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Philadelphia College of Osteopathic Medicine, susanna.carew@verizon.net

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Philadelphia College of Osteopathic Medicine

Department of Psychology

THE TRANSPORTABILITY OF TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY: A CASE STUDY WITH ADOLESCENTS IN A RESIDENTIAL TREATMENT SETTING

By Susanna A. Carew

Submitted in Partial Fulfillment of the Requirements for the

Degree of Doctor of Psychology

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PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by Susanna A. Carew on the 31st day of May, 2007, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

Bruce Zahn, Ed.D, ABPP, Chairperson

Virginia Salzer, Ph.D.

Angela Clack, Psy.D.

Robert A. DiTomasso, Ph.D., ABPP, Chair, Department of Psychology

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Dedication

This dissertation is dedicated to: my husband, D. Scott Carew and our two beautiful children, Jason and Rebecca, for their unconditional love, trust, and pride they have for me in our life together; and to my two dads – the late Dave Carew, whose goodness, loyalty, and humor live on in his family, and the late Dr. Joseph Lu, whose example and spirit lives on in me.

Abstract

Because of the increase in the numbers of adolescents presenting in residential care, the challenge and difficulty posed to therapists in treating this age-group, and the prevalence of chronic stress and complex trauma symptoms found in this population, the research conducted was a clinical case study investigating the transportability and effectiveness of using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), a manualized treatment format, with adolescent clients in a residential treatment setting. A doctoral candidate was trained to engage each of three residential clients in 12 individual sessions of TF-CBT. The Behavior Assessment System for Children (BASC), Children's Depression Inventory (CDI), Jesness Behavior Checklist (JBC), Revised Children's Manifest Anxiety Scale (RCMAS), Trauma Symptom Checklist for Children (TSCC), Working Alliance Inventory (WAI), were administered at pretest, mid-way through treatment, and at posttest to assess treatment outcome. A qualitative assessment of treatment outcome comparing pretest scores and posttest scores on measures were made, and a discussion of the treatment efficacy of TF-CBT with older adolescents in residential treatment was provided. Suggestions for future research of the application of TF-CBT with youth in a residential treatment setting are offered by the researcher. An empirical study proposal was devised to demonstrate the study's application to a larger sample size.

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Chapter 1: Introduction

Statement of the Problem

According to the National Child Abuse and Neglect Data System developed by the Children's Bureau of the U.S. Department of Human Services, 903,000 cases of child maltreatment including neglect, medical neglect, physical abuse, sexual abuse, and psychological maltreatment were substantiated in 2001 (Cook, Blaustein, Spinazzola, van der Kolk, 2003). The Third National Incidence Study of Child Abuse and Neglect (NIS-3; 1996ct), a congressionally mandated study, examined the incidences of abuse and neglect, using a nationally representative sample of 5,600 professionals, spanning 842 agencies in 42 counties (Sedlak & Broadhurst, 1996). Using the Harm Standard, which includes only children who have already experienced harm from abuse or neglect, an estimated 1,553,800 children were abused or neglected in 1993; these include 217,700 children that have been sexually abused, 338,900 physically neglected, 212,800 emotionally neglected, and 381,700 physically abused. Based on the Harm Standard incidence numbers from NIS-3, the annual cost of child abuse and neglect has been estimated at 94 billion dollars (Fromm, 2001), whereas the daily cost of childhood abuse and neglect is estimated to be $258 million (Pelletier, 2001).

Further exploration of the child welfare system data reveals that up to 60% of sexually abused children in foster care exhibit symptoms of posttraumatic stress disorder (PTSD), 42% are physically abused children, and 18% have experienced neglect (without known abuse-other causes), thus indicating a higher incidence of trauma and PTSD symptoms in the child welfare population, when compared to children in the general population (Wilson & Taylor, 2006).

Residential treatment is an increasingly popular placement for children and adolescents presenting with significant emotional and behavioral problems that in-home and community-based services are ineffective in serving (Chamberlain & Friman, 1997). Residential treatment services represent a common but expensive treatment intervention for children and adolescents with serious emotional disorders (LeCroy & Ashford, 1992). Most, if not all of these clients are placed by child protective/social service agencies or are Court-mandated for placement because of problems with emotional and behavioral functioning in the community, and problems resulting from neglect or abuse by past caregivers.

The majority of residents in residential treatment are often characterized as delinquent and aggressive (Hoff, DuPaul, & Handwerk, 2003). As aforementioned, many youth in the child welfare system have encountered multiple forms of trauma, but do not always meet full criteria for Posttraumatic Stress Disorder (PTSD), due possibly to the absence of acute or more "traditional" symptoms of the disorder. Instead, residential youth may exhibit symptoms that more often warrant diagnoses such as depression, anxiety, disruptive behavior disorder, substance abuse disorder, and personality disordered traits. Current diagnostic criteria for PTSD, which is based on symptoms resulting from the experience of short-lived trauma, does not often capture the severe psychological harm that occurs with prolonged, repeated trauma (Wheatlin, 2005). Therefore Dr. Judith Herman of Harvard University suggests that a new diagnosis, Complex PTSD (CPTSD), is needed to encompass the symptoms of long-term trauma (Wheatlin, 2005).

Another challenge faced by outpatient, inpatient, and long-term residential providers is that children and adolescents rarely refer themselves for treatment. Although many children are "forced" to be in treatment, often as the "identified patient", additional obstacles occur when children are required to live in a residential facility away from their families, their friends, and their communities. Therefore it is not uncommon or surprising for such clients potentially to approach treatment with higher levels of apprehension and resistance compared to adult consumers. Currie (2003) asserts that researchers contend that treatment *can* "work" for youth in some instances; however, the success rate for teenagers is often disturbingly low.

In the pursuit of treating this specific age group effectively, various methods and models of treatment continue to be developed and tested. However this is also the age of managed care, in which many current and potential mental health consumers are dependent. Thus the more efficient and cost-effective that treatments are, the more likely they are to be endorsed and to be reimbursed by managed care companies; this will ensure that mental health treatment does not persist to no end between consumer and provider. Out of this need, *manualized treatment*, a step-by-step, session-by-session outlined form of psychotherapy, was spawned.

The development of treatment manuals emerged from a number of multi-study research centers across the country (Scaturo, 2001). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is one such model that was developed to treat children and adolescents impacted by trauma. Multiple randomized controlled clinical trials have been run with children ranging from age 7-14. However to date there is little or no evidence to

support whether or not TF-CBT is effective when implemented with older children, ranging from 14 to 18 years of age in an actual community treatment setting.

Purpose of the Study

Synthesizing the aforementioned problem, the purpose of this study is to implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based manualized treatment model for child and adolescent trauma victims, with adolescents from the ages of 14 to 18 who are mandated or Court-adjudicated youth and who exhibit PTSD (as defined by the DSM-IV-TR) or complex PTSD symptoms in a residential treatment setting. The treatment model will be evaluated for its applicability with adolescents in the 14-18 age range, applicability to subjects in a residential treatment environment, and practicality of application. Furthermore, this study will evaluate the extent to which the TF-CBT model impacts cognitive, emotional, and behavioral functioning in subjects, using pretest and posttest measures.

Rationale and Related Research

Residential treatment. Residential placement is often a common but last resort treatment option for seriously emotionally and behaviorally disturbed children and adolescents that cannot be maintained within the family, in a home setting, or in a school environment due to the severity of the problems they pose. In 1982, an estimated 29,000 children lived in RTCs in the United States (Gilliland-Mallo & Judd, 1986). By 1990, that number increased to an estimated 65,000 youngsters (Chamberlain, Ray, & Moore,

1996). And by 1997, approximately 117,720 children were treated in separate day or residential schools in the United States (Spencer, Shelton, & Frank, 1997).

Child welfare and social service agencies often try, but fail in instituting less restrictive forms of treatment by referring consumers to community mental health centers for outpatient treatment, or by linking consumers and their families to in-home services such as intensive in-home family therapy and 1:1 behavioral assistants (Baker, Wulczyn, & Dale, 2005). Although there are no specific diagnostic criteria to determine eligibility for placement at a residential program, only youth with problems so severe that they cannot function in a lower level of care are placed here (Baker et al., 2005).

A residential treatment center (RTC) is defined as a 24-hour facility, not licensed as a hospital but one that offers mental health treatment programs for children with severe emotional and behavioral problems (Tuma, 1989). RTCs often incorporate individual therapy, group therapy, psychiatric treatment, psychoeducational and therapeutic activities, and sometimes a school component (depending on the sophistication of the treatment program) as a means to provide comprehensive care to this difficult population. Although less costly than psychiatric hospitalization on a per diem basis, RTCs are expensive because of extended stays that can result in annual costs between $50,000 and $75,000 per child (Lyons, Libman-Mintzer, Kisiel, & Shallcross, 1998).

Complex posttraumatic stress disorder. Previously dubbed as "shell shock", post-WW II era, symptoms experienced by war veterans were trivialized until Posttraumatic Stress Disorder (PTSD) was created for inclusion in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III;* American Psychiatric Association,

1980) to capture symptomatology exhibited by hundreds and thousands of veterans of the Vietnam War (van der Kolk, 2001). The diagnosis of PTSD accurately describes the symptoms that result when a person experiences a short-lived, time-limited trauma such as car accidents, natural disasters, and rape (Whealin, 2005). However, over the years it has become clear that many suffer from a variety of psychological problems that are not in the diagnosis of PTSD (van der Kolk, 2001).

Many researchers conducted factor analyses of available child abuse trauma studies (findings summarized in Herman, 1992a, 1992b) and determined that the effects of such trauma, although posttraumatic in nature, were significantly different from PTSD as defined in the DSM-III (American Psychiatric Association, 1980). Individuals exposed to trauma over a span of time and over developmental periods exhibited problems not included in the diagnosis of PTSD; these included depression, anxiety, self-hatred, dissociation, substance abuse, self-destructive and risk-taking behaviors, re-victimization, problems with interpersonal and intimate relationships (including parenting), medical and somatic concerns, and despair; problems that were categorized as comorbid conditions rather than as a conglomeration of symptoms under another single diagnosis (Courtois, 2004). Thus individuals suffering from the latter described symptoms are more accurately accounted for by the diagnosis of Complex PTSD (CPTSD) or “disorders of extreme stress not otherwise specified” (DESNOS; Pelcovitz et al., 1997).

Complex PTSD (CPTSD) is defined as the dual problem of children’s early and chronic exposure to traumatic events such as emotional abuse and neglect, sexual abuse, physical abuse, domestic violence, and the impact of this exposure on immediate and

long-term outcomes such as emotional dysregulation, loss of direction, inability to anticipate danger and negative consequences resulting in repeated trauma exposure, and the presence of externalizing and internalizing behaviors (Cook et al., 2003). Wilson & Taylor (2005) extend the definition further by asserting that adolescents suffering from CPSD may experience the following problems as a result of repeated trauma: antisocial behavior, dating violence, school failure/absenteeism, substance abuse, parentification, runaway behavior, eating/sleeping disturbances, depression/suicidal gestures, and relationship problems/loss of trust.

The diagnostic conceptualization of CPTSD consists of seven different problem areas shown by research to be associated with early interpersonal trauma (Herman, 1992a, 1992b):

1. *alterations in the regulation of affective impulses,* including difficulty with modulation of anger and self-destructiveness. This category has come to include all methods used for emotional regulation and self-soothing, including addictions and self-harming behaviors that are, paradoxically, often life saving;

2. *alterations in attention and consciousness* leading to amnesias and dissociative episodes and depersonalization. This category includes emphasis on dissociative responses different from those found in the *DSM* criteria for PTSD. Its inclusion in the CPTSD conceptualization incorporates the findings regarding dissociation that were mentioned earlier: namely, that dissociation tends to be related to prolonged and severe interpersonal abuse occurring during childhood and, secondarily, that children are more prone to dissociation than are adults;

3. *alterations in self perception,* such as a chronic sense of guilt and responsibility and ongoing feelings of intense shame. Chronically abused individuals often incorporate the lessons of abuse into their sense of self and self-worth (Courtois, 1979a, 1979b; Pearlman, 2001);

4. *alterations in perception of the perpetrator,* including incorporation of his or her belief system. This criterion addresses the complex relationships and belief systems that ensue following repetitive and premeditated abuse at the hands of primary caretakers;

5. *alterations in relationship to others,* such as not being able to trust and not being able to feel intimate with others. Another "lesson of abuse" internalized by victim/survivors is that people are venal and self-serving, out to get what they can by whatever means, including using/abusing others;

6. *somatization and/or medical problems.* These somatic reactions and medical conditions may relate directly to the type of abuse suffered and to any physical damage that was caused or they may be more diffuse. They have been found to involve all major body systems;

7. *alterations in systems of meaning.* Chronically abused individuals often feel hopeless about finding anyone to understand them or their suffering. They despair of ever being able to recover from their psychic anguish.

Challenges in the treatment of youth. Sometimes children, do indeed, exhibit emotional and behavioral problems that are limited to the child, and exhibit symptoms that are independent of post-natal familial or environmental influences. For example a child may have Asperger's Disorder, Pervasive Developmental Disorder, Autism, or

suffer from a medical condition that affects emotional or behavioral functioning such as Diabetes, Hypothyroidism or Hyperthyroidism. However, more times than not, children and adolescents presenting with emotional and behavioral problems are referred for professional counseling services by parents or caregivers. In the treatment of youth in residential treatment, therapists may identify target problems and develop treatment goals based on caregiver or parental report, past psychiatric, psychological, or school evaluations, and the reports of child protective agencies if they are involved.

The agenda for therapy that follows tends to be shaped to a significant degree by the parent's report and focuses on problems the parent has identified (Yeh & Weisz, 2001). Unfortunately, what is commonly found is that there is a disagreement between parent and child(ren) about what the identified problems are. This lack of parent-child agreement could complicate the therapist's problem-identification task and poses a dilemma: the therapist needs to identify target problems to plan treatment, but the clients do not agree on what those problems are (Hawley & Weisz, 2003). Some therapists may choose to focus solely on the problems that are identified by the caregiver. Therapists may invest primarily in their relationship with parents, who frequently have the most leverage and, arguably, the greatest potential to effect change (Diamond, Hogue, Liddle, & Dakof, 1999).

Another reason for frequent therapist-parent collaboration is that juveniles may have developmental limitations such as: the ability to appraise the nature, course, and severity of their problems appropriately; their inclinations to collaborate with therapists to determine appropriate targets of treatment; and their ability to express themselves verbally (Shirk & Saiz, 1992). Hawley & Weisz (2003) found in their study that

therapists showed significantly greater agreement with parents than with children on most target problems because of the possibility that they believe that parents are more reliable reporters than the child. This finding may pose a concern about therapists' potential to over-identify with parents at the expense of a strong alliance with the child, which would likely undermine the goals of treatment and outcome. Therefore it has been suggested that a balance be found among the needs and concerns of caregivers, children, and therapists in order to engage and motivate both parties, and to fulfill the treatment obligations of the therapist.

Because children rarely refer themselves for treatment, often do not recognize or acknowledge the existence of problems, and frequently are at odds with caregivers and adults about the goals of therapy, challenges arise for therapist in treating youth (Shirk & Russell, 1998; Diamond et al., 1999). For the most part, children and adolescents do not voluntarily initiate treatment but are usually involved in treatment because a parent or caregiver deems it a needed service or because they have been referred for treatment from other human service agencies (Bickman, Andrade, Lambert, Doucette, et al., 2004).

Between 50% and 75% of children and adolescents referred for therapy either do not initiate treatment or they terminate prematurely (Kazdin, 1994). Therefore transforming adolescents' initial reluctance and negativity into collaboration is one of the first and one of the most critical therapeutic tasks (Diamond et al., 1999). Church (1994) found that adolescents whose therapists used techniques (i.e., collaboration, emphasizing confidentiality) that were respectful of the individual needs and goals that occur during this stage of the adolescent's life reported the highest degree of treatment satisfaction, of openness about the alliance, and found the adolescent seeking the therapist's advice.

Therefore, from a developmental perspective, it has been suggested that the therapeutic relationship may be more critical in child therapy than in adult therapy (Shirk & Saiz, 1992).

Adolescent development considerations. Although developmental themes have traditionally been a central part of child therapy, only recently have researchers and therapists begun to consider adolescent development as an important aspect of psychotherapy with adolescents (Liddle, 1995; Weisz & Hawley, 2002). This is an evident need in more recent conceptualizations of child and adolescent psychopathology because, when compared to adults, youth can exhibit different symptomatology found in depression, post-traumatic stress disorder, anxiety, and adjustment disorders. Second only to infancy, adolescence entails the most rapid and pervasive developmental changes involving physiological, cognitive, emotional, and social transformations (Weisz & Hawley, 2002).

Psychotherapy interventions for adolescents are often modeled after adult intervention strategies (Shirk & Saiz, 1992). Bolton Oetzel & Scherer (2003) assert that therapists treating adolescents need to begin their work by assessing a variety of developmental considerations and determining how these developmental factors may help or hinder therapeutic engagement. Furthermore, children's normative shift toward increasing autonomy, largely found during the adolescent years, may make the creation and maintenance of this youthful alliance different from an alliance with adults (DiGiuseppe, R., Linscott, J., & Jilton, R. (1996). Thus, Bolton Oetzel & Scherer (2003) proposed the following considerations in relation to psychotherapy with adolescents:

"Physical maturation considerations: Girls who acquire physical sexual characteristics early are vulnerable to developing psychological adjustment problems that can manifest into the internalizing of problems. Both girls and boys with early sexual development have more contact with older and often delinquent peers. This creates more opportunity and exposure to premature sexual encounters, delinquency, and substance use, resulting in more advanced psychological problems. Thus, a longer history of problems may result in adolescents being more casual about problem behavior and less amenable to therapeutic interventions.

Cognitive considerations: Troubled adolescents may be less cognitively and socially mature and less able to understand the rationale behind treatment and the need for it. Lacking motivation and understanding of treatment, adolescents frequently fail to see the purpose of psychotherapy and doubt that it will have any meaningful impact on them.

Attachment and social maturity considerations: Seeking help, admitting to psychological problems or discomfort, and engaging constructively in psychotherapy may conflict with an adolescent's striving for autonomy. This may be particularly difficult for adolescents who have attachment difficulties and little experience engaging constructively with adults. Adolescent clients often find emotionally intense circumstances over-stimulating and may lack effective skills at emotion regulation" (pp. 220-221).

Weisz & Hawley (2002) found that therapist attempts to engage adolescents must be prepared to vary the levels of abstraction and cognitive sophistication with which he or she presents ideas. Being too abstract with cognitively delayed clients risks a lack of appreciation or understanding by clients, yet being too concrete with higher functioning clients can result in boredom or lack of attention. Additionally, children's normative shift toward increasing autonomy may make the creation and maintenance of a therapeutic alliance different with adults (DiGuiseppe et al., 1996). Church (1994) found that adolescents whose therapists used techniques that were respectful of developing individuation (i.e., collaboration, emphasizing confidentiality) reported the highest degree of treatment satisfaction, of openness about the alliance, and found the adolescents seeking therapists' advice. Because the cognitive level may play a role in alliance formation (Diamond et al, 1999), these are important points to consider.

Schrodt, Jr. & Fitzgerald (1987) contend that an adolescent client may endorse the belief that a therapist may be a threatening and malevolent authority figure who wishes to criticize and blame, and possible control them, for if not a direct agent of parents, the therapist is at best an adult authority who could not possibly understand the issues of immediate concern to the adolescent. Bolton Oetzel & Scherer (2002) suggest that addressing the stigma that many adolescents associate with psychotherapy and offering choices whenever possible may facilitate and bolster an adolescent's investment in treatment. Youth may become allies in treatment only to the degree that they believe change is necessary or desirable, understand the role they play in the problem's formation or maintenance, and believe that they can effect positive change (Diamond et al., 1999).

Trauma focused cognitive behavioral therapy. Cognitive-behavioral treatments which incorporate exposure, behavioral practice and cognitive therapy, have been found to be effective in the treatment of adult trauma victims, particularly rape victims and Vietnam War combat veterans (Foa, Rothbaum, Riggs, & Murdoch, 1991). Because of the empirical success of these interventions with adult suffers of PTSD, researchers have successfully adapted cognitive-behavioral interventions for use with sexually abused children (King, Tonge, Mullen, Myerson, Heyne, Rollings, Martin, & Ollendick, 2000).

There has also been a focus on evaluating of the efficacy and effectiveness of manualized treatments and their use with clinical populations in recent years. Weiss, Catron, Harris, & Phung (1999) conducted a randomized clinical trial to evaluate the effectiveness of child psychotherapy as typically delivered ("treatment as usual") in a school setting. One-hundred sixty children presenting with problems such as anxiety, depression, aggression, and attention were randomly assigned to treatment and to control conditions. The treatment group consisted of open-ended, "treatment as usual" with master's and doctoral level therapists who implemented either cognitive or psychodynamic-humanistic approaches without the guide of a manual. Children in the control group received academic tutoring. Results of the study revealed an effect size of -0.08, thus indicating that children's outcome in the treatment group was no better than those in the control group, implying that, for some children, "treatment as usual" and the mere passage of time may be detrimental to their ongoing functioning (Ollendick and King, 2004).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), a manualized treatment model that specifically aims to the treatment of trauma symptoms in youth, was

developed over the years through the collaborative efforts of researchers at the Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents in Pittsburgh, PA and the CARES (Child Abuse Research Education and Service) Institute in Stratford, NJ. TF-CBT was initiated following a series of assessment studies documenting the impaired emotional and behavioral problems exhibited by children who have experienced sexual abuse. More specifically, children and adolescents (ages 4 to 18) who have experienced significant behavioral or emotional problems related to traumatic life events can be treated using TF-CBT, even if they do not meet full diagnostic criteria for PTSD (National Child Traumatic Stress Network, 2005).

Various treatment elements have been incorporated over the last eight years to expand its application to children and adolescents who are exposed to other forms of trauma (physical, emotional, and neglect), and not just exclusively to sexual abuse trauma. Changes were also made to avoid some of the long-term negative consequences of traumatic stress, such as increased risk of substance abuse, suicide attempts, relationship problems, smaller brains, and lower I.Q.s (SAMHSA Model Program, 2005). Multiple controlled clinical trials using TF-CBT have demonstrated the fact that the treatment model is highly efficacious, effective, and superior to other treatment paradigms in reducing clinical symptomatology in children and adolescents generally ranging from ages 7 to 14. Other than TF-CBT, randomized controlled trials of different treatment models have been scarce (Cohen, Deblinger, Mannarino & Steer, 2004) as has research to study the effectiveness of TF-CBT with an older adolescent population.

TF-CBT was publicly introduced and was supported by an initial outcome study with sexually abused children completed by Deblinger, Lippmann, & Steer (1996). One

hundred child victims of sexual abuse between the ages of 7 and 13, and their parents, were recruited through referrals from cases substantiated for abuse through the Division of Youth and Family Services (DYFS) of New Jersey. Ninety of the one hundred children completed the pre treatment and post treatment assessments; eighty-three percent of the subjects were females and 17% were males, 72% were Caucasian, 20% were African-American, 6% were Hispanic, and 2% of other ethnic origins. Sixty-six percent of the children had experienced the last sexually abusive incident six months prior to the study's initial evaluation, 16 % experienced sexual abuse 6 months to 2 years before initial evaluation, and 18% had experienced the last abusive incident 2 or more years before the evaluation.

Subjects were randomly assigned to one of four treatment groups: community control condition 1 (standard community care), experimental condition 2 (child intervention only), experimental condition 3 (non-offending parent intervention), and experimental condition 4 (combined child and parent interventions). The control group, standard community care, consisted of subjects that were referred victims by DYFS or the prosecutor's office to community mental health agencies that commonly provided treatment to sexual abuse victims.

The three experimental conditions followed the TF-CBT (Deblinger & Heflin, 1996) manualized format during which participants received 12 sessions lasting 45 minutes each. Subjects assigned to the child-only condition received cognitive and behavioral intervention, including gradual exposure, modeling, education, coping, and body safety skills training. The non-offending parent-only condition participants engaged in 45 minute individual sessions, without the child present, during which parents

were trained to serve as their child's therapeutic agent. The third experimental group, parent-child combined intervention lasted 80 to 90 minutes during which children and parent were first seen separately and then later brought together for joint therapy.

Results of the study revealed, that compared to parents whose children received standard community care and the child-only intervention group, mothers assigned to treatment (i.e., parent-only and parent-child conditions) reported significantly greater decreases in children's externalizing behaviors and greater improvement in their own parenting skills and their children reported significantly greater decreases in their self-reported levels of depression (Deblinger et al., 1996). Conversely, results revealed children exhibited significantly greater reductions in overall PTSD symptomatology if they were assigned to the experimental treatment groups (i.e., child-only and parent-child conditions) compared to the children who were not (i.e., parent-only and standard community care) (Deblinger et al., 1996). Overall findings suggested that children having received individual intervention and intervention including their parents, showed the greatest improvement compared to children whose parents received the intervention-only and the children that were referred to community care. The authors noted that the small portion of the sample having received highly diverse community-based interventions "precluded any clear inferences regarding the effectiveness of nonspecific community treatment" (Deblinger et al., 1996). Therefore it is plausible that certain community treatment services could be effective in providing sufficient treatment to sexually abused children.

Deblinger, Steer, & Lippman (1999) conducted a two-year follow-up to the 1996 outcome study to examine the long-term effects of TF-CBT with the initial sample of 100

sexually abused children mentioned in the aforementioned study. The following measures were used to assess long-term outcome: a structured parent interview that had been used in the prior investigation was used to assemble demographic and abuse-related data (Deblinger, et al., 1993; Deblinger et al., 1990); PTSD sub-sections of the K-SADS-E (Orvaschel et al., 1982) from which mother and child composite scores were obtained to assess child PTSD symptoms related to sexual abuse; the Child Depression Inventory (CDI; Kovacs, 2001), a 27-item self-report questionnaire was administered to measure depressive symptoms in children ages 4-17; the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983), a 138-item parent report questionnaire to measure social competence and behavior problems in children ages 4 to 16; and a slightly revised version of the Parenting Practices Questionnaire (PPQ; Stauffer & Deblinger, 1996), a parent self-report measure was administered to assess the quality of parental interactions with their children.

