INTRODUCTION TO THE TF-CBT TOOLKIT

Congratulations on completing the online training in TF-CBT! (If you haven't there is still plenty of time to complete this at http://tfcbt.musc.edu/). We hope it has piqued your interest in providing evidence-based treatment services to traumatized children and their caregivers. We know the online training is not perfect. We would rate it good (three stars on a four star rating scale). But we also think it is the best introduction to TF-CBT.

Expert clinicians in TF-CBT strongly believe, however, that clinicians need more than just the online training in order to be prepared to deliver TF-CBT effectively. The usual recommended course of training is to follow-up the TF-CBT online training with in-person training and then ongoing clinical consultation with a TF-CBT expert until you have mastered TF-CBT. This course of training is not possible for most of us. That is why the developers of TF-CBT and researchers and clinicians at the University of Missouri in Columbia and Washington University in St. Louis have packaged a set of scaffolded learning components designed to help you learn and deliver TF-CBT effectively in your practice setting.

These activities are based on the educational science of scaffolded learning. Scaffolded learning is designed to optimize your skill acquisition by taking advantage of and respecting your existing knowledge and expertise, and tailoring the learning process to your individual needs. It puts you in charge of your learning. Scaffolded learning consists of four main components: (a) new knowledge and skills (in this case, TF-CBT); (b) materials designed to help you recall and apply the skills; (c) a set of systematic and sequenced activities and tasks designed to help you practice and master the skills; and (d) expert and peer support for trying out the new skills.

Individual learners employ these components to tailor a package to best meet their learning needs, using them when and how they find them most helpful, and proceeding at their own pace. That being said, the TF-CBT developers and trainers

believe that you will get the most out of this training package when you make use of all its components.

The TF-CBT Learning Package includes eight parts designed to provide you with the content, materials, activities and support you need to deliver TF-CBT effectively:

1. TF-CBT Online Training

If you have not yet started your TF-CBT learning, we strongly suggest you begin with the online TF-CBT training offered through the Medical University of South Carolina. Go to http://tfcbt.musc.edu/

2. TF-CBT Book

We have included the book, *Treating Trauma and Traumatic Grief in Children*, written by the developers of TF-CBT. The book serves as the treatment manual for TF-CBT. The authors recommend you read the book soon after taking the online TF-CBT training.

3. TF-CBT Toolkit

We have also included this "toolkit" of materials designed to help you recall key concepts from TF-CBT and apply them with your clients. It includes several of the materials mentioned in the TF-CBT book. We encourage you to look through the toolkit and see what you find most helpful. We will be sending additional pieces to add to your toolkit over the course of the training.

4. TF-CBT Learning Activities

Our toolkit includes a number of learning activities designed to help you practice the skills of TF-CBT. Most of these are practice activities, where you and another clinician role play using the skills and components of TF-CBT. Some of these activities reflect TF-CBT components demonstrated in the online training. Others are additional skills vital to the successful delivery of TF-CBT. These activities allow you to practice before you use TF-CBT with clients. These activities also include videos of expert TF-CBT clinicians modeling some of these skills, discussion questions, and other assignments to encourage you to think more deeply about your implementation of TF-CBT.

If you are learning TF-CBT in an agency setting with other clinicians, the learning activities have been designed to walk you and your group through a sequence of role plays and discussion questions.

If you are learning TF-CBT mostly on your own, we will provide you with contact information for a learning partner with whom we encourage you to meet to go over these learning activities, practice and discuss TF-CBT. You are also welcome to identify your own learning partner.

We think these learning activities are key. The role-plays and discussion questions are designed to help you practice the treatment components of TF-CBT with a few straightforward case examples. As you gain more comfort with the model, we also encourage you and your learning partner(s) to discuss how you would apply TF-CBT with more complex cases (e.g., multiple traumas, children in foster care). You can choose which skills are most important for you to practice, but we believe practice is a must. Some of these TF-CBT skills are not as easy as they may first seem!

5. TF-CBT Webinars

We will provide you with free access to four webinars presented by the TF-CBT developers Drs. Judith Cohen, Esther Deblinger, and Anthony Mannarino. We are really excited to be able to bring this opportunity to Missouri clinicians. They will teach you the secrets of doing TF-CBT well, using the experiences of their trainees across the country as their guides.

6. TF-CBT Workshop

We will also provide two free in-person workshops with a TF-CBT expert trainer Margaret Comford, LCSW that you can choose to attend. One of these workshops will take place in St Louis and one in Columbia. During these workshops, you will be provided with more in-depth training in TF-CBT and be able to ask about applying and using TF-CBT in your practice (i.e., how to apply TF-CBT with the kinds of children and families you see).

7. TF-CBT Phone Consultation

As you move forward with integrating TF-CBT into your practice, we have also arranged for free access to monthly phone consultations with a TF-CBT expert trainer. These phone calls will provide you with the opportunity to ask questions

and seek input from a TF-CBT expert. These calls will also be an opportunity to listen and learn from the questions and answers with other trainees.

8. TF-CBT Online Discussion Board

We have developed an online discussion board for TF-CBT at the Missouri Therapy Network web site. Here you can post questions about TF-CBT and read others' questions and the answers they received from others who are learning the same skills and applying them in their clinical practices. The online discussion board will also be monitored by a certified trainer in TF-CBT, ensuring that you get expert answers when needed. Visit motherapynetwork.wustl.edu.

9. TF-CBT Online Consult

You also may want to consider making use of a new free resource offered through the Medical University of South Carolina (the same group that provides the initial free web training). This resource is called TF-CBT Consult and can be accessed at http://etl2.library.musc.edu/tf-cbt-consult/index.php

10. TF-CBT Emailed Tips

We will also periodically email you with TF-CBT implementation tips, clinical tips, and suggestions for rounding out your TF-CBT training.

11. Website of TF-CBT Resources

The Missouri Therapy Network has also developed a website repository of resources for clinicians using TF-CBT. It includes links to additional training videos, books, discussions, measures and more. Online resources can be found at motherapynetwork.wustl.edu.

YOUR NEXT STEPS:

If you *have not* completed the online TF-CBT training, we encourage you to do so. Go to http://tfcbt.musc.edu/.

If you *have* completed the online training in TF-CBT, the next recommended steps are:

(1) Read the book, ***Treating Trauma and Traumatic Grief***. Some will want to read it cover to cover. It is a pretty quick read. Others will want to focus on areas where they know the least, or on the areas where the book provides substantially more detail than the online training.

(2) Look through the toolkit. Let us know what you find to be most helpful.

We will be in touch soon!!

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University of Chicago

Enola Proctor, Ph.D.
Washington University in St. Louis

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We have started this notebook of helpful handouts and reminder sheets for using TF-CBT with your clients. These materials are a starter toolkit that you can add to over time. We hope to send you additions to your toolkit as we learn from each other.

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TF-CBT Memory Jogger

CRAFTS I: Core Values

***C*omponents-based** treatment emphasizing a set of skills that progressively build on previously acquired skills. Rather than a rigid session-by-session approach, TF-CBT has interrelated components, provided in a manner that best matches the needs of the child and family.

***R*espect** for individual, family, religious, community, and cultural values is essential. Therapists work with the child and caregiver to decide the best way to implement the core components of TF-CBT for their family. TF-CBT must occur in harmony with the family's larger community and cultural context.

***A*daptability** is crucial to the success of TF-CBT. Therapists must be creative and flexible in implementing the core components of TF-CBT. Therapist clinical judgment and creativity are highly valued and respected in this approach.

***F*amily Involvement** A primary focus of TF-CBT is improving caregiver-child interactions, communication, and closeness. As such, caregivers are integrally involved in the child's treatment.

***T*herapeutic relationships** are central to TF-CBT. Developing and maintaining a trusting, accepting, empathic therapeutic relationship with the therapist is essential to restoring trust, optimism and self-esteem in traumatized children and their caregivers.

***S*elf-efficacy** including self-regulation of affect, behavior, and cognitions, is a long-term goal of TF-CBT. TF-CBT aims to provide life skills and enhance individual strengths so that children, caregivers, and families continue to thrive long after therapy has ended.

CRAFTS II: Domains for Assessment & Treatment Planning

Cognitive Problems

Relationship Problems

Affective Problems

Family Problems

Traumatic behavior Problems

Somatic Problems

TF-CBT PRACTICE: CORE COMPONENTS

*P*sychoeducation and *P*arenting Skills

*R*elaxation

*A*ffective modulation

*C*ognitive coping and processing

*T*rauma narrative

*I*n vivo mastery of trauma reminders

*C*onjoint child-parent sessions

*E*nhancing future safety and development

Domains for Assessment and Treatment Planning with Children who have experienced Trauma

Cognitive problems: Maladaptive patterns of thinking about self, others, and situations, including distortions or inaccurate thoughts (e.g., self-blame for traumatic events) and unhelpful thoughts (e.g., dwelling on the worst possibilities)

Relationship problems: Difficulties getting along with peers; poor problem-solving or social skills; hypersensitivity in interpersonal interactions; maladaptive strategies for making friends; impaired interpersonal trust

Affective problems: Sadness; anxiety; fear; anger; poor ability to tolerate or regulate negative affective states; inability to self-soothe

Family problems: Caregiver skill deficits; poor caregiver-child communication; disturbances in caregiver-child bonding; disruption in family relationships due to familial abuse or violence

Traumatic behavior problems: Avoidance of trauma reminders; trauma-related, sexualized, aggressive or oppositional behaviors; unsafe behaviors

Somatic problems: Sleep difficulties; physiological hyperarousal and hypervigilance toward possible trauma cues; physical tension; somatic symptoms (e.g., headaches, stomachaches)

ASSESSMENT TIPS

The TF-CBT developers believe that it is important for mental health clinicians to screen their child clients for the experience of traumatic events and the symptoms of PTSD. Sometimes clinicians may be afraid of bringing up trauma if the client doesn't bring it up first. However, experience has shown that clinicians often discover halfway into therapy that their child clients have had traumatic experiences that are affecting their current behavior and emotions. If clinicians screen for these traumatic events up-front, they can better plan for the treatment of their clients.

We have gained permission from the authors of the UCLA PTSD indexes for DSM-IV to include them in this packet. You can make copies of these instruments for clinical or research purposes. There are three forms of the PTSD index: a) one used with children, b) one used with adolescents and c) one used with parents. The UCLA PTSD index includes items that screen for the experience of trauma. Then, it moves on to asking about the symptoms of PTSD.

There are scoring templates for the 3 forms of the UCLA PTSD index as well, if you decide to use them to help diagnose PTSD or if you want to use them to measure client progress by determining an overall PTSD severity score. Please familiarize yourself with these instruments and how they work before you use them with clients. You may want to use them as "interview" instruments, where you read the items aloud to your clients, or you may use them as self-administered questionnaires.

UCLA PTSD INDEX FOR DSM IV (Revision 1)

INSTRUMENT INFORMATION:

Child Version, Parent Version, Adolescent Version

(Ned Rodriguez, Ph.D., Alan Steinberg, Ph.D., & Robert S. Pynoos, M.D., August, 1999)

For more information, please contact the UCLA Trauma Psychiatry Service via

telephone: (310) 206-8973, or email: rpynoos@npih.medsch.ucla.edu

Basic Features:

Researchers and clinicians at the UCLA Trauma Psychiatry Service have developed this series of self-report instruments to be used to screen both for exposure to traumatic events and for all DSM-IV PTSD symptoms in school-age children and adolescents who report traumatic experiences. These instruments are meant to serve as brief self-report screening tools to provide information regarding trauma exposure and PTSD symptoms. The items of the UCLA PTSD indices are keyed to DSM-IV criteria and can provide preliminary PTSD diagnostic information. However, these instruments are not intended to be used in place of a structured clinical interview to definitively establish a PTSD diagnosis. Instead, the instruments are meant to be used to quickly and efficiently screen for PTSD symptoms in children and adolescents who have experienced a traumatic event, and to provide information regarding the frequency of those symptoms.

Intended Populations:

The instruments are designed to assess for exposure to a wide variety of traumatic events and are suitable to be used to evaluate PTSD symptoms in children and adolescents who have experienced any type of traumatic stress.

The Child Version is worded for school-age children between the ages of 7 and 12. The Parent Version closely mirrors the Child Version and is intended to be used as the parent report of trauma exposure and PTSD symptoms for children between the ages of 7 and 12. The Parent Version was developed to complement the child's report of PTSD symptoms. Parent report of PTSD symptoms is often necessary and helpful in providing PTSD diagnostic information, particularly for the following symptoms: repetitive traumatic play, diminished interest and participation, sleep problems, irritability and angry outbursts, concentration problems, hypervigilance, and exaggerated startle. The Adolescent Version closely resembles the Child Version with minor changes in wording intended for youth age 13 or older.

Instrument Design and Item Content:

The content of the questions draws upon clinical and research experience regarding how to evaluate for exposure to traumatic experiences in children and youth, how they describe their subjective reactions during these experiences, and how traumatized children and youth describe their experiences of PTSD symptoms. All three versions of the UCLA PTSD Index are organized in the same format. Questions 1-13 comprise a trauma screen, as they assess for exposure to a variety of traumatic events. If participants report exposure to multiple events, Question 14 asks them to identify the event that currently distresses them the most. The remainder of Question 14 inquires when the event occurred and requests participants to provide a brief description of the event. Questions 15-21 assess for DSM-IV PTSD Criterion "A1" which concerns aspects of the traumatic event itself. Questions 21-26 evaluate DSM-IV PTSD Criterion "A2" which relates to the child or youth's subjective experience during or just after the traumatic event including intense fear (Question 22), helplessness (Question 23), horror (Question 24), and agitated or disorganized behavior (Questions 25-26). Question 27 assesses for a dissociative reaction at the time of the traumatic event. In questions 15-27, only parents are given the option to respond "do not know" for questions pertaining to the child's subjective reactions at the time of traumatic events. Children and youth are required to answer "yes" or "no" for each of these items. The remaining questions on pages 3 and 4 assess for the frequency of

self-reported DSM-IV PTSD symptoms (Criterion “B”, “C”, and “D,”) or associated features on a 4-point scale ranging from “none” (of the time) to “most” (of the time). Subjects refer to the Frequency Rating Sheet on Page 5 to explain their rating choices. The Frequency Rating Sheet is designed to assess for the occurrence of PTSD symptoms over the past month, but researchers and clinicians can adapt the Rating Sheet to assess for PTSD symptoms over the time period of their interest, such as the past week. Only parents are given the option to respond “do not know” for each question in this section of the instrument, since parents may be unaware or unsure of many PTSD symptoms experienced by their child.

Each question on pages 3 and 4 of the instrument contains a subscript that denotes the DSM-IV PTSD symptom assessed by that particular question. For example, question 1 inquires about DSM-IV Criterion “D4" (hypervigilance). The subscript “AF” denotes a PTSD “associated feature.” Although each version of the UCLA PTSD Index contains a different total number of questions, questions 1-19 are nearly identical across each version. These 19 questions assess for the 17 DSM-IV PTSD symptoms delineated in Criteria “B, C, and D,” and the PTSD associated feature of trauma-related guilt (Question 13). Note that each version contains one question to assess for each DSM-IV PTSD symptom except for the symptom of Emotional Numbing (DSM-IV symptom C6). Each version contains 2 questions (Questions 10 and 11) that assess for emotional numbing. Question 10 assesses for numbing of positive emotions, Question 11 assesses for numbing of negative emotions. The instruments are designed such that these 19 questions comprise the core of each PTSD index in each version.

