NC CHILD TREATMENT PROGRAM | CENTER FOR CHILD & FAMILY HEALTH

North Carolina Child Treatment Program (NC CTP)
Evidence-Based Treatment (EBT) Service Delivery Time Model Series

Clinical Service Delivery Time Model for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Case-level Time Estimate

TF-CBT Time Model Tool

The *NC CTP Clinical Service Delivery Time Model (TF-CBT)* tool was developed to support service utilization data collection, aggregation, and analysis at the level of the client, caseload, and agency. Additionally, it may be used to: establish agency-level service capacity; monitor intervention-specific processes and cost; and develop a *cost model* that reflects TF-CBT clinical delivery requirements.

TF-CBT service utilization estimates and data should be interpreted with caution, under the guidance of a TF-CBT clinical expert, when applied to: clinical network development and contracting; establishment of service delivery payment rates; utilization management; and clinical performance monitoring. This template should not be used to facilitate training, treatment, fidelity monitoring, and/or clinical supervision, as these standards are established by the TF-CBT model developers (www.tfcbt.org).

The *NC CTP Clinical Service Delivery Time Model (TF-CBT)* defines a "typical" case as one in which TF-CBT is delivered in an outpatient setting, to a client presenting with moderate clinical complexity, in the primary language of both the client and caregiver. Service delivery is described in terms of: a) total number of clinical encounters (in-session treatment); b) total clinical encounter time (hours); and c) total out-of-session clinical support activity time (hours). Case-level service utilization data may fall outside the "typical" range, yet remain acceptable clinically, due to case complexity and implementation-related factors.

NC CTP populated the *NC CTP Clinical Service Delivery Time Model (TF-CBT)* tool with case-level *estimates* to provide guidance regarding the development and sustainment of an outpatient TF-CBT program. Estimates are based on the peer-reviewed literature, TF-CBT trainer experience, and service utilization data from a large cohort of clients associated with NC CTP clinical trainees and graduates.

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TF-CBT Service Delivery Overview

- TF-CBT is a trauma treatment model that includes clinical assessment and eight core components. Clients typically progress sequentially through the eight core TF-CBT components as they demonstrate skills mastery, process trauma experiences, and demonstrate reduction in trauma-related symptoms.
- TF-CBT is conducted through a series of client-only, caregiver-only, and periodic client-caregiver (conjoint) session types. Typically, two to three session types are delivered during a single clinical encounter (on a single service date).
- Clinical encounters (treatment sessions) are typically conducted on a weekly basis over the course of several months; less frequent sessions may adversely impact the achievement of targeted clinical outcomes. In select circumstances, a client and/or caregiver may participate in two clinical encounters during a single week.
- A clinical encounter is typically 60 minutes in duration; however, 90-minute clinical encounters are often conducted due to agency scheduling practices or case-level implementation considerations.
- A typical course of community-based TF-CBT includes an estimated: a) 24.5 hours of total in-session activities; and b) 18.1 hours of total out-of-session activities (42 minutes out-of-session time for every 60-minute clinical encounter). Client and caregiver in-session participation time is approximately equal over the course of treatment.
- Treatment content and intensity, clinician fidelity, and clinical outcomes may vary across a TF-CBT caseload due to child-, caregiver-, family-, clinician-, agency-, and systems-level factors.

Table One: TF-CBT Total Treatment Time Estimate Summary *(Case-level)*

Clinical Activities (Case-level)		**Treatment Time**	
		Typical Case [a] (Hours)	Typical Range [b] (Hours)
Total In-Session Activities		**24.5**	**11.0 – 39.0**
TF-CBT-specific activities [c]	(Table Two)	20.0	10.0 – 30.0
General clinical activities [d]	(Table Two)	4.5	1.0 – 9.0
Total Out-of-Session Activities [e]	(Table Three)	**18.1**	**7.0 – 32.6**
Total Treatment Time	(In-Session + Out-of-Session)	**42.6**	**18.0 – 71.6**
Ratio [f]	(In-Session) : (Out-of-Session)	**(1.0) : (0.7)** 60 min : 42 min	**(1.0) : (0.6) – (1.0) : (0.8)**

[a] "Typical Case" includes TF-CBT delivery in a community-based setting, to a client presenting with moderate clinical complexity, in the primary language of both client and caregiver.
[b] Service utilization data may fall outside the "typical" range, yet remain clinically acceptable, due to case complexity and implementation-related factors.
[c] TF-CBT-specific activities are defined per the TF-CBT manuals. [1-3]
[d] General clinical activities are conducted in-session and include: client intake, additional clinical assessment, treatment and discharge planning, case coordination/communication, crisis management, and other general clinical activities.
[e] Clinical support activities are conducted out-of-session by a treating clinician and include: client intake, additional clinical assessment, treatment and discharge planning, case coordination/communication, crisis management, and other general clinical activities, clinical supervision/peer fidelity support/expert consultation, and other general support activities. These services are critical to successful TF-CBT implementation and improved clinical outcomes.
[f] A typical course of treatment includes an estimated 42 minutes of clinical support activity time (out-of-session) for every 60-minute clinical encounter (treatment session).

