cases such as substance abuse disorders it turns out that motivation for change can actually be as powerful as any intervention. The other process is engagement. This means involvement in the therapeutic context designed to bring about change. Obviously if families do not attend therapy, attend only sporadically or attend but do not believe in the value or do not participate in the change oriented interventions, therapy is not likely to make much difference.

Motivational interviewing and brief motivational enhancement interventions have been found to be highly successful for a variety of conditions and disorders. Developed initially for application to substance abusers, the principles have no been applied to other chronic medical conditions (e.g., diabetes). There is reason to believe that motivational approaches can be valuable for children as well (Erickson, Gerstle, & Feldstein, 2005; Suarez & Mullins, 2008). In the child abuse field, a motivational intervention has been specifically tested with physically abusive parents referred for Parent Child Interactional Therapy (PCIT). A recent study found that a pre-intervention motivational service significantly increased participation and successful completion of PCIT. However, the motivational intervention only made a difference when the formal intervention was evidence-based (Chaffin et al., 2004).

The key to motivational approaches is addressing ambivalence and moving clients toward agreement on the problem and becoming willing to engage in change behavior. This body of research has shown that certain skills are essential to increasing motivation. These skills are quite different from the usual methods that clinicians employ with clients. Instead of attempting to persuade clients that there is a problem and that they should want to change, the approach involves providing feedback (e.g., results of tests), being empathic and non-judgmental, increasing ambivalence, weighing pros and cons of change, and rolling with resistance. Such interviewing skills may very well have application to situations where parents/caregivers are not yet motivated to participate in treatments that may be effective for their children or addressing child or parent ambivalence about facing up to the trauma.

Engagement is the process of gaining attendance and participation in therapy. McKay and Bannon (2004) document several successful engagement strategies in increasing the show-up rate for child mental health treatment appointments for poor inner city children from <50% to >80%. Among these are (1) clarifying possible service options; (2) setting the foundation for a collaborative working relationship; (3) identifying concrete practical issues that can be addressed immediately; and (4) developing a plan to overcome barriers to ongoing attendance. Each of these engagement strategies are important for traumatized children, and may be particularly relevant for those with behavior problems. They have been incorporated with TF-CBT and other trauma-focused treatments with positive results (Hoagwood, in press). Nock and Kazdin (2005) have described engagement strategies that have some success with families with children with behavior problems. Explicitly eliciting motivational self-statements and commitment to the change process delivered both at the onset of treatment and during treatment sessions that have been shown to increase attendance.

The therapist's goal is to establish the foundation for a collaborative working relationship in which the parent will attend therapy and is prepared to engage in the change process. When behavior problems are the parents primary concern even if they acknowledge the contribution of trauma, the initial focus of treatment will need to address the behavior problems while at the same time making the link to the trauma so that the trauma-focus makes sense. We have found that it is helpful to provide psychoeducation about the connection between the behavior problems and the trauma and the fact that the parent and the environment are the crucial agents of change because behavior that achieves a goal will continue until the rewards diminish. It is crucial for the clinician to convey confidence about the success of trauma-focused treatment in improving behavior as well as trauma symptoms in order for parents to commit to this treatment. Finally, the clinician will gain mileage by listing behavior problems first on the list of problems in the treatment plan; this demonstrates to parents and children that the clinician takes seriously concerns about these problems and is keeping these concerns on the front burner during therapy. Explain why directly addressing the trauma even while focusing on the behavior problems will enhance the successful outcome because the child's maladaptive strategies for dealing with trauma impact may be maintaining the behavior problems.

An important way to establish this dual focus is to incorporate it into the treatment plan. There is good evidence that making a formal commitment to the activities that are necessary increases compliance. In the most supportive and appropriate manner possible the therapist can remind them that this is what everyone agreed to, and the rationale for this plan, when and if behavior problems threaten to dominate sessions later on.

The following examples illustrate some typical trauma-related behavior problems and how they might be explained to parents as a mechanism for engaging them in positive parenting component of TF-CBT.

Example: Child was sexually abused by baby sitter. Following revelation of the sexual abuse the parent was very supportive to the child. The child initially was very upset about being left by the parent or going to school away from the parent. The parent wanted to be supportive so initially stopped going out and allowed the child to stay home from school if she expressed anxiety. The parent sometimes is very responsive and allows exceptions to usual expectations especially if the child connects the behavior to the trauma and other times becomes frustrated and irritated. The child's behavior escalates.