The Child Version contains a total of 20 questions. In addition to the first 19 questions, Question 20 assesses a common problem reported by traumatized children, namely a fear that the traumatic event will reoccur.

The Parent Version contains a total of 21 questions. The questions are identical in content to the child version with one exception. Question 21 has been added to the Adult Version to assess for the DSM-IV PTSD symptom of repetitive traumatic play, an alternate expression of Criterion B1 in children. A parallel item was not included in the child version since the traumatic etiology of repetitive play is thought to occur outside of the awareness of the child.

The Adolescent Version contains a total of 22 questions. In addition to the first 19 questions, an alternative question (Question 20) has been included to assess for another component of DSM-IV Criterion "D2" (anger/irritability). An alternative question (Question 21) has also been included to assess for another dimension of DSM-IV Criterion “C7" (foreshortened future). Question 22 assesses a common problem reported by traumatized youth, namely a fear that the traumatic event will reoccur

Instructions for Administration:

All three versions have been designed as self-report instruments and can be administered as paper-and-pencil measures. Researchers should note that subjects often neglect to consult the Frequency Rating Sheet on Page 5 when completing pages 3 and 4 of the instrument. Therefore, it is helpful for researchers to detach this sheet and instruct subjects to refer to it when they complete pages 3 and 4.

While the Parent Version is easily administered via self-report, the Child and Adolescent Versions can easily be adapted to 1-on-1 verbal administration or to classroom administration to larger groups of children or youth.

A. 1-on-1 Verbal Administration for Child and Adolescent Versions: Based on prior work with the earlier generation instrument of the UCLA Trauma Psychiatry Service, the Child Posttraumatic Stress Disorder Reaction Index (Frederick, Pynoos, & Nader, 1992), the Child Version can be effectively administered verbally in a 1-on-1 format, where the evaluator reads the instructions and the questions to

the children. Children readily respond to this interactive format, which helps to insure that they comprehend the instructions of the instrument and the task of self report. Evaluators begin by reading the instructions for each section and emphasize that if the child hears a word he/she does not understand, he/she should ask the evaluator for clarification. Evaluators proceed through the trauma screen and criterion A assessment questions on pages 1 and 2 in a fairly straightforward manner. For pages 1 and 2, evaluators inform the child of their response options for each question (Yes or No), and proceed to read the child each question and record their response. After completing pages 1 and 2, evaluators read the instructions for pages 3 and 4 of the instrument. The evaluator should next familiarize the child with their response options on the Frequency Rating Sheet.

"For each question, I want to know how often these things have been true for you (in the past month)"

"Here are your choices (show them the Frequency Rating Sheet and point to each choice and the boxed calendar pictorial representation as you read the choice to the child)

"None of the time means not at all (in the past month)"

"Little of the time means about two times (in the past month)"

"Some of the time means about once a week (in the past month)"

"Much of the time means two or three days a week (in the past month)"

"Most of the time means almost every day (in the past month)"

Children can be asked to point to their choice on the Frequency Rating Sheet to indicate how often they have experienced the symptom in question over the past month or designated time period. Evaluators then circle the child's response to each question on the grid provided. To orient the child to the task of the self-report of symptoms, before beginning the first question on page 3, the child is given 2 practice questions and asked to point to the choice on the Frequency Rating Sheet to answer how often in the past month the following statements have been true for the child:

"I have had green hair"-Child should point to 0 to denote "none of the time"

"I have had a headache"-Child should point the choice denoting the number of times (in the past month) when they have had a headache

If children do not understand the concept of self-reporting on the frequency they experience a particular problem, this will become apparent during the practice questions, and evaluators should clarify the task as necessary to help children to understand the task.

When evaluators read the questions to the child or adolescent that assess for the DSM-IV PTSD Trauma-specific symptoms [Child Version Questions numbers (DSM-IV PTSD Symptom): 2(B4), 3(B1), 5(B2), 6(B3), 9(C1), 14(AF), 15(C3), 17 (C2), 18(B5), 20(AF)], [Adolescent Version Question numbers (DSM-IV PTSD Symptom): 2(B4), 3(B1), 5(B2), 6(B3), 9(C1), 14(AF), 15(C3), 17 (C2), 18(B5), 22(AF)], they should alter the wording of these questions to tailor them to the specific traumatic event experienced by the child or adolescent. Clinical experience with index administration indicates that a direct verbal reference in each of these questions to the specific traumatic event experienced by the child helps the child to better focus on that experience and its link to the symptom in question. Children with posttraumatic avoidance often have difficulty keeping the traumatic event in mind during instrument administration. Repeatedly bringing the specific traumatic event into the awareness of the child helps to facilitate their ability to report on explicitly trauma-linked symptoms. Thus, tailoring the above questions to the specific traumatic event experienced by the child helps to increase the reliability of the child's self report, particularly in children and adolescents suffering from posttraumatic avoidance. For example if the child or had witnessed a violent shooting, the evaluator should alter the wording of the questions as follows:

Question Number	Questions with reference to a generic traumatic event	Suggested alternative wording for questions tailored to a specific traumatic event, in this example a violent shooting
2 (B4)	When something reminds me of *what happened*, I get very upset, afraid, or sad.	When something reminds me of *the shooting*, I get very upset, afraid, or sad.
3(B1)	I have upsetting thoughts, pictures, or sounds of *what happened* come into my mind when I do not want them to.	I have upsetting thoughts, pictures, or sounds of *the shooting* come into my mind when I do not want them to.
5(B2)	I have dreams about *what happened* or other bad dreams.	I have dreams about *the shooting* or other bad dreams.
6(B3)	I feel like I am back at the time when *the bad thing* happened, living through it again.	I feel like I am back at the time when *the shooting* happened, living through it again.
9(C1)	I try not to talk about, think about, or have feelings about *what happened.*	I try not to talk about, think about, or have feelings about *the shooting.*
14(AF)	I think that some part of *what happened* is my fault.	I think that some part of *what happened during the shooting* is my fault.
15(C3)	I have trouble remembering important parts of *what happened.*	I have trouble remembering important parts of *what happened during the shooting*.
17(C2)	I try to stay away from people, places, or things that make me remember *what happened.*	I try to stay away from people, places, or things that make me remember *the shooting.*
18(B5)	When something reminds me of *what happened*, I have strong feelings in my body like my heart beats fast, my head aches, or my stomach aches.	When something reminds me of *the shooting*, I have strong feelings in my body like my heart beats fast, my head aches, or my stomach aches.
20(AF)	I am afraid that *the bad thing* will happen again.	I am afraid that *the shooting* will happen again.

B. Classroom or Group Administration for Child and Adolescent Versions: The Child and Adolescent Versions can be easily adapted for classroom or group administration. Based on previous work with the Child Posttraumatic Stress Disorder Reaction Index, UCLA researchers have employed two different strategies for classroom evaluation of student self-report of PTSD symptoms.

1. Evaluation Team: In this form of classroom administration, a team of trained evaluators goes to a classroom where the evaluators divide the students into subgroups. Each evaluator then administers the Index in a 1-on-1 format to each student in the subgroup assigned to them. While evaluators are going around the room administering the Index 1-on-1 to each student at their desk, students are asked to engage in a quiet individual task such as drawing or coloring. Instructions for 1-on-1 classroom administration in this team format are identical to the instructions just delineated for 1-on-1 verbal administration. Prior to evaluation, the team should decide on a set of uniform responses to common student questions to minimize the interevaluator variability in Index administration.

2. One Evaluator per Classroom: In this form of administration, a single evaluator administers the Index to the entire classroom of students. As in 1-on-1 administration, the evaluator reads the instructions to each section of the Index to the classroom and then proceeds by reading each question in that section. While the evaluator reads the questions, students who are seated at their desks, mark their responses on their own copies of the Index. It is important that classroom evaluators stress that students should answer all questions and leave no blanks. The evaluator can closely adapt the previous instructions for 1-on-1 verbal

administration to this format, although the interactive component of the 1-on-1 format is not possible in the classroom setting. Evaluators can answer student questions to clarify the task of self-report and explain how to record answers, etc. However, if evaluators are administering the Index to various classrooms in a given school, it is suggested that evaluators not attempt to answer student questions relating to the meaning of a particular item, since different questions may arise in each classroom which if answered may alter the administration and response conditions in each classroom. In this scenario, the potentially different administration conditions in each classroom would confound Index scores and make interclassroom comparison difficult. Instead of answering student questions regarding item content, in this administration format UCLA researchers suggest that evaluators respond neutrally to student questions stating: "Answer each question according to the meaning that question has for you" OR "The question means whatever it means to you, please try and understand the question as best as you can."

Scoring, Interpretation, and Psychometric Properties:

Questions 1-11 screen for exposure to events that may be experienced as traumatic. Questions 13-19 evaluate if the event meets DSM-IV Criterion A1, and Questions 20-23 assess if the participant's subjective response during or just after the event meets DSM-IV Criterion A2. If participants meet both Criterion A1 and A2 for the event endorsed, that experience can be classified as constituting exposure to a traumatic event according to DSM-IV.

As stated previously, the first 18 questions of each version comprise the core of each PTSD Index for evaluating Criterion B, C, and D Symptoms (the first 19 questions in the case of the Parent Version). All 17 DSM-IV PTSD symptoms are assessed by these questions, with the exception of question 13 which evaluates the associated feature of trauma-related guilt. Question 13 is excluded from scoring on all three versions. The remaining questions (Questions 19 and higher for the Child and Adolescent Versions, and Questions 20 and higher for the Parent Version) are included for experimental purposes only and are excluded from scoring.

The developers of the indices assume that the more often a symptom occurs, the more severely that symptom impacts the child or adolescent. In addition, the developers assume that the higher the number of symptoms reported by a participant, the higher the severity of their PTSD. Based on this rationale, two types of PTSD severity scores can be calculated from each index. An Overall PTSD Severity Score can be calculated by summing the scores for each question that corresponds to a DSM-IV Symptom. In addition, a separate PTSD Severity Subscore can be calculated for Criterion B, C, and D Symptoms by summing the scores for each question that assesses the symptoms belonging to each particular category. Finally, preliminary PTSD diagnostic information can be obtained by determining if participants endorse the number of symptoms from Criterion B, C, and D required for a DSM-IV PTSD diagnosis. Please note that investigators must make a determination regarding the minimum frequency reported for each item necessary for that question to be counted as a symptom. Certainly problems reported to occur "Much of the time" or "Most of the time" would likely qualify as symptoms. Whether or not problems reported to occur "Some of the time" or "Little of the time" would qualify as symptoms is best answered as an empirical question. Please refer to the Scoring Worksheets for step-by-step instructions for scoring each version.

These instruments have only recently been developed. At the current time, the psychometric properties of these instruments have not yet been established. However, researchers at the UCLA Trauma Psychiatry Service are currently conducting psychometric studies of the instruments. In one study involving the Child and Parent Versions in a sample of acutely traumatized children, researchers are investigating the test-retest reliability of each version. Researchers are cross-validating the trauma-screen portion of the Child and Parent Versions with other standardized self-report measures of trauma exposure. Researchers are cross-validating the Criterion B, C, and D portions of the Child Version with the Child Posttraumatic Stress Disorder Reaction Index (Frederick, Pynoos, & Nader, 1992) and cross-validating the Criterion A, B, C, and D portions of the Child version with a structured clinical PTSD diagnostic interview. In this study, UCLA researchers are also cross-validating the Criterion A, B, C, and D portions of the Parent Version with a structured clinical PTSD diagnostic interview.

Since the psychometric properties of these instruments are currently under investigation, UCLA researchers suggest that other researchers who use these instruments conduct empirical studies to determine the optimal scoring procedures for their particular research populations. To conduct these studies, researchers should consider conducting structured clinical interviews to diagnose PTSD in a randomly-selected subsample of their participants with a known standardized PTSD assessment instrument. The PTSD diagnostic status and intensity scores of this subsample could then serve as "gold standards" in empirical studies which evaluate the overall PTSD severity score on each version that would most efficiently classify subsample cases according to PTSD diagnostic status. Researchers could then utilize this empirically-determined cutoff score to classify cases in their larger sample according to likelihood of a PTSD diagnosis. Researchers could also then consider the individual item scores that are necessary to generate the empirically-determined cutoff score. For example, if statistical analysis indicated that a cutoff score of 32 most efficiently classified the cases in the subsample according to PTSD diagnostic status, a score of 2 on each of the 17 questions could be considered as the symptom cutoff score for each question. In this case, any questions answered 2 or above would likely indicate the presence of a PTSD symptom. If sample size permits, investigators may choose to conduct a series of statistical analyses that investigate the relationships between Index-derived severity scores for each DSM-IV Symptom Category (B, C, D) and DSM-IV PTSD diagnostic status for those Criteria as determined by structured clinical interview. These analyses could yield separate empirically-determined cutoff Index severity scores that would most efficiently classify cases according to PTSD diagnostic status for Criterion B, C, and D. For more information, please contact the UCLA Trauma Psychiatry Service via any of the following: writing to the letterhead address, telephone: (310) 206-8973, or email: rpynoos@mednet.ucla.edu

UCLA PTSD INDEX FOR DSM-IV:

CHILD VERSION

Name _____ Age _____ Sex (Circle): Girl Boy

Today's Date (**write month, day and year**) _____ Grade in School _____

School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences, some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION: **Check "Yes"** if this scary thing **HAPPENED TO YOU**
Check "No" if it **DID *NOT* HAPPEN TO YOU**

1) Being in a big earthquake that badly damaged the building you were in.
Yes [ ] No [ ]

2) Being in another kind of **disaster**, like a fire, tornado, flood or hurricane.
Yes [ ] No [ ]

3) Being in a bad **accident**, like a **very serious** car accident.
Yes [ ] No [ ]

4) Being in place where a **war** was going on around you.
Yes [ ] No [ ]

5) Being **hit, punched, or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters).
Yes [ ] No [ ]

6) Seeing a family member being **hit, punched or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters).
Yes [ ] No [ ]

7) Being **beaten up, shot at or threatened to be hurt badly** in your town.
Yes [ ] No [ ]

8) Seeing someone in your town being **beaten up, shot at or killed.**
Yes [ ] No [ ]

9) Seeing a **dead body** in your town (do not include funerals).
Yes [ ] No [ ]

10) Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.
Yes [ ] No [ ]

11) Hearing about the **violent death or serious injury** of a loved one.
Yes [ ] No [ ]

12) Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.

