Trauma-Focused Cognitive Behavioral Therapy for Children in Foster Care: An Implementation Manual

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Introduction

Almost half a million children may reside in foster care in the United States (U. S.) at any given time. According to the U. S. Department of Health and Human Services (2015), as of September 30, 2014, there were 415,129 children in foster care in the U. S. Among the children in foster care as of that date, 46% were in non-relative foster homes, 29% were in relative (i.e., kinship) foster homes, 8% were in institutions, 6% were in group homes, and the remaining 11% were in other placement types (pre-adoptive homes, etc.). The median age of children in foster care at that time was 8.0 years; 52% were male and 48% were female. With regard to race/ethnicity, 42% of the children were White, 24% were Black or African-American, 22% were Hispanic, 10% were other or multiracial, and the race/ethnicity of the remaining 3% was listed as unknown/unable to determine. The median amount of time spent in foster care was 13.3 months.

It has been repeatedly documented that children in foster care often present with a history of childhood trauma including neglect, sexual abuse, physical abuse, and emotional abuse. One study found that the mean number of traumas experienced by children in placement in their sample was 4.7 and for foster children considered to have complex trauma the mean number of traumas was 5.8 (Greeson et al., 2011). A study of older adolescents in foster care noted that 80% of the sample had one or more experiences that would be a qualifying trauma in the DSM-IV definition of Posttraumatic Stress Disorder (PTSD) and almost 62% had experienced two or more DSM-qualifying events (Salazar, Keller, Gowen, & Courtney, 2013). The rate of trauma exposure for youth in foster care in this study was double the rate of trauma exposure for youth in the general population (Salazar et al., 2013). A review of the literature found that the majority of children in foster care had a history of multiple forms of maltreatment (Oswald, Heil, & Goldbeck, 2010).

Among children in placement, this review documented rates ranging from 18-78% for neglect, 6-48% for physical abuse, 4-35% for sexual abuse, 8-77% for emotional abuse, and 21-30% for no available caregiver (Oswald et al., 2010). Parental substance abuse is a significant factor related to children being placed in foster care due to neglect. In fact, one study found a rate of parental substance abuse of 51% among children placed into foster care for neglect (Takayama, Wolfe, & Coulter, 1998). A study of children in treatment foster care found that 93% of the children were reported to have experienced one or more traumas and almost one-half experienced four or more types of trauma (Dorsey et al., 2012). The number of experienced traumas may, in fact, have been underreported as the information came from treatment home parents who may not have had full knowledge of the child's trauma history.

Applicability of TF-CBT for Children in Foster Care

It is well documented that children in foster care experience a wide range of significant difficulties, including PTSD, depression, and behavior problems typically targeted by Trauma-focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2016; Deblinger, Mannarino, Cohen, Runyon, & Heflin, 2015). In an early study of PTSD in children in foster care, Dubner and Motta (1999) found that among 150 children in foster care (50 who were sexually abused, 50 who were physically abused, and 50 who were not abused), 64% of children in the sexual abuse group, 42% of children in the physical abuse group, and 18% of children in the non-abused group met criteria for PTSD. More recent research on posttraumatic stress among children in foster care also has found clinically significant posttraumatic stress symptoms (e.g., Greeson et al., 2011; Kolko et al., 2010) and high rates of the PTSD diagnosis (e.g., Keller, Salazar, & Courtney, 2010; McMillen et al., 2005). More specifically, among a nationally representative

sample of 1848 children involved with the child welfare system, Kolko and colleagues (2010) found that posttraumatic stress symptoms were significantly higher among children removed from their homes as compared to children who remained at home. In another study, PTSD was the most common diagnosis among older adolescents in foster care and was diagnosed at a rate significantly higher than in the general population (Keller et al., 2010).

Diagnoses other than PTSD have been documented among children in foster care, including Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, depression, mood disorder, anxiety disorder, attachment disorder, and adjustment disorder (e.g., dosReis, Zito, Safer, & Soeken, 2001; McMillen et al., 2005; Oswald et al., 2010). One study examining Medicaid claims from 44 states found that youth in foster care had higher rates across externalizing disorder diagnoses, were more than 6 times as likely to be diagnosed with stress-related disorders, and were more than twice as likely to be diagnosed with any disorder as compared with Medicaid youth not in foster care (Vanderwerker et al., 2014). Also using Medicaid claims, dosReis and colleagues (2001) found the prevalence of mental health diagnoses among children in foster care to be two times greater than children receiving Supplementary Security Income and almost 15 times greater than youth receiving other types of aid. In addition to examining the diagnoses of children in foster care, many studies have utilized the Child Behavior Checklist (CBCL; Achenbach, 1991; Achenbach & Rescorla, 2001) to document internalizing and externalizing difficulties among these children. Oswald and colleagues' (2010) review of the literature suggests that foster children generally have elevated values on the total problems scale and subscales, and that 36-61% of children in foster care had scores over the cutoff for behavior problems.

Research also has focused on the difficulties of adolescents in foster care. Pilowsky and Wu (2006) compared adolescents with and without placement into foster care; the adolescents who had been placed in foster care exhibited more symptoms in every category assessed. The adolescents with a foster care placement had more than twice the number of conduct symptoms, were significantly more likely to report suicidal ideation, were about three times more likely to present with eight or more anxiety symptoms, about four times more likely to present with seven or more symptoms of disruptive behavior disorders, about four times more likely to have a history of suicide attempts, about two times more likely to use illicit drugs, about five times more likely to be drug dependent, and about two to four times more likely to have other substance use disorders (Pilowsky & Wu, 2006). Another study of adolescents in foster care found that 35% of the sample qualified for a substance use disorder and that having a diagnosis of PTSD or Conduct Disorder increased the likelihood of the use of multiple substances and being diagnosed with a substance use disorder (Vaughn, Ollie, McMillen, Scott, & Munson, 2007). Alcohol-related disorders and depression also have been noted among adolescents in foster care (e.g., Keller et al., 2010).

Beyond mental health concerns, children and adolescents in foster care have high rates of developmental delays (e.g., Leslie et al., 2005; Pears & Fisher, 2005), physical health concerns (e.g., Szilagyi, Rosen, Rubin, & Ziotnik, 2015; Takayama et al., 1998), and educational challenges (e.g., Smithgall, Gladden, Howard, Goerge, & Courtney, 2004). Research also has documented psychobiological correlates of maltreatment for children in foster care (e.g., Bick et al., 2012; Linares et al., 2008).

The Adverse Childhood Experiences (ACEs) research (e.g., Chapman et al., 2004; Dube et al., 2003; Felitti et al., 1998) has documented that trauma in childhood can lead to significant

psychological and physical difficulties, including substance abuse, depression, heart disease, and cancer, that can persist well into adulthood and can even lead to an increased risk of premature death. Further, the greater the number of ACEs/traumas experienced, the likelihood of difficulties increases in a strong and graded manner (e.g., Chapman et al., 2004; Felitti et al., 1998). For example, adults with a history of four or more ACEs were 10 times more likely to have injected street drugs and 12 times more likely to have attempted suicide than adults with no history of ACEs (Felitti et al., 1998).

The ACEs research is particularly relevant for children in foster care given reports that these children often have experienced multiple traumas. Studies investigating the cumulative effects of trauma among children in foster care also suggest this relationship of more trauma exposure leading to significantly greater emotional and behavioral difficulties (e.g., Greeson et al., 2011; Raviv, Taussig, Culhane, & Garrido, 2010; Salazar et al., 2013; Seiler, Kohler, Ruf-Leuschner, & Landolt, 2016). For example, Raviv and colleagues (2010) found that children ages 9 to 11 years in out of home care with more risk factors (including trauma exposure) were more likely to experience anxiety, depression, posttraumatic stress, dissociation, sexual concerns, and externalizing behavior problems. Consistent with the adult ACEs literature, the symptom levels among these children increased as the number of risk factors increased (Raviv et al., 2010). As another example, a study of older adolescents in foster care documented that the teens who had experienced two or more traumatic events were much more likely to meet PTSD criteria (22.5%) than those who had experienced one traumatic event (6.7%; Salazar et al., 2013).

The lasting impact of difficulties among children who have been in foster care is also supported by research on foster care alumni. One study of foster care alumni found that 54.4% met

criteria for one or more disorder in the 12 months prior to being interviewed (Pecora et al., 2005). Among those with one or more disorders, 25.2% were diagnosed with PTSD (a rate almost twice that of U.S. war veterans at the time), 20.1% were diagnosed with major depression, and 17.1% with social phobia (Pecora et al., 2005).

Although rates of mental health therapy utilization by foster children are higher than community samples, there are still concerns that children in foster care are not receiving the services they need (e.g., Bellamy, Gopalan, & Traube, 2010; Landsverk, Burns, Stambaugh, & Rolls-Reutz, 2006; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). Further, it is important to evaluate the effectiveness of the treatments that are being implemented with children in foster care. For instance, one study of children in long-term foster care found that the use of outpatient mental health services had no significant impact on externalizing or internalizing behavior problems (Bellamy et al., 2010). Landsverk and colleagues (2006) indicated that evidence-based practices have not been utilized consistently in foster care settings. Given the high rates of mental health difficulties among children in foster care, it is critical that children in foster care receive effective treatment to help derail the potential negative mental health trajectory that too often leads to a lifetime of difficulties.

Trauma-focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2016; Deblinger et al., 2015) is the treatment for child trauma with the most research support (Morina, Koerssen, & Pollet, 2016), having demonstrated its efficacy in 20 randomized trials to date (Cohen et al., 2016). Several research studies on TF-CBT have included children in foster care among the samples but two studies evaluated the use of TF-CBT specifically with a foster care population. Lyons, Weiner, and Schneider (2006) conducted a quasi-experimental study of three evidence-based treatments for

trauma (Child-Parent Psychotherapy, Structured Psychotherapy for Adolescents Responding to Chronic Stress, and TF-CBT) provided to 216 children ages 3 to 18 years in foster care. Significantly greater improvements were associated with all three evidence-based treatments when compared to a treatment as usual condition through the System of Care. The treatments were also noted to be effective across racial groups (Weiner, Schneider, & Lyons, 2009). Children in the TF-CBT condition had significantly greater improvements in traumatic stress symptoms and behavioral and emotional needs as compared to children in the treatment as usual condition replicating the results of previous comparisons of TF-CBT (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996; Deblinger, Lippmann, & Steer, 1996; Jensen et al., 2014). However, this study also documented that foster children in the TF-CBT condition were about one-tenth as likely to run away from their placement and about half as likely to have a placement disruption as compared to children in the treatment as usual condition (Lyons et al., 2006). These are important outcomes for children in foster care, as this population has significant emotional and behavioral difficulties, as noted above, and placement disruptions have been linked with increasing mental health problems over time (e.g., Newton, Litrownik, & Landsverk, 2000).

Dorsey, Pullmann, and colleagues (2014) conducted a randomized controlled trial with children and their foster parents comparing the standard implementation of TF-CBT with TF-CBT plus evidence-based engagement strategies based on strategies developed by McKay, Stoewe, McCadam, and Gonzalez (1998). Forty-seven children ages 6 to 15 years participated with one of their foster parents. Children in both conditions who completed at least four sessions improved significantly on all outcome measures, which included assessments of posttraumatic stress symptoms, internalizing and externalizing difficulties, depressive symptoms, and the children's

strengths. Children and foster parents in the TF-CBT plus engagement condition, however, were significantly more likely to complete at least four sessions and less likely to drop out of treatment prematurely (Dorsey, Pullmann, et al., 2014). Given the importance of effective mental health treatment for children in foster care, the finding that evidence based engagement strategies addressing concrete as well as perceptual barriers resulted in higher rates of successful treatment completion is critically important.

Clinical Application of TF-CBT with Children in Foster Care

As the developers of TF-CBT (Cohen et al., 2016; Deblinger et al., 2015), we received support through Substance Abuse Mental Health Services Administration (SAMHSA) funding (Grant No #54319) to review and examine how TF-CBT, a widely used evidence based treatment model for childhood trauma, could be applied most effectively to children and adolescents placed with foster families. We worked closely and collaboratively with colleagues associated with the National Child Traumatic Stress Network (NCTSN, www.nctsn.org) who were actively engaged in implementing TF-CBT with foster families with the ultimate goal of creating a TF-CBT implementation manual for therapists working with foster children and their caregivers. In order to meet the goals of the project, we conducted bimonthly conference calls during which we engaged NCTSN clinicians in case discussions regarding TF-CBT implementation with foster families, while also brainstorming regarding TF-CBT adaptations for this population. Melissa Runyon, Ph.D., and Elisabeth Pollio, Ph.D., assisted with this project by contributing to the conference calls, collecting and organizing the information, reviewing the foster care literature, and serving as co-authors of this manual. We are also greatly appreciative of the foster caregivers who have shared their wisdom and who have opened their hearts and their homes to children and adolescents during

what is often the most difficult times of their lives. Thus, this manual represents the collective knowledge and clinical expertise of many talented therapists, supervisors, foster caregivers, and others dedicated to ensuring children placed in foster care achieve optimal mental health outcomes. The overall goal of this manual is to offer guidance to clinicians and supervisors on adapting TF-CBT to optimally address the unique circumstances of children in foster placement settings. To bring to life the special challenges faced when implementing TF-CBT with foster families, we included many clinical examples throughout the manual. In order to protect the privacy of foster families, all clinical examples in this manual are *composite case descriptions*.

Review of TF-CBT Core Components

Therapists preparing to implement TF-CBT with children in foster care should have basic TF-CBT knowledge and skills for treating diverse traumas experienced by children and their families. TF-CBT implementation is described in detail in several current texts (Cohen et al., 2016; Deblinger et al., 2015). In addition, other chapters/articles offer an overview of TF-CBT implementation specifically with children in foster care and their foster parents (Dorsey & Deblinger, 2012; Dorsey, Conover, & Cox, 2014). Free of charge introductory online TF-CBT training is also available at www.musc.edu/tfcbt. To optimally utilize this TF-CBT foster care manual, readers are encouraged to take advantage of the above texts, the free of charge online training, as well as other opportunities for face-to-face training and consultation in TF-CBT implementation.

