NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

TFC: Trauma-Focused Coping in Schools (aka MMTT: Multimodality Trauma Treatment)

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** TFC (or MMTT) **Average length/number of sessions:** Fourteen group sessions with 6-8 members per group delivered during one class period a week. An individual pullout session is done mid-protocol to introduce narrative exposure in a controlled way. (An individual assessment session is also done prior to group work.) This allows the therapist to adjust treatment so that the balance between child, individual and group trauma processing can be optimized. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** The protocol lays out a components-based approach of key tasks that allows flexibility to accommodate individual and group membership needs. Adaptation to specific population needs is encouraged. Consultation can guide this if requested. **Trauma type** *(primary)*: See below **Additional descriptors** *(not included above)***:** TFC is a skills-oriented, cognitive-behavioral treatment (CBT) approach for children exposed to single incident trauma and targets posttraumatic stress disorder (PTSD) and collateral symptoms of depression, anxiety, anger, and external locus of control. It was designed as a peer-mediating group intervention in schools. It has been shown to be easily adaptable for use as group or individual treatment in clinic populations as well.
Target Population	**Age range:** 6 **to** 18 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Region** *(e.g., rural, urban)***:** English, French **Other characteristics** *(not included above)***:** Children and adolescents in grades 4 through high school who have experienced single-incident traumatic stressors (disaster, exposure to violence, murder, suicide, fire, accidents)—recognizing the fact that most children have experienced more than one PTSD qualifying stressor. TFC can address intrafamilial violence/abuse in individual treatment or in clinic-based groups where homogeneity of group membership can be assured and the treatment adapted to the needs of the child and family members.
Essential Components	**Key components:** **Major components noted below by session:** Session 1: Psychoeducation Session 2: Anxiety Management Session 3: Anxiety Management and Cognitive Training (Thinking, Feeling, Doing, and Stress Thermometer) Session 4: Cognitive Training (Traumatic Reminders) Session 5a: Anger Coping Session 5b: Grief Management Session 6: Individual Pull-out Session (Narrative Exposure)

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Essential Components continued

Session 7: Setting up the Stimulus Hierarchy (Group)
Session 8: Group Narrative Exposure
Session 9: Group Narrative Exposure (Cognitive and Affective Processing)
Session 10: Group Narrative Exposure (Worst Moment)
Session 11: Worst Moment Cognitive and Affective Processing
Sessions 12-13: Relapse Prevention and Generalization
Session 14: Graduation Ceremony

Clinical & Anecdotal Evidence

Are you aware of any suggestion/evidence that this treatment may be harmful?
❒ Yes ☒ No ❒ Uncertain

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ Yes ☒ No

Has this intervention been presented at scientific meetings? ☒ Yes ❒ No

If YES, please include citation*(s)* **from last five presentations:**
American Academy of Child and Adolescent Psychiatry (AACAP): Amaya-Jackson, 1996; 2000; March & Amaya-Jackson, 1996

International Society for Traumatic Stress Studies: Amaya-Jackson, 1998

Amaya-Jackson, L. Approaches for Complex Clinical Presentations. In: Plenary on Treatment Response to Children: What we know and how we can best apply it to the full range of clinical presentations. Chair Saunders, B. Presented at the Annual Meeting of the International Society of Traumatic Stress Studies. Nov 6, 2006.

Can your Clinic Deliver Evidence-Based Treatment? Lessons learned from the National Child Traumatic Stress Network. Presented at the annual meeting of the North Carolina Psychiatric Association, Sep 12, 2006.

Amaya-Jackson, L. and Farmer, E.M.Z. Implementing Research in Community Settings. 3-C Institute for Social Development Research Series in Child Mental Health. Funded Through a Grant from NIMH. February 22, 2006.

Learning from Research and Practice: Spreading Knowledge of Child Trauma Impact and Evidence-Based Treatment. Department of Psychiatry, University of North Carolina, Chapel Hill. May 20, 2005.