Yes [ ] No [ ]

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was really **SCARY, DANGEROUS, OR VIOLENT?**
Yes [ ] No [ ]

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank:
_____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank:
#_____

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? _____

d) Please write what happened:

_____

_____

_____

_____

_____

_____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.

15) Were you scared that you would die?
Yes [ ] No [ ]

16) Were you scared that you would be hurt badly?
Yes [ ] No [ ]

17) Were you hurt badly?
Yes [ ] No [ ]

18) Were you scared that someone else would die?
Yes [ ] No [ ]

19) Were you scared that someone else would be hurt badly?
Yes [ ] No [ ]

20) Was someone else hurt badly?
Yes [ ] No [ ]

21) Did someone die?
Yes [ ] No [ ]

22) Did you feel very scared, like this was one of your most scary experiences ever?
Yes [ ] No [ ]

23) Did you feel that you could not stop what was happening or that you needed someone to help?
Yes [ ] No [ ]

24) Did you feel that what you saw was disgusting or gross?
Yes [ ] No [ ]

25) Did you run around or act like you were very upset?
Yes [ ] No [ ]

26) Did you feel very confused?
Yes [ ] No [ ]

27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?
Yes [ ] No [ ]

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on the page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 5 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

HOW MUCH OF THE TIME DURING THE PAST MONTH	**None**	**Little**	**Some**	**Much**	**Most**
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid, or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
8_{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9_{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10_{C6} I have trouble feeling happiness or love.	0	1	2	3	4
11_{C6} I have trouble feeling sadness or anger.	0	1	2	3	4
12_{D5} I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13_{D1} I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14_{AF} I think that some part of what happened is my fault.	0	1	2	3	4
15_{C3} I have trouble remembering important parts of what happened.	0	1	2	3	4
16_{D3} I have trouble concentrating or paying attention.	0	1	2	3	4
17_{C2} I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18_{B5} When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19_{C7} I think that I will not live a long life.	0	1	2	3	4
20_{AF} I am afraid that the bad thing will happen again.	0	1	2	3	4

SAMPLE FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH, THAT IS SINCE _____, DOES THE PROBLEM HAPPEN?

0 1 2 3 4

NONE LITTLE SOME MUCH MOST

S	M	T	W	H	F	S

S	M	T	W	H	F	S
	X					
					X	

S	M	T	W	H	F	S
		X			X	
		X				
			X			
		X		X		

S	M	T	W	H	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

S	M	T	W	H	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

NEVER **TWO TIMES A MONTH** **1-2 TIMES A WEEK** **2-3 TIMES EACH WEEK** **EVERYDAY**

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH, THAT IS SINCE _____, DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**

S	M	T	W	H	F	S	S	M	T	W	H	F	S	S	M	T	W	H	F	S	S	M	T	W	H	F	S	S	M	T	W	H	F	S

NEVER	**TWO TIMES A MONTH**	**1-2 TIMES A WEEK**	**2-3 TIMES EACH WEEK**	**EVERYDAY**

UCLA PTSD INDEX FOR DSM-IV:

ADOLESCENT VERSION

Name _____ Age _____ Sex (Circle): Girl Boy

Today's Date (**write month, day and year**) _____ Grade in School _____

School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences; some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION: **Check "Yes"** if this scary thing **HAPPENED TO YOU**
Check "No" if it **DID *NOT* HAPPEN TO YOU**

1) Being in a big earthquake that badly damaged the building you were in.
Yes [ ] No [ ]

2) Being in another kind of **disaster**, like a fire, tornado, flood or hurricane.
Yes [ ] No [ ]

3) Being in a bad **accident**, like a **very serious** car accident.
Yes [ ] No [ ]

4) Being in place where a **war** was going on around you.
Yes [ ] No [ ]

6) Being **hit, punched, or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters).
Yes [ ] No [ ]

6) Seeing a family member being **hit, punched or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters).
Yes [ ] No [ ]

7) Being **beaten up, shot at or threatened to be hurt badly** in your town.
Yes [ ] No [ ]

8) Seeing someone in your town being **beaten up, shot at or killed.**
Yes [ ] No [ ]

9) Seeing a **dead body** in your town (do not include funerals).
Yes [ ] No [ ]

10) Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.
Yes [ ] No [ ]

11) Hearing about the **violent death or serious injury** of a loved one.
Yes [ ] No [ ]

12) Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.
Yes [ ] No [ ]

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was really **SCARY, DANGEROUS OR VIOLENT?**
Yes [ ] No [ ]

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank:

_____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank:
#_____

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? _____

d) Please write what happened:

_____

_____

_____

_____

_____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.

15) Were you scared that you would die?
Yes [ ] No [ ]

16) Were you scared that you would be hurt badly?
Yes [ ] No [ ]

17) Were you hurt badly?
Yes [ ] No [ ]

18) Were you scared that someone else would die?
Yes [ ] No [ ]

19) Were you scared that someone else would be hurt badly?
Yes [ ] No [ ]

20) Was someone else hurt badly?
Yes [ ] No [ ]

21) Did someone die?
Yes [ ] No [ ]

22) Did you feel very scared, like this was one of your most scary experiences ever?
Yes [ ] No [ ]

23) Did you feel that you could not stop what was happening or that you needed someone to help?
Yes [ ] No [ ]

24) Did you feel that what you saw was disgusting or gross?
Yes [ ] No [ ]

25) Did you run around or act like you were very upset?
Yes [ ] No [ ]

26) Did you feel very confused?
Yes [ ] No [ ]

27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?
Yes [ ] No [ ]

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on the page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 5 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

HOW MUCH OF THE TIME DURING THE PAST MONTH	**None**	**Little**	**Some**	**Much**	**Most**
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
8_{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9_{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10_{C6} I have trouble feeling happiness or love.	0	1	2	3	4
11_{C6} I have trouble feeling sadness or anger.	0	1	2	3	4
12_{D5} I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13_{D1} I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14_{AF} I think that some part of what happened is my fault.	0	1	2	3	4
15_{C3} I have trouble remembering important parts of what happened.	0	1	2	3	4
16_{D3} I have trouble concentrating or paying attention.	0	1	2	3	4
17_{C2} I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18_{B5} When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19_{C7} I think that I will not live a long life.	0	1	2	3	4
20_{D2} I have arguments or physical fights.	0	1	2	3	4

21_{C7} I feel pessimistic or negative about my future.	0	1	2	3	4
22_{AF} I am afraid that the bad thing will happen again.	0	1	2	3	4

SAMPLE FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME

DURING THE PAST MONTH, THAT IS SINCE ____________________,

DOES THE PROBLEM HAPPEN?

0

NONE

S	M	T	W	H	F	S

NEVER

1

LITTLE

S	M	T	W	H	F	S
	X					
					X	

TWO TIMES A MONTH

2

SOME

S	M	T	W	H	F	S
		X			X	
		X				
			X			
		X		X		

1-2 TIMES A WEEK

3

MUCH

S	M	T	W	H	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

2-3 TIMES EACH WEEK

4

MOST

S	M	T	W	H	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

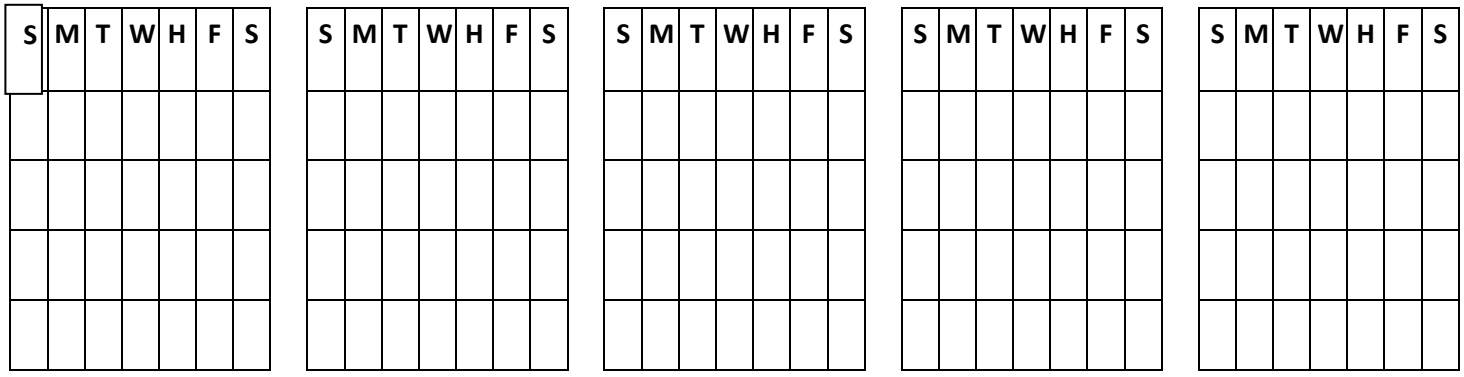
ALMOST EVERY DAY

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH, THAT IS SINCE _____,

DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**



NEVER	TWO TIMES A MONTH	1-2 TIMES A WEEK	2-3 TIMES EACH WEEK	ALMOST EVERY DAY

UCLA PTSD INDEX FOR DSM-IV:

PARENT VERSION

Child's Name _____ Age _____ Sex (Circle): Girl Boy

Person Completing this Form _____ Relationship to Child _____

Today's Date (**write month, day and year**) _____ Grade in School _____

School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to children. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some children have had these experiences, some children have not had these experiences.

FOR EACH QUESTION: Check "Yes" if this scary thing **HAPPENED TO YOUR CHILD**

Check "No" if it **DID *NOT* HAPPEN TO YOUR CHILD**

1) Being in a big earthquake that badly damaged the building your child was in. Yes [ ] No [ ]

---

2) Being in another kind of **disaster**, like a fire, tornado, flood or hurricane. Yes [ ] No [ ]

---

3) Being in a bad **accident**, like a **very serious** car accident. Yes [ ] No [ ]

---

4) Being in place where a **war** was going on around your child. Yes [ ] No [ ]

---

5) Being **hit, punched, or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

---

6) Seeing a family member being **hit, punched or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

---

7) Being **beaten up, shot at or threatened to be hurt badly** in your town. Yes [ ] No [ ]

---

8) Seeing someone in your town being **beaten up, shot at or killed.** Yes [ ] No [ ]

---

9) Seeing a **dead body** in your town (do not include funerals). Yes [ ] No [ ]

---

10) Having an adult or someone much older touch your child's **private sexual body parts** when your child did not want them to. Yes [ ] No [ ]

---

11) Hearing about the **violent death or serious injury** of a loved one. Yes [ ] No [ ]

---

12) Having **painful and scary medical treatment in a hospital** when your child was very sick or badly injured. Yes [ ] No [ ]

---

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to your child that was **REALLY SCARY, DANGEROUS, OR VIOLENT?** Yes [ ] No [ ]

Please write what happened: _____

---

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank. # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOUR CHILD THE MOST NOW** in this blank. #_____

c) About how long ago did this bad thing (your answer to Aa≅ or Ab≅) happen to your child? _____

d) Please write what happened: _____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK "Yes, No, or Do not know"** to answer **HOW YOUR CHILD FELT during or right after** the experience happened that you just wrote about in Question 14. Only check "Do not Know" if you absolutely cannot give an answer.

---

15) Was your child afraid that he/she would die? Yes [ ] No [ ] Do not know [ ]

---

16) Was your child afraid that he/she would

be seriously injured? Yes [ ] No [ ] Do not know [ ]

---

17) Was your child seriously injured? Yes [ ] No [ ] Do not know [ ]

---

18) Was your child afraid that someone else would die? Yes [ ] No [ ] Do not know [ ]

---

19) Was your child afraid that someone else would be seriously injured? Yes [ ] No [ ] Do not know [ ]

---

20) Was someone else seriously injured? Yes [ ] No [ ] Do not know [ ]

---

21) Did someone die? Yes [ ] No [ ] Do not know [ ]

---

22) Did your child feel terrified? Yes [ ] No [ ] Do not know [ ]

---

23) Did your child feel intense helplessness? Yes [ ] No [ ] Do not know [ ]

---

24) Did your child feel horrified; was what he/she saw disgusting or gross? Yes [ ] No [ ] Do not know [ ]

---

25) Did your child get hysterical or run around? Yes [ ] No [ ] Do not know [ ]

---

26) Did your child feel very confused? Yes [ ] No [ ] Do not know [ ]

---

27) Did your child feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life? Yes [ ] No [ ] Do not know [ ]

Here is a list of problems children sometimes have after very stressful experiences. Please think about your child's stressful experience that you wrote about in Question #14. Then, read each problem on the list carefully. CIRCLE one of the numbers (0, 1, 2, 3, 4 or 5) that tells how often the problem has happened to your child **in the past month**. Refer to the **Rating Sheet** (on page 5) to help you decide how often the problem has happened. Note: If you are unsure about how often your child has experienced a particular problem, then try to make your best estimation. **Only** circle "**Do not Know**" if you absolutely **cannot** give an answer. **PLEASE BE SURE TO ANSWER ALL QUESTIONS**

	None	Little	Some	Much	Most	Do not Know
1[D4] My child watches out for danger or things that he/she is afraid of.	0	1	2	3	4	5
2[B4] When something reminds my child of what happened he/she gets very upset, scared or sad.	0	1	2	3	4	5
3[B1] My child has upsetting thoughts, pictures or sounds of what happened come into his/her mind when he/she does not want them to.	0	1	2	3	4	5
4[D2] My child feels grouchy, angry or mad.	0	1	2	3	4	5
5[B2] My child has dreams about what happened or other bad dreams	0	1	2	3	4	5
6[B3] My child has flashbacks of what happened; he/she feels like he/she is back at the time when the bad thing happened living through it again.	0	1	2	3	4	5
7[C4] My child feels like staying by him/her self and not being with his/her friends.	0	1	2	3	4	5

8[C5] My child feels alone inside and not close to other people.	0	1	2	3	4	5
9[C1] My child tries not to talk about, think about, or have feelings about what happened.	0	1	2	3	4	5
10[C6] My child has trouble feeling happiness or love.	0	1	2	3	4	5
11 [C6] My child has trouble feeling sadness or anger.	0	1	2	3	4	5
12[D5] My child feels jumpy or startles easily, for example, when he/she hears a loud noise or when something surprises him/her.	0	1	2	3	4	5
13[D1] My child has trouble going to sleep or wakes up often during the night.	0	1	2	3	4	5
14[AF] My child feels that some part of what happened is his/her fault.	0	1	2	3	4	5

	None	Little	Some	Much	Most	Do not Know
15[C3] My child has trouble remembering important parts of what happened.	0	1	2	3	4	5
16[D3] My child has trouble concentrating or paying attention.	0	1	2	3	4	5
17[C2] My child tries to stay away from people, places, or things that make him/her remember what happened.	0	1	2	3	4	5
18[B5] When something reminds my child of what happened, he/she has strong feelings in his/her body like heart beating fast, head aches, or stomach aches.	0	1	2	3	4	5
19[C7] My child thinks that he/she will not live a long life.	0	1	2	3	4	5
20[AF] My child is afraid that the bad thing will happen again.	0	1	2	3	4	5
21[B1] My child plays games or draws pictures that are like some part of what happened.	0	1	2	3	4	5

SAMPLE

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH, THAT IS SINCE _____, DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**