Gradual exposure (GE) and Trauma Reminders

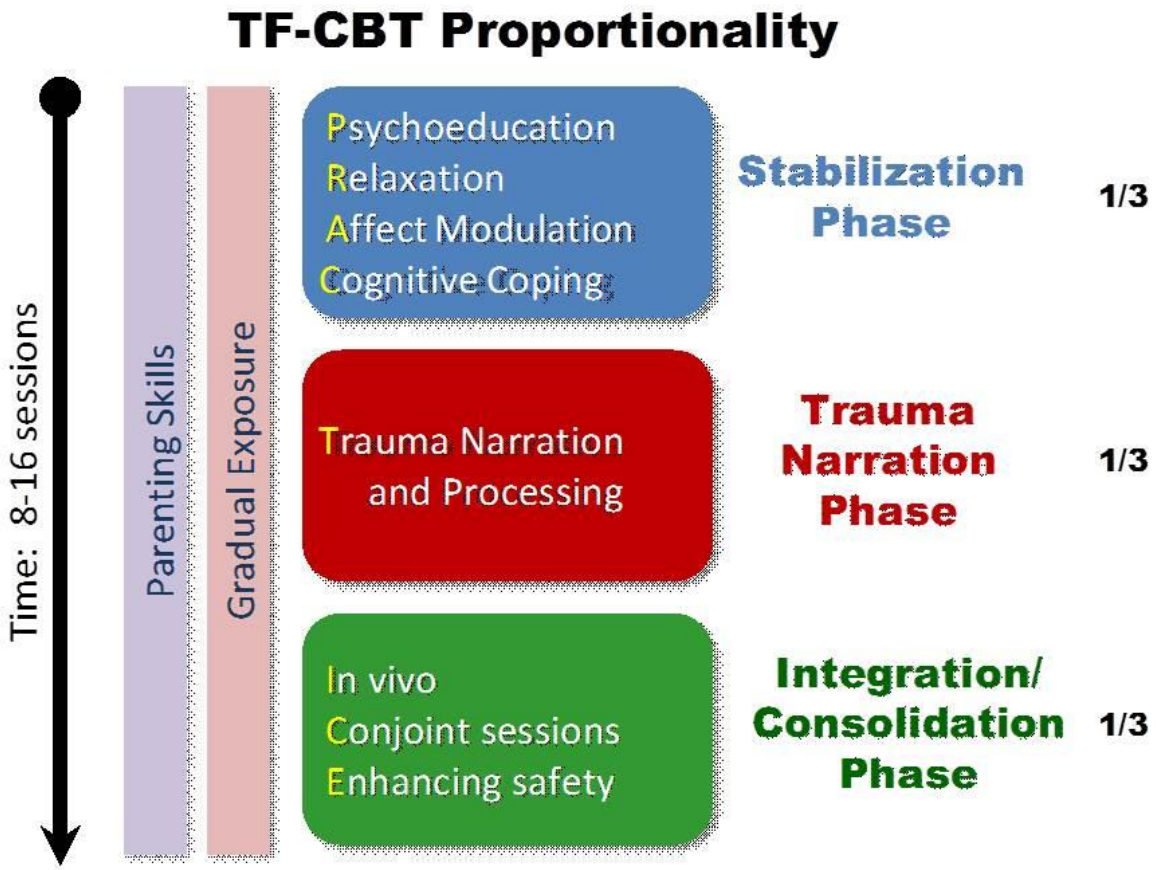
A guiding principle of TF-CBT implementation is the importance of helping children gradually face innocuous trauma reminders (e.g., trauma psychoeducation, environmental

reminders, etc.) as well as the actual memories of the trauma(s) endured in the context of a safe, therapeutic environment. Many children who have a history of traumatic experiences and foster placement present with posttraumatic stress symptoms and exhibit a tendency to avoid thinking or talking about and/or being in the presence of innocuous reminders of traumatic experiences. Such avoidant tendencies are often counterproductive in relation to the healing and recovery process. Thus, TF-CBT is designed to gradually engage children and their foster caregivers in initial exposure to less anxiety provoking reminders such as general educational information about traumas and foster care before engaging in discussions and/or trauma narration about the child's specific traumatic experiences. This gradual process makes such trauma reminders much more tolerable for children. Although the process may produce some anxiety initially, it will ultimately lead to feelings of strength rather than sparking the overwhelming negative feelings that were experienced at the time the trauma(s). Provided below are descriptions of additional central principles of TF-CBT as well as a diagram highlighting the core PRACTICE components of the treatment model (Deblinger et al., 2015).

Components based

TF-CBT is a model that incorporates specific treatment components that build on each other and are ultimately designed to be integrated in the final phase of treatment. The acronym PRACTICE is used to help clinicians not only remember each of the components which are depicted below in Figure 1, but it also highlights the importance placed on practicing the skills taught between treatment sessions and after therapy is completed.

Figure 1



R*espectful of cultural values*

TF-CBT is designed for families of diverse ethnic, racial, religious, and cultural backgrounds. Though the principles that guide therapy are universal in their application to all families, it behooves clinicians to inquire about and tailor therapy to acknowledge and demonstrate respect for each the child and foster families' backgrounds helping to provide a bridge across foster parent's and child's cultural practices to support and enhance healing.

A*daptable and flexible*

TF-CBT allows for considerable flexibility such that clinicians are encouraged to use their talents and creativity to adapt the psychoeducation, skill building, and trauma narration/processing activities to optimally serve the child and his/her family. Thus, clinicians may make adjustments that reflect the child's interests, developmental level, sexual identity and orientation, as well as the particular foster family's needs and circumstances.

F*amily focused*

As noted above, TF-CBT is designed to engage children, adolescents, and nonoffending caregivers, thereby acknowledging the impact of traumatic stress effects on the child and, in this case, the entire foster family. Though challenging at times, this model is designed to actively include and support the foster parent in serving as a therapeutic resource for the child as well. In fact, TF-CBT therapists are encouraged to spend at least half of each session with the foster caregiver whenever possible.

T*herapeutic Relationship is central*

The therapeutic relationship with a child in foster care is critical to helping the child overcome common feelings of distrust that children experience as a result of unfortunate experiences with authority figures removing them from home and separating them from important attachment figures. A therapeutic relationship with foster parents is also critical to motivating their treatment participation and follow through.

Self-Efficacy

TF-CBT is a strength-based model as it builds on and helps to further develop children's and caregivers' strengths in coping with trauma and other life stressors. Recent research, in fact, has documented that TF-CBT not only reduces traumatic stress symptoms and other difficulties, but it appears to enhance children's personal resiliency (Deblinger, Pollio, Runyon, & Steer, 2016). This is critical for children in care who are likely to face continued stressors as they cope with placements stressors and as they navigate the complex child welfare system.

Barriers to Effective Treatment for Children in Foster Care

There are numerous potential barriers to children in foster care receiving effective mental health services. A qualitative study of improving foster parent engagement in TF-CBT, however, found that perceptual barriers were most emphasized by foster parents and caseworkers (Dorsey, Conover, et al., 2014). These perceptual barriers included negative prior treatment experiences, concern about the level of participation expected, fit with the therapist, distrust of the system, unclear information about the therapy process, and beliefs that the child might be more comfortable with therapy provided in the school setting. Unsuccessful or less than optimal past experiences with therapy (either the foster parent's own or the foster child's) can impact the foster parent's view of the current therapy. Foster parents may not understand their critical role in the child's therapy, especially if their past experience with a child's treatment did not include their involvement. Similarly, caseworkers may not understand the critical importance of the foster parent's role in the child's treatment and therefore may not emphasize the need for their participation. The view of the therapist as part of the broader child welfare system can also be a perceptual barrier to engaging both foster parents and foster children in treatment.

There are also several concrete or practical barriers to children in foster care receiving effective therapy. In the Dorsey, Pullmann, and colleagues study (2014), the concrete barriers mentioned were limited appointment times, overwhelming caregiving demands, and treatment convenience (preferring in-home therapy or therapy in the school setting). Foster parents may have more than one child in the home and may be caring for other children with special needs. As a result, it may be challenging for foster parents to juggle multiple appointments for the children, particularly if they also work outside of the home. There also may be challenges for caseworkers with regard to arranging transportation and babysitting to ensure that the child and foster parent can participate in outpatient treatment. Therapists who are flexible with scheduling (and rescheduling) appointments, are able to provide in-home or school-based treatment, and try to prioritize foster families' rather than the therapist's scheduling needs, will go a long way towards engaging many of these families.

The unpredictability of placement changes can be a potential barrier to treatment as well. Since foster home placements in most cases are not intended to be permanent, there may be some hesitation on the part of therapists to initiate TF-CBT until the child is in a more "permanent" placement. However, data suggests that, on average, placements last about a year (U. S. Department of Health and Human Services, 2015). Thus, the short-term nature of TF-CBT may make it an ideal fit as most foster children are able to complete TF-CBT within 12-20 sessions. If treatment is initiated because the placement was thought to be stable but an unexpected placement change occurs, this change in placement can disrupt therapy. However, research findings described earlier suggest that TF-CBT (and/or the use of other evidence-based interventions) may enhance a

child's chances of remaining in a stable placement during the period of foster care (Lyons et al, 2006).

In sum, engagement strategies that have been found to be effective involve exploring and addressing both the concrete and perceptual barriers noted above. Such strategies have been shown to increase the potential for success in initiating and completing treatment with children and their caregivers (Dorsey, Pullmann, et al., 2014). Suggestions for specifically engaging foster caregivers are described below.

Engaging the System in Implementation of TF-CBT

Children in the foster care system are undoubtedly a unique subpopulation of the overall trauma population that we assess, diagnose, and treat. As outlined above, children who are placed in foster care are more likely than those who are not in foster care to present with a greater number of traumatic events, higher levels of PTSD symptoms, more behavioral problems and other symptoms, and greater number of prescribed psychotropic medications. Given their level of trauma exposure and distress and the degree to which that distress is often misinterpreted or mishandled, it is critical for us to engage children in the foster care system and their caregivers in effective treatments, like TF-CBT.

One obstacle to engaging systems and child welfare workers to optimally address the therapeutic needs of children in foster care may be a lack of education, knowledge, and understanding of the emotional and behavioral impact of child abuse, neglect, trauma, and placement in foster care on children and adolescents. This knowledge gap is being addressed via recently developed educational programs designed for local child protection workers, permanency planning workers, juvenile justice workers, and others who interact with children in the foster care

system. More specifically, members of the National Child Traumatic Stress (NCTSN) have developed the Child Welfare Trauma Training toolkit (Child Welfare Committee, 2008) to educate systems' workers about the prevalence and impact of childhood trauma, posttraumatic stress symptoms, and how these symptoms manifest. This education is critically important given the potential for mislabeling posttraumatic reactions as symptoms of conduct disorder, autism spectrum disorder, attention deficit hyperactivity disorder (ADHD), and/or bipolar disorder. This education may reduce the likelihood of inaccurate conceptualizations of children's presenting symptoms that can result in traumatic reactions going untreated and/or the child in care being inappropriately or overmedicated by professionals. As mentioned earlier, foster children receive significantly more psychiatric medications than the general child population (Zito et al., 2008). Thus, it is critical for trauma experts to educate system workers about traumatic responses and the need to develop a trauma-informed system, including trauma informed evidence based mental health interventions, to address the comprehensive needs of children in foster care - many who present with posttraumatic reactions and/or complex trauma (Greeson et al., 2011).

Professionals are beginning to recognize that removal from the home itself can be a potentially traumatic event for the child. In some cases, children experience feelings of traumatic loss when separated from their parents resulting in PTSD symptoms including intense worries, fears, and distrust of their new caregivers and surroundings ("traumatic separation", described at www.nctsn.org/trauma-types/traumatic-grief). Other children experience a sense of relief and enhanced safety once they are placed in an environment free of abuse or violence. Increasing recognition of the varied reactions children experience as a result of trauma and placement in foster care is in part due to the education being provided by members of the NCTSN as well as others to

the professionals and caregivers who are responsible for these children's well-being. Such education increasingly includes information about evidence-based therapies that have been specifically designed and evaluated for their efficacy in addressing the types of symptoms and difficulties presented by children in foster care. TF-CBT is one such intervention which is particularly well suited for children in foster care given the high level of trauma symptoms and behavioral difficulties they exhibit. TF-CBT has a wealth of data to support the model's effectiveness with the overall trauma population, but there is also evidence to support the model for specifically helping foster children to overcome the impact of trauma (Dorsey, Pullmann, et al., 2014) and to remain in a stable foster placement (Lyons et al., 2006).

Another important factor identified in the literature and emphasized by NCTSN experts participating in calls to develop this manual as important for a foster child's recovery after trauma is a supportive caregiver. In the foster care system, a positive relationship with the foster parent and in some cases a case worker often critically influences a child's ongoing recovery and emotional health. With the understanding of the foster parent's critical role, educated case workers can lay the essential groundwork for engaging foster parents in TF-CBT with the child. Court appointed guardians and judges are another important part of the system that can increase the utilization of effective treatment to support youth in foster care and their foster caregivers. If caseworkers, judges, and family court professionals are well-educated about the needs of youth in foster care, they can make appropriate therapy recommendations and initiate referrals for youth to connect them with a TF-CBT provider.

Engaging Foster Parents in TF-CBT

To further engage foster parents and enhance their understanding of the needs of children in the foster care system, NCTSN members developed a Resource Parent Curriculum (Grillo, Lott, et al., 2010). In some states, NCTSN members, agencies, and other professionals are providing this training to prospective resource parents/foster parents. This training enhances all foster parents' knowledge about how to respond to and support children who have experienced trauma. Mental health and child protection professionals are encouraged to educate foster parents about the child's need for trauma-informed evidence based treatment and the important role foster parents play particularly in the context of TF-CBT implementation. Many foster parents are pleased to be included in TF-CBT given their desire to support the child's recovery as a surrogate caregiver.

Despite the documented efficacy of TF-CBT, foster caregivers, with many demands on their time, may not be motivated to participate in therapy or may not show up for their scheduled sessions (Berliner, 2011). According to McKay and colleagues (McKay & Bannon, 2004; McKay et al., 1998) and Berliner (2011), only about 50% of children and caregivers who are referred for services actually follow through with services. After calling to schedule an appointment, only 30% attend their initial session. Of those who do attend the initial appointment, many drop-out prematurely receiving little to no benefit when they attend less than three treatment sessions.

Given this, the first task after receiving a referral of a child and foster parent for TF-CBT, is to use evidence-based engagement strategies to increase their motivation and attendance to their initial appointment. According to Berliner (2011), a simple reminder call reduces no-shows by 30%. Additionally, McKay and colleagues (1998) demonstrated that significantly more clients attended their first therapy appointment (74% compared to 43%) and had higher completion rates than clinic

comparisons after receiving a combination of a brief telephone and in-person engagement strategy as part of the intake process. The strategy involves (1) clarifying the need for mental health services by identifying the caregiver's greatest concern about the child, (2) establishing a collaborative relationship and building a strong case to motivate the caregiver to participate in treatment, (3) exploring past experiences with mental health treatment and emphasizing what is different about the process and expectations of the present treatment, and (4) problem-solving concrete barriers that interfere with participation. These strategies may be initiated during the first phone contact and may then be repeated at the initial appointment.

Recently, as noted above, Dorsey, Pullmann, and colleagues (2014) examined the utility of these evidence-based engagement strategies for increasing therapy attendance and completion rates of foster children and their caregivers referred for TF-CBT. Indeed, those children and foster parents who received an engagement strategy addressing perceptual and concrete barriers plus TF-CBT were more likely to attend four therapy sessions and were less likely to drop-out prematurely when compared to TF-CBT alone thereby enhancing accessibility and utilization of TF-CBT with children and caregivers. Thus, at the initial telephone contact and/or the initial treatment session, it is important to clarify the reason for referral as well as the need and benefits of therapy.

Clinical Example

At the initial contact, the therapist asked the foster parent, "What is most concerning to you about Jasmine's emotions and behaviors?" When Ms. Knight responded, the therapist reflected back the concerns, and in so doing he empathized and validated the foster mother's concerns, highlighting the importance of her role in TF-CBT, and responded directly to the concerns by explaining how the child's trauma history may be linked to the presenting problems. Ms. Knight

expressed particular concern about Jasmine's nightmares and angry outbursts. The therapist then highlighted how TF-CBT was a well-researched and highly effective treatment designed for exactly the type of problems Jasmine was experiencing. The therapist then praised the foster mother for her sincere concern for Jasmine and generosity in opening her home and her heart to this child. The therapist then asked the foster parent if she had prior experiences with therapy or therapists. Ms. Knight explained that many of the foster children she cared for had therapy, but it never seemed to impact their behavior much and she was never asked to be involved. The therapist then explained how and why she was asked to participate in TF-CBT. Ms. Knight seemed quite pleased and expressed hopefulness that this therapy seemed to be just what Jasmine seemed to need. The therapist then asked, "Is there anything that will get in the way of you and Jasmine attending therapy sessions regularly?"