Subjects' scores at 3 months, 6 months, 1 year, and 2 years post-treatment demonstrated improvements in externalizing behavior, depression, and PTSD. Such outcomes were maintained over the 2-year follow-up period, thus suggesting that gains from treatment were meaningful, given the pervasive and recurrent nature of PTSD symptoms (Deblinger et al., 1999). Some major limitations of the study included the facts that some initial subjects were lost and about 10% of the original sample had dropped out of the investigation by the post-treatment assessment, and that some subjects and their parents did not complete all of the post-treatment assessment measures, resulting in missing data (Deblinger et al., 1999).

King, N.J., Tonge, B.J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., et al. (2000) conducted the first randomized clinical trial, using a wait-list control group to evaluate the efficacy of the 1996 TF-CBT model. Thirty-six sexually abused youth ranging in age from 5 to 17, and with a mean age of 11.4 years (range 5.2-17.4) were recruited for the study; the majority of subjects were females (69% female, 31% male). In the majority of cases, the offenders were male adults who were known to the child such as the biological father, stepfather, family friend, neighbor, or teacher (King et al., 2000). Almost all of the children experienced multiple incidents of sexual abuse involving either penetration or other forms of sexual abuse.

All subjects had either to meet the diagnostic criteria for PTSD or had to fall short of the full diagnosis and exhibit significant stress reactions as determined by separate semi-structured parent and child interview, using the Child version of the Anxiety Disorders Interview Schedule for the DSM-IV (ADIS) (Silverman and Albano, 1996). Additionally, the interviews allowed for the assessment of other childhood psychopathology, which revealed the following: Sixty-nine percent (n = 25) of the subjects were given a primary diagnosis of PTSD and the remaining 11 subjects exhibited several PTSD symptoms. Four of the subjects were given the exclusive diagnosis of PTSD on Axis one and 9 had one comorbid diagnosis, 10 had two comorbid diagnoses, and 2 had three comorbid diagnoses. Comorbid diagnoses that were evident included: dysthymia (n = 7), oppositional defiant disorder (n = 7), separation anxiety disorder (n = 6), generalized anxiety disorder (n = 5), conduct disorder (n = 3), major depression (n = 2), attention-deficit hyperactivity disorder (n = 2), and specific phobia (n = 2). To assess for interrater reliability for subject diagnosis of PTSD, approximately one-third of the

interviews were reviewed by a second diagnostician who was blind to the original diagnosis. One-hundred percent interdiagnostic agreement was found (King et al., 2000).

Subjects were assigned to one of the following three groups: child-alone cognitive-behavioral treatment group, a family cognitive-behavioral treatment group which included both child and parent(s), and a wait-list control group. Subjects in the child-alone treatment group and family treatment group respectively received 20, 50-minute weekly sessions. Post-treatment and follow-up assessment results revealed treatment was beneficial for the abused children who were initially assessed as having a PTSD diagnosis or significant PTSD symptoms.

The treatment intervention resulted in a significant reduction in PTSD symptoms such as hyperarousal, re-experiencing abuse, and avoidance. Parent ratings measured by the Achenbach Child Behavior Checklist indicated improvement on the PTSD subscales of the measure. There were no findings to support the theory that caregiver treatment involvement improved treatment outcomes with the children in the study. The authors provided the rationale that caregiver involvement focused mainly on problems of the child. Additionally, the final sample of thirty-six participants was a major limitation that compromised statistical power to detect between group differences (King, 2000).

Finally, Cohen, Deblinger, Mannarino, & Steer (2004) completed a larger-scale multi-site study to investigate the differential efficacy of TF-CBT and Child-Centered Therapy (CCT) with children exhibiting PTSD symptoms and related emotional and behavioral problems resulting from sexual abuse. Two-hundred, twenty-nine children (ages 8 to 14) who had experienced sexual abuse confirmed by child protective services, law enforcements, or a professional independent forensic evaluator were included in the

study following parental consent. Of the 229 subjects, 5 (2%) never returned for treatment, 8 (3%) left after attending the first session, and 13 (6%) left after attending the 2nd session. Thus, the 26 (11%) subjects and their parents were considered dropouts and 203 (88%) of the subjects remained for at least three sessions.

One-hundred sixty (79%) of these subjects were female. The ethnic breakdown was as follows: 122 (60%) White, 56 (28%) African-American, 9 (4%) Hispanic-American, 14 (7%) Biracial, and 2 (1%) Other. Of the final sample, 19 (9%) had been taking psychotropic medications, and 39 (20%) had received prior counseling for the current sexual abuse episode. One-hundred eighty (89%) met the full criteria for current PTSD, but had also been described by their caregivers as having exhibited other psychological and behavioral problems as well.

The K-SADS-PL-PTSD was used to identify subjects' exposures to other forms of trauma such as having experienced the sudden illness or death of a family member, having witnessed domestic violence, having been a victim of physical abuse, having witnessed community violence, having experienced a natural disaster, medical trauma, or traumatic custody situations (i.e., kidnapping by non-custodial parent). Independent evaluators were trained in administering and scoring of semi-structured assessment instruments. Interrater reliability was found to be acceptable. The following instruments were administered to assess subjects: K-SADS-PL (Kaufman, Birmaher, & Brent, 1996); a semi-structured interview for parent and child to assess the presence of DSM-IV disorders; Children's Depression Inventory (CDI; Kovacs, 1985); State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973); and the Children's Attributions and Perceptions Scale (CAPS) (Mannarino, Cohen, & Berman, 1994).

Cohen et al. (2004) found that the children who received TF-CBT exhibited significantly improved symptoms when compared to the children that received CCT on measures of PTSD, depression, and total behavior problems. Furthermore, there was a statistically significant difference between treatment groups because twice as many children who received CCT continued to meet full PTSD *DSM-IV* criteria at post-treatment when compared to the children that received TF-CBT.

A major limitation of the study was that it did not include a no-treatment control group which was excluded because of ethical concerns and previous findings that children in wait-list control groups exhibited little to no symptom improvement. Another limitation was the fact that very few Hispanic and no Asian families were included in the study; this was reflective of the ethnic population of the geographic areas involved in the study (Cohen et al., 2004), thus suggesting that the generalizability of findings be evaluated to treat families and children of other ethnic groups.

To date, Cohen, Mannarino, and Deblinger (2006) report that only one controlled treatment trial for the treatment of adolescents with complex PTSD has been completed (Najavits, 1998); however, another has been initiated (Cloitre, Davis, & Mirvis, 2002), but findings are not yet available. The TF-CBT developers add, “although our treatment studies have included a few such youth, we have not systematically evaluated the efficacy of TF-CBT for this population of chronically traumatized adolescents” (Cohen et al., 2006) although chronically traumatized children have shown great improvement in PTSD symptoms in past randomized clinical trials.

Conclusion and Hypotheses

It is evident that the number of youth placed in residential treatment settings continues to increase during each decade and that, based on studies of child welfare systems, a significant portion of youth placed in these settings are found to have prolonged exposure to trauma and often present with symptoms of CPTSD. Furthermore, residential treatment providers encounter the additional challenge of treating adolescent consumers that are mandated or Court-adjudicated into long-term care.

Resistance and reluctance in receiving mental health treatment may be evident and can be considered commonplace when working with adolescents, particularly because they are not often self-referred. Instead, they are likely referred by parents/caregivers, schools, social service and child protective/welfare agencies, and the judicial system. Past research suggests that the obstacles that therapists face include existing resistance-specific developmental characteristics found in the adolescent stage; and adolescents' perception of mental health treatment, the stigma that may be associated with treatment, and the degree to which treatment can benefit them.

Although it cannot be assumed that adolescent clients are automatically treatment-resistant because they are "teenagers", it ought to be considered that such clients pose a greater challenge to treatment because they often are labeled the "identified patient". Adolescents' problems may conceivably stem from a larger systemic problem (i.e., parent/caregiver problems, social/environmental problems); especially when these clients, in lack of fairness, are the individuals that are removed from their homes and placed elsewhere for treatment purposes.

The contemporary zeitgeist in applied clinical psychology appears to focus on evidenced-based and efficacious treatments, including the way in which these treatments might render services that are efficient, cost-effective, and generate positive treatment outcome in clients. Various treatment models for child and adolescent trauma and the research supporting each model have been reviewed by organizations such the National Center for PTSD, National Child Trauma and Stress Network, and SAMHSA; these groups have high regard for TF-CBT as a stellar model in the treatment of child and adolescent trauma. However, the transportability of such treatment to actual practice settings and their efficacy in such settings must be established (Ollendick and King, 2004).

Therefore this study will examine the transportability of a controlled, clinical, trial-based, manualized treatment model, TF-CBT, to an actual treatment setting, and the effectiveness of TF-CBT in treating an adolescent residential population prevalent with youth exhibiting Complex PTSD symptoms. The current research study is guided by the hypotheses that subjects' scores on measures before receiving and after receiving 12 sessions of TF-CBT will reveal the following: (1) an inverse relationship will be found between scores on the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1998) and the progression of TF-CBT, thus demonstrating improved subject functioning in self-perception, emotional functioning, and behavior; (2) an inverse relationship will be found between scores on the Children's Depression Inventory (CDI; Kovacs, 2001) and the progression of TF-CBT, thus demonstrating subjects' decreases in symptoms of depression; (3) an inverse relationship will be found between scores on the Jesness Behavior Checklist (JBC; Jesness, 2003) and the progression of TF-CBT, thus

demonstrating subject improvement in social and interpersonal self-perception and behavior; (4) an inverse relationship will found between scores on the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978) and the progression of TF-CBT, thus demonstrating subjects' decreases in symptoms of anxiety; (5) an inverse relationship will be found between scores on the Trauma Symptom Checklist for Children (TSCC; Briere, 1996), thus demonstrating subjects' decreases in trauma symptoms; and (6) an increase in subjects' perceptions of therapeutic working alliance will be found in changes in sub-test ratings on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). It is anticipated that changes in subject pre test and post test assessment will support the efficacy of using TF-CBT with a residential youth population.

Chapter 2: Method

Participants

Inclusion criteria. Subjects were chosen from youth that were referred by a child protective agency or from youth who have been Court-ordered to attend and successfully complete a residential treatment program in southern New Jersey. The sample size consisted of 3 juvenile clients who had at minimum the following DSM-IV-TR Multiaxial Assessment (DSM-IV-TR; American Psychiatric Association, 2000) profile as diagnosed by the residential facility's clinical psychologist: Axis I: Posttraumatic Stress Disorder (PTSD); Axis II: No diagnosis or Deferred; Axis III: No significant medical problems; Axis IV: To be identified and recorded; Axis V: Global Assessment of Functioning was current and no lower than a score of 40. Subjects that did not meet the full diagnostic criteria for PTSD on Axis I, but demonstrated, on the Trauma Symptom Checklist for Children (TSCC), multiple symptoms indicative of Complex Posttraumatic Stress Disorder (CPTSD) due to long-term exposure to trauma, could also be included in the study.

Treatment was free of charge. Participation was voluntary and anonymity was maintained by coding the subjects numbers 1, 2, and 3, based on subjects' birthdays (from oldest to youngest). The participants were between the ages of 14 and 18. As assessed by the residential facility's on-site special education teacher, participants had to have at least a 5th grade reading level in order to understand and complete the measures to be administered in this study. Subjects were required to express a commitment by signing a statement of assent; their legal guardian(s) or custodial parent(s) also signed a statement of informed consent to participate in the study. The statement of assent

Comment [BSZ1]: Change to 3

Comment [BSZ2]: Describe exactly how you will do this. Usually you will do a matched coding system, keeping the identifying code separate from the actual assessments.

Comment [BSZ3]: Sign a statement of assent, in addition to having the legal guardian sign a statement of informed consent.

specified the expectations for participation in the study, including willingness to meet with and engage in therapy, willingness to focus on therapy in order to reduce behavioral problems that led to residential placement, and completing the self-report measures during specific sessions.

Exclusion criteria. Juveniles who were younger than 14 years of age or older than 18 years old were excluded, as well as anyone who exhibited serious psychiatric problems such as significant Mood, Psychotic, or Disruptive Behavior Disordered symptoms warranting the need for a client to be placed on one to one supervision by a direct care staff person. Those who were diagnosed with mild to moderate mental retardation, actively psychotic symptoms, pervasive developmental disorders, tic disorders, amnestic disorders, and a recent history of severe suicidal or homicidal behavior were not included in the study. Last, clients who did not have at least a 5th grade reading level, or the ability to read and comprehend the self-report measures could not participate.

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Research Design

Three clients in an adolescent residential treatment program were selected to participate in the study in which each subject received 12 sessions of individual therapy using TF-CBT. All subjects were assessed at baseline (pretest) on measures of cognitive, emotional, and behavioral functioning, and working alliance. Subjects were re-administered the same measures again at mid-point (following session 6), and after session 12 (posttest). Data for all three subjects were scored and analyzed at pretest, mid-

Comment [BSZ5]: three

point, and at posttest for comparison of changes in scores on subjects' measures in cognitive, emotional, and behavioral functioning.

The responsible investigator maintained subjective "reflection" notes to document the investigator's overall use of TF-CBT with subjects. Reflection notes were chronicled and were processed, providing qualitative observations and commentary on the practicalities, applicability, and challenges experienced by the investigator during the study. Commentary on aspects of TF-CBT warranting improvement or further development was provided by the investigator.

Setting

Three subjects participated in individual therapy sessions with a doctoral candidate at the YES Shelter and Residential Treatment Facility, a program of Center for Family Services, Inc. in Blackwood, New Jersey. The length of treatment for clients in this particular residential setting averaged from nine to twelve months and served up to 36 youth (ages 11-18) from Camden County, New Jersey. Clients were placed either by the Division of Youth and Family Services or by the County Court system. Clients at the YES Facility embodied a diverse socioeconomic status (though many represent low-SES), diverse cultural backgrounds, coming both from suburban and from inner-city neighborhoods.

All clients lived in a one-story building, in one to three person dormitory-style rooms, and shared bathroom facilities. Male and female clients resided on separate wings which were separated by a large multi-purpose room. On-site facilities included a nurse's station, psychologists', psychiatrists', and therapists' offices, program directors' offices,

cafeteria, weight/workout room, and outdoor basketball court and athletic field areas. Therapy sessions at the treatment facility were held in a private office space, free from extraneous stimuli or distraction, providing ample space for 2 to 5 individuals.

Independent Variables

Treatment manual. Trauma Focused Cognitive Behavioral Therapy (TF-CBT), an empirically-supported treatment model, was the applied intervention for this study. Multiple randomized and controlled clinical trials have been conducted over the last decade to demonstrate its efficacy. The current version of TF-CBT, developed by authors Cohen, Mannarino, and Deblinger (2006) is a clinic-based, short-term treatment for children and adolescents who have experienced past, recurrent, or recent trauma and who exhibit psychiatric symptomatology that impairs functioning. Trauma experiences include, but are not limited to sexual, physical, and emotional abuse, neglect, witnessing domestic violence, experiencing the death, loss, or sudden illness of a significant other, being the victim or having experienced loss resulting from natural disaster (i.e., flood, fire, hurricane, earthquake, etc).

Given the limitations of managed care in American society, and the need to fulfill treatment through time-limited, short-term care, TF-CBT incorporates cognitive-behavioral techniques and agenda-setting to help child and adolescent clients understand trauma, discuss and process their trauma experiences, increase self-awareness of symptoms and behaviors, and teaches clients coping strategies to deal with their trauma and the resulting symptoms.

The TF-CBT manual is devised to offer individual treatment for the child or adolescent or can be combined with child and parent joint-therapy. However, to standardize the application of TF-CBT, only individual therapy aspects of TF-CBT was not utilized and investigated, given the prevalence of youth in State custody in the residential program. Therefore, the TF-CBT family therapy component was not integrated.

Therapist. A doctoral candidate served as the responsible investigator and therapist in this case study in order to evaluate the subjective usefulness of TF-CBT and its effectiveness of its implementation in an actual treatment setting.

Threats to construct validity were plausible because subjects selected for this study had contact with the experimenter in addition to having individual contact with an originating primary therapist who provided case management services, but no individual therapy, to each subject during the 12-session treatment series with TF-CBT. Therefore results may have been confounded by the added attention and contact that each subject received both from the experimenter and from their primary therapists compared to clients that were not included in this study. To control for this potential confound, the responsible investigator met with all subjects' primary therapists prior to the onset of the study to instruct them to provide only case management to their respective client(s) and not to engage in therapy until treatment with TF-CBT concluded and a joint transfer session with the primary therapist was completed.

Training of the therapist. The therapist was under the supervision of the principal investigator, a doctoral-level licensed psychologist on faculty at the Philadelphia College of Osteopathic Medicine as well as a New Jersey licensed doctoral-level clinical psychologist consultant; and two on-site program directors. The following training sequence was adhered to by the therapist.

Weeks prior to onset of the study: review of the treatment manual.

Trauma-focused topics and skills learned prior to the study included

- Psychoeducation about the TF-CBT model of treatment, psychoeducation for children experiencing traumatic grief, troubleshooting in this area
- Relaxation: focused breathing/mindfulness/meditation, progressive muscle relaxation, relaxation for children with traumatic grief, and troubleshooting in this area
- Affective expression and modulation: feeling identification with children, through interruption and positive imagery, positive self-talk, enhancing the child's sense of safety, enhancing problem-solving and social skills, social skills building, managing difficult affective states, affective modulation for children with traumatic grief, troubleshooting in this area
- Cognitive coping and processing I / the cognitive triad: learning types of inaccurate and unhelpful thoughts, troubleshooting in this area
- Trauma narrative: trauma narrative for children with traumatic grief, troubleshooting in this area

- Cognitive coping and processing II / processing the traumatic experience: exploring and correcting inaccurate or unhelpful cognitions, cognitive processing of traumatic death
- In vivo mastery of trauma reminders (to be implemented if the child has generalized fears resulting from trauma)
- Enhancing future safety and development

Additionally, the experimenter accessed the internet-based training for TF-CBT at http://tfcbt.musc.edu/, an on-line website sponsored by the University of South Carolina, consolidators for on-line training on behalf of the researchers and developers of TF-CBT. The experimenter completed the on-line training modules for TF-CBT and obtained a training completion certificate prior to the onset of the study.

Measures

Trauma assessment. Trauma Symptom Checklist for Children (TSCC) is a 54-item self-report questionnaire that evaluates posttraumatic stress related symptoms in children and adolescents (ages 8 to 16, with normative adjustments for 17 year-olds) who have experienced traumatic events, including physical and sexual assault, neglect, victimization by peers, major losses, and have witnessed violence done to others and natural disasters (TSCC; Briere, 1996).

The TSCC has two validity scales (Under-response and Hyperresponse); six clinical scales including Anxiety (general anxiety, hyperarousal, worry, specific fears, episodes of free-floating anxiety, and sense of impending danger), Depression (feelings

of sadness, unhappiness, and loneliness, episodes of tearfulness, depressive cognitions such as guilt, self-denigration, and self-injuriousness and suicidality), Anger (angry thoughts, feelings and behaviors, including feeling mad, feeling mean and hating others, having difficulty de-escalating anger, wanting to yell at or hurt people, arguing or fighting), Posttraumatic Stress (posttraumatic symptoms including intrusive thoughts, sensations, and memories of painful past events, nightmares, fears, and cognitive avoidance of painful feelings), Dissociation (dissociative symptomatology, including de-realization, one's mind going blank, emotional numbing, pretending to be someone else or somewhere else, day-dreaming, memory problems and dissociative avoidance), two subscales of Dissociation (Overt dissociation and Fantasy), Sexual Concerns (sexual thoughts or feelings that are atypical when they occur earlier than expected or with greater than normal frequency, sexual conflicts, negative responses to sexual stimuli, and fear of being sexually exploited), and two Sexual subscales (Sexual preoccupation and Sexual distress).

Reliability analysis of the TSCC scales in normative samples yielded high internal consistency for five of the six scales, ranging from .82 to .89. Four clinical subscales demonstrated variance in reliability in Over Dissociation and Sexual Distress, having relatively high internal consistency, but the shorter Fantasy Dissociation and Sexual Distress subscales exhibited less reliability.

Adolescent depression. The Children's Depression Inventory (CDI; Kovacs, 2001) is a 27-item self-report measure that assesses symptoms of major depressive disorder or dysthymic disorder in children between the ages of seven and 17 years. Each

item contains three statements from which the subject chooses one as the best statement that best describes the subject's experience within the previous two weeks.

The CDI was normed, using two sample groups based on age (ages 6-11 and 12-17) and gender. The normative sample included 1,266 public school students (592 boys, 674 girls) 23% of whom were either African American, American Indian, or Hispanic; 20% of the subjects were from single-parent households. Reliability analysis yielded internal consistency coefficients ranging from .71 to .89 and test-retest coefficients ranged from .74 to .83 after two to three weeks.

Adolescent Anxiety. The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978) is a 37-item self-report measure that assesses anxiety in children and adolescents (6-19). The RCMAS consists of 28 Anxiety items and 9 Lie (social desirability) items. The RCMAS has been researched extensively to ensure psychometric soundness. Reynolds, Bradley and Steele (1980) administered the RCMAS to 97 kindergarten children and demonstrated reliability with coefficient alpha (α = .79 with males, α =.85 with females, and α =.82 for the total sample). Wisniewski, Mulick, Genshaft and Coury (1987) evaluated the test-retest reliabilities of the RCMAS with 161 children in Grades 6 to 8. Analyses of retesting after weeks one and five yielded Pearson correlations from .60 to .88 ($p \leq .01$) and an insignificant difference between test and retest mean raw scores, thus supporting the stability of the RCMAS over brief periods. With retesting after a substantially longer period, nine months, Reynolds (1981) found a .68 correlation between RCMAS Anxiety Scale scores and a .58 correlation with the Lie Scale scores, for 534 children in Grades 4 to 6, thus indicative of relatively high temporal stability.

Behavioral Functioning. The Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1998) is multidimensional approach to evaluating behavior and self-perceptions of children and adolescents, and measures positive (adaptive) and negative (clinical) aspects of behavior and personality. There are three main components: Teacher Rating Scales (TRS), Parent Rating Scales (PRS), and Self-Report of Personality (SRP); all of which are self-report questionnaires. Additional components include the Structured Developmental History (SDH) and Student Observation System (SOS). Reliability of the BASC (TRS – adolescent level) reveals high internal consistency median value of .85, test-retest reliability median value of .82, and interrater reliability median values are .83 for four pairs of teachers, and .63 and .71 for mixed groups of teachers. Validity for the BASC (TRS) was established through covariance structure analysis as well as through correlations with other measures (Achenbach *Teacher's Report Form*, the *Revised Behavior Problem Checklist, Conners' Teacher Rating Scales, Burks' Behavior Rating Scales*, and the *Behavior Rating Profile.* Many of the TRS scales and composites (externalizing problems, internalizing problems, school problems, and adaptive skills), particularly those measuring externalizing and school problem behaviors, correlate very highly with corresponding scores on the TRF, RBPC, and BBRS, thus supporting the construct validity of those TRS dimensions (Reynolds & Kamphaus, 1998).

Reliability of the BASC (PRS – adolescent level) reveals high internal consistency with a median value of .81 for the PRS scales and .94 for PRS composites with a normed clinical sample. Test-retest reliability yielded a median value of .70. Interrater reliability yielded a median value of .67 although it was noted that parents are

less consistent in their evaluations of younger (?) children's internalizing problems and adaptive skills but parents of adolescents, specifically, are almost as consistent in rating these dimensions as in rating externalizing problems. Validity was measured by using a covariance structure analysis and correlation with four other measures: the *Child Behavior Checklist* (CBCL), the *Personality Inventory for Children-Revised* (PIC-R), the *Connors' Parent Rating Scales* (CPRS), and the *Behavior Rating Profile* (BRP). High correlations were obtained with the CBCL and with externalizing scales of the CPRS, but correlations with PIC-R and BRP scores were moderate (Reynolds & Kamphaus, 1998). Overall, externalizing behaviors were measured more consistently across instruments than are internalizing or adaptive behaviors.

Reliability of the BASC (SRP – adolescent level) reveals high internal consistency averaging at about .83. There were no notable differences in reliability between males and females. Test-retest reliability correlations are almost as high as the internal consistency reliabilities with a median value for the scales of .76 at each level and retest correlation for composites is .84. Validity of the SRP was established by correlating it was four other measures: the *Minnesota Multiphasic Personality Inventory* (MMPI), the Achenbach *Youth Self-Report,* the *Behavior Rating Profile* (BRP), and the *Children's Personality Questionnaire* (CPQ). The first three measures demonstrated a number of high correlations with the SRP scales, thus supporting the construct validity of the SRP. In contrast, the CPQ, which focuses on normal-range personality, correlated at a lower level with the SRP, but related most strongly to the SRP's Personal Adjustment composite, the sections of the SRP most similar in content to the CPQ (Reynolds & Kamphaus, 1998).

The Jesness Behavior Checklist (JBC; Jesness, 2003) is an 80-item scale measuring anti-social behavior and 14 Bipolar behavioral tendencies in adolescents, ages 13-20. It contains the following subscales, measuring, Unobtrusiveness vs. Obtrusiveness, Friendliness vs. Hostility, Responsibility vs. Irresponsibility, Considerateness vs. Inconsiderateness, Independence vs. Dependence, Rapport vs. Alienation, Enthusiasm vs. Depression, Sociability Poor Peer Relations, Conformity Non-Conformity, Calmness vs. Anxiousness, Effective Communication Inarticulateness, Insight vs. Unawareness and Indecisiveness, Social Control vs. Attention-Seeking, and Anger Control vs. Hypersensitivity. The JBC is normed on a delinquent adolescent sample, and includes both self-report and observer measures.

Test-retest reliability for the JBC Observer Form reveals stability coefficients ranging from a low of .09 (Insight vs. Unawareness and Indecisiveness) to a high of .51 (Conformity vs. Non-Conformity), with a median of .42. Administration of the JBC Self-Appraisal Form on the same group of subjects revealed stability coefficients from a high of .58 (Considerateness vs. Inconsiderateness) to a low of .05 (Insight vs. Unawareness and Indecisiveness), with a median of .38. Uncorrected correlations of inter-rater reliability ranged from a high of .57 (Responsibility vs. Irresponsibility) to a low of .36 (Conformity vs. Non-Conformity). Corrected correlations of a composite of three raters fell between .63 (Conformity vs. Non-Conformity) and .80 (Responsibility vs. Irresponsibility. Validity of JBC scores ranged from a high score of .57 (Responsibility vs. Irresponsibility) to a low score of .36 (Conformity vs. Non-Conformity).