S	M	T	W	H	F	S

S	M	T	W	H	F	S
	X					

S	M	T	W	H	F	S
		X			X	
		X				
			X			
		X		X		

S	M	T	W	H	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

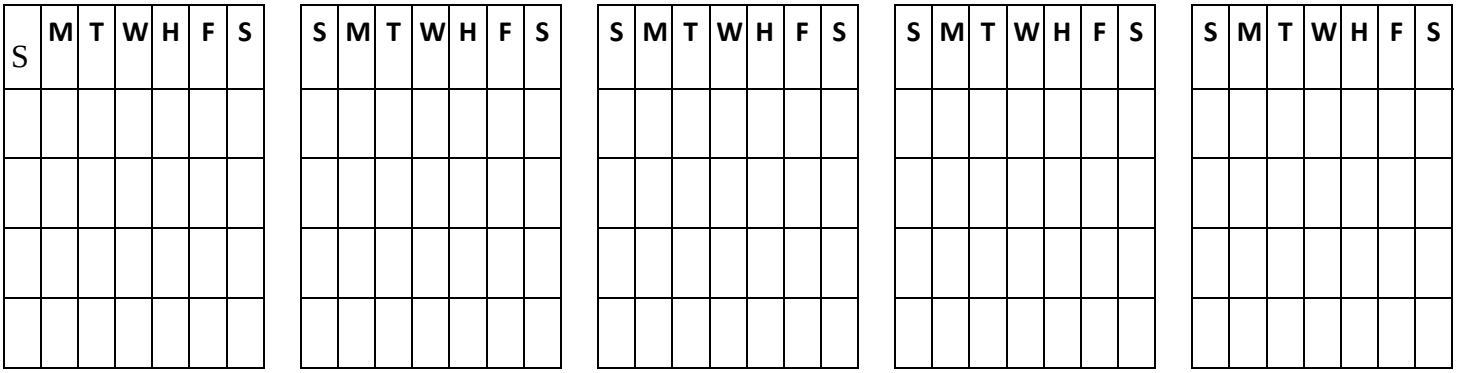
S	M	T	W	H	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

NEVER	TWO TIMES A MONTH	1-2 TIMES A WEEK	2-3 TIMES EACH WEEK	ALMOST EVERY DAY

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH, THAT IS SINCE _____, DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**



NEVER	**TWO TIMES A MONTH**	**1-2 TIMES A WEEK**	**2-3 TIMES EACH WEEK**	**ALMOST EVERY DAY**

UCLA PTSD INDEX FOR DSM-IV:

SCORING SHEETS

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: CHILD VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT **PTSD SEVERITY: OVERALL SCORE**

Exposure to Traumatic Event	**Question # /Score**	**Question # /Score**
Questions 1-13: at least 1 "Yes" answer **YES** **NO**	1._____	12._____
	2._____	13._____
Type of Traumatic Event rated as most	3._____	[Omit 14].
distressing (Question 14: write trauma	4. _____	15._____
type in the blank) _____	5._____	16._____
	6._____	17._____
Criterion A1 met	7. _____	18._____
Questions 15-21: at least 1 "Yes" answer **YES** **NO**	8. _____	19._____
	9. _____	[Omit 20].
Criterion A2 met	* 10. *or*	
Questions 22-26: at least 1 "Yes" answer **YES** **NO**	11._____	
	(Sum the items from the above 2 columns, write sum below)	
Criterion A met **YES** **NO**	**(Sum total of scores) = _____**	**PTSD SEVERITY SCORE**
Peritraumatic Dissociation **YES** **NO**	*Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____	
Question 27: answer "Yes"		

CRITERION B (REEXPERIENCING) SX. **CRITERION C (AVOIDANCE) SX.**

Question #/DSM-IV Symptom	**Score**	**Question #/DSM-IV Symptom**	**Score**
3. (B1) Intrusive recollections	_____	9. (C1) Avoiding thoughts/feelings	_____
5. (B2) Trauma/bad dreams	_____	17. (C2) Avoiding activities/people	_____
6. (B3) Flashbacks	_____ # of Criterion B	15. (C3) Forgetting	_____ # of Criterion C
2. (B4) Cues: Psychological	Questions with	7. (C4) Diminished interest etc.	_____ Questions with

reactivity _____ Score ≥ Symptom 18. (B5) Cues: Physiological Cutoff: _____ reactivity _____ **CRITERION B SEVERITY** **SCORE** (Sum of above scores): = _____ **DSM-IV CRITERION B MET**: (Diagnosis requires at least 1 "B" Symptom): **YES** **NO**	8. (C5) Detachment/estrangement _____ Scores ≥ Symptom *10. *or* 11. (C6) Affect restricted _____ Cutoff: _____ 19. (C7) Foreshort. future _____ [*Place the highest Score from either Question 10 *or* 11 in the blank above.] **CRITERION C SEVERITY** **SCORE** (Sum of above scores): = _____ **DSM-IV CRITERION C MET**: (Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

CRITERION D (INCREASED AROUSAL) SX. **DSM-IV PTSD DIAGNOSTIC INFO.**

Question #/DSM-IV Symptom **Score**	
13. (D1) Sleep problems _____ 4. (D2) Irritability/anger _____ 16. (D3) Concentration problems _____ # of Criterion D 1. (D4) Hypervigilance _____ Questions with 12. (D5) Exaggerated startle _____ Score ≥ Symptom Cutoff: _____ **CRITERION D SEVERITY** **SCORE** (Sum of above scores): = _____ **DSM-IV CRITERION D MET**: (Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**	**DSM-IV FULL PTSD DIAGNOSIS LIKELY** (Criteria A, B, C, D all met) **YES** **NO** **PARTIAL PTSD LIKELY** [Criterion A met and: Criteria (B + C) or (B + D) or (C + D)] **YES** **NO**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: ADOLESCENT VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT **PTSD SEVERITY: OVERALL SCORE**

Exposure to Traumatic Event Questions 1-13: at least 1 "Yes" answer **YES** **NO** Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____ **Criterion A1 met** Questions 15-21: at least 1 "Yes" answer **YES** **NO** **Criterion A2 met** Questions 22-26: at least 1 "Yes" answer **YES** **NO** **Criterion A met** **YES** **NO** **Peritraumatic Dissociation** **YES** **NO** Question 27: answer "Yes"	**Question # /Score** **Question # /Score** 1. _____ 12._____ 2. _____ 13._____ 3. _____ [Omit 14]. *4. *or* 15._____ 20. _____ 16._____ 5. _____ 17._____ 6. _____ 18._____ 7. _____ ***19. or 8. _____ 21._____ 9. _____ [Omit 22]. **10. *or* **(Sum total PTSD SEVERITY** 11._____ **of scores) = _____ SCORE** *Place the highest Score from either Question 4 *or* 20 in the blank above: Score Question 4.____/Score Question 20.____ **Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____ ***Place the highest Score from either Question 19 *or* 21 in the blank above: Score Question 19.____/Score Question 21.____

CRITERION B (REEXPERIENCING) SX. **CRITERION C (AVOIDANCE) SX.**

Question #/DSM-IV Symptom **Score** 3. (B1) Intrusive recollections _____ 5. (B2) Trauma/bad dreams _____ 6. (B3) Flashbacks _____ # of Criterion B	**Question #/DSM-IV Symptom** **Score** 9. (C1) Avoiding thoughts/feelings _____ 17. (C2) Avoiding activities/people _____ 15. (C3) Forgetting _____ # of Criterion C

2. (B4) Cues: Psychological reactivity _____ Questions with Score ≥ Symptom 18. (B5) Cues: Physiological reactivity _____ Cutoff: _____ **CRITERION B SEVERITY** **SCORE** (Sum of above scores): = _____ **DSM-IV CRITERION B MET**: (Diagnosis requires at least 1 "B" Symptom): **YES** **NO**	7. (C4) Diminished interest etc. _____ Questions with 8. (C5) Detachment/estrangement _____ Scores ≥ Symptom *10. *or* 11. (C6) Affect restricted _____ Cutoff: _____ **19. *or* 21. (C7) Foreshortened future _____ [*Place the highest Score from either Question 10 *or* 11 in the blank above; **Place the highest Score from either Question 19 *or* 21 in the blank above.] **CRITERION C SEVERITY** **SCORE** (Sum of above scores): = _____ **DSM-IV CRITERION C MET**: (Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

CRITERION D (INCREASED AROUSAL) SX. **DSM-IV PTSD DIAGNOSTIC INFO.**

Question #/DSM-IV Symptom **Score**	
13. (D1) Sleep problems _____ *4. *or* 20. (D2) Irritability/anger _____ 16. (D3) Concentration problems _____ # of Criterion D 1. (D4) Hypervigilance _____ Questions with 12. (D5) Exaggerated startle _____ Score ≥ Symptom Cutoff: _____ [*Place the highest Score from either Question 4 *or* 20 in the blank above.] **CRITERION D SEVERITY** **SCORE** (Sum of above scores): = _____ **DSM-IV CRITERION D MET**: (Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**	**DSM-IV FULL PTSD DIAGNOSIS LIKELY** (Criteria A, B, C, D all met) **YES** **NO** **PARTIAL PTSD LIKELY** (Criterion A met and: Criteria B + C or B + D or C + D) **YES** **NO**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: PARENT VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT **PTSD SEVERITY: OVERALL SCORE**

Exposure to Traumatic Event Questions 1-13: at least 1 "Yes" answer **YES** **NO** Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____ **Criterion A1 met** Questions 15-26: at least 1 "Yes" answer **YES** **NO** **Criterion A2 met** Questions 22-26: at least 1 "Yes" answer **YES** **NO** **Criterion A met** **YES** **NO**	**Question # /Score** **Question # /Score** 1. _____ **10 or 2. _____ 11._____ * 3 or 12._____ 21. _____ 13._____ 4. _____ [Omit 14]. 5. _____ 15._____ 6. _____ 16._____ 7. _____ 17._____ 8. _____ 18._____ 9. _____ 19._____ [Omit 20]. *(Sum the items from the above 2 columns, write sum below)* **(Sum total PTSD SEVERITY of scores)** = _____ **SCORE** *Place the highest Score from either Question 3 *or* 21 in the blank above: Score Question 3. ____/Score Question 21._____ **Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION B (REEXPERIENCING) SX. **CRITERION C (AVOIDANCE) SX.**

Question #/DSM-IV Symptom Score	Question #/DSM-IV Symptom Score
3. (B1) Intrusive recollections or ____* 21. (B1)Repetitive Traumatic Play 5. (B2) Trauma/bad dreams _____ 6. (B3) Flashbacks _____ # of Criterion B	9. (C1) Avoiding thoughts/feelings_____ 17. (C2) Avoiding activities/people_____ 15. (C3) Forgetting _____ # of Criterion C 7. (C4) Diminished interest etc. _____ Questions with 8. (C5) Detachment/estrangement _____ Scores ≥ Symptom

2. (B4) Cues: Psychological reactivity _____ Questions with Score ≥ Symptom Cutoff: _____

18. (B5) Cues: Physiological reactivity _____

*Place the highest Score from either Question 3 or 21 in the blank above: Score Question 3 (Intrusive recollections) _____

Score Question 21(Repetitive play) _____

CRITERION B SEVERITY

SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:

(Diagnosis requires at least 1 "B" Symptom): **YES** **NO**

*10. *or* 11. (C6) Affect restricted _____ Cutoff: _____

19. (C7) Foreshortened future _____

CRITERION C SEVERITY

SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:

(Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

*Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION D (INCREASED AROUSAL) SX. **DSM-IV PTSD DIAGNOSTIC INFO.**

Question #/DSM-IV Symptom Score

13. (D1) Sleep problems _____

4. (D2) Irritability/anger _____

16. (D3) Concentration problems_____ # of Criterion D

1. (D4) Hypervigilance _____ Questions with

12. (D5) Exaggerated startle _____ Score ≥ Symptom Cutoff: _____

CRITERION D SEVERITY

SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:

(Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**

DSM-IV FULL PTSD DIAGNOSIS LIKELY

(Criteria A, B, C, D all met) **YES** **NO**

PARTIAL PTSD LIKELY

(Criterion A met and:

Criteria B + C or B + D or C + D) **YES** **NO**

Sample TF-CBT Treatment Plan

Participant Information	**Provider Information**
Name: Jane Doe	Therapist: John Smith, MSW, LCSW
MO HealthNet Number: ########	Group NPI Number: ##########
DOB: ##/##/####	Treatment Plan Date: ##/##/####

Other Agencies Involved:	**Plan to Coordinate Services:**
-Missouri Children's Division	Therapist will coordinate services with Jane's caseworker as appropriate.

Diagnosis:

Axis I:	309.81	PTSD, chronic
Axis II:	V71.09	No diagnosis
Axis III:	V71.09	No diagnosis
Axis IV:		Problems with primary support group, problems related to social environment
Axis V:	Current CGAS=50	

Justification for Diagnosis Change: (omit if Initial Treatment Plan)

1. **Problem/Symptom:** Jane presents with clinically significant symptoms of Posttraumatic Stress Disorder.

Long Term Goal: Jane will experience a clinically significant reduction in PTSD symptoms as demonstrated by day-to-day functioning and results on assessment measures.

Anticipated completion date: ##/##/####

Current Goals/Objectives: (Add more as needed)	**Date Established**	**Projected Completion Date**	**Date Achieved**
1. Jane will demonstrate accurate and healthy knowledge about trauma & PTSD as evidenced by the retention of at least 50% of this information when quizzed.			
2. Jane will be able to recognize and talk about some of the ways that stress/trauma has affected his life.			
3. Ms. Doe, Jane's grandmother, will implement a behavior management system at home such as a reinforcement chart or time out.			
4. Ms. Doe will learn skills and knowledge (i.e., relaxation, psychoeducation, affect regulation, active listening, cognitive coping and processing, safety skills) in parallel sessions and will demonstrate mastery in joint sessions with the client.			
5. Jane will learn and successfully practice at least two relaxation techniques in session and report successful practice outside of session at least once a week for two weeks.			
6. Jane will be able to identify and rate her the intensity of her emotions and explain the meaning of at least seven emotion words			
7. Jane will be able to verbalize ways in which feelings are experience physiologically in his body.			
8. Jane will be able to explain the relationship between thoughts, emotions, and feelings and give one example of how the three are related.			
9. Jane will write a first draft of her trauma narrative			
10. Jane will revise her trauma narrative to include additional details			
11. Jane will revise her trauma narrative to include her thoughts and feelings			
12. Jane will use cognitive processing to modify and distortions identified via her trauma narrative. She will report more accurate and/or more helpful beliefs			
13. Jane will process memories of previous traumatic experiences and will demonstrate significantly reduced distress during this activity (as measured by SUD).			
14. Jane will report knowing behaviors and information to enhance her future safety.			
15. Jane reports significant improvement in her day-to-day functioning at home, school, and in the community, which is confirmed by her Ms. Does and/or caseworker and is evident more times than not.			
16. Jane comes up with and implements effective ways to deal with problems more times than not. Jane talks to other people respectfully and explains her own point of view successfully more times than not.			

Intervention/Action	Responsible Person(s)	1. John Smith, MSW, LCSW

Psychoeducation about trauma		
	2.	3.
Intervention/actions: Distress tolerance training	Responsible Person(s):	1. John Smith, MSW, LCSW
	2.	3.
Intervention/actions: Gradual exposure to traumatic experiences	Responsible Person(s):	1. John Smith, MSW, LCSW
	2.	3.
Intervention/actions: Cognitive processing/restructuring	Responsible Person(s):	1. John Smith, MSW, LCSW
	2.	3.

