Treatment of children and adolescents with PTSD

Practice guidelines for the assessment and treatment of children and adolescents with PTSD were first developed by an expert panel convened more than a decade ago by the American Academy of Child and Adolescent Psychiatry (1998). Since the release of that seminal set of practice guidelines, substantial additional validation has been provided in scientific studies of the most robustly evidence-based treatment model: Trauma-Focused Cognitive Behavior Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006; Cohen, Mannarino, Deblinger, & Berliner, 2008). Other approaches to the treatment of children and adolescents with PTSD have been sufficiently clinically or scientifically tested to be included as actually or potentially evidence-based (Ford & Courtois, 2013; Nader, 2008; Saxe, MacDonald, & Ellis, 2007; Vickerman & Margolin, 2007) in the second edition of the International Society for Traumatic Stress Studies (ISTSSs) Practice Guidelines, Effective Treatments for PTSD (Foa, Keane, Friedman, & Cohen, 2008). These include Eye Movement Desensitization and Reprocessing (EMDR; Wesselman & Shapiro, 2013), school-based cognitive behavior therapies (Jaycox, Stein, & Amaya-Jackson, 2008), psychodynamic therapies (Lieberman, Ghosh Ippen, & Marans, 2008), creative arts therapies (Goodman, Chapman, & Gantt, 2008), and psychopharmacotherapy (treatment with therapeutic medications; Donnelly, 2008). Family systems therapies were included in the ISTSS Practice Guidelines only for adults, but promising approaches for family therapy with children with PTSD have been developed (Ford & Saltzman, 2009). Psychotherapies that focus on affective and interpersonal self-regulation also have been identified as promising for children with PTSD by the National Child Traumatic Stress Network (see Ford & Cloitre, 2009; Ford & Courtois, 2013).

This chapter provides an overview of the evidence-based and promising evidence-informed treatments for children and adolescents with PTSD. Case study examples illustrate the use of several of these treatments, with a discussion of the clinical and ethical considerations necessary to ensure the safe and effective application of PTSD treatment for children and adolescents (Box 8.1).

Evidence-based and empirically informed psychotherapy models for children with PTSD

The key elements in psychotherapy for children with PTSD have been summarized by the acronym, PRACTICE (Cohen et al., 2006): Parenting skills and Psychoeducation; Relaxation skills; Affect modulation (helping the child and caregivers manage emotional distress); Cognitive coping skills; Trauma narrative reconstruction; In vivo
Box 8.1 Key Points

1. Psychotherapy for children with PTSD follows the three-phase treatment model established for psychotherapy with adults with PTSD, including ensuring that the child is safe from further traumatization and prepared to engage in and benefit from therapy; reducing avoidance of memories of past traumatic experiences; and helping the child and family to restore or achieve a positive adjustment in as many walks of life as possible.

2. The core goal for the treatment of children with PTSD is to enable them (and their caregivers) to attain what Harvey (1996) described as mastery or “authority” in relation to their own memories—including but not limited to memories of traumatic events.

3. The essential elements in all approaches to psychotherapy for children with PTSD have been summarized by the acronym PRACTICE (Cohen et al., 2006): Parenting skills and Psychoeducation; Relaxation skills; Affect modulation (helping the child and caregivers manage emotional distress); Cognitive coping skills; Trauma narrative reconstruction; In vivo application of skills (practicing skills and confronting reminders of traumatic experiences in daily life); Conjoint parent-child sessions (treatment sessions with the parent and child together); and Ensuring safety and posttherapy adjustment.

4. The PTSD psychotherapy for children with the strongest scientific evidence base is TF-CBT. TF-CBT consistently has been shown to be more effective than traditional supportive psychotherapy and was recently found to be equally effective alone as when combined with medication therapy.

5. Three other cognitive behavior therapy models for children and adolescents with PTSD have been sufficiently clinically or scientifically tested to be included as actually or potentially evidence-based: EMDR, cognitive behavioral intervention for traumatized students (CBITS—which is conducted in schools), and Parent-Child Interaction Therapy (PCIT [Parent Child Interaction Therapy]—which is conducted with parents of abused children, including parents who have been abusers).

6. A dyadic psychotherapy that takes a psychodynamic approach and emphasizes restoring or enhancing parent-child attachment (and that includes a parent as well as the traumatized child in all sessions) has been found in scientific studies to be effective with young children.

7. Creative arts therapies and family systems therapies are widely used clinically and were included in the ISTSS Practice Guidelines as promising treatments (although neither has demonstrated effective in scientific studies with traumatized children).

8. Psychotherapies that focus on affective and interpersonal self-regulation also have been identified as promising for children with PTSD by the National Child Traumatic Stress Network, including TARGET, Life Skills Life Story, Real Life Heroes, and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS).

9. Treatment with children and families is always relational. PTSD is so debilitating for children that therapists may feel compelled to achieve large goals such as complete recovery in order to prevent the child and parent from suffering disappointment in the face of what may seem to be intractable problems. The challenge for therapists is to shift from emphasizing overcoming pathology or deficits as the goal of treatment to focusing on a series of smaller goals that are of immediate personal relevance to the child and caregiver.

(Continued)
application of skills (practicing skills and confronting reminders of traumatic experiences in daily life); Conjoint parent-child sessions (treatment sessions with the parent and child together); and, Ensuring safety and posttherapy adjustment. Each approach to psychotherapy provides these forms of assistance in different ways.

Over the past 20 years, several empirically supported psychotherapies have been developed for both acute and chronic pediatric PTSD (Berkowitz, Stover, & Marans, 2011; Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011; Ford, Blaustein, Habib, & Kagan, 2013; Stein et al., 2003). Common treatment elements that are empirically supported include (i) psychoeducation about PTSD; (ii) relaxation and coping skills; (iii) emotion awareness, expression, and regulation skills; (iv) cognitive processing of reactions to trauma; (v) helping the child to construct a therapeutic trauma narrative; (vi) in vivo exposure to trauma reminders and practicing of coping skills; (vii) conjoint parent-child sessions; and (viii) monitoring and enhancing individual safety (Carrion, 2013; Ford & Courtois, 2013; Schneider, Grilli, & Schneider, 2013).

**Trauma-focused Cognitive Behavioral Therapy**

The most extensively researched model of PTSD psychotherapy with children and adolescents is TF-CBT (Cohen, Berliner, & Mannarino, 2010, Cohen, Mannarino, & Iyengar; 2011). TF-CBT includes emotion identification, stress inoculation (e.g., breathing, relaxation) techniques, direct discussion of trauma experiences through gradual exposure exercises, cognitive restructuring, psychoeducation, and safety skill building. Several randomized clinical trials have demonstrated TF-CBT’s superiority to supportive therapy with children (including ~33% adolescents) with PTSD following abuse, violence, and single-incident (e.g., severe accidents) traumatic stressors (Cohen et al., 2011; de Arellano et al., 2014). Outcomes for depression and behavioral problems have been mixed, with moderate effect sizes in some studies (Cohen et al. 2010; de Arellano et al., 2014). When children (or their parents) decline to engage in or cannot seem to emotionally tolerate the processing of specific trauma memories, there are evidence-based therapeutic options for either preparing the child and parents to feel sufficiently safe, confident, and able to modulate distressing emotions so that
the child can experience the trauma narrative portion of treatment successfully (Cohen, Mannarino, Kliethermes, & Murray, 2012; Matulis, Resick, Rosner, & Steil, 2014) or to enable the child and parent to develop cognitive behavioral (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011) and self-regulation (Ford, Steinberg, & Zhang, 2011, Ford, Steinberg, Hawke, Levine, & Zhang; 2012) skills that address PTSD by reducing everyday traumatic stress reactivity and increasing emotion regulation, self-efficacy and social support.

For traumatized toddlers and preschoolers, adaptations of TF-CBT have shown promise and evidence that trauma memory work (exposure) and relaxation skill training are feasible as long as the protocol is developmentally appropriate and the parent is able to bind her anxiety sufficiently to be able to help the child with each step of the process (Scheeringa et al., 2007)—although to date this has been tested only with victims of disaster or motor vehicle accidents.

TF-CBT was developed to decrease symptoms of PTSD and depression by providing a combination of cognitive-behavioral skill building and gradual therapeutic exposure to trauma memories and reminders. TF-CBT follows a three-phase approach comparable to that used in psychotherapy with adults with PTSD (see Chapter 7). TF-CBT is designed to be conducted in 12–16 sessions of 90 minutes each (Cohen et al., 2006), although in community settings, session length may be shorter and treatment duration may be longer.

Phase one includes a careful assessment of potential current dangers (including possible further exposure to traumatic stressors such as abuse or family or community violence) and crises (including suicidality; other forms of self-injury; substance use; and parental psychiatric, substance abuse, or legal problems). If potential danger or the likelihood of crisis is high, treatment focuses on stabilizing the child’s situation and support system before continuing on to the main therapeutic focus of Phase one TF-CBT. Phase one’s therapeutic focus is on helping the child and parent(s) build a foundation of knowledge about psychological trauma and PTSD and skills for managing anxiety effectively. Education is provided to the child and to the parents separately about PTSD symptoms and how they may result when a child experiences a traumatic stressor. The child is taught skills for using physical relaxation, labeling specific emotion states, and effective thinking (“cognitive coping”) to reduce anxiety. Simultaneously, during Phase one, separate sessions are held with parents to teach them skills for listening supportively, using positive reinforcement to motivate desired behaviors, and setting and keeping consistent rules and limits with their child. Periodic sessions with both the child and parent(s) are provided to help them learn from each other and to determine when to begin Phase two (Box 8.2).

The second phase of TF-CBT involves the therapist assisting the child in constructing a “narrative” (story-like) description of a specific traumatic event that has been identified as the most troubling event currently for the child. This “narrative reconstruction” is done in careful steps in order to enable the child to gradually confront the traumatic memory without feeling overwhelmingly frightened or otherwise distressed (ashamed, guilty, angry, sad, etc.). Based on Phase one history-taking with the child, parent(s), and other sources (such as child protective service workers, teachers, the child’s pediatrician, or counselors), the therapist first identifies a specific traumatic
Box 8.2 Building a Trauma Story in TF-CBT

“Rachel” and “Julio” are composites (combinations) of several girls and boys who have made a personal story out of a traumatic memory while doing TF-CBT with the therapists at the University of Connecticut Health Center Child Trauma Clinic. Rachel is a 9-year-old African American girl who witnessed her biological father beating her mother and older siblings for “as long as I can remember” until her mother got a restraining order and divorced the father a year ago. Julio is a 15-year-old Latino boy who was sexually assaulted by a formerly trusted uncle at age 10 and who has been physically assaulted and threatened with murder repeatedly by his two older brothers. Rachel and Julio were assessed using the Clinician Administered PTSD Scale (CAPS-CA; see Chapter 6) and diagnosed with severe PTSD. Rachel also has severe depression symptoms, and Julio has had serious problems with anger outbursts and panic attacks. Portions of the beginning of their narrative reconstruction sessions are presented, without going into the precise traumatic details that they subsequently recounted. The dialogues illustrate how narrative reconstruction is explained and how the therapist helps the young person differently, depending on his or her age (in this case, a younger child and an adolescent) and the specifics of their experiences.

Rachel’s picture book

Rachel was excited to learn how to relax her body using the Phase one progressive muscle relaxation and breathing skills, and she found the “emotion faces” game (figuring out a specific emotion state for each of several circular drawings depicting emotions) to be fun. Her therapist was able to use these pleasant activities both to build a trusting relationship and to teach Rachel about how bad experiences make the body tense and create upsetting feelings that she can cope with by using relaxation skills and labeling her specific emotion(s). The therapist then explained:

Therapist: It’s good to make a story out of bad experiences because that helps your body to relax so you can feel good emotions that you like. The story tells what happened, what you were thinking and doing, and what your body and emotions were feeling. Because it’s a story, it means that it isn’t happening anymore, and you don’t have to think about it unless you want to.

Rachel: I never want to think about when my daddy was beating up on my mommy and sister. I don’t like it when I have dreams about that. I don’t want to tell that story; it’s awful.

