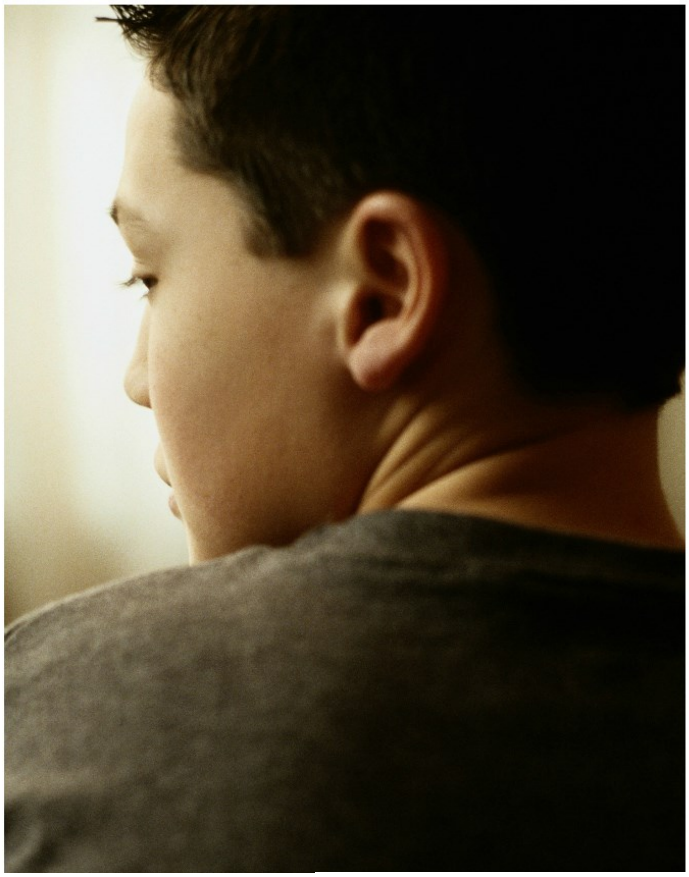
Implementing TF-CBT for Youth with Complex Trauma



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This newsletter provides an update about implementing TF-CBT for youth who have complex trauma. Although childhood trauma is inherently complex, the term "complex trauma" (or complex PTSD) has not been formally included as a diagnosis in DSM. For the first time, the International Classification of Diseases (ICD-11) proposes to include Complex PTSD as a new diagnosis. In this newsletter, we provide a discussion of this new proposed diagnosis, describe clinical applications of TF-CBT for youth with complex trauma including a brief case description using these applications, and summarize the research about TF-CBT effectiveness for this population. We anticipate that there will be more newsletters on this topic, as additional knowledge becomes available in this rapidly evolving field.

Judith Cohen, M.D., Anthony Mannarino, Ph.D., & Esther Deblinger Ph.D.

Clinical TF-CBT Applications for Youth with Complex Trauma

Judith Cohen, M.D. & Anthony Mannarino, Ph.D.

Since many TF-CBT therapists treat youth with complex trauma, we have suggested some TF-CBT applications for these youth based on clinical experience (Cohen, Mannarino, Kliethermes & Murray, 2012; Kliethermes & Wamser, 2012). Very briefly, these include:

1. Safety first: many of these youth live with ongoing danger, feel unsafe trusting another person and thus may experience therapists as trauma reminders. Instead of waiting until the end of TF-CBT to implement the Enhancing Safety component, implement this component first and throughout treatment for youth with complex trauma.

2. Identify unifying trauma themes: Since youth with complex trauma experienced chronic, multiple traumas (e.g., sexual and physical abuse, neglect, domestic violence and multiple deaths) identify a unifying theme (e.g. "The people who should have kept me safe, hurt me.") Focus on this theme instead of a "worst trauma" experience during TF-CBT treatment. This theme ties together the youth's multiple types of traumatic experiences, and serves as the basis for gradual exposure, skill building, and developing the trauma narration and processing.

(Continues Page 2)

During trauma narration and processing, use this theme as the unifying thread to include multiple trauma experiences that the theme "weaves together". During cognitive processing, use the theme to connect these experiences in meaningful ways.