Review Date:	**Progress:** (omit if Initial Treatment Plan)
Review Date:	**Progress:**

Involvement of Family: Jane's grandmother, Ms. Doe, is actively involved in Jane's treatment.

Services Needed beyond scope of organization or program: N/A

Estimated Completion date for level of care: ##/##/####

Therapist Signature:	Date:

Therapist Name/Title: (Print) John Smith, MSW, LCSW

TF-CBT Fidelity Checklist

***Modality**

Individual session with child: IC

Individual session with parent: IP

Conjoint session with client and parent(s): con

Family Session: FS

TF-CBT Techniques	Session Dates	*Modality	Notes
a. Psychoeducation			
b. Parenting Skills			
c. Relaxation			
d. Affective Expression and Regulation			
e. Cognitive Coping and Processing			
f. Trauma Narrative			
g. Traumatic Grief			
h. In Vivo Exposure			
i. Conjoint Parent-Child Treatment			
j. Enhanced Safety Skills			

TF-CBT Tracking Form-Treatment Steps

Treatment Phases	Date	Crisis of the Week	Homework/Modality	Notes/Suggestions
Parenting/Behavior Management o Behavioral problems o Id specific problem o Modeled how to praise o Taught active ignoring o Role played strategies o Systematically measured goals				
Psychoeducation about trauma o Others experience trauma o Provided info about post trauma o Talked about who perpetrates o Provided "fact sheet" o Assessed client's understanding o Reviewed information o Played psychoeducation game				
Emotion Id and expression o Talk about feelings to assess skill o Expand feelings vocab o Improve expression of feelings o Identified physiological response o Worked w/caregiver to prepare for further support				
Coping skills (regulation) o Mindfulness o Grounding o Deep breathing o Muscle relaxation o Guided meditation o Thought stopping o Positive self-talk o Had client use own strategy o Had youth teach caregiver				
Cognitive Coping o Taught cognitive triangle o Provided relevant examples o Practiced scenarios o Explained cognitive distortions o Taught caregiver cognitive triangle o Helped caregiver id thoughts o Coping statements with caregiver				

TF-CBT Supervisor's Clinical Adherence Checklist

Therapist: _____ Session date: _____ TF-CBT session number: ___

Indicate whether component was addressed in given session and estimate the level of skill in adherence to each component.

Skill rating: (-) = needs improvement; (0)= adequately addressed; (+)= addressed with enhances skill or creativity.

Please use comments section when scoring at (-) or (+) level.

This session was with (circle): Parent Child Conjoint parent/child

TF-CBT Component	Demo Y / N		Skill Rating: (-)	(0)	(+)	Comments:
(P) Psychoeducation: about TF-CBT model, about abuse, typical reactions, normalizing reactions, safety skills, healthy sexuality						
Parenting Skills: responding to behavior (praise, active ignoring, quiet time, etc.), effective communication						
(R) Relaxation Skills: focused & deep breathing, mindfulness, muscle relaxation						
(A) Affective Expression & Regulation: feelings vocabulary, identification, expression and management						
(C) Cognitive Coping & Processing: cognitive triangle, skills for (+) vs.(-) focus on events, ID and correct inaccurate attributions, self/world view, (+) self-talk, learned optimism, distraction techniques, coping with feelings						

TF-CBT Supervisee Rating Form

Please rate your supervisor on each of the items below using the following scale:

1	2	3	4	5
Not at all	**A little/rarely**	**Somewhat**	**Often**	**Almost Always**

Please circle the appropriate number on the right.

1.	My supervisor effectively helps me identify children for whom TF-CBT would be a good fit.	1	2	3	4	5
2.	My supervisor encourages me to directly discuss traumatic experiences with children in treatment sessions.	1	2	3	4	5
3.	My supervisor helps me prioritize which trauma to address for children who have experienced multiple types of traumatic events.	1	2	3	4	5
4.	My supervisor helps me implement TF-CBT in culturally competent ways and for culturally diverse clients.	1	2	3	4	5
5.	My supervisor helps me prioritize problems with families that have multiple problems and crises.	1	2	3	4	5
6.	My supervisor is able to provide me with several alternative ways of implementing each of the TF-CBT components.	1	2	3	4	5
7.	My supervisor is able to structure and process group supervision effectively.	1	2	3	4	5
8.	My supervisor is skillful at balancing issues of flexibility and fidelity to the TF-CBT treatment protocol.	1	2	3	4	5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POINTS TO MAKE WHEN EDUCATING CHILDREN AND FAMILIES AND TRAUMA AND TF-CBT

- The child is having significant PTSD or other trauma-related symptoms (e.g., depression, anxiety, sexual behavior problems based on the clinical assessment that has been completed prior to treatment initiation).
- Clinical experience and research both suggest that these PTSD and other trauma-related symptoms need to be addressed as early as possible to prevent long-term difficulties.
- Talking directly about the trauma is important in resolving these difficulties and integrating the experience into the child's life in an optimal way (e.g., similar to taking out a splinter or cleaning a wound).
- This component will be implemented in a gradual, supportive manner so that the child will be able to tolerate the discomfort associated with such discussion; furthermore, it will typically not be initiated until the child has learned some skills to help him/her cope with the discomfort.
- The therapist will work in collaboration with the caregiver throughout treatment, and the therapist welcomes the caregiver's suggestions at any time.

  People of different religions, ethnicities, and cultures have different ways of expressing and dealing with trauma responses; the therapist is eager to learn from

  the child and caregiver the traditions of their culture, religion, and family and will remain respectful of these in the treatment process.

How Stress and PTSD Affect Our Bodies

Stress and trauma can affect us by stimulating the production of chemicals and causing changes in our brains. The good news is that all of these effects can be reduced through the use of relaxation.

The *amygdala* is responsible for assigning emotional meaning to the things we hear, see, smell, and feel. Trauma can cause the *amygdala* to start giving more emotional meaning to things. For example, after a traumatic event, things that we usually would not see as being scary are now labeled scary by the *amygdala*.

The *prefrontal cortex* is responsible for extinguishing learned fear responses. However, trauma can cause the *prefrontal cortex* to become less active, which makes it harder to get over things that scared us in the past, even when there is no more danger.

In response to stress, the brain increases production of the neurotransmitter *norepinephrine* (also called *noradrenaline*), which leads to an increased presence of *epinephrine* (also called *adrenaline)*. Increased levels of *cortisol* and *epinephrine* lead to:

- Increased heart rate
- Pounding heart
- Shortness of breath
- Sweating
- Weakness, dizziness
- Muscle tension
- Stomach upset
- Skin rashes
- Fight, flight, or freeze response

Also in response to stress, the *hypothalamus* produces a chemical called CRF. CRF stimulates the *pituitary gland* to release a chemical called ACTH. ACTH then acts on the *adrenal glands* to increase the production of *cortisol.*

Cortisol stops the brain from doing a lot of things. This can be good in the moment of crisis, but *cortisol* is bad news at all other times. People who have experienced severe traumas often have *cortisol* levels higher than the rest of us. It is believed that effective treatment for the trauma and increases in life stability can restore normal *cortisol* levels.

TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY

DOMESTIC VIOLENCE INFORMATION FOR CAREGIVERS

WHAT IS DOMESTIC VIOLENCE?

Domestic violence is a pattern of control over the behavior, emotions, and choices of a partner. The methods of control can include physical abuse, sexual abuse, psychological abuse, financial abuse, social restrictions, and the destruction of property and/or family pets. Other terms that are often used when referring to domestic violence include, but are not limited to, *spouse abuse, intimate partner violence,* and *battering*. Regardless of the term used, domestic violence is a social problem where one's property, health, or life is endangered as a result of the intentional behavior of a partner. Current estimates are that in heterosexual relationships, domestic violence is most frequently committed by men against women. Domestic violence is as frequent in gay and lesbian relationships as in heterosexual ones. Domestic violence is also believed to be largely unreported.

WHAT ARE THE EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN?

Being exposed to domestic violence affects children's emotional, developmental and physical well-being. These children are more likely to be abused themselves, may be caught in harm's way during a violent episode and be inadvertently injured, may experience behavioral problems related to anger, aggression, and oppositional behaviors, and are more likely to experience depression and anxiety than other children. They also tend to spend less time with their friends and are less likely to have a best friend. At school, children exposed to domestic violence may present with elevated rates of behavior problems, hyperactivity, social withdrawal and learning difficulties.

Many of these children develop symptoms of posttraumatic stress disorder (PTSD) due to exposure to domestic violence. These symptoms include, but are not

limited to, distressing memories and/or nightmares of the violence; efforts to avoid thoughts, feelings, or conversations that may remind them of the violence; diminished interest in activities that were once pleasurable; social isolation; difficulty falling or staying asleep; difficulty concentrating; and anger outbursts.

Children exposed to domestic violence are also at a higher risk of being exposed to other forms of abuse. It is currently estimated that 50% of perpetrators who abuse their spouses also abuse their children. These children have also been found to be at a higher risk of being emotionally abused and sexually abused than other children.

Exposure to domestic violence may also cause other long-term effects such as an increased risk of entering the juvenile justice system, attempting suicide, committing sexual assault crimes, and abusing drugs and alcohol. There is also an increased risk of becoming victims of abuse as adults and of developing distorted belief systems in regard to relationships, personal responsibility, violence and aggression, and sex-role expectations.

Every child responds to domestic violence exposure differently due to the influence of such characteristics as age, length of time the abuse had occurred, frequency and severity of the abuse, the child's relationship with the abuser, type of abuse, support system available to the child, and the child's overall resiliency and vulnerability.

HOW COMMON IS DOMESTIC VIOLENCE?

Domestic violence occurs across all races, religions, ethnicities, and economic groups. It is estimated that more than 1 million women are victims of domestic violence every year, with a high percentage of these assaults being witnessed by one or more children. In other words, more than 3 million American children are exposed to domestic violence each year.

WHAT ARE SOME COMMON BEHAVIORAL SYMPTOMS OF A CHILD WHO HAS BEEN EXPOSED TO DOMESTIC VIOLENCE?

- Bullying, physical aggressiveness, and insulting behavior toward peers.
- Withdrawal from peers and social contacts, and overall poor peer relationships.
- Difficulty separating, especially from the battered caregiver.

- Oppositional and defiant behaviors with authority figures, especially with the battered caregiver.
- Increased verbal aggressiveness/talking back.
- Bed-wetting, daytime “accidents,” “baby talk,” or other regressive behaviors.
- Difficulty focusing and learning while at school.
- Loss of appetite or changes in eating patterns.
- Failure to thrive in infants.
- Nightmares, insomnia, or other sleep problems.
- Increased violent behavior toward siblings and peers.
- Running away from home.
- Role reversal: taking on caregiver role.

WHAT ARE SOME BEHAVIORAL SYMPTOMS IN PRETEENS AND TEENAGERS WHO HAVE BEEN EXPOSED TO DOMESTIC VIOLENCE?

- Physically, verbally, or sexually abusing their dating partners.
- Being victimized physically, verbally, or sexually *by* their dating partners.
- Violence toward the battered caregiver/imitating words and behaviors of the abuser.
- Acting as the battered caregiver’s “protector.”
- Drug and/or alcohol abuse.
- Poor peer relationships and choices.

WHAT ARE SOME EMOTIONAL SYMPTOMS OF EXPOSURE TO DOMESTIC VIOLENCE?

- Increased nervousness, anxiety, and fear.
- Depressed mood and suicidal thoughts.
- Insecurity.
- Feeling responsible for protecting the battered caregiver and siblings.
- Excessive worry about the safety of others.
- Embarrassment (not wanting peers to be aware of family violence).
- Resentment toward the battered caregiver and siblings.
- Fear of day-to-day arguments.
- Fantasies of standing up to, or hurting, the abuser.
- Confusion regarding “loyalty” to both the abusive and abused caregiver.

WHO PERPETRATES DOMESTIC VIOLENCE?

A perpetrator or "batterer" is a person who exercises a pattern of coercive control in a partner relationship, with one or more acts of intimidating physical violence, sexual assault, or threatening physical violence. This pattern may be manifested in the form of psychological control, economic control, sexual coercion, or primarily through physical violence. Although there are batterers in both sexes, most are male. Even though the batterer may be violent only toward his (or her) partner, he (or she) is also the person responsible for exposing the child to the violence. Battering is not due to impulse control problems, drinking problems, or anger management problems. It is a problem of intentional, repeated coercive controlling behavior that one partner exerts over the other in an intimate relationship. For this reason, anger management, Alcoholics Anonymous, or couple therapy are not the appropriate treatments to stop domestic violence.

HOW CAN I HELP MY CHILD?

- Tell him/her that abusive behavior is wrong.
- Reassure your child that none of the violent episodes were in any way his/her fault.
- Remind your child how much you love him/her.
- Develop a safety plan to prepare for crisis situations.
- Encourage your child to talk about his/her feelings.
- Prepare to get extra help for your child's schooling.
- Seek help from a mental health professional.

TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY

DOMESTIC VIOLENCE INFORMATION FOR CHILDREN

WHAT DOES DOMESTIC VIOLENCE MEAN?

Domestic violence means that one adult family member is hurting another family member. This "hurt" can occur when an adult pushes, shoves, hits, slaps, punches, or uses objects to hurt another family member. The hurting can also occur through name calling, not allowing someone to do what he/she wants, making a person do things that he/she doesn't want to, and by threatening to push hit, slap, or even kill the person. This can all seem very scary, but the most important thing to remember is that when adults fight, it is *never* the child's fault. Children cannot stop the fighting between the adults in their home, no matter how good they are.

ARE THERE A LOT OF KIDS WHO WITNESS DOMESTIC VIOLENCE IN THEIR HOMES?

Yes. More than 3 million kids see this violence in their homes every year. This means that there are lots of children who see and hear adult family members hurting one another.

WHAT CAN KIDS DO TO HELP THEMSELVES WHEN THEY WITNESS THIS KIND OF VIOLENCE IN THEIR HOMES?

1. When there is no fighting, they can talk to their caregivers about how it feels when one caregiver hurts another.
2. Plan with their caregivers to have a "safe" house or place where they can go when their caregivers are fighting.
3. Come up with a safety plan with the battered caregiver in case of emergencies.
4. Talk to a grandparent, aunt or uncle, a grown-up friend, a friend's parents, or a family helper about how they feel when their parents fight.
5. Draw pictures of what they are feeling.

6. Do things that make them happy, such as reading favorite books, playing board games or video games, watching TV shows, and talking to friends on the phone (or visiting them).
7. Remember that they are not the reason one caregiver is abusing the other.

WHAT CAN KIDS DO IF THEY ARE FEELING UNHAPPY OR SCARED, EVEN IF THEY NO LONGER LIVE WITH THE PERSON WHO WAS VIOLENT TO THEIR ABUSED CAREGIVER?

1. Talk to the abused caregiver or other trusted adult about how it feels when they saw or heard the violence in their home.
2. Talk to the abused caregiver or other trusted adult about what it feels like now that things are different, even if the feelings are confusing.
3. Talk to a family helper about all of these confusing feelings.
4. Do things to help them feel happy, such as drawing, reading, coloring, playing board games, playing video games, watching TV, playing sports, and spending time with family and friends.
5. Remember that no matter what happened between their caregivers, it was *not* their fault.