American Academy of Child and Adolescent Psychiatry (AACAP): Amaya-Jackson, 1996; 2000; March & Amaya-Jackson, 1996.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:
March, Amaya-Jackson, Murray & Schulte, 1998

Amaya-Jackson, Reynolds, Murray, McCarthy, Nelson, Cherney, et al., 2003

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Clinical & Anecdotal Evidence continued	**Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other countries?** *(please list)* South Africa, Nigeria, India, Australia, and France **Other clinical and/or anecdotal evidence** *(not included above)*: TFC was also replicated in a randomized controlled (unpublished as yet) study in a residential treatment setting (Michael, Hill, Hudson & Furr, 2002) This work received two awards: 1996 American Academy of Child & Adolescent Psychiatry Norbert and Charlotte Reiger Excellence in Service Award 1998 American Academy of Child & Adolescent Psychiatry Scientific Achievement Award TFC has been used as a model and prototype for several other empirically supported school and clinical setting trauma-focused cognitive-behavioral treatments, such as "Cognitive-Behavioral Treatment in Schools" (Jaycox, 2004) and "Preschool PTSD Treatment" (Scheeringa, Amaya-Jackson & Cohen, 2002).	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**21 **By other cultural factors:** rural	Amaya-Jackson, Reynolds, Murray, McCarthy, Nelson, Cherney, et al., 2003
Clinical Trials *(w/control groups)*	**N=**17	March, Amaya-Jackson, Murray & Schulte, 1998
Randomized Controlled Trials		Michael, Hill, Hudson & Furr, 2002
Studies Describing Modifications	**N=**7	Amaya-Jackson, Reynolds, Murray, McCarthy, Nelson, Cherney, et al., 2003
Other Research Evidence	**N=**4	Berthiaume & et Turgeon, 2004

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Outcomes

If research studies have been conducted, what were the outcomes?

The following were used in the 1998 study (research tools):

- Child and Adolescent Trauma Survey—CATS (March & Amaya-Jackson, 1997)
- Clinician-Administered PTSD Scale—CAPS-C
- Children's Depression Inventory (Kovacs, 1985)
- Clinical Global Improvement (Guy, 1976)
- Multidimensional Anxiety Scale for Children—MASC (March et al., 1997)
- Stait-Trait Anger Expression Inventory (Spielberger, 1988)
- Nowicki-Strickland "What Am I Like" Scale (Nowicki & Strickland, 1973)
- Conner's Teacher Rating Scale for ADHD (Conner, 1995)

General Treatment Measure Recommendations for the model:

- Any measure of PTSD, depression, and anxiety can be used. An exposure to violence measure is also suggested as part of the assessment and several can be recommended.
- The CATS is a screening tool that is useful in settings such as schools to identify child candidates for group membership in conjunction with teacher/counselor recommendations. Group membership may be selected via other strategies as well.

TFC was the first controlled study of a protocol-driven CBT intervention for children and adolescents suffering from PTSD arising in the context of a single incident trauma (March et al., 1998). Experimental control across time and setting in a small sample (in two elementary and two junior high schools) demonstrated robust beneficial effects of treatment for reducing PTSD, depression, anxiety, and anger using an 18 session protocol. Locus of control remained external from pre- to posttreatment but became strongly internal at follow-up.

Additional studies using a shortened (14 session), developmentally enhanced protocol in two elementary schools, one high school, and a community based clinic revealed similar (published) findings.

Implementation Requirements & Readiness

Space, materials or equipment requirements?