3. Adjust the total length of TF-CBT treatment: Since youth with complex trauma have significant dysregulation of affect, self-cognition and interpersonal relationships, including of trusting the therapist, TF-CBT may take longer than the usual 12-16 sessions, i.e., 16-25 session; and

4. Adjust the proportionality of TF-CBT phases: Given the above problems, the initial Stabilization Phase may take proportionally longer than for typical PTSD, to enable the youth to trust you, to fully disclose their trauma experiences and understand their trauma reminders, to use gradual exposure and to implement TF-CBT skills. Thus, instead of devoting 1/3 of treatment to each TF-CBT phase, for youth with complex trauma, you may instead spend ½ of total treatment sessions on the Stabilization phase, ¼ on Trauma Narration and Processing, and ¼ on Integration/Consolidation. This is illustrated in Figures 1 and 2.

We emphasize that these suggestions were based on clinical experience, rather than research data. When these applications were developed, complex PTSD/ complex trauma was excluded from formal diagnostic classification systems such as DSM or ICD. We still lack a validated instrument to assess complex PTSD in children or adolescents, and thus, evaluating the impact of these treatment applications remains challenging. The upcoming introduction of Complex PTSD into ICD-11 will allow researchers to use standardized diagnostic criteria and a validated assessment instrument to evaluate the impact these treatment applications for youth with complex trauma.

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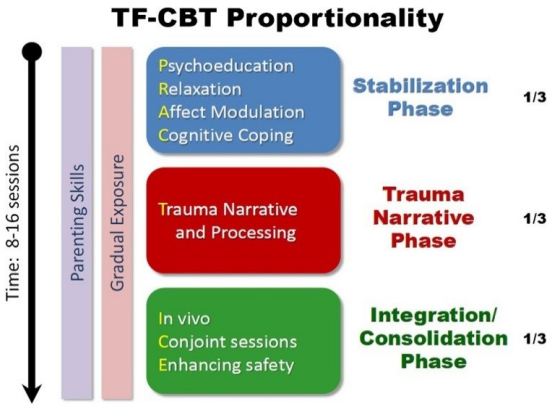

Figure 1 TF-CBT Components and Phases. © 2012, J. Cohen, A. Mannarino & E. Deblinger

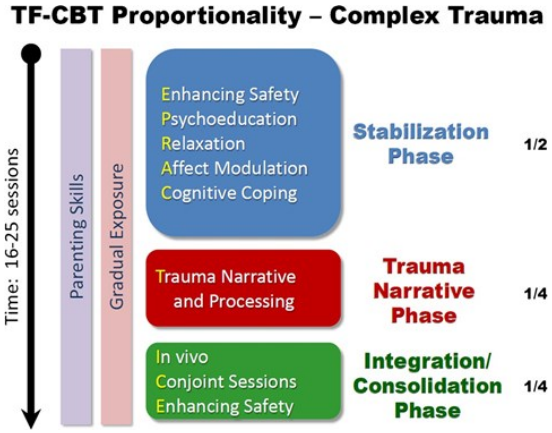

Figure 2 TF-CBT Components and Phases for Complex Trauma. © 2012, J. Cohen, A. Mannarino & E. Deblinger

What does the research tell us about how TF-CBT works for youth with complex trauma? Due to the lack of standardized diagnostic criteria or assessment instruments for this condition, we have mostly had to infer the answer from studies that do not specifically examine complex trauma per se.

Several treatment studies suggest that TF-CBT is effective for youth with complex trauma. For example, two randomized controlled trials (RCT) of group TF-CBT provided to African youth with very complex trauma exposure (mean trauma types=12) showed significantly greater improvement with TF-CBT than in wait list across multiple domains consistent with complex trauma outcomes, e.g., PTSD, depression/anxiety, conduct problems, prosocial behaviors, and overall psychological distress (McMullen et al, 2013; O'Callaghan et al, 2013). Similarly, an RCT among multiply traumatized Norwegian youth (mean number of trauma types =3.6) documented that TF-CBT was superior to usual care in community clinics for improving youth outcomes in multiple domains that overlapped with complex trauma including PTSD, depression, and general mental health symptoms (Jensen et al, 2013). A German RCT of multiply traumatized youth (mean number of traumas =6.35) documented that TF-CBT was superior to a wait list control condition in improving PTSD, depression, anxiety, behavioral problems, negative cognitions, and overall functioning (Goldbeck et al, 2016). Another RCT among multiply traumatized, sexually abused youth showed that TF-CBT was superior to child centered therapy for improving trauma problems such as PTSD, depression, behavior problems and shame (Cohen et al, 2004). Youth in juvenile justice residential treatment facilities with likely complex trauma (mean trauma types=6) experienced significant improvement in PTSD and depressive symptoms after receiving a mean of 14 sessions of TF-CBT treatment (Cohen et al, 2016). Youth in foster care experienced significantly greater improvement in PTSD and significantly less running away and placement disruption with TF-CBT than with System of Care treatment as usual (Weiner et al, 2009). Importantly, these studies evaluated standard TF-CBT i.e., without the complex trauma modifications described above.