Working alliance. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is a 36-item self-report measure used to assess the alliance construct

proposed by Bordin (1979). The goal of the WAI is to measure alliance factors in all types of therapy, to document the relation between the alliance measure and the theoretical constructs underlying the measure, and to connect the alliance measure to a general theory of therapeutic change (Horvath, 1994). Using techniques that focused on content validity, they developed the WAI so that it would measure Bordin's three aspects of the alliance: the bond, the agreement on goals, and the agreement on tasks (Martin Garske, & Davis, 2000). The inventory is composed of 5-point Likert-type items (1 = "*never*," 5 = "*always*"), from which three subscales are derived: (a) agreement on tasks, (b) bond between client and therapist, and (c) agreement on goals. Examples of these items include: "_____and I agree about the things I will need to do in therapy to help improve my situations: (task); "I feel uncomfortable with _____" (bond); and "We agree on what is important for me to work on" (goal). Research has yielded strong support for the reliability of the WAI scales and some for support its validity (see Horvath, 1994, for a review). Horvath and Greenberg (1989) found that the WAI's reliability ranged from $r = .85$ to $r = .93$ and that the scale correlated with a variety of outcome indices.

Procedure

Based on the recommendations of the clinical treatment team at the site of the study (Y.E.S. Facility), potential subjects were identified, based on the inclusion and exclusion criteria three weeks prior to the onset of the study. Subsequently, the responsible investigator presented and reviewed the parent/guardian informed consent form, juvenile informed assent form, and consent form to audiotape sessions with all potential subjects and their guardians to obtain consent and assent to participate in the

study. The responsible investigator retained the original consent and assent forms and provided copies to each subject and his or her guardian or custodial parent. The clinical team selected three subjects to participate in the study from the pool of potential subject/parent dyads who provided consent and assent.

Data collection & treatment series. A Senior Resident Counselor, who provided direct care to clients and supervised all direct care staff, completed the BASC Parent Rating Scales (PRS) and the JBC (Observer Form). The Senior Resident Counselor served as parent/observer rater because they observed subjects' cognitive, emotional, and behavioral functioning while living in a residential treatment setting. The Senior Counselor completed the BASC and JBC at baseline (pretest), after session 6 (mid-point), and after session 12 (posttest). Subjects were administered the BASC Self-Report of Personality (SRP), CDI, JBC (Self-Appraisal Form), RCMAS, TSCC and the Working Alliance Inventory (WAI) at baseline, after session six (mid-point), and after session twelve (posttest). All data was maintained in individual subject files.

Treatment sessions lasted approximately 45-50 minutes each, and took place two times per week for six weeks. The following session plan, based on the TF-CBT manual chapter sequence, was followed with subjects to address all pertinent areas of TF-CBT:

- Session 1: "Educate" - Provide psychoeducation about the TF-CBT model of treatment with subject
- Session 2: "Relax" - Relaxation training with subject (focused breathing, mindfulness, meditation, progressive muscle relaxation)

- Sessions 3 & 4: “Feelings & Controlling Them” - Affective Expression and Modulation (identifying subject feelings, thought interruptions and positive imagery, positive self talk, learning and enhancing problem-solving, social skills-building, managing difficult affective states)
- Sessions 4 & 5: “Thoughts, Feelings, & Behaviors and Learning Distortions” - Cognitive Coping and Processing I / The Cognitive Triangle (learning types of inaccurate and unhelpful thoughts)
- Sessions 6, 7, & 8: “Let’s Talk about What Happened to You” - Trauma Narrative (describing the details of what happened before, during, and after the traumatic event(s) through writing and discussion, integrating thoughts and feelings about the event(s) into a consistent and meaningful experience, focus on subject’s place in the trauma and in the present)
- Sessions 9 & 10: “How Did the Trauma Cause You to Think about Things?” – Cognitive Coping and Processing II / Processing the Traumatic Experience (exploring and correcting inaccurate or unhelpful cognitions)
- Session 11: “Don’t Be Afraid” – *In Vivo* Mastery of Trauma Reminders (if required: desensitizing subject to innocuous cues that have elicited feared responses)
- Session 12: “Get Smart” – Enhancing Future Safety and Development (role playing potentially dangerous situations, learning personal safety)

With the consent of the legal guardian(s) or custodial parent(s) and the assent of the participant, sessions 1, 4, 8, and 12 was audio taped to allow the therapist’s

supervisor to review the therapist's adherence to the TF-CBT and provide the therapist with feedback to ensure treatment integrity.

Safety plan. Given the trauma history experienced by subjects and the trauma-focused nature of the treatment model, it was plausible that interruptions in treatment could occur. If at any time a subject exhibited symptoms of suicidal or homicidal ideation, active symptoms of psychoses, or any other acute symptoms that threaten the integrity of the subject, the experimenter was to follow the site's clinical protocol. Treatment would be paused for at least a period of one week to assess the subject's immediate needs, but could resume at the discretion of the clinical treatment team and the parent or guardian.

Sessions could be discontinued for various types of interruptions such as: run away behavior, hospitalization for psychiatric or medical reasons, discharge due to legal charges (i.e., simple or aggravated assault, possession of contraband, violation of probation, Judge's bench warrant), or any other extenuating circumstances that resulted in extended absence or permanent removal from the program. Sessions could resume if a subject returned to the program for continuous treatment within three weeks of initial departure and exhibited sufficient cognitive, emotional, and behavioral stability as determined by the clinical treatment team. However, if the clinical treatment team and a subject's parent or guardian believed it would be detrimental to the well-being of a subject to continue in the study, at any time or if an interruption occurred, the treatment series of TF-CBT would immediately terminate. Psychotherapy would resume under the full care of the originating primary therapist if the subject were to remain at the program.

Comment [BSZ6]: What willhappen to the subject? Taken to hospital? Mobile crisis? Spell out the option.

Also, if tx is interrupted several times, under what conditions will you finally decide to discontinue working with that subject?

If, at any time, there was an interruption to a subject's involvement in the study, parent or guardian consent had to be re-obtained for a subject to resume participation in the study from the point at which treatment sessions left off. However, if two interruptions occurred half-way through the treatment series (prior to session 7), or if more than two interruptions occurred over the course of the treatment series, the subject would have been terminated from the study.

At the conclusion of the treatment series, a joint session was held with each subject and his or her primary therapist as a means to transition subjects for receiving standard treatment. Subjects were permitted to withdraw from the study or be withdrawn by their parent or guardian at any time without penalty. Subjects terminating prior to the conclusion of the study would return to their primary therapists for standard care.

Chapter 3: Results

Overview

All three subjects began treatment with TF-CBT within the same week. However, the days on which sessions were held with each subject varied and varied week-to-week, based on subjects' schedules and availability. Of the three subjects, Victor and Sam completed all twelve sessions in the TF-CBT series. Alice completed the first two sessions; however, she was terminated from the study because she ran away from the residential facility, and was absent from the program beyond three-week time limit outlined in the procedural protocol. The therapist followed the recommended sequence of the major treatment segments (i.e., psychoeducation, relaxation training, affect modulation, etc.) outlined in the TF-CBT manual as well as the recommended components in each major segment. The following summary of objective/observable information derived from the therapist's reflection notes and data from assessment measures highlight all three subjects' participation in the study.

Psychoeducation

Subjects were shown the TF-CBT manual and were given a brief history about the treatment model, its purpose and effectiveness in treating children and adolescents who have experienced trauma and traumatic grief. Reinforcement was given to the fact that TF-CBT was meant to be a time-limited treatment modality, thus subjects' participation in this study encompasses twelve individual sessions within a six week period. Subjects were informed that the therapist would provide them with individual therapy only, and

their primary therapist would continue to provide them with case management, family therapy, and responsibility over subjects' privileges.

The therapist asked each subject if he or she understood the reasons why each one was asked to participate in this study. Alice indicated she was required to receive therapy two times per week according to the treatment plan but did not specify any specific reasons for receiving TF-CBT. Sam indicated during the initial session that he "has been through some trauma and the treatment team (at the residential facility) needed him to work it out for himself". Victor reported problems in his life such as his mother dying, his grandmother dying, and his "boy" (a classmate) having died recently.

The therapist prompted each subject for his or her definition of *trauma*. Alice described trauma as "something that happens to someone that is really bad or something that's bad to them". Therapist asked if this meant "a boyfriend that breaks up with you". Alice specified that trauma was something more serious such as deaths in the family. She added that she has heard of people being burned with cigarettes or beaten very badly. Victor described trauma as "something, or a coincidence, that could ruin your whole life". Sam defined trauma as something "really bad that happens to someone like if a girl gets raped, she might not trust anyone anymore or will not want to have sex anymore".

Further examples of trauma were discussed with each subject to broaden their awareness of differences between trauma and other negative events such as death of a significant other to a sudden or tragic event versus a chronic illness. Therapist discussed with each client different types of trauma such a sexual abuse and assault, physical abuse, emotional abuse, natural disasters, witnessing community or domestic violence, neglect, and residential instability, and the unexpected death of a significant other due to

homicide, natural causes, or suicide. Subjects were asked to give specific examples of the different traumas. Victor referenced "shell shock" in his understanding of how war veterans respond to combat trauma. He shared information about a friend who recently returned from the war in Iraq has adverse reactions to the sound of helicopters or other loud aircraft sounds. Alice and Sam both discussed how some parents beat their kids with bats or stab them.

Subjects were educated about how trauma impacts children and adolescents and how trauma responses from youngsters contrast to responses exhibited by adults. The therapist discussed with all subjects how childhood trauma symptoms may mimic symptoms exclusively of depression, anxiety, attention-deficit and hyperactivity, disruptive behavior problems, and sleep disturbances, informing subjects that many children may be misdiagnosed, may be treated for the wrong problem, and may not have their trauma addressed for years or at all.

To educate subjects about the effects of trauma on the physiological and behavioral function in youth, the therapist asked each subject to think of different emotional reactions one can have after a traumatic experience. All three subjects named anger as the most notable emotion. Alice named depression as another emotion and Sam and Victor reported frustration as a second emotion. Based on the response of anger, the therapist asked each subject in his or her respective sessions about what type of bodily sensations one might experience when angry. All subjects reported similar experiences of increased heart rate, feeling hot, inability to sit still, increased energy that needed to be expelled. Alice stated that when she gets depressed, she becomes withdrawn

Subjects were made aware that their own experiences with trauma, which would be discussed in more detail at a later stage in TF-CBT, were shared with a large number of youngsters in the community and throughout the country which is the reason why TF-CBT was developed, widely adopted, used, and evaluated for its effectiveness. To conclude the initial session, the therapist gave each subject an overview of the topics to be covered in future sessions, and informed each subject that the relaxation skills training portion of TF-CBT would begin at the next session.

Relaxation Training – Deep Breathing

Relaxation training was accomplished in sessions 2 and 3. The majority of session 2 was spent teaching each subject diaphragmatic breathing and session 3 was devoted to teaching subjects how to meditate and use progressive muscle relaxation. At the beginning of session 2, the therapist initially reviewed with each subject the topic of the initial session (trauma psychoeducation), then proceeded to introduce the purpose of learning relaxation skills and the reasons why this was relevant to the treatment of trauma symptoms. The therapist elaborated on the idea that it was normal to "feel afraid and to have specific body reactions that occur in response to chemicals in our brains such as: quick, shallow breathing/shortness of breath, muscle tension, anxious feelings, feeling as if we are on ‚high alert', and may also include headaches, dizziness, lightheadedness, stomachaches, nausea, skin rashes, itching, and other irritation" (Cohen, Mannarino, Deblinger, 2006, p. 74).

Both Sam and Victor were able to begin the discussion and the trial of relaxation skills. However, Alice reported in the beginning of the session 2 that she was not doing

well. Therefore therapist spent the first 20 to 25 minutes discussing the problems that Alice had experienced; however, she was informed that the therapist wanted to devote at least 20 minutes of the session to the discussion of relaxation skills training. Alice agreed and began to tell the therapist about a negative experience she had with her parents during a home visit over the weekend. She stated that she asked her mother whether or not she was allowed to attend the 16th birthday party of a friend in another town. Alice said that her mother replied, saying that it would have to be discussed with Alice's father. Alice said that she had hoped that her father would be left out of the decision because she did not want to involve him. The therapist inquired about the reason why this was a problem for her. She shared the information that her father had not been a part of her life actively until she was in late elementary school. Her parents had her out of wedlock, did not cohabitate for many years, and did not decide to get married until she was in middle school.

The therapist asked further about the conflicts that arose over the weekend. Alice reported that her father was home; this occurred rarely because he typically worked on the weekends. She said, "He lost his job *again*, and just sits around like a kid playing his video games, hanging around, and goes bowling". Alice added, "things are better if he's not around because he doesn't have to get involved and I can just do things through my mom…it's just better that way". She shared information about how she disapproved of how her mother involved her father in her request to go to a birthday party. The therapist inquired about her parents' decision. Alice said that her father permitted her to attend the party provided that he contacted the parents of the birthday person and informed the parents that Alice needed to be fully supervised by the parent/hosts, and that she would

be dropped off and picked up by her parents at the beginning and end of the party. The therapist asked about the concerns that Alice had surrounding this arrangement to which she explained that she did not fit to this arrangement because she had her own transportation arranged with a peer, who was a friend. Alice also stated that she did not want her parents to call the host parents to inform them that she had to be supervised.

Alice said that after she told her father that she did not want him to take any of the aforementioned steps that he said that she would not be permitted to go to the party if she did not agree to them. Alice said she became angry and argumentative with her father at this point and left the home. She said that she went down to the local convenience store, where the police found her. Apparently her parents had called the local police and reported her missing and explained to the police that she was currently on leave from a residential program and left the parent's home without permission. Alice said that the police escorted her back home after which her parents brought her back to the residential facility.

The therapist and Alice discussed her mother's role in the conflict that transpired. She said that her mother remained distant and uninvolved "like she always does". Alice said that she never wanted her mother to marry her father and that they were "doing fine" until her father became actively involved in her life. Alice explained that her father used to beat her to discipline her for "little things" she used to do. Alice described one instance when she was nine years old. She said that her parents wanted her to participate in a church outing to Clementon Amusement Park. Alice stated that she did not want to attend and refused to get ready to leave with her parents. This angered and frustrated her father which resulted in him taking of his belt and hitting Alice repeatedly. She said that

his belt broke from having hit her with it. Alice said that her father did not stop and proceeded to get another belt to continue hitting her with it. She said that her mother did not do anything to intervene.

The therapist asked about how she felt about each of her parents as a result of these experiences and the current state of family dynamics. Alice said that she and her mother do not talk and that her mother does not try to talk to her. She described her mother as being aloof and deferred decisions to her husband. Although Alice's mother was reported as taking a passive position in the parental dyad, Alice felt that she had a more positive regard for her mother because her mother did not try to start conflicts with her. Alice stated that she disliked her father when it came to parent-child interactions. She reported that she and her father have a lot in common such as personality traits and interests. Alice said that their relationship is fair as long as it revolved around superficial issues. However, she described having disdain for her father when it came to his asserting parental authority. She admitted to not trusting him because of the physical abuse she endured from him when she was young.

The therapist and Alice discussed how trust can be greatly compromised when one is traumatized by another person; especially that of a parent. The therapist pointed out that even if her father had been doing the proper thing when she wanted to go to a birthday party that she would naturally have opposed his authority because she still mistrusts him. The therapist added that she may continue to be frustrated with her mother because her mother defers authority to the father which may be reminiscent of the fact that her mother did not do anything to stop past physical abuse. Alice agreed with the therapist's feedback. However, she asserted that she was not interested in having any

home visits with her parents in the near future, nor was she willing to have any family sessions to process the incident that had transpired over the weekend. The therapist suggested the relaxation techniques that would be presented at the current session could help to decrease some of the stressful feelings that she was experiencing at the present time.

Having given Alice the opportunity to process with the therapist, the incident involving her parents over the weekend, Alice agreed to utilize the remaining 15-20 minutes to learn diaphragmatic breathing. Parallel to the therapist's individual sessions with Victor and Sam, the therapist described to Alice how trauma victims may feel "on edge", irritable, annoyed, may "snap" at people more frequently, may respond to stressors in a more severe manner compared to others, and experience an overall sense of tension. Subjects were asked whether or not they experienced any of the above mentioned characteristics. All subject confirmed that they experienced many of the trauma response symptoms. The therapist discussed with each client how such physiological and behavioral responses to trauma can be minimized and controlled through the use of relaxation techniques.

The therapist began with explaining the role of deep/diaphragmatic breathing, and explained that this is a foundation in learning how to relax. Subjects were taught the difference between breathing while raising one's chest versus "belly" breathing by having subjects place their hands on their abdomen and having subjects practice breathing in a manner that made their abdomens rise and fall. Subjects were then asked to inhale for five seconds by specifically instructing them to count, "one-one thousand, two-one thousand" and then they were instructed to exhale in five seconds, thus learning

how to control the speed of their breathing. The therapist had each subject repeat the breathing exercise for a few minutes and asked subjects to describe how they felt. All subjects reported feeling calmer and more relaxed. Sam reported feeling a little light-headed and "woozy". The therapist explained that the desired effect was that each client feel more calm, relaxed, and light. The therapist asked each subject to practice "belly" breathing that evening at bedtime and for the next couple of evenings to master the use of the breathing technique, informing all subjects that the next session would be devoted to learning the additional relaxation techniques of meditation and progressive muscle relaxation. All subjects agreed to practice breathing exercises as homework for the next session.

Relaxation – Meditation & Progressive Muscle Relaxation

Alice refused to meet for session 3. When asked to come for session 3, she complained about feeling drowsy because she had just taken her medication thirty minutes prior to the therapist coming to get her. When asked two days later to meet for session 3, Alice again turned down the prompt to meet for therapy and reported that she did not feel like meeting. The therapist did not approach her for the remainder of the week and informed her that the therapist would "check in" with her in a few days. Alice ran away from the program in the same week, did not return to the program within a week's time, and was discharged from the residential program by the program directors. Therefore all subsequent TF-CBT session data will be based on sessions completed with the two remaining subjects.

The therapist reviewed with Sam and Victor the results of the practice of "belly" breathing. Both subjects reported that they practiced breathing at bedtime and that the technique was effective inducing relaxation. Both Sam and Victor reported a history of sleep difficulties. Sam described the situation in which he typically had difficulty staying asleep and would wake up in the middle of the night and would not be able to fall asleep again. He added that after practicing the breathing technique, he had the "best sleep in months" because he was able to fall asleep in a shorter period of time and was able to remain asleep for the entire night, during the previous two nights. Victor, who suffered from sleep problems due to trauma and Bipolar Disorder, reported that he was able to fall asleep quickly and remained asleep through the night. To build upon the breathing exercise, the therapist began to discuss combining the art of meditation and mindfulness with breathing.

Both subjects were asked about their understanding of meditation. Sam described meditation as closing one's eyes and thinking about something and Victor described meditation as doing something like yoga. Therapist confirmed that their ideas were relevant; however, she specified for each subject that meditation and mindfulness was the art of being aware of one's surroundings but not being involved in what is happening around them. Therapist likened meditation to "mentally stepping outside of one's body" and "looking at a videotape of what is happening to oneself". Both subjects confirmed an understanding of what the therapist described before the therapist proceeded further.

The therapist asked each subject to describe what they observed around them at the present time. Victor described the scene, saying that he heard a copy machine making noises in the next room, the sound of geese making "honking noises" outside, and

the fact that the lights were dim in the therapist's office. Sam described the scene, saying that he heard people talking loudly in the hallway and that it was dark outside. The therapist asked both subjects to "take in" what they were sensing around them but to not allow themselves "to actively be apart of what they were sensing and not to judge what was happening around them".

The therapist introduced the concept of the *mantra* and defined for Victor and Sam that it was a word or thought that one will say in one's mind while he or she is practicing breathing and being aware of, but not part of, what is going on around each person. The therapist asked each subject to choose a word that he would use while practicing breathing. Sam chose the words "be cool" and Victor chose the word "relax". The therapist proceeded to sit comfortably and they practiced breathing; their eyes were closed and they said their mantras silently, remembering to be aware of their surroundings but not being active part of what they are sensing. Both subjects practiced meditation/mindfulness combined with breathing for a few minutes and reported that they felt calm and relaxed.

The therapist began to discuss the purpose of learning progressive muscle relaxation and how this relates to the treatment of trauma response symptoms. The therapist reiterated the fact that trauma may cause a person to have a heightened physiological arousal compared to those that do not experience trauma. Individuals with increased arousal states may be "overly watchful and on the look out for threats" (hypervigilent) and may be prone to "jumping on people" when frustrated or irritable. The therapist explained that at the times when children experience a traumatic event, their bodies may remain on high alert during which other negative events, thoughts and

reminders may set up more body reactions, thereby creating ongoing emotional and bodily sensations of tension and anxiety (Cohen et al., 2006).

The therapist instructed both subjects to sit comfortably and follow a script to teach them muscle relaxation (Cohen et al., 2006; p. 80). Both Sam and Victor followed the therapist's directions. Victor was able to follow the script until completion and reported feeling significantly less tight and tense than before the exercise. Sam was able to follow the script for one minute and fell asleep. The therapist had to wake him up to complete the exercise. Sam reported that he did not realize that he had fallen asleep and said that the muscle relaxation exercise induced drowsiness.

The therapist instructed both subjects to practice the breathing, meditation/ mindfulness, and muscle relaxation techniques for the remainder of the week through the weekend. The therapist asked for subjects' feedback on relaxation training, at which time both subjects indicated that the exercises were interesting and beneficial to them. Both subjects agreed to practice relaxation as homework. The therapist informed Sam and Victor that affective expression and modulation would be topic for the next session.

Affective Expression & Modulation

This segment of TF-CBT required the therapist to engage subjects in order to identify feelings, understand the difference between feelings and thoughts, and teach subjects about how they can control and stop their thoughts. The therapist educated the subjects on how trauma victims may have difficulty controlling their feelings, elaborating on the fact that some children do not learn how to manage their feelings properly as they develop; this is due to neglect, abandonment, residential instability, having lived in a

chaotic household where adult supervision was sparse, or had caregivers who lacked the ability to teach or model appropriate affective control themselves. Subjects were taught how to use positive self-talk, building problem-solving and social skills to manage conflict. The therapist also discussed with Victor, as well as Sam, how to modulate affect in response to traumatic grief.

Victor and Sam were initially asked to identify as many emotions as they could; they did this with little difficulty. Both subjects identified anger as the emotion which they experienced the most difficulty in managing. The therapist introduced a "feeling thermometer" handout to the subjects to assist them in visualizing varying degrees of emotion. The therapist prompted Victor for an example of a recent event during which he became angry. With the therapist's prompting, he was able to identify the thoughts and behaviors associated with low, low-medium, medium, medium-high, and high levels of anger on a scale of zero to ten on the feeling thermometer. In response to a stress-provoking event, Victor first identified he would initially be annoyed which could escalate to feeling agitated followed by not being able to sit still, telling others to leave him alone, slamming doors, cursing and making threats to others, and ultimately assaulting a person or destroying property.

Sam identified the fact that at low levels of anger, he "has words" with others and engages them and allows himself to engage himself in debate and arguments. At moderate levels of anger, he reported telling people to "get out of his face" and verbally provokes others to fight him at moderate-high levels of anger by saying "come on, if you want to fight me, fight me". At the peak of anger, Sam reported that he engages in a fight, resulting in his having to be restrained by others.

The therapist highlighted the idea that each subject experiences different thoughts at different stages which lead to experiencing of different levels of anger. This in turn influences his actions and results in consequences. Both Sam and Victor were encouraged to review the feeling thermometer exercise and apply the model to the experience of other emotions.

During the thought interruption segment of treatment, Sam and Victor learned that they could gain control over their thoughts and cease troublesome thoughts. The therapist asked both subjects to begin telling the therapist about what they did that day, starting with their morning routine. The therapist allowed each subject to talk for about 30 seconds about what he did over the course of the day. The therapist then clapped her hands and said, “Stop,” in a stern manner, at which time both subjects ceased to talk. The therapist pointed out that they can do the same by telling themselves to stop if they “catch” themselves ruminating about something troublesome. The therapist explained that thought interruption was not meant to be used to avoid thoughts and feelings pertaining to trauma, but was meant to be used if the rumination interfered with their functioning at work, school, or any other activity that required their attention to be focused on tasks.

The therapist proceeded to discuss positive self-talk with Sam and Victor, and went over different statements that subjects could tell themselves in order to minimize negative affective responses to a stress or anger-provoking event. Examples of positive statements included, “I can get through this, things are hard now, but they will get better, I still have a family and they will help me, lots of people care about me, and some things have changed but lots of things are the same as there were before” (Cohen et al., 2006; p.

93). The therapist indicated that the point of using positive self-talk was to help one to reassure oneself and to intervene in order to prevent escalation of negative affect.

The therapist discussed with Sam and Victor problem-solving and social skills-building by asking both to provide examples of a problem each subject had encountered recently which resulted in a negative consequence. Using the examples, the therapist engaged each subject to process the following steps as outlined in the TF-CBT manual: (1) describe the problem, (2) identify possible solutions, (3) consider the likely outcomes of each solution, (4) pick the solution most likely to achieve the desired outcome and implement the choice, (5) evaluate their choice to see how it worked, (6) if it did not work out, figure out what went wrong, and (7) include what they learned the next time a problem arose (Cohen et al., 2007; p. 95).

Victor provided the example of getting into an argument with a male peer at the program. Victor was able to describe how the peer would not give him the broom so Victor could complete his assigned chore. The peer eventually gave him the broom but attempted to engage Victor into an altercation. He identified the fact that he could have continued arguing with the peer which would have led to his hitting the peer or he could have "let it go" and have walked away from the peer. Victor processed that had he engaged in a fight with his peer, he may have been restrained by staff, would have lost his privilege levels, and would have lost his home visit for the weekend. Conversely, he could have chosen to walk away, thus resulting in no reprimand or loss of privileges. Victor said that he eventually chose to walk away from the peer and stopped engaging in conflictual interaction, resulting in positive consequences.