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Table Two: TF-CBT Clinical Activities Estimates *(In-Session Activities)*

In-Session Activities [a] (Case-level)	**Clinical Encounters [b]** (# Sessions)			**Total Treatment Time [c]** (Hours)		
	Typical Case	Typical Range		Typical Case	Typical Range	
		Minimum	Maximum		Minimum	Maximum
TF-CBT-specific Components [d]						
Pre-Treatment Assessment [e]	1	1	2	1.0	1.0	2.0
Psychoeducation	1	1	2	1.0	1.0	2.0
Parenting [f]	2	1	3	2.0	1.0	3.0
Relaxation	2	1	2	2.0	1.0	2.0
Affective Expression and Modulation	2	1	3	2.0	1.0	3.0
Cognitive Coping	2	1	3	2.0	1.0	3.0
Trauma Narration and Processing	6	2	8	6.0	3.0	8.0
Enhancing Future Safety and Development	2	1	2	2.0	1.0	2.0
Post-Treatment Assessment and Termination [e]	1	1	2	1.0	1.0	2.0
Optional Imminent Safety Risk	0	0	1	0	0	1.0
Optional In Vivo Desensitization	1	0	2	1.0	0	2.0
Subtotal	**20**	**10**	**30**	**20.0**	**10.0**	**30.0**
General Clinical Activities (In-Session)						
Client intake [g]	0.5	0	1	0.5	0	1.0
Additional clinical assessment [h]	1	0	2	1.0	0	2.0
Treatment planning	0.5	0.5	1	0.5	0.5	1.0
Discharge planning	0.5	0.5	1	0.5	0.5	1.0
Case coordination/communication [i]	1	0	2	1.0	0	2.0
Crisis management [j]	1	0	2	1.0	0	2.0
Other general clinical activities	--	--	--	--	--	-
Subtotal	***4.5***	***1***	***9***	***4.5***	***1***	***9.0***
TOTAL IN-SESSION ACTIVITIES	**24.5**	**11**	**39**	**24.5**	**11.0**	**39.0**

[a] Includes general and TF-CBT-specific clinical activities delivered during a clinical encounter (treatment session); multiple activities may be delivered during a single clinical encounter.

[b] One or more session types (client-only, caregiver-only, and/or client-caregiver) may be delivered during the same clinical encounter (on the same service date).

[c] Assumes clinical encounters are 60 minutes in duration; 90-minute treatment sessions may be conducted due to agency-level scheduling practices and/or case-level implementation considerations.

[d] Defined by the TF-CBT manuals[1-3].

[e] Includes: administration of standardized clinical measures; clinical interviews and observation; and feedback to client and caregiver.

[f] Parenting skills are introduced early in treatment, and reinforced through all subsequent components.

[g] Includes consent and other agency-specific documentation and activities.

[h] Includes interval/periodic clinical assessment; does not include pre- and post-treatment clinical assessment.

[i] Critical to successful TF-CBT implementation and improved clinical outcomes; typically delivered by treating clinician. Highly variable across clients.

[j] Includes urgent or emergent in-session case coordination and communication. Highly variable across clients.

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***Table Three: TF-CBT Clinical Support Activities Estimates** (Out-of-Session Activities)*

Out-of-Session Activities [a] (Case-level)		**Time per Activity** Typical Case (Hours)	Typical Range (Hours) Minimum	Maximum
Case Support Activities (out-of-session)	Client intake [b]	0.5	0	1.0
	Clinical assessment + case conceptualization [c]	1.0	1.0	2.0
	Treatment planning + documentation [d]	0.5	0.5	1.0
	Session preparation [e]	4.2	1.8	6.5
	Session documentation + fidelity monitoring [f]	6.3	2.8	9.8
	Discharge planning + documentation [g]	0.5	0	1.0
	Case coordination/communication [h]	2.0	0	4.0
	Crisis management [i]	1.0	0	4.0
TF-CBT Fidelity Support Activities (out-of-session)	Clinical supervision/peer fidelity support/ expert consultation [j]	2.1	0.9	3.3
General Support Activities (out-of-session)	Insurance + billing support	--	--	--
	Court preparation + testimony	--	--	--
	Clinician travel for treatment session	--	--	--
	Clinician travel for case coordination	--	--	--
Other Activities (out-of-session)	Other activities	--	--	--
TOTAL OUT-OF-SESSION ACTIVITIES		**18.1**	**7.0**	**32.6**

[a] Conducted out-of-session by a treating clinician; critical to successful TF-CBT implementation and improved clinical outcomes.

[b] Out-of-session intake activities include: referral review; caregiver engagement and scheduling; clinical screening; consent process; and other clinical activities and documentation.

[c] Out-of-session clinical assessment includes: scoring and interpretation of clinical assessment measures; collateral contact; record review; case conceptualization; and documentation of assessment process, findings, and treatment recommendations.

[d] Out-of-session treatment planning includes: documentation of specific treatment goals and recommendations; and consideration of potential treatment barriers.

[e] Assumes ten (10) minutes per clinical encounter (treatment session); includes review of clinical notes, development of a written agenda, and preparation of clinical materials and activities.

[f] Assumes fifteen (15) minutes per clinical encounter (treatment session); includes any session-level documentation and fidelity-monitoring. Fidelity is monitored by a treating clinician, using a structured tool, at the clinical encounter level.

[g] Includes out-of-session development of recommendations for remaining treatment or service needs.

[h] Includes routine out-of-session: treatment/multidisciplinary team participation; collateral contact; service coordination and monitoring; provision of consultation to non-clinical professionals; and caregiver contact. Highly variable across clients.

[i] Includes urgent or emergent out-of-session case coordination and communication. Highly variable across clients.

[j] A treating clinician should participate in case-specific: a) clinical supervision provided by a trained supervisor; b) fidelity-driven peer case support; and/or (c) expert consultation. Frequency depends upon caseload size, case complexity, supervision structure, agency requirements, and other factors. Assumes five (5) minutes per clinical encounter (treatment session).

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Agency-level TF-CBT Program: Additional Resource Requirements

The following implementation requirements should be considered when determining the resource allocation necessary to develop and sustain an outpatient TF-CBT program:

Clinician Training and Certification

To become and/or remain nationally certified, a clinician must complete all training and certification/re-certification requirements, as outlined by the TF-CBT National Therapist Certification Program (www.tfcbt.org).

The cost associated with participation in a TF-CBT training program is variable.