CHILD PHYSICAL ABUSE INFORMATION FOR CAREGIVERS

WHAT IS CHILD PHYSICAL ABUSE?

The National Center on Child Abuse and Neglect defines child physical abuse as the physical injury of a child by a person responsible for the child's welfare. The most common ways children experience physical abuse are by being beaten, being burned, being thrown, and being shaken. But the number of ways children are injured by adults is unlimited. It can involve things like being locked in a cage or being forced to eat feces.

WHAT ARE THE EFFECTS OF CHILD PHYSICAL ABUSE?

Many studies have attempted to understand the effects of child physical abuse on children. The most consistent finding is that children who experience physical abuse are at risk of becoming aggressive toward others and developing conduct problems. Children who have experienced physical abuse are more likely to have problems taking the perspective of another child (empathy), are more likely than other children to see hostile intent in other people's actions, and have a harder time developing alternatives to fighting. Children who have experienced physical abuse are also of greater risk of developing problems like anxiety or depression. Some of these children may develop problems in behavior and in feelings.

HOW COMMON IS CHILD PHYSICAL ABUSE?

Estimates of child physical abuse range from 1.5 kids per 1000 to 2.5 kids per 1000 being physically abused each year. This may sound like a small number, but it translates to millions of children who experience physical abuse in their lifetimes.

WHO PHYSICALLY ABUSES CHILDREN?

It is not possible to predict who is going to physically abuse a child because the causes of child physical abuse are many. Children who grow up in families where there is a lot of stress, substance abuse, psychiatric problems and other forms of violence are at risk of being physically abused. We know that homes where a parent is being abused by a domestic partner are particularly risky places for children to also be abused. When there is physical abuse going on in a home, there are often other problems. People who physically abuse children are often not skilled at nurturing, loving and stimulating.

Parents who abuse children may be poor at understanding a child's intentions. For example, they may assume children wet the bed, cry or ask for attention because they are trying to annoy the adult. Other parents who maltreat may have misguided views of what is helpful to the child, assuming that physical abuse will teach a child a lesson. The lesson it often teaches is to be afraid of adults.

HOW CAN I HELP MY CHILD WHO HAS BEEN PHYSICALLY ABUSED?

- Tell him/her that abusive behavior is wrong.
- Reassure your child that none of the physical abuse was in any way his/her fault.
- Remind your child how much you love him/her.
- Develop a safety plan to keep your child away from adults who have been abusive or when these adults are at greater risk of abusing your child.
- Encourage your child to talk about his/her feelings.
- Prepare to get extra help for your child's schooling.
- Seek help from a mental health professional.

TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY

CHILD PHYSICAL ABUSE INFORMATION FOR CHILDREN

WHAT DOES PHYSICAL ABUSE MEAN?

Physical abuse means that an adult who is supposed to care for and protect a child injures that child by beating the child, burning the child, throwing the child, shaking the child or hurting them in some other way.

ARE THERE A LOT OF KIDS WHO ARE PHYSICALLY ABUSED?

Yes. Hundreds of thousands of children are physically abused each year.

WHAT CAN KIDS WHO LIVE WITH PEOPLE WHO ABUSE THEM DO?

1. They can talk to an adult that they trust and who doesn't hurt children about what has happened to them and how they feel.
2. Call 911 if they are in danger.
3. Plan with their caregivers to have a "safe" house or place they can go when someone in their home is angry and may want to hurt a child.
4. Draw pictures of what they are feeling.
5. Do things that make them happy, such as reading favorite books, playing board games or video games, watching TV shows, and talking to friends on the phone (or visiting them).
6. Remember that they are not the reason that they have been hurt.

WHAT CAN KIDS DO IF THEY ARE FEELING UNHAPPY OR SCARED, EVEN IF THEY NO LONGER LIVE WITH THE PERSON WHO ABUSED THEM?

1. Talk to a trusted adult about how it felt to live in a place that was unsafe.
2. Talk to a trusted adult about what it feels like now that things are different, even if the feelings are confusing.
3. Talk to a family helper about all of these confusing feelings.

4. Do things to help them feel happy, such as drawing, reading, coloring, playing board games, playing video games, watching TV, playing sports, and spending time with family and friends.
5. Remember that no matter what happened between their caregivers, it was *not* their fault.

TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY

CHILD SEXUAL ABUSE INFORMATION FOR CAREGIVERS

WHAT IS CHILD SEXUAL ABUSE?

Child sexual abuse is often defined as contacts or interactions between a child and an adult in which the child is used for the sexual gratification of the offender or another person. Sexual abuse may also be committed by a person under the age of 18 when the person is either significantly older than the child or is in a position of power or control over that child. Most often, sexual abuse involves some direct physical contact—e.g., sexualized touching and/or kissing; fondling; rubbing, and/or fondling, rubbing, and/or penetration of the vagina or anus with the fingers; oral sex; and simulated intercourse or penile penetration of the vagina or anus. Some sex offenders gratify themselves by exhibiting their genitals to a child or by observing or filming a child removing his or her own clothes.

Children are often engaged in these sexually abusive activities by playful coaxing (e.g., "This will be our special secret…") or bribed with offers of money, candy, and favors. Sometimes they are bullied or threatened. On some less frequent occasions, physical force or violence may be used. It is important to remember that whether or not the child is actually "hurt," whether or not the child objects, and whether or not the child likes it, such sexual engagement by an adult or a coercive older child is considered to be child sexual abuse.

WHAT ARE THE CONSEQUENCES WHEN CHILDREN EXPERIENCE SEXUAL ABUSE?

Children who have endured sexual abuse may experience a wide range of emotional and/or behavioral reactions to the abuse. The nature and severity of these difficulties may depend upon the age of the child, the identity of the offender, the circumstances of the abuse, and the family's reaction to the child's disclosure. Children may exhibit symptoms indicative of anxiety and distress, such as wetting the bed, withdrawn or acting-out behavior, nightmares, difficulty in school, and running away. These

difficulties are similar to the problems exhibited by children who have experienced any kind of trauma. Children may also exhibit symptoms that are more specific to sexual abuse, such as repetitive sexual talk and play, age-inappropriate sexual behavior and fears of specific situations or people that remind them of the abuse. Additionally, some children do not exhibit any apparent difficulties as a result of their traumatic experience.

Once the abuse has been disclosed and stopped, some children return to relatively normal behavior and emotions. The support and protection of people close to them are very important in helping them get back to normal. However, some children have symptoms that persist long after the abuse itself has ended. In fact, a significant number of children who have experienced sexual abuse exhibit posttraumatic stress symptoms. Therefore, it is important for a child who has experienced sexual abuse to receive a psychological evaluation and, if necessary, treatment.

WHAT KIND OF TREATMENT IS AVAILABLE FOR CHILDREN WHO HAVE EXPERIENCED SEXUAL ABUSE?

Many therapy formats have been used to help children overcome the effects of sexual abuse. These include individual, family and group therapy formats. The therapy techniques used have been derived from a wide range of psychological theories, including psychodynamic, behavioral, cognitive, insight-oriented, structural and strategic theories of family therapy. There has been only limited research regarding the effectiveness of these varying approaches in assisting children to deal with the difficulties they experience as a result of sexual abuse. However, there is considerable research indicating that cognitive-behavioral therapy, applied in both individual and group settings, effectively decreases the problems experienced in the aftermath of sexual abuse.

Cognitive-behavioral interventions have been successful in helping children who have been sexually abused as well as their non-offending caregivers. The cognitive-behavioral therapist may help non-offending caregivers cope with their own thoughts and feelings about their child's abuse. At the same time, they teach caregiver skills that help caregivers respond more effectively to their children's disclosures and abuse-related difficulties. Cognitive-behavioral interventions are individually tailored to target the particular child's difficulties and include educational, coping skills, and processing exercises. *Processing* exercises encourage children to

confront memories, thoughts, and everyday reminders (e.g., bathrooms, sleeping alone, undressing, showering) of the abuse in a graduated fashion over time. Discussion, doll play, drawing, reading, writing, poetry, singing, etc., may be used in the process. By reducing the anxiety associated with abuse-related discussion, these therapy activities help children who have experienced sexual abuse to express their thoughts and feelings more openly, thereby enhancing their understanding and emotional processing of the abusive experience(s).

Finally, it is important for caregivers to know that the research in the field of child sexual abuse has repeatedly demonstrated that the most important factor influencing children's psychological adjustment following sexual abuse is the degree of support they receive from caregivers and other adults. With strong emotional support from caring adults and effective medical and mental health intervention, children who have experienced sexual abuse can look forward to healthy, satisfying and fulfilling futures.

WHO IS SEXUALLY ABUSED?

Child sexual abuse cuts across all social classes and racial and religious groups. Both boys and girls are victimized, and it is not a very rare occurrence. Our best estimates suggest that, by the age of 18, one of every four females and one of every seven males have been subjected to some form of sexual abuse.

WHO SEXUALLY ABUSES CHILDREN?

Although a small percentage of sex offenders are women, the majority are male. Sex offenders are generally *not* "dirty old men" or strangers lurking in alleys. They usually are not obviously mentally ill or retarded. In fact, sex offenders are often well known and trusted by the children they abuse. Offenders are often family members (e.g., cousin, uncle, parent, stepparent, grandparent) or individuals who are unrelated but well known to the child (e.g., a neighbor, coach, babysitter). There is no clear cut description or profile for a sex offender, and there is no way to recognize a potential abuser. For this reason, it is often hard to believe that a trusted individual would be capable of sexually abusing children.

Some offenders have been sexually abused themselves as children. Others have suffered other forms of abuse and neglect in childhood. Some may be unable to function sexually with adult partners and may have many different encounters with

children. Others are able to maintain sexual relationships with adults, but may turn to children for gratification during times of stress. A small percentage of offenders sexually abuse children while the offender is under the influence of drugs or alcohol.

WHY DOES SEXUAL ABUSE OCCUR?

Although the question as to why sexual abuse occurs is frequently asked by children and their caretakers, there is no simple answer. *The main point to remember is that children and adolescents who have experienced sexual abuse and their non-offending caregivers are not to blame.* The responsibility for sexual abuse rests squarely on the shoulders of the sex offender, regardless of the problems which may have contributed to his/her abusive behavior.

Our society is generally uncomfortable with sexuality and has made limited efforts to prevent child sexual abuse; these attitudes may also be responsible for keeping the problem hidden for so long. For this reason, it is essential that we communicate our concerns about child sexual abuse clearly and openly. As a society, we must become more aware of the seriousness and prevalence of the problem, and we must increase our present efforts to address this problem worldwide.

WHY DO NOT CHILDREN TELL US WHAT'S HAPPENING?

Child sexual abuse is, by its very nature, secretive. It almost always occurs when a child is alone with an offender. In order for the sexual activity to continue, offenders rely on the children to keep the secret. There may be direct threats of physical harm to the children and/or to their pets, family members, etc., if they tell. Often children are led to believe that the abuse is their own fault and that they will be blamed, rejected or disbelieved if they tell. They feel embarrassed, ashamed, and fearful about the abuse as well as the secrecy. In fact, many children who have experienced sexual abuse grow to adulthood without ever telling anyone because they fear rejection, punishment, or retaliation.

WHEN SHOULD YOU SUSPECT CHILD SEXUAL ABUSE?

Because of the secretive nature and wide range of behavioral reactions of children, child sexual abuse is a difficult problem to detect. Children who have been sexually abused, however, are most often identified as a result of their own

accidental or purposeful disclosures. Some children accidentally reveal their abuse by exhibiting adult-like sexual behaviors or by sharing sexual knowledge that is beyond their years. Some children may make a vague disclosure or tell a friend who then tells an adult. Caregivers should be aware of sudden changes in behavior: nightmares, withdrawal, avoidance of particular persons, places, or things, unusual aggressiveness, jumpiness, and/or inappropriate sexual behavior. These behaviors may suggest the presence of a wide range of possible traumatic difficulties that need to be explored.

Children's reactions to the person who abuses them are quite varied. One cannot determine if sexual abuse is occurring by observing the child and alleged offender together. Some children are fearful and/or avoid their offenders; others talk very negatively about the offender but behave positively to him/her. Still others remain very attached and loving to an offending parent or caretaker. Whether they are positive, negative, or ambivalent, the child's feelings toward the offender should be accepted. Children need to know that none of their feelings are wrong.

Teaching your child personal safety skills and maintaining open lines of communication within the family may increase the likelihood that your child would disclose sexual abuse and/or other traumatic childhood experiences, if experienced.

HOW CAN YOU REDUCE A CHILD'S RISK OF SEXUAL VICTIMIZATION?

In general, it is important to maintain open lines of communication with children. Specifically, children should receive age-appropriate sex education as well as information about sexual abuse. Just as we teach our children about fire prevention, we also need to teach them about child sexual abuse. Children should be taught, in a matter-of-fact way, that their bodies belong to them and that they have the right to say "no" to a "not OK" touch. They need to be taught that they can tell an adult about any touching that makes them feel uncomfortable or that they think is "not OK." In addition, children and adolescents can be taught how to make safe decisions about where they go and what they do when there is no parental or adult supervision.

It is important to remember, however, that it may be extremely difficult for a child or an adolescent to stop, or tell about, sexual abuse. Therefore, *a child or adolescent should never be blamed for not stopping the abuse from happening or for waiting a while*

before telling about it. Many children never tell, and most children do not tell the right way.

HOW SHOULD YOU RESPOND IF YOU SUSPECT CHILD SEXUAL ABUSE?

It is natural for caregivers to feel quite distressed upon discovering that their child may have been sexually abused. However, the most important action to take as a caregiver is to *try to remain calm.* Children, including adolescents, are very sensitive to caregiver emotional reactions, and if they see or feel how upset or angry you are, they may be very frightened and "clam up." You want to convey to your child that it is good that he/she has told you. If you cannot question your child calmly by yourself, it is better to wait for help from a professional. Be careful not to say anything that sounds like you blame him/her, and be sure to emphasize that the abuse is not his or her fault. Some children report that the sexual contact felt good. This does *not* mean that the child is, in any way, to blame or that the child should feel guilty for having enjoyed the sexual interaction and/or the offender's attention. Sometimes children who have been victimized may even initiate sexual behavior with other adults. However, it is *always* the *adult's responsibility* to set appropriate limits.

Do not encourage your child to "forget about it" and shut off the conversation. On the other hand, it is not helpful to push the child beyond what he/she is ready to say. Just be open to whatever your child can tell you and to any questions he/she may ask. Try to understand that the child may have mixed feelings about the offender and what has happened. Although you may feel like keeping your child at your side continually for protection, it is important that you not be overly restrictive and that you help your family return to as normal a routine as possible. It is also important not to be afraid to show your child your normal expressions of affection and physical closeness. Sometimes this is difficult, especially for non-abusive fathers. But you do not want to give the child the impression that your feelings about him/her have changed because of what has happened.