Therapist: Maybe if I help you to tell the story in a way that you think is good, you won’t have to dream about it so much. You’re very good at telling stories with words and pictures, like the story of the princess that you told, and those nice drawings you did. So maybe we could tell the unhappy story about your daddy and mommy and your sister together and draw it like you want to.

(Continued)
Box 8.2 Continued

Rachel: Okay, I guess I could try. You start.

Therapist: Here’s a storybook you can draw and write in, and I’ll help if you want. What do you want to call the story? We can put that on the front with a picture, just like on a book.

Rachel: It’s called *The Rachel Princess Wish Story*, because I’m a princess, and I get any wish I want. Here, I’ll draw me with a princess dress and sparkly shoes and that shiny thing in my hair.

Therapist: That’s a beautiful picture! You look just like a princess. Do you want to write the name of the story on the cover? Do you want me to write some of it?

Rachel: I’ll write my name, “R A C H E L,” and you write the rest. Okay, let’s start the story. *[Turns the page]* I’ll draw me before I was a princess, when I was little and daddy was hitting mommy and I didn’t have any wishes so I felt very sad. See, I’m crying there, and my daddy’s very big and my mommy’s crying ’cause he’s hurting her. He shouldn’t do that.

Therapist: That’s right, your daddy shouldn’t you’re your mommy and make you and her cry, but it’s just a story, so you can draw it any way that you want now. Let’s pick just one time that you remember that story. Maybe one you dream about. We could make the bad dream into a story, and then you can tell it like you want to instead of it being a bad dream. How old are you in the story? Is it night or day? Is it cold or hot outside, like winter or summer? [Therapist asks questions to help Rachel locate the memory approximately in time, pausing after each question so Rachel can think about her answer and then tell or draw the story gradually in more detail.] Tell me when you want to turn the page, and we’ll keep going on with the story, but only when you want to.

Rachel: I’ll tell some more about the story, and then I’ll finish this picture. See, my daddy’s face is very angry, and my mommy’s face is very sad, and I’m still not a princess because my face is scared.

Therapist: That’s a good story because I can see how each person’s face tells the emotion they’re feeling. And you’re writing that, too, “Daddy angry. Mommy is sad. Rachel scared face.” In the story, is Rachel, thinking about being a princess or about something else?

Rachel: I’m not a princess yet. I don’t have my wish, so I can’t be a princess.

Therapist: So are you thinking about your wish, then? Is it a secret, or can you tell it?

Rachel: *[Dramatically turning the page]* Here’s the wish I’m thinking about. I wish my daddy would be a good king, and then I could be a princess. But he’s too angry to be a good king.

Therapist: He’s so angry, he’s hitting your mommy and your sister, too? And you and your mommy and sister are still crying because he’s still angry and hitting?
Rachel: Yes, he’s too angry and hitting. [Draws a giant man hitting a smaller woman and little girl and another little girl in the corner, hiding behind a chair. Then draws red and black slashes all across the tableau.] He’s hurting them, I want him to stop, too scary. [Starts to cry]

Therapist: Okay, let’s do the relaxation game now so you can feel better. Breathe in and out with me. Where do you want to make your muscles tense and relax? That’s really good. You’re helping your body to relax. Even though the story is really scary, you’re telling and drawing the story really well, and you remembered to make the emotion faces really well, too. We can do the story some more next time so you can tell me the story of how you made your wish to be a princess come true. It must be true because you sure look like a real princess to me now!

Rachel: Well, I’m not a real princess, but I like being a pretend one. And I’ll be a princess in the story when it’s all done and I’ve colored every page.

Therapist: And princesses get to be happy even if they used to be scared or sad, and their mommies and sisters, too. Maybe the daddy gets to be a real king, or maybe he just has to stop hitting, but you can decide when you tell me more about the story next week, okay?

Rachel: Yes, I’ll decide. And when I’m done, I’ll show my princess wish story to my mommy.

Therapist: I’ll bet she’ll really like to see the story you’re telling and drawing; it’s a good one.

Julio’s assault narrative

Julio: I don’t really want anyone to know what my uncle did to me. If they do, they’ll think I’m a punk who likes that kind of sex, and they’ll have no respect for me. Then I’m really done.

Therapist: What happened to you is private, your business and no one else’s. But it could help you to not lose respect for yourself—which you’ve said is an issue—if you know you can deal with the bad memory and put it into the past where it belongs. We can’t change what happened or erase the memory completely, but we can make it into just a very bad memory by dealing with it.

Julio: But if I don’t want to remember something, I just don’t let myself think about it. I don’t think about something like that on purpose; that just makes me feel worse!

Therapist: Remember how we talked about what happens when you try to not think about an emotion or tell yourself you’re just not going to think about something and it won’t bother you?

Julio: Yeah, I feel worse, and I think about it more. And I get real down on myself.

(Continued)
Therapist: And that’s nothing wrong about you; you’re just not dealing with the first rule of thinking and emotions: if you can think it and you know what you’re feeling, you’re in control, but if you avoid a thought or feeling, then the negative thoughts and feelings take control. When you choose to deal with what you really think and what you’re really feeling, you’re in control.

Julio: Yeah, but what if what I think is that I’m a total f-up and I feel hopeless?

Therapist: That’s what happens when you stop thinking and don’t deal with something. Your natural thoughts and feelings aren’t about giving up, they’re about making things right. So one way to make something bad that happened right now, even if you can’t make it right back then, is to just deal with the memory honestly, and then it’s over and done, even if you still remember it.

Julio: Okay, like if you’ve got a beef with someone and you deal with them directly instead of pretending to make nice and waiting to get your revenge. But I really want to get revenge on my uncle for what he did to me; it was too bad to just let it go. He should die for that.

Therapist: I won’t argue that it was really bad and that it’s his responsibility and not yours. Before you decide for sure what you think about him or revenge, if you feel that you’ve handled the memory and it’s behind you, then that won’t interfere with your thinking clearly about the rest.

Julio: Like getting your mind clear before you make any big decisions, I can relate to that.

Therapist: Okay, so here’s how we can do this. See how this sounds. You start with whatever you remember about what was happening—what you were doing and thinking and feeling, where you were, how you were dressed, who you were with—just before your uncle assaulted you. Then you take it just one step at a time, what happened first, then what happened next, and we break it down so that you don’t dwell on the bad parts but you just tell the whole story in detail until it’s over. And you get to decide when it ends and how you know it’s over. I realize that emotionally it’s still not over now. That’s why dealing with the memory is important: to close the book on the bad parts of the memory without just sweeping them under the rug where they still bother you.

Julio: Well, they’re still gonna bother me, no doubt, no matter what you say.

Therapist: Indeed, some bad parts may still bother you, but maybe not as many or as much. And we need to get the memory complete, so it may take several times to tell it right, but you’re the judge. I’ll just help you not skip over important parts and not get stuck in bad parts. When you’re ready to tell the memory to the one person you’ve chosen, your mentor—and not to anyone else unless you decide you want to—then I’ll be there for you while you do that, and you’ll know that you’ve made the bad experience a regular—yes, as bad as it is, just a regular—memory and not something that makes you feel stressed and sick all the time.

Box 8.2 Continued
Julio: Okay, let’s get on with it. I’ll do the writing and the telling; that’s the way I want it. I was just waking up on a Sunday morning after being out late at a party with friends the night before. I was wearing the shorts that I always used to sleep in. My first thought was that I had a huge headache. I definitely got wasted at that party, but it was a blast. Then I was rubbing my eyes, and I turned over and I about jumped a foot in the air because there’s somebody else in my bed. I was like “What the hell, get out of here, you m-f.” And then I felt an arm around my throat choking me and something was blocking my mouth so I couldn’t yell. Then I got really scared.

Therapist: Take a breath, and see if you need to tense or relax any muscles until you know that you’re okay now, even though you’re feeling really bad in the memory. Okay, how about stepping back and writing down what you just told me? Let’s put it on paper so you can see it.

Summary
Although the details of the dialogue and the patients’ memories differed in many ways, the common factors in these dialogues include (i) helping the young person to view the telling of his or her memory as a way to gain a sense of closure (albeit partial) and control (for Rachel, her wish to be a princess, and for Julio, his goal of not feeling or being viewed as a helpless victim); (ii) providing the young person with a way of telling the story and making a record of it that fits with their interests and preferences (for Rachel, a picture book with her as the artist and the therapist as the scribe; for Julio, a diary-like written record based on his visualized recollection); (iii) helping the young person to focus on details of the place, circumstances, actions, emotions, and thoughts in a step-by-step manner in which one thing leads to the next without any final stopping point until they decide that the “story” is over; (iv) helping the young person to use their self-management skills in order to keep their physical and emotional arousal within a tolerable “window” (not too much and not too little); and (v) highlighting the young person’s ability and accomplishment in small consistent ways in order to teach them that they are capable of confronting distressing memories and feelings successfully and with a sense of pride and confidence in themselves despite also feeling distress.

event that either clearly is the most troubling memory currently for the child or that is a particularly vividly recalled example of several similar events. The child may not be able to recall every aspect of the traumatic event that will be the focus of “narrative reconstruction”—indeed, details that were not recalled originally often emerge as important features of the event—but the overall memory should be clear to the child from the outset, and the event should have a distinct beginning and end. Phase two memory-telling is not a “fishing expedition” or an attempt to retrieve or recover “lost” or “repressed” memories (see Chapter 1). The purpose is to enable the child to purposefully describe—in words and pictures—a very troubling experience in a manner that demonstrates to the child (and the parent(s)) that the child can choose to recall
this memory and cope successfully with the distressing feelings associated with it. A related purpose is to enable the child to tell that memory in a way that is meaningful to the child to an adult who is consistently able to be both encouraging and empathic (the therapist), and then after using this first “telling” as practice, to also tell the memory to a parent or caregiver (whom the therapist has helped to prepare to communicate a similar blend of empathy and encouragement).

The goal of Phase two narrative reconstruction is to provide the child with a sense of self-confidence and mastery enables the child not to avoid the memory or reminders of it, and thus to be less troubled if the memory occurs (i.e., less severe “intrusive reexperiencing” symptoms), less emotionally shut down in general (i.e., less severe “emotional numbing” symptoms), and less worried about the traumatic event or the memory of the event occurring again (i.e., less severe hyperarousal and hypervigilance symptoms). The goal for the parent(s) is to enable them to similarly realize that their child can cope with a very troubling memory without having severe PTSD symptoms, and thus to enable them to be a role model and source of encouragement and emotional support for their child by communicating confidence as well as concern and empathy. The self-management skills learned in Phase one provide children (and parents) with tools they can use, with the therapist’s guidance, to manage their anxiety and other distressing feelings as they separately and then together put a traumatic memory into the form of a story that can be told without anyone being emotionally overwhelmed or in any way harmed. PTSD involves memories of traumatic event(s) that have become so disturbing that children (and often the parents) believe they must simply keep them to themselves, often as shameful secrets that can cause chronic anxiety and depression. Narrative reconstruction demonstrates experientially to children and the parents that even the most troubling memory can be faced and turned into a real-life story that can be coped with and need not be a toxic secret or a permanently unhealed emotional wound.

In Phase three, the child and parent apply the new confidence and skills they have learned to deal with any remaining troubling memories (sometimes with a second round of narrative reconstruction) and to move forward with their lives and personal development. Problem-solving skills may be applied to address difficulties in school, with peers, in the family, or in parenting, as well as the self-management skills from Phase one. Activities that provide opportunities for success and positive interactions are encouraged by the therapist. Episodes of renewed anxiety or other PTSD symptoms are discussed using the storytelling technique from Phase two, so the child and parent further develop the skill of reflecting on stressful experiences, and thus feeling able to cope with rather than feeling overwhelmed by stressors in their daily lives.