In this case FBA would help the parent understand that the child initially sought to decrease distress at separation from the parent where they felt safe. By allowing the child's distress to determine the parent behavior, the behavior was reinforced. The therapist helps the parent understand the origins of the child's behavior and the effect of inadvertent reinforcement of this maladaptive trauma-related behavior in the child as well as the negative impact on the parent-child relationship. The parent learns that confronting the feared experience in a supportive and gradual way is the cure and is helped to carry out specific focused intervention to assist the child in returning to normal behavioral expectations.

Example: The child was exposed to domestic violence of the mother and physically abused by the father over a period of years. Even though the abusing parent is now out of the family, the non-offending parent-child relationship is characterized by irritability, conflict, and negative interactions. The non-offending parent is supportive regarding the domestic violence exposure and abuse but is frustrated with the child's behavioral responses and as a result warmth is reduced and the behavior continues. She tends to see the child as being like the abusive father.

The therapist helps the mother to see how the child may be handling the trauma impact and may have learned aggressive behavior as a result of the trauma exposure and the mother's depression and inability to parent effectively under those circumstances. She is helped to see that enhancing her parental capabilities by learning new skills will improve her relationship with the child, reduce trauma impact and reduce behavior problems.

The treatment plan should identify goals to address both trauma-focused and behavior goals. The treatment goals should be concrete and the treatment method clearly stated. For example, for the behaviors the treatment goal and plan might be "child will decrease in aggression towards his brother as demonstrated by hitting his brother less than once per week" and methods is "parent management training 45 minutes/week." For the trauma impact the treatment goal might be