The proposed ICD-11 diagnostic criteria for Complex PTSD have introduced new opportunities for evaluating the impact of treatment for youth who meet these diagnostic criteria. The researchers who conducted the German RCT described above additionally used the proposed diagnostic criteria for PTSD and Complex PTSD to compare TF-CBT outcomes for youth who met these respective diagnoses at pre-treatment. The study was important both in that it validated the distinct entity of Complex PTSD as defined by ICD-11 criteria, and also because it documented that relative to their baseline PTSD symptoms, youth with PTSD and Complex PTSD responded equally well to TF-CBT (large effect sizes for both groups). Additionally, youth with Complex PTSD experienced significant improvement (medium to large effect sizes) with regard to complex PTSD symptoms. However, it is important to note that youth with Complex PTSD started and ended treatment with clinically and statistically greater symptoms than those with PTSD (Sacher et al, in press).

To our knowledge, this was the first study to directly document the relative impact of evidence-based treatment for youth with vs. without complex PTSD. Somewhat surprisingly, standard TF-CBT without modifications was equally effective for both groups. An important next step will be to compare different treatments for effectiveness for complex trauma, e.g., standard TF-CBT vs. TF-CBT with complex trauma modifications (described above), examining complex trauma as the primary outcome. We need such studies in order to design the best evidence-based treatment for youth with complex trauma.

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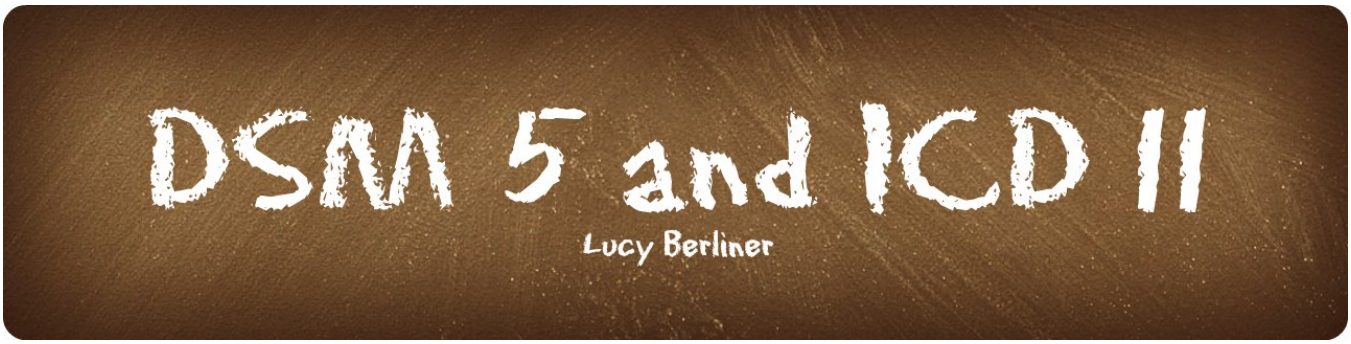

Many are by now familiar with the differences of opinion and controversies about the diagnosis of PTSD in the DSM5 and the proposed definitions to appear in the ICD 11. The American Psychiatric Association sponsors the Diagnostic and Statistical Manual that specifies the criteria for receiving a psychiatric diagnosis (https://www.psychiatry.org/psychiatrists/practice/dsm). The DSM is mainly used in the USA. The other main scheme for naming and describing psychiatric diagnoses appears in the International Classification of Diseases (ICD). The ICD is sponsored by the World Health Organization and is used all over the world including the USA for medical diagnoses (http://www.who.int/classifications/icd/en/). Most other countries also use the ICD for psychiatric diagnoses. There are cross walks in Medicaid and other insurance companies in the US to link DSM diagnoses to ICD diagnoses.

Both the DSM and the ICD use similar mechanisms for arriving at the recommended diagnostic criteria. Committees are selected consisting of prominent, highly regarded and influential experts in the topic area. They rely on the extant research or may commission research on the particular diagnosis. For PTSD, there were some members on both committees. To reduce the differences to their essence, the DSM 5 expanded the diagnostic criteria to encompass a broader range of symptoms to better reflect the variability of trauma responses, whereas the ICD 11 went another direction. The ICD 11 proposes two diagnoses: PTSD and Complex PTSD. The DSM 5 changes include increasing the number of symptoms and modifying the definitions of some of the existing symptoms.