Post-Training Clinical Supervision

While maintaining an active caseload, TF-CBT clinicians should participate in regular, case-specific: a) clinical supervision provided by a clinical supervisor (TF-CBT-trained supervisor is preferred); and/or b) fidelity-driven peer case review. Additionally, clinicians should self-monitor fidelity across their caseload, using a structured fidelity metric, throughout treatment delivery.

When allocating resources to support supervision or peer case review, consider: caseload size and complexity; TF-CBT fidelity requirements; supervision structure; agency requirements; and other factors.

Clinical Assessment Measures

TF-CBT requires the administration of standardized clinical measures at pre- and post-treatment to assess client trauma history and post-traumatic stress symptoms. It is recommended that each client also be evaluated at pre- and post-treatment for internalizing and externalizing symptoms, as well as other clinically-relevant domains. Standardized assessment of relevant caregiver domains is also recommended.

The cost associated with purchase or licensing of standardized clinical assessment measures should be considered when allocating resources to support an agency TF-CBT program.

Clinical Materials

TF-CBT delivery utilizes component-specific clinical materials during each clinical encounter; the cost is variable.

Clinician Travel

A TF-CBT clinician may participate in activities that require travel, including: home- or community-based treatment delivery, clinical support activities (out-of-session), and/or *in vivo* desensitization clinical sessions.

When allocating resources to support an agency TF-CBT program, consideration should be given to clinician travel time, as well as direct travel expenses.

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North Carolina Child Treatment Program
Evidence-Based Treatment (EBT) Service Delivery Time Model Series

Clinical Service Delivery Time Model for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Model Overview, Research Base, and Outcomes

Section One: TF-CBT Overview

Model Developers

- Judith Cohen, M.D.
  - Center for Traumatic Stress in Children and Adolescents
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- Esther Deblinger, Ph.D.
  - Center for Children's Support
  - University of Medicine and Dentistry of New Jersey
- Anthony Mannarino, Ph.D.
  - Center for Traumatic Stress in Children and Adolescents
  - Alleghany General Hospital

Treatment Protocols (Manuals)

- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (Eds.) (2012). *Trauma-Focused CBT for Children and Adolescents: Treatment Applications.* New York: Guilford Press.[1]
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2015). *Child Sexual Abuse: A Primer for Treating Children, Adolescents, and Their Nonoffending Parents*, *2nd edition*. New York: Oxford University Press.[2]
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating Trauma and Traumatic Grief in Children and Adolescents, 2nd edition*. New York: Guilford Press. [3]

Model Description

TF-CBT is an evidence-based, mental health treatment for children experiencing symptoms following a wide range of traumatic experiences or exposures. TF-CBT is a components-based, cognitive behavioral intervention. The model emphasizes trauma-specific gradual exposure and psychoeducation; acquisition of coping skills; effective child-parent communication; trauma processing; and enhancement of client future safety and development.

Treatment Theory

TF-CBT is based on attachment, biological and neurodevelopmental, cognitive-behavioral, empowerment, family systems, humanistic, and trauma theory.

Target Population

TF-CBT is indicated for the treatment of children from 3 to 18 years of age who are demonstrating trauma-related symptoms following a significant traumatic experience or exposure. Treatment delivery may be tailored based on the developmental age, rather than chronological age, of a client with intellectual and/or developmental disabilities.

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Targeted Clinical Outcomes

TF-CBT outcomes include: decrease in child and caregiver posttraumatic stress, depressive, anxious, and externalizing symptoms; improvement in adaptive functioning and self-efficacy; and improvement in caregiver support of children following trauma.

Treatment Participants

TF-CBT typically includes a child (client) and at least one primary caregiver. The client and caregiver attend treatment sessions both individually and together throughout the course of treatment.

Treatment Delivery Professionals

TF-CBT is delivered by a licensed mental health clinician who is actively engaged in training with an endorsed trainer or has successfully completed all clinical training requirements, as defined by the model developers (www.tfcbt.org).

Service Setting and Type

TF-CBT may be delivered in an outpatient clinic, school, home, residential or confined facility, or other community setting. Additionally, TF-CBT may be offered through a variety of service delivery models, including: telehealth, outpatient, enhanced outpatient, intensive in-home, day treatment, psychiatric residential treatment, and others.

Treatment Delivery and Intensity

- Clients typically progress sequentially through the eight core TF-CBT components as they demonstrate skills mastery, process trauma experiences, and demonstrate reduction in trauma-related symptoms. Caregivers typically progress as they demonstrate skills mastery in support of client treatment.
- TF-CBT is conducted through a series of client-only, caregiver-only, and periodic client-caregiver (conjoint) session types; typically, two to three types are delivered during a single clinical encounter (single service date).
- Clinical encounters are conducted on a weekly basis over the course of several months; less frequent sessions may adversely impact the achievement of targeted clinical outcomes. In select circumstances, a client or caregiver may participate in two clinical encounters during a single week.
- A clinical encounter is typically 60 minutes in duration; however, 90-minute clinical encounters are often conducted due to agency-level scheduling practices or case-level implementation considerations.
- A typical course of community-based TF-CBT includes an estimated: a) 24.5 hours of total in-session activities; and b) 18.1 hours of total out-of-session activities (42 minutes out-of-session time for every 60-minute clinical encounter). Client and caregiver in-session participation time is approximately equal over the course of treatment.

Clinical Supervision

While maintaining an active caseload, TF-CBT clinicians should participate in regular, case-specific clinical supervision provided by a clinical supervisor (TF-CBT-trained is preferred) and/or fidelity-driven peer case review. Additionally, clinicians should self-monitor fidelity across their caseload, using a structured fidelity metric, throughout treatment delivery.

Factors Impacting Treatment Delivery and Outcomes

Treatment content and intensity, clinician fidelity, and clinical outcomes may vary across a TF-CBT caseload due to child-, caregiver-, family-, clinician-, agency-, and systems-level factors.