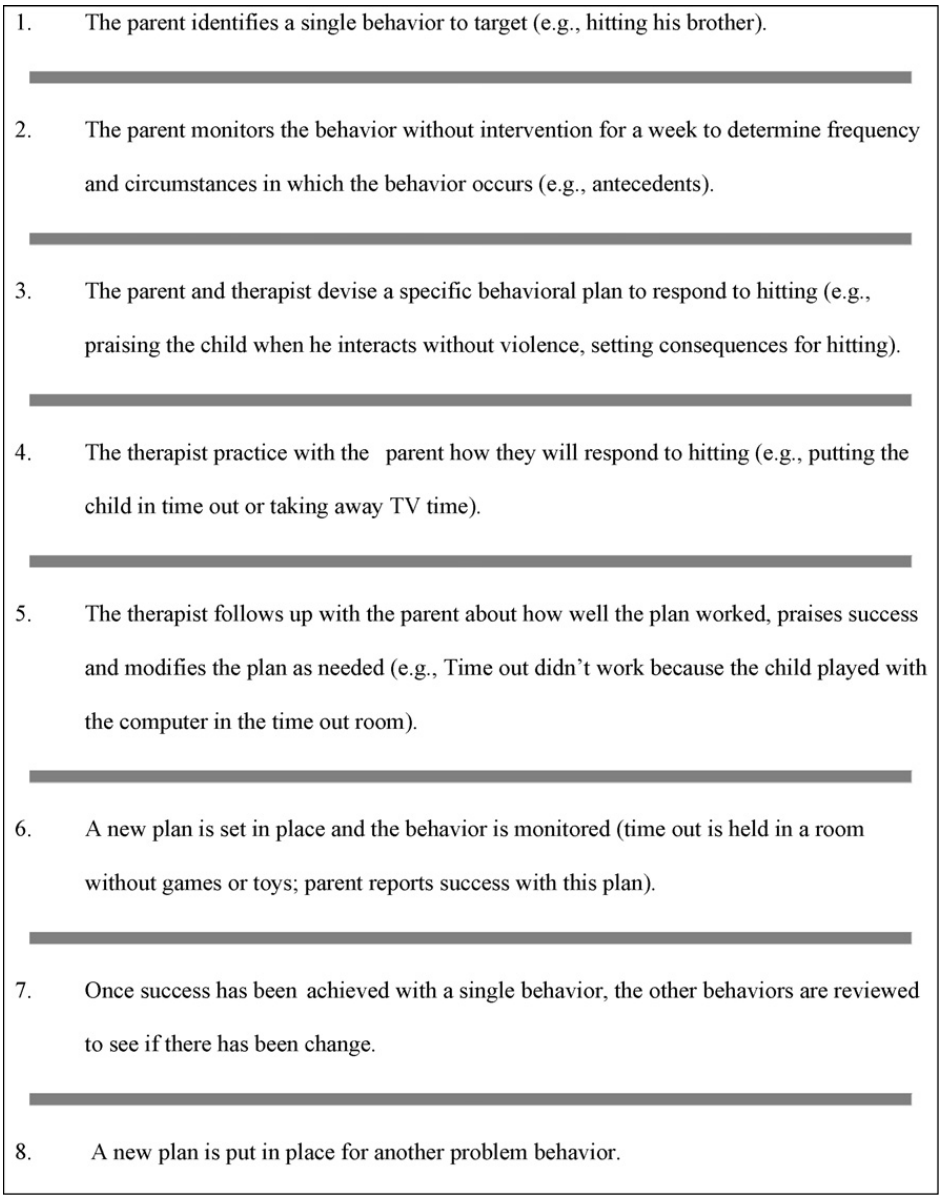

Fig. 2. Sample behavior management plan.

"develop an accurate and helpful view of the domestic violence and abuse" and the method "gradual exposure and cognitive restructuring." An example of a behavioral management plan is provided in Fig. 2.

During the early stages of delivering TF-CBT for children with behavior problems three types of challenges most commonly arise: sticking with trauma-focused treatment when behavior problems or extreme responses continue to occur; COW which are almost always of a behavioral nature; and overwhelming family or social problems that are usually beyond the scope of what any therapist can address or hope to change in the context of individual child therapy.

Addressing ongoing behavior problems

Behavior problems respond to training parents in behavioral skill interventions and teaching older youth TF-CBT skills such as relaxation, affective regulation and cognitive coping skills. When children's behavior does not improve it is usually because the behavioral interventions are not being implemented consistently or because they are being implemented incorrectly. It is the therapist's responsibility to ascertain why behavior problems are persisting by carefully analyzing why the agreed upon behavioral management or specific skill (e.g., problem solving, family communication) is not working. Then the therapist develops a strategy to provide additional psychoeducation about the method or increase parental or child motivation to consistently apply the behavioral plan. In some cases the parent and child need additional assistance in practicing and rehearsing (e.g., role play) to carry out the planned interventions.

The following options have proven feasible in addressing ongoing behavior problems and still adhering to a trauma-focused approach. The therapist addresses the behaviors with the parent before seeing the child. During this part of the

session the therapist assesses that the parent has agreed to carry out their end of this agreement by implementing the agreed upon behavioral suggestion but is struggling with implementation. It is usually best to only ask parents to implement a single behavioral strategy each week (e.g., praise your child every time you catch him sitting quietly and not hitting his brother; OR: This week I want you to ignore your child when he calls you bad names.) The therapist helps the parent problem solve and practice the agreed-upon skill during the parent session. Then the therapist can call the child into the session and together the child and parent can practice implementing the strategy until the parent is confident that he or she has mastered it. In this scenario the therapist may take the role of the other sibling who is getting hit or of a "coach" helping to explain to the child the purpose of the practice and to assist the parent in practicing the appropriate implementation. The parent or therapist should explain to the child what is going on: "your mother is practicing how to praise you for not hitting your brother," "I am practicing paying attention to your good behaviors, like doing your homework and sitting quietly," and so on. This is helpful in reinforcing to the child what is expected.

If the parents did not implement the behavioral strategy, the therapist should consider the possibility that the parent is still ambivalent about committing to the behavior change strategy and is not making a genuine effort. If this is the case, the therapist should return to the motivational mode instead of persisting in trying to get the parent to do the behavioral intervention. In this circumstance, the therapist should apply the principles and respectfully not respond to parental complaints about the child's behavior other than to state that the only way to bring about change is if the parent participates in a behavioral plan. It is entirely appropriate for therapists to communicate that adhering to behavioral plans is difficult and often frustrating especially initially and to offer support and assistance them carrying it out. In some situations the therapist might suggest to the parents that the clinic based therapy seems to not be working for them. Using the motivational strategy of offering a menu of options the therapist can present a variety of alternatives if the parent is interested and leave the choice to the parent. Possible options might be home-based, school-based or wrap around services. The key again is to avoid persuasive approaches while at the same time communicating that within the TF-CBT model (or for that matter any other evidence-based behavioral treatment) change in the child's behavior will require a change in the environmental response. For example, the therapist might say "I can see that you are unsure whether this approach will work for you. Unfortunately I just don't know any other way to go for BP. It is entirely up to you what you would like to do." But the therapist should not deviate from the basic message that behavior change within the model requires a change in responding to behavior.