TF-CBT has been well accepted by children, parents, and clinicians for the treatment of PTSD related to sexual abuse, traumatic loss, and, more recently, mass disaster (Cohen et al., 2008). However, when child patients do not have a clear specific memory of traumatic incidents that can serve as the focus for TF-CBT, or if their behavioral or psychosocial problems are of sufficient acuity or severity or their family/caregiver support systems are sufficiently unstable or fragmented (e.g., due to severe family violence, parental psychopathology, or multiple out-of-home placements) to require being addressed prior to group or individual PTSD education and trauma memory work, other psychotherapy models warrant consideration as an approach to stabilization prior to implementing TF-CBT or an alternative approach entirely (Box 8.3).
Box 8.3 Deciding When and with Whom to Use TF-CBT

In the real world, clinicians are faced with the question of when and how best to use TF-CBT as the sole therapeutic intervention or combined with other psychosocial or pharmacotherapy treatment modalities. Lang, Ford, and Fitzgerald (2010) summarized the following recommendations to guide this decision based on the published clinical research on TF-CBT.

For what age range is TF-CBT effective? Children from 3 to 17 years old have received TF-CBT in research studies, primarily school-age children and adolescents. Preschool children have been able to participate beneficially in all phases of TF-CBT (Scheeringa et al., 2007) as long as more extensive caregiver involvement and emphasis on teaching behavior management skills to parents are provided than with older children (Bouchard, Mendlovitz, Coles, & Franklin, 2004).

Is TF-CBT effective in the aftermath of traumatic stressors other than sexual abuse? A modified form of TF-CBT, called Cognitive Behavioral Therapy for Child Traumatic Grief (CBT-CTG), has also been shown to be associated with improvement in symptoms of PTSD and CTG in children following the traumatic death of a loved one, although no definitive research studies have been completed (Lang et al., 2010). When TF-CBT was provided in New York City to multiply traumatized children and adolescents after the September 11, 2001, terrorist incidents, the recipients showed a greater rate of improvement over 6 months than children who received other services, despite the TF-CBT group having more severe traumatic exposure (including physical abuse, sexual abuse, community violence, and painful medical procedures) and greater family adversity (CATS Consortium & Hoagwood, 2007). Thus, TF-CBT may be applied to children or adolescents who are troubled by specific memories of traumatic stressors when those memories include traumatic experiences of a wide variety of types.

Is TF-CBT effective without caregiver participation? Children who receive TF-CBT fare best when their parent(s) are able to participate and provide positive support without expressing high levels of distress. TF-CBT also may help parents improve their own depression symptoms, emotional reactions, and parenting practices. One study by King et al. (2000) found no significant differences in improvement on PTSD symptoms, depression, anxiety, or behavior problems when sexually abused children received TF-CBT with or without a participating parent. However, parent participation was related to greater reductions in the child’s degree of emotional distress about having been sexually abused. Parents are not mere bystanders in TF-CBT but play a crucial role in providing acceptance and role modeling for their child, which may be a source of renewed hope, confidence, and self-worth for children who are emotionally wounded by abuse.

(Continued)
Three special cases that arise unfortunately often with abused children and adolescents have not been formally studied in relation to whether TF-CBT can be done safely and effectively. The first is children who have no current primary caregiver or multiple temporary adult caregivers (such as due to placements in residential treatment or foster care, having an incarcerated parent). The second is children whose primary caregiver is significantly psychologically or emotionally impaired (such as due to mental illness or substance use disorders). The third is children whose primary caregivers significantly in conflict (such as an ongoing contentious divorce). In these cases, a clinical decision should be made about whether any reliable caregiver is psychologically stable enough to participate and support the child in TF-CBT. Parents expectably experience mixed feelings of anger, shock, guilt, shame, disbelief, avoidance, and minimization related to their child’s traumatic experiences, and TF-CBT is designed to help the parent deal with their own distress in order to be emotionally available and supportive for their traumatized child. If a parent is unable to play that role and participate in TF-CBT, another adult caregiver (which may include foster parents, a mentor, a family member who is a surrogate parent) should be included as long as that caregiver is likely to be involved with the child for more than a temporary period. A caregiver’s willingness to be consistently involved in the child’s life and ability to understand the importance of making and following through with an emotional commitment to the child’s full recovery and healthy development appear to be the crucial factors in determining whether TF-CBT can benefit the caregiver and, through the caregiver, benefit the child. However, the specifics of caregiver involvement remain a question in need of further scientific investigation.

When parental unavailability, conflict, or psychological or behavioral problems are sufficient to cause additional ongoing stress for a traumatized child, several alternative therapies described in this chapter may be helpful before or in lieu of TF-CBT. With young children, CPP and PCIT are designed to enhance caregiver empathy, responsiveness, consistency, and communication in relation to their child, potentially preparing the caregiver as well as the child for TF-CBT. When caregiver substance abuse may compromise the safety or emotional security of the child, Seeking Safety or TARGET may help the caregiver to simultaneously address their substance use issues.

Is TF-CBT effective without trauma memory work? A study with more than 200 children ages four to eleven years old who had experienced sexual abuse and had current posttraumatic stress symptoms found that TF-CBT was equally effective in reducing the children’s PTSD and depression symptoms and increasing their ability to maintain safe relationships without the trauma narrative as when the trauma narrative was conducted (Deblinger et al., 2011). However, a relatively brief version (8 sessions) that included the trauma narrative was shown to be
particularly effective in reducing the parents’ and children’s distress related to the past abuse. On the other hand, a lengthier (16 session) version that did not include the trauma narrative led to greater improvements in parenting practices and fewer “acting out” behavior problems by the children. Thus, there seem to be a number of potential active ingredients in TF-CBT that address different aspects of the adverse impact of traumatic stress reactions by children who have been sexually abused – including but not limited to the trauma narrative. There is evidence that other cognitive and behavioral components of TF-CBT may certainly be beneficial to children suffering from PTSD symptoms (Feeny, Foa, Treadwell, & March, 2004). For example, the CATS study (CATS Consortium & Hoagwood, 2007) showed that providing only the initial TF-CBT preparatory components (psychoeducation, parenting skills, relaxation, affective expression, cognitive coping) without the trauma narrative was as effective for children with mild PTSD symptoms as the full TF-CBT model was for children with severe PTSD symptoms.

Is TF-CBT effective for children with “complex traumatic stress disorders” or those with other (“comorbid”) psychiatric conditions? TF-CBT studies have included children with other psychiatric symptoms, including problems with depression, panic, obsessions and compulsions, substance abuse, eating disorders, suicidality, and complex traumatic stress symptoms (such as dissociation, self-injury, and oppositional behavior). TF-CBT has been shown to be effective in reducing the severity of depression symptoms, but specialized interventions may be needed during or prior to Phase one in order to ensure that anxiety, addiction, suicidality or self-injury, dissociation, or oppositional-defiance do not interfere with Phase two narrative reconstruction. Specialized therapies designed for other psychiatric disorders or others designed to enhance children’s or adolescents’ emotion regulation skills may serve this purpose (such as Life Skills Life Story, Real Life Heroes, Seeking Safety, SPARCS, or TARGET; Ford & Courtois, 2014). Research is needed to identify if, when, and for whom different combinations of therapies lead to enhanced outcomes, and when and for whom TF-CBT’s preparation for the child and caregiver prior to trauma narrative work is sufficient to address complex traumatic stress symptoms.

The most extensively validated self-regulation intervention for youth with PTSD is Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford, 2015;
TARGET teaches a seven-step sequence of self-regulation skills summarized by the acronym FREEDOM. The first two skills—focusing and recognizing triggers—provide a foundation for shifting from stress reactions driven by hypervigilance to proactive emotion regulation. The next four skills provide a dual-processing approach to differentiating stress-related and core value–grounded emotions, thoughts, goals, and behavioral options. The final skill teaches ways to enhance self-esteem and self-efficacy, recognizing how being self-regulated makes a contribution to the world. Youth also create a personal “lifeline” through drawing, collage, poetry, and other creative arts, in order to chart the course of their entire life, including traumatic events, losses, and times of success and happiness.

A randomized clinical trial with delinquent or justice-involved girls with dual diagnosis PTSD, substance use, and other (e.g., oppositional-defiant, depression, panic) disorders showed that a 10-session individual TARGET intervention was superior to relational psychotherapy in reducing PTSD and depression and improving emotion regulation (Ford et al. 2012). Additional evidence for TARGET’s effectiveness as a group and milieu therapeutic intervention with detained or incarcerated boys and girls was provided by two quasi-experimental studies that showed reductions in violent behavioral incidents and coercive restraints and improvement in PTSD, depression, and hope/engagement in rehabilitation following TARGET (Ford & Hawke, 2012; Marrow et al. 2012). TARGet also has been shown to be effective in enhancing emotion regulation and reducing PTSD with traumatized mothers of young children (Ford et al., 2011).

A four-step skill set, T4, was developed based on the field trials for JJ facility and community (e.g., probation) staff. TARGET has been disseminated in several state juvenile justice and child protective services systems (e.g., Connecticut, Florida, Illinois, Ohio) and is being disseminated in Learning Communities in the New York City, Oakland (Alameda County), and San Jose (Santa Clara County) juvenile justice systems by the NCTSN Center for Juvenile Justice and Trauma Recovery. TARGET has been certified as an “effective” intervention (highest level of evidence) by the Office of Juvenile Justice and Delinquency Programs Model Programs website (http://www.ojjdp.gov/mpg/Program) and received the highest rating for dissemination infrastructure (and a positive rating for the science evidence base) by the National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov).

Emerging evidence-based psychotherapies for children and youth with PTSD

Five manualized treatments originally developed and validated with adults with PTSD also have been adapted for and empirically evaluated in clinical trial studies with latency age children and adolescents: Prolonged Exposure (PE; an exposure-based trauma memory processing intervention; Foa, McLean, Capaldi, & Rosenfield, 2013; Gilboa-Schechtman et al., 2010), Cognitive Processing Therapy (CPT; a cognitive
restructuring intervention but includes narrative memory processing; Matulis et al., 2014), EMDR (a modification of exposure and cognitive therapies; Shapiro, 2013), Trauma and Grief Components Therapy for Adolescents (TGCTA; a group therapy with exposure and narrative processing components; Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001), and KID Narrative Exposure Therapy (KIDNET; a modification of exposure and narrative processing therapies; Ruf et al., 2010). In addition, two school-based group therapy and psychoeducation programs (Cognitive Behavioral Intervention for Trauma in the Schools, CBITS; Kataoka et al., 2011; Stein et al., 2003; and Enhancing Resiliency Amongst Students Experiencing Stress, ERASE-Stress; Berger, Gelkopf, & Heineberg, 2012; Gelkopf & Berger, 2009) and a dyadic mother-child therapy for toddlers exposed to violence (Child-Parent Psychotherapy, CPP; Lieberman, Ghosh Ippen, & Van Horn, 2006) have been found to be effective in rigorous studies.

Prolonged Exposure Therapy

PE utilizes two primary therapeutic tools: imaginal exposure and in vivo exposure. Imaginal exposure involves “revisiting” the most currently distressing traumatic memory and providing a detailed verbal account of the traumatic memory that includes sensory information, thoughts, feelings, and reactions experienced. While recounting their traumatic memory in vivid detail, patients are instructed to verbalize subjective units of distress every 5–7 minutes on a scale from 0 to 100 or 0 to 10. In vivo activities outside of session involve actually having contact with feared people, places, and things that are reminders of past traumas but that are not currently dangerous. This is done starting with reminders that elicit a moderate level of anxiety (i.e., SUDS of 40) and keeping track of SUDS while remaining in the situation until distress decreases. A published manual provides detailed instructions for carrying out each PE phase (preparation, imaginal exposure, in vivo exposure, closure; Foa, Chrestman, & Gilboa-Schechtman, 2008). Two randomized clinical trial studies with girls who had experienced sexual abuse (Foa et al., 2013) and adolescent girls and boys who had experienced single-incident traumatic stressors (e.g., severe accidents; Gilboa-Schechtman et al., 2010) provided evidence of lasting therapeutic benefit (i.e., reduced PTSD and depression, improved psychosocial functioning) that was greater for 14-session PE than for supportive or psychodynamic therapies.