The therapist reinforced the fact this may have helped to prove to Victor that the choices that he made through problem-solving had a direct impact on the consequences he experienced, which may have positive implications on how he handles similar conflicts in the future. Furthermore, Victor's fighting behavior would have reinforced his habit of fighting, having been encouraged by his childhood peers to fight to resolve conflict.

Sam discussed the situation in which he was faced with the problem of his residential discharge being extended another three months. The two solutions he identified were staying at the program for another three months or running away. He said the outcomes of running away included staying in hiding, worrying about getting caught and risking incarceration if he were caught as a result off violating a Court order to complete residential programming. Conversely, remaining at the program would result in a positive discharge to home and being in compliance with the Court without any concerns. Sam chose to remain at the program and complete residential treatment and reasoned that he completed nine months of programming and had "come too far to ruin it" for himself. The therapist pointed out to Sam that the urges to run away may have stemmed from the lack of control he experienced in life as a result of being in foster care and other out-of-home placements because his mother physically abused him, and the lack of decisions he is able to make about what happens to him.

The therapist provided both Sam and Victor with homework assignments to enhance their skills in feeling identification and gauging varying degrees of specific emotions. Another homework assignment included having the subjects identify thoughts

that lead to feeling angry, anxious, happy, and depressed. Both subjects completed their assignments and were reviewed during the affective modulation sessions.

The therapist obtained feedback from Sam and Victor about their understanding of affective expression and modulation. Both subject verbalized the fact that they understood the different components of this segment of TF-CBT.

Cognitive Coping & Processing I – The Cognitive Triangle

This segment of TF-CBT involved introducing to the subjects the concept of the *cognitive triangle,* which is based in the concept that individuals can choose to change their own thought, which in turn changes their feelings and behaviors (Cohen et al., 2006). Subjects were also educated about "automatic thoughts", which are thoughts that "pop up" out of habit and occur without intention. The therapist further clarified with the subjects the difference between thoughts and feelings, and gave examples of automatic thoughts by discussing case scenarios. After the subjects acknowledged an understanding of the cognitive triangle and automatic thoughts, the therapist worked with them on developing *alternative thoughts* to situations that would lead to more accurate assumptions or appraisals of situations. Cohen et al., (2006) likens the use of alternative thought to "switching the channel on the television" to find better shows to watch.

Subjects learned that the cognitive principles and concepts related to trauma because trauma victims, especially children, may develop inaccurate perceptions of their involvement in the traumatic event(s). The therapist provided the example of a child witnessing domestic violence between his or her parents and the fact that the child may blame him or herself for the reason why the parents are fighting. Another example

provided was how a girl who was sexually abused or assaulted may have feelings of guilt because she did not tell anyone about the trauma for months or years after the occurrence, or may blame herself for what happened.

The therapist provided subjects with handouts describing common types of inaccurate thoughts identified in the TF-CBT manual. Inaccurate thought examples included having *all or nothing* thinking, in which things are viewed as all good or all bad with no middle ground viewpoint, repeatedly viewing all future situations in the same manner based on an isolated situation, having *catastrophic* thinking in which a person resorts to thinking about the worst case scenario, and engaging in negative thinking in which a person thinks that nothing will work out and nothing is good.

Sam's cognitive coping sessions.

In two sessions on cognitive coping, Sam learned about the cognitive triangle conceptualization and automatic thoughts. He and the therapist went over a real-life example of his having inaccurate, automatic thoughts through a discussion about his perceptions, had he walked into a school cafeteria and approached a group of friends who started laughing as he walked closer. Sam stated that he would automatically think that his friends were laughing at him. The therapist asked him how this automatic thought would cause him to feel and behave. He described a situation in which he would feel angry; this would cause him to want to confront them in a hostile manner. Sam was prompted to think of an alternative way of appraising the situation of walking in the room and seeing his friends laughing. However, Sam could not generate any alternative perceptions.

Conversely, the therapist provided the example of how his friends may have been talking about something funny as he was walking into the room, and glanced over at him because they took notice that he was walking in. The therapist added that perhaps his friends were not able to stop laughing because what was discussed was really funny and because it is sometimes hard to stop laughing. Based on the alternative thought, the therapist asked Sam what he would feel and do based on the new thought. He acknowledged that he would not feel angry but "okay" instead, and would approach his friends in a casual manner and inquire about what was so funny. The therapist reinforced with Sam the idea that a different appraisal or alternative thought results in the experience of different feelings and different behaviors.

Victor's cognitive coping sessions.

The therapist discussed with Victor the cognitive triangle, automatic thoughts, and alternative thoughts concepts. After acknowledging an understanding of these concepts, the therapist provided him with examples of how automatic and inaccurate thoughts unfold in the cognitive triangle process. Victor brought up his own example of how he believed he had perceived things inaccurately by talking about the recent death of a school mate. He shared the knowledge that he knew his friend had a very severe substance abuse problem and knew that his friend and the friend's parents had been quarreling. Victor said that he initially thought that he should have intervened and told his friend's parents that the friend was using drugs. By doing so, Victor thought that this might have prevented his friend from dying from a drug overdose following an argument

with the parents. He said that he blamed himself and felt guilty for not having done something and believed, early on, that the absence of action resulted in his friend's death.

Victor stated that this belief led him to feel depressed and upset, causing him to use marijuana. He said that he felt terrible after having smoked marijuana because he had over eight months "clean time". The therapist reinforced with Victor the idea that his lapse in using was a part of the recovery process and that he was able to stop using instead of continuing to use and "get back on track" with the residential program and his schooling. Victor acknowledged that he still continues to experience grief over his friend's death but came to realize that he should not blame himself for the death because cannot control another person's actions and the choices they make. Victor's response was, "It's not like anyone held a gun to his head and told him to use drugs and overdose" as he explained that his friend chose to use drugs to cope with his problems resulting in his death.

The Trauma Narrative

This segment of TF-CBT involved having subjects create a trauma narrative to describe and process, sequentially, various aspects of their traumatic experiences. The goal of the narrative is to "unpair thoughts, reminders, or discussions of the traumatic event from overwhelming negative emotions such as terror, horror, extreme helplessness, shame, or rage" (Cohen et al., 2006; p. 119). Subjects' trauma narratives were developed over the course many sessions; subjects began with the discussion of general detail of trauma experiences then progressed to discuss more specific detail about the trauma. Subjects were also asked to describe what things were like before, during, and after the

traumatic events, and were asked to describe the thoughts and feelings about the events and other people involved in the trauma.

Sam's trauma narrative – introduction.

Therapist began the first session of trauma narrative development by asking Sam to describe a memory of the happiest time of his life. He indicated that the best day of his life was the day he ended six years of being in foster care and was sent home to live with relatives. He recalled being told that he was going to live with his maternal grandfather whom he had never met. Although he did not have a pre-existing relationship with his grandfather, Sam was eager to leave the child welfare systems and did not care what relative he went to stay with.

The therapist asked Sam to describe what his life was like prior to his being placed into foster care. Sam stated that he lived in with both his mother and maternal grandmother for the majority of his childhood. Even though he and his two younger maternal siblings lived in their mother's house, he specified that his grandmother was always the primary caretaker and disciplinarian of the family. His mother was a teenager when she gave birth to Sam and gave custody of him to the grandmother. Sam said that he called his grandmother "mom" since he was a toddler because he thought his grandmother was his mother. He did not learn until he was elementary school that she was his grandmother and was shocked to learn this. He added that the role of his mother was that of a friend or companion who did not take on regular parental tasks.

Sam described memories of his childhood before his removal from the family. He remembers him and his siblings going to his Nana's house (maternal great grandmother),

spending time eating her cooking and spending time with his uncle playing video games. He regarded these times as pleasant, family-time events during which he had no worries or concerns. Sam recalled doing regular "kid" things like going to school and playing with other children in the neighborhood.

Sam's trauma narrative – his worst experiences.

The therapist asked Sam to talk about the worst experience of his life. Sam spoke of having been hit by a car when he was about eight years old while running home from school. He said that he was not injured and sustained only some cuts and bruises; however, he was not very upset by the situation because the fear of being hit by a car was overshadowed by the fear of "getting beat" if he was late getting home from school.

The therapist clarified for Sam that the idea was to discuss the situation that significantly impacted his life, one that had negative consequences. Sam said he was regularly expected to wait for his younger sister to leave her school and rendezvous with him to walk home together. He described one instance at age nine; he waited for his sister but later learned that her school had dismissed students earlier. He went home and found his mother waiting for him. She instructed him to go upstairs and take all his clothes off and to return downstairs at which time she took a broom handle and hit it with him repeatedly for many minutes. The therapist asked about what occurred following his mother's hitting him. He said that she told him to go to his room until dinner was ready.

Sam stated that this incident was not the only time that he hit him. He elaborated on the fact that his mother was often quick to turn to beating him whenever he misbehaved or did "something little" like losing a dime when she sent him to the store to

buy something. He recalled a time when she became angry at him and took a shoe out of the closet, with which Sam thought she was going to throw at him. Instead, she hit him over his eye with the heel of the shoe causing him to have a black eye and broken capillaries across the whites of his eyes.

The therapist asked what transpired following the day of the school incident. Sam explained he was asked about visible bruises on his body by school personnel. Sam said, "I loved my mom so much, even after she beat me, that I lied and some boys who didn't like me, threw rocks at me". He claimed that the school officials called DYFS (agency to report child abuse in New Jersey) to report suspicion of child abuse. Sam added that DYFS came to his house later that day and asked his mother whether or not she had hit him and caused the bruising. He said that his mother confirmed that she had "beat him". He was removed from her home in the same instance and was told he was going into foster placement to which his mother's reaction was, "bye nigga, I hope you get better". Sam was asked to write about the incident and include the details that were discussed during the session.

Victor's trauma narrative – introduction.

Victor was asked to describe what his life was like as a child growing up. He stated that he grew up in a large Italian-American family in the Kensington section of Philadelphia, where he lived with his parents and older sister (by seven years) until his parent's divorce when he was about a year old. Victor's father moved to southern New Jersey and took physical custody of Victor and his sister. Both children attended school

full-time in New Jersey during the week, but they spent their weekends with their mother in Philadelphia.

On the weekends, Victor enjoyed his time with his mother and sister. He played with his old neighborhood friends. He said that his mother gave him “a lot of leash” as a child and was allowed to play outdoors without much supervision. In retrospect, he was surprised that he was never harmed from the lack of supervision. He said that living in Kensington is rough and that people are “tough cookies”. Physical fighting among peers was not an uncommon way to “play around” or settle disputes. Therefore he found himself unpopular with parents in his father’s neighborhood in New Jersey because he often engaged in aggressive behavior with other children.

Victor recalled spending time playing video games and watching movies with his mother with whom he felt very close. He also enjoyed playing many sports and was involved with an ice hockey team from the time he could start to skate. He played on an ice hockey team until he was Court-ordered to complete the current residential treatment facility program. His father, who was in his forties when Victor was born, did not interact with Victor as much as Victor’s mom. Instead, Victor said that he felt like he and his father were more like friends who talked. Occasionally his father would discipline him for misbehaving by “gripping him up”, or “slapping him upside the head”. Victor recalled that his father once punched him in the face, but thought that he deserved it because he had been disrespectful towards his father’s new wife.

Victor's trauma narrative – his worst experiences.

The therapist asked Victor about the experience(s) that he were traumatic to him. He identified two events: his mother's sudden death and witnessing his "step" cousin get molested. Therapist began by asking Victor to describe how his mother died and how he found out that she had died. He explained that his mother had been in the process of applying for physical custody of him and his sister and had missed a custody Court hearing. Victor's sister went to Philadelphia to check on their mother and had found her on the floor, slumped over into a pillow. Victor said his father picked him up from school which was unusual because he typically rode the school bus home. Victor's father told him in the car that Victor's mother had died from unknown causes.

The therapist asked about how matters were handled after his mother's body was found. Victor believed that his sister had called for an ambulance, which came to their mother's home to take her body. His sister remained at the mother's house to pack up personal belongings which would be picked up by their father a day or two later. Victor recalls having arrived at his mother's house and finding the door kicked in and the belongings missing. He said that he later found out that his maternal uncle and grandmother went to the mother's house and took the items that had been packed up and put them in the grandmother's basement; Victor believed they were to be used and sold because "that side of the family had a big drug problem".

Victor said that he went to his mother's funeral a few days later and remembers being in denial and disbelief that his mother was deceased. He remembered thinking that he had only seen her a few days prior, on the weekend, and never got to see her body because the funeral involved a closed casket service. In the months following his

mother's death, Victor recalled being depressed. He confirmed the fact that his father took him to a female psychologist or psychiatrist for therapy which he thought was slightly helpful at the time. Victor believed that he went for therapy for a number of weeks on a regular basis, but eventually refused to continue therapy because he did not want to be obligated to go to therapy while his friends were allowed to stay home and play. Victor said that the therapist kept asking about his mother, which left him feeling annoyed and wanting to avoid discussion of the topic of her death.

The second traumatic event that Victor discussed was having witnessed his "step" cousin being molested. Victor described a situation when he and his cousin were both ten years old. Both their families were vacationing in Wildwood, NJ; one evening, both boys were permitted by their parents to walk around on the boardwalk. Victor stated that he talked his cousin into stealing fake gold chains and medallion necklaces from a vendor. A man approached the boys and confronted them about stealing. He told them that he was a police officer and that they had to follow him to the police station to be spoken to. Victor said that the man asserted himself authoritatively, like a police officer, even though the man wore street clothes. Both he and his cousin were worried that they would be in trouble so they followed the man. Victor said that the situation began to seem strange when the man led them down the boardwalk, down the ramp/steps leading to the beach, and told them to go under the boardwalk.

The therapist asked Victor to describe what occurred next. He explained that the man molested his cousin. The therapist asked Victor to explain, in detail, what he witnessed. Victor told the therapist that the man told Victor's cousin to take off his pants after which the man performed fellatio on his cousin. Afterwards, the man instructed the

cousin to perform fellatio on the man. Victor said that he witnessed, what seemed like, two minutes of the molestation ordeal. He said he became very scared and worried that the man would try to go after him next. Victor said left his cousin behind and fled back to the hotel where their families were staying.

Victor returned to the hotel where his uncle asked him where the cousin was. Victor only reported that he left the cousin behind. The uncle instructed to return to the boardwalk and retrieve the cousin. Victor did as his uncle instructed and found his cousin walking back to the hotel by himself. The cousin asked if Victor had told anyone about what happened to which Victor responded, “No”. The cousin asked Victor to not tell anyone, which he promised to do. Victor stated that he still has not told anyone in his family or the police about what happened. He stated that his cousin and he still talk to each other once in a while but he has not seen him in a year. He added that his cousin lives in Philadelphia with his family and has a severe substance abuse problem. Victor discussed the fact that he felt guilty for having left his cousin behind and that he should have done something to help his cousin.

Cognitive Coping & Processing II

Subsequent sessions following the discussion of the trauma narrative involved having subjects discuss the thoughts and feelings they had before, during and after traumatic experiences. The goal in this segment of treatment was to normalize common beliefs, perceptions, emotions, and behaviors resulting from such experiences, and to identify and explore accurate and inaccurate beliefs surrounding trauma.

Sam's cognitive processing – physical abuse trauma & removal from family.

Sam described his life as "ordinary and normal" to him as a child growing up in Camden, New Jersey. He said that he never knew his father which did he claimed, "did not bother him". He said that conflict among family members; i.e., his mother and grandmother, and between aunts and uncles, was not uncommon. He described the notion that there was always "commotion" going on in his family. Sam said that he did not get along with a lot of peers in the community or at school because he was known as a "fighter" because "people got on his nerves a lot". He said that it was common for him to get his "butt beat" by his grandmother when he did not get home from school on time. He added that when his grandmother went out and left him and his siblings in the care of their mother, his mother would easily resort to "beating". Sam distinguished beating from spanking because she would use objects with which to hit him: boards, belts, broomsticks, shoes, and wire cords.

The therapist asked what he thought of his mother using such forms of punishment. He stated that he did not like getting punished in such a fashion. However, such experiences were commonplace and not much different from some of his peers' experiences in their homes. The therapist asked him about the thoughts that would go through his mind when he was hit. Sam described the idea that he would always get angry because he did not think that his negative behaviors, which he deemed "minor", did not warrant getting beaten. He stated that his mother would punish him for things that his younger siblings did, and would be punished for a misunderstanding or for things he did not actually do. He added that his grandmother would also be angry at his mother for punishing him in these situations. Sam indicated that he often thought of his treatment by

his mother as unfair, thought of himself as a victim when punished by her, and thought she was "crazy" and that "something wasn't right with her".

The therapist reiterated to Sam how he had lied to school personnel about the source of his bruises because he loved his mother. The therapist asked him to express his thoughts further about reasons why he did not tell the truth. He responded that he did not want his mother to "get locked up" and to risk his siblings being taken away to go into an out-of-home placement. He stated that he would have felt guilty risking the breakup of the family if he had told the truth about what happened. The therapist discussed with Sam how this choice is not uncommon in order to preserve the family cohesion and that children do not want have negative feelings associated with being responsible for fragmentation.

The therapist also reiterated that the school officials appeared to have reported suspected abuse anyway. The therapist inquired about how DYFS approached his family about the suspicion of physical abuse. Sam stated that his mother admitted to DYFS and said, "Yeah, I hit him". After his mother and grandmother were informed by DYFS that he was going to be placed into foster care because he was the only child having presented with signs of physical abuse, Sam stated that his mother seemed to have no problem with his being removed and described her as having a "good riddance" demeanor. The therapist asked him what he thought that her response; he said that he was shocked and thought that she would plead with DYFS not to take him away from the family and fight for him to stay home. The therapist asked Sam how this made him feel. He indicated that he felt very hurt and angry to the point that he "wanted to punch her in her face".

The therapist asked Sam about his grandmother's reaction to DYFS presence at the home. He said that she was angry and upset about the situation and did not want them to take him away. He explained that she had legal custody of him; however, she could not do anything to stop his removal because they were living in his mother's home and no alterative relatives could be identified with whom he could live. Sam added that his grandmother told him to give her a few weeks to get her own place so she could get him out of foster care. Sam said that he believed his grandmother, trusted that she would do so, and that these promises were settling to him.

The therapist discussed with Sam how he remained in foster care for six years from the time he was removed from his family at age nine until he was fifteen years old. The therapist asked about what he thought about his grandmother's intent to find housing within a few weeks of his removal. Sam stated that he initially believed that she would keep her promise and was confident in his grandmother because she always took care of him. He said that after weeks and months went by without any word about whether or not she obtained housing, he began to believe that she forgot about him and that he was unimportant. Sam said this caused him to grow increasingly frustrated with his grandmother and with other family members because it seemed that no one would step forward to bring him back to the family. At one point, his grandmother moved to the State of Virginia for a couple of years, causing Sam to feel depressed and angry because he believed that no one cared about him.

The therapist asked how this caused him to behave towards others while in foster care. He stated that he fought peers often, was disrespectful towards authority figures (foster parents, teachers), and began to smoke marijuana. He recalled having done

relatively well in the last foster home where he lived for about two years. He said his foster family treated him well, which gave him a sense of belonging and comfort. In retrospect, he thought that it may have been better to have remained with this family instead of being sent to live with a grandfather he did not know.

Sam was able to identify inaccurate and unhelpful thoughts that stemmed from his trauma experiences. One belief was that he was unlovable and expendable. Another belief was that authority figures are untrustworthy and try to control him. The therapist discussed how it was understandable and not surprising that he concluded that he was unlovable and expendable, based on his mother's treatment of him, including his grandmother's broken promise to get him out of foster care. With the therapist's prompting, Sam acknowledged the fact that he had not spent his entire adolescence in foster care and was pursued by his grandfather to have DYFS return Sam to the family. He also acknowledged that he is slated to be discharged to his grandmother in Pennsylvania once he completes residential treatment, thus demonstrating care, concern, and commitment by his family. Sam also discussed the fact that he came to increase the ability to trust adults after seeing his grandmother's involvement in his life after she moved back North from Virginia. Furthermore, he noticed how program staff did not give up on him and continued to work with him after he exhibited many negative behaviors.

The therapist inquired about how the trauma of physical abuse and the removal from his family affected him after his return home from foster care. Sam explained that he and his grandfather had a falling out after which he went briefly to live with his mother, then with his grandmother, who had moved to Norristown, Pennsylvania.

However, he returned to New Jersey to visit with friends and family at which time he was arrested for “holding” drugs for a friend and was subsequently detained at the county youth detention center. He was Court ordered to complete a residential treatment program in New Jersey as an alternative to incarceration. Sam said he did not use good judgment during the time of his visit to Camden and “hustled to make a few extra bucks” even though his grandmother provided well for him.

Besides engaging in illegal activity and associating with a drug-selling peer group, Sam was asked about other problem behaviors that he continued to exhibit. Sam indicated that he did not like being told what to do, even by his grandmother. He specified that he did not like noisy situations and was prone to being irritable and belligerent when he could not get people to quiet down. This experience occurred frequently at the residential program because he lived among many peers.

The therapist confirmed that it is difficult living among peers that have emotional and behavioral problems themselves. However, Sam stated that the program has taught him how to cope better with his peers and has helped him to commiserate with others sharing similar life experiences. He added that he behaved very poorly in the first four to six months after admission and had engaged in numerous incidents of acting out (i.e., smoking on program grounds, going out of his window at night, engaging in physical fights with others, and threatening the staff). Sam indicated that he decided to change after six months because he became weary of the consequences of his behavior. He said that his behavior was not helping to “get out of the program” and return home to his family. With the help of an individual mentor assigned to work with him on social skills, his behavior showed drastic improvement after the winter holiday season.

Victor's cognitive processing – traumatic grief.

For quite some time, Victor's family asserted that his mother had died from complications from Crohn's Disease. However, he later found his mother's death certificate which listed the cause of death as "multiple substance intoxication". Victor admitted that he knew his mother drank alcohol and smoked marijuana. However, he was not aware of the full extent to which she abused drugs, which he learned included heroin and prescription pills. In response to learning these facts, he felt betrayed and angry towards family members for keeping the truth from him.

The therapist discussed with Victor the thoughts and feelings he experienced in response to his mother's death. He reiterated that he was in disbelief and denial about her death. In retrospect, Victor recalls feeling extremely depressed over the loss of his mother but did not try to express his grief other than by getting into fights. Victor denied blaming himself for any part in his mother's death; however, he has regrets that he never got to "say goodbye" to her. He continued to engage in aggressive behaviors, became increasingly disrespectful towards his father and other authority figures, and began to use alcohol and drugs during adolescence. Victor admitted that his drug use began with smoking cigarettes and marijuana, then onto the use of methamphetamine and prescription pills. Socially, he spent time with a delinquent peer group and engaged in robbery with these peers to support his drug habit and partying lifestyle. The culmination of his behaviors led to his being involved in the legal system and being Court ordered to complete a residential treatment program.

Vincent also discussed the fact that he was diagnosed with Bipolar Disorder in the last two years which further complicated his problems with grief. He expressed how he

used to blame specific members of his family for his problems because he believed that "being betrayed about the true cause of death" of his mother and the belief that his father "killed his mother" by engaging her in a custody battle led to his emotional and behavioral problems. Vincent compared himself to his older sister who is now 24 years old, works full-time as a bartender, and goes to college part-time. He viewed his sister as an individual who had the same problems but focused her energy into school and work while he engaged in self-destructive and harmful behaviors in the community. Victor shared the information that he no longer views himself as a victim who blames others for his choices. He reiterated, as in the recent death of his friend, that no one "put a gun to his head" and forced him to make the choices he made. The therapist reinforced for Victor the fact that he was able to restructure some of his thoughts on his own and developed more accurate beliefs surrounding his mother's death; she also indicated how grief issues were manifested and displayed in his emotional and behavioral functioning.

Victor's cognitive processing – witnessing child molestation.

Victor identified the fact that the primary problem he experienced from having witnessed his cousin being molested was having feelings of regret and guilt. The therapist asked Victor why he had regretful and guilty feelings at which time he indicated that had he not insisted on stealing on the boardwalk that his cousin would never had been molested. He added that he believed that he should have done something to stop the man from harming his cousin. Victor also expressed the idea that he felt guilty about running away from the scene "like a little bitch" and was ashamed for not having been more of a man and doing something about it.

The therapist informed Victor that feelings of guilt, regret, shame, and feeling responsible are common feelings that result from being a witness much like one experiences “survivor’s guilt”. In this sense, it was explained to Victor that it was not odd for him to come to such conclusions. Victor expressed the fact that he continued to experience such feelings at the present time. He added that he and his cousin never told family or police about the cousin’s being molested and believes that his cousin has drug problems because of being molested. However, his cousin told him that he did not harbor any negative feelings toward Victor and did not blame him for running away from the scene because the cousin would have done the same.

The therapist discussed with Victor the inaccurate thoughts he appeared to have about the abuse of his cousin. The therapist reiterated that Victor felt guilty because he talked his cousin into stealing, which he believed led to his cousin’s being molested. Victor confirmed this belief as he asserted that his cousin’s perpetrator would never have confronted them. The therapist asked Victor whether or not the stealing behavior warranted someone getting molested. After Victor stated, “No,” the therapist indicated that because they were stealing did not give the perpetrator the right to violate his cousin. The therapist asked, “If a woman wore short, tight clothing, did it give someone the right to take advantage of her”. Victor responded, “No”. Therefore the therapist indicated that the perpetrator made his own decision to harm Victor’s cousin, regardless of what the boys were doing and used their stealing as a way to coerce them.

Victor agreed but still believed if he had not stolen with his cousin they may never have been confronted by the man. The therapist indicated that this may or may not have been the case; however, she explained how the perpetrator may have approached

them by using another credible reason such as asking for help. The therapist reinforced Victor's understanding that the perpetrator was responsible for making the choice to commit a crime regardless of what they were doing and that there was never a justification for anyone to sexually abuse another person. Victor agreed that this made sense and indicated an understanding that their behavior did not warrant being preyed upon.