Criterion	Symptom category	# Symptoms required	Specific symptoms
A	Exposure to a traumatic event (A_1)		1. Directly experiencing the event(s) 2. Witnessing the event(s) 3. Learning that the event(s) occurred to a close relative or close friend[a] 4. Experiencing repeated or extreme exposure to aversive details of the event(s)
A_2			Eliminated in *DSM-5* (i.e., fear, helplessness, or horror)
B[b]	Intrusion symptoms	1	1. Intrusive distressing memories of the traumatic event(s) (*DSM-IV* B_1) 2. Recurrent distressing trauma-related dreams (*DSM-IV* B_2) 3. Dissociative reactions (e.g., flashbacks) (*DSM-IV* B3) 4. Intense psychological distress when exposed to traumatic reminders (*DSM-IV* B_4) 5. Marked physiological reactions to reminders of the traumatic event(s) (*DSM-IV* B_5)
C[b]	Avoidance symptoms	1	1. Persistent avoidance of thoughts and memories (*DSM-IV* C_1) 2. Persistent avoidance of external reminders (*DSM-IV* C_2)
D[b]	Negative alterations in cognitions and mood	2	1. Dissociative amnesia of the traumatic event(s) (*DSM-IV* C_3) 2. Persistent negative expectations (*DSM-IV* C_7) 3. Persistent distorted blame of self or others about the traumatic event(s) (new) 4. Persistent negative emotional state (new) 5. Diminished interest or participation in significant activities (*DSM-IV* C_4) 6. Feeling of detachment or estrangement from others (*DSM-IV* C_5) 7. Persistent inability to experience positive emotions (*DSM-IV* C_6)
E[a]	Alterations in arousal and reactivity	2	1. Irritable behavior or angry outbursts (*DSM-IV* D_2) 2. Reckless or self-destructive behavior (new) 3. Hypervigilance (*DSM-IV* D_4) 4. Exaggerated startle response (*DSM-IV* D_5) 5. Problems with concentration (*DSM-IV* D_3) 6. Sleep disturbance (*DSM-IV* D_1)

The additions include cognitive and mood impacts. As well it includes non-specific symptoms that are seen in multiple clinical diagnoses (persistent negative expectations, diminished interest in activities, sleep problems, concentration problems, irritability/outbursts). PTSD now has 20 symptoms versus the previous 17. There are only 16 symptoms for children under six years. Some symptoms were removed because they would not be possible to evaluate in very young children. This is the main developmental adjustment for children in the DSM 5 definition.

The ICD 11 reduced the number of symptoms to six and only includes symptoms that are uniquely associated with PTSD. There are two intrusion symptoms that do not appear in any other disorder (nightmares, flashbacks), two active avoidance symptoms, and two unique arousal/reactivity symptoms (hyper vigilance, exaggerated startle). The proposed ICD 11 classification system does not at this time include any adjustments for children. The Complex PTSD diagnosis was created to address the broader impacts associated with severe and pervasive trauma impact. In order to meet the criteria for Complex PTSD, the patient must meet ICD 11 criteria for PTSD and then meet additional Complex PTSD criteria. The symptoms of complex PTSD include:

ICD–11 *Complex PTSD in U.S. National and Veteran Samples* 5

Table 1. National Stressful Events Survey Complex Posttraumatic Stress Disorder Items

Item cluster	Stem item
Affect dysregulation	• Have you ever had a persistent pattern of becoming overly emotionally reactive to situations and finding it difficult to calm down afterward? NOTE: When you were overly emotionally reactive, the emotion could include any kind of feelings including anxiety, fear, anger or sadness
	• Have you ever had a persistent pattern of never letting yourself have any feelings or letting anyone else see what you were feeling?
Interpersonal problems	• Have you ever had a persistent pattern of being in relationships that had lots of ups and downs, conflicts, misunderstandings, or mistrust?
	• Have you ever had a persistent pattern of avoiding or withdrawing from relationships because you thought they were not worth having or that they were too painful to have?
Negative self-concept	• Have you ever had a persistent pattern of feeling insecure about close personal relationships because you thought bad things would happen such as the person would die, be harmed in some other way, leave you, or betray you?
	• Have you ever had a persistent pattern of having difficulty knowing what you felt or describing what you felt to others?
	• Have you ever had a persistent pattern of relying on other people to guide you about what you should feel or do, or you felt that other people's opinions were more valid or important than your own opinions?