Cognitive Processing Therapy

CPT is an individual psychotherapy that was originally 10–12 sessions for adults with PTSD but has been adapted in a longer format for youth with PTSD. CPT involves first writing an impact statement of the personal meaning of the currently most distressing traumatic event, including the effect on beliefs about self, others, and the world, including themes such as trust, safety, self-esteem, and life goals. Subsequent
sessions focus on identifying maladaptive thoughts (stuck points), increasing awareness of connections between thoughts and feelings, and processing a traumatic event by writing and reading a detailed narrative account and Socratic questioning designed to help challenge maladaptive thinking patterns while reexamining and elaborating or modifying the trauma memory’s narrative description by “weighing the evidence” for and against maladaptive thoughts. Two versions of CPT are available: the original manual, which includes the creation of a detailed trauma narrative, and the CPT-C manual, which involves the creation only of an “impact statement” regarding the aftermath of the trauma without requiring a detailed narrative account. Research suggests that the two versions are equally effective and that the CPT-C manual may confer the advantages of demonstrating more rapid treatment gains with fewer clients terminating prematurely (Resick et al., 2008; Walter, Dickstein, Barnes, & Chard, 2014). Although the manuals developed for adults have been used with success in samples of traumatized youth (e.g., Chard, Weaver, & Resick, 1997), recently a revised version of the CPT manual has been developed specifically for adolescents (Matulis et al., 2014). Research to date shows that a brief group version of CPT with incarcerated boys was superior to wait-list control in reducing PTSD and depression symptoms (Ahrens & Rexford, 2002). In addition, the longer (31 session) developmentally adapted individual manual (which includes emotion regulation and interpersonal effectiveness skills) showed evidence of reduced PTSD and depression with 10 female and 2 male adolescents with abuse-related PTSD (Matulis et al., 2014).

Eye Movement Desensitization and Reprocessing

In EMDR, a currently distressing trauma memory is repeatedly described briefly (unlike PE, typically for less than 1 minute), with titration of the exposure intensity (as done in PE) and negative beliefs carefully identified (as done in CPT). In addition, a distractor task is used during memory recall. Originally, as implied by the intervention’s name, the task was eye movements done back and forth, but it alternately can be any form of bilateral (i.e., moving from left to right and vice versa) audio, visual, tactile, or kinesthetic stimulation (such as tapping on alternate sides of the shoulders, or moving the limbs alternately on each side of the body). The client then “blanks out” the memory while refocusing on body awareness and breathing deeply. When trauma memory recall is associated with little or no subjective distress, a cognitive exercise called resource installation is conducted, with the client focusing on a positive belief rather than the trauma memory while performing the distractor task. Positive beliefs (e.g., “I can handle this”) also are identified and rated on a seven-point Validity of Cognitions scale.

Trauma and Grief Components Therapy for Adolescents

TGCTA is delivered in group sessions that comprise four modules. The first teaches foundational knowledge and skills to enhance posttraumatic emotional, cognitive, and
behavioral regulation and interpersonal skills. Next, the group processes members’ narratives of traumatic events (similar to CPT), followed by additional sessions in which grief and loss narratives are processed in order to facilitate the resolution of traumatic bereavement. A final module involves sessions to facilitate application of the knowledge and skills to current and future life challenges.

TGCTA was first developed, disseminated, and evaluated in a randomized trial for adolescent war survivors in Bosnia in the 1990s (Layne et al., 2008). It has since been implemented successfully for urban, gang-involved and at-risk youth in California (Saltzman et al., 2001) and for at-risk youth in the Delaware schools (Grassetti et al., 2014). It has been disseminated in NCTSN Learning Collaboratives and Learning Communities in many states since 2011 with trauma-informed milieu training (Think Trauma; see www.NCTSN.org) for facility staff. TGCTA’s four modules address: (i) foundational knowledge and skills to enhance posttraumatic emotional, cognitive, and behavioral regulation and improve interpersonal skills; (ii) group sharing and processing of trauma experiences; (iii) group sharing and processing of grief and loss experiences; and (iv) resumption of adaptive developmental progression and future orientation. In both the randomized Bosnian trial and open trials with gang-involved US youth, TGCTA was associated with reduced PTSD, depression, and maladaptive grief reactions and improved school behavior (Layne et al., 2008; Saltzman et al., 2001). The manual is designed to be used not only by trained, masters-level clinicians but also by teachers, facility staff, and coaches. Each session contains step-by-step instructions for implementation, including suggested scripts for the exact language to use while conducting groups. Groups of 8–10 youth are generally led by two group leaders. Although single-gender groups are recommended, some facilities report successful implementation with mixed-gender groups. TGCTA’s unique contributions for justice-involved youth are twofold: it includes group processing of trauma experiences (most often community violence exposure), which harnesses adolescent peer influence to promote greater self-regulation, and it has a full component for group processing of grief and loss. Because TGCTA is a modularized intervention, facilities that retain youth for briefer periods can implement only Modules I and IV, rather than implementing the full four-module version of 24 sessions, and the Bosnian research showed effectiveness for the briefer version (Layne et al., 2008).

KID Narrative Exposure Therapy

KIDNET is an adaptation of Narrative Exposure Therapy, a short-term therapy for individuals with PTSD symptoms due to traumatic exposure to organized violence (including refugees and asylum seekers) and natural disasters. KIDNET provides eight individual therapy sessions designed for refugee children with PTSD related to war and other types of organized violence. Rather than focusing only on trauma memories, the child is helped to build a chronological narrative of his or her entire life, including a detailed description of traumatic experiences (similar to PE) that is recorded in writing by the therapist and given to the child (as a form of personal
“testimony” to underscore the child’s resilience as a survivor) at the end of therapy. Active listening, unconditional positive regard, and creative tasks (e.g., constructing a lifeline with flowers and stones; representing positive and negative events along a rope to illustrate significant events; reenacting body positioning, during which children show therapists the ways they physically positioned their body during an event). Research studies testing KIDNET have shown its effectiveness in reducing children’s PTSD symptoms even when traumatic violence is still ongoing or is an imminent danger (Robjant & Fazel, 2010). In one study, 26 children traumatized by organized violence were randomly assigned to KIDNET or to a waiting list. Children who received KIDNET group but not the controls showed a clinically significant improvement in PTSD, depression, and anxiety symptoms and in their functioning with their families, peers, and at school, with these gains continuing a year later (Ruf et al., 2010).

Seeking Safety

Seeking Safety is a 25- to 30-session multicomponent group or individual therapy designed originally for adults with co-occurring PTSD and substance use disorders. Seeking Safety teaches cognitive behavioral skills for coping with both PTSD symptoms (including complex symptoms such as emotion dysregulation, dissociation, and impulsivity) and addictive urges and habits involving alcohol or other drug use. Seeking Safety has shown promising results in numerous clinical field trial studies with generally comparable positive outcomes to those of comparison therapies such as relapse prevention and multimodal case management (Najavits & Hien, 2013). The most consistent findings for Seeking Safety with multiply disadvantaged and polyvictimied adults have been reduction in PTSD symptoms (Najavits & Hien, 2013). In a study with 33 primarily Caucasian female adolescents who reported multiple traumatic exposures (88% sexual abuse, 82% disaster/accident, 73% physical abuse) and met criteria for PTSD and one or more substance use disorders, Seeking Safety was associated with greater improvements than a wait-list control group on self-reported addiction and physical health problems. Seeking Safety’s immediate posttreatment (but not 3-month follow-up) outcomes across a range of domains (including addictive disorders risk factors, depression, somatic/anorexic problems)—but not PTSD symptoms—surpassed those of SUD treatment-as-usual (Najavits, Gallop, & Weiss, 2006).

Cognitive Behavioral Intervention for Trauma In Schools

CBITS involves ten 60-minute weekly group sessions (with between six to eight children in each group) and one to three individual sessions to prepare the child for the group session in which group members each describe a trauma memory. Parents are provided with two education sessions and teachers with one education session so that they can support the child(ren) involved in the group. Six activities are included in C-BITS, including education about PTSD symptoms, relaxation training, skills
for challenging anxious thoughts ("cognitive therapy"), trauma memory reconstruction ("stress or trauma exposure"), in vivo confrontation of reminders of traumatic or stressful experiences, and skills for solving problems in relationships ("social problem solving skills").

Thus, CBITS differs from TF-CBT in the setting (schools), format (group rather than individual and parent-child therapy), and age (10–15 years old, but not younger or older children) and types of traumatic stressors (including family and community violence, and disasters and severe accidents, but not sexual abuse) of the children for whom it was designed. CBITS is similar to TF-CBT in teaching self-management skills and assisting participants in trauma memory reconstruction, although the trauma memory work in CBITS is done in a much briefer manner (one to two sessions) and trauma narratives are shared with the entire group. CBITS has shown evidence of reducing youth- and parent-rated PTSD and depression symptoms in two studies, one with primarily ethnoculturally minority-group children and a comparison group of children from another location (Stein et al., 2003), and the second with an ethnoculturally diverse urban sample of children and delayed treatment comparison condition (Kataoka et al., 2011).

**ERASE-Stress**

ERASE-Stress involves 12–16 classroom sessions each lasting 90 minutes, with psychoeducation about PTSD, training in stress management and emotion regulation skills, and resiliency strategies. The intervention is unique in that it is delivered by homeroom teachers with training and supervision by traumatic stress clinician. In two studies (Berger et al., 2012; Gelkopf & Berger, 2009), middle school (early adolescence) students living in Israel who were exposed on an ongoing basis to the threat and actual occurrence of war-related violence received either the 12- to 16-session ERASE-Stress classroom education program or the school’s usual classes. Almost half of the youths initially had a likely diagnosis of PTSD. In follow-up assessments 1 or 3 months after the ERASE-Stress intervention ended, students receiving ERASE-Stress reported reduced PTSD, anxiety, depression, and physical health symptoms and improved school, peer, and family functioning, but the usual curriculum students did not.

**Child-Parent Psychotherapy**

CPP engages mothers in verbal and nonverbal play with their infant or toddler in order to strengthen or restore the mother’s capacity to be empathically and responsively available to her child (Klatzkin, Lieberman, & Van Horn, 2013). CPP therapists do not instruct or correct the mother or child, but instead provide developmental guidance through reflective comments that are hypotheses about what the child may be thinking and intending and the meaning that this has for the mother in light of the tension between her own posttraumatic reactions and her caring and affection for her
child. CPP therapists also model appropriate protective behavior, provide the mother with emotional support, and assist her with crisis intervention and practical problem solving when stressors occur in the family’s current life. CPP therapists pay special attention to helping the parent and child understand the impact of traumatic events on their individual and shared experience, as well as to access and share memories of positive experiences together (and for the mother, experiences of being cared for as a child or adult by her own parents) in order to sustain the mother as she cares for her child and both recover from the impact of trauma.

### Other empirically based psychotherapy models for adolescents with PTSD

Several other psychotherapies for children or adolescents with PTSD have been developed (Ford & Courtois, 2013) or adapted from adult versions (Courtois & Ford, 2009) with detailed manuals and training programs to ensure that the intervention is delivered accurately.

**Attachment, Self-Regulation, and Competency (ARC).** ARC provides therapeutic activities to achieve goals within three domains: attachment (building and supporting safe and responsive care by primary caregivers, providers, and milieus); self-regulation (supporting youth capacity to identify, modulate, and express emotional and physiological experience); and competency (building self-reflective capacities, problem-solving skills, and a coherent and positive understanding of self). A published manual describes experiential activities to address each goal in psychotherapy and in modifications to the youth’s milieu through staff training and family education (Blaustein & Kinniburgh, 2010).

**PCIT** (Urquiza & Timmer, 2013). PCIT is a behavioral parent management approach to family psychotherapy with traumatized young children and their parent(s) that takes a more behavioral approach to teaching parents skills for encouraging positive behaviors (such as active play and compliance with parental rules and requests) and reducing negative behaviors (such as angry defiance or impulsive acts) while they play with their child. PCIT has shown evidence of helping abusive parents to function more effectively in parenting (Timmer, Urquiza, Zebell, & McGrath, 2005), but it does not directly address traumatic stress reactions, and it has not been tested specifically with traumatized children with PTSD.

**Real Life Heroes.** Kagan (2008) developed and field tested Real Life Heroes as an therapy and educational intervention for young to school-age children. The therapy helps children identify their heroes, recognize how they have the same or similar qualities and skills as their heroes, and utilize this sense of “the hero within” to restore their confidence and overcome fear.