The therapist discussed Victor's guilt about having run away from the boardwalk while his cousin was being molested. Victor was asked about what he should have done. He responded that he should have done "something, anything, instead of running away like a little bitch". The therapist hypothesized that Victor, being a male, might be inclined to think that he needed take action, protect, and fight back in the face of conflict and danger. The therapist added that anything short of such behavior might be viewed or felt as cowardly. The therapist, however, pointed out that he was only ten years old while the perpetrator was a large adult male. The therapist added that at age ten, one is still quite little in comparison to an adult against a teenager. Victor was asked what he thought may have happened had he stayed with his cousin and attacked the man. He stated that he may have been molested himself or may have been hurt or killed because the man may have overpowered him.

The therapist discussed with Victor that human instinct, similar to animal instinct, will fight or flee in the face of a threat. Based on conclusions of what may have happened to him, the therapist reinforced the idea that fleeing may have been the more viable, life-preserving option, and how running away likely prevented him from

sustaining mental and physical harm. The therapist reinforced with Victor how his cousin told him that he would have done the same thing, in retrospect.

In Vivo Mastery of Trauma Reminders & Enhancing Future Safety

In this segment of treatment, the therapist worked with the subjects to identify innocuous cues in their environment that triggered trauma responses, and engaged in problem-solving to develop positive coping strategies to address these cues. After developing coping skills to address trauma cues, the therapist reinforced with both subjects the importance of practicing to master the skills to create positive habits and to increase safety in the future in order not to re-experience trauma. Although the subjects may not opt to implement the skills, the importance was to try them and use them as frequently and consistently as possible in order to make progress rather than to achieve perfection.

Sam's trauma reminders.

Sam identified loud noises, boisterous peer interactions, and being accused of things he did not do as reminders of physical abuse. He paired these experiences with ones that he had with his mother who would yell and shout to control his behavior and discipline him. Additionally, he believed his mother often punished him for things he did not do or for things his younger siblings did. Sam acknowledged that he is easily irritated and becomes confrontational with other when he experiences the trigger cues which often lead to negative consequences.

Safety planning.

The therapist discussed steps that Sam can take in response to cues and identified the following: (1) ignore what is going on around him, (2) use self-talk to tell himself that "things will be okay", "not to stoop down to peers' level of negative behavior", "think about what the outcomes are if I react negatively", "this is not worth my time and energy", (3) go to his room and use relaxation skills, (4) talk to staff about the problem for support or for intervention. If wrongly accused of something, Sam identified the following interventions: (1) use self talk to "not jump to conclusions", say "I can get through this", "I'll be treated in the way that I act", (2) ask to talk to staff if wrongfully accused by peers or staff in order to process the problem and elicit support, (3) ask to speak to the Senior Counselor if the problem cannot be resolved with direct care staff, and (4) speak with his therapist so that the problem can be addressed and support can be obtained.

After discharge from residential treatment, Sam projected that he will return to his grandmother in Pennsylvania and that both will receive in-home therapy services to facilitate the transition home. Furthermore, he planned to complete his senior year of high school and work part-time to earn spending money. Because a concern of his was the possible deterioration of his grandmother's cardiovascular health, he planned to assist her around her house as much as possible. To minimize risk of future incarceration or another out-of-home placement, Sam identified the fact that he needs to stay at home more rather than loitering and cavorting with negative peers, stay busy with sports and part-time work, and attend to school.

In the long-term, Sam plans to graduate from high school, get a full-time job, and get a car and an apartment. Granted his grandmother's health is good in the next year or two, Sam acknowledged that the success of remaining at home and in the community is dependent his decisions.

Victor's trauma reminders.

Victor identified two trauma cues: listening to his mother's favorite song, played every night on the radio station he listens to at bedtime, and other people dying. In response to hearing the song every night, Victor indicated that he cries upon hearing it because it reminds him of his mother. He added that he tries not to cry and covers his face with a blanket or pillow fearing that someone will walk into his room and see him crying. Victor discussed how his friend overdosed and died a couple of months ago; this triggered thoughts of traumatic grief which resulted in his smoking marijuana after achieving almost a year of sobriety.

The therapist asked Victor whether it was positive or negative for him to listen or to avoid the song on the radio. He indicated that it was not a bad thing although he did not like crying or "risk getting caught" crying. He reported that his sister is reminded of their mother by a specific song but often insists on listening to it and crying even after Victor urges her to switch the station. The therapist discussed with Victor observable gender differences in the open display of emotions such as sadness. The therapist supported him because he does not avoid listening to the same song every evening, and reinforced the idea that avoidance often reinforces negative feelings. Victor acknowledged that he does not want to "break down" in public; however, he came to

agree with the therapist that crying in private was an acceptable way to grieve the loss of his mother.

Safety planning.

The therapist addressed the fact that there will always be reminders of the deceased throughout his lifetime, through songs, smells, experiences, talking with others about the deceased, he and his sister displaying characteristics of their mother, and meeting people that may remind him of his mother in looks or personality. Therefore Victor learned that it is important to desensitize oneself to certain reminders of the deceased in order to cope with other unexpected reminders that spontaneously emerge in life.

Victor and the therapist discussed how the death of others that are close to him will remind him his mother's death. The therapist indicated that this is an inevitable occurrence and that it is normal to experience parallel thoughts and feelings. Victor and the therapist focused on how he could prevent relapse of substance abuse in response to the death of a significant other. Victor was prompted to discuss what he had learned while receiving additional outpatient drug and alcohol treatment services in the last nine months outside of residential treatment. He reported that he learned to forgive himself for relapsing and "to get back on the horse". He added that he learned to stop using his problems as reasons to use drugs. Victor gave the example, "I used because my friend just died", as a type of thought to eliminate.

Victor explained how he used to rob houses to get money to support his drug habit and partying lifestyle. To counteract this risk, he plans to obtain a job during the

summer and to work as many hours as he can in order to earn money, to stay active and busy, and to avoid boredom. Because he recently graduated from high school, he wants to enlist in the U.S. Coast Guard Service in a few months to serve the country and to earn money for college.

He added that he intends to receive outpatient therapy and drug and alcohol treatment services after being discharged from the residential program, and understands that he needs to continue taking psychotropic medication to manage symptoms of Bipolar Disorder.

Treatment Outcome Assessment

All subjects were asked to complete a battery of six measures (BASC-SRP, CDI, JBC Self-Appraisal From, RCMAS, TSCC, and WAI) at pretest, midpoint in treatment, and posttest to assess treatment outcome. Two subjects, "Sam" and "Victor" completed full batteries at all three assessment points, but "Alice" was assessed only at pretest because she ran away from the program after session two. A senior resident counselor completed the JBC-Observer Form and the BASC-PRS to obtain observer data at pretest for all subjects and at mid treatment and post treatment for Sam and Victor. The following is a summary of the assessment outcome data.

Behavior assessment system for children self-report of personality (BASC-SRP).

Subjects' *T score*s on the BASC-SRP are found in Table 1. Subjects' scores were compared to a clinical normed group in which subjects' scores were compared to scores for peers in a clinical/mental health sample. Based on the caution index on the BASC-

SRP, Alice's assessment was valid. *T scores* for all clinical scales (e.g., attitude to school, attitude to teachers, sensation seeking, atypicality, locus of control, somatization, social stress, anxiety, depression, sense of inadequacy) were within *average* range. Scores for adaptive scales (e.g., interpersonal, self-esteem, and self-reliance) were also *average* except for an *at-risk* score range on the *relations with parents* subscale.

Results on the BASC-SRP at pretest and midpoint for Sam were regarded as cautious. The V (validity) index showed that he may have answered questions carelessly, failed to understand certain questions on the questionnaire, or was not cooperative in the question-answer process on the BASC-SRP. Furthermore, Sam's answers on the measure showed very high levels of inconsistent answers and patterned responding in which he may have been responding to questions with no regard for the item content. Sam showed that he functioned in the *average* range in all clinical scales with the exception of having scored in the *at-risk* range for depression and sense of inadequacy subscales. On the adaptive scales, he exhibited *at-risk* scores in self-esteem and self-reliance, and scored within the average range for relationships with parents and interpersonal skills.

At posttest assessment, Sam again generated a questionable performance on the BASC-SRP. Although his response pattern and consistency in answering questions were in the acceptable range, it was evident that he may have attempted to place himself in an "unfavorable light" by giving excessively negative responses in describing his own behaviors as shown in the F index. Conversely, Sam also may have attempted to "fake good" as seen in the L scale and to lie about his true perceptions of his behavior. Additionally, he answered questions carelessly and uncooperatively as reflected in V

index. Post test scores revealed *average* functioning on all clinical scales and functioning in the *average* range on all adaptive scales. Therefore, from pretest and midpoint to post-test, Sam's responses on the BASC-SRP exhibited changes in *T score* ranges with respect to depression, sense of inadequacy, self-esteem and self-reliance.

Victor's pre test BASC-SRP scores generated a valid assessment. At midpoint, the results cautioned that he may have attempted to "fake good" by answering questions in a manner that portrays him favorably. *T score*s on the clinical scales spanned from the *low* to *average* range. Victor's functioning in the adaptive scales indicated *average functioning* on all subscales. Overall, scores on the BASC-SRP at pretest and midpoint showed that he did not exhibit any significant or at-risk behaviors based on his self-assessment.

At posttest, BASC-SRP results indicated caution with respect to his response pattern on certain question items. This suggests that he may not have been responding with much care and answered questions with little regard. Clinical scales scores reflected *low* to *average T score*s, indicating low risk. Adaptive scales scores indicated *average* functioning with the exception of having scored in the *at-risk* range in the self-reliance subscale.

Table 1

T scores for the BASC-SRP

	Alice	Sam			Victor		
Scale and Subscales	**Pretest**	**Pretest**	**Midpoint**	**Posttest**	**Pretest**	**Midpoint**	**Posttest**
Clinical Scales							
Attitude to school	44	54	50	47	35	35	38
Attitude to teachers	36	50	51	54	36	40	47
Sensation seeking	59	56	55	45	48	48	45
Atypicality	56	52	58	48	40	35	38
Locus of control	54	50	48	56	43	40	35
Somatization	56	52	56	47	47	42	42
Social Stress	49	46	47	44	36	36	44
Anxiety	49	40	47	44	39	37	37
Depression	49	58	62	54	41	41	43
Inadequacy	52	62	62	58	35	35	35
Adaptive Scales							
Rel. w/ parents	37	52	49	49	49	62	49
Interper. Relations	58	50	47	53	56	58	47
Self-Esteem	59	35	39	47	59	59	55
Self-Reliance	48	30	36	42	53	59	36

Note. The values represent the *t scores* obtained for subjects on the Behavior Assessment System for Children – Self-Report of Personality.
[a]*T score* values for clinical scales >60 indicate at-risk or significant problems.
[b]*T score* values for adaptive scales <40 indicate at-risk of significant problems.

Behavior assessment system for children parent rating scales (BASC-PRS).

The BASC-PRS questionnaire consists of Caution Indexes which assess the validity of the responses by the parent-rater. The Caution Indexes include the following: F Index which indicates the presence of significant maladaptive behavior that the parent-rater reports and suggests whether or not the parent-rater rates the child severely; Patterned Responding indicates the parent-rater may answer questions in a sequential manner that does not reflect true responses to questions; and the Consistency Index measures the extent to which a rater responds differently to similar questions.

The BASC-PRS has the following Clinical Scales to measure a parent-rater's appraisal of a child in the following areas of functioning subscales: externalizing Problems (hyperactivity, aggression, conduct problems, internalizing Problems (anxiety, depression, somatization) a typicality ("odd behaviors"), withdrawal, and attention problems. The BASC-PRS has Adaptive Scales (social skills and leadership), which reflect a child's ability to interact appropriately with peers and adults as well as his or her ability to work well with others and accomplish academic, social, and community goals. All subjects were compared to a clinical, normed group in which subjects scores were compared to scores for peers in a clinical/mental health sample. Results for the BASC-PRS are seen in Table 2.

The Senior Counselor's completion of the BASC-PRS for Alice at pre test yielded a valid assessment. *T score*s on the clinical scales revealed *average* functioning in all subscales except for appraising Alice in the *at risk* range for conduct problems and anxiety. Alice obtained *average* scores on adaptive scales. Therefore the Senior

Counselor rated Alice as having demonstrated adequate overall functioning, but exhibiting the propensity to have delinquent behavior and exhibit anxious symptoms.

The BASC-PRS at pretest, midpoint, and posttest for Sam were valid. Both pre-test and mid point assessments showed that Sam functioned in the *average* range in all clinical scales, *average* range in adaptive scale. At posttest Sam obtained *average* scores on all clinical scales; however, he obtained *low* scores in the anxiety subscale. The adaptive scales score for leadership was in the *at-risk* range.

The BASC-PRS for Victor at pretest, midpoint, and posttest were valid. At pre-test, Victor obtained *average* ratings in all clinical scales except for having obtained *low* ratings in hyperactivity, anxiety, withdrawal, and attention problems. Pretest adaptive scales indicated that he was in the *average* range both for social skills and for leadership. At midpoint, Victor exhibited *average* functioning in all clinical subscales with the exception of being rated in the *at-risk* range in the subscales of aggression, conduct problems, and somatization. Adaptive scales at midpoint showed that Victor had *at-risk* scores in social skills and *average* scores in leadership. Posttest scores on the clinical scales showed *low* to *average* ratings on all subscales except for an *at-risk* rating on the aggression subscale. Ratings of the adaptive scales revealed *average* functioning in social skills and *at-risk* functioning in leadership. A comparison of pretest and posttest rating changes indicated a decrease in risk for somatization and an increase in risk for leadership. Other clinical scale ratings remained either in the *low* or *average* risk categories.

Table 2

T scores for the BASC-PRS

	Alice	Sam			Victor		
Scale and Subscales	**Pretest**	**Pretest**	**Midpoint**	**Posttest**	**Pretest**	**Midpoint**	**Posttest**
Clinical Scales							
Hyperactivity	50	48	52	46	39	52	46
Aggression	41	48	50	54	50	66	62
Conduct Problems	65	57	54	49	57	67	54
Anxiety	61	46	46	37	39	49	42
Depression	49	47	45	44	45	52	45
Somatization	43	46	53	46	56	63	41
Atypicality	54	46	49	49	43	35	40
Withdrawl	40	42	43	43	40	48	40
Attention Problems	55	49	46	58	31	37	34
Adaptive Scales							
Social Skills	55	47	46	44	49	41	44
Leadership	54	42	47	39	56	46	39

Note. The values represent the *t scores* on the Behavior Assessment System for Children- Parent Rating Scale

[a]*T score* values for clinical scales >60 indicate at-risk or significant problems

[b]*T score* values for adaptive scales <40 indicate at-risk of significant problems

Children's depression inventory (CDI).

Results for the CDI are found in Table 3. Alice's pretest responses on the CDI revealed *average* scores for Total Depression, Negative Mood, Ineffectiveness, Anhedonia, and Negative Self-Esteem, and *slightly below average* scores for Interpersonal Problems. These scores indicate that Alice reported average experience of depression relative to other individuals her own age. Sam's responses on the CDI revealed *below average* to *slightly above average* for total depression and all depression subscales. There was an increase in scores for Negative Mood from pretest to midpoint from *below average to slightly above average.* However, scores for the Negative Mood subscale returned to the *below average rang* at posttest. A change occurred on the Anhedonia subscale (loss of interest/pleasure) in scores that went from *slightly above average* at pretest to *average* at posttest. Scores on the Interpersonal Problems subscale remained *slightly above average* from pretest to posttest.

Pretest, midpoint, and posttest scores for Vincent on the CDI revealed overall *below average* to *average* scores on total depression and depression subscales. However, scores on the Interpersonal Problems subscale decreased from *average* to slightly below average from pretest to posttest.

Table 3

T scores for the CDI

	Alice	Sam			Victor		
Scale	**Pretest**	**Pretest**	**Midpoint**	**Posttest**	**Pretest**	**Midpoint**	**Posttest**
Total CDI	46	47	54	45	39	36	39
Negative Mood	48	39	62	39	39	39	39
Interpersonal Prob.	43	56	50	56	50	44	44
Ineffectiveness	52	43	53	38	38	38	38
Anhedonia	45	60	44	48	37	37	44
Negative Self-Est.	45	40	64	52	45	40	39

Note. The values represent the *t scores* on the Children's Depression Inventory.
[a]*T scores* below 30 = *very much below average*, 30 to 34 = *much below average*, 35 to 39 = *below average*, 40 to 44 = *slightly below average*, 45 to 55 = *average*, 56 to 60 = *slightly above average*, 61 to 65 = *above average*, 66 to 70 = *much above average*, above 70 = *very much above average.*

Jesness behavior checklist self-appraisal (JBC S-A).

The JBC S-A measured subjects' self-reports of social behavior. Scales measuring levels of social behavior include: unobtrusiveness (agreeable), friendliness, responsibility, considerateness, independence, rapport, enthusiasm, sociability, conformity, calmness, communication, insight, social control, and anger control. Interpretative guidelines indicate higher *T score*s on scales indicate increased functionality in each area. Table 4 summarizes subjects' *T score*s on the JBC S-A at pretest, midpoint, and posttest.

Pretest administration of the JBC S-A revealed that Alice reported *average* functioning in the areas of unobtrusiveness, friendliness, responsibility, considerateness, conformity, and social control. She reported *slightly above average* functioning in enthusiasm, *above average* functioning in sociability, communication, and insight.

Conversely, Alice reported *slightly below average* functioning in independence, *below average* functioning in anger control, and *much below average* functioning in rapport and calmness.

Sam's responses on the JBC S-A revealed increases in *T score*s by at least two standard deviations from the mean in the following scales: responsibility (*very much below average* rating increased to *slightly above average*), considerateness (*much below average* rating increased to *slightly above average)*, enthusiasm (*very much below average* rating increased to *average*), calmness (*much below average* rating increased to *average*), and communication (*below average* rating increased to *average*), insight (*average* rating increased to *above average*), and anger control (*very much below average* rating increased to *average*).

Increased scores beyond one standard deviation were observed in the following scales: social control *(below average* to *slightly below average*). However, Sam scored within the below average ranges and showed decreases in *T score*s from pretest to posttest in scales measuring unobtrusiveness and conformity. Scores in the following scales remained unchanged at pretest and posttest points: sociability (*average),* friendliness (*below average)*, independence (*very much below average*), and rapport (*much below average*). Overall, Sam's scores represented notable improvements in half the scales measuring social functioning and behavior.

Table 4

T scores for the JBC-SA

	Alice	Sam			Victor		
Scale	**Pretest**	**Pretest**	**Midpoint**	**Posttest**	**Pretest**	**Midpoint**	**Posttest**
Unobtrusiveness	51	40	43	39	58	56	54
Friendliness	53	36	44	39	63	67	67
Responsibility	47	26	28	53	80	80	80
Considerateness	49	36	30	56	80	80	80
Independence	43	28	35	28	53	56	63
Rapport	33	33	27	33	80	80	80
Enthusiasm	56	37	29	52	69	69	74
Sociability	63	43	45	50	80	80	73
Conformity	53	36	39	31	56	58	67
Calmness	31	23	30	52	61	63	65
Communication	65	36	47	47	80	80	80
Insight	62	46	57	65	80	80	73
Social Control	45	35	35	41	80	80	80
Anger Control	38	29	12	45	77	77	77

Note. The values represent the *t scores* on the Jesness Behavior Checklist - Self-Appraisal Form.
[a]*T score*s below 30 = *very much below average*, 30 to 34 = *much below average*, 35 to 39 = *below average*, 40 to 44 = *slightly below average*, 45 to 55 = *average*, 56 to 60 = *slightly above average*, 61 to 65 = *above average*, 66 to 70 = *much above average*, above 70 = *very much above average.*

Jesness behavior checklist observer (JBC-O).

The JBC-O was completed by the Senior Resident Counselor to rate each subject on areas of social behavior and functioning, based on adult/parent observation. Subjects' *T score* ratings on the JBC-O at pretest, midpoint, and posttest are found in Table 5.

At pretest, Alice was rated as functioning between *average* to *very much above average* on scales of social behavior. Specifically, she obtained *average* scores on scales measuring responsibility, independence, conformity, social control, and anger control. Alice obtained a *slightly above average* rating for unobtrusiveness; *above average ratings* for rapport, calmness, communication, and insight; and *very much above average* ratings for friendliness, considerateness, enthusiasm, and sociability. Overall, Alice was observed as having satisfactory social functioning at pretest.

Scores on the JBC-O for Sam from pretest to posttest showed increases in *T score*s for unobtrusiveness (*below average* to *average)*, friendliness (*slightly below average* to *average)*, considerateness (*average* to *much above average)*, independence (*above average* to *very much above average*), rapport (*average* to *above average*), enthusiasm (*slightly below average* to *average)*, sociability (*slightly above average* to *much above average*), calmness (*slightly above average* to *above average*)*,* and communication (*average* to *above average*). Decreases were found in responsibility (*slightly below average* to *below average)*, insight (*above average* to *average),* and social control (*much below average* to *very much below average*), whereas no change occurred with respect to anger control, which remained at *below average.* Overall, Sam was observed as having exhibited improvement in ten out of fourteen scales measuring social behavior on the JBC-O from pretest to posttest.

Victor's scores on the JBC-O from pretest to posttest revealed observed increases in *T score*s for scales measuring unobtrusiveness (*very much below average* to *much below average)*, friendliness (*below average* to slightly below average*)*, responsibility (*average* to *above average*), conformity (*below average* to *average*), communication (*much above average* to *very much above average*), insight (*much above average* to *very much above average*), and social control (*average* to *much above average*). Constant ratings from pretest to posttest were found in scales measuring considerateness (*average* to *below average*), sociability (*average* to *much below average*), and anger control (*slightly below average* to *very much below average)*. Scores remained constant in independence (*very much above average*), enthusiasm (*average)*, calmness (*average*), and social control (*average)*. Overall, Victor exhibited satisfactory social functioning in the majority of JBC-O scales and showed improvement in seven scales and maintained *average* or above ratings in four scales.

Table 5

T scores for the JBC-O

	Alice	Sam			Victor		
Scale	**Pretest**	**Pretest**	**Midpoint**	**Posttest**	**Pretest**	**Midpoint**	**Posttest**
Unobtrusiveness	60	38	35	47	23	32	32
Friendliness	77	44	39	47	36	34	44
Responsibility	53	43	45	34	49	38	65
Considerateness	72	53	56	69	49	47	38
Independence	48	63	72	80	72	72	72
Rapport	65	54	50	61	61	50	74
Enthusiasm	80	40	44	52	48	44	52
Sociability	73	59	63	63	50	39	34
Conformity	53	47	46	53	40	36	47
Calmness	61	58	61	65	52	46	48
Communication	64	55	68	64	68	68	71
Insight	61	65	52	54	65	61	68
Social Control	54	32	35	30	52	47	45
Anger Control	52	35	32	38	38	29	28

Note. The values represent the *t scores* on the Jesness Behavior Checklist - Observer Form.
[a]*T score*s below 30 = *very much below average*, 30 to 34 = *much below average*, 35 to 39 = *below average*, 40 to 44 = *slightly below average*, 45 to 55 = *average*, 56 to 60 = *slightly above average*, 61 to 65 = *above average*, 66 to 70 = *much above average*, above 70 = *very much above average.*

Revised children's manifest anxiety scale (RCMAS).

The RCMAS was administered to measure subjects' overall physiological anxiety, level of worry/oversensitivity, social concerns/concentration, overall anxiety, and subjects' proclivity to lie or "fake good" about their anxiety. Subjects' percentile ranks are found in Table 6, indicating the percent of normed peers' subjects exceeded in measures of anxiety and lying about anxiety symptoms.

At pretest, Alice's scores on the RCMAS ranked her in the following percentiles: total anxiety (85th percentile) physiological anxiety (70th percentile), worry/oversensitivity (50th percentile), social concerns (94th percentile), and lie (8th percentile). Overall, Alice revealed that she may have been experiencing moderate to very high levels of anxiety at pretest but her tendency to lie about her symptoms was low.

Sam's responses on the RCMAS showed the following percentile ranks with respect to pretest, midpoint, and posttest assessment points: total anxiety (48th percentile, 60th percentile, and 27th percentile), physiological anxiety (67th percentile, 89th percentile, and 25th percentile), worry/oversensitivity (47th percentile, 58th percentile, and 22nd percentile), social concerns/concentration (44th percentile, 27th percentile, and 27th percentile), and lie (54th percentile, 54th percentile, and 91st percentile). Pretest and midpoint administration of the RCMAS revealed that he experienced an average level of anxiety compared to peers, but exhibited relatively higher level of physiological anxiety at midpoint. At posttest assessment, Sam's RCMAS revealed lower levels of anxiety but a very high inclination to lie about symptoms.

At pretest, midpoint, and posttest, Victor's RCMAS scores reflected the following percentile ranks were as follows: total anxiety (2nd percentile, 2nd percentile, and 18th

percentile), physiological anxiety (9th percentile, 9th percentile, and 68th percentile), worry/oversensitivity (8th percentile at all three points), social concerns/concentration (9th percentile at all three points), and lie (90th percentile, 99th percentile, and 90th percentile). Victor's scores on the RCMAS indicate a strong tendency to lie about or deny symptoms of anxiety. Furthermore, he did not report feelings of anxiety as reflected as scoring in the 68th percentile for physiological anxiety at posttest.

Table 6

Percentile Ranks for Subjects Scores on the RCMAS

	Alice	**Sam**			**Victor**		
Scale	**Pretest**	**Pretest**	**Midpoint**	**Posttest**	**Pretest**	**Midpoint**	**Posttest**
Total anxiety	85	48	60	27	2	2	18
Physiological anxiety	70	67	89	25	9	9	68
Worry/ oversensitivity	50	47	58	22	8	8	8
Social concerns/ concentration	94	44	27	27	9	9	9
Lie	8	54	54	91	90	99	90

Note. The percentile ranks reflect the percentage of normed peers subjects exceeded.

Trauma symptom checklist for children (TSCC).

Subjects' *T score*s for the TSCC are seen in Table 7. *T score*s of 65 or higher are considered clinically significant and *T scores* in the range of 60 to 65 suggest difficulty and may represent sub-clinical symptomatology. Alice'*s* pretest responses on the TSCC were valid and revealed *average* scores in anxiety, depression, anger, and posttraumatic stress subscales. In the dissociation subscale, Alice had a *T score* of 63 for fantasy dissociation, thus suggesting she may engage in daydreaming or pretending to be someone else or be somewhere else to avoid dealing with the "real" world. She had a *T score* of 65 on the sexual preoccupation scale, suggesting that she may have the compulsion to exhibit sexually provocative behavior.