There have been a quite a number of studies assessing prevalence rates of PTSD using the new DSM 5 criteria. Overall the results suggest that the DSM 5 captures most people classified with PTSD under DSM 4 and the overall rates are roughly equivalent. However, although there is overlap, some who met diagnostic criteria under the DSM 4 do not meet diagnostic criteria under DSM 5, whereas some who would not have met criteria under DSM 4, now qualify (e.g., O'Donnell, 2014).

Most studies comparing DSM 5 PTSD with the proposed ICD 11 PTSD criteria find that the application of proposed ICD 11 criteria results in fewer people meeting PTSD diagnostic criteria (Hyland, et al, 2016a; O'Donnell et al; 2014; Wisco, et al, 2016), however see Morina et all (2014). Hyland et al (2016a) found the lower rates of ICD 11 PTSD were primarily accounted for by lower endorsement of the ICD 11 re-experiencing criteria. When nightmares were replaced with recurrent thoughts and memories the rate differences across the DSM 5 and ICD 11 were less pronounced. In the only available study on DSM and ICD 11 prevalence of PTSD in children and adolescents, in a clinical sample of traumatized children, ICD 11 criteria resulted in 27% fewer children meeting DSM 4 PTSD criteria (Sacher & Goldbeck, 2016).

A few studies have looked at the classification validity for the ICD Complex PTSD construct. In a clinical sample of adults, Cloitre et al (2014) identified three classes using the ICD 11 PTSD and Complex PTSD criteria: PTSD with low levels of the Complex PTSD symptoms, PTSD with Complex PTSD symptoms, and a group low on both. Hyland et al (2016b) also found support for construct validity of the ICD 11 Complex PTSD. In a non-clinical sample of adolescents and young adults and using various measures to capture the Complex PTSD construct, Perkonigg et al (2016) found four classes, two of which appear to support the ICD PTSD diagnoses: one that had a higher probability of meeting the ICD 11 PTSD criteria and another with higher conditional probability for ICD 11 Complex PTSD.

It is likely that there will be continued controversy about the ICD 11 formulation and the DSM 5 classification because overall, the proposed ICD 11 captures fewer cases. There is worry that if fewer adults or children can be diagnosed with PTSD under the ICD 11, many will not be able to receive treatment because of the necessity for a diagnosis to have care reimbursed. As well there is a major conceptual distinction about what PTSD is under the two different schemes. The key is whether PTSD is directly manifested as symptoms that are explicitly linked to the trauma or whether it encompasses a range of symptoms that are non-specific but are precipitated or exacerbated by the traumatic event. There does appear to be emerging support for the ICD 11 Complex PTSD as distinct from ICD 11 PTSD.

Complications may arise in the future when the ICD 11 is released. As mentioned, the use of the DSM is unique to the USA and psychiatric diagnosis. Typically the DSM diagnosis has been able to be crossed walked to ICD 10. It is not clear how that will worked of the proposed new definitions appear in the ICD 11 when it is released in 2018.

From a clinical perspective diagnostic classification should not be over emphasized. Just the fact that diagnoses can change over time demonstrates that they are far from stable entities. Diagnoses can come and go (e.g., no more Asperger's, welcome Autism Spectrum Disorder). As well many commentators have argued for a more dimensional approach, versus the current disorder or no disorder classification method. And of course, our goal should not be to have more children diagnosed with PTSD or any other disorder. What should be prioritized is when children with legitimate need are barred from reimbursed care.

It is important to keep in mind that many trauma-affected children currently do not meet DSM 4 or 5 criteria because they only have subthreshold levels of posttraumatic stress symptoms. It seems likely that when there is demonstrable clinical need, other diagnoses may apply or the adjustment disorders can capture these children. As well, many children who have been exposed to trauma develop conditions that are not trauma-specific per se (e.g., behavior problems, anxiety, and depression).