So far we have focused on engaging parents in and implementing behavior management approaches within the positive parenting component of TF-CBT. In addition, other components of TF-CBT may be helpful in addressing behavior problems in traumatized children. Behavior problem specific focus in the emotion regulation and maladaptive cognitions components may also be useful in addressing behavior problems.

In terms of the emotion regulation component, specifically addressing the emotion of anger is important. Uncontrolled anger can produce behavioral consequences such as defiance or aggression. Dealing with anger in victimized children can be tricky because anger is a legitimate response to victimization or failure to protect. Anger can also be an understandable response in children in foster care whose parents have not made the changes necessary for their children to be safely returned to them. However, anger related behavioral response generally will have negative consequences for the child in terms of internal distress, social adjustment, placement stability, or reunification within parents.

The emotional regulation component of TF-CBT can incorporate the evidence-based approaches to anger control. The standard approach includes: (1) Recognition the physical signs of anger (e.g., tension, flushing); (2) using a calming or interrupting strategy (e.g., controlled breathing, tensing and relaxing muscles, counting backwards); and (3) taking an alternative action (e.g., talking to someone, leaving the situation, distraction). If anger is the prominent emotional response to the trauma, then anger focused emotion regulation strategies are appropriate.

In the addressing maladaptive cognitions component, the cognitions that are fueling the angry emotions can be targeted. Cognitions might include the belief that what happened is unfair or those parents or others are acting deliberately to make life harder for the child. In some cases these cognitions may be inaccurate and could benefit from the usual cognitive strategies to help the child arrive at a more accurate understanding. An example might be a child in a sexual abuse or domestic violence situation who believes that his or her parent intentionally allowed the victimization. The therapist might help the child adopt the view that the parent does care but did not know what was happening or was too afraid to act protectively.

In other cases the child's views might be accurate but unhelpful. Assisting the child to arrive at a more helpful cognition is essential to reducing anger. An example might be where the parent has not complied with CPS expectations to engage in treatment so the child could return home. The child might be helped to acquire a belief that even though this is true, it is not intentional or child directed; the parent has problems that are unrelated to the child.

Addressing crises of the week

Crises of the week (COW) are common in children with behavior problems. These typically take the form of episodes of disruptive behavior that the parents or others (e.g., schools) continue to be upset about or do not believe have been effectively resolved and therefore they are brought to the attention of the therapist as a pressing concern. Examples of serious COW are fire setting, stealing, initiating fights with peers, running away, alcohol or drug use, abusive behavior towards siblings or family members. The consequence in some cases might be quite significant such as school suspension or expulsion, involvement of criminal justice authorities, hospitalization, or disruption of a placement. In some cases the parent may have responded to the child's misbehavior with severe physical punishment or even abuse.

It is not surprising that troubled children have periodic episodes of behavior problems especially early on in treatment before the new parenting practices and skills have taken hold. However, parents and other authorities often respond to these episodes as evidence that the child is not progressing or that therapy is not working. They may express great frustration and want to spend significant therapy time discussing the COW, usually with the purpose of pointing out the child's failings. It is also often observed that some families and alternative caregiver situations such as foster care or residential treatment seem to operate much of time on a crisis reactive basis and COW appear to dominate the functioning of the family or environment.

COW can usually be understood as evidence of continuing, ineffectively managed behavior problem or as reflective of a family and systems maladaptive functioning. However, traumatic avoidance is also a factor to consider. If the therapist's attention is constantly diverted from the trauma-focus to attending to the COW and the child (and/or parent) is avoidant of addressing the traumatic material, the child who produces more COW succeeds in the goal of avoiding trauma-focused treatment. Therapists should be aware of this dynamic and not allow COW to deter them from continuing to spend some time each session on trauma-focused material.