**Sanctuary.** Sanctuary is an organizational change model rather than an individual or group therapy (Bloom, 2013). Its aim is to establish a trauma-informed culture that supports youth in recovery from the impacts of traumatic stress, while simultaneously providing safety for clients, families, staff, and administrators. Seven features of the
environment are addressed in order to build a culture of nonviolence, emotional intelligence, inquiry and social learning, shared governance, open communication, social responsibility, and growth and change.

Skills Training in Affect and Interpersonal Regulation (STAIR). STAIR is a well-validated individual psychotherapy for women with PTSD related to childhood maltreatment and violence (Cloitre et al., 2010) that was adapted as a group therapy (STAIR-A) for adolescents by Cloitre, Cohen, and Koenen (2006) to teach skills for emotion regulation and interpersonal effectiveness, and, with this as a base, to guide the youth in narrative reconstruction of the story of their entire life (including traumatic events). A psychoeducation module addressing psychological trauma and emotion identification is followed by modules on emotion regulation and interpersonal communication skills, with deep breathing and safety planning integrated into all sessions. A preliminary clinical study of the adolescent adaptation (Gudino et al., 2014) with 38 adolescent psychiatric inpatients reported decreases in PTSD and depression symptoms and increased coping self-efficacy after participating in between 3 and 36 group STAIR-A sessions.

SPARCS. SPARCS (DeRosa & Pelcovitz, 2008) is a group therapy that integrates key concepts from three evidence-based treatment models: Dialectical Behavior Therapy (DBT; DeRosa & Rathus, 2013), TARGET (Ford, 2015); and TGCTA. SPARCS is designed to enhance self-regulation, relationships, self-perception, and confidence in pursuing future goals.

Trauma Systems Therapy (TST; Saxe, Ellis, & Kaplow, 2007). TST takes a family systems perspective with a “wraparound” approach to providing the full range of services needed by children and families recovering from PTSD. The “wraparound” approach involves parents, teachers, counselors, pediatricians, child protection workers, mentors, probation officers, educational guidance professionals, recreational and occupational therapists, social workers, psychiatrists, and psychotherapists as a collaborative team working together to identify and address needs and stressors affecting each child and their family, school, and community. TST includes education about PTSD, cognitive behavior therapy skills for self-management of anxiety, affect and interpersonal regulation skills, and family therapy to these wraparound teams, thus helping a large array of providers to better help children with PTSD. TST is designed to help youths and families move through five phases of recovery from posttraumatic stress: “Surviving, Stabilizing, Enduring, Understanding, and Transcending.” Ellis et al. (2012) reported positive results in a sample of 124 children and adolescents exposed to potentially traumatic events. Over the course of a 15-month follow-up, youth who received the TST intervention showed improvements in emotion regulation, general functioning, and social-environmental stability and were less likely to be hospitalized than children in routine mental health care.

Pharmacotherapy for children with PTSD

Pharmacological interventions are often considered as an adjunct to psychotherapy for PTSD. Medications can reduce symptoms when impairment disrupts daily functioning
or help the child tolerate emotional pain associated with traumatic memories that may be augmented by psychotherapy (Connor, Ford, Arnsten, & Greene, 2014). Selective serotonin reuptake inhibitors (SSRIs) are often chosen for treating pediatric PTSD, but Cohen, Mannarino, Perel, and Staron (2007) found no evidence in a randomized clinical trial of added benefit when a SSRI (sertraline) was combined with TF-CBT for 10- to 17-year-old youth who had histories of sexual abuse. A 10-week randomized controlled trial using an independent sample of sertraline (50–150 mg/day, mean dose 115 mg/day) did not offer any advantage over placebo on a measure of PTSD symptom severity (Robb, Cueva, & Sporn, 2010). Although SSRIs may have a role in treating anxiety and depressive disorders comorbid with PTSD, their efficacy for children with PTSD is not evident. Adrenergic medications such as guanfacine extended release (which has shown promise in an open trial for traumatized children’s daytime hyperarousal) and prazosin (which has demonstrated efficacy in reducing adults’ PTSD hyperarousal) warrant clinical trial studies (Connor et al., 2014).

Many psychiatric medications have been used by clinicians to treat children with PTSD, but there is very little scientific evidence about either the efficacy or the safety of these medications for these children. The most widely used medications are antidepressants, particularly the SSRIs such as sertraline (Zoloft) or paroxetine (Paxil), both of which have been approved by the US Food and Drug Administration for the treatment of adults with PTSD but not for children, and the selective serotonergic/noradrenergic reuptake inhibitors (SSNRIs) such as nefazodone (Desyrel) or venlafaxine (Effexor). Medications that have shown benefit with anxiety (such as the antihypertensive medicines propanolol (Inderol) or clonidine), aggression (such as the antiseizure medication carbamazepine (Tegretol) or atypical antipsychotic medicines), and attention deficit hyperactivity disorder (such as the stimulant medicines methylphenidate (Ritalin or Concerta) or Adderall).

Concerns about the safety of antidepressant medications because of increased risk of suicide among children taking them for depression led the FDA to issue a warning on all such medications. However, when prescriptions of these medicines for childhood depression became less common, suicides among teens increased (Gibbons et al., 2007). Suicidality, although uncommon, is a risk for children with PTSD, but depression also increases the risk of suicide, so effective treatment of depression is important with children who suffer from PTSD. Unfortunately, the only scientific study of the efficacy of medication for children with PTSD reported disappointing results (Cohen et al. 2007). Sertraline had no benefit compared to placebo with child patients who also received TF-CB alone. Therefore, Connor and Fraleigh (2008) make the following recommendation:

Medication therapy is considered adjunctive to other psychosocial treatments in childhood PTSD, and has two roles to play in the treatment of pediatric PTSD. These are to (a) target disabling PTSD symptoms so that daily impairment is diminished and the child may pursue a healthier developmental and psychosocial trajectory; and (b) help traumatized children tolerate emotionally painful material in order to participate in rehabilitative psychosocial therapy. Medication interventions should be considered for pediatric PTSD with the following characteristics: (a) severe PTSD symptoms that significantly interfere with daily
functioning; (b) moderate PTSD symptoms with a marked physiological component (autonomic nervous system hyperarousal, sleep disturbance, rage attacks, irritability); (c) disabling PTSD symptoms that do not respond to 6 to 8 weeks of psychosocial intervention with a family component; and (d) PTSD symptoms, which are comorbid with other pharmacologically responsive psychiatric disorders such as attention deficit/hyperactivity disorder, other anxiety disorders, psychotic symptoms, and/or depression. (p. 473)

No systematic studies of antipsychotics or mood stabilizers have been reported with children with PTSD (Connor et al., 2014). For children with ASD due to burn traumas, tricyclic and SSRI antidepressants have shown inconsistent evidence of efficacy, but a chart review study found a correlation between average morphine dose and amount of decrease in PTSD symptoms. Thus, pharmacologic pain control may help mitigate against ASD when traumatic events involve physical as well as psychological injury (Connor et al., 2014).

**Creative arts therapies**

Art is a familiar mode of communication, interaction, and learning for most children. Art therapy has been used as a means to help children express their observations, feelings, and thoughts in a visual or auditory rather than verbal manner, potentially providing a buffer against the intense emotional distress evoked by traumatic experiences and a way to experience mastery and competence as well as safety (Goodman et al., 2008). Art therapy has been provided to children in the wake of natural disasters (tsunamis, hurricanes, floods, fires), terrorism (the September 11 and Oklahoma City bombings), traumatic illness or injury and hospitalization, war, and traumatic losses. Although widely used, scientific research on the effectiveness of creative arts therapy for children with PTSD has not been reported. Orr (2007) describes the many media through which children can be engaged in art therapy:

... crayons, oil pastels, clay, paint, lots of paper, pencils, colored pencils, felt pens, paper, watercolor, tempera paint, watercolor paper and card stock, model magic, Playdoh, plasticine, water-based clay, precut magazine images, construction paper, tissue paper, string, yarn, glitter glue, and white glue. Materials were chosen for their ease of transportation to the sites, as well as for their therapeutic qualities. Drawing materials were brought to help children with storytelling of their experiences because they allowed for control, while paint was used to increase expression of feelings. Collage materials were used because they inherently provide structure, are easy to control, and stimulate children’s numbed imaginations. Three-dimensional materials were used to provide children with the opportunity to construct and reconstruct their environments and objects. (p. 355)

**Family systems therapies** (Ford & Saltzman, 2009). Family therapy addresses the impact of PTSD on all members of affected families, whether only one member (e.g., a rape) or the entire family (e.g., disaster or war in the family’s community) was
exposed to traumatic events. Family therapy is designed to (i) establish a functional “family system” by enhancing family members’ communication with one another and problem solving so as to increase the actual and perceived sense of safety, respect, caring, trust, and healthy development; and (ii) help family members get access to social support and resources (e.g., from neighbors and community members, or educational, governmental, or religious organizations or family/parent support programs). Family systems therapies have shown consistent evidence of effectiveness in achieving those goals with families in crisis due to losses, addiction, psychiatric illness, and legal and educational/work problems (Diamond & Josephson, 2005). However, few studies have investigated the efficacy of family therapy with families who have experienced psychological trauma or PTSD (Welch & Rothbaum, 2007). The only one scientific study of family therapy for PTSD did not involve children and failed to show any added benefit by family therapy when it was added to cognitive behavior therapy for PTSD (Glynn et al., 1999). However, an intervention for adolescents who have recovered from cancer and their families, and for children who are newly diagnosed with cancer and their families, has shown evidence of effectiveness in assisting the parents and children in reducing PTSD symptoms (Kazak et al., 2005) (Box 8.4).

Box 8.4  A Sample of Family Therapy for PTSD

The following simulated case vignette provides family therapy with a single-mother parent, her 15-year-old daughter from one prior relationship, and her 4- and 8-year-old daughter and son from a more recent relationship that ended 6 months ago due to the older daughter (M) reporting an incident of physical assault by her stepfather. M was described by her mother as oppositional-defiant at home since the age of 11. M accused her stepfather of emotional and sexual abuse at that age, but her mother had attributed the behavior to M’s “jealousy” toward her stepbrother and sister. M was born out of wedlock when her mother was 16 years old, and both lived with the maternal grandparents (with the truth of M’s parentage kept hidden) until her mother left home to marry M’s stepfather when M was 6 years old and brought M with her. When therapy began, M’s mother had called the police numerous times because M had stolen from her, was associating with friends who were using drugs, were several years older, and had dropped out of high school. Placement in a foster home was being recommended by the juvenile probation and child protective services professionals working with the family because there was no improvement in M’s “beyond parental control” behavior, and M’s mother was fearful that M would get pregnant and run away to live with one of the young men with whom she associated.

After six initial assessment and stabilization sessions in which the therapist (T) helped M and her mother to reframe their conflicts as mutually escalating stress reactivity, several altercations occurred between M and her mother, with the mother calling the police and M being arrested and placed in a juvenile detention facility. The following excerpts are from the next conjoint session.
T: I’m glad to see you again after what I’m sure has been a stressful period for all of you.

Mother: *(Sighs, looks at M with a combination of annoyance and resignation)*: I don’t think my daughter really wants to be a part of this family; she just wants her own way.

M: *(Looks off into space with no expression; then looks down at her hands)*

T: I can see that you’re each in a reactive state, so we need to deal with the triggers for each of you right now to help you get back in focus. *(Turning to the younger children)* How about if you two help us by showing us how good you are at being really focused with the books and art stuff over on this table? Could you do that? That’s great; we need you to just have fun and be really focused on whatever you like there, while your mom and M and I have a talk to help them get focused, too. So we’ll all be working on being focused, and we’ll check in with you so you two can show us how you do it, okay? *(Turns back to mother, while M intently watches her younger brother and sister play)* I can see how much you want M to be a part of this family, but I think your stress alarm is keeping you stuck in reactive feelings and thoughts. I can understand why you might be feeling very reactive, as a parent who loves your daughter and wants her to be safe and happy, and also to not make mistakes like ones that you feel you made at her age. Even though you’re certainly feeling some reactive feelings, including maybe feeling hurt or worried when you think that M isn’t going to be safe or be a part of the family. Would it be fair to say that love and hope for M are your main feelings underneath? It must be hard to get to those main feelings, and main thoughts like what you value about M and your relationship with her, when you’re having these understandably strong reactions.