Concrete barriers are important to identify at the start of treatment as foster parents often have other appointments and obligations relating to children in their care. Thus, the more flexible the therapist can be, the more likely the foster parent will transport and accompany the youth to sessions. For example, offering evening hours that do not interfere with the foster parent's work schedule, the youth's school schedule, or other special activities can increase attendance. Other strategies to eliminate concrete barriers include identifying sources of or providing transportation for children and families, offering in-home services when possible, and offering snacks, particularly to those who are coming directly after school or during meal times.

In some cases, having the TF-CBT session with the preschool child and/or the foster parent's individual session during the day when school-aged children are at school can reduce stress and barriers associated with treatment. When needed, TF-CBT may be provided in home or school

settings with children, and therapy sessions may be provided to foster parents via phone and/or skype, particularly with foster caregivers who are otherwise unable to attend sessions in person.

Recent research documented that perceptual as opposed to concrete barriers were more likely to impede the engagement of foster parents and youth in treatment (Dorsey, Conover, et al., 2014). A primary perceptual barrier that hinders attendance to TF-CBT is youth and foster parents' past experiences with treatment services. Therefore, it is important for the therapist to discuss experiences with past mental health services, especially identifying negative factors or experiences. This provides an opportunity to emphasize what will be different about their participation in TF-CBT in terms of treatment course and outcome expectations as compared to past therapies. For example, foster parents who were not previously asked for their opinions about how to manage the child's trauma responses, for their observations about how the therapeutic interventions were working, or were not even involved in a foster child's therapy, may not immediately understand the importance of their role in the youth's therapy and may doubt therapy's usefulness for producing changes in the youth's behaviors. If they were not previously involved in therapy, they may have observed little to no change in the youth's behavior over the course of therapy. If the youth did not receive therapy that encouraged the child to discuss and process the traumatic experiences or teach the child skills to more effectively cope with trauma and the associated stressors, the foster parent may have perceived therapy as unhelpful. The therapist has the important job of helping the child and foster caregiver understand that TF-CBT has been shown to produce improvements in all of these areas. Some foster parents may have completed specialized training when going through the foster system licensing process or worked with a behavior specialist and believe that their involvement in additional therapy is not essential. Therapists can clarify that while the education

the parent received is very valuable and most definitely will be useful in responding to and supporting the client, TF-CBT is different from the general training received. TF-CBT will help the foster parent respond to and support this specific child, it also focuses on the relationship between the foster parent and this specific child and it guides the parent and youth in processing the specific trauma(s) experienced by the child.

Ideally, at least some of the engagement strategies described above should be utilized during the first phone contact. However, these strategies may be initiated, further explored, or revisited during the initial treatment session. Acknowledgement of the foster parents' generosity in opening their home and the importance of their role in helping the youth overcome the traumatic experiences should be repeatedly emphasized during initial contacts and throughout the course of therapy.

Legal Issues When Implementing TF-CBT with Children in Foster Care

When treating children in foster care, consent and legal issues may be more complex. Though a comprehensive discussion of such issues is beyond the scope of this manual, TF-CBT therapists are encouraged to have a good working understanding of the treatment relevant state statutes, while working closely with their agency attorneys to ensure that appropriate treatment consents are obtained and legal issues are addressed properly. For example, many biological parents maintain legal guardianship of their children while they are in foster care, whereas in other cases parental rights have been terminated and the state has legal guardianship of the children. Agencies should maintain clear policies and ensure consistency with regard to their requirements for who is expected to sign treatment consents on behalf of participating children. However, regardless of who is deemed appropriate to sign on behalf of the child, the foster parent should sign treatment consent for themselves given the expectation for active participation on their part.

Additional challenges include responding to third party requests for treatment information, preserving the confidentiality of TF-CBT in general and specifically in relation to the trauma narrative, maintaining a boundary between therapy and forensic issues (Mannarino & Cohen, 2001), and dealing with subpoenas vs. court orders. In order to work optimally with these systems, it can be helpful to educate local child protection, attorneys, and others in the legal system with regard to the importance of treatment confidentiality and what a trauma narrative is and what it is not. For example, the trauma narrative does not reflect the documentation of a forensic interview. Rather, it is a collaborative process that is intended to focus more on processing the child's thoughts and feelings as opposed to simply recounting the facts. Therapists working with foster children may also be more likely to be asked to provide opinions with respect to visitation and/or custody. Thus, therapists are encouraged to be well versed in the relevant state laws and professional ethics that often provide guidelines for preserving the confidentiality of the patient-therapist relationship and avoiding the conflict of interest that can result from offering therapy and simultaneously offering opinions about visitation and custody. Thus, it is typically best to encourage child protection and the courts to obtain an independent evaluation of custody or visitation issues thereby maintaining the legal-therapist boundary and confidentiality of treatment. Many states have a victim counselor's privilege that directly addresses victim rights with respect to preserving the confidentiality of their therapy experience as well as their treatment records.

Assessment Strategies and Measures

Specific strategies and standardized measures for assessing emotional and behavioral symptoms in youth and their caregivers referred for TF-CBT are outlined in the TF-CBT treatment books (Cohen et al., 2016; Deblinger et al., 2015). At the time of the referral, the youth may have

only been residing in the foster parent's home for a short period of time leading to a challenge specific to this population which is difficulty obtaining an accurate assessment of the youth's current functioning. While it is important to administer measures to the foster parent to obtain their current observations of the youth's emotional and behavioral functioning, in some instances it may be helpful to seek information from persons who have additional information or observations of the youth, such as the case worker, foster care therapist, teacher, and biological parent. In addition, youth in foster care who fear betraying their parent(s) and/or who are anxious to return home may deny exposure to certain traumas (e.g., child abuse) and/or may minimize symptom reports. Still, attempting to assess children's trauma exposures and related symptoms is critically important with this population in light of the research suggesting that PTSD diagnoses are often missed in children being served by the child welfare system (Grasso et al., 2009). Moreover, with this population, it is often helpful to repeat trauma-related assessment measures once a child has acclimated to the foster home and gained greater trust in the therapist. The assessment findings can be particularly important to use to demonstrate the necessity for TF-CBT, while helping foster parents understand the link between the youth's behavioral difficulties and their trauma history as well as the means by which TF-CBT will help to alleviate the youth's presenting problems. More specifically, psychoeducation, for example, can highlight that the child's symptoms are, in fact, common reactions to traumatic events and as such they can be effectively addressed by TF-CBT, a treatment specifically designed for such difficulties.

TF-CBT Implementation with Children in Foster Care and Their Caregivers

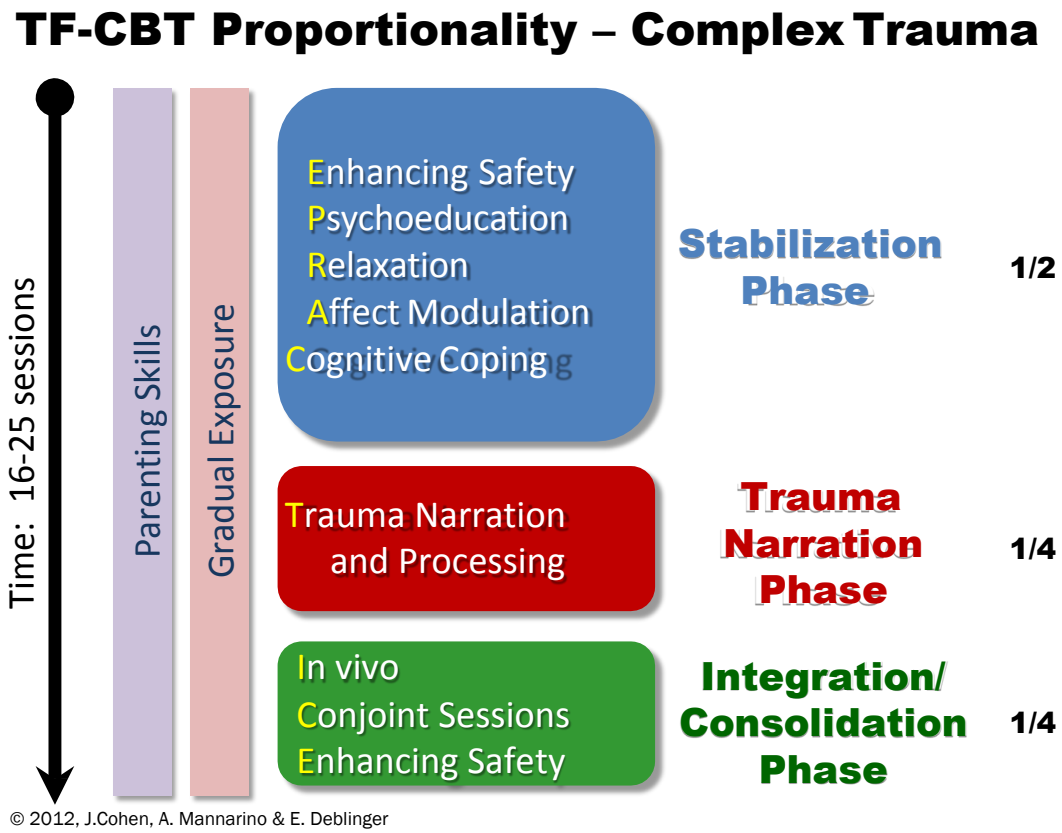
Generally speaking, the TF-CBT PRACTICE components are delivered in the same way to a child who has experienced trauma regardless of whether or not the child is residing in foster care.

While few modifications to the model are necessary, outlined below are some important points to consider when implementing TF-CBT with youth in foster care and their caregivers.

Individual Work with Children in Foster Care

There are a number of factors to consider when teaching TF-CBT PRAC skills to foster children. Youth in foster care may be more likely to have a history of chronic, ongoing traumatic events than those children who remain in their homes of origin. Given the nature of their traumatic experiences as well as the placement in a new environment with new support people, some proportion of children in foster care will develop complex trauma responses, but not all will (Cohen, Mannarino, Kliethermes, & Murray, 2012). Currently there is not a universally accepted definition of complex trauma or a validated instrument with which to assess this condition in children and adolescents. Some children in foster care who develop complex trauma responses may need additional time to learn, practice, and implement coping skills (i.e., relaxation, affect expression and regulation, and cognitive coping skills) as well as to make interpersonal connections and/or identify those individuals to whom they can safely share their feelings and experiences. These children may also need to address safety at the start of TF-CBT treatment, and therapists may slightly extend the length of TF-CBT treatment (up to 25 sessions) to accommodate the longer PRAC skills, as well as identify common unifying trauma themes. These complex trauma modifications for TF-CBT are described in greater detail elsewhere (Cohen et al., 2012). These modifications are briefly depicted in Figure 2. Although they may be useful for some children in foster care, empirical research has documented that many children in foster care benefit from standard TF-CBT without these modifications (e.g., Cohen et al., 2004; Dorsey, Pullmann, et al, 2014).

Figure 2



Helping a foster child identify support persons can be complicated and vary depending on the setting. For example, the youth may have supervised visits with the biological parent who may have perpetrated some of the identified traumas. Therefore, the youth may be encouraged to express emotions to the foster parent, but he/she may not feel safe doing so with a parent during visitation. Therapists can also educate case workers, therapeutic visitation supervisors, and others about the impact of trauma, including traumatic reminders that the child may experience during visits with biological parents. Cultivating a relationship with the visitation supervisor, often the child protective services (CPS) case worker, is critical so the youth can be encouraged to utilize

their newfound coping skills and cue the supervisor when she doesn't feel comfortable so the visit can be redirected or terminated.

It is critical to emphasize the important role of the foster parent and case worker in the therapy and life of a foster child. First, the therapist should encourage and confirm the foster parent's commitment to be the "safe person" for the child. In conjunction with the therapist, both the foster parent and CPS case workers should encourage and praise the youth for the appropriate expression of emotions in words rather than through acting out and/or problematic behaviors. This is important as some people in the youth's life to this point may have invalidated and/or dismissed his/her emotions as opposed to encouraging appropriate expression that can serve to exacerbate angry outbursts and other exaggerated emotional responses.

Psychoeducation about the specific trauma(s) and traumatic reactions the child has experienced may include information about reasons children are placed in care, the prevalence of foster care placements, and common reactions to placements. This information can help children feel less alone and also begin to address children's misinformation (maladaptive cognitions) about their placement. With children in placement, it is important to acknowledge the distrust that may be present toward all authority figures including the therapist because of their unexpected removal from their home, their neighborhood, and often times their school. This distrust and or questions about the many professionals now involved in their lives may be directly addressed in the first phase of treatment with psychoeducation. Such education should include a review of the distinct responsibilities of child protection workers, the courts, the foster caregiver as well as the therapist, highlighting the differences in these roles in terms of their capacities to make decisions and even recommendations regarding the child's placement. In addition by making the protections as well as

the limits of treatment confidentiality clear and the therapist's lack of or highly limited influence over decisions regarding placement, the child may begin the process of becoming more able and willing to share his/her innermost feelings and associated thoughts later during the trauma narration and processing phase. This education may also decrease children's sense that they were removed from their homes due to their behavior or "something they did." *Maybe Days* (Wilgocki & Wright, 2002) and other books specific to foster care may be utilized for psychoeducation and later for introducing the trauma narration and processing component especially for those children that view foster care placement and separation from their parents as traumatic.

Relaxation is particularly important for foster children as preparation for trauma narration development and to increase their comfort in their new placement, new school, or during visits with biological parents. It is important for children to learn to manage the anxiety and stress related to their placements so they feel safe and secure when they begin developing the narrative about their traumatic experiences. Acknowledging the anxiety children naturally feel when they are separated from their parent(s) and placed in unfamiliar surroundings is as important as teaching children relaxation skills for managing such anxiety. In addition, the practice of mindfulness can help reduce foster children's tendencies to ruminate about their parents' whereabouts and welfare and/or worry about their future, by helping them to manage their anxiety by focusing on the present moment.

Affect Expression and Regulation skills are particularly important for children in foster care because of the myriad of emotions they likely experience and must manage. Affect expression may focus on the entire range of emotions and responses with an emphasis on feelings such as confusion, loneliness, fear, distrust, etc. that may be particularly common among children placed in foster

homes. It is common for children to love and miss their parents despite having a desire for the mistreatment by their parents to cease. Some children do not acknowledge any negative feelings and report that they always feel "happy." In this situation, it may be helpful to provide psychoeducation about the four basic emotions that everyone has (fear, anger, sadness, happiness). The therapists' phrasing of questions is very important at this juncture. For example, stating that "children feel these feelings, which one did you feel?" - leaves no option for the child to say "nothing" (vs. "what did you feel?" – "nothing" is a potential response). When reviewing the four basic emotions, therapists can share an innocuous situation in which they had a negative feeling. They can also use books or YouTube videos that depict a range of emotional reactions by others in response to different scenarios. This exercise can increase the child's comfort with talking about emotions, particularly negative ones, in general. Next, the therapist should move to helping the children identify personal negative emotions in response to specific situations. Body drawings can be helpful in identifying emotions and the intensity of these emotions as youth often have a sense of how their body feels, gut visceral reactions, in a particular situation and later are able to label the related emotion.

Since many children in placement may have experienced significant and sometimes chronic trauma in the context of important attachment relationships, complex traumatic reactions are not uncommon. This occurs when children's normal developmental milestones are delayed due to disruptions in the development of healthy, protective attachment relationships that support developing skills for emotion regulation. Thus, children who exhibit complex trauma have greater difficulty with self-regulation of their emotional reactions. Their emotional reactions may be exaggerated compared to others and they are often unaware of why they are experiencing such

intense emotions leading to them feeling more out of control. These "extreme emotional responses" to seemingly minor incidents may reflect lack of emotional regulation skill development as well as stress reactions to innocuous trauma reminders. Such intense emotional reactions may lead others' to perceive children in placement negatively which, in turn, increases their feelings of social isolation and heightens their risk of placement disruption. This unproductive cycle of isolation and alienation may lead to intensified attachment issues and multiple failed placements which further reinforce the children's negative view of themselves, the world, and their future. Psychoeducation about trauma impact and reminders along with emotional regulation skills training can help children identify, understand, and manage these overwhelming emotions better. Affect expression and regulation skills also are important preparatory skills for later engaging in trauma narration and processing during which their underlying negative beliefs may be uncovered and addressed.