Sam's pretest scores on the TSCC revealed low to average trauma symptoms on all scales. However, pretest and posttest assessment showed respective *T scores* of 70 and 74 on the under response scale, suggesting careless responding to questions without regard for item content. Sam also obtain *T scores* of 67, 87, and 67 at pretest, midpoint, and posttest on the hyper response scale, suggesting that he may have indiscriminately chosen high scores for items that are not typically scored high in normed samples. TSCC scores in all symptom scales were visibly augmented at midpoint as all but three scales indicated above average to extreme levels trauma symptomatology. However, at posttest all scales diminished to low to average range except for the scale measuring sexual concerns (distress), which remained at a clinically significant level.

Victor's scores on the RCMAS revealed low symptoms of anxiety from pretest to posttest. However, he obtained a *T score* of 70 for the under response scale at all assessment points, indicating a tendency to deny symptoms, be avoidant or defensive

about acknowledging thoughts, feelings, and behaviors related to trauma. All trauma scales indicated below average symptoms of trauma according to Victor's responses.

Table 7

T scores for the TSCC

	Alice	Sam			Victor		
Scale	**Pretest**	**Pretest**	**Midpoint**	**Posttest**	**Pretest**	**Midpoint**	**Posttest**
Underresponse	42	70	42	74	70	70	74
Hyperresponse	46	67	87	67	47	47	47
Anxiety	48	39	77	41	39	44	39
Depression	48	46	69	46	41	41	39
Anger	50	38	59	50	36	41	36
Posttraumatic Stress	55	45	68	41	45	45	43
Dissociation	61	39	79	43	37	37	37
Overt Dissocation	59	42	58	47	39	39	39
Fantasy Dissocation	63	38	61	38	38	38	38
Sexual Concerns	59	51	≥111	51	44	38	38
Sexual Preoccupation	65	48	98	48	42	38	38
Sexual Distress	41	45	≥111	67	56	45	45

Note. The values represent the *t scores* on the Trauma Symptom Checklist for Children.
[a]*T scores* ≥ 65 are considered clinically significant.
[b]*T scores* of 60 to 65 are considered sub-clinical but clinically significant
[c]*T scores* ≥ 70 are considered clinically significant for the Sexual Concerns, Preoccupation, and Distress.

Working alliance inventory (WAI).

Subjects completed the WAI to assess levels of working alliance between subject and therapist over the course of receiving TF-CBT. The 36-item questionnaire consists of twelve questions in each of the three areas of alliance: bond, agreement on therapy tasks, and agreement on therapy goals. A maximum of 60 points is summed in each area of alliance. The questionnaire was qualitatively reviewed to assess levels of alliance because there is no available rating scale. Results for the WAI are found in Table 8.

Pretest administration of the WAI for Alice revealed the following scores: bond (43), agreement on tasks (43), and agreement on goals (40), thus indicating an above average level of alliance between subject and therapist at the pretest assessment point.

Sam's WAI assessment at pretest, midpoint, and posttest revealed the following respective scores: bond (44, 45, and 55), agreement on tasks (43, 41, and 55), and agreement on goals (43, 44, and 52). His scores initially fell within an above average range for overall alliance ratings and ended with ratings in the high range.

Victor's ratings on the WAI from pretest to posttest revealed the following: bond (55, 60, and 60), agreement on tasks (55, 60, and 60, and agreement on goals (53, 60, and 60) which indicated scores increased as therapy progressed and remained in the high range.

Table 8

T scores for the WAI

	Alice	**Sam**			**Victor**		
Scale	**Pretest**	**Pretest**	**Midpoint**	**Posttest**	**Pretest**	**Midpoint**	**Posttest**
Bond	43	44	45	55	55	60	60
Task	43	43	41	52	53	60	60
Goal	40	43	44	55	55	60	60

Note. The values represent the subjects' raw scores on the Working Alliance Inventory
[a]Highest possible score on each scale of the WAI is 60.

Chapter 4: Discussion

Summary and Interpretation of Results

To evaluate the transportability and effectiveness of applying TF-CBT to an older adolescent population in residential treatment setting, a case study of three subjects, ages 15 to 17, was performed. Two of the three subjects, Sam and Victor, completed the entire treatment series during which subjects engaged in 12 individual therapy sessions for six weeks with the responsible investigator who served as the therapist for the study. However, the third subject, Alice, was discontinued from the study after having run away from the treatment facility at the end of the second week of treatment.

Sam and Victor completed all outcome measures at pretest, midpoint, and posttest data points over the course of six weeks of treatment. Alice, whose results are briefly discussed, completed measures at pretest. An evaluation of the data collected from the measures for Sam and Victor suggest overall improved functioning in subjects' personality, cognitive, emotional, behavioral, and social functioning after having received six weeks of TF-CBT. Subjects' improvement appeared to be most evident in the BASC-SRP, BASC-PRS, JBC-SA, JBC-O. Pretest and posttest comparisons of self and observer scores on the BASC and JBC measures revealed some slight and significant directional changes in subjects' functioning, in keeping with the research hypotheses, thus implying self-reported and observed improvement in overall functioning. Based on all outcome measures for Sam and Victor, subjects exhibited positive outcomes after having received six weeks of TF-CBT in a residential setting.

Alice – evaluation of outcome.

An evaluation of Alice's measures at pretest revealed satisfactory personality, emotional, and behavioral functioning compared to peers in a clinical population, based on Senior Counselor ratings on the BASC-PRS. However, the Senior Counselor rated Alice as being *at*-risk for conduct problems by indicating that she sometimes got into trouble with the police, stole from home, ran away from home, and seized opportunities to abuse drugs and alcohol, or to use tobacco. This rating was congruent with documented instances of running away behavior because of parent-child discord during home visits, a history of marijuana and nicotine use, and involvement with the legal system for assaultive behavior towards her parents. Alice's ratings on the BASC-SRP indicated satisfactory functioning as well. However, an *at-risk* rating registered on the relations with parents subscale on the BASC-SRP. The *at-risk* rating appeared to be congruent with the historically poor relationship with her parents as reported by Alice in the second TF-CBT session and as documented in the family history section of her intake assessment.

A comparison of the JBC-SA and JBC-O show a contrast in Alice's self-report of social functioning compared to the appraisal of the Senior Counselor. Although Alice appeared to report average to above average levels of functioning in many areas of social behavior, she also rated herself substantially lower in the rapport and calmness scales compared to high ratings by the Senior Counselor. Therefore it is evident that she is able to present as being more functional than she is in actuality, and demonstrates the potential to behave appropriately. However this could also be problematic because a "cover up" of actual thoughts, feelings, and behaviors in relation to social functioning may lead others

to believe that she is “fine” and “okay”. It is also inferred that she may not be apt to display her “true self” because she has reported difficulties trusting adults because she was not able to trust her own parents.

An evaluation of the CDI at pretest indicated low levels of depressive symptoms for Alice. She acknowledged having experienced feelings of sadness and depression when she and the therapist discussed different post-trauma symptoms in the initial TF-CBT session. However she did not indicate recent feelings of depression. Because the CDI asks a person to rate, on the questionnaire, his or her feelings experienced in the previous two weeks, it may not be an accurate assessment of the depression she experienced in recent months versus recent weeks. It is plausible, had she remained in the study, CDI scores would have reflected increased feelings of depression, resulting from the conflict situation between Alice and her parents during a home visit following the initial TF-CBT session. Alice’s scores on the RCMAS revealed high levels of anxiety because she was in the 85th percentile for total anxiety.

Sub-clinical scores on the TSCC for sexual preoccupation concerns were congruent with past reports of Alice’s tendency to engage in aggressive, dominant, and sexually coercive behavior with female peers. She also may have experienced issues about her sexual orientation because she was femininely dressed for a formal dance, but dressed in a masculine fashion on a daily basis and exhibited attraction to members of the same sex. Sub-clinical scores for dissociation (fantasy) may be supported by Alice’s desire to be someone she is not, but is evidenced in her need to “escape” reality and life difficulties through substance abuse and through running away from home.

The strength of the alliance between Alice and the therapist was not able to be assessed beyond the pretest data point. However, based on the initial scores on the WAI, it appears that she experienced a moderately high level of alliance with the therapist. The level of alliance at pretest may have likely been high due to the visible presence of the therapist in the therapeutic milieu of the residential treatment environment. Although the therapist had provided therapy to Alice prior to involvement in the study, the fact she interacted with the therapist (i.e., saying "hello" in passing, hearing about the therapist through peers) may have increased the probability of a stronger alliance at the start of TF-CBT sessions, thus already "breaking the ice".

Victor - evaluation of outcome.

Evaluating pretest and posttest BASC-PRS assessment for Victor, scores largely remained in the low to average risk range on many scales. This implied that Victor was observed as functioning well compared to others in a clinical population. However, observer scores for social skills and leadership reflected slight decompensation in these areas. It may be important to take into consideration that Vincent was approaching discharge from the residential program as he received TF-CBT in the last two and half months of residential treatment. After having spent at least a year at the program, it is plausible that he was beginning exhibit some behavioral decline as his discharge neared.

Similar to the Senior Counselor's ratings on the BASC, Victor's self-report on the BASC indicated low to average risk. However, Victor rated himself as functioning better and at lower risk than his functioning as perceived by the Senior Counselor. The same trend occurred on the JBC-O and JBC-SA. Therefore it seemed that Victor held himself

in high regard in many areas of functioning when in actuality his behavior and coping style was not viewed as such by an observer. It is plausible that Victor may be in denial about the quality and severity of cognitive, emotional, and behavioral functioning, or may attempt to portray himself favorably. Also it was cautioned on the BASC-SRP that Victor may have lied to "look good" and embellish his qualities. Furthermore, it is likely that grandiose beliefs, characteristic of Bipolar Disorder, are evident because he seems to minimize problems.

On the JBC-SA, Victor rated himself average to very high for overall social functioning. There were slight self-reported improvements in specific scales; however, overall ratings contrasted sharply from the Senior Counselor's observer scores. The JBC-O indicated more varied levels of functioning, ranging from very poor to average functioning at pretest and midpoint, and slightly poor to high at posttest. Pretest to posttest results on the JBC-O showed that there were improvements in many areas of social functioning; however Victor's scores appeared more "optimistic" than those of the Senior Counselor's observations of Victor's behavior.

Administration of the CDI at pretest, midpoint, and posttest revealed consistent low levels of depressive symptoms which were congruent with Victor's affect throughout treatment. The RCMAS revealed low levels of anxiety at pretest and midpoint, but registered a moderately high level of physiological anxiety. The surge on this scale of anxiety may have been due to Victor having lost substantial program privileges because of a severe level drop in the program's level system. The RCMAS also revealed Victor's inclination to lie about anxiety symptoms which further supports the claim of Victor is minimizing or denying problems.

The TSCC revealed low levels of trauma symptomatology at all data points. However, Victor consistently showed a high degree of under responding which meant he had a tendency of denying behaviors, thoughts, and feelings that others would report at some level on the measure. He was cooperative and forthcoming throughout the entire treatment process and did not exhibit defensive or oppositional characteristics in test-taking or therapy sessions. However, the pattern of high scores on scales for under responding and lying as seen on the BASC-SRP and the RCMAS further indicate that Victor was inclined to downplay symptoms and problems, and instead view himself as more functional than he is in actuality.

Coupled with the aforementioned characteristics were Victor's ratings on the WAI. At pretest, he had rated his alliance with the therapist as extremely high. By midpoint and posttest, he had given "perfect" scores in each component of alliance (bond, goal, and task). As in Alice's case, it is likely that alliance was easier to establish because Victor was pre-exposed to the therapist because he had group therapy with the therapist in previous months. However, perfect scores for alliance may support the previous suggestion that Victor may be overly optimistic about events and situations, and ignore or be in denial about the actual state of affairs in reality.

Sam – evaluation of outcome.

The validity of Sam's results on the BASC-SRP were considered with caution because it appeared as though approached the questionnaire in a non-serious and careless manner; he did not read items carefully or did not read them at all. At pretest, areas registering some impairment in functioning included: depression, sense of inadequacy,

self-esteem and self-reliance, implying Sam's tendency to feel sad and unsure of himself. However at posttest, Sam's scores in these areas improved into the average range of functioning. Therefore it appears Sam's opinion of cognitive, emotional, and behavioral functioning increased from pre- to posttest.

Pretest, midpoint, and posttest administration of the BASC-PRS were valid and revealed similar results in functioning. Overall the majority of the Senior Counselor's ratings of Sam's functioning remained in the average range, but slight decreases were noted on scales for conduct problems and anxiety, indicating observed improvement in these areas of emotional and behavioral functioning. Therefore compared to peers in a clinical population, Sam's functioning appears to have remained largely in the average range with slight improvement in specific areas.

Although the JBC-SA lacks a validity scale, Sam appeared to complete the measure in a more serious manner as the results obtained were observably different from results on the BASC-SRP. One reason for this may be that the BASC-SRP consists of "true or false" answer options, but the JBC-SA requires a respondent to answer on a 5-point likert-type scale, which may yield more accurate responding compared to a 50/50, "hit or miss" response pattern. An evaluation of Sam's pretest and posttest self-report on the JBC-SA reveal improved functioning in multiple areas because numerous scales of social functioning increased from the very poor range to the average or above average range within a six-week period.

The Senior Counselor's ratings on the JBC-O from pretest to posttest revealed similar improvement patterns because observer ratings of Sam's social functioning increased from low/average at pretest to above average/very high ranges at posttest

within a six-week period. However, a disparity was evident between Sam's ratings and the Senior Counselor ratings. It appeared that Sam perceived himself as less functional at all data points compared to the Senior Counselor's observation. This implies that Sam can present himself as more functional than he perceives himself to be. This observation is congruent with findings of sub-clinical ratings for depression, self-esteem, and self-reliance, therefore implying that Sam may have a negative self-image of himself even though he demonstrates the capability and potential to function adequately in cognitive, emotional, behavioral, and social domains.

Sam's ratings on the CDI further evidenced slight depressive symptomatology. Slightly above average symptoms were revealed at pretest, increased to above average at midpoint, but decreased to average levels at posttest. It is plausible that midpoint scores "spiked" in response to Sam„s being dropped in his behavioral levels as a result of negative behavior incidents that occurred at this point in treatment, thus resulting in Sam's having experienced an increase in negative mood. However depressive symptomatology decreased overall from pre- to posttest.

Results of the RCMAS were regarded with caution because Sam showed an average to high tendency to lie about feelings of anxiety. However results at pretest indicated that Sam reported a moderate level of anxiety, moderate to high levels at treatment midpoint, and low levels of anxiety at posttest. Again, "spiked" symptoms at midpoint on the RCMAS, as seen on the CDI, may also be attributed to having been in trouble at the program. It is notable that anxiety symptoms increased at midpoint but problems with social concerns and with concentration decreased as Sam may not have cared about how his behavior affected or bothered others after he engaged in negative

behavior. Low levels of anxiety at posttest indicate decrease in anxiety symptomatology at the end of six weeks of treatment.

TSCC results were considered with caution because the validity of Sam's responses was questionable. He exhibited high levels of under responding and hyper responding similar to his test-taking approach found in the BASC and RCMAS measures. Pretest measures on the TSCC revealed low levels of trauma symptomatology. However Sam's scores at midpoint exhibited significant increases on nearly all clinical scales for trauma, specifically in the sexual concerns domain. Again the ratings may reflect the trouble in which he was involved at the program. Reportedly Sam left his bedroom in the middle of the night through his window, met up with a female peer, and engaged in unprotected sexual intercourse. As a result he lost all his privileges and dropped many behavioral levels. Three weeks later at posttest, Sam TSCC scores returned to below average/average levels, but continued to show slight elevation in the sexual concerns (distress) scale. Perhaps he may have been concerned with the personal repercussions of having engaged in sexual intercourse.

Lastly, Sam's pretest and midpoint ratings on the WAI indicated slightly above average levels of alliance between him and the therapist. However, scores were high at posttest indicating Sam's opinion about the quality and level of alliance had improved since earlier sessions.

Evaluation of Transportability of TF-CBT to a Residential Setting

For the last decade, the efficacy of the TF-CBT model in treating children and young adolescents has been well-supported through controlled clinical trials by the

models developers. TF-CBT has been featured in a number of websites such as the SAMHSA Model Programs and the National Child Traumatic Stress Network, in addition to having its own website at http://tfcbt.musc.edu/ sponsored by the Medical University of South Carolina where individuals can complete on-line training in TF-CBT. Various workshops are offered throughout the United States by trainers in TF-CBT to educate professionals on how to apply the treatment model.

The TF-CBT model, discussed and described in the book, *Treating Trauma and Traumatic Grief in Children and Adolescents* (Cohen, Mannarino, & Deblinger, 2006), outlines and describes, chapter by chapter, the theory, assessment and treatment components, and techniques for applying TF-CBT. These components are also reiterated and reinforced in the aforementioned web-based training. TF-CBT does not specify the settings in which the treatment can be delivered, but highlights the success of its application in outpatient clinics, and with children in foster and group homes who are brought to a setting where TF-CBT is used. Cohen et al. (2006) state, "the grief-focused interventions we describe do not address how to treat children dealing with uncomplicated grief issues or children who have undergone traumatic experiences and separation from parents without death (e.g., placement in a foster home), however it should be noted that children in foster care have responded well to TF-CBT with modifications" (p. 19).

Moreover, the current publication does not specify adaptations or modifications of TF-CBT for its application to a residential treatment population by their own "in house" therapists. Furthermore, much published data on the efficacy of TF-CBT seems to have been done on children and young adolescents (ages 11 to 13) and has not been fully

investigated for older adolescents (ages 14 to 17). Therefore the following discussion, with consideration to the aforementioned outcome data, is meant to shed light in the investigation of treatment transportability of TF-CBT to a residential setting.

Setting the stage.

The current TF-CBT model advises therapists be trained by reading the book, completing the online training, and attending training workshops. The therapist in this study completed the first two but was not able to attend any training workshops because none was offered at the time preceding study onset. However the therapist did attend colloquia on childhood trauma sponsored by the CARES Institute at the University of Medicine and Dentistry of New Jersey, at which an overview of the treatment model was discussed. It appears that in-person training workshops are offered regionally throughout the United States, but are offered at sporadic times. Therefore it may be feasible for many therapists to be trained in TF-CBT only via the book and website. After using TF-CBT in this study, it is clear that reading the book is important as is completing the online training to reinforce learned theory and technique. If a therapist has had prior training in traditional cognitive-behavioral techniques, learning TF-CBT will be familiar because it is relevant to standard CBT practices, yet more specific to diagnoses.

Obtaining subjects for the study through the clinical team at the residential facility was quite simple because the majority of clients at the program present with post-trauma or complex trauma symptoms. Though the treatment facility from which subjects were recruited is a small representation of the larger residential population; many clients at the residential facility had previously been clients at other residential programs. Furthermore

the current residential referral process through the DYFS system in New Jersey is heavily controlled by a systems agency which limits consumer, family, and DYFS choice about the place where youth receive treatment. The probability that residential programs in the State of New Jersey serve consumers with great diagnostic variation is high. Therefore it would be likely that residentially-referred youth with diagnoses such as Bipolar Disorder, Posttraumatic Stress Disorder, or Conduct Disorder can be housed "under the same roof" at various programs throughout the State.

During the subject recruitment phase prior to study onset, one potential candidate declined to assent to participating because she expressed lack of emotional readiness to receive trauma-specific treatment to address issues of severe sexual abuse. In this instance, the therapist respected the client's feelings on the matter and did not include her in the study. The therapist informed her that if she changed her mind, she was welcome to participate but would not be further solicited after initial approach. As with many teens, she may have felt pressured to engage in something against her will had the therapist continued to ask her to participate. Having experienced severe sexual abuse, the pressure to participate in the study could have triggered automatic trauma response from the client. Therefore it is important to gauge and be sensitive to the readiness and comfort level even of older adolescents. This is not to say that such individual should be left to their own devices, especially if they are engaging in harmful, maladaptive, and destructive behaviors resulting from trauma. The alternative would be to involve such youths in other services such as after school therapeutic programs, mentoring, group counseling and support groups to sensitize them to the benefit of therapeutic intervention.

TF-CBT indicates that clients do not have to meet full criteria for PTSD, but should have a history of related symptoms stemming from significantly negative experience(s). Of the three subjects in this study, only Alice had a diagnosis of PTSD because she was a victim of physical abuse by her father. Sam was included in the study because he had the negative experience of being physically abused by his mother and was subsequently removed from his family and placed in foster care for about six years. Victors was included because of having experienced the sudden death of his mother, resulting in unresolved grief issues, because of witnessing the molestation of his cousin, and because of the recent loss of a close friend to drug overdose which re-activated grief issues.

Although largely focusing on treating trauma issues, TF-CBT also incorporates the treating of traumatic grief; this is found in a separate section of the book. The authors advise that psychoeducation and coping strategies (i.e., relaxation skills, affective regulation, and cognitive coping) be discussed before disseminating grief issues. Although this is a recommendation, the therapist applied this format in working with Victor; this seemed to work well because it eased him into discussing trauma issues by first talking about trauma, affect, and cognition superficially.

Another large component of TF-CBT is discussing and encouraging conjoint parent-child therapy sessions. These conjoint sessions also focus on training parents and caregivers in coping strategies in order to help clients cope at home and reinforce therapy techniques that clients learned in sessions. Because a large proportion of clients at the study site are representative of youth in the child welfare system, parents were not included in this study. Instead, the effectiveness of applying TF-CBT to the individual

client was determined through evaluation. Cohn et al. (2006) indicate, "although inclusion of a parent or caretaker is optimal, we have provided TF-CBT to children only which demonstrated significant improvement in PTSD symptoms…while we strongly advocate that parents or other caretaking adults participate in this treatment, we also acknowledge that children may benefit even in the absence of parental involvement" (p. 40).

Psychoeducation & relaxation training segment evaluation.

All subjects were cooperative in beginning TF-CBT with the therapist after completing all pretest measures. As described in the TF-CBT book, all subjects were open to learning about trauma and the impact that trauma can have on their functioning. Subjects were able to discern trauma from normal, everyday negative experiences. However with the exception of Victor, neither Alice nor Sam had received previous formal treatment to address their trauma issues. Therefore it is reasonable to conclude that many adolescent clients in residential treatment may never have received prior trauma intervention until the clients' behaviors "spiraled out of control" at home or in the community. Therefore it appears that early warning signs of post-trauma symptoms should be addressed at early-onset, thereby reducing the probability of a child ever having to go into residential care. None of the problems indicated in the troubleshooting section of the book was experienced by the therapist in the first session, thus making for an easy transition into teaching subjects the relaxation techniques.

As mentioned earlier, Alice was not able to "immediately jump" into learning about relaxation techniques because she had more weighty matters on her mind. In

keeping with the TF-CBT training, it was important to give her some time to discuss present crises rather than to delve into relaxation training at the start of the session. The therapist was able to allocate time to discuss her problem, but reinforced the idea that a segment of the session be dedicated to the agenda topic of relaxation. By allowing Alice about 25 minutes to discuss and process her problem, she was able to move on comfortably with the session agenda. She was able to attend to learning about controlled breathing and appeared to be under less duress at the close of the session. Therefore, as discussed in the treatment model, it is important to give attention to client's personal problems rather than to ignore them. By ignoring a client's crisis is only to disregard what is important to them in the moment, thus risking a loss of rapport building, alliance, and trust.

Both Sam and Victor verbalized the sense of finding the relaxation skills training interesting and helpful. Both subjects were amenable to using relaxation techniques immediately and reported positive results in helping them to relax and to sleep at night. Victor reported at a later point that he used deep breathing and meditation techniques to decrease feelings of anxiety and to decrease his heart rate just prior to receiving oral surgery. He shared the information that his heart rate dropped by about 25 beats per minute, thus reinforcing the effectiveness of using relaxation techniques.

Alice ran away from the residential program after session two. Although it was unfortunate that she was discontinued from the study after an absence of over two weeks, it is possible that she benefited from the two sessions she had with the therapist. The TF-CBT book discusses how participants can experience some benefit from just a few sessions compared to never having received any trauma-specific treatment. Therefore it

is hopeful that Alice is able to incorporate to her knowledge base the psychoeducation and skills provided to her. It would be important for residential providers to know that even short-term application of TF-CBT can have some positive impact in the event that clients run away, become hospitalized, or are incarcerated. Alice never returned to the program, nor did she emerge from hiding over the duration of this study. Had this not been a study, it would have been feasible to resume treatment had she returned. Previous session content would have had to be reviewed in addition to processing with Alice the circumstances surrounding her runaway incident or any other incident that resulted in treatment interruption.

Affective modulation & cognitive coping.

Only Sam and Victor continued on and beyond this segment of treatment. Based on the therapist's experience with both subjects, each subject progressed at different rates. For instance, Victor was able to go through this segment of treatment in two sessions, but Sam required three sessions. The therapist's experience with Sam during this segment of treatment seemed rushed even though three sessions were spent discussing affective and cognitive components. It appeared that Sam was bored and disinterested in this segment which required him to do worksheets as homework. Compared to relaxation training, from which he could tangibly apply and experience immediate results, learning about affect and cognitive distortion may have seemed mundane and depersonalized. However he was able to complete this segment and demonstrate an understanding of the concepts. The treatment manual for TF-CBT does not stipulate the number of sessions per segment, but encourages therapists to concentrate

on segments which clients appear not only to understand better but also appear to gain the most from.

Because different clients present with different levels of resistance, different cognitive functioning levels, different levels of knowledge from previous treatment, and various interest levels, it is conceivable that some components will have a greater focus than others, or have no focus at all. For instance, some subjects experience little difficulty in bringing up detailed trauma issues early in treatment. Therefore development of the trauma narrative segment may begin sooner than planned. Other clients, lacking cognitive sophistication, may need to be reminded of coping strategies throughout treatment and beyond. If a client shows disinterest in specific TF-CBT components, it would be reasonable to move on to the discussion of other components and return later to ones that were skipped.

Evaluation of the trauma narrative & cognitive coping II.