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Section Two: TF-CBT Clinical Inclusion and Exclusion Criteria

	Inclusion Criteria	Exclusion Criteria

Client	○ 3 to 18 years of age [a]
	○ Clinical indication:
	  ○ Traumatic experience(s) or exposure(s) [b], *and*
	  ○ Trauma-related symptoms that impact functioning, *and*
	  ○ Child has verbal memory of the targeted trauma(s)
	○ Available to participate in regularly scheduled treatment sessions [c]
		○ Referral symptoms are unrelated to trauma history
		○ Communication and cognitive skills at a level < 36 months of age
		○ Unable to participate in regularly scheduled treatment sessions [c]
		○ Child is exposed to ongoing trauma/safety issues

Caregiver	○ Available to participate in regularly scheduled treatment sessions [c]	○ Perpetrator of sexual abuse ○ Active perpetrator of domestic violence, physical abuse, or psychological abuse ○ Has active psychosis, cognitive impairment, or thought disorder that precludes participation ○ Unable to participate in regularly scheduled treatment sessions [c]

[a] TF-CBT may be delivered at the developmental age, rather than chronological age, of a client with intellectual and/or developmental disabilities.

[b] A traumatic experience or exposure is defined as “a frightening, dangerous, and/or violent event that poses a threat to a child’s life or bodily integrity” *and/or* “witnessing a traumatic event that threatens the life or physical security of a loved one.” [4]

[c] Clinical encounters (treatment sessions) are typically conducted on a weekly basis; less frequent sessions may adversely impact the achievement of clinical goals.

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Section Three: TF-CBT Clinical Assessment Strategy

Case-level TF-CBT clinical assessment should be individualized and include:

- Administration, scoring, and interpretation of standardized clinical assessment measures;
- Comprehensive trauma-informed clinical interview with client, if developmentally appropriate, and caregiver;
- Clinical observation;
- Collateral contacts;
- Record review;
- Case conceptualization;
- Documentation of the assessment process, findings, and conclusions;
- Provision of feedback.

TF-CBT Clinical Assessment Measure Domains (Per Treatment Phase)

Clinical assessment measures are administered and interpreted during the pre- and post-treatment phases. Clinical assessment measures may also be administered during treatment, if clinically indicated.

		Pre-Treatment Phase	During Treatment	Post-Treatment Phase
Assess Client	Required	○ Trauma history ○ Posttraumatic stress symptoms	○ As clinically indicated	○ Posttraumatic stress symptoms
	Recommended	○ Internalizing symptoms ○ Externalizing symptoms	○ As clinically indicated	○ Trauma history ○ Internalizing symptoms ○ Externalizing symptoms
	As clinically indicated	○ Problematic sexual behaviors ○ Substance use ○ Suicidal ideation ○ Other domains, as indicated	○ As clinically indicated	○ Problematic sexual behaviors ○ Substance use ○ Suicidal ideation ○ Other domains, as indicated
Assess Caregiver	Required	--	--	--
	Recommended	○ Parenting stress ○ Caregiver anxiety and depression ○ Caregiver trauma history ○ Caregiver posttraumatic stress symptoms ○ Other domains, as indicated	○ As clinically indicated	○ Parenting stress ○ Caregiver anxiety and depression ○ Caregiver trauma history ○ Caregiver posttraumatic stress symptoms ○ Other domains, as indicated

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Section Four: NC CTP TF-CBT Service Delivery Checklist

The *NC CTP Clinical Service Delivery Checklist (TF-CBT)* was developed to support the collection, aggregation, and analysis of service utilization data within an outpatient TF-CBT program. The *Checklist* describes core clinical and fidelity requirements for the delivery of TF-CBT, per standards established through the TF-CBT manuals[1-3]. *Checklist* adaptation may be required to support service utilization analysis within other service delivery models or treatment environments.

The *Checklist* should not be used to facilitate training, treatment, fidelity monitoring, or clinical supervision. Rather, the TF-CBT manuals [1-3] and/or clinical fidelity monitoring tools should be used for this purpose.

NC CTP TF-CBT Service Delivery Checklist

TF-CBT Treatment Components	Clinical Activities	Requirements
Pre-Treatment Assessment	1. Conduct clinical interviews and observation 2. Administer and score client and caregiver standardized assessment measures 3. Contact collateral sources and review records 4. Provide feedback to client and caregiver 5. Determine treatment focus and goals 6. Conduct functional analysis of targeted symptoms 7. Prepare client and caregiver individually for conjoint session, if conjoint session is clinically indicated 8. Document assessment process, findings, conclusions, and treatment plan 9. Conduct out-of-session case support activities, as clinically indicated 10. Self-assess and document fidelity	Use standardized measures to assess client trauma history and symptoms Complete assessment prior to initiation of treatment
Psychoeducation	1. Enhance client and caregiver knowledge and beliefs regarding general impact of trauma and client-specific trauma type 2. Introduce TF-CBT model 3. Prepare client and caregiver individually for conjoint session, if conjoint session is clinically indicated 4. Document treatment strategies and client and caregiver progress 5. Conduct out-of-session case support activities, as clinically indicated 6. Self-assess and document fidelity	Conduct TF-CBT clinical activities in client-only and caregiver-only sessions If conjoint session is clinically indicated, prepare client and caregiver individually prior to initiating conjoint session Integrate gradual exposure to client-specific trauma throughout treatment session
Parenting	1. Develop caregiver ability to: a. Use praise with client b. Use selective attention with client c. Use contingency reinforcement with client d. Use other parenting skills, as indicated e. Integrate parenting skills 2. Document treatment strategies and caregiver progress 3. Conduct out-of-session case support activities, as clinically indicated 4. Self-assess and document fidelity	Conduct TF-CBT clinical activities during caregiver-only sessions Content of parenting component is provided in multiple sessions over the first third of the model Integrate gradual exposure to client-specific trauma throughout treatment session

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NC CTP TF-CBT Service Delivery Checklist Continued