Cognitive coping skills may be another helpful technique for managing emotions and improving mood, once the youth demonstrates an ability to identify, appropriately express, and manage their emotions in a variety of situations. Specific to the foster care population, cognitive coping skills may help children in placement cope with ambivalent feelings related to their parents, foster caregivers and new placement, as well as new schools, new friends, and the uncertainty of what the future holds with regards to placement and parents. Children in placement may find themselves struggling with thoughts related to feeling different from others at school that are not in foster placement.

Clinical Example

Christian's foster mother reported that while he was doing well at home, he had been

having conflicts with other children at school which have escalated into physical fights. He was now reporting fearfulness about returning to school and threatening to run away. The therapist engaged Christian in behavioral functional analyses relating to the most recent conflicts experienced in school and elicited not only the details of the exchanges, but Christian's thoughts and feelings during and after those interactions. In the context of the behavioral analyses, the therapist learned that Christian was being bullied about his foster placement and other kids were making comments about his mother not loving him. Christian further revealed that he felt worthless and wondered to himself if his mother loved the drugs more than she loved him. In this context, the therapist offered psychoeducation about the impact of substance abuse on the brain and utilized Socratic questioning to help Christian identify experiences that lead him to conclude that his mother loved him deeply, but was also unable to make good decisions as a parent because of her drug addiction. In addition, the therapist worked with Christian on developing assertiveness skills, while learning to make friends with kids at school, as well as responding to the bullying and taunts more effectively.

Trauma narration and processing with foster children should be carefully timed given the possibility of placement changes. If it is likely that a child is going to be moved to a new placement, the therapist should continue helping the child use the newly learned coping skills to manage feelings and distressing thoughts relating to the upcoming change in placement and delay the start of the trauma narrative. However, it is important to continue lower level gradual exposure exercises and to introduce or review a trauma-related topic in every session (e.g., card game to review psychoeducation about trauma types, review of abuse-related feelings or abuse-related thoughts) to avoid inadvertently reinforcing the child's avoidance and to increase the child's comfort with

working on the trauma narrative in the future. Despite the therapist's best efforts, placement changes are not always predictable, so it is possible that a placement change could occur during the development of the trauma narrative. When this occurs, it is best for the child to continue with the same therapist allowing for some stability as well as the opportunity to continue the trauma narration and processing work. When that is not possible, the child may be referred to another therapist, ideally one who has experience with implementing TF-CBT so that the therapist can help the child continue the trauma narration and processing work, while also encouraging the use of coping skills and assisting the child in adjusting to the new placement.

Some children in placement may experience intense feelings of betrayal and abandonment by their parents while also having a strong desire to remain loyal and protect their parents from further consequences. Thus, they may be reticent to share negative details about their experiences in their home of origin. It is therefore critical to review issues related to confidentiality and the rationale for treatment. In addition, in some instances, it can be helpful to acknowledge, validate, and normalize feelings previously expressed including feelings of love and loss as well as simultaneous feelings of anger towards biological as well as foster parents. Many children may cope with these feeling by blaming themselves which also creates the illusion of control over the situation – "*If I change my behavior, I can go home and my mom will stop hitting me."* As the child develops the narrative, it is important to elicit all such feelings and thoughts anticipating and accepting that some will seem contradictory. In fact, it can be helpful to have youth identify and describe feelings related to positive experiences with their biological parents as well as feelings related to traumatic experiences or distressing interactions with parents. Common dysfunctional thoughts that children in foster care share with therapists or include in their narratives may include:

My dad didn't love me.

I will never be happy if I can't return to my parents.

I am going to be a drug addict like my father.

My mom would do what's necessary to get me home if she loved me.

It's my fault that I was removed from my home because I am bad.

I wouldn't tell anyone if my mom hit me again, because I don't want to be placed again.

As is true with all children, the final chapter of the narrative may incorporate what has been learned in the course of therapy. However, with children in foster care, it is useful to encourage them to include who provided support and assistance during their placement (e.g., foster parent, helpful relative, etc.), what they learned about their strengths and relationships with other caregivers and families, what they would like other children in foster care to know, and their hopes and positive expectations for the future.

Enhancing safety skills is particularly important for children in placement given the possibility that they may return to a less than optimal family environment. Thus, it is important to consider moving this component up to an earlier stage of treatment if there are concerns about unexpected placement changes or reunification. In addition, when multiple children are placed in care together, rules regarding privacy and body safety are important to review and establish to reduce the risk of age inappropriate sexual interactions. When children have had prior problems with age inappropriate or abusive sexual behaviors, body safety skills training may not be sufficient and placement with other vulnerable children in a foster home may be ill advised.

Individual Work with Foster Parents

Children in foster care may have learned unproductive coping skills from parents who were experiencing mental health and/or substance abuse problems. Thus, it is particularly important to work with foster parents to engage them in utilizing, modeling and reinforcing healthy coping skills. Below are suggestions for engaging foster parents in individual TF-CBT skill building as well as trauma-focused sessions.

Psychoeducation and parenting guidance is important for all foster parents especially for those who may be feeling overwhelmed and/or ineffective when youth placed in their home are not responding to the parenting strategies that worked with their own children. It is important to acknowledge any feelings experienced by foster parents including frustration and self-doubt, by explaining that most adults are not prepared to parent a child who has experienced significant trauma in childhood including abuse or neglect at the hands of the very people to whom children rely on for protection and support. Thus, it is sometimes helpful to remind foster parents that as TF-CBT therapists our role is to help them tweak and tailor their previously successful parenting skills to help the child in their care overcome the devastating effects of abuse, neglect, and/or other traumas.

Psychoeducation about the impact of trauma begins early in treatment when the assessment results are reviewed with the foster caregiver. Some foster parents are preoccupied with youth's behaviors in the home. Educating them about typical emotional and behavioral reactions to traumatic events as well as the manifestation of PTSD in conjunction with providing specific details about the youth's reactions to his/her multiple trauma exposures can greatly enhance the foster parent's empathy for the child. One of the NCTSN group members providing information for this

manual reported that one foster parent described the psychoeducation component as "powerful, changing his perspective on the child's difficulties being related to traumas suffered," which resulted in him adopting four children in his care and co-facilitating a foster parent support group because he wanted to help other foster parents understand the emotional and behavioral responses exhibited by traumatized children.

Psychoeducation and Parenting, in conjunction with coping skills, can alter the foster parent's perceptions of the youth, decrease the stress associated with parenting the youth, improve the youth's behavior, and enhance the parent-youth relationship. As previously mentioned, foster parents may be focused on the youth's behavior and perceive the traumatized youth as "the problem." Thus, when helping foster parents fine-tune their parenting skills, it is often helpful to conduct functional analyses of difficult parent-child interactions. Such analyses may not only identify less than optimal parenting strategies, but may also identify times when foster parents could benefit from more effectively utilizing the very same coping skills the children are being taught. As described in more detail below, when appropriate, it is critically important to help the foster parent recognize connections between the child's trauma reminders and their problematic behaviors, and supporting the child in using newly acquired TF-CBT coping skills as an alternative way of responding to these reminders.

Functional analyses reviewing antecedents, behaviors, and consequences associated with parent-child interactions may be highly beneficial in helping caregivers identify parenting behaviors that may be inadvertently reinforcing children's behavior problems. In addition to being useful for examining foster parenting practices, functional analyses can be used to elicit the foster parent's feelings and thoughts related to the youth's behaviors during difficult parent-child interactions.

Such information can help to support the foster's parents development of more effective parenting skills, while also identifying coping skills needs and inaccurate and/or problematic thoughts that may be driving dysfunctional foster parent reactions to children's problem behaviors.

Relaxation, affect regulation, and cognitive coping skills development can help foster parents manage stress so that they will not only better manage the significant day to day challenges of caring for a traumatized child, but they will more effectively model the coping skills the child is learning in therapy as well. Foster parents may be reminded that they are powerful role models for the children in their care regardless how long they remain. Thus, it is critically important for foster parents to model and reinforce healthy coping and communication skills. In fact, modeling and encouraging optimistic thinking may also be critical to the child's developing resiliency. Some examples of common dysfunctional thinking reported by foster parents include those listed here:

I can't imagine how she could recover from all the traumas.

The child will be just like her father (violent/aggressive towards others).

I don't understand why this child isn't better after being in my home.

Why doesn't the child show any appreciation for everything I'm doing?

They are just not grateful for what we give them.

I raised my children this way and they turned out fine. It's the child, not me.

The above thoughts may be addressed through the utilization of psychoeducation that corrects the misconceptions that some foster parents have. For example, to counter the foster parent's thought, "I can't imagine how someone gets through or gets better after all the trauma she has experienced," the therapist may share that "research shows that having one supportive/loving caregiver in life may be the most important factor in helping children overcome trauma." To

address the kinship parent's thought that the child was going to amount to nothing and grow up to be violent like her father, the therapist might use a combination of education and Socratic questions that are designed to elicit hopeful information known by the therapist based on research or known case details. The following Socratic questions, for example, may lead foster parents to think more optimistically about a child's future.

Do you think most children who have experience adversity bounce back?

What do you see in this child's behavior that suggests that he/she is quite resilient?

What positive qualities has this child inherited from his parent(s)?

How do you think you are influencing this child's future?

Foster parents' hopefulness concerning the adjustment of the child in their care may be enhanced by their acknowledgement of the powerful impact supportive caregivers can have and the benefits of effective therapy on children's functioning and future development.

Below is a case illustration involving a 13-year-old who experienced sexual abuse, physical abuse, neglect, and witnessed domestic violence. Her foster parents had misconceptions about her behavior and consequently viewed the child in a negative light. In this scenario, the therapist was able to help the foster parents identify and change some misconceptions they had about the youth's behavior.

Clinical Example

First, the therapist explained to the foster parent she will ask her to describe parent-child interactions in great detail so that she can best understand what might be underlying and motivating Lora's behavior. In addition, by having the foster mother share her parenting thoughts and feelings during these interactions, the therapist explained that she will be able to best assist the

foster mother in her parenting efforts. Next, the foster mother was asked to think of a specific time she found challenging when parenting Lora or a time she felt extremely frustrated with Lora.

Foster Mother: *I was feeling very frustrated, agitated, and confused just yesterday after school.*

Therapist: *What were you thinking when you were experiencing those feelings?*

Foster Mother: *I was standing there trying to get dinner ready. She has few responsibilities and she's not following through. I'm going to spend the rest of the night policing. I wish it could be easier and I wish we could have a relaxing evening.*

Therapist: *Were you thinking or feeling anything else?*

Foster Mother: *Angry. Very angry.*

Therapist: *How did you respond when you felt angry?*

Foster Mother: *I started slamming pots and becoming worked up.*

Therapist: *I so appreciate you honesty in sharing your frustrations. Did you say anything?*

Foster Mother: *About 10 minutes later, I yelled, "Are you finished yet?" Lora didn't respond.*

Therapist: *What were you thinking and feeling at that moment?*

Foster Mother: *I felt that she is ignoring me and showing no appreciation for all I have tried to do for her and that just increased my frustration.*

Therapist: *What happened next?*

Foster Mother: *I knocked on her door, no answer, so I went in. She had her headphones on and appeared to be working on her homework.*

Therapist: *How did you feel at that moment?*

Foster Mother: *I felt relieved and embarrassed because I thought she was not doing her homework.*

Therapist: *What were you saying to yourself?*

Foster Mother: *I thought, "Damn it! Why did you have to get me so worked up? Why didn't you answer me?" I thought, "I can't believe she is doing her homework."*

Therapist: *And how were you feeling when you were saying those things to yourself?*

Foster Mother: *Really mad still and frustrated with her and myself. Because I noticed she seemed to have gotten a lot of her homework done, but I was still fuming and angry with her for making me come up to her room.*

Therapist: *How did you respond?*

Foster Mother: *I said, "You're going to have to speed it up, dinner is almost ready- no help to you. Why can't you answer me when I am calling you?"*

Therapist: *How did Lora respond to your comments?*

Foster Mother: *I think she kind of rolled her eyes and went back to doing her homework which surprised me again.*

In this situation, the foster mother was basing her actions on a misconception that her 13-year-old foster daughter was not completing her homework. First, it is important to validate the foster mother's feelings and experiences and praise even small efforts in the right direction. For example, the foster mother is juggling many tasks and has taken on the important and daunting task of raising someone else's child. She also has the important goal of wanting the child to do well in school and to succeed. In addition, it is critically important to praise how honestly she was sharing her thoughts and feelings in the moment even when those that did not reflect her best self. As a result, she was able to reflect on the fact that she was becoming frustrated and angry based on

inaccurate thoughts and beliefs about Lora's behavior. The foster mother's inaccurate beliefs and misconceptions almost resulted in a very negative interaction between her and the foster child.

In this situation, the therapist used Socratic questioning to encourage the foster mother to examine her own thoughts, feelings, and behaviors in this parent-child interaction, while also offering education and eliciting replacement thoughts to assist the foster mother in managing her own emotions and thoughts and responding in a more positive and appropriate manner to the foster child.

Therapist: *Looking back on this interaction with Lora, what do you think you did right?*

Foster Mother: *Looking back … I guess I didn't do anything right in that situation.*

Therapist: *Now, wait. You did do a few things differently, particularly in terms of tempering your tendency to yell.*

Foster Mother: *That is true. I took your suggestion to stop yelling from room to room and I went to her room with the intention to make eye contact with her before giving an instruction to do her homework.*

Therapist: *Exactly, so that was a great step in the right direction.*

Foster Mother: *But I never anticipated that she would be doing her homework. And I couldn't stop my intention to yell so I yelled a little even though she was doing her homework.*

Therapist: *Wow, it is fantastic that you have that insight and recognize that it is difficult to change a habit as ingrained as yelling. But do you think you curtailed your yelling when you saw that she was doing her homework?*

Foster Mother: *I guess I did, because I didn't blow up the way I do sometimes.*

Therapist: *What do you think lead her do her homework?*

Foster Mother: *To be honest, I have been trying to notice Lora's positive behaviors and I have been praising her as you suggested, particularly when she shares what she is learning in school. Do you think that has led her to want to do well in school?*

Therapist: *I certainly think that is very possible and that would explain her effort to do her homework. And I would encourage you to continue those efforts to specifically praise her interest and efforts in school. And next time, when you are wondering what she is doing in her bedroom, what can you do and say to yourself as you are walking toward her room?*

Foster Mother: *Well, I guess I should take a few deep breaths and anticipate that she might be doing something positive and if not, I could encourage her to do her homework with a clear instruction, while being prepared to praise her for any small effort in that direction. I have to remember that her biological parents were so neglectful that they didn't even seem to care if she went to school. So all of this is very new for her.*

Therapist: *You are absolutely right, and Lora is so lucky to have a foster parent who understands how her history is impacting her current behavior.*

Providing education to normalize the child's behavior can offer relief to a concerned foster caregiver. It can be helpful to realize that the child's current behavior is not concerning or overly problematic and that typical 13-year-olds do not like to do homework. As a result the caregiver, in the above example, began reducing the negative attention the client received for not doing homework resulting in a reduction in stress level for both caregiver and child. The foster mother praised the child more when she independently initiated homework.