Therapists should conduct a functional behavioral analysis of the COW behavior to determine why the behavior occurred and what is reinforcing it. The procedure permits the therapist to make a thoughtful decision about how to handle the COW in session. In some cases, the COW may be a quite legitimate and understandable reaction to an unusual or stressful situation (e.g., a relative dies, a placement changes through no fault of the child, the case against the offender being scheduled to go to trial). Even smaller events may have heightened importance based on developmental stage (e.g., not getting on a team, break-up of a relationship). In these situations, brief supportive listening is entirely appropriate to maintain the therapeutic alliance. But the therapist must remain fully aware that they are departing from delivering active therapy and take care not to reinforce avoidance of the task for therapy which is to achieve change.

Other COW may signal a need for more intensive treatment focus or provide information about how behavior is addressed in the family. The key is for the therapist to respond in a way that is therapeutically matched to the concern or behavior that constituted the COW. For example, the therapist may choose to briefly listen and then explicitly return to the treatment task at hand or use the COW as an opportunity to generalize a skill that has been taught in therapy.

Example: Teenager comes to the session very distressed and tearful because she learned that friend was spreading rumors about her and trying to take her boy friend away. The therapist might respond: "I am sorry to hear that, it must be aggravating. So how would you like to handle this today? We can just talk about it for a few minutes and then get back to our plan for today, or we can use this situation to see if there is any way you would apply what you have been learning. For example, how did you handle the feelings you had about it? How could you use the cognitive triangle to make sense of your reaction and maybe identify some ways to think about it differently? What would you like to do?"

Example: Parent is mad and frustrated because of an incident in which the child got into a fight with peers at the afterschool program and was rude to the teacher and now the program is threatening to expel him. The therapist might respond: "Yes, I can understand why that would be upsetting, you are trying so hard to keep everything going and if he gets kicked out it will be a big hassle finding a new place and might cause you some trouble at work. So how can I help you? Would you be interested in using that behavioral analysis we discussed and coming up with a plan? Otherwise we will get back on track with what we were working on related to the trauma impact."

It is crucial for therapists to maintain the focus of the therapy while skillfully addressing COW. Effective treatments are those that are structured and systematic. An essential ingredient of TF-CBT is that it is trauma-focused and is working step by step toward the goal of children's being able to remember without extreme distress and putting the experience into perspective. These goals are partially achieved through gradual exposure by connecting every component during every session to the trauma to some extent. Deviating from the trauma link or being derailed by COW serves to slow therapy down, may reinforce maladaptive avoidance, and even maintain significant psychopathology. If the COW are so persistent and distracting that they cannot be used to accomplish TF-CBT goals, then a discussion with the parent about alternative treatment approaches or alternative treatment settings is warranted.

Overwhelming family or social problems

Some children are brought to therapy to address behavioral or emotional problems even though there are more pressing problems in the family or environment that cannot be addressed through child psychotherapy. It is unfortunate but relatively common for well meaning providers and systems to recommend numerous services to troubled families in the hope of addressing their myriad problems and needs. For example in the child welfare system, parents are often expected to attend parenting classes, substance abuse treatment plus meetings, anger management interventions, personal therapy as well as take their children to counseling. The family may in addition be on the verge of homelessness, not have adequate child care, and struggle financially. In this circumstance it is not reasonable to expect the parents to devote the attention and effort that effective therapy requires from clients. It is most helpful in such situations to help the family and the referrers prioritize and triage services to the family with an initial focus on basic stabilization of housing and finances. If behavior problems are extreme then clearly these will need to be a focus of attention, perhaps through use of home-based family preservation services. Therapists need to communicate clearly to families and systems what therapy can and cannot achieve.

Summary

TF-CBT is a highly versatile therapy model that targets trauma-specific emotional impacts and provides skills to children and families that are proven to be helpful in addressing behavior problems. When families of traumatized children present with behavior problems or complex situations, the therapist should decide whether the behavior problems can be effectively addressed by TF-CBT with the focus on the behavior problems being triaged up for immediate attention or whether the behavior is so severe or is not trauma-related such that is preferable to provide a different behavioral-focused intervention. Once behavior problems are identified as a treatment target within TF-CBT, it is important to adhere to the basic principles for addressing these problems. Finally even if behavior problems are a primary target of treatment, TF-CBT is not what is being provided unless there is a consistent and regular trauma-focus during every treatment session.

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