- Clinical supervisors with training in trauma specific CBT and a good working knowledge of the model
- Clinical staff with training in the model
- Established relationship with school, school personnel & designated school staff collaborating on implementation
- Determine if a school counselor will be co-leading group (not required but should be considered—especially in elementary school settings)
- Private rooms conducive to group treatment

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Implementation Requirements & Readiness continued	• Flip boards, chalk boards • Consideration of target population needs and if adjunct services are necessary **To ensure successful implementation, support should be obtained from:** School administrators, parents
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Manuals available (no charge) by contacting Dr. Amaya-Jackson or at http://epic.psychiatrry.duke.edu/our-work/projects/trauma-focused-coping **How/where is training obtained?** Contacting Dr. Amaya-Jackson **What is the cost of training?** Depends on intensity and use of Learning Collaborative methods **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** French **Other training materials &/or requirements** *(not included above)*: • Recommended for clinician supervisors and therapists with a master's degree or higher.
Training Materials & Requirements continued	• Readiness assessment for general CBT experience • Basic understanding of childhood PTSD and related symptoms • Reading the manual and select articles • Organizational Readiness assessment for school and/or clinic intervention Training depends on extent of training/experience with trauma-focused mental health interventions. • (Recommend) Intensive skills based training, one to two days • (Recommend) Ongoing expert consultation from trainers for 4-6 months (this may require longer if consultation is needed on establishing the relationship with school or school district). • Advanced training as requested
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Specifically developed in schools and groups. Allows both group & individual pullout component benefits. Has been tested in elementary, middle, and high school groups and in individual, group clinic settings and residential settings.

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Pros & Cons/ Qualitative Impressions continued	**What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** School based treatments require consents and may or may not be reimbursable depending on ability to bill. No difficulty in clinic/residential settings.
Contact Information	**Name:** Ernestine Briggs-King, PhD, Director, Trauma Evaluation and Treatment Program; or Robert Murphy, PhD, Executive Director, Center for Child and Family Health, NC **Address:** Center for Child and Family Health, Durham, NC **Phone number:** (919) 419-3474 ext. 228 or ext. 291 **Email:** brigg014@mc.duke.edu or Robert.Murphy@duke.edu **Website:** www.ccfh.nc.org
References	Amaya-Jackson, L. (1996, October). Cognitive behavioral treatment of post-traumatic stress disorder. In J.S. March (Chair), *Institute on Cognitive Behavior Therapy.* Symposium conducted at the annual meeting of the American Academy of Child and Adolescent Psychiatry, New York. Amaya-Jackson, L. (1998, November). *Cognitive-behavioral strategies in pediatric post-traumatic stress disorder.* Presented at the annual meeting of the International Society of Traumatic Stress Studies, Washington, D.C. Amaya-Jackson, L. (2000, October). Trauma-Focused Cognitive Behavioral Therapy. In J. Cohen (Chair), *The evaluation and treatment of traumatized children.* Symposium conducted at the annual meeting of the American Academy of Child and Adolescent Psychiatry, New York. Amaya-Jackson, L., Reynolds, V., Murray, M., McCarthy, G., Nelson, A., Cherney, M., et al. (2003). Cognitive behavioral treatment for pediatric posttraumatic stress disorder: Protocol and application in school and community settings. *Cognitive and Behavioral Practice, 10,* 204-213. Berthiaume, C. & et Turgeon, L. (2004). *Application d'un traitement cognitivo-comportemental auprès d'un enfant présentant un trouble de stress post-traumatique.* Symposium au Congrès de l'Association française des thérapies cognitivo-comportementales, Paris, France. Conners, C. (1995). *Conners' Rating Scales.* Toronto, Canada: Multi-Health Systems. Guy, W. (1976). ECDEU *Assessment Manual for Psychopharmacology,* 2nd Ed. (DHEW Publication ABM 76-388). Washington, DC: US Government Printing Office. Jaycox, L. (2004). *Cognitive-Behavioral Intervention for Trauma in Schools.* Longmont, CO: Sopris West. Kovacs, M. & Beck, A. (1983). *The Children's Depression Inventory: A self-rating depression scale for school-aged youngsters.* Unpublished manuscript, Western Psychiatric Institute and Clinic, Pittsburgh, PA. March J. & Amaya-Jackson L. (1996, October). Presented at the Awards Symposium at the annual meeting of the American Academy of Child and Adolescent Psychiatry, New York. March J. & Amaya-Jackson L. (1997). *Child and Adolescent Trauma Survey-CATS.* Multi-Health Systems, Inc. Research Version.

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