In terms of complex trauma or complex PTSD, a variety of issues remain. For starters, what exactly is it? It seems to be an "I know it when I see it" phenomenon. In many formulations the presumed contributors (other adversities, preexisting conditions, characteristics of the trauma) are conflated with the outcomes. Complex trauma definitions tend to lean heavily on historical variables such as compromised early caregiving, younger age at onset of trauma exposure, child abuse trauma, and polyvictimization along with outcomes that are presumed to be worse but are not always specified. Although the literature does confirm that certain historical, contextual and trauma characteristic variables increase risk for PTSD as well as overall worse outcomes, risk is not destiny. And this is not just true for trauma-specific impacts such as PTSD. It turns out that childhood adversities, especially the non-trauma adversities, are highly predictive for onset of any disorder in childhood or adolescence (McLaughlin, et al, 2012). In other words, children with depression, anxiety and disruptive behaviors are likely to have trauma and other adversities in their backgrounds as well.

The focus on complex trauma or complex PTSD can over emphasize the historical variables and under attend to the impacts that are what can be treated. For example, take the teenager who is brutally gang raped, not supported afterwards and is severely and pervasively affected; in addition to developing PTSD and depression she drops out of school and is disaffected from her family and peers? Is it "simple" trauma because she is older and the event was one time? What about a child who has a documented prior history of physical abuse, does not report memories or distress about the specific physical abuse event, but is highly distressed about the aftermath experiences including multiple placements and failure of parents to comply with required services for reunification. Is it complex PTSD or even PTSD?

Diagnostic systems focus on current symptoms or problems not how the patient got there. The purpose is to guide interventions. Many children affected by trauma experiences do not develop a trauma-specific psychiatric disorder. We should be aware that children with mental health problems are quite likely to have trauma and adversities in their backgrounds. It is perfectly possible to be trauma-informed without calling their experiences complex trauma or giving a trauma-specific diagnosis. All children exposed to trauma should receive acknowledgement, validation, normalizing and support whether they have a diagnosis or not, and whether or not the diagnosis is trauma-specific.

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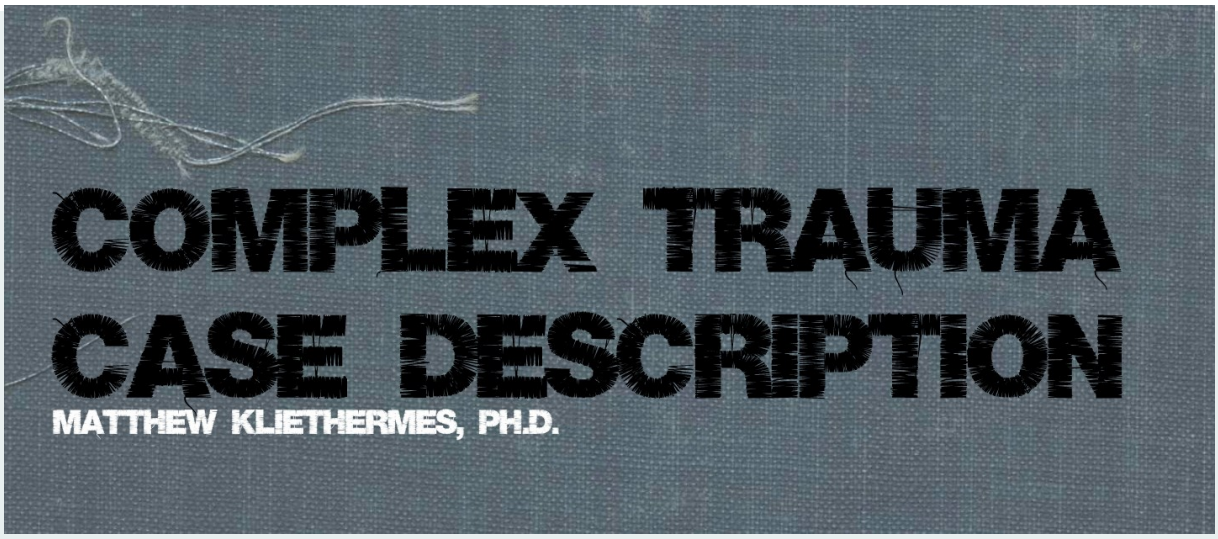

Kiarra Jones is a 13-year-old biracial female living with her biological mother, Ms. Jones, and her stepfather. Kiarra experienced domestic violence, severe emotional abuse by her stepmother, sexual abuse by her stepmother's older son, and severe bullying at school. Assessment results indicated significant symptoms of PTSD, depression, and social anxiety. She often used maladaptive coping strategies, primarily self-injury and marijuana, to cope with distress. TF-CBT was started with the agreement that recurrent self-injury would result in progress through TF-CBT components being halted until sufficient safety and stability could be restored.