The TF-CBT manual emphasizes the fact that the trauma narrative segment of treatment is the most crucial portion of the treatment process. The trauma narrative is considered to be the "meat" of TF-CBT in order to allow a client to discuss and process their trauma experience(s) safely and without judgment or severe reaction from the therapist. By developing the trauma narrative, the clients can "clean out the closet" and become comfortable with "looking into the face" of their traumas. The manual instructs therapists, in careful increments, to lead clients to provide more and more detail during trauma narrative development. This advisement was not necessary in this study because both Sam and Victor exhibited little difficulty in discussing their traumatic experiences

from the start of trauma narrative development. Over the course of four sessions with each client, the therapist required that both subjects review and sketch details of their experiences and describe in greater detail the thoughts and feelings each one experienced in response to the events. Both subjects were responsive to the therapist's cue to add these details in later sessions and exhibited little resistance in doing so.

Sam exhibited little motivation to write out his trauma narrative. Although the therapist was able to "jot down" a few notes to assist him, Sam was not amenable to writing out the narrative in its entirety. Therefore the therapist focused on engaging Sam in a thorough discussion of trauma and in an examination of thoughts and feelings surrounding the trauma, and in discussing inaccurate thoughts resulting from his trauma experiences. Conversely, Victor took a great interest in writing his trauma narrative and demonstrates exceptional writing skills. He was able to weave in a more detailed analysis of his trauma experiences and exhibited pride with being able to discuss and write about these issues in a therapeutic setting for the first time in his life. In the end of the trauma narrative segment of TF-CBT, Victor emphasized how developing the trauma narrative and evaluating his cognitions, pre-trauma and post-trauma, changed the way he perceived things. He added that he felt differently about his trauma experiences because he felt better after changing his perceptions about these experiences.

When working with a residential population, it is conceivable that clients may be more comfortable talking about trauma issues because they see therapists around the residential grounds on a daily basis. Therefore there is less formality because therapy is conducted at the place where clients live. Because both Sam and Victor had been at the facility for nearly a year and had contact with the therapist through greetings and other

therapeutic avenues, it was not surprising for either subject to exhibit ease when engaged in formal treatment with the therapist.

Transference was apparent; i.e., subjects would "transfer" feelings towards the therapist as they would to an adult female figure in their lives. Prior to their involvement in the study, Sam and Victor had received individual therapy with a primary male therapist. Both Sam and Victor provided feedback to the therapist at the end of trauma narrative sessions and at the end of treatment, indicating that they felt more comfortable expressing their thoughts and feelings about their issues with a female therapist than with their male therapist. This did not imply they could not be forthcoming with their primary therapist merely because he was a male, but rather may have been due to individual and stylistic differences in the delivery of therapy.

Victor was able to talk openly about his grief issues about his mother's death, the recent death of his friend, and feelings of remorse and guilt from witnessing the molestation of his cousin. He specified the fact that he was not able to talk about these issues with his primary therapist in the past and exhibited a great deal of motivation and relief when talking about such issues in the TF-CBT sessions. Victor indicated that he found it difficult to share such intimate thoughts and feelings with his primary therapist because the primary therapist was fully responsible for determining his privilege levels week-to-week, controlled home visit privileges, and controlled his discharge.

Because Victor's primary therapist played an authoritarian, parent-like role in the residential treatment process, Victor found it difficult to talk to him much as a teenager is reluctant to share secrets with his or her parent. Furthermore, because the therapist in this study was not involved in controlling the aforementioned aspects of Victor's case, there

was less child-parent transference, and ultimately fewer barriers to developing therapeutic trust. Thus Victor was more forthcoming about trauma issues because of decreased authoritative influence.

At an outpatient clinic, TF-CBT can be effective in treating adolescents because there are fewer behavioral consequences stemming from the therapist. Outpatient therapists will not likely influence clients' loss of privileges or reprimands for negative behavior compared to the influence of a residential therapist. Because parents or other adult caregivers are responsible for disciplining a client at home, or because of discipline in a foster or group home environment, there is a decreased chance of transference towards an outpatient therapist, whereas a residential therapist may bear more burden. This could influence the quality not only of trauma-specific treatment, but also treatment in general.

The TF-CBT model encourages clients to share their trauma narratives with their parents or caregivers. Because subjects did not receive conjoint parent-child TF-CBT sessions, the therapist did not require subjects to present their trauma narratives to their parents. However, the therapist encouraged subjects to present their narratives to their parents at a later time if they were comfortable with the idea, or during standard family therapy sessions with their primary therapist after completing the study.

Last, during early sessions, educating clients about cognitive coping should be completed to help clients understand cognitive distortions one might have and to learn alternative ways of thinking to increase coping strategies. However therapists using TF-CBT may approach treatment with the assumption that adolescents *will* have cognitive distortions surrounding trauma events. It should be cautioned that this may not always be

the case. It is conceivable, as in Sam's trauma narrative, for clients to have some accurate views about their traumatic experiences. For example, Sam described how his mother was wrong for physically abusing him. Although the physical abuse he endured was commonplace within his family system, he knew that the abuse was wrong. He also indicated that he never blamed himself for the abuse nor did he think he deserved it. Sam expressed feelings of hurt and disdain towards his biological mother for her past actions, which were not unrealistic to this situation.

The issue of realistic blame, in which the client blames the parent for the trauma, is touched upon in the "troubleshooting" section of *the Cognitive Coping and Processing II* chapter of the TF-CBT book. However it might be relevant to caution therapists using TF-CBT to avoid that assuming cognitive distortions or unhelpful thoughts will always be present. However negative but realistic perceptions help the client to survive. These issues should not be ignored but should be brought to the client's attention and discussed. Sam expressed feeling abandoned and unwanted by his family because he spent nearly six years in foster care. Family members did not take aggressive steps to get him back as evidenced by his grandmother's breaking her promise to bring him home within a few weeks only later to move to Virginia. Sam *was* left behind and the thoughts and feelings he had regarding family neglect were probably accurate. In this instance it would not be appropriate for a therapist to contradict these thoughts and feelings or challenge the client to regard them as thought distortions. Unless there is verifiable information contradicting the circumstances surrounding the trauma, the therapist should support the client by validating and reinforcing his or her realistic thoughts and feelings.

In vivo mastery of trauma reminders & safety development.

Aside from sleep difficulties, neither subject exhibited overt anxiety symptoms in response to trauma, nor did either exhibit problems in daily functioning due to anxiety. As mentioned earlier, both subjects reported using relaxation skills over the course of treatment and found them to be very beneficial. Had Victor or Sam exhibited distressing anxiety problems, the therapist would have implemented TF-CBT techniques to address anxiety and other negative affective states that impaired functioning. The therapist would have developed a "subjective units of distress scale" (SUDS) and have practiced relaxation techniques with clients. Additionally, the therapist would have worked with the subject, exposing them gradually to feared stimuli until the feared response is eliminated.

Although not at a clinical level, Victor expressed the urge to avoid listening to a specific song played on the radio at night because it reminded him of his mother, for fear that his crying would be the source of embarrassment. Because this concern was not a source of distress or impairment in daily functioning, the therapist reinforced the fact that it was appropriate to allow himself to experience feelings of grief. The therapist explained the avoidance of hearing the song would only reinforce his inclination to avoid negative feelings of grief, thereby stifling the grief process.

As discharge approaches for client in outpatient, inpatient, or residential settings, good continuity of care is paramount. However, residential clients may be ambivalent towards or reject aftercare services after spending a significant amount of time living in a treatment environment. Clients may believe their "time was served". Moreover, it is uncertain about whether or not clients and their caregivers will accept and engage in

aftercare treatment after a client is discharged from any treatment setting. Unless Court mandated or required in writing by probation officers, client and caregiver use of aftercare services are often voluntary.

At the conclusion of the study, Sam and Victor were both about six weeks away from discharge from residential treatment. Therefore discussing safety and future risk factors at the end of TF-CBT was important and relevant. Victor indicated that substance abuse relapse was the greatest risk for him and Sam reported drug selling would be his. The therapist was able to engage both subjects in a discussion about risk reduction. Victor discussed the fact that he needs to continue attending outpatient drug and alcohol treatment to remain active in recovery, avoid negative peer influences, and stay active and busy with pro social activities (i.e., full-time employment, resume playing ice hockey, taking college courses). Sam discussed plans to stay at home more with his family instead of gallivanting and loitering around town with peers, complete high school, help his grandmother around the house, and work part-time.

The therapist also discussed with each subject the different triggering situations that could be reminders of trauma or cause subjects to react in a negative manner. The subjects reviewed with the therapist the different cognitive coping techniques and interventions that could be utilized to cope with real-life triggers. Although it is hopeful that the subjects will embrace and follow-through with using discharge services, and hopeful that the subjects will expedite positive plans, recidivism can occur because clients may be re-exposed to the same environmental stressors were previously experienced.

Evaluation of outcome measures.

The TF-CBT recommends various measures to assessment treatment outcome, such as the CBCL, BASC, K-SADS, TSCC. Alternative and additional measures were chosen for this study. Had the study not been limited to six weeks, assessment points at pretest, midtest, and posttest would have been appropriate. In retrospect, it seemed more feasible to have assessed outcome at pretest and posttest data points because the length of the study was short and required subjects to fill out a number of questionnaires after two week periods. Had the data points been farther apart, greater changes may have been seen. Using the BASC and JBC measures seemed redundant. The JBC appeared to be more applicable to this residential population because many of the youth are pre-adjudicated and have problems in social functioning.

The TSCC for all subjects did not register significant symptoms of trauma although subjects had a history of trauma experience. Clients suffering from complex trauma symptoms may be desensitized to typical trauma symptoms; thus these may not be indicated on the questionnaire. Therefore another trauma measure assessing more long-term trauma symptomatology would have been more appropriate for this study because the questions on the TSCC were geared towards more present-day trauma symptoms.

The same issue would apply to the use of the CDI and RCMAS, which require clients to rate their symptoms within the previous two weeks. It is plausible that individuals might not experience problem symptoms within a two-week period, but indicate problems when there is a significant and obvious problem at other times.

Therefore other measures assessing "trait" versus "state" affect would have been more appropriate, especially with a time-limited treatment model such as TF-CBT.

The WAI could be useful within the first four to six weeks of treatment to assess alliance. After a moderate to high level of alliance is achieved, the WAI may not be needed because alliance levels either remain constant or continue to increase. The WAI would assist therapists to gauge the quality of alliance early in treatment because this appears to be the most important phase for alliance to be established.

Subject feedback.

All subjects provided the therapist with subjective feedback regarding their experiences receiving TF-CBT. Alice shared early on that she did not think she would have effectively engaged in trauma-specific treatment with her primary therapist. Like Victor, Alice had difficulty talking about intimate thoughts and feelings about trauma comfortably because the primary therapist at the residential program was viewed as the disciplinarian and the "holder of the lock and key" to Alice's privileges and freedom. Victor found the TF-CBT to be more enjoyable treatment because the role of the therapist in the study was strictly to provide therapy. Sam verbalized the idea that he was able to talk to his primary therapist in general details about his problems, but would go only so far in revealing details about the "real reasons" why he felt hate for his mother.

Both Sam and Victor described their experiences with TF-CBT as unique because it was very specific in treating underlying problems; it was also interesting and organized. They further commented on how each segment of treatment was followed in an appropriate order to help them build confidence to discuss their trauma issues in more

progressive detail. Victor encouraged that TF-CBT be offered to all clients at the residential facility who had experienced traumatic issues because it would "help a lot of people and help them to deal with their issues" and "help people to cope better at the program".

Victor concluded had he received TF-CBT in the first few months of residential placement, he might have been discharged sooner because his behavior might have more rapidly improved. Although Sam specified that he would have been able to engage in TF-CBT at the start of his residential placement, Victor stated that it would have taken him about six to eight weeks before he would have agreed to trauma-specific treatment because he was in denial about having to spend time at a residential treatment program. Last, Victor shared his feeling that he would have liked to continue receiving TF-CBT beyond the time limit of the study. He expressed the idea that meeting twice per week for six weeks was "fine", but not overwhelming.

Therapist's feedback on treatment application.

The therapist/responsible investigator in this study generated subjective opinions about the use of the TF-CBT manualized treatment. For one, the use of a manualized form of treatment helped to structure sessions and gave each session purpose and meaning both to the therapist and to clients. Rather than discussing what was happening in the a client's life at the program, the use of TF-CBT helped clients to "zoom in" on significant trauma issues, likely to be the cause of their cognitive, emotional, and behavioral difficulties; these may have been missed, ignored, or skimmed over in prior treatment.

The fact that the therapist in this study did not have dictatorial and parent-like control over clients' cases and privileges was a great benefit to enhancing positive feelings of a therapeutic alliance between the therapist and clients. However, this experience may be more on par with what outpatient therapists might experience versus therapists in residential settings who have a great deal of influence regarding clients' lives outside of individual therapy sessions.

The use of TF-CBT was a good teaching tool in helping the therapist to become comfortable yet sensitive to the discussion of trauma detail. Some therapists may find it difficult to discuss with clients, in detail, their accounts of sexual abuse because of the topic's being taboo. TF-CBT requires therapist to discuss such topics using proper reproductive medical terms such as "vagina" and "penis", and sexual actions such as "when he/she put their ___ in your ___"; this use of medical terminology helps the therapist to be more at ease with discussing such issues, thereby helping a client to be ease and less shameful about discussing sexual abuse openly.

Although the TF-CBT manual encourages the use treatment components to be used in conjoint family therapy sessions between the client and parent/caregiver(s), the manual indicates that these sessions are beneficial, but not required. This was particularly helpful knowledge because many youth referred to the study setting, lack family support or involvement. Therefore implementing components for individual therapy could be applied solely, without compromising the integrity of the treatment model.

At times subjects did not seem to be in the mood to meet for therapy, especially because sessions occurred two times per week; clients were not used to receiving this

much therapy. Because clients lived in a residential treatment center, the therapist would interrupt clients while they were doing their hair or playing video games to have them present for sessions, thus requiring clients to pause in a desirable activity. This would cause the therapist to feel sad about being the source of the interruption and being concerned about decreasing the motivation of clients in session.

Last, the use of a structured treatment model such as TF-CBT may best serve traumatized children such as those in prevailing numbers in residential treatment settings. Traumatized youth, especially those experiencing complex PTSD, may have come from families with chaotic family backgrounds and challenging socioeconomic circumstances. Many youth who have suffered trauma early in life may have impaired or poor affect regulation and impulse control due to the neurological effects of trauma on brain development. Therefore the psychoeducation, skills training, and safety planning components of TF-CBT would particularly help clients with early trauma by increasing knowledge and use of skills and reduce past feelings of frustration because they do not know how to handle difficult situations.

The therapist had been trained in cognitive-behavioral therapy; the short-term application of TF-CBT was in keeping with traditional cognitive-behavioral practices and therefore made the treatment application desirable to her. The therapist appreciated the fact that there was a beginning, middle, and an end to treatment, and that clients could experience having started and having completed something successfully, much like course work. Traumatized teens, such as those participating in this study, can benefit from the short-term, structured format of manualized treatment because clients know the treatment is time-limited, skills-based, and specific in what it aims to treat, therefore

dispelling any preconceived questions of client such as “What are we here for?”, “How long is this going to take”, and “What am I supposed to get out of this?”

Therapist feedback for the treatment agency setting.

The agency serving as the treatment setting was supportive of study having been conducted in their residential program. Initially there was slight reservation about the description of the possible negative outcomes of treatment (i.e., increased suicidal or homicidal ideation). However program administrators were informed about the efficacy of TF-CBT and the way in which the model would be beneficial to the population served by the program. A few weeks into the study, participants conveyed to program personnel that TF-CBT was helpful to them and that they had developed specific coping strategies to cope with negative affect, stress, and conflict situations. The testimonial of the participants was brought up at the program’s open house, which was then highly regarded by the program administrators.

The therapist was able to convey to the program directors that participants in the study exhibited interest in receiving TF-CBT and in the coping skills they were able to quickly develop within the first few sessions. Because of this experience, it is suggested that TF-CBT or aspects of the treatment model be implemented into residential treatment; in addition to dealing with the experience of trauma, the program may also help clients cope with the daily stressors and pressures of living with other youth who have serious emotional and behavioral difficulties. Skills learned such as relaxation training and cognitive coping would be beneficial to help youth in the program deal with peer conflict,

negative peer influence, trauma triggers, and difficulty with being in an out-of-home placement, away from familiar surrounding and significant others.

Study Limitations

Because this study was only a three-subject case study, the generalizability of findings to a general residential population is limited by a number of factors. Because it was a qualitative case study, the therapist/responsible investigator, serving as the sole evaluator of treatment effectiveness, offered largely subjective opinions, thus limiting the description of the "true state" of outcome. Although a large proportion of clinicians are female, the results are limited because the outcome is based on treatment administered by a female. Subjects also continued to have contact with their primary therapists for case management purposes. Therefore it is conceivable that the results were confounded by the additional therapeutic contact that subjects had with their primary therapists, in addition to having contact with the TF-CBT therapist. The fact that the remaining subjects were fast approaching discharge implies *history* effects; the subjects' functioning improved merely because time passed and subjects looked forward to leaving.

A female subject ran away early in the treatment series, thus limiting the amount of reportable data to the outcomes of two males. Although the outcome data from the two remaining subjects was valuable, it would have been interesting to observe gender differences in attendance to treatment and in the outcome data.

Also, only one residential facility was used to conduct the study which accepted only clients from Camden County, New Jersey. This largely limits the generalizability of results to other residential programs throughout New Jersey, especially programs that

serve only specific populations (i.e., sex offenders, youth in Juvenile Justice-related programs, all female or all male environments, pregnant teens, substance abuse rehabilitation centers). Furthermore, the site of the study was located in a large metropolitan area outside a major U.S. city; those demographics differ from other parts of the country. Finally, the subjects in the study did not represent a racially diverse population because Victor was Caucasian, and Sam and Alice were African-American. Therefore the outcome for older adolescents of other ethnic groups (Asian, Hispanic/Latino, Native American), who are in residential treatment, cannot be commented on.

Recommendations for Development & Future Research

Components of TF-CBT can be adapted for use by direct-care counselors who provide most often, the hands-on, day-to-day intervention with residential clients. Such staff has constant, face-to-face interactions with clients while supervising therapeutic activities, and reinforcing and assisting clients with responsibilities (i.e., room care, hygiene, chores, attending scheduled activities). Staff also provides immediate emotional and behavioral intervention when problems arise, using redirection, counseling, and physical restraint if necessary. Compared to constant supervision by direct care staff, clients may interact with a therapist only a few times a week for therapy sessions.

Specific elements of TF-CBT such as educating staff on understanding different types of trauma, the serious consequences of abandonment and neglect, and the impact of traumatic grief would help to sensitize staff to the professional conduct expected of them to respond effectively to youth with trauma background. Psychoeducation could be

implemented with staff during orientation by members of the clinical staff with trauma background and can be re-visited during periodic staff in-service trainings. Treatment components such as relaxation skills training and some cognitive coping techniques could also be adapted for use by direct-care staff.

It would not be necessary for direct care staff to access the online web-based training site because it is designed to aid in the training of therapists in techniques for therapy. However, treatment components such as relaxation skills training and some cognitive coping techniques could be extracted from the web-based training site and adapted for use by direct-care staff. These components should be simplified for quick and easy use by staff with little or no therapy background. Specifically, staff can be taught, can learn, and can practice relaxation skills such as diaphragmatic "belly" breathing and progressive muscle relaxation so they understand how to apply it with all clients.

Cognitive coping skills such as helping a client to generate alternative thoughts about problem situations, helping clients to process different outcomes to situations based on a client's actions, and helping clients to learn to identify their feelings in response to situations could feasibly be applied by staff when counseling clients. Additionally, staff can learn to help clients implement alterative behaviors to help copes with problem situations. For example, if a client is agitated because of a verbal altercation with another peer, a staff person can suggest that the client take a "time out" in his or her room to calm down, offer to accompany the client to take a walk outside to walk off frustration, engage in journaling if the client is reluctant to talk about the problem, or listen to music to help

calm down. By suggesting alternatives to negative acting out, staff can have a quick and direct impact on helping clients to broaden their repertoire of coping strategies to handle stressful and upsetting situations.

It is plausible that some direct care professionals, who have little background in mental health and therapy, can benefit from learning adapted TF-CBT techniques and using them with clients daily. This may aid to strengthen the morale and effectiveness of staff by having a positive impact from the use of therapeutic interventions with their clients. By using adapted TF-CBT techniques, direct-care staff will reinforce the skills that clients learn in therapy sessions, thus enhancing the goals of TF-CBT and treatment outcome.

Another recommendation is that the developers of the TF-CBT model include a section in future revised editions of the TF-CBT treatment publication for out-of-home treatment providers to provide TF-CBT on-site. Clinicians working for group home programs, residential treatment facilities, psychiatric community placements, therapeutic foster programs, shelters, and transitional/independent living programs should be advised about potential “authoritarian/disciplinarian” transference issues in treatment, especially if clinicians have a lot of control over clients’ cases. High levels of case control may render TF-CBT less effective with clients in need of trauma-specific treatment. Therefore, it is recommended that the power over clients’ cases be dispersed, if possible, to other clinical team members. This will allocate client responsibility to other clinical professionals involved in client care, and will improve the therapeutic/working alliance between the primary therapists and clients, thus enhancing clients’ acceptance and trust in therapy.

Additionally, out-of-home providers should be advised to consider applying TF-CBT early in placement to likely candidates for trauma-specific treatment. TF-CBT does not have to begin at first contact between therapist and client, but can be segued into within the first few months following client admission. Early TF-CBT intervention will help clients learn coping strategies early so they can be applied to stressors stemming from an out-of-home placement (i.e., peer conflict, problems with authority, being away from friends and family, less freedom). Early intervention may help to shorten the length of stay in a residential program.

Contrary to traditional session-scheduling of one hourly session per week, sessions in residential settings can be increased to two or more sessions per week. This format was easily expedited in this study; clients in residential settings can be easily obtained for sessions because they live on-site. The number of sessions should be determined by the motivation and interest level of individual clients because some clients may not be used to having multiple sessions per week. Some clients are more amenable to meet for therapeutic intervention, but others may view therapy as a cumbersome chore. If the latter is experienced, a therapist may continue to meet with a client often to "touch base" and implement TF-CBT techniques in smaller increments per session to avoid antagonizing a less treatment-motivated client. Realistically, scheduling frequent sessions of TF-CBT will be largely dependent on therapists' schedules, availability, and caseload level. Therapists whose responsibilities are limited to clinical duties such as individual, group, family therapy, and treatment planning may have more flexibility to hold frequent sessions but therapists with variable duties extending to case management and liaison work may not be able to accommodate such flexibility.

Future research of TF-CBT should be extended to evaluate its efficacy with clients in out-of-home treatment settings. Although TF-CBT has been found to be effective in treating children in foster homes and group homes, many youth living in group homes and residential facilities are older, usually ranging in age from 11 to 18. It is likely that adolescents, more than young children, occupy higher levels of care because their behaviors are too high risk for caregivers in home environments to manage, compared to behaviors exhibited by younger children. Although not fully representative of all residential programs, the majority of clients at the site at which this study was conducted were between the ages of 15 and 17. Therefore it would be valuable to evaluate the application of TF-CBT to youth ages 14 to 18.

Future research should attempt to look at gender differences not only in treatment outcome of clients but also in outcome based on therapist gender. Some female TF-CBT recipients are victims of sexual abuse; the perpetrators of the abuse were male, thus they may be more comfortable engaging in treatment with a female. This is not to say that male clinicians cannot be just as effective. Conversely, a male clinician may be able to help a female victim overcome fears and mistrust of male figures through a positive alliance and transference with a male clinician. The male clinician can also serve as “living proof” that some men are trustworthy and do not perpetrate crimes on others, and can help the female client to work through negative generalized beliefs about males that stem from her abuse. Furthermore, the differences in relationship between different-gendered dyads with male clients should be researched to see if there are differences in the quality and level of communication. Male clients may not be open or forthcoming about intimate thoughts and feelings with a male therapist in TF-CBT because of learned

social norms. It would be interesting to see if there are differences when male clients engage in treatment with a male therapist rather than a female therapist.

Research has shown successful trauma-specific treatment of youth in out-of-home placements by outpatient clinicians. Given the aforementioned feedback and concerns regarding case control and transference issues, it would benefit the residential treatment community if future researchers were to evaluate, using a larger sample size, the efficacy of TF-CBT used by on-site therapists compared to the client outcome when TF-CBT is applied by outpatient therapists.

Chapter 5: Empirical Study Proposal

Rationale

Many youth who are placed by child welfare agencies or the Court system into residential treatment programs are likely to exhibit emotional and behavioral problems related posttraumtic stress, traumatic grief, and most of all, complex trauma in which youth have been exposed to long-term traumatic events such as caregiver neglect, domestic and community violence, loss, and residential instability (i.e., moving from home to home, experiencing multiple out-of-home placements). Research studying the efficacy of specific trauma treatment with youth has been historically conducted on outpatient samples such as youth that come to a treatment center for trauma-specific therapy. Past participants in such studies may have resided in foster homes or other placements such as a group home or residential treatment program. However, little is known about the efficacy of trauma-specific treatment when utilized with youth in a residential setting with therapists on-site. Furthermore, it is not uncommon for youth placed in State-placed or Court-mandated residential treatment program to have little family to no family or caregiver involvement. Therefore, it is important to investigate the outcome of trauma-specific treatment with youth in such circumstances.

Study

This study will be conducted to test the outcome of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), a highly regarded evidence-based model of treatment, with youth in treatment programs who suffer from trauma symptoms and have no or limited family involvement. Youth will be recruited from six residential treatment

programs representing the three regions (north, central, and south) of the State of New Jersey, and will have youth who are placed by the State or the Court system. Study participants will engage twelve weeks of TF-CBT in individual sessions. Five measures will be used to assess treatment outcome including: the Behavior Assessment System for Children Self-Report of Personality (BASC-SRP) and Behavioral Assessment System for Children Parent Rating Scales (PRS), Children's Depression Inventory (CDI), Jesness Behavior Checklist Self-Appraisal (JBC S-A) and Jesness Behavior Checklist Observer (JBC-O) forms, Revised Children's Manifest Anxiety Scale (RCMAS, and the Trauma Symptom Checklist for Children (TSCC).