Parenting skills are particularly important for foster parents given that when children feel threatened, fearful, or experience a loss of control, it is common to observe an increase in

uncooperative or defiant behaviors. According to the research described in the opening sections, foster children exhibit significantly more problem behaviors than other children. Many of these same behaviors may have been exhibited in their biological homes and modeled by parents who engaged in aggressive, coercive, and/or violent behaviors. In addition, noncompliant behaviors may have served as protective mechanisms increasing children's feelings of control and safety. Such behaviors may be exacerbated when children are placed in foster care and experience increased feelings of insecurity, betrayal, and fear of the unfamiliar circumstances. Thus, it is helpful for the therapist to work with the foster parent to establish normalcy, routines, and rituals for the foster home to increase children's feelings of security. It is important to note that it takes some time before children who have grown up in chaotic environments to fully trust the consistency and predictability of a new warm, nurturing but structured foster home. When possible, it can help to have the foster parent identify and initiate some of the child's favorite past routines and rituals to increase the child's sense of comfort in a new environment, for example, by continuing involvement in important hobbies, interests, or activities that may put the child at ease in the past.

Establishing clear house rules and expectations in conjunction with positive and negative consequences associated with rules and expectations as soon as possible after the child is placed, enhances the consistency and predictability of the new environment, decreases the likelihood of a failed placement, and establishes a positive relationship between foster parent and child. However, when children have grown up in neglectful environments they may need time to adjust and accept unfamiliar house rules that may seem overly restrictive given the lack of rules or limits experienced previously. Psychoeducation can help foster parents understand youth's normal reactions to such dramatic changes in household expectations. Thus, clear rules and expectations are important to set

in the context of a warm, positive, and communicative family environment in which children's prior circumstances are acknowledged and their feelings are validated. This sets the stage early in the placement for children to practice the positive communication and coping skills they are learning. It is important for foster parents and therapists to praise even the smallest efforts foster children demonstrate to express their feelings in appropriate ways and utilize effective coping efforts. This is particularly important given that many children in foster care may have received little praise or positive acknowledgement from caregivers in their lives. Although therapists frequently suggest to foster parents that they "actively ignore" minor behavioral transgressions, it is also important that foster parents not become detached as this could be interpreted by the child as a trauma trigger related to their previous neglect. It is critical for foster parents to catch youth's positive behaviors and offer enthusiastic and warm praise as frequently as possible. Administering consequence to the child in a nurturing manner ensures that the child does not perceive the treatment as harsh or replicating the previous mistreatment by their parents, strengthens the caregiver-child relationship, and models healthy relationships for youth.

With regard to addressing and managing children's behavior problems in the foster home (e.g., lying, stealing), a combination of Psychoeducation, coping skills, and parenting skills may be extremely helpful for the foster parent. For example, in a case example where the foster parent had extremely negative thoughts about a child whose father had been in jail for violent criminal activity, it is important to begin by having the foster parent explore underlying thoughts related to these behaviors (e.g., "this child is a pathological liar," "this child will be a psychopath") then challenge the accuracy and helpfulness of these thoughts. If these negative distorted thoughts are left unchallenged, the foster parent may react negatively towards the child, treating the child differently

from other children in the home or in a harsh and distant manner. These interactions can result in less cooperative behavior from the child and can reinforce the behavior (e.g., if the foster parent treats the child as a criminal, the child may view him/herself that way and steal more) and, in turn strengthening the foster parent's negative beliefs thus perpetuating a very negative pattern of interactions between foster parent and child and perhaps leading to a failed placement.

Psychoeducation and cognitive coping may also be helpful to the foster parent who is concerned that a child in his/her care is a pathological liar or worse a psychopath because of observed lying or lack of remorse. Though lying is not uncommon among children in the general population, among foster children this type of behavior tends to be overly pathologized. In fact, children in foster care may have more reason to lie, but they are not likely to be anymore pathological in so doing. Rather children who have grown up in chaotic or violent homes may be more likely to lie to avoid getting in trouble because of the inappropriate abuse or violence they have experienced. For example, a foster child may have lied in their biological home to avoid getting a beating or some other severe punitive consequence. Unfortunately, that pattern of behavior may continue in the foster home despite the fact that lying is no longer necessary because they need not fear a beating in their foster home. It is often helpful for the therapist to directly acknowledge to the child that the behavior (e.g., lying, stealing, etc.) may have served a survival function in the past, but now that the abuse or trauma is no longer occurring, the behavior no longer serves that purpose and is getting the child into trouble. The therapist and child thus need to work together to develop more adaptive coping strategies that will work better in the child's current circumstances (Cohen et al., 2012).

Clinical Example

James' foster father entered session looking very upset and expressing that he thought it might be best if James was removed from his home. He explained that he was concerned that his biological children might pick up on James' pathological lying. Mr. Millen reported that even when he catches James in the act of hiding food, he blatantly denies breaking the rules. The therapist asked Mr. Millen to describe the most recent interactions around these problem behaviors. In the context of conducting detailed functional analyses, Mr. Millen shared his feelings of frustration and reported that he threatened to call child protection to remove James from the home each time he caught him breaking the family rules. When the therapist inquired as to whether he thought James wanted to stay in the home, Mr. Millen reported that James seemed very happy in his home and he couldn't understand why he would lie about simple things and break the rules about no food in bedrooms. When Mr. Millen was educated about how James might have suffered some level of starvation which leads many foster children to hide food, he showed a great deal of compassion and immediately expressed a desire to work with James so he would not fear being without food. Furthermore, psychoeducation was provided about the fact that most children lie sometimes especially when they think they might be in trouble if they tell the truth. It was explained that one of the reasons we recommend avoiding the use of severe consequences like having to leave the home when children break rules is because such consequences increases the likelihood that children will lie or take extreme measures to hide their transgressions because of fear of suffering the consequences. Mr. Millen seemed to understand that and believed that it could be the motivation for James' lies. Thus, Mr. Millen was encouraged to identify mild negative consequences that could be discussed with James in the next session, while also increasing his

effort to praise James when he demonstrated honesty both in acknowledging a problem behavior and when he simply shared negative feelings. Mr. Millen seemed willing to take these steps. The therapist also reported that James was making excellent progress on the trauma narration and processing component, which he was looking forward to sharing with his foster father. It was emphasized that when the foster father had more understanding about the kinds of traumas James had been through he might find it easier to understand what was underlying some of James' challenging behaviors.

In some instances, children in foster care may have been left to fend for themselves in their biological homes and may have had little structure and few rules. As such, foster parents may observe an increase in children's noncompliant behaviors as they begin to implement structure, rules, expectations, and consequences to help children change their behaviors. It may be helpful for foster parents to view themselves as a teacher who is going to help the child learn new behaviors. It is also helpful for foster parents to understand that on average children are noncompliant about 20% of the time. As the foster parent is teaching children new, adaptive behaviors, it is helpful to approach consequences in a positive way and provide prompts and reminders to help children remember the rules. Consistent and predictable consequences help the child to achieve a trusting relationship with the foster parent and to develop more independence.

It is often helpful to explain to foster parents that the foster child's traumatic responses are correlated with trauma-related neurobiological changes (McLaughlin, Peverill, Gold, Alves, & Sheridan, 2015). Supporting the child in regularly practicing TF-CBT skills (e.g., for 20 minutes each evening) can promote the development of new, resilient neural pathways that in turn can contribute to reversing the child's trauma responses (Craske et al., 2008; McLaughlin et al., 2015).

The therapist meets with the foster parent each session to review the skills that the child is learning in treatment, so that the foster parent can encourage the child to regularly practice these skills and use them when trauma reminders occur. Through this process, the child develops a tool kit of coping skills and gradually gains increasing mastery over trauma reminders. The handout "Trauma and the Brain" (Appendix A) may be helpful in educating foster parents and youth in this regard.

Conjoint Work with Youth and Their Foster Parents

Foster parents should be carefully prepared for conjoint sessions both that address skill building and behavior management issues as well as for conjoint sessions designed for the sharing of the child's written trauma narrative. When foster parents review the child's narrative in individual parent sessions with the therapist, it may be the first time they are hearing about all that the child has endured in his/her own words. In fact, in many states, foster parents are told little to nothing about the child's trauma history when the child is placed. Thus, these sessions may be extraordinarily powerful in helping foster parents gain a better understanding of the origins of the child's emotional and behavioral difficulties, while also leading to increased feelings of compassion for the child. In fact, these preparation and conjoint sharing of the narrative sessions may partially explain the reduced rates of placement disruption and runaway attempts reported when foster children have participated in TF-CBT as opposed to more general community counseling (Lyons et al., 2006). Again, it is important for the therapist as well as the foster parent to reflect back what the child reports in the narrative, validating the child's feelings including both positive and negative feelings that the child expresses with respect to biological parents. This can be difficult for kinship parents because of their own feelings and relationships with the child's parent(s). Foster parents may be educated that children's seemingly unhealthy ongoing acceptance and love for their parents

is common and such feelings may continue to evolve as they mature and gain a deeper understanding of their biological parent(s) own histories, motives, and problems associated with the neglect or abuse of their children.

Special Considerations for Involving the Biological Parent in the Child's Treatment

When visits with the biological parent are instituted over the course of TF-CBT, the therapists should assess the child's emotional state related to these visits and monitor the impact of these visits on the child. Many children may experience concerns, worries, or fears related to these visits, particularly in cases where the child was removed due to the quality of care or type of discipline the parent used with the child. The therapist can help the child use the TF-CBT PRACTICE skills to manage their emotions related to these visits. The foster parent(s) and case worker can also be involved in assisting the child in utilizing these coping skills to manage emotions prior to and during visits. To maintain appropriate legal and ethical boundaries, the therapist, with appropriate releases from the legal guardian, may share information with case workers about the impact of visits on the child, but cannot make recommendations about whether the visitation schedule should be modified or visits stopped.

The committee of experts who developed this manual indicated that it is important to consider the stage of TF-CBT treatment in conjunction with the visitation/placement plan and adjustments to the plan when making a determination about integrating the biological parent(s) into the treatment with the child. When a decision is made by the court or child protection system for children in foster care to have visitation with and/or to begin working towards reunification with their parents, it is important to assess the appropriateness of including the biological parent in TF-CBT with the child. This may involve the therapist meeting with the parent alone before integrating

the parent into the child's treatment. In most cases where the decision is to reunify the child with the biological parent, the TF-CBT therapist must consider both the clinical appropriateness and/or the timing of including the biological parent in TF-CBT or even the appropriateness of this model. Such decisions may be influenced by the initial reason for the child's removal from the home (e.g., child physical abuse or neglect by the biological parent; parental medical or mental health illness) as well as other factors.

The committee concurred that if the child is near the end of treatment that it is important not to interrupt the therapy, but to complete TF-CBT, and then include the biological parent later in the treatment process when clinically appropriate. In some instances, it may be important to allow the child to have a graduation to celebrate his/her accomplishments and to allow the child to take a break from therapy while the therapist works with the biological parent(s) to cover the TF-CBT PRACTICE components that have already been covered with the child and foster parent. It is particularly important in these instances to work with the parent to enhance positive parenting skills, including praise, communication skills, and reflective listening skills in order to prepare the parent(s) to support the child during conjoint sessions in treatment and continue the positive interactions to strengthen their relationship once the child returns home. This can be quite valuable if the initial placement was due to a sudden parental medical or mental health problem that led to a need for the state to care for the children. Having received treatment themselves, such biological parents may be prepared and grateful for the guidance in responding to their children's distress associated with their illness and the subsequent foster placement.

If the reunification plan is initiated much earlier in treatment, then the clinician is faced with a decision as to how to involve the biological parent. If the biological parent has not had his/her

own treatment and has not acknowledged the impact of any traumatic experiences on the child, it might be appropriate for the parent to receive some type of parallel treatment separate from the child that focuses more on parent commitment and motivation rather than on TF-CBT. Also, behavioral interventions with the parent separate from trauma treatment might be critical in regard to a successful reunification.

As described above, it is important for the child to be able to complete a trauma narrative in a safe and therapeutic treatment environment with an identified nonoffending supportive adult whenever this is possible. In cases where the child and foster parent have a positive relationship, it may be beneficial to continue this process with the foster parent as opposed to including the biological parent in the process at this juncture. In some cases, another therapist may be identified to work with the biological parent on whatever issues led to the placement. This therapist may then continue with the parent and child when reunification and supervised as well as unsupervised visits begin.

As clarified elsewhere (Cohen et al, 2016), TF-CBT is not designed to address the needs of perpetrating parents except in very exceptional cases. (Exceptions are those in which the offending parent 1) has participated in individual treatment focused on his or her offending behavior, 2) accepts full responsibility for the perpetrating behavior, 3) openly expresses remorse for the perpetrating behavior to the child and therapist, 4) openly encourages the child to express details about the abusive experiences to the therapist as well as related feelings and thoughts, and 5) takes necessary steps to assure the child's safety. Since these are extremely rare situations, strategies for including offending parents in TF-CBT treatment are not described in this manual.) In cases where the biological parent physically abused or neglected the child, the therapist should complete TF-

CBT with the child and foster parent when possible; the offending parent should not be included in this treatment. Ideally, the offending parent should receive individual treatment while the child is attending TF-CBT. Alternatively, the biological parent and the child may be referred for screening for the appropriate therapy so they can begin services while waiting for the child to gain some closure in the context of TF-CBT. After graduating from TF-CBT, if family reunification is being pursued, the child and offending parent might be referred for other effective treatments that address the needs of both the child and the offending parent, such as Alternatives For Families Cognitive Behavioral Therapy (AF-CBT; Kolko, 1996; Kolko & Swenson, 2002), Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT; Runyon & Deblinger, 2014; Runyon, Deblinger, & Steer, 2010), Parent-Child Interaction Therapy (PCIT; Chaffin et al., 2004), or SafeCare (Chaffin, Bard, Bigfoot, & Maher, 2012; Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012; Gershater-Molko, Lutzker, & Welsh, 2002). With regard to other cognitive-behavioral based therapies, like AF-CBT and CPC-CBT, it may not be necessary to conduct a complete course of therapy with the child. Given the overlapping CBT skills, the therapist may review effective coping skills with the child and review how these skills may be helpful when living in the home with the parent and to help the child manage any anxiety or other emotions related to the transition home. (In some cases, CPS and/or the birth parent might decide to begin one of these treatments instead of TF-CBT from the outset. The important point for therapists providing TF-CBT is that offending parents are not included in the child's treatment except under the very rare circumstances described above.)

In cases where it remains unclear whether reunification with the parent is going to occur or where reunification is very unlikely, the therapist generally would not include the biological parent in TF-CBT. However, there are cases where the plan for reunification changes abruptly to

termination of parental rights. Refer to the section below for an example of how to manage the child's traumatic separation related to termination of his/her parents' rights.

Special Considerations for Treatment When Parental Rights Are Terminated

Recently the NCTSN Child Traumatic Grief Committee and the Resource Parent Group have collaborated to develop new resources for children who develop trauma responses following separation from attachment figures who are still alive. This condition has been termed "Traumatic Separation", and is especially common among children in foster care. An information sheet about Traumatic Separation is available for mental health professionals at: http://www.nctsn.org/sites/default/files/assets/pdfs/children_with_traumatic_separation_professionals.pdf

A critical issue in providing TF-CBT for foster children is that these children often identify "being taken away from my parent" or "being placed in foster care" as their worst (or only) trauma. In many cases foster children blame the judge, CPS, and/or "the system" because they minimize or deny the previous traumatic experiences (e.g., child abuse, neglect, parental substance abuse, etc.) that caused them to be removed and placed in foster care. Therapists (and other professionals) must understand and acknowledge the real trauma that children may experience when they are separated from attachment figures without warning, in embarrassing, chaotic, unpredictable, frightening, and/or emotionally fraught circumstances. It is equally critical for therapists who are implementing TF-CBT with foster children to recognize and explore with the child and (when appropriate) the foster parent and/or birth parent, the impact of previous traumatic experiences that led to the child's removal and foster care placement. Minimizing *either* the impact of the child's removal and foster care placement, *or* the child's previous traumas, will fail to best help children in foster care to fully

understand (address maladaptive cognitions about) their circumstances and move forward in healthier developmental trajectories.