TF-CBT Treatment Component	Clinical Activities	Requirements
Relaxation	1. Develop client ability to use relaxation skills to manage trauma symptoms and reminders 2. Develop caregiver ability to support client use of relaxation skills to manage trauma symptoms and reminders 3. Prepare client and caregiver individually for conjoint session, if conjoint session is clinically indicated 4. Document treatment strategies and client and caregiver progress 5. Conduct out-of-session case support activities, as clinically indicated 6. Self-assess and document fidelity	Conduct TF-CBT clinical activities during client-only and caregiver-only sessions If conjoint session is clinically indicated, prepare client and caregiver individually prior to initiating session Integrate gradual exposure to client-specific trauma throughout treatment session
Affective Expression and Modulation	1. Develop client ability to: a. Use emotions vocabulary b. Identify physiologic response to emotions in self c. Assess emotional intensity in self d. Identify indicators of emotion in others e. Integrate TF-CBT skills 2. Develop caregiver strategies to reinforce client: a. Use of emotions vocabulary b. Identification of physiologic response to emotion c. Self-assessment of emotional intensity d. Identification of indicators of emotion in others e. TF-CBT skill integration 3. Prepare client and caregiver individually for conjoint session, if conjoint session is clinically indicated 4. Document treatment strategies and client and caregiver progress 5. Conduct out-of-session case support activities, as clinically indicated 6. Self-assess and document fidelity	Conduct TF-CBT clinical activities during client-only and caregiver-only sessions If conjoint session is clinically indicated, prepare client and caregiver individually prior to initiating session Integrate gradual exposure to client-specific trauma throughout treatment session
Cognitive Coping	1. Develop client ability to: a. Differentiate cognitions from emotions b. Apply the cognitive triangle c. Identify automatic thoughts and thought patterns d. Assess cognitive distortions e. Use cognitive coping techniques f. Integrate TF-CBT skills 2. Develop caregiver strategies to reinforce client: a. Ability to differentiate cognitions from emotions b. Application of the cognitive triangle c. Identification of automatic thoughts and thought patterns d. Assessment of cognitive distortions e. Use of cognitive coping techniques f. TF-CBT skill integration 3. Prepare client and caregiver individually for conjoint session, if conjoint session is clinically indicated 4. Document treatment strategies and client and caregiver progress 5. Conduct out-of-session case support activities, as clinically indicated 6. Self-assess and document fidelity	Conduct TF-CBT clinical activities during client-only and caregiver-only sessions If conjoint session is clinically indicated, prepare client and caregiver individually prior to initiating session Integrate gradual exposure to client-specific trauma throughout treatment session

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NC CTP TF-CBT Service Delivery Checklist Continued

TF-CBT Treatment Component	Clinical Activities	Requirements
Trauma Narration and Processing	*Client-Only Sessions* 1. Introduce and initiate trauma narration or review trauma-specific content from prior narration sessions 2. Incorporate specific trauma memories in narration, including "worst" trauma memory 3. Address trauma reminders and cognitive distortions regarding trauma experience 4. Enhance perception of self-efficacy regarding trauma experience 5. Incorporate helpful perceptions of self, others, or world within narration 6. Prepare client for conjoint session 7. Document treatment strategies and client progress 8. Conduct out-of-session case support activities, as clinically indicated 9. Self-assess and document fidelity	Conduct TF-CBT clinical activities during client-only sessions
Trauma Narration and Processing	*Caregiver-Only Sessions* 1. Introduce trauma narration and processing, addressing potential client treatment resistance or symptom escalation or review trauma-specific content from prior client narration sessions 2. Enhance caregiver ability to: a. Address trauma reminders b. Reinforce client accurate and helpful cognitions regarding trauma experience c. Reinforce client perception of self-efficacy regarding trauma experience d. Reinforce client perception of trauma as a meaningful experience 3. Prepare caregiver for conjoint session 4. Document treatment strategies and caregiver progress 5. Conduct out-of-session case support activities, as clinically indicated 6. Self-assess and document fidelity	Conduct TF-CBT clinical activities during caregiver-only sessions
	Client-Caregiver Sessions 1. Review processed trauma narration 2. Reinforce client ability to address trauma reminders 3. Enhance accurate and helpful client cognitions regarding trauma experience 4. Enhance client perception of self-efficacy 5. Enhance client perception of trauma as a meaningful experience 6. Address sub-optimal caregiver response to client trauma experience 7. Document treatment strategies and client-caregiver progress 8. Conduct out-of-session case support activities, as clinically indicated 9. Self-assess and document fidelity	Conduct TF-CBT clinical activities during client-caregiver conjoint sessions

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NC CTP TF-CBT Service Delivery Checklist Continued

TF-CBT Treatment Component	Clinical Activities	Requirements
Enhancing Safety and Healthy Development	1. Identify potential (future): a. Risk to client physical and psychological safety b. Impact of trauma on client development 2. Develop client ability to: a. Use trauma-related safety skills b. Identify and address potential impact of trauma on development 3. Develop caregiver strategies to: a. Reinforce client use of trauma-related safety skills b. Identify and address potential impact of client trauma on development 4. Prepare client and caregiver individually for conjoint session, if conjoint session is clinically indicated 5. Document treatment strategies and client and caregiver progress 6. Conduct out-of-session case support activities, as clinically indicated 7. Self-assess and document fidelity	Conduct TF-CBT clinical activities during client-only and caregiver-only sessions If conjoint session is clinically indicated, prepare client and caregiver individually prior to initiating session Integrate gradual exposure to client-specific trauma throughout treatment session
Post-Treatment Assessment and Termination	1. Administer and score client and caregiver standardized assessment measures 2. Document assessment process, findings, conclusion, and post-TF-CBT plan 3. Provide feedback to client and caregiver 4. Prepare for TF-CBT termination 5. Prepare client and caregiver individually for conjoint session, if conjoint session is clinically indicated 6. Develop and implement graduation activities 7. Document treatment strategies and client and caregiver progress 8. Conduct out-of-session case support activities, as clinically indicated 9. Self-assess and document fidelity	Use standardized measures to re-assess trauma history and symptoms Compare pre- and post- treatment results Integrate gradual exposure to client-specific trauma throughout treatment session