Research Question

The proposed study is guided by the following research questions: do levels of functioning improve in cognitive, emotional, and behavioral functioning of youth with trauma symptomatology specific to TF-CBT?

Hypotheses

1. Levels of cognitive and behavioral functioning will be better as measured by the BASC (SRP and PRS) and JBC (S-A and O) for subjects in the Experimental Group who received TF-CBT compared to the Wait-List Control Group.
2. Levels of depression will be better as measured by the CDI for subjects in the Experimental Group compared to the Wait-List Control Group.

3. Levels of anxiety will be better as measured by the RCMAS for subjects in the Experimental Group compared to the Wait-List Control Group.
4. Trauma symptomatology will decrease and will be better as measured by the TSCC for subjects in the Experimental Group compared to the Wait-List Control Group.

Method

Participants

Participants will be drawn from six residential treatment programs throughout the State of New Jersey. The residential programs will have accepted youth placed by the state's child welfare agency, the Department of Children and Families (DCF), and youth who are Court-mandated to receive long-term treatment as an alternative to incarceration.

Inclusion Criteria. Clients will range from 14 to 17 years of age and will meet at minimum the following DSM-IV-TR Multiaxial Assessment (DSM-IV-TR; American Psychiatric Association, 2000) profile as assessed by each program's clinical team: Axis I: Posttraumatic Stress Disorder (PTSD); Axis II: No diagnosis or Deferred; Axis III: No significant medical problems; Axis IV: To be identified and recorded; Axis V: Global Assessment of Functioning was current and no lower than a score of 40. Subjects who do not meet the full diagnostic criteria for PTSD on Axis I, but have shown multiple symptoms indicative of Complex Posttraumatic Stress Disorder (CPTSD) due to long-term exposure to trauma, may also be included in the study.

Participants' legal guardian(s) and/or custodial parent(s) must sign a statement of informed consent to participate in the study. Subjects' participation must be voluntary and expressed through a commitment by signing a statement of assent. The statement of assent will specify the expectations for participation in the study, including willingness to meet with and engage in therapy, willingness to focus on therapy in order to reduce behavioral problems having led to residential placement, and completing the self-report measures during specific sessions. Partcipants must have at least a 5th grade reading level in order to understand and complete the measures administered in this study.

Comment [BSZ7]: Sign a statement of assent, in addition to having the legal guardian sign a statement of informed consent.

Exclusion criteria. Juveniles who were younger than 14 years of age or older than 18 years old will be excluded, as well as anyone who exhibits serious psychiatric problems such as significant Mood, Psychotic, or Disruptive Behavior Disordered symptoms warranting the need for a client to be placed on one to one supervision by a direct care staff person. Those who are diagnosed with mild to moderate mental retardation, actively psychotic symptoms, pervasive developmental disorders, tic disorders, amnestic disorders, and a recent history of severe suicidal or homicidal behavior will not be included in the study. Last, clients who do not have at least a 5th grade reading level, or the ability to read and comprehend the self-report measures cannot participate.

Comment [BSZ8]: Define term. How is this statement differenct from the next sentence?

Research Design

A total of 60 clients will participate in the study. Subjects will be randomly assigned at each of the six settings to one of two groups: the experimental group who will receive TF-CBT or the Wait-list Control, who will receive the intervention after the experimental group concludes their series of the treatment intervention.

Setting

Subjects in the experimental group will receive TF-CBT from a master's-level or higher degreed clinician while subjects in the wait-list control group receive standard psychotherapy. Therapy sessions at the treatment facility will be held in a private office space, free from extraneous stimuli or distraction, providing ample space for 2 to 5 individuals.

The length of treatment for subjects these residential settings may range anywhere from nine to twelve months or beyond, and serve youth ranging from 11 to 18 years of age. The majority of client served in these programs are New Jersey State residents. Clients may be placed by the Department of Children and Families or by the Court system. Some youth at these residential programs may be private pay clients or be placed through the *Value Options* system, the contracted systems administrator for mental health services for the state. Therefore, clients at such residential programs represent diverse socioeconomic statuses (though many represent low-SES), diverse cultural backgrounds, coming both from suburban and from inner-city neighborhoods. Therefore, subjects in this study will be representative of youth who are placed in residential programs throughout New Jersey.

Independent Variables

Treatment manual. Trauma Focused Cognitive Behavioral Therapy (TF-CBT), an empirically-supported treatment model, will be the applied intervention for this study. The TF-CBT manual is devised to offer individual treatment for the child or adolescent or can be combined with child and parent joint-therapy. However, to standardize the application of TF-CBT, only individual therapy aspects of TF-CBT will be utilized and investigated, given the prevalence of youth in State custody in residential programs. Therefore, the TF-CBT family therapy component will not be integrated.

Therapists. There will be 12 therapists participating in this study. The therapists will be at least master's level, will have experience in providing therapeutic services with children and adolescents, and will have a training background of either clinical social work, counseling/clinical psychology, marriage/family therapy, or any other individual counseling background. Therapists will receive training on the core components of TF-CBT three months prior to the onset of the study.

Trauma-focused topics and skills learned prior to the study will include

- Psychoeducation about the TF-CBT model of treatment, psychoeducation for children experiencing traumatic grief, troubleshooting in this area
- Relaxation: focused breathing/mindfulness/meditation, progressive muscle relaxation, relaxation for children with traumatic grief, and troubleshooting in this area
- Affective expression and modulation: feeling identification with children, through interruption and positive imagery, positive self-talk, enhancing the

child's sense of safety, enhancing problem-solving and social skills, social skills building, managing difficult affective states, affective modulation for children with traumatic grief, troubleshooting in this area

- Cognitive coping and processing I / the cognitive triad: learning types of inaccurate and unhelpful thoughts, troubleshooting in this area
- Trauma narrative: trauma narrative for children with traumatic grief, troubleshooting in this area
- Cognitive coping and processing II / processing the traumatic experience: exploring and correcting inaccurate or unhelpful cognitions, cognitive processing of traumatic death
- In vivo mastery of trauma reminders (to be implemented if the child has generalized fears resulting from trauma)
- Enhancing future safety and development

In addition, therapists will access the internet-based training for TF-CBT at http://tfcbt.musc.edu/ and will be required submit a completion certificate prior to the onset of the study. Lastly, therapists will be instructed on how to administer the measures for this study but will not be responsible for scoring them. The researcher for this study will collect the measures from each site periodically and will score the measures.

Measures

Six measures will be administered in this study. Trauma symptomatology will be assessed using the TSCC. Cognitive and behavioral functioning will be assessed using the BASC (SRP and PRS) to measure general levels of functioning and the JBC (S-A and O) will be utilized to specifically assess anti-social behavior and Bipolar disorder symptoms. Lastly, depression and anxiety symptoms will be measured by the CDI and RCMAS respectively.

Procedure

Based on the recommendations of the clinical treatment teams at each residential site, potential subjects will be identified, based on the inclusion and exclusion criteria one month prior to the onset of the study. Therapists at each site will present and review the parent/guardian informed consent form and juvenile informed assent form with all potential subjects and their guardians to obtain consent and assent to participate in the study. Each site will submit the original consent and assent forms to the researcher and will retain copies at the respective sites. Copies of signed consent and assent forms will also be provided to each subject and his or her guardian or custodial parent. The clinical team selected three subjects to participate in the study from the pool of potential subject/parent dyads who provided consent and assent.

Data collection & treatment series. Direct care supervisors will complete the BASC Parent Rating Scales (PRS) and the JBC (Observer Form) because they observe subjects' daily cognitive, emotional, and behavioral functioning while living in a

residential treatment setting. Supervisors will complete the BASC and JBC at baseline (pretest), after session 6 (mid-point), and after session 12 (posttest). Subjects will be administered the BASC Self-Report of Personality (SRP), CDI, JBC (Self-Appraisal Form), RCMAS, and TSCC at baseline, after session six (mid-point), and after session twelve (posttest). All data will be maintained in individual subject files maintained by the researcher.

Treatment sessions will last approximately 45-50 minutes each, and will take place one time per week for twelve weeks. The following session plan, based on the TF-CBT manual chapter sequence, will be followed with subjects to address all pertinent areas of TF-CBT:

- Session 1: "Educate" - Provide psychoeducation about the TF-CBT model of treatment with subject
- Session 2: "Relax" - Relaxation training with subject (focused breathing, mindfulness, meditation, progressive muscle relaxation)
- Sessions 3 & 4: "Feelings & Controlling Them" - Affective Expression and Modulation (identifying subject feelings, thought interruptions and positive imagery, positive self talk, learning and enhancing problem-solving, social skills-building, managing difficult affective states)
- Sessions 4 & 5: "Thoughts, Feelings, & Behaviors and Learning Distortions" - Cognitive Coping and Processing I / The Cognitive Triangle (learning types of inaccurate and unhelpful thoughts)
- Sessions 6, 7, & 8: "Let's Talk about What Happened to You" - Trauma Narrative (describing the details of what happened before, during, and after the traumatic

event(s) through writing and discussion, integrating thoughts and feelings about the event(s) into a consistent and meaningful experience, focus on subject's place in the trauma and in the present)

- Sessions 9 & 10: "How Did the Trauma Cause You to Think about Things?" – Cognitive Coping and Processing II / Processing the Traumatic Experience (exploring and correcting inaccurate or unhelpful cognitions)
- Session 11: "Don't Be Afraid" – *In Vivo* Mastery of Trauma Reminders (if required: desensitizing subject to innocuous cues that have elicited feared responses)
- Session 12: "Get Smart" – Enhancing Future Safety and Development (role playing potentially dangerous situations, learning personal safety)

Safety plan. Given the trauma history experienced by subjects and the trauma-focused nature of the treatment model, it is plausible that interruptions in treatment could occur. If at any time a subject exhibits symptoms of suicidal or homicidal ideation, active symptoms of psychoses, or any other acute symptoms that may threaten the integrity of the subject, the therapist will follow their site's clinical protocol. Treatment will be paused for at least a period of one week to assess the subject's immediate needs, but can resume at the discretion of the clinical treatment team and researcher, and with the consent of the parent or guardian.

Sessions may be discontinued for various types of interruptions such as: run away behavior, hospitalization for psychiatric or medical reasons, discharge due to legal charges (i.e., simple or aggravated assault, possession of contraband, violation of

probation, Judge's bench warrant), or any other extenuating circumstances that resulted in extended absence or permanent removal from the program. Sessions may resume if a subject returns to their program for continuous treatment within three weeks of initial departure and exhibited sufficient cognitive, emotional, and behavioral stability as determined by the clinical treatment team. However, if the clinical treatment team and a subject's parent or guardian believes it would be detrimental to the well-being of a subject to continue in the study, at any time or if an interruption occurs, the treatment series of TF-CBT will immediately terminate. Psychotherapy will resume under normal operating procedure at the site if the subject is to remain at the program (i.e. resume standard treatment sans specialized treatment format).

Comment [BSZ9]: What willhappen to the subject? Taken to hospital? Mobile crisis? Spell out the option.

Also, if tx is interrupted several times, under what conditions will you finally decide to discontinue working with that subject?

If, at any time, there is an interruption to a subject's involvement in the study, parent or guardian consent must be re-obtained for a subject to resume participation in the study from the point at which treatment sessions leave off. However, if a subject has two interruptions occurring half-way through the treatment series (prior to session 7), or if more than two interruptions occurred over the course of the treatment series, the subject would have been terminated from the study.

At the conclusion of the treatment series, a debriefing session will be conducted by each therapist to discuss with subjects their experience in the study and to share feedback with one another. Subjects will be permitted to withdraw from the study or be withdrawn by their parent or guardian at any time without penalty. Subjects terminating prior to the conclusion of the study will resume standard care with their therapists.

Statistical Hypothesis

A Multivariate Analysis of Variance (MANOVA) will be used to evaluate the statistical significance of the effect of the two independent variables (TF-CBT and Wait-list Control group) on a set of five dependent variables (BASC, CDI, JBC, RCMAS, and TSCC). The measures will be administered from pretest to posttest for both groups with follow-up three months after the treatment series concludes for both the experimental and wait-list control groups.

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Appendix A: Parental Consent Form

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE

DEPARTMENT OF PSYCHOLOGY
215-871-6442
215-871-6458 FAX
psyd@pcom edu E-MAIL

Philadelphia College of Osteopathic Medicine Institutional Review Board Approval Date: 1/23/07 through Expiration: 1/24/08

INFORMED CONSENT FORM

TITLE OF STUDY

The Transportability of Trauma-Focused Cognitive Behavioral Therapy: A Case Study with Adolescents in a Residential Treatment Setting

TITLE OF STUDY IN LAY TERMS

The usefulness of applying a treatment manual called Trauma-Focused Cognitive Behavior Therapy for children and adolescents with 3 teenage subjects living in a mental health treatment center.

PURPOSE

The purpose of this research is to find out whether symptoms relating to trauma such as depression, anxiety, or problems with feelings and thinking improve in adolescents living in a residential treatment facility after receiving 12 individual therapy sessions of Trauma-Focused Cognitive Behavioral Therapy.

Your child is being asked to participate in this research study because he/she has experienced significant trauma in his/her past and has exhibited serious emotional and behavioral problems that have affected his/her functioning at home, school, or in the community. If your child is under the age of 14 or over the age of 18 , he/she can not participate in this study.

INVESTIGATOR(S)

Principal Investigator: Bruce Zahn, Ed.D., ABPP	Co-Investigator:
Philadelphia College of Osteopathic Medicine	Institution:
Department: Psychology	Department:
Address: 4190 City Avenue, Philadelphia, PA 19131	Address:
Phone: 215-871-6498	Phone:

Responsible (Student) Investigator: Susanna Carew, M.S.

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through Expiration: 1/24/08

The treatment your child is being asked to volunteer for is part of a research project.

If you or your child has any questions regarding this research project, you can call Dr. Zahn at (215) 871-6498.

If you or your child has any questions or problems during the study, Dr. Zahn will be available during the entire study. If you wish to learn more about Dr. Zahn's background, or the rights of research subjects, you can call the PCOM Research Compliance Specialist at (215) 871-6782.

DESCRIPTION OF THE PROCEDURES

If you and your child decide to participate in this study, your child will stop receiving standard therapy with their primary therapist and instead receive Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), a specific model of therapy meant to treat trauma symptoms in youth. TF-CBT differs from regular therapy by specifically focusing on treating the effects of trauma in youth standard therapy does not address. Standard therapy applies a broad approach to many problems that your child experiences and the daily problems that he/she exhibits at the program. TF-CBT will address the trauma that your child has experienced and examine how these experiences may be the possible cause of these problems.

Your child will be asked to fill out the following questionnaires:

- Trauma Symptom Checklist for Children (TSCC): to measure trauma symptoms
- Behavior Assessment System for Children Self-Report of Personality (BASC): to measure behavior, thinking, and feelings related to personality traits
- Jesness Behavior Checklist Self-Appraisal Form (JBC): to measure mood and behavior
- Revised Children's Manifest Anxiety Scale (RCMAS): to measure anxiety symptoms
- Children's Depression Inventory (CDI): to measure depression symptoms
- Working Alliance Inventory (WAI): to measure bond between your child and therapist

Completing each questionnaire should take your child approximately 15-30 minutes to complete. All six questionnaires will be given to your child before treatment starts, mid-way through treatment, and at the end of treatment.

The following questionnaires will be given to a Senior Resident Counselor at the Y.E.S. Facility to complete regarding your child before the treatment begins, mid-way through his/her treatment, and at the end of treatment:

- Behavior Assessment System for Children Parent Rating Scale (BASC): to measure your child's behavior, thinking, and feelings related to his/her personality

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- Jesness Behavior Checklist Observer Form (JBC): to measure your child's mood and behavior

The Senior Resident Counselor will complete the questionnaire to rate your child's functioning at the treatment facility over the course of his/her participation in the study.

The study will take about 45-50 minutes for each session. There will be 12 sessions over the course of six weeks, for a total of 540-600 minutes of your child's time.

Your child's individual sessions of TF-CBT may include the following procedures:

- Educating your child about the TF-CBT model through explanation and discussion.
- Teaching your child relaxation techniques such as focused breathing, meditation, relaxing muscles through the use of breathing exercises and progressive muscle relaxation training.
- Teaching your child to be able to identify his/her feelings, replacing negative thoughts with positive ones, using positive self-talk, improving problem-solving skills and social skills, and managing difficult emotions through explanation, discussion, and role-play with your child's TF-CBT therapist, use of worksheets and charts, and maintaining a journal.
- Teaching your child about general inaccurate and unhelpful thoughts through explanation, discussion, and therapist's use of specific types of questioning to challenge your child's inaccurate and unhelpful thoughts.
- Helping your child to describe the details of his/her traumatic experiences and what happened before, during, and after the traumatic event(s) through writing a story of your child's experiences before, during, and after his/her trauma, and discussing it in therapy.
- Helping your child to understand the meaning of his/her trauma experiences and how these events relate to his/her current life through discussion with his/her therapist.
- Helping your child to understand any inaccurate and unhelpful thoughts that came from their traumatic experiences through discussion and having these thoughts challenged with specific questions by his/her therapist.
- Helping your child to be less anxious about things in his/her everyday life that may remind him/her of their traumatic experiences through explanation, discussion, reminding your child of the use of breathing and relaxation exercises, and the therapist's use of skills to decrease your child's level of sensitivity to anxiety causing situations.
- Teaching your child about potentially dangerous situations and about personal safety to avoid future trauma or a re-experiencing of past trauma through discussion and role-play with his/her therapist.

Your child's therapist will audiotape sessions 1, 4, 8, and 12 so that they can be reviewed with the therapist's supervisor, Bruce Zahn, Ed.D., ABPP. Your child's audiotaped sessions will be destroyed at the end of the study.

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Once your child has completed 12 individual sessions of TF-CBT, a joint therapy session will be held among your child, the TF-CBT therapist, and your child's primary therapist to discuss how your child did when receiving TF-CBT, and to assist your child to re-start standard therapy with his/her primary therapist.

POTENTIAL BENEFITS

Overall, your child may improve in many areas such as the way he/she thinks, feels, and behaves. For example, your child may exhibit decreased symptoms and problems related to trauma such as depression, flashbacks, anxiety, agitation, irritability, poor concentration and sleep difficulties. Additionally, your child's improvement in functioning may benefit the relationship he/she has with you, family members, friends, other people involved in their lives, and may improve their ability to functioning in school and in the community.

Your child may not benefit from being in this study. Other people in the future may benefit from what the researchers learn from the study.

RISKS AND DISCOMFORTS

Because your child will be required to stop receiving standard individual therapy with his/her primary therapist, receive 12 individual therapy sessions of TF-CBT, then re-start standard therapy, there are risks that your child may have difficulty establishing a positive therapy relationship with the therapist providing TF-CBT and may have difficulty adjusting to a different type of therapy. Another risk is that your child may not want to stop receiving TF-CBT and may not want to return to receive standard therapy with his/her primary therapist.

While receiving TF-CBT, your child may not want to talk about or deal with the issues that relate to their trauma. He or she may experience uncomfortable feelings related to trauma and may experience flashbacks. Your child may also show increased symptoms of depression, anxiety, irritability, and agitation discussing the topic of trauma. In severe cases, your child may want to harm him/herself or others, or may suffer from actively psychotic symptoms (hallucinations or delusions) at which time the Y.E.S. Facility will take appropriate steps to provide the most appropriate treatment according to the program's policies and procedures. If it is found that it would be detrimental to the well-being of your child to continue in the study, he/she will not continue to receive TF-CBT.

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ALTERNATIVES

The other choice is for your child to not participate in this study and to receive the standard treatment that is automatically provided and consists of individual, group, and family therapy, and case management services through the treatment program.

PAYMENT

You and your child will not be paid for participating in this study.

CONFIDENTIALITY

All information and records relating to your child's participation will be kept in a locked file. Only the researchers, members of the Institutional Review Board, and the U.S. Food and Drug Administration will be able to look at these records. If the results of this study are published, no names or other identifying information will be used.

REASONS YOU MAY BE TAKEN OUT OF THE STUDY WITHOUT YOUR CONSENT

If health conditions occur that would make staying in the study possibly dangerous to your child, or if other conditions occur that would damage your child's health, the researchers may take your child out of this study.

In addition, the entire study may be stopped if dangerous risks or side effects occur in other people.

NEW FINDINGS

If any new information develops that may affect your child's willingness to stay in this study, you will be told about it.

INJURY

If your child is injured as a result of this research study, he/she will be provided with immediate necessary care.

However, you and your child will not be reimbursed for care or receive other payment. PCOM will not be responsible for any of your bills, including any routine care under this program or reimbursement for any side effects that may occur as a result of this program.

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If you believe that your child has suffered injury or illness in the course of this research, you should notify the PCOM Research Compliance Specialist at (215) 871-6782. A review by a committee will be arranged to determine if your injury or illness is a result of your child being in this research. You should also contact the PCOM Research Compliance Specialist if you think that you or your child have not been told enough about the risks, benefits, or other options, or that you or your child are being pressured to stay in this study against your wishes.

VOLUNTARY PARTICIPATION

You or your child may refuse to be in this study. You or your child voluntarily consent to be in this study with the understanding of the known possible effects or hazards that might occur while your child is in this study. Not all the possible effects of the study are known.

You or your child may withdraw from this study at any time.

If you or your child decides to leave the study, your child will resume standard care at the facility which includes your child receiving individual, group, and family therapy, and case management services until your child is discharged from the program.

If your child drops out of this study, there will be no penalty or loss of benefits to which he/she is entitled.

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I have had adequate time to read this form and I understand its contents. **I have been given a copy for my personal records.**

I agree to allow my child be in this research study.

Only one parent/guardian signature is required.

Signature of Parent/Guardian:_______________________________________

Date: ____/____/______ Time:____________AM/PM

Signature of Witness:____

Date: ___/____/________ Time:____________AM/PM

Signature of Investigator or Designee_________________________________
(circle one)
Date: ___/___/_________ Time:____________AM/PM

Appendix B: Parental Consent Form for Audiotaping

02/13/2007 TUE 12:10 FAX 215 871 6540 PCOM EVANS 329 002

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PARENT/GUARDIAN
CONSENT FOR TAPING SESSIONS

I, ______________________________, the parent/guardian of

______________________________, agree to allow his/her treatment sessions with Susanna Carew to be audiotaped and then copied for typing

I understand that these tapes will be kept secure and private as will all other notes, treatment plans, forms, self-reports and any other papers related to my child's treatment. Also, I understand that these tapes are to be used for study and research only and will not be used for any other purpose unless I agree in advance and in writing.

I understand that the taped sessions will be typed and will become part of a written record of my child's case to include in a study. My child's name will not be used in either the tapes or the written paper from the tapes. No one will know that the tapes or the written paper are about my child, except for Susanna Carew and myself.

I understand that the audiotapes of my child's sessions will kept for a period of 6 months after my child's sessions have ended and will be destroyed at the end of the 6 months.

____________________	____________________	__________
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
____________________	____________________	__________
Witness Name (Print)	Witness Signature	Date

Appendix C: Child Assent Form

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Assent Document
for Minors Ages 14 - 18

Trauma-Focused Cognitive Behavioral Therapy
with Adolescents in a Residential Treatment Program

You are being asked to be in a research study about the usefulness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) with adolescents in a residential program. TF-CBT is a specific type of therapy for children and teenagers that have experienced trauma and experience problems with thoughts, feelings, and behaviors. This study is being conducted by Susanna Carew, M.S., who is a student at Philadelphia College of Osteopathic Medicine (PCOM).

If you agree to be in this study, you will stop receiving normal individual therapy with your primary therapist and will start to receive 12 individual sessions of TF-CBT within a time frame of 6 weeks with Ms. Carew. During the 12 individual sessions of TF-CBT, Ms. Carew will do the following:

- Educate you on the purpose of TF-CBT
- Teach you relaxation skills
- Help you to identify your feelings and learn to improve problem-solving and social skills
- Help you to use positive "self-talk" and to cope with difficult emotions
- Teach you to be aware of unhelpful and inaccurate thoughts that people can have
- Help you to process your trauma experience(s) through writing and talking, and discuss what such experience(s) mean to you
- Help you to understand the unhelpful or inaccurate thoughts that came from your trauma
- Teach you how to cope better with everyday things that cause your fear and anxiety because of your trauma
- Educate you on how to prevent future trauma and learn about personal safety

You will be asked to fill out a set of 6 questionnaires. Each questionnaire will take between 15-30 minutes, but can be completed over a few days. You will be asked to fill out the set of questionnaires before you start to receive TF-CBT, half-way through receiving TF-CBT, and at the end of receiving TF-CBT. You may skip any questions you are not comfortable answering. Your name will NOT be on the forms, but you will be asked to write your date of birth, grade, and gender on the form. Please do NOT write your name anywhere on the forms.

Your sessions will also be audiotaped to ensure that Ms. Carew is using TF-CBT properly. Only sessions 1, 4, 8, and 12 will be taped. The audio tapes will be destroyed 6 months after the end of the study.

After completing 12 sessions of TF-CBT, Ms. Carew and your primary therapist will meet with you to discuss how you did when receiving TF-CBT. You will return to your primary therapist for normal individual therapy and case management afterwards.

If you become upset or uncomfortable during the therapy sessions or during the study at any time, Ms. Carew, your primary therapist, or any of the program directors can speak with you about this. If you choose to drop out of the study, you may do so at any time.

You will not be in any trouble or lose any privileges if you decide to be or not be in the study. Also, your school grades will not be affected if you decide not to participate in this study. You might not benefit from being in this study. However, this study may provide information on whether TF-CBT is useful in treating adolescents suffering from trauma.

A parent/guardian has already given written permission for you to be in the study. They have a phone number for Ms. Carew, in case you or your parents have any questions about the research. You will be given a copy of this form to keep.

I was given enough time to read this form and ask questions. I understand the study.

I have been given a copy of this form to keep.

I agree to be in this research study.

Student signature ______________________________ Date _____________

Student name (printed) __________________________ Date _____________

I understand and give permission for sessions 1, 4, 8, and 12 to be auditaped.

Student signature ______________________________ Date _____________

Investigator signature ___________________________ Date _____________

Witness signature ______________________________ Date _____________

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