Child traumatic grief components may be helpful with many children placed in foster care, but they can be crucial for children in care when the parental rights of their biological parents have been terminated. When a child learns that the parents' biological rights have been terminated and the opportunity for them to return home to the parent no longer exists, the therapist can assist the child in addressing this loss by implementing the traumatic grief components of TF-CBT (described in TF-CBT book [Cohen et al., 2016], and traumatic grief web training [CTG*Web*]). After the trauma therapy has been completed, it may be appropriate for this child to work on grief-related issues. For example, psychoeducation about feelings of loss and grief may be helpful. In addition, some children may find the "What I miss and what I don't miss", preserving positive memories techniques, and/or the balloon technique helpful in discussing, remembering and redefining the relationship with the biological parents. If possible, when the therapist has been working with the biological parents and child, a goodbye visit with the biological parents may be appropriate. When possible, receiving a concrete memento from the birth parents (and perhaps giving something to them from the child) is important and meaningful for many children.

Clinical Example

In this case example, the therapist was conducting TF-CBT with 9-year-old Diego and his foster mother when the course of treatment was suddenly impacted by a judge's unexpected decision to terminate the biological parents' rights. The caseworker addressed this sudden decision with the biological parents who were, of course, very sad about their next visit being the last time that they would see their son. The worker was extremely compassionate with these biological

parents and showed great respect for their humanity and sense of loss. Very importantly, the caseworker along with another TF-CBT therapist carefully prepared the biological parents to explain to their child the reasons for the judge's decision in a compassionate manner that highlighted their love for the child and the child's safety and future development. They emphasized their responsibility for what happened and that he was not "bad" for what occurred. Diego's TF-CBT therapist along with the foster mother planned a session that allowed the child to review what he understood from the very emotional last meeting with his biological parents and the caseworker. In addition, the therapist planned to help the child continue to engage in the narration and processing of his experiences with his biological parents. Also, the therapist anticipated that Diego's fears of abandonment would need to be addressed as part of the implementation of TF-CBT with the child's foster and potentially pre-adoptive mother. The foster/adoptive mother in this case wanted to change this child's given name because she associated it with the biological parents. The therapist assisted the adoptive mother in cognitively processing the need for this name change issue so that the therapist could better understand the pre-adoptive mother's reason for wanting to change the child's name and how this would potentially affect her son. Importantly, at this point in TF-CBT, the child had already acknowledged and processed the previous traumas perpetrated by birth parents (physical and sexual abuse; substance abuse) that had led to his removal and foster placement, and had expressed his thoughts and feelings about his parents. To prepare the pre-adoptive mother for the conjoint session, the therapist had additional individual sessions that allowed her to review and process her future son's trauma narrative including his mixed feelings of love and anger toward his biological parents. The therapist was able to help the pre-adoptive mother to consider Diego's feelings particularly with regard to his first name rather changing his

name without his consent as that may convey to the child that the first part of his life was not important and that he has to sever all ties to his past. The pre-adoptive mother came to the conclusion that being more accepting of this child's past, including his name, will help him feel good about himself which, in turn, will likely contribute to him having more positive feelings about the adoption and more adaptive behaviors. Later in treatment, the pre-adoptive mother was able to support the child in engaging in the TF-CBT grief components related to the permanent loss of his birth parents from his life. The therapist addressed psychoeducation about termination of parental rights, reviewing information the child had received earlier about parental substance abuse and why his birth parents were not able to take care of him even though they loved him. The child especially engaged in "what I miss and don't miss" about his birth parents, as well as preserving positive memories of these parents. With her growing understanding about how to enhance his self-esteem, the pre-adoptive mother fully supported these activities rather than feeling threatened by them. Sensing her complete engagement and support, her son was able to openly cry about missing his birth parents, but also to openly express relief that he would soon be adopted. This further cemented the pre-adoptive mother's confidence and her connection with her son.

Special Considerations for Implementing TF-CBT with Foster Kinship Families

Kinship care families arranged informally are likely to greatly outnumber those determined by the system. Informal arrangements that are not necessarily determined by the courts sometimes present complications with regard to who is sanctioned to provide appropriate consents. The expectations with regard to who signs treatment consents may vary by agency and state. Thus, consent requirements are best determined on a case by case basis in consultation with an attorney (see prior legal issues section).

Whether the kinship arrangements are informal or formally established by child protection or the courts, the relationships between the child, the child's parent, and a kinship caregiver (e.g., a grandparent, an aunt, an uncle, or an adult sibling) naturally change when a child is placed in kinship care. Many kinship caregivers lack information and may not have easy access to resources that are available to traditional foster parents. Therefore, as a part of early psychoeducation, clinicians may educate kinship providers (particularly informal caregivers) about some available resources that may exist in their community in addition to offering the standard information about the impact of trauma and the treatment model.

In kinship care cases (especially those arranged informally), contact with the biological parents may occur quite liberally. In some instances, in the context of TF-CBT, the biological parent may not only provide treatment consent, but may participate in treatment with the kinship caregiver. When informal kinship care placements occur because of a trauma that led to parental homelessness (e.g., hurricane, tornado, etc.) or a temporary inability to care for the child (e.g. parental medical, psychiatric, or substance abuse hospitalization), such a parent may be appropriate to participate (e.g. after careful assessment and preparation) in the child's recovery process. In such cases, the TF-CBT process may not only support the child's healing, but it may also help the family relationships grow stronger and closer.

Conversely, when placement is due to abuse, involvement of the parent who was abusive in the TF-CBT process is most often contraindicated due to clinical concerns and/or contact restrictions stipulated by the courts or the child protection agency. In general, it is important to note that the typical active parental participant in TF-CBT is the nonoffending kinship caregiver who has primary day to day oversight of the child at the time of treatment. The biological parent, however,

in such circumstances may be obtaining therapy from another therapist who is addressing the concerns that led to the placement including parenting skills development and/or other parental mental health problems. When reunification is planned by the child protection system and/or the courts, an effort should be made to complete the TF-CBT process and prepare the child to participate in a therapy process designed to help the parent who was abusive and the child to communicate and heal. There are a number of evidence based treatment models designed to support parents and children in this regard. These include CPC-CBT, AF-CBT, MST, and PCIT (see treatment model names in prior section).

At times, kinship care may be the best possible arrangement for children who must be placed outside their home. However, it can lead to relationship stressors for all family members as they work to manage their new roles in relation to the child. The kinship caregiver may, for example, be in charge of planning and/or overseeing supervised visits with the biological parent and thus, may struggle with frustration when the biological parent doesn't show for planned visits. Other conflicted feelings may emerge, for example, if an offending biological parent tells the child during a visit not to talk about the abuse "or else" and the child discloses this to the kinship caregiver, the child and the caregiver may fear for the child's safety but simultaneously feel conflicted loyalties and not want to cause more family conflict. This scenario could potentially have significant consequences for the child's engagement in TF-CBT and for the child's safety. In addition, the parent and kinship caregiver may blame each other for the child's placement and/or for the trauma that led to the placement decision. Long standing family conflicts may, in fact, complicate the kinship caregiver's attitude toward the biological parent. However, it is critically important for the TF-CBT therapist to educate the kinship caregiver about the commonly held

feelings of loyalty and love children often retain toward their parent(s) despite experiences of abuse. Thus, remaining neutral and minimizing kinship caregiver and child discussions regarding the biological parents until both are prepared to discuss feelings in the context of TF-CBT therapy is preferable.

Many kinship caregivers experience guilt and shame related to how they cared for their own children, particularly if they are the parents of the person who abused their grandchild or exposed the grandchild to some other kind of trauma. Accordingly, these caregivers not only have the responsibility for caring for their grandchild but the burden of their own guilt and shame related to their previous child rearing. In addition, some kinship caregivers are single, unemployed, less educated, and sometimes older. Therefore, they may not have a peer group and may experience feelings of isolation. Accordingly, they may need additional emotional support from therapists and may find the skills training particularly helpful for coping with their stress and modeling healthy coping for their foster children. Some kinship caregivers may have ambivalence about parenting another child. Kinship grandparents may feel that they were finished with child rearing and that it is a burden to be raising a child again, even if they love the child. TF-CBT therapist may continue to praise such caregivers for generously giving of themselves and working to develop a nurturing relationship with the child, while also brainstorming ideas to get support and assistance that may alleviate some of the burden felt by the kinship caregivers.

Clinical Example

When Ms. Hightower, a grandparent, presented for treatment, she expressed a great deal of anger toward her daughter who she held responsible for her granddaughter Kisha's sexual abuse. Ms. Hightower reported that she believed her daughter worked too much and allowed the

grandmother's developmentally delayed adult son who functioned at the level of a 12 year old to babysit for her granddaughter. She reported that if her daughter had supervised the household better and let her know when she needed babysitting support, the sexual abuse would not have occurred. Mother, on the other hand, blamed the grandmother as the perpetrator was the grandmother's son who she had sponsored to come to the US and she allowed him to live with her family because of the grandmother's declining health. Due to initial concerns that mother was neglectful in allowing the individual who offended to babysit her daughter, Kisha was placed with the grandmother. Thus, when the child was referred for TF-CBT, she was initially seen with the grandmother who was her day-to-day caregiver. During the initial phase of treatment, engagement was emphasized due to the fact that the grandmother was ambivalent about treatment and seemed to view the system response as highly intrusive into private family matters. However, the assessment findings and psychoeducation helped Ms. Hightower understand the importance of TF-CBT for her granddaughter. Ms. Hightower was also provided with some information to help her obtain legal and other guidance concerning her son who engaged in the sexually abusive behavior. In addition, the therapist worked to help the grandmother more effectively cope with her distress with an emphasis on cognitive coping. Initially, distressing thoughts that fueled her anger toward her daughter were tackled until grandmother was able to see that her daughter was as distressed and concerned for the children as she was and would never have allowed this to happen if she could have predicted it (which of course neither she nor anyone else could have). When the child protection agency began to discuss plans to reunify the child and her mother, the child's therapist continued individual skills work with both the grandmother and the child, while the mother began to participate in the TF-CBT process with another therapist. Eventually, the grandmother was feeling

less angry and more prepared to work together with her daughter to support her granddaughter's optimal recovery. By the time the child completed and processed her trauma narrative, both grandmother and mother were prepared to hear it together in a powerful family session that was followed by personal safety skill sessions.

Finally, though TF-CBT does appear to produce reductions in depression and other trauma symptoms experienced by caregivers (Deblinger et al., 1996; Deblinger, Stauffer, & Steer, 2001), it should be noted that like other caregivers, some kinship caregivers have their own trauma histories and relationship difficulties, and a referral for outside therapy may be helpful particularly if the difficulties interfere with their parenting and/or participation in TF-CBT with their child. It is inappropriate to make overgeneralizations about how TF-CBT needs to be applied for children in kinship care given the diversity of such families. However, kinship caregivers, relative to trained foster parents, may need to spend more effort on cognitive processing particularly with respect to any guilt, shame, or angry feelings associated with a child in their family being abused. Moreover, the shift in familial relationships toward the child in placement can require a great deal of patience and sensitivity as all those involved adjust to their new roles. For example, children whose grandparents suddenly become their primary caregivers often resist grandparents' initial efforts to discipline them as children naturally prefer the more relaxed role that their grandparents played in their lives previously.

Special Considerations for Implementing TF-CBT with Young Children

Prior to implementing TF-CBT with a young child, it is important to establish that the child has at least some verbal memory of the traumas experienced to participate in this treatment model. This can be difficult to do when the child is in foster placement and there is no parent who can

corroborate the trauma history shared by a young child. However, a child's trauma history may be assessed through direct interview of the child and/or based on information provided by the caseworker or the foster parent. When children are very young, it is often hoped that the trauma(s) experienced will be forgotten. However, while children may not retain verbal memories of traumas experienced during their early years long term, the traumatic effects of such experiences may be manifested in ongoing problematic behaviors and distressing emotional reactions to innocuous trauma reminders. Moreover, young children may have current and ongoing questions or concerns that are best addressed and resolved to reduce their risk of developing and maintaining negative emotional after effects. It is important to educate foster parent(s) by providing the above treatment rationales for young children in order to optimally motivate the participation of foster parents in TF-CBT. Preschool children are capable of both the skill building and trauma processing associated with TF-CBT and show greater body safety skills development and more significant symptom reductions when engaged in TF-CBT as compared to when they participate in play therapy and/or other nondirective therapies (Cohen & Mannarino, 1996; Deblinger et al., 2001).

When initiating TF-CBT with a young child, the role of foster parents should be highlighted given that oftentimes more time may be spent with the foster parents as opposed to the children. In fact, young children may not be able to identify trauma reminders, thus foster parents in collaboration with therapists may work to identify such reminders by conducting functional behavioral analyses to ascertain factors that may underlie young children's problematic emotional or behavioral reactions. In addition, children in placement directly benefit when their foster parents learn to utilize effective parenting skills, while simultaneously modeling and encouraging optimal coping skills for managing day-to-day stressors as well as trauma reminders.

Though it may be difficult to determine if young children are unable to remember certain details of traumatic experiences or are avoidant of such memories, it can be useful to acknowledge trauma(s) that are known to have impacted the child and his/her family openly and in a developmentally appropriate manner, as with time children will learn about trauma(s) and losses from others. Thus, it may be better for even young children to have an opportunity to learn about and ask questions about the experienced traumas in the context of a therapeutic environment. For children who remember their birth parents, it may be helpful to ask why they no longer live with these parents. A three year old said, "Mommy took medicine and died" (describing a drug overdose); another said, "Daddy did bad things to us" (describing sexual and physical abuse), and thus provided initial information about traumatic experiences that led to their placement. Psychoeducation, for example, about the general types of traumas the child experienced may answer important questions that even very young children may have about traumas they have experienced. Many resources are available for young children in this regard (e.g., *Let's talk about taking care of you: An educational book about body safety for Young Children* [Stauffer & Deblinger, 2003]).

Furthermore, it should be noted that seemingly highly dysregulated (particularly at the time of initial placement) young children can learn basic coping skills including relaxation, affect expression and regulation, and even cognitive coping skills. In fact, young children are naturally inclined toward engaging in relaxation and mindfulness as they tend to be fully immersed in the present moment more frequently than adolescents and adults. Young children are also able to identify and express primary emotions and are highly receptive to affect regulation skill building in this area. Cognitive coping, though more complex than the previously mentioned coping skills, may be presented to young children in terms of how thoughts (or what our brains say to us) affect

our feelings and how thoughts affect our behaviors, rather than present the more complex cognitive triangle relationships.