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NC CTP TF-CBT Service Delivery Checklist Continued

TF-CBT Treatment Component	Clinical Activities	Requirement
Optional Imminent Safety Risk	1. Assess imminent risk to physical or psychological safety 2. Develop and initiate plan to address imminent risk to physical or psychological safety 3. Document assessment process, findings, conclusion, and safety plan 4. Monitor and adjust safety plan 5. Document treatment strategies and client and caregiver progress 6. Conduct out-of-session case support activities, as clinically indicated 7. Self-assess and document fidelity	Optional component, at clinician's discretion according to need
Optional *In Vivo* Desensitization	1. Assess client impairment in response to innocuous trauma reminders 2. Introduce *in vivo* desensitization process 3. Facilitate development of a stimulus hierarchy and *in vivo* desensitization plan 4. Initiate implementation of *in vivo* desensitization process 5. Monitor and adjust *in vivo* desensitization plan 6. Assign *in vivo* desensitization homework 7. Prepare client and caregiver individually for conjoint session, if conjoint session is clinically indicated 8. Document treatment strategies and client and caregiver progress 9. Conduct out-of-session case support activities, as clinically indicated 10. Self-assess and document fidelity	Optional component, at clinician's discretion according to need

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Section Five: TF-CBT Research Base

NC CTP faculty conducts an annual literature review of the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) research base, with a particular emphasis on populations studied and treatment outcomes for the TF-CBT model and/or model adaptations. A paper is eligible for inclusion if, minimally, the study: 1) is published in a peer-reviewed journal, 2) incorporates a pre-post evaluation design that includes at least one group of children and families, and 3) represents an original randomized efficacy trial (RCT), quasi-experimental study, single-group pretest-posttest design study, pilot study, systematic review, or meta-analysis. Model adaptation studies are confined to the *Populations Studied* and *Outcomes with Adaptations and Non-Traditional Modalities* subsections of the TF-CBT Research Base section if the TF-CBT model design was significantly altered through adaptation. Studies are excluded entirely from the TF-CBT Research Base section if they do not meet all three inclusion criteria, with the exception of selected cross-sectional and/or qualitative findings deemed relevant for inclusion in the *Systems Outcomes* table. Further, systematic review and meta-analytic studies are excluded if they summarize findings for TF-CBT in combination with findings for one or more other cognitive-behavioral interventions. A specific outcome is included in this review if a statistically- and/or clinically-significant main effect was found over time for that outcome.

Detailed information about study rationale, methodology, and other content may be accessed directly via the cited research article.

Last Updated: March 2022

Populations Studied:

- Children experiencing traumatic grief [5-9]
- Children who have experienced traumatic loss[10]
- Children who have experienced complex trauma [11]
- Children who have experienced sexual abuse[12-29]
- Children who have experienced physical abuse [30, 31]
- Children who have experienced sexual exploitation [32]
- Children exposed to or involved in war [32-34]
- Children exposed to intimate partner violence[35]
- Children exposed to a natural disaster[36]
- Children affected by terrorism[37, 38]
- Children exposed to different and/or multiple types of trauma.[39-96]

- Diverse ethnic and racial populations living in the United States, including African or African American, American Indian or Alaskan Native, Asian, Caucasian, Latinx, multiracial, and/or other groups.[5, 6, 8, 11-21, 23-26, 29, 35-38, 40-45, 54, 58-67, 73-81, 83-85, 88, 91, 96]
- Children living in countries outside of the United States, including: Australia[22, 27, 92, 93], Canada[28, 46, 82], Democratic Republic of Congo[32-34], Germany[10, 55-57, 68, 86, 95], Republic of El Salvador[90, 94], Kenya [9], Iran[31, 70], Japan[48, 89], Jordan[30], Netherlands[49], Norway[39, 53, 69, 71, 72, 87], Sweden[50], Tanzania[7, 9], United Kingdom, Zambia[51, 52], and various countries[62, 65, 79, 81]

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Section Six: TF-CBT Research Outcomes and North Carolina Outcomes

Client Outcomes	
Immediate Post-Treatment Outcome	**Outcome Sustained Following Treatment**
Decrease in posttraumatic stress symptoms[10-12, 17-19, 22, 24, 25, 28, 29, 35-39, 41-49, 51-54, 58-61, 63-66, 68, 72-75, 78, 79, 81, 83-95]	At 1 month[89] At 6 weeks [95] At 3 months[20, 22, 38, 41, 43-45, 58, 63] At 6 months[13, 17, 20, 23, 28, 38, 41, 46, 56, 63, 86, 95] At 1 year[13, 17, 20, 23, 56, 61, 71, 86] At 1.5 years[53, 71, 87] At 2 years[20]
Decrease in dissociative symptoms [17, 28, 88]	At 6 months[17, 28] At 1 year[17]
Decrease in posttraumatic stress disorder (PTSD) diagnosis[12, 22, 35, 36, 39, 44, 45, 47, 49, 73, 81, 89, 93, 95]	At 1 month[89] At 6 weeks[95] At 3 months[22, 44, 45] At 6 months [56] At 1 year[56]
Decrease in severity/functional impairment associated with posttraumatic stress symptoms[10, 39, 43-45, 54]	At 3 months[43-45] At 1 year[71] At 1.5 years[71]
Decrease in self-organization difficulties (emotion regulation, negative self-concept, interpersonal problems) associated with ICD-11 complex posttraumatic stress disorder (C-PTSD)[68]	--
Decrease in shame and/or maladaptive trauma-related cognitions[11, 24, 46, 51] [12, 25, 47, 52, 85, 86]	At 6 months[13, 23, 56, 86] At 1 year[13, 23, 56, 86] At 1.5 years[87]
Decrease in abuse-related fear[22, 25]	At 3 months[22] At 6 months[23] At 1 year[23]
Decrease in internalizing symptoms (anxiety, depression, and/or somatic symptoms)[10, 11, 14, 15, 17, 25, 28, 29, 41, 42, 44, 45, 47, 58, 59, 63, 66, 73, 88, 91, 94]	At 1 month[89] At 3 months[41, 44, 45, 58, 63] At 6 months[17, 23, 28, 41, 56, 63] At 1 year[15, 17, 23, 56]
Decrease in depression symptoms[10, 12, 16-19, 22, 24, 25, 29, 38, 39, 47, 53, 58, 60, 61, 65, 66, 73, 74, 86-88, 90, 93, 95]	At 1 month[89] At 6 weeks[82] At 3 months[20, 22, 38, 58] At 6 months[13, 17, 20, 23, 38, 56, 86] At 1 year[13, 17, 20, 23, 56, 61, 71, 86] At 1.5 years[52, 71, 87] At 2 years[20]
Decrease in sense of inadequacy[66, 85]	--
Decrease in depression diagnosis[43]	At 3 months[44]
Decrease in anxiety symptoms[16-18, 22, 25, 29, 35, 38, 39, 47, 53, 65, 74, 86, 88, 90, 91, 93]	At 1 month[89] At 3 months[22, 38] At 6 months [13, 17, 23, 38, 56, 86] At 1 year [13, 17, 23, 56, 71, 86] At 1.5 years[53, 71]

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Client Outcomes	
Immediate Post-Treatment Outcome	**Outcome Sustained Following Treatment**
Decrease in physical complaints[95]	--
Decrease in externalizing symptoms (attention difficulty, rule-breaking behavior, aggression, and/or other conduct problems) [11, 14, 15, 19, 25, 28, 29, 37, 41, 42, 44, 45, 47, 58, 59, 61, 63, 65, 73, 77, 91, 96]	At 1 month[89] At 3 months[20, 41, 44, 45, 58] At 6 months[15, 20, 23, 28, 41, 56] At 1 year[15, 20, 23, 56, 61, 96] At 2 years[20]
Decrease in anger symptoms[17, 88]	At 6 months[17] At 1 year[17]
Decrease in problematic sexual behaviors[14-17, 25, 75]	At 6 months[15, 17, 23] At 1 year[15, 17, 23]
Decrease in attention deficit and/or hyperactivity symptoms[49, 66]	--
Decrease in executive function difficulties[96]	At 1 year[96]
Decrease in overall mental health problems (combination of internalizing and externalizing symptoms) [11, 12, 14-18, 39, 47, 54, 75, 95]	At 1 month[89] At 6 weeks[95] At 6 months[13, 17, 56] At 1 year[13, 15, 17, 56, 71] At 1.5 years[71]
Decrease in risk behaviors[11, 59]	--
Decrease in substance abuse proneness[66]	--
Decrease in suicidal tendency[66]	--
Decrease in emotional reactivity to stressors[24]	--
Decrease in maladaptive emotion regulation strategies[66]	--
Decrease in sense of inadequacy [85]	--
Improvement in child strengths/resources[11, 58, 59]	At 3 months[58]
Improvement in emotion regulation[31, 82, 85]	At 6 months[82]
Improvement in adaptive emotion regulation strategies[70]	--
Improvement in feelings of emotional relatedness[24]	--
Improvement in posttraumatic growth[70]	--
Improvement in body safety skills[25]	At 6 months[23] At 1 year[23]
Improvement in feelings of mastery[24]	--
Improvement in social competence or functioning[15-17, 31, 48]	At 6 months[17] At 1 year[15, 17]
Improvement in overall or life domain functioning[11, 22, 47, 51, 59, 92]	At 1 month[89] At 3 months[22] At 6 months[56] At 1 year[56]
Improvement in quality of life[47, 53]	At 6 months[56] At 1 year[56] At 1.5 years[52]

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Caregiver Outcomes	
Immediate Post-Treatment Outcome	**Outcome Sustained Following Treatment**
Decrease in posttraumatic stress symptoms[28, 80, 86, 90, 96]	At 6 months[28] At 1 year[96]
Decrease in trauma-specific emotional distress[12, 18, 25, 69, 80]	At 6 months[13, 23] At 1 year[13, 23]
Decrease in dysfunctional posttraumatic cognitions related to child's trauma[57, 86]	--
Decrease in depression symptoms[12, 25, 55, 69, 75, 80]	At 1 month[89] At 6 months[23] At 1 year[23]
Decrease in general psychological distress[28, 42]	At 6 months[28]
Decrease in anxiety [86]	At 1 month[89]
Improvement in caregiver quality of life	At 1 month[89]
Improvement in caregiver strengths/resources[11]	--
Improvement in caregiver support of child[12, 18]	--
Improvement in effective parenting practices[12, 19, 25, 75]	At 6 months[23] At 1 year[23]
Improvement in treatment response and/or remission [44, 45]	At 3 months[44, 45]

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Systems Outcomes	
Cost-Effectiveness	More cost effective than non-directive counseling[27] Likelihood of being cost-effective varied from 91-96% compared with treatment as usual[53] Similar cost-effectiveness compared to three other (non-branded) individual forms of trauma-focused cognitive behavioral therapy; and greater cost-effectiveness compared to six other types of trauma-focused interventions[62] Lower costs for high-end mental health services and higher costs for low-end mental health services over one year compared to a matched control group of youth[76]
Child Welfare	Reduction in use of child welfare services compared with treatment as usual[53]
Mental Health	Reduction in use of medication compared with treatment as usual[53]
School	Reduction in use of school psychological counseling services and school nurses compared with treatment as usual[53] Improvement in adaptation to school[66]
Social Services	Reduction in use of social services compared with treatment as usual[53]
Various Systems	Fewer serious adverse events (serious physical intimate partner violence, reportable episodes of child abuse, child self-injury, and other serious problems requiring psychiatric hospitalization) than completers of Child-Centered Therapy[35]