Children who may have been sexually abused should undergo a specialized physical examination that includes the genital area. Although children may feel hurt by the sexual abuse, their bodies usually remain unchanged. Well-trained physicians can reassure children that their bodies are OK.

WHERE SHOULD YOU GO FOR HELP?

Anyone who suspects that a child has been sexually abused should contact the child protection agency in his/her state. Most states have a 24-hour toll-free number for this purpose. (Here is a link to the Child Welfare Information Gateway's website, which lists child abuse reporting numbers by state: http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172). You may remain anonymous, but the caseworker will ask you important questions about the child, the possible offender, and the circumstances. The agency will most likely investigate the sexual abuse allegations and provide guidance and help to the child and family.

TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY

CHILD SEXUAL ABUSE INFORMATION FOR CHILDREN

WHAT IS CHILD SEXUAL ABUSE?

Child sexual abuse occurs when an adult or older child touches or rubs and child's private parts (penis, testicles, vagina, bottom, breasts), or when an adult or older child asks a child to touch the other person's private parts. This kind of touching is **not OK**. The person who does this is called a sex offender. The offender might make the child do these things and be rough, or he/she might pretend it is a game or even give the child a reward to do it. The offender could be someone known to the child—a relative, a family friend, a teenager, or another child. Still, it is not OK even if the person tries to make it fun, and the child thinks it is fun.

WHO IS SEXUALLY ABUSED?

Sexual abuse happens to a lot of children. It can happen to boys and girls of all ages, religions and races. Some children who have been sexually abused are rich, some are poor, and they are all from different neighborhoods. By the age of 18, one of every four girls and one of every seven boys may have experienced sexual abuse.

WHO SEXUALLY ABUSES CHILDREN?

Some people sexually abuse children, but many more people only touch children with *not* OK touches. Most sex offenders are men, though some are women. Children cannot tell by the way these people look, dress, or act that they are offenders. Most of the time, the offender is not a stranger but someone whom the child knows very well. The offender could be a family member (such as a cousin, uncle, parent, or grandparent) or someone who is well known to the child (such as a coach, babysitter, or neighbor).

WHY DON'T CHILDREN TELL?

Sometimes the offender tells the child to keep the not OK touching a secret. The offender may use tricks to keep the child from telling. The person may say that it is the child's fault or that the child or his/her family will get hurt if the child tells. These are all tricks. Sometimes children just keep it a secret because they feel ashamed, embarrassed, or scared. For those reasons, many children do not tell about sexual abuse or they take a little while to gain the courage to tell. It helps the children to keep telling adults until they find an adult who will help them to stop the sexual abuse.

WHY DOES SEXUAL ABUSE HAPPEN?

There are a lot of different reasons, just like there are lots of different offenders. But it is very hard to know the reason why it happens to any child. We do know this much: No child is responsible for what an adult does.

HOW CAN YOU TELL THAT A CHILD HAS BEEN SEXUALLY ABUSED?

You cannot tell by looking at a child that he/she has been sexually abused. Sometimes you can tell by the way the child is acting that something is bothering him/her, but you do not know what it is. That is why it is so important for children to tell somebody when they experience a not OK or confusing touch.

HOW DO CHILDREN FEEL WHEN THEY HAVE BEEN SEXUALLY ABUSED?

Children may have all kinds of feelings in response to sexual abuse. The sexual touching may feel good to some children, and they may still like the person who did it. But some children have other feelings; they are very angry at the person who did the abuse or are scared of him/her. Other children might feel guilty about what happened. Any of these feelings are OK. Sometimes when people have these feelings, the feelings affect the way they behave. A child who is afraid may not want to sleep alone or be left alone. Sometimes children get into more arguments, and some may just feel sad and want to be alone. Some children feel upset for a long time after the abuse has ended but often feel better with the help of counseling. If children are having a hard time with these feelings, talking with a counselor or caregiver can help them feel better.

HOW CAN CHILDREN RESPOND TO CHILD SEXUAL ABUSE?

All children need to know that their body belongs to them. If you feel uncomfortable in the way you are being touched, you can tell the person "NO!" Saying "NO!" can sometimes be hard to do, especially if you are scared, shy or embarrassed. But the next and most important thing to do is "GO TELL"—although this can also be hard to do, it is important to tell an adult (such as a caregiver, other family member, or a teacher) about what happened. It is important to keep telling until someone listens and helps. Remember the steps: NO-GO-TELL!

It is great to talk to a counselor or a caregiver. It helps to talk about sexual abuse, even though it can be hard. Talking, writing, and even singing and drawing can help children who have been sexually abused feel better after awhile.

It is important to tell adults about child sexual abuse so that they can get help. There is a special agency in every state that is available to help children who have experienced abuse.

TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY

DIAPHRAGMATIC or BELLY BREATHING

Sit or lie comfortably.

Put one hand on your chest and one hand on your diaphragm or belly.

Breathe from the belly, not the chest.

Breathe in through your nose.

Breathe out through your pursed lips.

Notice your belly expand like a balloon as you inhale and deflate as you exhale.

Try to breathe in and out smoothly.

Breathe at a comfortable rate (usually about 8-12 breaths per minute).

Inhale a normal amount of air, not huge breaths.

Count “1” as you inhale and think “relax” as you exhale. Count up to 10 on your inhalations and then start back at 1.

Practice for about 5-10 minutes.

Practice belly breathing during a relatively calm time. Once you feel comfortable with belly breathing, you can also use it to feel better when you are worried or afraid.

RELAXATION SCRIPT FOR CHILDREN

[NOTE: These exercises can be done seated OR lying down.]

Introduction

Today we are going to do some special kinds of exercises called "relaxation exercises." These exercises help you learn how to relax when you are feeling uptight and help you get rid of those butterflies-in-your-stomach kinds of feelings.

In order for you to get the best feelings from these exercises, there are some rules you must follow. First, you must do exactly what I say, even if it seems kind of silly. Second, you must try hard to do what I say. Third, you must pay attention to your body. Throughout these exercises, pay attention to how your muscles feel when they are tight and when they are loose and relaxed. And fourth, you must practice. The more you practice the more relaxed you can get.

Are you ready to begin? Okay. First, get comfortable as you can in your chair. Sit back, get both feet on the floor, and just let your arms hang loose. That's fine. Now, close your eyes and do not open them until I say so. Remember to follow my instructions very carefully, try hard, and pay attention to your body. Here we go.

Hands and Arms

Pretend you have a whole lemon in your left hand. Now squeeze it hard. Try to squeeze all the juice out. Feel the tightness in your hand and arm as you squeeze. Now drop the lemon. Notice how your muscles feel when they are relaxed. Take another lemon and squeeze it. Try to squeeze this one harder then you did the first one. That's right. Really hard. Now drop your lemon and relax. See how much better your hand and arm feel when they are relaxed. Once again, take a lemon in your left hand and squeeze all the juice out. Do not leave a single drop. Squeeze hard. Good. Now relax and let the lemon fall from your hand.

[REPEAT THE PROCESS FOR THE RIGHT HAND AND ARM.]

Arms and Shoulders

Pretend you are a furry, lazy cat. You want to stretch. Stretch your arms out in front of you. Raise them high over your head. Way back. Feel the pull in your shoulders. Stretch higher. Now just let your arms drop back to your side. Okay, kitten, let's stretch again. Stretch your arms out in front of you. Raise them over your head. Pull them back, way back. Pull hard. Now let them drop quickly. Good. Notice how your shoulders feel more relaxed. This time let's have a great big stretch. Try to touch the ceiling. Stretch your arms way out in front of you. Raise them way up high over your head. Push them way, way back. Notice the tension and pull in your arms and shoulders. Hold tight, now. Great. Let them drop very quickly and feel how good it is to be relaxed. It feels good and warm and lazy.

Shoulder and Neck

Now pretend you are a turtle. You are sitting out on a rock by a nice, peaceful pond, just relaxing in the warm sun. It feels nice and warm and safe here. Oh-oh! You sense danger. Pull your head into your house. Try to pull your shoulders up to your ears and push your head down into your shoulders. Hold in tight. It is not easy to be a turtle in a shell. The danger is past now. You can come out into the warm sunshine and, once again, you can relax and feel the warm sunshine. Watch out now! More danger. Hurry, pull your head back into your house and hold it tight. You have to be closed in tight to protect yourself. Okay, you can relax now. Bring your head out and let your shoulder relax. Notice how much better it feels to be relaxed than all tight. One more time now. Danger! Pull your head in. Push your shoulders way up to your ears and hold tight. Do not let even a tiny piece of your head show outside your shell. Hold it. Feel the tenseness in your neck and shoulders. Okay. You can come out now. It is safe again. Relax and feel comfortable in your safety. There's no more danger. Nothing to worry about. Nothing to be afraid of. You feel good.

Jaw

You have a giant jawbreaker bubble gum in your mouth. It is very hard to chew. Bite down on it. Hard! Let your neck muscles help you. Now relax. Just let your jaw hang loose. Notice how good it feels just to let your jaw drop. Okay, let's tackle that jawbreaker again now. Bite down. Hard! Try to squeeze it out between your teeth.

That's good. You are really tearing that gum up. Now relax again. Just let your jaw drop off your face. It feels so good just to let go and not have to fight that bubble gum. Okay, one more time. We are really going to tear it up this time. Bite down. Hard as you can. Harder. Oh, you are really working hard. Good. Now relax. Try to relax your whole body. You've beaten the bubble gum. Let yourself go as loose as you can.

Face and Nose

Here comes a pesky old fly. He has landed on your nose. Try to get him off without using your hands. That's right, wrinkle up your nose. Make as many wrinkles in your nose as you can. Scrunch up your nose real hard. Good. You've chased him away. Now you can relax your nose. Oops, here he comes back again. Right back in the middle of your nose. Wrinkle up your nose again. Shoo him off. Wrinkle it up hard. Hold it just as tight as you can. Okay, he flew away. You can relax your face. Notice that when you scrunch up your nose that your cheeks and your mouth and your forehead and your eyes all help you, and they get tight too. So when you relax your nose, your whole face relaxes too, and that feels good. Oh-oh. This time that old fly has come back, but this time he's on your forehead. Make lots of wrinkles. Try to catch him between all those wrinkles. Hold it tight now. Okay, you can let go. He's gone for good. Now you can just relax. Let your face go smooth, no wrinkles anywhere. Your face feels nice and smooth and relaxed.

Stomach

Hey! Here comes a cute baby elephant. But he's not watching where he's going. He doesn't see you lying there in the grass, and he's about to step on your stomach. Do not move. You do not have time to get out of the way. Just get ready for him. Make your stomach very hard. Tighten up your stomach muscles real tight. Hold it. It looks lie he is going the other way. You can relax now. Let your stomach go soft. Let it be as relaxed as you can. That feels so much better. Oops, he's coming this way again. Get ready. Tighten up your stomach. Real hard. If he steps on you when your stomach is hard, it won't hurt. Make your stomach into a rock. Okay, he's moving away again. You can relax now. Kind of settle down, get comfortable, and relax. Notice the difference between a tight stomach and a relaxed one. That's how we want it to feel – nice and loose and relaxed. You won't believe this, but this time he's really coming your way and no turning around. He's headed straight for you. Tighten up. Tighten hard. Here he comes. This is really it. You've got to hold on tight. He's stepping on you. He's stepped

over you. Now he's gone for good. You can relax completely. You are safe/ Everything is okay, and you can feel nice and relaxed.

This time imagine that you want to squeeze through a narrow fence and the boards have splinters on them. You'll have to make yourself very skinny if you are going to make it through. Suck your stomach in. Try to squeeze it up against your backbone. Try to be as skinny as you can. You've got to get through. Now relax. You do not have to be skinny now. Just relax and feel your stomach being warm and loose. Okay, let's try to get through that fence now. Squeeze up your stomach. Make it touch your backbone. Get it real small and tight. Get as skinny as you can. Hold tight, now. You've got to squeeze through. You got through that skinny little fence and no splinters. You can relax now. Settle back and let your stomach come back out where it belongs. You can feel really good now. You've done fine.

Legs and Feet

Now pretend that you are standing barefooted in a big, fat mud puddle. Squish your toes down deep into the mud. Try to get your feet down to the bottom of the mud puddle. You'll probably need your legs to help you push. Push down, spread your toes apart, and feel the mud squish up between your toes. Now step out of the mud puddle. Relax your feet. Let your toes go lose and feel how nice that is. It feels good to be relaxed. Back into the mud puddle. Squish your toes down. Let your leg muscles help push your feet down. Push your feet. Hard. Try to squeeze the mud puddle dry. Okay. Come back out now. Relax your feet, relax your legs, relax your toes. It feels so good to be relaxed. No tenseness anywhere. You feel kind of warm and tingly.

Conclusion

Stay as relaxed as you can. Let your whole body go limp and feel all your muscles relaxed. In a few minutes I will ask you to open your eyes, and that will be the end of this session. As you go through the day, remember how good it feels to be relaxed. Sometimes you have to make yourself tighter before you can be relaxed, just as we did in these exercises. Practice these exercises every day to get more and more relaxed. A good time to practice is at night, after you have gone to bed and the lights are out and you won't be disturbed. It will help you get to sleep. Then, when you are a really good relaxer, you can help yourself relax at school. Just remember the elephant, or the jawbreaker, or the mud puddle, and you can do our exercises and nobody will know.

Today is a good day. You've worked hard in here, and it feels good to work hard. Very slowly, now, open your eyes and wiggle your muscles around a little. Very good. You've done a good job. You are going to be a super relaxer.

TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY

RELAXATION SCRIPT FOR ADOLESCENTS AND ADULTS

Go ahead and settle back so you feel comfortable. Let all your muscles go loose and heavy. Close your eyes and take three deep, slow breaths. As you breathe in slowly, concentrate on the air as it fills your lungs, and as you breathe out slowly, notice your breath rushing out through your nose and mouth. Breathe in slowly, thinking about the feeling of air passing in [PAUSE] and out of your body [PAUSE 10 SECONDS].

Now, I want you to clench your right fist as tight as you can, and hold it while I count down from five . . . pay attention to the tight feeling in your fist as I begin to count . . . 5 . . . 4 . . . 3 . . . 2 . . . 1 . . . relax your fist and notice the feelings of warmth and relaxation that flow through your fingers into your arm . . . pay attention to the feeling of relaxation that fills your arm . . . [PAUSE 10 SECONDS]. Now, clench your left hand into a fist and hold it while I count down from five . . . pay attention to the tight feeling in your arm. . . 5 . . . 4 . . . 3 . . . 2 . . . 1 . . .release your fist and notice how the tight feeling leaves your arm and is replaced by the warm heavy feeling of relaxation [PAUSE 10 SECONDS]. Now hunch your shoulders so they press against your head and neck, and pay attention to the tight feeling this causes as I count down from five -- . . . 5 . . . 4 . . . 3 . . . 2 . . . 1 . . . As you relax your shoulders, pay attention to the warm soothing feelings of relaxation that run down your head, neck, and shoulders . . . [PAUSE 10 SECONDS]. Hunch your shoulders again, paying attention to the tight feeling this creates as I count down from five -- . . . 5 . . . 4 . . . 3 . . . 2 . . . 1 . . . As you relax your shoulders again, notice the feelings of relaxation that flow down your neck and through your body . . . [PAUSE 10 SECONDS]. Now I want you to scrunch up your face like you bit

something really sour like a lemon, wrinkle up your forehead, and hold it while I count down from five . . . pay attention to the tightness in your forehead while I count down from five -- . . . 5 . . . 4 . . . 3 . . . 2 . . . 1 . . . relax your forehead again, smoothing out all the wrinkles. Notice how smooth and relaxed you feel [PAUSE 10 SECONDS]. Now clench your jaws, bite your teeth together and hold it while I count down . . . 5 . . . 4 . . . 3 . . . 2 . . . 1 . . . relax [PAUSE 10 SECONDS]. Let your lips open a little bit and breathe deeply. Notice the warm heavy feelings of relaxation in your body. Now, I want you to tighten up your whole body, from your scrunched up face, to your hunched up shoulders, your tight fists and arms, your stiff back and tight stomach, to your tight legs and curled up toes. Make your whole body tense and stiff as a board and hold it while I count down from five -- . . . 5 . . . 4 . . . 3 . . . 2 . . . 1 . . . let go and relax [PAUSE 10 SECONDS]. Just relax and feel how warm and heavy your whole body feels. Relax.