Mother: Well, wouldn’t any parent feel like this if she had a daughter who was disrespectful and selfish? She is making the same mistakes I made, and she’s just as pigheaded as I was when I thought I knew everything as a teenager. Look what happened to me!

T: You want M to be openminded and thoughtful about her choices, not stubbornly or impulsively doing things that aren’t really what she wants or needs. Sounds like that’s not easy for you to do either, even now, so maybe it’s more that you and M both are very strong willed and emotionally intense, and that can look pigheaded or impulsive, but it’s really just needing to not be controlled by your stress reactions. And you’re working very hard to stay focused on making a good life for yourself and your children; as a single working mother, that’s a lot of stress—especially when you had to choose to protect your children instead of staying in your marriage. That took a lot of courage and a real focus on doing the right thing.
Box 8.4 Continued

Mother: I know I should have ended that relationship a long time ago, when
M said he was being abusive, but I just didn’t know what to do or
who to believe. (M looks up intently at her mother) I never wanted
my daughter or any of my children hurt, but I didn’t know it was
so bad until the time when I left M with him while the kids and I
visited my family. As soon as M told me what happened, I said that’s
it, enough, he’s out. I won’t let anyone hurt my daughter. (Looks
tearfully at M) I wish she could stop being angry at me and accept
that I really love her and will do whatever it takes so she’s okay.

T: (Turning to M, who looks down and away again after a pause) Is it a
trigger for you when your mom says things that might sound like she
thinks you’re the problem and maybe doesn’t want you to be in this
family? I’m not hearing your mom saying that exactly, but that could
be what you’re hearing now—or what you might have felt for a long
time if you didn’t know how to get your mom to understand how bad
things were.

M: (Pauses, looks intently at mother, who has her eyes closed, then looks
down, nods yes)

T: (Turns to the younger children, who have stopped their previously
active play and are looking wide-eyed at their mother and sister)
Well, this is some important stuff we’re talking about, and I see that
you two want to be sure that it all gets worked out okay. I’ll make
sure your mom and sister figure out how to make this okay, if you
could just help us by showing us how to focus again? That’s what
I’m doing with your mom and sister, but since you two already are
very good at focusing, it would be a very big help if you remind us
how to be focused. You should focus on stuff that you like, like those
books and toys and drawing, and that will help us focus really well
on the talking we’re doing. How does that sound? Is that a good plan,
Mom? (Mother refocuses on the younger children, smiles and nods
yes) Great, thanks, you guys for being such a good help to us by
showing us how you focus. (Younger children smile and resume play)
So I think maybe some of those really bad times are still bothering
each of you, and you haven’t known how to get your focus, together
as well as individually, back on your main feelings and thoughts and
goals. There are two ways to do that: one is to take some time, not
a lot but some sessions, and just deal with the triggers and reactive
emotions and thoughts that didn’t get dealt with entirely in past
stressful situations. I can help you do that in a way that is hard work
but doesn’t dredge up all the old stuff—just the specific triggers and
reactions that you don’t want to be bothered by all the time now. I
can do that privately with each of you and both of you together, but
we’ll need to do that when the younger kids aren’t here because it’s
really adult or young adult talk and not something that they are old
enough to be involved in. Is that something you’d each be willing to
do with me, maybe in some sessions in the next several weeks?
Mother and M: (Silently look pensive, then sigh and look accepting, and nod yes)

T: Okay, the other way we can do it right now, while you’re both more focused than you were when we started—did you notice that? (Pauses) You’re both very good at getting focused when you just do an SOS—slow your thoughts down, get oriented to what’s really important to you, and then start thinking or doing things that give you more personal control—and I see the younger kids are very good at focusing in their own way, too. (Everyone looks over at the younger children, who are playing happily and intently) So what we can do to help you both deal with the triggers and reactive feelings and thoughts that are coming between you is to talk about a recent situation where you lost your focus, but we need to focus on figuring out the specific triggers right then for each of you and how you tried to keep your focus so you can do that again and maybe be able to succeed a little better in keeping your focus when something similar happens.

M: Okay, how about the argument that happened between last night, when M took my phone and then wouldn’t admit it. After I told her I couldn’t trust her if she kept doing that, she turned around and didn’t get up to go to school this morning. How about that?

T: (Turns to M) Okay if we talk about that? Here’s the ground rules: we’re not just going to focus on what you did or didn’t do; we’ll include that, but we’re also going to talk about how your mom got triggered and what she did or didn’t do to be focused. The goal is for each of you to be able to keep your focus better, not to blame or punish anyone.

M: (Looks at mother, smiles) That would be different. I usually get blamed and punished.

Mother: (Looks affronted, turns to T, who calmly gives her a look of curious interest) I think a parent has to hold her daughter responsible and set limits. I don’t call that blame and punishment. Am I supposed to just give up and let her do anything?

T: You each make a good point. So it’s important to M to not be blamed or punished, and it’s important to your mom to be able to expect responsible behavior and set some limits. Those are good “main” goals, except M, I think that tells us more about what you don’t want than what you do want in your relationship with your mom. If she isn’t blaming or punishing you, do you just want her to let you do anything and totally leave you alone?

M: Sometimes, yes. (Turns to mom, smiles) But no, not really. I know I can’t just do what I want all the time, and I need to be responsible, but I try to do that, and she doesn’t notice except when she gets stressed out, and then I’m always the one she blames.

(Continued)
Posttraumatic Stress Disorder

Box 8.4 Continued

*T:* So what’s your main goal in your relationship with your mom and your life? What do you want her to do, and what do you want for yourself?

*M:* (Pauses) I just want her to notice when I do good things and not send me away. (Tears)

*Mother:* (Tears) That’s what I want, too, really. I never want you to go away, and I know I need to be better at noticing what you do that’s good so you know I think you’re great and I love you. I just get so stressed and worried. I know I shouldn’t have such high expectations for M. I do want her to be able to be a girl and not have to be an adult and miss out on all the fun and freedom of being a teenager, but these days that seems to mean doing things that kids never would have dreamed of when I was that age—smoking marijuana, staying out to all hours, having a car of her own. It’s just not what I think is right—it’s really dangerous for her because the drug use gets her depressed.

*T:* Let’s just slow down and take a moment to get focused, Mom. M seems very focused and is listening very carefully, so it’s important that she hears your “main” feelings and goals right now, and that you do, too. The reactive feelings and thoughts are important, but we don’t want them to take your focus away from what you really feel and want.

*Mother:* (After an extended pause) Okay, you’re right; it’s just hard. M always thinks very deeply about things, and she says she understands why I worry but that I should trust her and that I shouldn’t try to keep her a child when she needs to grow up and be her own person. She’s like me in that way: she wants her mom to trust her. And I want to, but I’m afraid I’ve failed her, and because of that, she’s going to shut me out and just do whatever she wants—or thinks she has to—like I did when I was her age.

*T:* So things happened to you when you were M’s age or younger that made you feel unsafe or unprotected, and you shut people out and just did what you felt you had to.

*Mother:* (Looks down, tearful) It’s not something I talk about, and it was different back then; the expectations were different, and some things could happen that you had to just keep secret. I thought I’d dealt with all that, and I don’t want M to have that happen.

*T:* Sometimes feelings from bad experiences can get triggered even if you’ve tried to put the memories behind you, and if that interferes with your focus when you really want to do the right thing—as a parent or as a 15-year-old—and when you don’t want it to turn into a conflict or hurt someone you care about—whether you’re the daughter or the mother—then you may have dealt with it very well but just not quite finished by putting it all into focus so you know how to deal with triggers when they come up again now. I think that’s what comes between you both now, more than anything else. M, do you sometimes have feelings or even memories that are from the past but all of a sudden can really bother you now? Maybe that’s when you do things like taking stuff from your mom, which you know you shouldn’t and don’t even really want to, but those feelings can just take your focus away, and you’re not really choosing but reacting?
Treatment of children and adolescents with PTSD

Real-world challenges in treating children with PTSD

In order to select, adapt, and successfully deploy available evidence-based or promising (evidence-informed) assessment and intervention protocols clinically with children with PTSD, several practical, therapeutic, and ethical considerations are essential (see Ford & Cloitre, 2009).

1. Identifying and addressing threats to the child or family’s safety and stability are the first priority. The ethical principles of “primum non nocere” (first do no harm) and “parens patriae” (temporary guardianship) are crucial because potential threats to the safety of children with PTSD include (i) self-harm and suicidality; (ii) ongoing family violence, abuse, neglect, substance abuse, or psychopathology; or (iii) behavior that places the child or youth at risk for sexual victimization, community violence (e.g., physical assault, gang
conflicts), abduction or kidnapping, life-threatening accidents, life-threatening illness (e.g., sexually or needle-transmitted diseases), or legal problems and incarceration. When threats to safety are ongoing or imminent, treatment should concentrate on accessing resources (such as child protective services, legal protections such as restraining orders on violent adults or supervised visitation with past or potentially abusive adults, and in-home services such as multisystemic therapy (Henggeler, 1998) or multidimensional family therapy (Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005)). If a youth is abusing substances, treatment for addiction and PTSD (such as Seeking Safety or TARGET) should be provided.

2. The first step in treatment is developing a therapeutic relationship with the child and caregiver(s). Traumatized children are young enough that they and their caregivers still are developing what Bowlby (1969) described as their “working models” of secure, responsive, helpful, and trustworthy primary relationships. When psychological trauma occurs, particularly developmentally adverse interpersonal trauma (Ford, 2005), children’s working models (and associated capabilities for self-regulation of emotion, consciousness, impulses, and bodily functioning) may remain in flux and become chronically disorganized for the rest of childhood and adolescence (Miltenerg & Singer, 1999) and into adulthood (Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006). The children’s caregivers, often traumatized in their own lives (as well as stressed by their child’s traumatization), may have difficulty in establishing and maintaining a secure and responsive relationship with their child and with the therapist. Thus, the therapeutic relationship with children with PTSD should be viewed as triadic rather than dyadic: bridges linking the child, caregiver, and therapist affectively to one another such that the therapist provides coregulation for the child and caregiver, empowering the caregiver to assume this role with the child while secure in the therapist’s unconditional, nonintrusive, noncompetitive empathy and guidance. The therapist’s role as coarchitect and cobuilder of these affective bridges with and between the child and caregiver is most evident in dyadic parent-child psychotherapies with young children such as CPP. However, creating and maintaining the triadic affective bridge is equally important with traumatized children and their attachment figures (who may be peers or mentors as well as, or instead of, the more obvious caregivers as the child grows into (pre)adolescence) at all ages.

3. Treatment with children and families is always relational. PTSD is so debilitating for children that therapists may feel compelled to achieve large goals such as complete recovery in order to prevent the child and parent from suffering disappointment in the face of what may seem to be intractable problems. The challenge for therapists is to shift from emphasizing overcoming pathology or deficits as the goal of treatment to focusing on a series of smaller goals that are of immediate personal relevance to the child and caregiver(s) (Ford & Russo, 2006). For example, rather than assuming that a child or caregiver will automatically agree that reducing avoidance of reminders of past traumatic experiences is a desirable treatment goal, the child’s and caregiver’s engagements and buy-ins to therapy are likely to be stronger if the therapist links reducing avoidance to the child’s desire to be successful in school, sports, theater, dance, arts, auto mechanics, or video games and with the caregiver’s hope that the child will be happier and more successful. Psychoeducation is important in every therapy for children with PTSD, and it is an opportunity to learn the child’s and caregivers’ goals, as well as to teach them about PTSD and recovery.