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Outcomes with Adaptations and Non-Traditional Modalities	
Treatment Modality / Adaptation	**Outcomes**
Telehealth: *Standard TF-CBT*	Decrease in child posttraumatic stress, depression, anxiety, internalizing, and externalizing symptoms, and overall mental health problems[67]
Tablet-based adaptation: *Standard TF-CBT*	Similar decrease in child posttraumatic stress, depression, internalizing, and externalizing symptoms, and PTSD diagnosis as compared to standard TF-CBT[73]
Adaptation for 3-6 year olds: *Standard TF-CBT*	Decrease in child posttraumatic stress, depression, anxiety, and oppositional defiant symptoms[40] ○ Sustained at 6-month follow-up[40]
Adaptation of treatment length +/- inclusion of trauma narrative: *Standard TF-CBT*	Decrease in child posttraumatic stress, depression, anxiety, abuse-related fear, shame, internalizing, externalizing symptoms, abuse-related fear, sexualized behaviors, caregiver trauma-specific distress and depression across both 8- and 16-session conditions, with or without the trauma narrative[25] Improvement in child body safety skills and caregiver use of effective parenting practices across both 8- and 16-session conditions, with or without the trauma narrative[25] Largest decrease in caregiver trauma-specific distress and child abuse-related fear and general anxiety found for the 8-session TF-CBT condition that included the trauma narrative[25] Largest decrease in child externalizing symptoms and greatest improvement in effective parenting practices found for the 16-session TF-CBT condition without the trauma narrative[25]
Group adaptation: *Standard TF-CBT*	Decrease in child posttraumatic stress symptoms and problematic sexual behaviors, and caregiver general psychological distress[26] ○ Sustained at 3-month follow-up[26] Improvement in child body safety skills[21] ○ Sustained at 3-month follow-up[21] Decrease in caregiver posttraumatic stress symptoms and trauma-specific emotional distress[21] ○ Sustained at 3-month follow-up[21] Improvement in effective parenting practices[26] ○ Sustained at 3-month follow-up[26]
Group adaptation: *For war-affected Congolese youth*	Decrease in child posttraumatic stress symptoms, depression, anxiety, and conduct problems[32-34] ○ Sustained at 3-month follow-up[32, 33] ○ Sustained at 6-month follow-up[34] Decrease in child overall psychosocial distress[33] ○ Sustained at 3-month follow-up[33] Improvement in child prosocial behavior[32, 33] ○ Sustained at 3-month follow-up[32, 33]
Group adaptation: *For unaccompanied refugee minors in Sweden*	Decrease in child posttraumatic stress and depressive symptoms[50]

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Outcomes with Adaptations and Non-Traditional Modalities (continued)	
Treatment Modality / Adaptation	**Outcomes**
Group adaptation: *For physically abused children in Jordan*	Decrease in child posttraumatic stress and depressive symptoms[30] ○ Sustained at 4-month follow-up[30]
TF-CBT for Childhood Traumatic Grief (CBT-CTG)	Decrease in child posttraumatic stress, traumatic grief, depression, anxiety, internalizing, and externalizing symptoms, and overall mental health problems[5, 6] Improvement in child adaptive functioning[5] Decrease in caregiver posttraumatic stress[5, 6] and depression[5] symptoms
Group adaptation: *TF-CBT for Childhood Traumatic Grief (CBT-CTG) for orphaned children in Tanzania*	Decrease in child posttraumatic stress, traumatic grief, and depression symptoms, and overall mental health problems[7] ○ Sustained at 3- and 12-month follow-up[7]
Stepped Care TF-CBT (SC-TF-CBT)	Similar decrease in child posttraumatic stress symptoms and associated severity/functional impairment as compared to standard TF-CBT[42, 44, 45] ○ Sustained at 3-month follow-up[42, 44, 45] Similar decrease in child internalizing and externalizing symptoms, posttraumatic stress disorder (PTSD) diagnosis, and similar treatment response as compared to standard TF-CBT[44, 45] ○ Sustained at 3-month follow-up[44, 45] Similar decrease in child depression diagnosis compared to standard TF-CBT[43] ○ Sustained at 3-month follow-up[44] Similar treatment remission compared to standard TF-CBT[45] ○ Sustained at 3-month follow-up[45] Significantly lower direct and indirect costs for patients/parents and providers compared to standard TF-CBT[44, 45]
TF-CBT + animal-assisted therapy (AAT)	Similar decrease in child posttraumatic stress symptoms as compared to standard TF-CBT[91] Similar decrease in child internalizing symptoms as compared to standard TF-CBT [91] Similar decrease in child externalizing symptoms as compared to standard TF-CBT [91]

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North Carolina TF-CBT Clinical Outcomes

The NC Child Treatment Program provides intensive TF-CBT training and clinical coaching to approximately 120 licensed clinicians each year. Since 2006, NC CTP has monitored clinical outcomes for a minimum of two clients per clinician-trainee; additionally, select caregiver outcomes are assessed. Per comparison of pre-and post-treatment assessment results (caregiver report, client self-report, and caregiver self-report):

- The majority of clients demonstrate a statistically significant reduction in PTSD symptoms, depression and anxiety symptoms (social phobia, panic disorder, major depression, separation anxiety, generalized anxiety, and obsessive-compulsive symptoms), conduct problems, and hyperactivity.
- The majority of caregivers demonstrate a statistically significant reduction in depression, anxiety, and global symptom severity.

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