Psychoeducation: The therapist connected Kiarra's current distress to past traumas. Posttraumatic stress reactions were conceptualized as being "stuck in survival brain". Even though she was not currently in life or death situations, her brain was reacting as though she was. Kiarra's difficulties were described as faulty "survival responses" such as fighting (e.g., arguments with step-father), escaping (e.g., social withdrawal), freezing (e.g., shutting down in social situations), giving up (e.g., no longer attempting to make friends), and crying for help (e.g., suicidal threats, clinging to her mother). During a conjoint session, Kiarra and Ms. Jones played a game of "Trauma Trivia" to encourage playful, yet meaningful, communication. Upon reflection, Kiarra commented that she never would have believed they could have a positive conversation about trauma.

Parenting: The concept of "survival brain" was used to help Ms. Jones understand Kiarra's behavior during parenting situations, including how parenting behaviors such as threats, expression of anger, and judgmental statements could be triggering. Ms. Jones practiced de-escalation techniques such as speaking in a low, calm voice, and using validation when Kiarra was distressed. Role plays were used to practice implementing parenting strategies (e.g., loss of privileges) in a minimally triggering fashion.

Relaxation: Kiarra was taught that due to trauma her body was primed for survival responses, which are counter to relaxation. Relaxation techniques were used to "turn down survival brain." Kiarra had limited awareness of her arousal level, so she learned a modified SUDS scale including ratings of distress and self-control. Kiarra reported increased self-regulation simply from using this scale. Kiarra previously used aromas and visual images for relaxation and meditation. Therefore, sensory-based relaxation strategies (e.g., scented candles) were encouraged and used with traditional techniques such as meditation. The therapist introduced Ms. Jones to the rationale for relaxation and familiarized her with techniques that Kiarra found helpful. In a conjoint session, Kiarra taught Ms. Jones the mindfulness strategies she had learned, which they practiced together and discussed using at home.

Affect Expression and Modulation: Kiarra presented with a well-developed vocabulary of "feeling words" and a solid ability to identify and express emotions. However, she tended to "wallow" in her emotions. Kiarra learned that the primary functions of emotions are to help understand our environment, help communicate how we are doing to others, and to motivate action. She learned that when in survival brain, emotions may be triggered by situations that resemble past trauma. Kiarra historically responded to these emotions with maladaptive coping, such as marijuana or self-injury. Kiarra learned that emotions can be tolerated without action and eventually dissipate. She practiced "emotional tolerance" along with relaxation strategies. Kiarra developed behavioral strategies focused on changing her surroundings and becoming active (e.g., going for a walk) to break out of mood states.

Ms. Jones learned the concept of "emotion coaching," that is, helping Kiarra label her emotions and accepting her emotions in a validating fashion. Ms. Jones struggled with this type of interaction, tending to focus on her own emotions and become defensive and blaming. Subsequently, role plays were used to practice responding empathetically. Ms. Jones became more adept at this and successfully engaged in a conjoint affect session focused on Kiarra's feelings about her father's upcoming release from prison.

Cognitive Coping: Many of Kiarra's difficulties were tied to inaccurate and unhelpful trauma-related beliefs. Kiarra made frequent negative statements about herself and others. She expressed that she was worthless or deficient and that people were predatory or untrustworthy. These beliefs had significant negative impact on her current relationships. The cognitive triangle was used to demonstrate the connection between thoughts, feelings, and behaviors. For example, Kiarra recognized that her thoughts about people being dangerous resulted in periods of anxiety and withdrawal.

Kiarra began tracking her thoughts and practiced testing her thoughts. The term "thought balancing" was used due to Kiarra's tendency to focus on extreme interpretations of events. She learned to "balance" thoughts by including all available information. For example, Kiarra reported thoughts that "she wasn't good enough" to be successful at school, due to recent difficulty with an assignment. Kiarra "balanced" this thought by paying attention to other "evidence," such as that she recently received high grades on multiple assignments and that all students struggle with schoolwork on occasion. Ms. Jones learned the same cognitive skills. She practiced applying the cognitive triangle and thought balancing to her own experiences. The therapist conducted a conjoint session in which Ms. Jones helped Kiarra identify a recent thinking error and walk through the process of thought balancing.