4. Treatment for children with PTSD is always strengths-based. The goals of psychotherapy for children and adolescents with PTSD include not only reducing the frequency and severity of PTSD symptoms but also enhancing biopsychosocial functioning. Existing or former strengths, resources, and resilience are the best predictor of children’s recovery from complex traumatic stress disorders and socioeconomic adversity. It can be very
difficult to discern meaningful strengths or competences with children or youth who seem to be severely impulsive, withdrawn, oppositional, despondent, terrified, regressed, dissociative, or detached. Similarly, their parents or caregivers often seem to be reactive, dejected, resigned, confused, and easily narcissistically wounded, although this may be an understandable outcome of experiencing frustration, loss, isolation, and helplessness secondary to their child’s past victimization and ongoing complex traumatic stress reactions. This requires a rigorous and disciplined focus on identifying and building on the capabilities that have made it possible for the child and caregiver(s) to continue to seek help (even if they seem to be rejecting or sabotaging that very help) and to pursue their personal goals (even if the goals seem to be primarily dysfunctional), beginning from the first therapeutic encounter and continuing in each subsequent assessment and treatment session. Interventions that explicitly orient the therapist and clients toward identifying the functional aspects of the clients’ goals and behavioral choices (e.g., TARGET’s distinction between “reactive” and “main” personal goals and behaviors; Real Life Heroes’ emphasis on finding the inner hero; Life Skills Life Story’s provisions for helping youths express their achievements as well as disappointments in a personal life story; ARC’s competence interventions) can help therapists maintain a consistent strengths-based approach in treating children with PTSD.

5. **All phases of treatment should aim to enhance self-regulation competences.** In order to help the child shift from a posttraumatic “survival brain” to a “learning brain” (see Chapter 5), self-regulation skills are essential. Self-regulation requires a shift by the traumatized child (and the child’s caregivers and role models) from emotional chaos to modulated emotion awareness and expression, from dissociation to planful and mindful goal-directed behavior, from neglect of their bodies to awareness and utilization of bodily cues as a guide to self-care and healthy growth, and from disorganized attachment models to responsible and healthy relationships.

6. With young children recovering from PTSD, dyadic psychotherapies such as CPP help caregivers to be a living example of emotion regulation. With school-age and preadolescent children, PTSD psychotherapies such as TF-CBT, CBITS, Real Life Heroes, SPARCS, and TARGET address emotion regulation by assisting children to develop a balance of autonomy, relatedness, and impulse control in peer interactions as well as in family. In adolescence, emotion dysregulation must be addressed in the form of eating disorders, conduct disorder, sexual and gender identity disorders, substance dependency, suicidality, and self-injurious behaviors that gravely complicate PTSD and compromise the youth’s safety due to serious problems such as incarceration, truancy, teen pregnancy, gang involvement, and suicidality. Intensive psychotherapies such as Seeking Safety or TARGET, or integrative programs such as ARC and TST, are critical to successful treatment of PTSD with adolescents who are not only anxious but out of control.

7. Posttraumatic dissociation is a reflection of severely disturbed affect regulation that is very challenging to treat directly in children because, for most children until adolescence, the degree of reflective self-awareness necessary to recognize dissociation has not yet developed. Therefore, childhood dissociation and PTSD are best addressed by helping the child to learn how to be aware of different states of mind just as she or he is learning to be aware of anxiety, fear, anger, sadness, and troubling emotions as recognizable and manageable stress reactions. For example, labeling specific emotions in TF-CBT and role modeling (e.g., by “thinking out loud”) a mindful or focused approach to defining immediate goals and behaviors that increase the child’s access to positive feelings and reduce the intensity of negative affect in TARGET can help a child to be aware of and able to (re)gain the ability to change dissociative states into manageable emotions.
8. Take steps to determine with whom, when, and how to address traumatic memories. The core goal for the treatment of children with PTSD is to enable them (and their caregivers) to attain what Harvey (1996) described as mastery or “authority” in relation to their own memories—including but not limited to memories of traumatic events (Vickerman & Margolin, 2007). As children develop or regain affect and interpersonal regulation competences that they need in order to recognize and utilize their emotions, think and remember clearly, and cope with reminders of traumatic experiences, they become able to actually tolerate and understand traumatic memories. However, if memories remain troubling and avoided, PTSD is likely to persist. Thus, the answer to the first question—“With whom should traumatic memories be addressed in psychotherapy?”—clearly is with every child (and as possible, caregiver) who is impaired as a result of PTSD or complex traumatic stress disorders (Cohen et al., 2006; Saxe et al., 2007).

9. The answer to the second question—“When?”—depends on the answer to the third question—“How?” There are really three answers to the latter question: (i) the therapist recognizes the cues and reactions that indicate that a child is probably experiencing, or about to experience, traumatic stress reactions and associated self-dysregulation and guides the child and caregiver in anticipating, preparing for, and nonavoidantly coping with these posttraumatic sequelae in the course of therapeutic and daily activities; (ii) the therapist teaches the child and caregiver to recognize traumatic stress reactions as ways that they adaptively coped with past traumatic events and helps them to use self-regulation skills to mindfully choose how to modify unnecessary or unhelpful aspects of those reactions, while preserving and intentionally utilizing the currently egosyntonic and psychosocially adaptive aspects of those reactions (i.e., to keep the baby but not the bathwater); and (iii) the therapist guides the child and caregiver in story-building activities that enable the child to purposively recall and gain a sense of mastery in relation to memories of specific past troubling traumatic events.

10. The first option—sensitive psychotherapeutic management of clients’ triggered distress—is at the core of Phase one in TF-CBT and all cognitive-behavioral, psychodynamic, and affect and interpersonal regulation psychotherapies for children with PTSD. Therefore, teaching self-management skills is the first step in PTSD treatment with any child or adolescent.

11. The second option—psychoeducation and self-regulation skills training to enhance clients’ understanding of and ability to manage trauma-related stress reactions and self-dysregulation—is indicated when (i) a history of exposure to specific psychologically traumatic event(s) has been confirmed or is probable based upon credible (preferably multiple independent) sources, including archival (e.g., child protective services, legal, school) or clinical records, and child and caregiver self-reports on structured trauma history instruments (see Chapter 6); and (ii) the child’s living arrangements and social support network are sufficiently stable to enable the child to regularly attend therapeutic sessions frequently enough to learn and practice self-regulation skills in emotionally and physically safe and relatively predictable and validating relationships.

12. When the third option—direct reconstruction of traumatic memories is undertaken—this typically is done with young children and caregiver(s) conjointly in spontaneous nonverbal activities (Van Horn & Lieberman, 2008). With older children (Cohen et al., 2006) and adolescents (Cloitre et al., 2006), traumatic memory reconstruction more often is done separately with the youth as a project in which the therapist assists the youth in repeatedly confronting a troubling memory (i.e., “exposure therapy”) with the goal of enabling the youth to think of the memory as a past experience that is over and done and that can be recalled as fully (i.e., including self-validating as well as upsetting aspects) as other
memories and placed within the youth’s larger personal story of her or his life (i.e., “narrative reconstruction”). With older children and adolescents, if possible, separate sessions are conducted with caregivers to prepare them and to help them address their own traumatic memories or stress reactions, followed by conjoint closure session(s) in which the child shares the reconstructed memory with the caregiver.

13. Therefore, trauma memory reconstruction requires (i) a physically and psychologically available permanent primary caregiver who is willing and able to help the child work through traumatic memories; (ii) a child with adequate core self-regulation capacities and environmental supports (in daily life settings and via a therapeutic safety net) to be able to manage episodically intense distress and stress reactions without becoming sufficiently affectively, dissociatively, or behaviorally destabilized to pose an immediate or chronic threat to the child’s psychological health or safety (e.g., due to suicidality, psychosis, severe self-injury, substance dependence, or severe aggression); and (iii) a therapist with expertise in conducting traumatic memory reconstruction intervention with children of this age and developmental epoch who have significant complex traumatic stress disorder impairments and who has access to sufficient psychiatric and crisis backup (e.g., pharmacotherapy, acute crisis evaluation and hospitalization, case management wraparound resources, pediatric care) to be able to identify, prevent, or rapidly resolve treatment-related or -unrelated crises.

14. The overall approach involves progressing from options one to three, with each successive approach utilized only if (i) traumatic stress or potentially traumatic stress-related symptoms and impairments are present and not sufficiently resolved or managed, and (ii) the necessary resources and competences are in place to move to the next level. In practice, the progression from trauma-informed psychotherapy (option 1) to traumatic memory reconstruction (option 3) might occur as rapidly as within a single intake evaluation or initial treatment session (e.g., a child referred following or during a course of psychotherapy and pharmacotherapy in which the child and caregiver were stably and productively involved, but the child nevertheless was persistently troubled or impaired by PTSD or complex traumatic stress symptoms associated with well-documented traumatic experience(s) and the therapist did not feel qualified to conduct trauma memory reconstruction interventions). Alternately, therapy might progress from the trauma-informed to the trauma-focused (option 2) approach following a few or several sessions of initial assessment and therapeutic engagement, and then continue at that level while completing an affect and interpersonal regulation-based intervention for PTSD.

15. Prevent and manage crises. Many (but not all) children with PTSD have had to cope with chronic and often unpredictable discontinuities in their primary relationships and social support systems: losses due to deaths, out-of-home placements, institutionalization, family abandonment, and serial treatment providers (Faust & Katchen, 2004), as well as neglect and abuse due to parental and familial psychopathology, substance use disorders, violent or antisocial lifestyles, or severe socioeconomic adversities. They often have come to associate caring adults or positive peers and peer-group activities as undependable and likely to lead to disappointment or rejection; thus, even apparently positive events (e.g., birthday, holidays, field trips, family visits, recognition for accomplishments in school, sports, or arts, graduation ceremonies, new residence or school) may escalate PTSD symptoms. This may be misinterpreted in pathologizing terms as self-sabotage, psychopathy or incorrigibility, inability to tolerate delay of gratification, or passive dependency. However, such distress and dysregulation is predictable when traumatic memories are elicited by and reenacted in times of relational uncertainty. Therefore, the best approach to preventing or managing crises or deterioration is to assist the child and caregiver (including health
care, educational, judicial/legal, and mental health professionals and social/human service program staff) in anticipating and addressing the predictable dysregulation. This involves understanding the adaptive components (such as the attempt to protect against additional distress and demoralization and to communicate to responsible adults the importance of relational continuity), and collaboratively joining with the child in using self-regulation skills to increase everyone’s sense of hope and trust. For example, to prepare for the transition from an intensive residential treatment program to a group or foster home, treatment for a child with PTSD might focus on helping the child to use affect regulation and relational skills to be able to remember that relationships don’t end just because people can’t see each other every day.

When crises cannot be prevented, a similar approach focused on restoring a sense of relational continuity and self-regulation provides a framework for helping to deescalate and stabilize the traumatized child or adolescent. This is an adaptation or special case of generic models of crisis intervention, which prescribe activating two key factors: (i) social support to reduce extreme spikes in the intensity of anxiety, dysphoria, anger, confusion, or detachment, and (ii) active problem solving in order to increase the sense of control, efficacy, and optimism. The primary threat to both objective and subjective social support for children with complex traumatic stress disorders is the loss of core relational (attachment) security, which the child experiences as a breakdown not just in relationships but in self-regulation of the body, emotions, impulse control, memory and thinking, and consciousness (dissociation). Thus, beyond the generic approaches to providing reassurance, immediate safety, structure, and limits (e.g., verbal deescalation tactics, time-out), crisis deescalation with traumatized children requires the use of several focal interventions: “grounding” strategies to counteract detachment, dissociation, and impulsivity (e.g., Cloitre et al., 2006; DeRosa & Pelcovitz, 2008; Ford, 2015) and affective engagement strategies to reestablish an immediate sense of emotional connection. In the aftermath of crises, therapeutic processing includes discussion of how the child used these self-regulation skills to successfully cope with PTSD’s stress reactions. Every crisis thus is an opportunity for PTSD treatment to highlight and enhance the traumatized child’s competence and sense of efficacy in her or his self-regulation skills and her or his trust in healthy relationships (Box 8.5).