Trauma narration and processing can be implemented with verbal children as young as 2 ½ years of age. Young children in foster care often have had multiple individuals who have served in caregiving roles. Thus, prior to initiating a trauma narrative, it is important to establish the ways in which the child refers to each of those individuals. This will help the child, in collaboration with the therapist, create a more coherent narrative. Increasing the coherence of traumatic memories is associated with reduced risk of ongoing PTSD. Though young children's narratives often consist of a few sentences or a couple short paragraphs, when paired with drawings depicting the trauma(s) experienced, they can be among the most arresting and powerful trauma narratives. Moreover, such narratives can reveal important and problematic dysfunctional thinking. Simple thoughts like "mommy left because she was mad at me" or "I got hit because I was a bad kid" are critically important to elicit, address, and correct as such processing of inaccurate developing beliefs can potentially forestall a lifetime of self-doubt and feelings of worthlessness. More information about implementing TF-CBT for young children is described elsewhere (Cavett & Drewes, 2012; Drewes & Cavett, 2012)

Special Considerations for Managing Possible Placement Changes

Placement changes are not uncommon particularly for children with a history of significant trauma and emotional and behavioral difficulties. Due to many factors (e.g., difficulty adjusting, lack of communication about youth's needs to foster parents, increase in symptoms associated with change in structure/placement) associated with foster care placement, children are not infrequently moved from placement to placement to find the right "fit." In other instances, a foster parent may

request that the youth be moved, but the identification of another placement may take time. In other cases, court decisions about reunification with parents and/or legal guardians can stretch across months or can be made "overnight" unexpectedly. These and other scenarios associated with foster placements leave the treating therapist wondering if TF-CBT should be initiated when placement stability is threatened or unknown. These potential placement changes highlight the importance of moving forward through the model and maintaining positive momentum in treatment even when crises arise. Despite the fact that many children in care have complicated trauma histories, most children in can successfully complete TF-CBT within 12 to 25 sessions.

If there is a concrete plan to move a youth to a new placement in the next few weeks, it may be prudent to delay the initiation of TF-CBT with the youth and caregiver until the child is in the new placement. In other situations when the placement plan is unclear and the youth seems to be in limbo about whether he will stay in the present home or go, TF-CBT may be initiated as soon as possible. As noted earlier, research by Lyons and colleagues (2006) suggests that TF-CBT with youth in foster care is associated with fewer failed placements and less running away. In many situations, failed placements are typically related to foster parents who do not understand the difficulties the youth are presenting or do not know how to respond to or manage the emotional and behavioral difficulties the youth is exhibiting which leaves the foster parents feeling overwhelmed and ineffective. The earlier in placement that TF-CBT can be initiated the better as the initial stabilization and skill building phase of TF-CBT can assist the foster parent in understanding the nature of the youth's trauma(s) and behavioral reactions to those experiences. The initiation of coping skills development can help both children and their caregivers to manage their own emotional reactions so that they can respond to parent-child interactions in a more positive and

productive manner. For example, a foster parent may believe that a child who engages in inappropriate sexual behavior is destined to be a sexual offender. Through education and cognitive coping skills, the foster parent can change this distorted view (that is not uncommon for caregivers) recognizing that children often imitate behaviors they experienced and/or observed and such behaviors can be unlearned. Moreover, it is important to provide the education that most children who have been sexually abused do not go on to sexually abuse others. Furthermore, education and positive parenting skills assist foster parents in providing the appropriate balance of nurturance and structure that children need to thrive in out of home placement. Positive parenting skills in conjunction with education about appropriate boundaries and healthy sexuality can result in significant reductions in children's sexual behavior problems -a problem behavior that many foster parents feel ill-equipped to handle. Thus, implementing TF-CBT early in placement could potentially prevent a failed placement and empower the caregiver and help the youth thrive in the current placement.

Given the great potential for TF-CBT to help stabilize a placement, it is worth considering initiating such treatment even in cases in which the placement may be in danger of disrupting. Conversely, when a placement is regarded as a temporary or emergency placement, it may not serve the child well to begin treatment and then be moved such that they cannot continue with the identified therapist. If continuing with the therapist is possible, there need not be a delay. However, the timing of TF-CBT components should be considered if the placement is highly unlikely to be stable. In some instances, there is the added trauma of being placed in foster care. As such, introducing TF-CBT skills as early as possible is important and beneficial and may further help the youth cope with previous failed placements and the transition to the new placement. In these

situations, initiating trauma narration and processing is discouraged until the youth is in a new placement when there is a lower probability that the youth will be moved while in the middle of this important and perhaps more sensitive TF-CBT component.

It is natural for TF-CBT therapists to be cautious about initiating the trauma narration and processing phase when the placement does not appear to be stable. However, it is important for therapist to move forward with this phase even when there is no assurance of placement stability as often this phase helps to reveal the trauma-related thoughts and beliefs that may be underlying some of the child's most distressing emotions and disruptive behaviors, and contributes to greater behavioral stability. In fact, when concerned about the stability of a placement, it may sometimes be prudent to work actively with foster parent in every session and to move through TF-CBT components at an accelerated pace with the goal of maintaining the placement. If the placement fails, the youth has as many skills as possible to help him/her cope productively with the transition and may have begun to better understand the connection between his/her behaviors and the history of trauma. Not surprisingly, many foster children attribute their placement to their own behavior and/or blame the system for their families' problems. Thus, the trauma narration and processing phase can be critical in helping children recognize their birth parents' difficulties that may have contributed to the need for foster placement. Such an approach allows children to better understand factors that precipitated their placement without feeling that they or their parents are being negatively judged by the therapist, the foster parent, the caseworker, or the system. Thus, as soon as the child in placement completes the initial phase of treatment and appears to be at least "stably unstable" in their behavioral patterns, it may be best to initiate the trauma narration and processing phase. Moreover, given the history of multiple and chronic traumas experienced by many children

in placement, it is important for therapists to encourage the narration of representative trauma experiences as opposed to overly extending this phase of treatment inadvertently encouraging rumination on the past. Rather, it is critical to help the child get through the trauma narration phase and move on to complete the narrative incorporating a final chapter that highlights strengths in overcoming the traumas endured as well as acknowledging the individuals that provided hope and support (e.g., foster parents) particularly during the therapy process. *Completing this phase often contributes to behavioral stabilization and to placement stability.* Finally, given the possibility the children in placement may return to a more chaotic family environment, the final integration phase that revisits enhancing safety skills is critical. Safety skills and planning, in fact, should be specifically tailored to the potential needs of the child based on the child's history and possible placement decisions.

Special Considerations: Psychotropic Medication Use with Children in Placement

High rates of psychotropic medication use with children in foster care are well documented (e.g., dos Reis et al., 2001; Zito et al., 2008). Children in foster care may receive psychotropic medication at a rate of 3.5 to 11 times greater than that of youth insured by Medicaid due to low family income (Zito et al., 2008). One study found that among those children in foster care prescribed psychotropic medication, 41.3% received three or more different classes of these medications and 15.9% received four or more different classes (Zito et al., 2008). The use of psychotropic medication even among very young children in foster care has been documented. A recent study of the use of psychotropic medication among children in foster care age six years and younger found that among those children who spent 365 days or more in foster care, 12% received at least one psychotropic medication (dosReis et al., 2014). Vanderwerker and colleagues (2014)

investigated the use of antipsychotic medication among children in foster care. Results indicated that youth in foster care had significantly higher rates of antipsychotic use as compared with youth not in foster care, and that even after controlling for demographics and diagnostic variables (the higher rate of externalizing disorders among foster children), foster care status more than doubled the odds of antipsychotic use (Vanderwerker et al., 2014).

While clearly there are children who greatly benefit from appropriate psychotropic medication (e.g., stimulants for ADHD), as noted above, recent research has documented that children in foster care are much more likely to be prescribed psychotropic medications than non-foster children Moreover, there are serious concerns about both the misdiagnosing and the possible inappropriate or overmedication of youth in placement reported by child welfare workers and others (McMillen, Fedoravicius, Rowe, Zima, & Ware, 2007). However, based on findings suggesting that children in care may receive regimens that include multiple psychotropic medications at higher than generally prescribed doses, there have been increasing efforts to evaluate and positively influence the psychiatric assessment and utilization of psychotropic medications with children in state care (Government Accountability Office [GAO], 2011).

It is also worth noting that the results of a randomized controlled trial, in which children with a history of trauma were randomly assigned to either TF-CBT with antidepressant medication or TF-CBT with a placebo, demonstrated no differences on measures of PTSD, depression, or behavior problems (Cohen, Mannarino, Perel, & Staron, 2007). Thus, the findings suggest that a trial of TF-CBT, before prescribing medication, may produce significant improvements in PTSD, depression, and other difficulties. It should be noted that although this trial was underpowered, subsequent trials have also not shown any benefit of psychotropic medications for treating PTSD in

children or adolescents (Wilkinson & Carrion, 2012) It has also been found that adult clients generally do not derive greater benefit from the combination of exposure-based cognitive behavioral treatments (like TF-CBT) and psychotropic medications above and beyond CBT treatments alone (Otto, McHugh, & Kantak, 2010; Otto, Smits, & Reese, 2005). These findings may have implications for children in terms of the combination of therapy and medication. However, all decisions regarding medication and therapy should be based on individual clients' symptom severity, chronicity, and course of treatment.

When children present for TF-CBT on multiple psychotropic medications, it is may be best to request a review of the child's medication regimen. With careful monitoring and simultaneous support and guidance for foster parents, some children may be weaned off certain medications and others may be changed and/or adjusted depending on the re-evaluation findings. This allows clinicians to initiate TF-CBT after youth have been stabilized on an appropriate medication regimen or after medication has been discontinued. By so doing, one can best distinguish medication and therapy effects (Cohen, Scheid, & Gerson, 2014),

Clinical Example

Selena was first placed in foster care at 10 years of age when her father, in a drug addicted fit of rage, murdered her mother in her presence. In the two years that followed, she and her 11 year old half-brother had been in and out of foster homes due to inappropriate sexual interactions with each other and other children in the homes. Selena's half-brother was placed in a kinship home, but since Selena had no kinship options, she was placed in a therapeutic foster home. At the time of this placement, Selena was on multiple medications for ADHD and depression. After a difficult initial adjustment to the home, Selena was referred for TF-CBT. The trauma history

assessment revealed a history of child sexual abuse by her father and older brother. Though the foster parents initially resisted participation in treatment, the therapist explained the powerful influence they could have in helping this child overcome the tragedies she had endured. Moreover, when the foster parents reported previous unproductive therapeutic experiences with their pre-adoptive daughter, the therapist described specifically how the structure and course of TF-CBT differed from their prior therapy experience. After overcoming some initial avoidance of sharing the details of her mother's murder and later the sexual abuse, Selena's response to TF-CBT was excellent. The foster parents came to appreciate the need to be warm but also very specific in praising Selena so that she could follow their rules better and have success in her interactions at home and in school. In addition, they understood that there were no rules in the home Selena grew up in. Thus, they created only two critical rules and in conjoint session agreed on clear consequences for not following those rules, as well as rewards for success in following the rules. Toward the end of therapy, when Selena was showing considerable improvement with respect to her depressive and behavioral difficulties, the foster parents raised the question of the ongoing need for medication. This question was referred to the prescribing psychiatrist who agreed it was appropriate to wean Selena off the antidepressant medication and monitor and re-evaluate the ADHD diagnosis over time. In fact, by the time Selena graduated therapy, she was not only no longer taking antidepressant medication, but her foster parents were inquiring with the state about the possibility of adopting Selena as well.

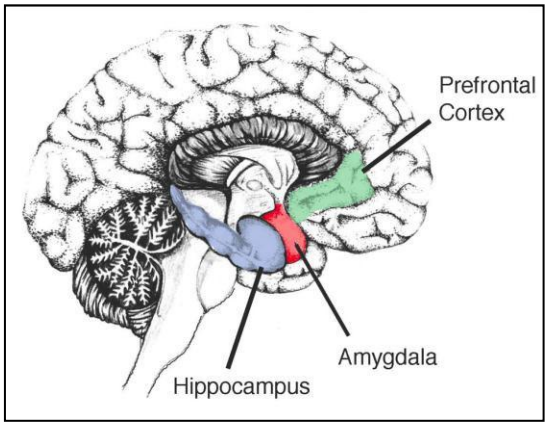
Summary

Children placed in foster care experience rates of childhood trauma significantly greater than the general population (Greeson et al., 2011; Salazar et al., 2013). As a result, they are at high risk

for experiencing significant mental health difficulties (e.g., Pecora et al., 2005), physical health concerns (e.g., Szilagyi et al., 2015; Takayama et al., 1998), as well as educational challenges (e.g., Smithgall et al., 2004). Early, effective interventions may forestall the negative life trajectories often faced by children in foster care potentially increasing their chances of experiencing full and productive lives despite abuse, neglect, and/or other trauma(s) experienced in childhood. TF-CBT is an evidence-based intervention that has been documented to be effective in over 30 pre-post investigations, quasi-experimental studies, and randomized trials including several studies that specifically targeted youth in state care (Deblinger et al., 2015). Given that TF-CBT has been recognized as the most well supported approach designed for treating childhood trauma (Morina et al., 2016), this manual was developed to highlight the unique challenges presented when applying TF-CBT to youth in placement, while also describing strategies for addressing the special considerations related to engaging and working with foster parents.

Appendix A

How can trauma affect the brain?



The way trauma influences brain development will be different for each child. Just as each child will have different emotional responses to a traumatic event, the way that the brain responds to trauma will also vary across children. The following regions of the brain are the most likely to change following a traumatic event.

The **amygdala** is designed to detect and react to people, places, and things in the environment that could be dangerous. This is important for safety and survival. After trauma, the amygdala can become even more highly attuned to potential threats in the environment, leading a child to closely monitor their surroundings to make sure they are safe and have strong emotional reactions to people, places, or things that might be threatening or that remind them of the trauma. This heightened attention to potential threats in the environment can make it hard for children to pay attention in school, go new places, or interact with people they don't know.

The **medial prefrontal cortex** (mPFC) helps to control the activity of the amygdala and is involved in learning that previously threatening people or places are now safe. Connections between the mPFC and amygdala are sometimes not as strong in children who have experienced trauma. As a result, the mPFC is not as effective at reducing amygdala reactivity to people, places, and things that are in fact safe and no longer predict danger. This can lead to persistent elevations in fear and anxiety about cues that remind children of the trauma they experienced.

The **hippocampus** is involved in learning and memory. Impairments in learning and memory have been seen in children who have experienced trauma. This suggests that trauma may affect how the hippocampus develops. Trauma likely impacts a variety of types of learning and memory, such as the ability to learn and remember information about the surrounding environment. As a result, children who experience trauma may not be able to retain information about how to tell if one situation is safe and another is dangerous, leading them to experience harmless situations as scary. For example, a child who has experienced trauma may have difficulty distinguishing between activities that are dangerous (e.g., walking down a dark alley) and safe (e.g., walking around a dark corner at home).

Critically, these changes in the brain are *not* permanent. The brain is remarkably plastic, meaning that it changes in response to social and environmental experiences. This enables us to learn, form relationships with people, and develop new skills. Changes in the brain that happen after trauma can improve over time. This is particularly likely to happen when children experience safe, stable, and supportive

environments after trauma. In fact, certain kinds of psychotherapy, like cognitive behavioral therapy, can actually lead to positive changes in the same regions of the brain that are influenced by trauma.

Tips for Helping Children who have Experienced Trauma

1. Make sure that the children's environment is and feels as safe as possible.

    a. Minimize fighting, arguing, or raised voices that might seem like they will lead to violence.
    b. Keep doors locked.
    c. Review how to handle calls or someone coming to the door that is unfamiliar.

2. Create a safety plan for situations where there may be ongoing dangers (e.g., Domestic Violence, unsafe neighborhoods).

    a. Set up a written plan for specific risky situations.
    b. Have back up plans for getting in contact when separated or unable to reach by usual methods.
    c. Identify safe people and places that children can turn to if necessary.

3. Increase support and reassurance from caregivers.

    a. Give a lot of reassurance. Be specific that the situation is safe now.
    b. Be careful not to communicate that because of the trauma the world should be seen as a very dangerous place.