At this point in treatment, Kiarra reported increased conflict with her stepfather. She became increasingly depressed and engaged in her first self-injury since beginning TF-CBT. Kiarra was hospitalized for a week and changes were made to her medications. Subsequently, her depressive symptoms decreased and she reported no longer experiencing urges to self-harm. The therapist resumed services with Kiarra, but typical progress through TF-CBT was delayed. The Enhancing Safety component was prioritized, with a focus on assessing current stability and revisiting coping strategies. Kiarra was experiencing benefit from her new medications and asked to resume TF-CBT, stressing that early components had been helpful. Ms. Jones confirmed that Kiarra was functioning better at home. The therapist resumed TF-CBT, with frequent monitoring of suicidal ideation and urges to self-harm.

Trauma Narration and Processing: Kiarra developed a timeline of critical events she had experienced during her life. This allowed the trauma narrative process to capture all events that might have an impact her current functioning, without detailed processing of each event. It also allowed for the therapist to gradually increase the intensity of trauma exposure by first talking about traumatic events generally, but then shifting to more detailed discussion of specific events.

Kiarra stated that her experiences of emotional abuse and sexual abuse caused her the most distress. Kiarra processed these experiences in greater detail, describing specific instances of each. Kiarra initially reported distress levels reaching a "9" on the SUDS scale. When these periods of distress occurred, the therapist reminded Kiarra that her distress was a manifestation of "survival brain" and encouraged her to use coping skills to calm her "survival response." Kiarra took brief breaks to use one or more skills and then resume trauma processing. Kiarra eventually found that she could tolerate extended periods of trauma processing with only mild to moderate levels of distress.

Two cognitive themes were consistent across Kiarra's trauma narrative; beliefs that she was worthless and all people were dangerous. The therapist helped Kiarra explore how various traumas influenced these beliefs. For example, Kiarra's feelings of worthlessness corresponded to emotional abuse by her stepmother. She came to realize that these beliefs were the by-product of trauma and not accurate in a broader context. Kiarra concluded, "Although people have tried to convince me I was worthless, my view of myself does not have to be based on their opinion." She also determined, "Some people have tried to hurt me in my life, but many people have not. I don't have to be afraid of everyone."

The therapist shared Kiarra's work on her trauma narrative individually with Ms. Jones and discussed how to provide appropriate support and empathy around trauma. This was difficult for Ms. Jones as she experienced significant guilt related to Kiarra's trauma exposure and tended to want to tell Kiarra how to cope with her trauma, rather than validate her experience. Cognitive processing helped her recognize the difference between being responsible for versus regretting an outcome, which reduced her need to respond defensively. Kiarra shared her timeline and "lessons learned" with Ms. Jones in a conjoint session. Ms. Jones was appropriately supportive and was pleased by Kiarra's positive response.

In Vivo Mastery: This component was beneficial due to Kiarra's social anxiety. She initially avoided the waiting room at the therapist's office due to social anxiety. Remaining in the waiting room for increasing periods of time became the first form of in vivo exposure. Kiarra received homework to explore safe social settings (e.g., a coffee shop). Ms. Jones stayed with Kiarra in the coffee shop, but gradually moved further away. Kiarra became able to remain in some public places on her own for up to 30 minutes.

Enhancing Safety and Future Development: Safety was an ongoing focus throughout treatment, but was reemphasized at the conclusion of treatment. The focus shifted from present concerns to maintaining her current level of safety into the future. Kiarra identified future triggers such as criticism from teachers or employers. The therapist focused on cognitive coping skills, stressing the importance of balancing her thoughts on a regular basis, to help ensure that her assessment of safety is accurate. Ms. Jones considered future parenting challenges (e.g., dating, conflict between Kiarra and her stepfather) and learned parenting approaches (e.g., negotiation) to use in response to those challenges.

Toward the end of treatment Kiarra and Ms. Jones completed assessment measures to re-evaluate Kiarra's trauma-related difficulties. Both reported that Kiarra was exhibiting reduced symptoms of PTSD and depression and that she had not engaged in any further self-injurious behavior since the incident that occurred mid-treatment, and that she had significantly decreased her marijuana use. Having completed all PRACTICE components, and based on Kiarra's improved functioning, Kiarra, Ms. Jones, and the therapist determined that Kiarra had successfully completed TF-CBT. Kiarra and her mother both participated in a "graduation" session that focused on celebrating Kiarra's progress during TF-CBT. Ms. Jones conveyed her pride in Kiarra's accomplishments. More importantly, Kiarra expressed feeling proud of herself and communicated her strengthening belief that she was competent to face her future.

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