### Box 8.5 Real-World Challenges in Treating Children with PTSD: A Case Example

Danielle (whose name and specific identifying information have been disguised to protect privacy) is a 16-year-old girl referred for treatment after her adoptive mother called emergency mobile psychiatric services because Danielle was unable to calm down following an argument. Danielle was removed from her biological mother’s care at the age of 4 due to her mother’s neglect, substance use, and domestic violence between her mother and her boyfriend. She was
placed in a series of foster homes, moving frequently between placements due to tantrums and accusations that she was stealing food and hiding it under her bed. At the age of 6, her biological father gained custody of her, but she was removed from his care and placed in a foster home at the age of 9 because he and her stepmother were physically and emotionally abusive toward her. She was adopted by her foster mother when she was 11 years old. Initially, Danielle got along well with her adoptive mother and did well in school, where she was a friendly and hard-working student. However, about 3 years ago, she began to exhibit a number of concerning behaviors. She started smoking cigarettes and marijuana and engaged in self-injurious cutting. She began wearing suggestive clothing and spending more time with a group of older adolescents, including a 16-year-old boy she referred to as her boyfriend. She became easily angered when she was told she could not do something, and she and her adoptive mother began to have increasingly heated arguments, often culminating in Danielle running away. Her adoptive mother reported that she did not feel able to control Danielle or keep her safe. In the past 2 years, Danielle has been involved in several individual outpatient and intensive outpatient therapy programs. She has been taken to the emergency department three times for evaluation due to behavioral concerns and has been hospitalized in an inpatient unit once due to an attempted overdose of pills. Her teachers report that she appears angry much of the time and seems to have difficulty paying attention in class. She is frequently defiant toward authority figures, and she has been suspended twice for fighting with other students. She often skips classes and leaves school grounds without permission, and she is at risk of failing several of her classes. Danielle frequently has trouble falling asleep, and in recent months she has had repeated nightmares of being murdered.

Alex was a typically developing boy before experiencing a single traumatic accident. He has had consistent social support and a stable and safe home environment. Immediately after the accident, he experienced symptoms of PTSD, including intrusive reexperiencing (nightmares and psychological distress at exposure to trauma reminders), avoidance of reminders of the accident (going outside to play), negative alterations in cognitions and mood (withdrawal from relationships, persistent sadness), and alterations in arousal and reactivity (irritable behavior and difficulty sustaining attention). Alex’s pediatrician was notified by the emergency department following his visit on the day of the accident. An APRN in the pediatrician’s office who was familiar with Alex and his family made a follow-up phone call to Alex’s parents to see how he was recovering physically and emotionally and arranged follow-up office visits for Alex. The pediatrician and APRN observed and talked with Alex and his mother at each visit, initially identifying no posttraumatic behavioral or emotional changes. At a 1-month post-ED visit, Alex was noticeably more on edge than usual, and his mother reported the preceding changes. The pediatrician explained to Alex’s mother that these were expectable reactions to the emotional shock of the accident and described how meeting with a therapist who specialized in

(Continued)
helping children to recover from traumatic stress reactions could enable them to keep track of Alex’s adjustment and provide a practical and efficient behavioral treatment if the symptoms did not improve. The APRN provided Alex’s mother with contact information for two therapists who had evaluated and treated other patients in the practice successfully after traumatic events, and encouraged her to call back if she had any questions or concerns and, if she decided to have Alex see one of the therapists, to have the therapist contact the pediatric office to coordinate care.

Alex’s mother decided to talk with both therapists and to take him to see the one with whom she felt most comfortable. To meet his needs, Alex’s therapist developed a treatment plan that addressed not only his anxious response but also his significant attention problems and social withdrawal, and she chose TF-CBT, an evidence-based approach to addressing posttraumatic stress symptoms in children (Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012) as her treatment modality. This involved a series of skill-based components presented to children and parents in parallel sessions and culminating in conjoint-sessions in which the child shares his or her “trauma story” with his parent(s). With the mother’s release, the therapist immediately contacted the pediatric office and described the treatment plan to the APRN in order to enable the APRN and pediatrician to check with Alex and his mother about their satisfaction with the treatment and Alex’s progress emotionally and behaviorally at a next visit.

Using this approach, the therapist first provided psychoeducation to both Alex and his mother about trauma and PTSD to help them understand Alex’s symptoms and behaviors as common responses to stressful events. Next, Alex was taught relaxation skills to help him recognize, understand, and reduce the physiological reactivity he is experiencing. His parents were taught positive parenting techniques to help them address specific concerns and behaviors. Next, affective recognition and modulation (including feelings identification, intensity ratings, and positive self-talk) was addressed, and then cognitive coping skills were suggested. Once Alex was able to effectively identify and express his feelings, regulate his emotions, and use cognitive coping skills to address distressing thoughts, his therapist told him that he was ready to create his trauma narrative, which could take the form of any developmentally appropriate undertaking that engaged him in thinking about his traumatic experience, including creation of a story, comic, or song. Alex chose to create a book about his life, his family, and the accident. Through exposure and therapist-guided cognitive-processing, Alex increased his ability to tolerate thinking and talking about his accident and identified and altered unhelpful and inaccurate beliefs about what happened (“it was my fault”), himself (“I’m a bad boy”), and the world (“it’s not safe to go outside”). When his trauma narrative was complete, Alex shared it with his parents, who had been carefully prepared by the therapist for this meeting, including engaging in role plays of supportive and validating responses, praise,
and feedback for Alex, thus providing the family the opportunity to practice talking about the trauma together and simultaneously enhancing the parents’ role as supportive and careful listeners for Alex. In addition to TF-CBT, an important piece of the intervention provided by the therapist was to work collaboratively with Alex’s school to help them understand and address the ways that his PTSD affected his school functioning. The therapist also kept track with Alex’s mother of subsequent pediatric visits and provided the APRN with a brief summary of the therapy and Alex’s progress prior to each visit. With this information, the APRN and pediatrician were able to efficiently check with Alex’s mother about her perception of Alex’s recovery and therapy and to observe how Alex was doing behaviorally in each visit. There were no setbacks in this case, but had Alex experienced a worsening or resurgence of traumatic stress symptoms, the APRN was prepared to inform the therapist so the psychotherapy could be adapted to address the problems in a timely manner.

In contrast, Danielle endured multiple interpersonal victimization events and traumatic losses throughout her early childhood, including emotional and physical abuse at the hands of both her mother and father, twice being removed from her biological parents’ home, and multiple placements in foster homes. While initially Danielle was relatively asymptomatic despite her significant trauma history, the onset of adolescence brought with it a delayed posttraumatic response. Danielle exhibited some of the more typical symptoms of PTSD, including intrusive reexperiencing (nightmares), avoidance of school, and hypervigilance (sleep and concentration problems), but her predominantly dysphoric, angry, and aggressive symptom presentations (including cutting herself) were not identified as associated with posttraumatic stress. However, as previously noted, the DSM-5 diagnosis of PTSD has added symptoms of pervasive blame, dysphoria, aggression, and self-harm, consistent with Danielle’s pervasive difficulties with self-regulation and interpersonal relatedness that manifest as difficulties with emotion regulation, somatization, attention, impulse control, dissociation, interpersonal relationships, and self-attributions. Danielle had had limited and inconsistent pediatric care until she was adopted, but her adoptive mother recognized that this was essential in order to protect Danielle from developing chronic medical problems and to provide both her and Danielle with a consistent nonjudgmental source of support. Her adoptive mother identified a pediatric practice that specialized in adolescent female health issues and scheduled regular checkup visits twice yearly in order to help Danielle develop better self-care and physical hygiene.

Danielle had been required to undergo psychosocial and psychiatric treatment in several of her prior placements and on an emergency basis when she was hospitalized for crises. Danielle felt that none of these therapies had been helpful, because either the clinician seemed critical and “made me feel like there was something wrong with me that needed to be fixed” or the contact was only for a very limited time period and “as soon as I started to like [the therapists],

(Continued)
Box 8.5 Continued

I had to stop seeing them because I was moved to another group home or foster family.” Danielle had been indifferent toward and unwilling to engage with two therapists who the Child Protective Services worker had required her to see, and her adoptive mother did not want to force Danielle to be in therapy. The adoptive mother talked privately about this dilemma with a nursing case manager in the pediatrics office, and the case manager then talked with both Danielle and her mother about what Danielle viewed as helpful in her positive past experiences with therapy and how they could identify therapists with a similar style and orientation whom Danielle could “audition” and then work with for as long as necessary without fear of untimely terminations. Danielle shifted from being unwilling to consider therapy to being skeptical but open to seeing if there was a therapist with whom she felt comfortable who could help—but not “fix”—her.

Once Danielle had decided to give one of the pediatric nurse’s referrals a try, in order to meet Danielle’s needs, her therapist developed treatment goals that addressed the multiple domains of self-regulation and relatedness that were affected by the emotional and physical violence and the disruption of primary attachment bonds that occurred within the context of her familial relationships. In addition, addressing the strained relationship between Danielle and her adoptive mother and helping her mother to provide consistent care, structure, and monitoring of Danielle’s high-risk behaviors, while also supporting Danielle’s normative adolescent strivings for autonomy and privacy were important components of her treatment. The therapist, with Danielle’s knowledge and permission (and her mother’s release), updated the nurse case manager on a monthly basis about the progress, and setbacks, in Danielle’s therapy. When Danielle had her next semiannual pediatric visit, the pediatrician and the nurse case manager were able to ask her and her mother what seemed helpful or not in the therapy and how they each viewed Danielle’s progress in dealing with emotional and behavioral challenges. With the preparation provided by the therapist’s updates, this discussion was efficient and enabled the pediatric professionals to support Danielle’s progress and her continued therapeutic involvement.

The mental health clinician used a combination of Parent Management Training and TARGET to achieve these goals. Danielle presented to therapy with the same defiant and angry presentation that her adoptive mother and teachers reported. She quickly told her therapist that she was “fine,” that she would not talk about her past experiences, and that she didn’t need any therapy. She followed this up with the assertion that she’d already been in lots of therapy and “it didn’t help anyway.” Danielle’s therapist reassured her that she would not have to talk about her worst memories unless she chose to do so and that therapy would involve her and her mother learning about how coping with trauma turns on an alarm in the brain (the amygdala) that stays on even when it’s not needed unless a trauma survivor knows how to reset it. Danielle liked the idea that her brain had become so proficient at protecting her when she was being abused that
now it was stuck in a high alarm state, which was the source of her difficulty with anxiety and anger in relationships and school. As a result, now even small stressors were causing her brain to send out signals to prepare her body for extreme danger (the “fight-flight-freeze” response).

Danielle’s therapist further explained to Danielle and her mother that therapy would help Danielle learn skills to deal with these extreme stress reactions by developing abilities that she already had—but hadn’t known to apply to handle stress reactions—to think clearly and focus on her core values when she recognized that her brain and body were going back into “alarm mode.” In subsequent sessions, Danielle (and her mother in parallel sessions) learned TARGET’s mental focusing skills to help her clear her mind and think before acting and started to identify the triggers that activated her brain’s alarm response. Together, these two skills were the first steps in helping Danielle learn how to prepare for and manage her alarm reactions. Next, Danielle’s therapist introduced TARGET skills aimed at helping Danielle to become aware of her emotions and thoughts in order to identify and differentiate those that were “reactive” (generated by her alarm) from those that reflect her “main” values, hopes, and goals (those that occur when her alarm is reset by focused thinking). Danielle then worked with her therapist to define her “main” goals and identify the choices and behaviors that would help her achieve them. Once Danielle was able to recognize and modulate what had seemed to be uncontrollable stress reactions, she began to recognize her strengths and the many positive qualities she had to offer. As a result, she was able to become closer with her adoptive mother, enjoy her company, and earn her respect and trust, and ultimately regain a stabilizing sense of hope and self-esteem. While she still felt troubled and saddened by memories of trauma, her PTSD symptoms subsided.

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**Conclusion**

Important innovations have been developed for the psychosocial treatment for children and adolescents with PTSD. Therapists who treat children and adolescents with PTSD have a responsibility to serve as a role model by personally using the affect and interpersonal regulation skills themselves that they teach to children and parents—that is, to not only “talk the talk” but also “walk the walk.” This is not because therapists who treat children and adolescents with PTSD are “traumatized” by these patients or their families; it is quite the contrary because, despite the tough challenge that PTSD poses for recovery, most therapists working in this field are inspired by the children and families with whom they work (see Chapter 12). Advances in treatment for childhood PTSD also are developing at a very rapid pace as a result of innovative clinicians
and increasingly rigorous scientific testing. However, most of the treatments now available for children and adolescents with PTSD have not been definitively proven to be effective, so there is much work to be done and many opportunities for creative and dedicated students and new professionals to make an important contribution to the treatment of children with PTSD.

References