4. Help children face up to non-dangerous situations to learn they can handle them.

    a. Identify people, places, and topics, things that may be reminders of the trauma but are not in themselves dangerous, that the child seems to be reacting strongly to or avoiding.
    b. Support children in approaching, not avoiding, these non-dangerous reminders.
    c. Help them learn to tell the difference between danger and non-dangerous reminders (e.g., every raised voice is not a sign of impending DV).

5. Make sure children have coping skills they can use.

    a. Review coping skills such as relaxation, breathing, distraction (listening to a favorite song, game), meditating. Identify which ones the child is likely to use and practice it with him or her.
    b. Prompt the child to use the coping skills when he or she seems to be getting anxious or worried unnecessarily.

6. Find them a therapist who can provide Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) if they have persistent posttraumatic stress symptoms.

    a. If the child has significant ongoing distress, TF-CBT is a proven treatment.

These are all strategies to prevent any brain changes from becoming permanent and to restore the child to normal functioning. You can help support your child's brain development!

Created by Katie McLaughlin, Stress and Development Lab, University of Washington (http://stressdevelopmentlab.org). CBT+ 2014.

References

Achenbach, T. M. (1991). *Integrative guide for the 1991 CBCL/4-18 YSR and TRF profiles*. Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms and profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families.

Bellamy, J. L., Gopalan, G., & Traube, D. E. (2010). A national study of the impact of outpatient mental health services for children in long-term foster care. *Clinical Child Psychology and Psychiatry, 15*(4), 467-479.

Berliner, L. (2011). *Engaging children and families in treatment: Overcoming barriers.* Presentation at the CARES Institute Quarterly Expert Lecture, Trenton, NJ, October 25, 2011.

Bick, J., Naumova, O., Hunter, S., Barbot, B., Lee, M., Luthar, S. S., … Grigorenko, E. L. (2012). Childhood adversity and DNA methylation of genes involved in the hypothalamus-pituitary-adrenal axis and immune system: Whole-genome and candidate-gene associations. *Developmental Psychopathology, 24*(4), 1417-1425.

Cavett, A. M., & Drewes, A. A. (2012). Play applications and trauma-specific components. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), *Trauma-focused CBT for children and adolescents: Treatment applications* (pp. 124-148). New York: The Guilford Press.

Chaffin, M., Bard, D., Bigfoot, D. S., & Maher, E. J. (2012). Is a structured, manualized, evidence-based treatment protocol culturally competent and equivalently effective among American Indian parents in child welfare? *Child Maltreatment, 17,* 1-11.

Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide

trial of the SafeCare home-based services model with parents in child protective services. *Pediatrics, 129,* 509-515.

Chaffin, M., Silovsky, J. F., Funderburk, J. F., Valle, L. A., Breston, E. V., Balachova, T., … Bonner, B. L. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. J*ournal of Consulting and Clinical Psychology,*

72, 500-510.

Chapman, D. P., Anda, R. F., Felitti, V. J., Dube, S. R., Edwards, V. J., & Whitfield, C. L. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders, 82*, 217–225.

Child Welfare Committee, National Child Traumatic Stress Network. (2008). *Child welfare trauma training toolkit: Comprehensive guide* (2nd ed.). Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A multisite randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*, 393–402.

Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, *35*(1), 42–50.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2016). *Treating trauma and traumatic grief in children and adolescents* (2nd edition). New York: The Guilford Press.

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect, 36,* 528-541. PMID 22749612

Cohen, J. A., Mannarino, A. P., Perel, M. D., & Staron, V. (2007). A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 46,* 811-819.

Cohen, J. A., Scheid, J., & Gerson, R. (2014). Transforming trajectories for traumatized children. *Journal of the American Academy of Child & Adolescent Psychiatry, 53,* 9-13.

Craske, M. G., Kircanski, K., Zelikowski, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy, 46,* 5–27.

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*(4), 310–321.

Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Heflin, A. H. (2015). *Child sexual abuse: A primer for treating children, adolescents, and their nonoffending parents* (2nd ed.). New York: Oxford University Press.

Deblinger, E., Pollio, E., Runyon, M. K., & Steer, R. A. (2016). Improvements in personal resiliency among youth who have completed Trauma-Focused Cognitive Behavioral Therapy. *Manuscript submitted for publication.*

Deblinger, E., Stauffer, L. B., & Steer, R. A. (2001), Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. *Child Maltreatment, 6*(4), 332–343.

Dorsey, S., Burns, B. J., Southerland, D. G., Cox, J. R., Wagner, H. R., & Farmer, E. M. Z. (2012). Prior trauma exposure for youth in treatment foster care. *Journal of Family Studies, 21*(5), 816-824.

Dorsey, S., Conover, K. L., & Cox, J. R. (2014). Improving foster parent engagement: Using qualitative methods to guide tailoring of evidence-based engagement strategies. *Journal of Clinical Child & Adolescent Psychology, 43*(6), 877-889.

Dorsey, S., & Deblinger, E. (2012). TF-CBT applications for children in foster care. In J. Cohen, A. Mannarino, & E. Deblinger (Eds.), *Trauma-Focused Cognitive Behavioral Therapy for Children and Adolescents: Treatment Applications* (pp. 49–72). New York: The Guilford Press.

Dorsey, S., Pullmann, M. D., Berliner, L., Koschmann, E., McKay, M., & Deblinger, E. (2014). Engaging foster parents in treatment: A randomized trial of supplementing Trauma-focused Cognitive Behavioral Therapy with evidence-based engagement strategies. *Child Abuse & Neglect, 38,* 1508-1520.

dosReis, S., Tai, M., Goffman, D., Lynch, S. E., Reeves, G., & Shaw, T. (2014). Age-related trends in psychotropic medication use among very young children in foster care. *Psychiatric Services, 65*(12), 1452-1457.

dosReis, S., Zito, J. M., Safer, D. J., & Soeken, K. L. (2001). Mental health services for youths in foster care and disabled youths. *American Journal of Public Health, 91,* 1094-1099.

Drewes, A. A., & Cavett, A. M. (2012). Play applications and skills components. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), *Trauma-focused CBT for children and adolescents: Treatment applications* (pp. 105-123). New York: The Guilford Press.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R.F. (2003) Childhood abuse, neglect and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experience Study. *Pediatrics, 111,* 564–572.

Dubner, A. E., & Motta, R. W. (1999). Sexually and physically abused foster care children and posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 67,* 367-373.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14(4),* 245-258.

Gershater-Molko, R. M., Lutzker, J. R., & Welsh, D. (2002). Using recidivism to evaluate project SafeCare: Teaching bonding, safety, and health care skills to parents. *Child Maltreatment, 7,* 277-285.

Government Accountability Office (GAO). (2011). *Foster children: HHS guidance could help states improve oversight of psychotropic prescription.* (GAO-12-270T).Washington, DC: Government Printing Office.

Grasso, D., Boonsiri, J., Lipschitz, D., Guyer, A., Houshyar, S., Douglas-Palymberi, H., … Kaufman, J. (2009). Posttraumatic stress disorder: The missed diagnosis. *Child Welfare*, *88*(4), 157-176.

Greeson, J. K. P., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake, G. S., Ko., S. J., … Fairbank, J. A. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the National Child Traumatic Stress Network. *Child Welfare, 90*(6), 91-108.

Grillo, C. A., Lott, D. A., Foster Care Subcommittee of the Child Welfare Committee, National Child Traumatic Stress Network. (2010). *Caring for children who have experienced trauma: A workshop for resource parents— Participant handbook.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Jensen, T. K., Holt, T., Ormhaug, S. M., Egeland, K., Granly, L., Hoaas, L. C., … Wentzel-Larsen, T. (2014). A randomized effectiveness study comparing Trauma-focused Cognitive Behavioral Therapy with therapy as usual for youth. *Journal of Clinical Child & Adolescent Psychology, 43*(3), 356–369.

Keller, T. E., Salazar, A. M., & Courtney, M. E. (2010). Prevalence and timing of diagnosable mental health, alcohol and substance use problems among older adolescents in the child welfare system. *Child Youth Services Review, 32*(4), 626-634.

Kolko, D. J. (1996). Individual cognitive-behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1,* 322-342.

Kolko, D. J., Hurlburt, M. S., Zhang, J., Barth, R. P., Leslie, L. K., & Burns, B. J. (2010). Posttraumatic stress symptoms in children and adolescents referred for child welfare investigation. *Child Maltreatment, 15*(1), 48-63.

Kolko, D. J., & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families: A cognitive-behavioral approach.* Thousand Oaks, CA: Sage.

Landsverk, J., Burns, B., Stambaugh, L. F., & Rolls-Reutz, J. A. (2006). *Mental health care for children and adolescents in foster care: Review of research literature.* Seattle, WA: Casey Family Programs.

Leslie, L. K., Gordon, J. N., Meneken, L., Premji, K., Michelmore, K. L., & Ganger, W. (2005). The physical, developmental, and mental health needs of young children in child welfare by initial placement type. *Journal of Developmental & Behavioral Pediatrics, 26*(3), 177-185.

Linares, L. O., Stovall-McClough, K. C., Li, M., Morin, N., Silva, R., Albert A., & Cloitre, M. (2008). Salivary cortisol in foster children: A pilot study. *Child Abuse & Neglect, 32,* 665-670.

Lyons, J. S., Weiner, D. A., & Schneider, A. (2006). *A field trial of three evidence-based practices for trauma with children in state custody*. Report to the Illinois Department of Children and Family Services. Evanston, IL: Mental Health Resources Services and Policy Program; Northwestern University.

Mannarino, A. P., & Cohen, J. A. (2001). Treating sexually abused children and their families: Identifying and avoiding professional role conflicts. *Trauma, Violence and Abuse, 2*(4), 331-342.

McKay, M., & Bannon, Jr. W. M. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America*, *13*, 905–921.

McKay, M., Stoewe, J., McCadam, K., & Gonzales, J. (1998). Increasing access to child mental health services for urban children and their caregivers. *Health and Social Work, 23,* 9–15.

McLaughlin, K. A., Peverill, M., Gold, A. L., Alves, S., & Sheridan, M. A. (2015). Child maltreatment and neural systems underlying emotional regulation. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*, 753–762.

McMillen, J. C., Fedoravicius, N., Rowe, J., Zima, B. T., & Ware, N. (2007) A crisis of credibility: Professionals' concerns about the psychiatric care provided to clients of the

child welfare system. *Administration and Policy in Mental Health and Mental Health Services Research, 34,* 203-212.

McMillen, J. C., Zima, B. T., Scott, L. D., Auslander, W. F., Munson, M. R., Ollie, M. T., & Spitznagel, E. L. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child & Adolescent Psychiatry, 44,* 88-95.

Morina, M., Koerssen, R., & Pollet, T. V. (2016). Interventions for children and adolescents with posttraumatic stress disorder: A meta-analysis of comparative outcome studies. *Clinical Psychology, 47,* 41-54.

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect, 24*(10), 1363-1374.

Oswald, S. H., Heil, K., & Goldbeck, L. (2010). History of maltreatment and mental health problems in foster children: A review of the literature. *Journal of Pediatric Psychology, 35*(5), 462-472.

Otto, M. W., McHugh, R. K., & Kantak, K. M. (2010). Combined pharmacotherapy and cognitive behavioral therapy for anxiety disorders: Medication effects, glucocorticoid and attenuated treatment outcomes. *Clinical Psychology Science and Practice, 17*(2), 91-103.

Otto, M. W., Smits, J. A. J., & Reese, H. E. (2005). Combined psychotherapy and pharmacotherapy for mood and anxiety disorders in adults: Review and analysis. *Clinical Psychology and Practice, 12(*1), 72-86.

Pears, K., & Fisher, P.A. (2005). Developmental, cognitive, and neuropsychological functioning in preschool-aged foster children: Associations with prior maltreatment and placement

history. *Developmental and Behavioral Pediatrics, 26*(2), 112-122.

Pecora, P. J., Jensen, P. S., Romanelli, L. H., Jackson, L. J., & Ortiz, A. (2009). Mental health services for children placed in foster care: An overview of current challenges. *Child Welfare, 88*(1), 5-26.

Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., English, D., … Holmes, K. (2005). *Improving family foster care: Findings from the Northwest Foster Care Alumni Study.* Seattle, WA: Casey Family Programs.

Pilowsky, D. J., & Wu, L. (2006). Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care. *Journal of Adolescent Health, 38*(4), 351-358.

Raviv, T., Taussig, H. N., Culhane, S. E., & Garrido, E. F. (2010). Cumulative risk exposure and mental health symptoms among maltreated youths placed in out-of-home care. *Child Abuse & Neglect, 34*(10), 742-751.

Runyon, M. K., & Deblinger, E. (2014). *Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): An approach to empower families at-risk for child physical abuse*. New York, NY: Oxford University Press.

Runyon, M. K., Deblinger, E., & Steer, R. A. (2010). Group cognitive behavioral treatment for parents and children at-risk for physical abuse: An initial study. *Child and Family Behavior Therapy, 32*(3), 196-218. doi:10.1080/07317107.2010.500515

Salazar, A. M., Keller, T. E., Gowen, L. K., & Courtney, M. E. (2013). Trauma exposure and PTSD among older adolescents in foster care. *Social Psychiatry and Psychiatric Epidemiology, 48,* 545-551.

Seiler, A., Kohler, S., Ruf-Leuschner, M., & Landolt, M. A. (2016). Adverse childhood experiences, mental health, and quality of life of Chilean girls placed in foster care: An exploratory study. *Psychological Trauma: Theory, Research, Practice, and Policy, 8*(2), 180-187.

Smithgall, C., Gladden, R. M., Howard, E., Goerge, R., & Courtney, M. (2004). *Educational experiences of children in out-of-home care.* Chicago: University of Illinois, Chapin Hall Center for Children.

Stauffer, L. B., & Deblinger, E. (2003). *Let's talk about taking care of you! An educational book about body safety for young children.* Hatfield, PA: Hope for Families, Inc.

Szilagyi, M. A., Rosen, D. S., Rubin, D., & Ziotnik, S. (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics, 136*(4), 1142-1166.

Takayama, J. I., Wolfe, E., & Coulter, K. P. (1998). Relationship between reason for placement and medical findings among children in foster care. *Pediatrics, 101,* 201-207.

U. S. Department of Health and Human Services. (2015). *The AFCARS Report: Preliminary FY 2014 Estimates as of July 2015, 22.* Washington, DC: Government Printing Office.

Vanderwerker, L., Akincigil, A., Olfson, M., Gerhard, T., Neese-Todd, S., & Crystal, S. (2014). Foster care, externalizing disorders, and antipsychotic use among Medicaid youth. *Psychiatric Services, 65*(10), 1281-1284.

Vaughn, M. G., Ollie, M. T., McMillen, J. C., Scott, L., & Munson, M. (2007). Substance use and abuse among older youth in foster care. *Addictive Behavior, 32*(9), 1929-1935.

Weiner, D. A, Schneider, A., & Lyons, J. S. (2009). Evidence-based treatment for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review, 31,* 1199-1205.

Wilgocki, J., & Wright, M. K. (2002). *Maybe days: A book for children in foster care.* Washington, DC: Magination Press.

Wilkinson, J. M., & Carrion, V. G. (2012). Pharmacotherapy in pediatric PTSD: A developmentally focused review of the evidence. *Current Psychopharmacology, 1*, 252-270.

Zito, J. M., Safer, D. J., Sai, D., Gardner, J. F., Thomas, D., Coombes, P., … Mendez-Lewis, M. (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics, 121*(1), 157-163.