Now, with your eyes still closed, I want you to imagine [INSERT HIS/HER SPECIAL PLACE].

[CONTINUE DESCRIBING THE SPECIAL PLACE, STRESSING SENSORY DETAIL -- THE WARMTH OR COOLNESS OF THE AIR, THE SOFT SOUNDS IN THE BACKGROUND, ETC. PAUSE BETWEEN IMAGES TO LET THE CLIENT REMEMBER AND FEEL. YOU CAN INCLUDE PEOPLE AS A CHOICE -- "THERE MAY BE SOMEONE SPECIAL WITH YOU SHARING THIS NICE PLACE, A FRIEND OR SOMEONE IN YOUR FAMILY. REMEMBER HOW GOOD IT FELT TO BE TOGETHER," AS APPROPRIATE].

Now it is time to leave your special place and come back to this room. We are going to take five imaginary steps, each step moving father away from [INSERT SPECIAL PLACE] and closer to this room. I'll count each step out loud for you . . . 1 . . . you are stepping away from your special place . . . 2 . . . you've moved away a little farther from [SPECIAL PLACE] . . . 3 . . . you are halfway back to this room . . .

4 . . . you are almost here, just one small step away . . . 5 . . . and you are back. When you feel ready, go ahead and open your eyes.

[WHEN THE CLIENT HAS OPENED HIS/HER EYES, ASK IF S/HE WOULD LIKE TO SHARE HIS/HER EXPERIENCE - WHAT THE CLIENT REMEMBERED, HOW S/HE FELT, HOW S/HE FEELS NOW. ASK WHAT IT WAS LIKE TO TENSE AND RELAX DIFFERENT MUSCLES. REMIND AGAIN THAT RELAXATION TAKES PRACTICE.]

Affective Modulation: 25 Ways to Feel Better Right Now

1. Stop whatever you are doing, close your eyes, and take 10 slow, deep breaths.
2. Visualize your “safe place.”
3. Go to a quiet room and read a good book.
4. Meditate or focus on your special relaxation phrase.
5. Listen to your favorite music.
6. Sing out loud.
7. Dance.
8. Play.
9. Listen to, watch, or read something funny.
10. Go outside and take a walk in a safe area.
11. Run in place for 5 minutes.
12. Call a friend.
13. Talk to a caregiver or other adult who understands and listens.
14. Write in your journal.
15. Volunteer.
16. Tell yourself that things will get better.
17. Take a warm bath.
18. Make something with your hands—knit, sew, crochet, woodwork, etc.
19. Tell yourself five good things about yourself.
20. Draw, color or paint.
21. Talk about your feelings with someone you trust.
22. Tell someone you love him or her.
23. Play with your pet.
24. Do something to help someone else.
25. What else helps you feel better?

PROBLEM-SOLVING STEPS

Problem solving involves several steps that can be summarized as follows:

State, or describe, the problem.

Think of, or identify, possible solutions to the problem. Try to think of as many as you can, without judging them as good or bad.

Evaluate, or consider, the likely outcomes of each possible solution. What good or bad might happen if you chose that solution?

Pick the solution most likely to help and try it out.

See how your choice worked. If it worked, great! If it didn't work out as you hoped, try to figure out what went wrong. Go back and pick another solution to try to solve the problem.

Cognitive Triangle

_____

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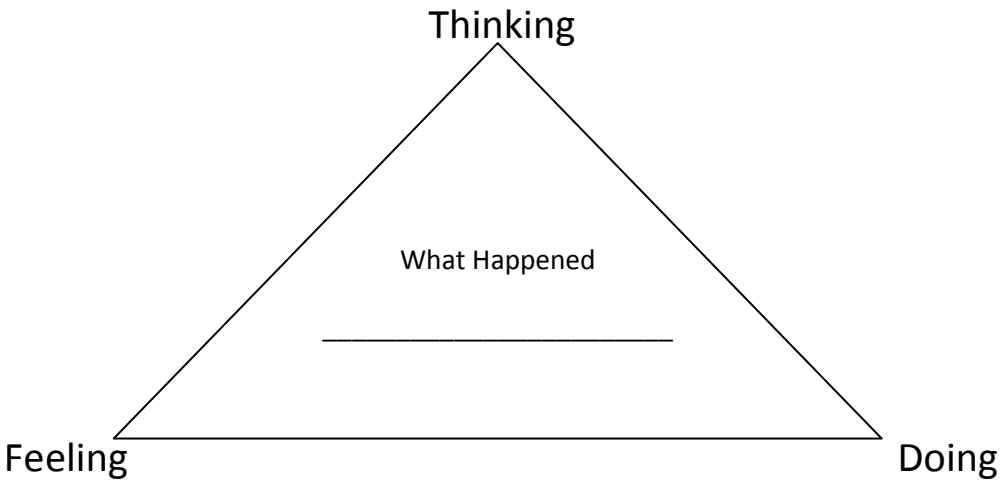
_____



_____ _____

_____ _____

_____ _____

Example of the Cognitive Model in Action

Event	Thinking	Feeling	Doing
I step in dog poop on my way to school	I've heard this stuff carries disease - I bet I could catch something.	Nervous or Anxious	Go back inside, wash vigorously, and change shoes.
	This kind of thing always happens to me - I'm such a loser.	Unhappy or Depressed	Go to school expecting a bad day – maybe not even wipe off the poop.
	I've told that guy a hundred times to keep his dog in his own lawn!	Angry or Irritated	Go next door and scream at neighbor.
	At least I wasn't wearing sandals.	Relieved or Indifferent	Wipe off the poop and go to school.

BLUE

- ✓ **UNHELPFUL thinking makes us feel bad, or BLUE.**
- ✓ **REALISTIC thinking makes us feel BETTER.**

Types of UNHELPFUL thinking to look out for:

B . . . Blaming myself

L . . . Looking for the bad news

U . . . Unhappy guessing

E . . . Exaggerating – Imagining a disaster

4 STRATEGIES FOR DISPUTING UNHELPFUL THOUGHTS

When we feel upset about something, we tend to be thinking unhelpful thoughts. We can ask ourselves 4 main questions in order to (a) evaluate whether these thoughts are realistic or helpful to us, and (b) come up with more realistic or helpful thoughts.

1. ***Evidence?***

What is the evidence for this thought or belief?
Are your judgments based on how you feel rather than what you are doing or have done (rather than the evidence)?
Are you confusing a low probability event with a high probability event?
Are you underestimating what you can do to deal with the situation?

2. ***Alternatives?***

Is there any alternative way of looking at the situation?
How would someone else think about the situation?
Are you overestimating how much control and responsibility you have in this situation?

3. ***Implications?***

What are the consequences of you thinking this way?
What would be the worst thing that could happen?
If this is true, so what? What does it mean?
What are the real and probable consequences of the situation?

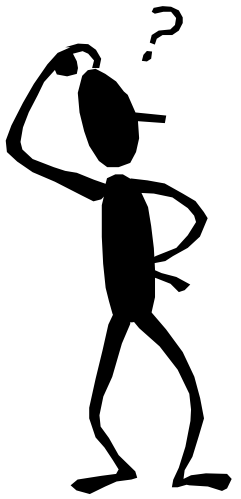
4. ***Usefulness?***

Is it useful for you to think this way?
What are the advantages of holding on to this belief?
What are the disadvantages of holding on to this belief?
Are you setting yourself up for an unrealistic standard?

Double Bubble

Unhelpful, BLUE Thoughts

Helpful, Realistic Thoughts

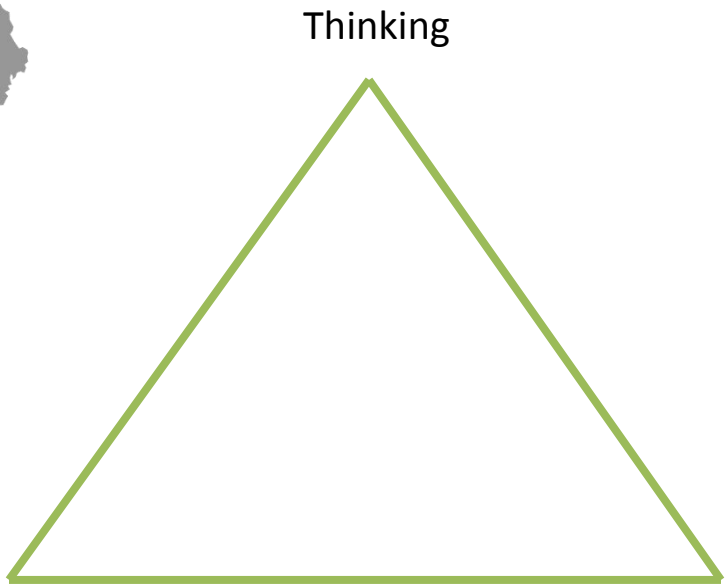


Situation that made me feel bad _____

_____

_____

PRACTICING THE COGNITIVE TRIANGLE



During the coming week, whenever you feel upset about something, write down the situation and how it makes you feel. Then "track back" to what your thought was about the situation that made you think that way. Ask yourself whether that thought is (1) accurate and (2) helpful. Come up with alternative thoughts in this situation and write down how they make you feel and whether they are accurate and helpful. To identify new, more helpful thoughts, think about what you would say to a good friend in a similar situation if he/she shared the distressing thought(s).

Situation:_____

Thought:_____

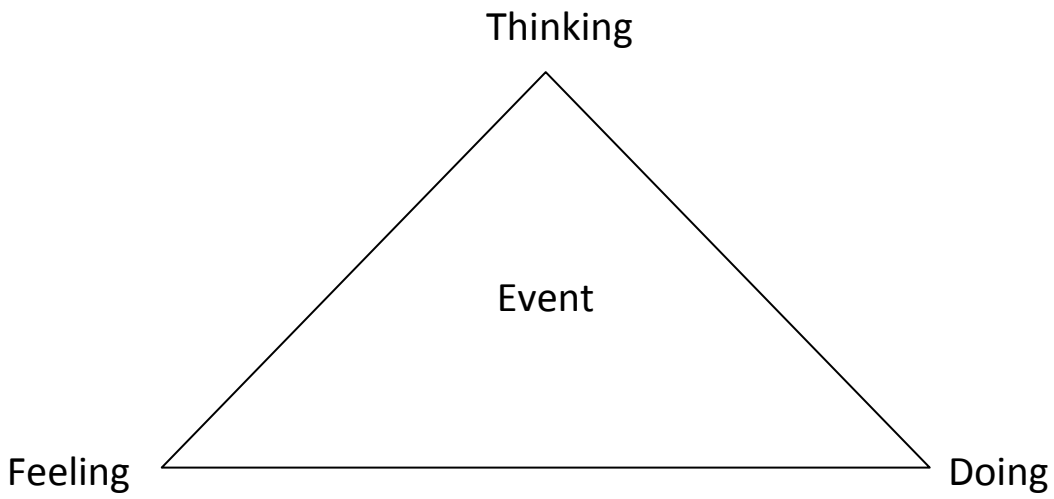
Feeling:_____

New thought:_____

New feeling:_____

New Behavior:_____

Cognitive Triangle: Challenging Your Thinking Mistakes



EVENT	THOUGHTS	FEELINGS	BEHAVIORS
"Something Happens"	"I tell myself something"	"I feel something"	"I do something"

Are my thoughts accurate?

_____

Are my thoughts helpful?

_____

Am I falling into a Thinking Mistake trap (If so, which one)?

_____

What could I say to myself that would be more accurate, positive, or helpful?

_____

How would I feel if I told myself this?

_____

HELPFUL HINTS FOR THE TRAUMA NARRATIVE

1. Introduce the child and caregiver to the theory behind TF-CBT and the trauma narrative (e.g., cleaning a wound, taking out a splinter).
2. Prepare the child for the trauma narrative by talking about upsetting aspects of the traumatic event(s) a little bit at a time so that talking about it becomes less painful, frightening, and overwhelming over time.
3. Have the child write a chapter about a positive experience s/he has experienced. This will allow the child to practice creating a narrative, so s/he will be better prepared to create a trauma-related narrative. This also helps the therapist differentiate between the child showing trauma-related avoidance versus having limited ability to express experiences verbally or in writing.
4. Introduce the trauma narrative by reading a book about another child's experience with similar traumatic events (e.g., *Please Tell, A Place for Starr*).
5. Suggest that children start their trauma narrative with non-traumatic information, such as with whom they live and where they go to school. They can then be encouraged to describe the specific context leading up to the traumatic experience.
6. Help the child develop the trauma narrative:

a) The child can create a book that tells the story of the traumatic event(s).

b) The child can create a "life narrative" instead of just a "trauma narrative."

c) The child can verbally describe the traumatic event(s). The therapist can suggest that the child write down what he/she has described afterwards. Alternatively, the therapist can act as a recorder while the child talks.

d) The child can start by providing just one or a few details of the event. The therapist can then ask questions such as what s/he was doing at the time the incident occurred, what happened next, and so on.

e) The therapist should provide a lot of praise and encouragement for the child's efforts.

f) It is best not to interrupt the child in the flow of his/her narrative to ask about his/her thoughts and feelings regarding the event since this may make it more difficult for him/her to keep focused on the event. Instead, let him/her first describe his/her perception of the event, and then return to the beginning to clarify things or to ask about his/her feelings and thoughts.

7. Once the child has written a full narrative of his/her memories, thoughts and feelings about the traumatic event, the therapist should employ cognitive-processing techniques to explore and correct cognitive distortions and errors.

8. Prepare the child and caregiver(s) to share the child's trauma narrative with the child's caregiver(s). The narrative is shared with the caregiver only after considerable preparation is provided for the caregiver in parent sessions, and only when the caregiver is capable of providing a supportive response to the client (e.g., if a caregiver does not believe the abuse occurred it may not be a good idea to share the narrative with them).

FEAR THERMOMETER

or

SUDS (Subjective Units of Distress Scale)

SUDS helps clients to tell you in a number how distressed they are. You can have the child make his or her own thermometer with descriptive words for each number, or use this one: