Adding Comments and Notes to Your PDF

To facilitate electronic transmittal of corrections, we encourage authors to utilize the comment/annotations features in Adobe Acrobat. The PDF provided has been *comment enabled,* which allows you to utilize the comment and annotation features even if using only the free Adobe Acrobat reader (see note below regarding acceptable versions). Adobe Acrobat's Help menu provides additional details on the tools. When you open your PDF, the annotation tools are clearly shown on the tool bar (although icons may differ slightly among versions from what is shown below).

For purposes of correcting the PDF proof of your journal article, the important features to know are the following:

- To **insert text,** place your cursor at a point in text and select the Insert Text tool () from the menu bar. Type your additional text in the pop-up box.
- To **replace text,** highlight the text to be changed, select the Replace Text tool () from the menu bar, and type the new text in the pop-up box. Do this instead of deleting and then reinserting.
- To **delete text,** highlight the text to be deleted and press the Delete button on the keyboard.
- Use the **Sticky Note tool** () to describe changes that need to be made (e.g., changes in bold, italics, or capitalization use; altering or replacing a figure) or to answer a question or approve a change from the editor. To use this feature, click on the Sticky Note tool in the menu bar and then click on a point in the PDF where you would like to make a comment. Then type your comment in the pop-up box.
- Use the **Callout tool** () to point directly to changes that need to be made. Try to put the callout box in an area of white space so that you do not obscure the text.
- Use the **Highlight and Add Note to Text tool** () to indicate font problems, bad breaks, and other textual inconsistencies. Select text to be changed, choose this tool, and type your comment in the pop-up box. One note can describe many changes.
- To view a list of changes to the proof or to see a more comprehensive set of annotation tools, select **Comment** from the menu bar.

As with hand-annotated proof corrections, the important points are to communicate changes clearly and thoroughly, to answer all queries and questions, and to provide complete information to allow us to make the necessary changes to your article so it is ready for publication. Do not use tools that incorporate changes to the text in such a way that no indication of a change is visible. Such changes will not be incorporated into the final proof.

To utilize the comments features on this PDF you will need Adobe Reader version 7 or higher. This program is freely available and can be downloaded from http://get.adobe.com/reader/

REPRINTS

Authors have two options for ordering reprints: Authors who need to use purchase orders may order reprints from the standard *Purchase Order Service.* For a substantially lower price, authors may use the *Prepaid Service.* The rate schedules on page 3 give the prices for each service. All international prices include shipping via WWDS. All domestic shipments will be made via UPS. We request that you do not use Post Office box numbers; provide a full street address if possible. Authors may request expedited shipping – the additional cost will be billed. You are required to pay all duties that apply.

- **Prepaid Service:** To take advantage of this lower price option, submit your credit card information with your order or enclose a money order, certified check, or personal check. The prices given on page 3 include postage.

- **Purchase Order Service:** Reprint orders that are not prepaid must be accompanied by a purchase order. Cadmus Reprints will bill you later for the cost of the reprints. **Do not send remittance with the reprint order form and purchase order.** Remember that the price you see on page 3 includes postage, so it is the exact amount you will be billed. (Exception: Authors requesting expedited shipping will be billed the additional cost.)

Complete the order form on the next page and return it to Cadmus Reprints (not to APA). Only one order form is provided – include your coauthors' orders on this form or make photocopies of the order form for your coauthors. Check the box for either the prepaid service or the purchase order service. Give explicit instructions for all authors receiving reprints, using the space at the bottom of the order form.

To determine the cost of the reprints, count the number of pages in the printed article and refer to the rate schedules on page 3. For example, if your article is 11 pages long, you want 100 reprints, you live in the United States, and you are using the prepaid service, your total cost would be $126. If your proof includes a page of queries following the text, do not include the query page in your article page count.

Send the order form to Cadmus Reprints when you return the page proofs. Reprints will be mailed within two weeks of the publication of the journal. Orders received after the issue goes to press will be processed with the next issue.

Where to Order Reprints

Send your order form with credit card information, money order, certified check, personal check, or purchase order in the amount indicated on the rate schedule to:

Cadmus Reprints
P.O. Box 822942
Philadelphia, PA 19182-2942

Phone: (410) 943-0629 FAX: (877) 705-1373

Personal checks must clear before reprints are processed. There is a $30.00 charge for returned checks.

AMERICAN PSYCHOLOGICAL ASSOCIATION

2013 REPRINT ORDER FORM

EPF Journal Authors: To order reprints, complete all sections of this form. Please read the instructions on page 1.

Peace and Conflict: Journal of Peace Psychology

2013-0059

3831053

SEND the reprint order and
(1) credit card number, or
(2) money order/certified check, or
(3) approved purchase order, or
(4) check

to:

Cadmus Reprints
P.O. Box 822942
Philadelphia, PA 19182-2942

BILLING NAME

ORGANIZATION

ADDRESS (no P.O. Box)

CITY STATE ZIP CODE

ARTICLE TITLE

AUTHOR

DATE

PHONE #

FAX #

E-MAIL

REPRINTS INCLUDE COLOR? ☐ YES ☐ NO

OF TOTAL ARTICLE PAGES

OF REPRINTS

OF COVERS

PAYMENT METHOD: CHECK ONE:

___ CREDIT CARD CARD NUMBER _____
_____ VISA EXPIRATION DATE _____
_____ MASTERCARD SIGNATURE _____
___ MONEY ORDER/CERT. CHECK (make payable to **Cadmus Reprints**)
___ APPROVED PURCHASE ORDER (original PO must be attached)
___ CHECK (shipment delayed until check clears)

COMPLETE SHIPPING LABEL below. No P.O. Boxes.
Include phone number on international shipments. International shipments can be made via AIR for additional charges; please indicate in Special Shipping Instructions if you desire this expedited service.

COMPUTE COST OF ORDER

PRICE (per chart)	$
Add'l for Covers	$
SUBTOTAL	$
PA residents add 6% tax	$
Add'l for Expedited Shipping	$
TOTAL	$

(TYPE OR PRINT MAILING LABEL BELOW)

SHIP TO: Phone No. _____
Name _____
Address _____
_____
City _____ State _____ Zip _____
Expedited Service (enter service required): _____

AMERICAN PSYCHOLOGICAL ASSOCIATION

RATES EFFECTIVE WITH 2013 ISSUES

Black and White Reprint Prices Prepaid						
Domestic (USA only)						
# of Pages	50	100	200	300	400	500
1-4	$110	$150	$170	$232	$296	$360
5-8	$144	$194	$294	$390	$490	$592
9-12	$186	$252	$400	$556	$714	$876
13-16	$214	$314	$512	$714	$918	$1,116
17-20	$252	$374	$618	$880	$1,128	$1,384
21-24	$292	$428	$732	$1,038	$1,336	$1,646
25-28	$330	$496	$848	$1,196	$1,594	$1,980
29-32	$368	$558	$958	$1,370	$1,794	$2,212
33-36	$406	$620	$1,076	$1,548	$1,994	$2,440
37-40	$438	$686	$1,190	$1,722	$2,194	$2,670
41-44	$486	$746	$1,308	$1,898	$2,394	$2,898
45-48	$520	$814	$1,424	$2,072	$2,592	$3,128
Covers	$136	$152	$202	$252	$310	$364

Color Reprint Prices Prepaid						
Domestic (USA only)						
# of Pages	50	100	200	300	400	500
1-4	$240	$410	$580	$780	$906	$992
5-8	$378	$496	$742	$1,088	$1,318	$1,542
9-12	$418	$550	$858	$1,264	$1,662	$1,968
13-16	$452	$594	$980	$1,438	$1,900	$2,356
17-20	$496	$642	$1,108	$1,624	$2,136	$2,752
21-24	$542	$692	$1,238	$1,806	$2,376	$3,160
25-28	$708	$1,032	$1,752	$2,514	$3,222	$4,080
29-32	$878	$1,366	$2,252	$3,222	$4,060	$5,018
33-36	$1,046	$1,700	$2,760	$3,932	$4,900	$5,954
37-40	$1,212	$2,036	$3,264	$4,642	$5,740	$6,890
41-44	$1,382	$2,368	$3,772	$5,350	$6,578	$7,826
45-48	$1,548	$2,708	$4,278	$6,060	$7,418	$8,762
Covers	$136	$152	$202	$252	$310	$364

Black and White Reprint Prices Prepaid						
International (includes Canada and Mexico)						
# of Pages	50	100	200	300	400	500
1-4	$166	$200	$248	$354	$450	$556
5-8	$230	$272	$446	$610	$780	$952
9-12	$310	$372	$618	$886	$1,134	$1,402
13-16	$370	$468	$802	$1,136	$1,474	$1,806
17-20	$450	$570	$976	$1,408	$1,818	$2,234
21-24	$516	$652	$1,156	$1,660	$2,160	$2,664
25-28	$600	$758	$1,330	$1,912	$2,544	$3,160
29-32	$664	$848	$1,516	$2,194	$2,878	$3,558
33-36	$728	$940	$1,702	$2,474	$3,184	$3,956
37-40	$794	$1,032	$1,864	$2,752	$3,514	$4,352
41-44	$870	$1,124	$2,050	$3,030	$3,842	$4,750
45-48	$934	$1,216	$2,236	$3,308	$5,522	$5,146
Covers	$196	$210	$300	$412	$522	$630

Color Reprint Prices Prepaid						
International (includes Canada and Mexico)						
# of Pages	50	100	200	300	400	500
1-4	$296	$462	$658	$900	$1,060	$1,188
5-8	$464	$574	$896	$1,306	$1,606	$1,900
9-12	$542	$670	$1,078	$1,594	$2,082	$2,496
13-16	$610	$750	$1,270	$1,860	$2,458	$3,046
17-20	$694	$838	$1,466	$2,152	$2,826	$3,604
21-24	$768	$916	$1,660	$2,430	$3,200	$4,176
25-28	$980	$1,294	$2,234	$3,228	$4,172	$5,260
29-32	$1,174	$1,656	$2,808	$4,048	$5,144	$6,364
33-36	$1,370	$2,018	$3,386	$4,860	$6,090	$7,470
37-40	$1,568	$2,382	$3,938	$5,672	$7,058	$8,574
41-44	$1,764	$2,746	$4,514	$6,484	$8,028	$9,678
45-48	$1,962	$3,110	$5,090	$7,296	$10,346	$10,782
Covers	$196	$210	$300	$412	$522	$630

Additional Rates	
Set title page, each	$16.00
Each extra mailing	$32.00
Remake pages, each	$50.00

AMERICAN PSYCHOLOGICAL ASSOCIATION

RATES EFFECTIVE WITH 2013 ISSUES

Black and White Reprint Prices Purchase Order						
Domestic (USA only)						
# of Pages	50	100	200	300	400	500
1-4	$120	$162	$184	$252	$322	$390
5-8	$156	$210	$318	$422	$532	$644
9-12	$202	$274	$434	$604	$774	$950
13-16	$232	$340	$556	$774	$996	$1,210
17-20	$274	$406	$670	$956	$1,224	$1,500
21-24	$316	$464	$794	$1,126	$1,450	$1,786
25-28	$358	$538	$920	$1,298	$1,730	$2,148
29-32	$398	$606	$1,040	$1,488	$1,946	$2,400
33-36	$440	$674	$1,168	$1,678	$2,164	$2,648
37-40	$476	$744	$1,292	$1,868	$2,380	$2,896
41-44	$528	$810	$1,418	$2,058	$2,596	$3,144
45-48	$564	$882	$1,544	$2,248	$2,814	$3,392
Covers	$148	$166	$218	$274	$338	$396

Color Reprint Prices Purchase Order						
Domestic (USA only)						
# of Pages	50	100	200	300	400	500
1-4	$260	$446	$628	$846	$984	$1,076
5-8	$410	$538	$806	$1,180	$1,430	$1,674
9-12	$454	$596	$932	$1,372	$1,804	$2,136
13-16	$490	$644	$1,064	$1,560	$2,062	$2,556
17-20	$538	$698	$1,202	$1,762	$2,318	$2,986
21-24	$590	$750	$1,342	$1,960	$2,578	$3,428
25-28	$770	$1,120	$1,900	$2,728	$3,496	$4,428
29-32	$952	$1,482	$2,444	$3,496	$4,406	$5,444
33-36	$1,136	$1,844	$2,994	$4,266	$5,316	$6,460
37-40	$1,316	$2,210	$3,542	$5,036	$6,226	$7,566
41-44	$1,498	$2,570	$4,092	$5,806	$7,138	$8,492
45-48	$1,678	$2,938	$4,642	$6,576	$8,048	$9,506
Covers	$148	$166	$218	$274	$338	$396

Black and White Reprint Prices Purchase Order						
International (includes Canada and Mexico)						
# of Pages	50	100	200	300	400	500
1-4	$180	$218	$268	$384	$488	$602
5-8	$250	$294	$484	$660	$846	$1,032
9-12	$336	$404	$672	$960	$1,230	$1,522
13-16	$402	$508	$870	$1,232	$1,598	$1,960
17-20	$488	$618	$1,058	$1,528	$1,972	$2,424
21-24	$560	$708	$1,254	$1,802	$2,344	$2,890
25-28	$652	$822	$1,444	$2,074	$2,762	$3,428
29-32	$720	$920	$1,644	$2,382	$3,122	$3,860
33-36	$790	$1,018	$1,846	$2,684	$3,454	$4,292
37-40	$860	$1,118	$2,022	$2,986	$3,812	$4,722
41-44	$944	$1,218	$2,224	$3,288	$4,170	$5,154
45-48	$1,014	$1,318	$2,426	$3,590	$5,990	$5,584
Covers	$212	$226	$326	$448	$566	$682

Color Prices Purchase Order						
International (includes Canada and Mexico)						
# of Pages	50	100	200	300	400	500
1-4	$320	$500	$712	$976	$1,150	$1,288
5-8	$504	$622	$972	$1,418	$1,742	$2,062
9-12	$588	$728	$1,170	$1,728	$2,260	$2,708
13-16	$662	$812	$1,378	$2,018	$2,666	$3,304
17-20	$754	$910	$1,592	$2,334	$3,066	$3,910
21-24	$832	$994	$1,802	$2,636	$3,472	$4,532
25-28	$1,062	$1,404	$2,422	$3,504	$4,526	$5,708
29-32	$1,274	$1,796	$3,048	$4,392	$5,582	$6,904
33-36	$1,486	$2,190	$3,872	$5,272	$6,606	$8,104
37-40	$1,700	$2,584	$4,272	$6,154	$7,658	$9,302
41-44	$1,914	$2,978	$4,898	$7,036	$8,710	$10,500
45-48	$2,130	$3,374	$5,524	$7,916	$11,226	$11,698
Covers	$212	$226	$326	$448	$566	$682

Additional Rates	
Set title page, each	$16.00
Each extra mailing	$32.00
Remake pages, each	$50.00

Subscriptions and Special Offers

In addition to purchasing reprints of their articles, authors may purchase an annual subscription, purchase an individual issue of the journal (at a reduced rate), or request an individual issue at no cost under special "hardship" circumstances.

To place your order online, visit http://www.apa.org/pubs/journals/subscriptions.aspx; or you may fill out the order form below (including the mailing label) and send the completed form and your check or credit card information to the address listed on the order form.

For information about becoming a member of the American Psychological Association, visit http://www.apa.org/membership/index.aspx; or call the Membership Office at 1-800-374-2721.

2013 EPF Journal Subscription Rates

Journal*	Individual Rate	APA Member Rate	Journal*	Individual Rate	APA Member Rate
Asian American Jrnl of Psychology	$ 116	$ 67	Jrnl of Theoretical & Philosophical Psych	$ 111	$ 67
Canadian Jrnl of Behavioural Science	$ 126	$ 89	Jrnl of Threat Assessment & Management	$ 111	$ 67
Canadian Jrnl of Experimental Psych	$ 126	$ 89	Law and Human Behavior	$ 126	$ 83
Canadian Psychology	$ 126	$ 89	Peace & Conflict: Jnl of Peace Psychology	$ 104	$ 67
Clin Pract in Pediatric Psychology	$ 111	$ 67	Personality Disorders: TRT	$ 116	$ 67
Consulting Psychology Journal	$ 111	$ 67	Psychiatric Rehabilitation Jrnl	$ 158	$ 83
Couple & Family Psychology: Res & Prac	$ 116	$ 67	Psychology of Violence	$ 116	$ 67
Cultural Diversity & Ethnic Minority Psych	$ 111	$ 67	Psychoanalytic Psychology	$ 111	$ 67
Dreaming	$ 126	$ 67	Psychological Services	$ 111	$ 67
Families, Systems & Health	$ 168	$102	Psychological Trauma: TRPP	$ 158	$ 78
Group Dynamics: Theory, Res, and Practice	$ 111	$ 67	Psychology of Aesthetics, Creativity & Arts	$ 111	$ 67
History of Psychology	$ 111	$ 67	Psychology of Men & Masculinity	$ 111	$ 67
International Jrnl of Play Therapy	$ 126	$ 67	Psychology of Popular Media Culture	$ 116	$ 67
International Jrnl of Stress Management	$ 111	$ 71	Psychology of Religion & Spirituality	$ 116	$ 67
International Perspectives in Psychology: RPC	$ 116	$ 67	Psychomusicology: Music, Mind & Brain	$ 116	$ 67
Jrnl of Diversity in Higher Education	$ 111	$ 67	Psychotherapy	$ 142	$ 74
Jrnl of Latina/o Psychology	$ 110	$ 67	Review of General Psychology	$ 111	$ 67
Jrnl of Neuroscience, Psychology & Econ	$ 116	$ 67	School Psychology Quarterly	$ 126	$ 67
Jrnl of Occupational Health Psychology	$ 111	$ 67	Sport, Exercise, & Performance Psychology	$ 116	$ 67
Jrnl of Psychotherapy Integration	$ 111	$ 83	The Psychologist-Manager Jrnl	$ 111	$ 67
Jrnl of Rural Mental Health	$ 70	$ 35	Training & Education in Prof. Psych.	$ 126	$ 67

*For journal descriptions, see APA's website: http://www.apa.org/pubs/journals

---

Instructions: Check the appropriate box, enter journal title and price information, and complete the mailing label in the right column. Enclose a check made out to the **American Psychological Association**, and mail it with the form to the APA Order Department or complete the credit card information below. Orders can also be placed online at http://www.apa.org/pubs/journals/subscriptions/aspx.

☐ Annual Subscription (available on January-December basis only). To subscribe, specify calendar year of the subscription. Refer to the Subscription Rates shown above.

Journal: _____

Calendar year of subscription: _____ Price: _____

Special Offers! If you are a journal article author, you may take advantage of two Special Offers.

☐ **Individual Copy.** You may order individual copies of the entire issue in which your article appears. As an author, you receive a special reduced rate of $5 per copy for up to a maximum of 25 copies. No phone requests accepted.

Journal: _____

Vol. no.: _____ Issue no.: _____ Issue month: _____

____ copies @ $5 a copy = $_____ (order amount)
+_____ (handling; see below)
TOTAL enclosed: $_____

Shipping & Handling Fees			
Order amount:	U.S. & Puerto Rico	Guaranteed Non-U.S.*	Economy Non-U.S.**
Up to $14.99	$5.00	$50.00	$15.00
$15 to $59.99	$6.00	$75.00	$16.00
$60.00+	10% Order Total	$125.00	$20.00

*International rates for guaranteed service are estimates.

**I agree that international economy service is non-guaranteed and does not provide tracking or date/time specific delivery. Delivery time for this level of service can take up to 8 weeks. If this level of service is selected, APA will not be held liable and will not honor any claims for undelivered, delayed, or lost shipments.

☐ **Hardship Request.** If you do not have a personal subscription to the journal and you do not have access to an institutional or departmental subscription copy, you may obtain a single copy of the issue in which your article appears at no cost by filing out the information below.

Journal: _____

Vol. no. : _____ Issue no.: _____

Issue month: _____

CREDIT CARD PAYMENT

___ VISA ___ MASTERCARD ___ AMERICAN EXPRESS

CARD NUMBER_____

Expire Date _____ Signature _____

PRINT CLEARLY – THIS IS YOUR MAILING LABEL

SHIP TO: Phone No. _____

Name _____

Address _____

_____

City _____ State _____ Zip _____

Expedited Service (enter service required): _____

Send the completed form and your check, made out to the **American Psychological Association**, or your credit card information to:

APA Order Department
750 First Street, NE
Washington, DC 20002-4242

All orders must be prepaid. Allow 4-6 weeks after the journal is published for delivery of a single copy or the first copy of a subscription.

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

Peace and Conflict: Journal of Peace Psychology

1078-1919/13/$12.00 DOI: 10.1037/a0032533

AQ: 1

Trauma-Focused Cognitive Behavioral Therapy for Youth Who Experience Continuous Traumatic Exposure

AQ: au

L. K. Murray
Johns Hopkins School of Public Health, Baltimore, Maryland

J. A. Cohen and A. P. Mannarino
Allegheny General Hospital, Pittsburgh, Pennsylvania

Many evidence-based treatments are now available for traumatized children and youth, and their families. Although these are typically based on past traumas, a large portion of these youth experience continuous traumas. Trauma-focused cognitive–behavioral therapy (TF-CBT) is an evidence-based treatment that has been used successfully with youth and families who experience ongoing traumas. Within these studies and projects, TF-CBT trainers have worked collaboratively with stakeholders, families, and service providers to develop TF-CBT strategies to best respond to populations with continuous trauma. This article highlights certain projects, presents common conceptualizations of continuous trauma, and describes four practical strategies commonly and successfully utilized with youth/families experiencing continuous trauma. Each strategy is exemplified with case studies. The addition of such strategies helped to assure safety and enhance the uptake of coping skills as traumas arise. Research suggests that even in cases of continuous traumas, youth can be treated with TF-CBT and significantly improve symptoms.

Keywords: children, trauma-focused CBT, continuous trauma, domestic violence, evidence-based practice

Many evidence-based treatments (EBTs) are now available for traumatized children and youth (National Child Traumatic Stress Network, n.d.; Silverman et al., 2008). These treatments are typically based on the conceptualization of trauma as a series of past events to which youth develop overgeneralized reminders that cause problems in a variety of domains (e.g., affective, behavioral, cognitive, sensory, perceptual, and/or interpersonal regulation difficulties; Cohen & Mannarino, 1998; Cutajar et al., 2010; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989). However, youth who experience continuing traumas such as war, community or domestic violence have realistic expectations of danger and ongoing threat.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT, Cohen, Mannarino, & Deblinger,

Laura K. Murray is an Assistant Scientist at Johns Hopkins University School of Public Health, Department of Mental Health. She regularly conducts TF-CBT trainings and consultation, and her research focuses on implementation of evidence-based practices such as TF-CBT in low-resource settings.

Judy A. Cohen, MD, is a Professor of Psychiatry and the Medical Director for the Center for Traumatic Stress in Children and Adolescents in the Department of Psychiatry at MCP-Hahnemann/Drexel University School of Medicine/Allegheny General Hospital. She is a co-developer of TF-CBT and has published, trained, and delivered TF-CBT extensively throughout her career.

Anthony Mannarino, PhD, is Professor of Psychiatry, Temple University School of Medicine and Drexel University College of Medicine, Vice Chair, Department of Psychiatry, Allegheny General Hospital and Program Director, Center for Traumatic Stress in Children and Adolescents. He is a co-developer of TF-CBT who has published extensively in the area of child trauma.

In order to protect client confidentiality all examples in this article are composite case descriptions. Funding for this project was provided by grants from the Substance Abuse and Mental Health Services Administration (Grant SM 54319) and the National Institute of Mental Health (Grants No.R01 MH72590 and K23 MH077532).

Correspondence concerning this article should be addressed to Laura Murray, Johns Hopkins Bloomberg School of Public Health, Department of International Health, 615 N. Wolfe Street, Baltimore[exclude_city], MD, 21205. E-mail: lamurray@jhsph.edu

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

2006; www.musc.edu/tfcbt) is one such EBT for traumatized youth, including those who experience continuing trauma (Cohen, Mannarino, & Iyengar, 2011). TF-CBT was developed to address the multiple negative impacts of traumatic life events for youth aged 5–17 years old and their parents or primary caregivers (when available). This treatment has several components including: Psychoeducation, Relaxation, Cognitive Coping, Trauma Narrative and Processing (i.e., gradual exposure), In-Vivo Exposure, Conjoint Parent–Child Sessions and Enhancing Safety Skills. The components are taught and practiced in a logical sequence with each element building on skills from the element previously taught. In TF-CBT, children are encouraged to approach (rather than avoid) increasingly detailed and distressing trauma-related reminders and memories (i.e., exposure). Equally important in TF-CBT is the cognitive reprocessing of unhelpful thoughts. Multiple randomized controlled studies conducted in high-income countries have demonstrated that TF-CBT is highly effective in treating the sequelae of child trauma (Deblinger, Mannarino, Cohen, & Steer, 2006; Dorsey, Briggs-King, & Woods, 2011). Follow-up studies provide evidence of sustained benefit at 6 months, 1 year, and 2 years posttreatment (Cohen & Mannarino, 1998; Deblinger et al., 2006; Deblinger, Steer, & Lippmann, 1999). TF-CBT has been adapted and used with a variety of populations including Latinos (de Arellano & Danielson, 2005), and Native Americans (Big-Foot & Schmidt, 2010). It has demonstrated broad applicability as well as acceptability among ethnically diverse therapists, children, and parents (Huey & Polo, 2008).

Numerous studies and projects of TF-CBT treatment have been conducted in the U.S. and internationally with children who are exposed to ongoing traumas (e.g., Cohen et al., 2011; Murray et al., 2010). These types of populations may be characterized as "stably unstable." For example, there may be a youth who witnessed a fatal shooting, and yet still has to live in a neighborhood that is violent and perhaps even see the location of the shooting. Alternatively, there may be a child whose mother has been physically and emotionally abused by a partner, and this partner remains in their lives. In low-resource settings, the perpetrator of sexual abuse of a youth may still be living in the village due to poverty, and limited legal and child protection systems. Many service providers of such cases utilize stabilization interventions alone, citing concern in using exposure-based interventions although there is ongoing violence or traumas. One of the most frequently heard questions by TF-CBT trainers is how to do exposure treatment safely when there is ongoing traumatic exposure.

Over many years, TF-CBT trainers have worked collaboratively with stakeholders, families and service providers to develop TF-CBT strategies to best serve their needs, and respond to populations with continuous trauma. The goal is to still give youth and families effective treatment, but to modify it to account for the continuous trauma they are experiencing and the concomitant loss of safety. Some of these strategies have been briefly described in a previous article (Cohen, Mannarino, & Murray, 2011) and in forthcoming book chapters (Cohen, Mannarino, & Navarro, 2012; Kliethermes & Wamser, 2012). The purpose of this article is to share some conceptualizations of continuous trauma and some practical strategies learned from these efforts, and to ultimately address the above concerns of therapists who are trying to help youth exposed to continuous trauma.

Sample Projects Implementing TF-CBT for Continuous Traumas

The projects below have participated in developing the conceptualization of continuous trauma for youth/families and the design and subsequent use of these strategies. The Children Recover after Family Trauma (CRAFT) Project was conducted from 2004–2009 to evaluate the effectiveness of TF-CBT compared with usual child treatment in a community domestic violence center, the Women's Center and Shelter of Greater Pittsburgh (WCS). Many of these families were returning to the abusive partner to some degree. Data show that TF-CBT led to significantly greater improvement in anxiety and Post Traumatic Stress Disorder (PTSD) symptoms than child centered therapy for youth experiencing domestic violence in the CRAFT Project (Cohen et al., 2011). Importantly, youth receiving TF-CBT also experienced significantly fewer serious adverse events such as reabuse, psychiatric hospitalization, or repeated episodes of domestic violence (Cohen et al.,

AQ: 2

AQ: 3 2011). Another contributing project is from a major roll-out of TF-CBT within the state of California through the California Institute of Mental Health (CIMH). Since 2005, TF-CBT trainers have consulted with organizations working with families living in dangerous communities with continuous trauma (e.g., constant shootings), or with children living with ongoing domestic violence and/or the threat of it. These cases were discussed with local supervisors and counselors as well as the TF-CBT developers and a list-serve of TF-CBT trainers. TF-CBT has been demonstrated to be effective across multiple sites (CIMH, 2010). Globally, there have been ongoing TF-CBT studies in Zambia and Cambodia where there is a limited amount of mental health infrastructure and legal systems to protect children. For example, children may have to remain in a household with a perpetrator because this person is the breadwinner. Due to extensive poverty, there is often a payoff to abused families and the abuser remains free and often in the same area. Significant prepost improvement in PTSD and shame among youth experiencing domestic violence, sexual abuse and multiple traumas was demonstrated in the Zambia projects (Murray et al., 2010).

As a result of these collaborative efforts, the authors noted therapist and site conceptualization of continuous trauma, and similarities of approaches that were commonly and successfully used in cases of continuous trauma. We organized these approaches under general strategies, and below present cases that exemplify each of these.

TF-CBT Strategies in Contexts of Continuous Trauma Exposure

Working with cases where there is ongoing traumatic experiences is complicated, and requires balance. For example, when there is continuous trauma, there is a need to constantly reflect and act upon the level of danger, and learn to distinguish between real danger and overgeneralized trauma reminders. For therapists, it can be challenging to stay on track with any treatment while also giving due attention to safety issues. Service providers we have worked with sometimes talk about "being stuck in stabilization for safety reasons." In addition, youth experiencing ongoing traumas often have little time to reflect upon any one traumatic experience before the next trauma or stressful life event occurs. It is exceedingly difficult to see oneself and one's situation clearly while still being immersed within that situation. Also, youth experiencing ongoing trauma might not be able to successfully apply coping strategies until they are able to differentiate between realistic danger and overgeneralized trauma reminders. Finally, continuous trauma can also lead to a level of hopelessness that may be apparent in youth and families. For example, we may hear a defeatist phrase such as "this is just how it is and will always be" from youth or families. Occasionally therapists also adopt this hopelessness, which may lead to getting "stuck" in therapy. These may be accurate thoughts, but they are not helpful when working to feel better. The following strategies demonstrate how TF-CBT can be effectively used in the situations described above. Each strategy is followed by case examples that exemplify the unique nature of ongoing trauma exposure and the use of the particular strategy.

TF-CBT Practical Strategy #1: Prioritize Safety

Safety is prioritized early in treatment, and runs throughout each component of TF-CBT. For example, early and ongoing validation of the youth's legitimate safety concerns is crucial. Equally important is bringing to awareness unsafe or potentially unsafe situations that the family may not be acknowledging. The therapist explores the impact of diminished safety (e.g., overestimation of danger at times when the youth is temporarily safe; unnecessary risk-taking, etc.) and provides enhanced safety-seeking skills. Even in extreme danger there are gradations of lesser and greater danger, so the therapist would try to help the youth and caregiver (if available) to recognize opportunities for improving safety. When teaching skills like relaxation, the therapist is careful to assure the child understands when it is safe to relax and times when relaxation should not be used.

Safety planning is best when is it done collaboratively in the spirit of empowering the youth/family to use this skill independently in the future. This is particularly important for families with continuous trauma. The safety plans should be very concrete and highly de-

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

tailed, and rehearsed. In other words, we would not want the plan to simply be "call someone." We often spend significant time walking through different scenarios, and having families check into options between sessions. Of course this type of planning in the context of ongoing traumas depends on several factors, including the nature and severity of danger involved in the trauma, the youth's developmental level and ability to carry out concrete safety plans, the participating caregiver(s) availability and ability to serve as a source or aid of safety, and the availability of other individuals who can serve as backup sources of safety for the youth.

Case example: Mutinta, a 13-year-old girl in Zambia, had witnessed years of domestic violence and had been hit multiple times herself. More recently, her father began sexually abusing her. Her mother was also very sick with HIV/AIDS. Although the abuse was reported, there was never any legal action taken as the father was the breadwinner and the family depended on him to provide for them. The counselor working with Mutinta moved the component "enhancing safety skills" up to the very first session with psychoeducation and talked about various safety plans. The counselor was careful not to judge Mutinta or the caregiver, but helped her begin to understand different levels of safety. She made a scale from 1–10 with Mutina about situations that were "the most unsafe" to just "minimally unsafe." Through doing this exercise the therapist learned about certain triggers that seemed to make violence and sexual abuse more likely including: (a) the father being drunk, (b) dinner not being ready when her father got home, (c) the baby crying loudly and not stopping, and (d) hard rains. The therapist helped Mutinta become aware of these as early signs she could watch for, and then suggested designing a safety plan for each of these. They brainstormed together different ideas and Mutinta agreed to try two things. First, before 6 p.m., Mutinta would put her baby brother on the floor to help her mother try to finish dinner on time. Second, if dinner was not ready by 6 p.m. when the father came home, she could take her younger siblings outside to play where she could hear if he was getting angry or not. If her father was calm, they would return to the house. If he was angry and violent, they would walk to a neighbor's house (whom agreed to this). The therapist asked if they should write it down to help her remember but Mutinta said she would not want her father finding a piece of paper with these ideas on it. In this case, Mutinta's mother was not able to attend sessions due to weakness, multiple jobs, and childcare. Mutinta said she would explain this to her mother, and thought her mother would be happy that Mutinta could help keep her baby siblings safe. They verbally and behaviorally repeated the plan multiple times in order to help Mutinta remember it. The therapist asked her to also write a list of places she might be able to go when it rained. Mutinta said that she sometimes stayed with an "auntie" (a neighbor) when she was scared. She agreed to ask the auntie if she could come and stay with her every time it rained hard.

Younger children are more dependent on adults for protection, therefore safety plans must take into account individual developmental, cognitive, and emotional factors as well as the abilities of the adults to protect the child. In addition to obvious physical factors (e.g., young children are not as fast, smart, or coordinated as adults), children also may not be capable of fully grasping the danger due to their emotional attachment to the perpetrator. For example, a young child may really love her father and not believe that he would hurt his or her mom again even if the child knew he had done it repeatedly before. For these children, providing a concrete behavioral plan with in-session role play, practice at home, rewards for following the plan, and clear consequences for noncompliance is more effective than trying to use logic with the child. However, therapists and parents must also consider how to validate the child's emotional attachment to the perpetrator within this plan or it will likely be ineffective.

Case example: Sam was a 6-year-old child living in the United States who experienced ongoing severe domestic violence between his biological parents. His father had a restraining order and was awaiting a hearing from a previous incident, but would still often come by the house. Sam believed his father was a good person, and often said that he loved him and that he never meant to hurt anyone (as his father often said to him).

Sam's mother explained her fear for her son's safety, and the therapist reassured her that addressing safety plans was the very first

thing they were going to work on together. The therapist explained the need for concrete, detailed, and rehearsed plans for younger children. The therapist collaboratively worked with the mother to develop a clear behavioral plan for when/if his father arrived unexpectedly at the house. The therapist met with Sam and suggested that mother join them to address some safety issues in this first session. The therapist then said that in light of the recent incidents with father coming to the house, it was important that the family develop safety rules in case father returned and any violence occurred. Sam repeated that his father had not meant to hurt his mother and his father would not do that again. The therapist explained that even when someone didn't mean to hurt someone else, when they become violent people can get hurt, like Sam's mother got hurt. It was her job (the therapist's) to see that Sam's family had rules in place to be as safe as possible. During this explanation, the mother expressed understanding for the child's love of his father and belief that he would not hurt them. The therapist outlined the plan (developed collaboratively with the mother) that included Sam going to his room as soon as his mother said the words "big truck," and going to the big truck that had an emergency phone in it. He could push one button and the phone would automatically dial his aunt, who would not answer but would immediately call 911. They practiced this several times in session. Sam's reward for adhering to the safety plan was going out for pizza at his favorite place with his mom.

Youth and their parents experiencing community violence may perceive that their entire environment is dangerous and that there is no way to stay safe. Therapists work with these youth and their parents to identify safe places, people, and settings that may exist even within the most dangerous communities. Identifying churches, mosques, or other faith-based organizations, neighborhood watch organizations, schools, YMCA or other community organizations, relatives' and neighbors' apartments or homes where the youth can seek refuge, can help youth and parents identify safe options despite the ubiquitous danger. Youth and parents plan alternative routes to places they might go, with several "safe" places along the way. Therapists may also practice specific safety strategies if the youth were to encounter someone with a weapon (e.g., hiding, lying still).

Case example: George was a 14-year-old exposed to ongoing community and domestic violence whose mother brought him to TF-CBT due to truancy. George refused to attend school since being attacked and beaten there. He lived in a dangerous inner-city neighborhood where shootings were a nightly occurrence and bullets sometimes entered the family's apartment. The mother's boyfriend was also violent toward his mother at unpredictable times. At the start of TF-CBT George stated that he didn't feel very safe anywhere: home was dangerous because of mother's boyfriend and the gunshots being fired randomly into their home and the neighborhood was dangerous because of the random shooting, gangs, and drug dealers. The therapist started TF-CBT safety planning by meeting together with George and his mother, Clara. The therapist acknowledged how dangerous and precarious their lives sounded, and asked them how they had managed to get through their difficulties this far. Clara said all they had was their family and faith. The therapist asked Clara to tell him more about this, and she said that they had a network of family and friends and a faith community that supported them. Once Clara and George started naming several individuals, the therapist asked them to identify these individuals' locations on a map of their neighborhood in relationship to the family's home. This became a physical map of the family's support network. George's mother also added the family's church and the younger children's after school program, both of which mother identified as supportive and safe settings. This added up to more than two dozen locations all within two miles of the family's home. George added a few of his own friends to the map, making more than 30 locations on the map.

The therapist then asked about the layout of the family's own home and had George and his mother draw a map of the house to consider whether all the rooms in the house had been hit by bullets, or only some. George and Clara identified several rooms that had been hit by bullets, but a few had never been hit. They realized there were two "safe" rooms without windows in the house. This led Clara to come up with the idea that they could use these rooms for sleeping areas instead of sleeping in their current bedrooms, both of which had been hit

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

with bullets. This, she added, might help them start sleeping better.

Clara and George said that just looking at these maps made them realize that there were more "safe" places in their community and their home than they had realized, making them feel like they had some control over their safety. They then started mapping out routes from the family's home to George's school, the supermarket, and other places that George or Clara often went, that passed by several "safe" places along the route. They also agreed that calling ahead to one or more of the "safe" people when they were walking along one of these routes might reassure them that someone would be on the lookout for them on the way to support that they were safe. They agreed that arranging to walk with others would feel safer, and they discussed how to make such arrangements. George and his mother implemented these plans, and created some in relation to Clara's boyfriend. Both reported feeling much safer.

TF-CBT Practical Strategy #2: Enhancing Engagement

This strategy includes engaging helpful adults such as caregiver(s), the faith community, extended family, school, and other potential community or family supports that may enhance resilience and safety and diminish risk and danger. If possible, the therapist should identify one or more adults who can participate in TF-CBT with the youth to provide enhanced support and safety and to validate the impact that continuing trauma has had on the youth.

As with any effective trauma treatment model, engagement is a critical part since betrayal of trust and avoidance are core issues for traumatized individuals. For example, some women who are survivors of domestic violence (DV) have difficulty trusting therapists for fear of having their child taken away or the abuser threatening them if they do talk to someone. Some DV survivors also do not want to talk about the violence (i.e., a coping mechanism, avoidance). With ongoing trauma, therapists need to use even more proactive engagement strategies. We describe some of these strategies below in brief, followed by case examples.

As is often the case in domestic violence, caregivers return to abusive partners for a number of reasons such as believing there is more danger in leaving the perpetrator than remaining, or feeling they could not survive (meet basic food and shelter needs) without the abusive partner. Counselors may work to engage caregivers in these situations by simultaneously validating the parent's desire to protect their children from violence, and the parent's fears about leaving the perpetrator. Providing psychoeducation that demonstrates the therapist's insight into the parent's present quandary may be a helpful initial engagement strategy. For example, explaining that many domestically abused women leave multiple times before leaving permanently, and validating that the risk of violence often increases at the time the abused woman leaves, often helps clients trust that their counselor really understands their situation without seeming judgmental.

Case example: Melissa brought her 9-year-old son Ron for an assessment at his school's insistence because Ron was having repeated stomachaches at school and wanted to go home in the middle of the day. Melissa initially denied knowing why Ron would have such problems but reluctantly acknowledged that she had left her husband twice in the past and took her children to live with her parents. Melissa's mother (a devoutly religious woman) made comments to Melissa and the children such as "a wife belongs with her husband," "children need their father," and "you belong to him now." Feeling she had no choice, Melissa returned to her husband.

At the assessment Ron described the domestic violence and acknowledged wanting to leave school because he was worried about his mother. He endorsed significant PTSD symptoms and the assessing clinician referred Ron and his mother to TF-CBT.

During the initial TF-CBT appointment Melissa minimized the domestic violence and said that Ron had "barely seen anything." Melissa said she did want to take good care of her children. The therapist said that she could tell what a good parent Melissa was because she didn't want anything bad to happen to Ron, and she wanted very much to protect her child. The therapist then said that she had seen a lot of mothers who had suffered from domestic violence, and that she would like to share some information with Melissa about these women. Melissa warily agreed, and the therapist said that most women who experienced domestic vi-

olence had left and returned to their husbands or partners more than five times. Melissa was surprised to hear this. The therapist said, "Did you know that the average number of times a battered woman leaves her husband or partner before she leaves permanently is six times? You've only left twice. Most women have done this three times more than you have. And many battered women never leave at all." Melissa said, "I had no idea. No idea at all. I thought I was such a coward. I thought everyone would look down on me if they knew I had left and gone back." The therapist said, "Coward? You are very brave! You're here getting help for your son. Most women would never have the courage to come here and help their child talk about it and heal. I really admire you for helping your child like this." Melissa was able to see herself in a different light through receiving this praise and psychoeducation, and agreed to begin the TF-CBT therapy.

Engagement is also an important strategy for parents who are inadvertently reinforcing their youth's negative behaviors due to the parent's personal trauma issues. This often occurs in situations in which the youth's trauma-related behavioral or emotional problems serve as personal trauma reminders for the parent. Psychoeducation and other TF-CBT coping skills are unlikely to be useful for these parents and youth unless therapists have first effectively engaged the parent.

Case example: Sonkwe was a 15 year-old Zambian male. His father was suffering from AIDS and had a long history of violence toward everyone in the home. He also sexually abused the mother and Sonkwe's younger sister Mary, both of whom were now HIV positive. Sonkwe had been sexually abused himself by an uncle, but was HIV negative. Sonkwe's mother did not see her son as a victim. Unlike Mary, who was sad and withdrawn, Sonkwe was angry and sullen. Sonkwe's mother was worried that Sonkwe was going to grow up to be "just like his father" and she was upset that he acted "without respect" toward her. The therapist initially tried to explain that Sonkwe's anger was a normal response to sexual abuse by his uncle and to the ongoing violence in the home. Sonkwe's mother responded, "I was sexually abused and live with violence; the same for my daughter. We do not act like Sonkwe. It cannot be because of abuse that he acts like this. It must be that he is just his father's son." The therapist explained that different people respond differently to stress, and asked Sonkwe's mother how she personally had managed to cope so resiliently—however, these techniques were not successful in engaging her.

The therapist was stymied in how to connect with this mother. The therapist, along with the help of a local supervisor, asked herself, "What would I be most afraid of if I were her?" The Zambian therapist thought that if she were the mother, she might be afraid that if her son did grow up to be a perpetrator like his father, this would shame her family and she would have failed him as a parent. This would be an especially potent concern for this mother in light of the fact that she could not leave the father given the family's current situation, and the likelihood that mother would die before Sonkwe reached adulthood. The mother could not prevent Sonkwe from having ongoing exposure to his father's "bad influence" and the therapist guessed that the mother may feel helpless to keep Sonkwe from following in father's footsteps. By trying to understand this mother's concerns, the therapist gained insight into how to engage the mother.

When the therapist met with Sonkwe's mother for the second session, rather than trying to explain Sonkwe's anger and disrespect as being due to trauma, she validated his mothers' concerns about Sonkwe's behaviors and said that she understood how concerned she was about these. The therapist asked the mother to talk more about her worst worries about what might happen to Sonkwe. The mother said that Sonkwe was the only member of their family who did not have HIV; their family's future (including "family name") rested on him. If Sonkwe someday abused his own wife or daughter, their family would be disgraced. The mother was tearful as she said this and looked away from the therapist in shame.

The therapist validated how frightening it was for the mother to see similar behaviors in Sonkwe as what she saw in her husband, and said, "I understand your concern about Sonkwe and agree with you that it is very important that he not abuse another person. I am so glad that you have brought him here for help. Sonkwe does not have to grow up to be like his father, and I do not believe he will, because he has something so important that his father did not

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

have as a child. Sonkwe has a brave mother who is determined to raise him into a kind and respectful husband who does not abuse his wife or children. He is very lucky to have you. How lucky for your future daughter-in-law and grandchildren that Sonkwe has you to help him to grow up to be different from his father and uncle. You are a wonderful mother and I will help you help Sonkwe so that he does not do the things his father has done. I think he will have a happy future with your help." This engagement approach was much more effective, and the mother was positive about her own ability to help her son.

Therapists may find it challenging to avoid blaming or shaming nonoffending parents for decisions that may contribute to increased vulnerability for their children. This may be especially difficult if a caregiver minimizes or denies the degree of her/his own abusive experiences (as in Melissa's case) or that of the youth. Working with chronic victims of interpersonal violence can be very frustrating for therapists because struggling to effectively protect oneself and one's children is a core feature of many such individuals. When youth experience abuse, therapists may feel a sense of personal responsibility for failing to sufficiently protect them. Therapists may inadvertently (or even intentionally) communicate this sense of responsibility to the nonoffending parent. However, if therapists find themselves "blaming the victim" instead of the perpetrator, this will threaten effective engagement and ultimately interfere with effective treatment. In these situations therapists must carefully monitor and address their own maladaptive attributions about themselves (e.g., "I should have done something differently;" "It's partly my fault this youth was abused;" "I'm a bad therapist for letting this happen") or nonoffending parents (e.g., "Women like her have no right becoming parents;" "She's such a terrible mother, no wonder her husband gets mad at her"). Therapists who struggle with these should understand that this is normal and promptly seek additional supervision in order to develop more accurate and helpful cognitions and other coping strategies to effectively address these issues.

Case example: Lynn had just started to provide TF-CBT with Sharon and her 9-year-old son Terry. Sharon was living with her abusive boyfriend JT but denied this until Terry told the therapist. Sharon then defended JT and said that Terry exaggerated the severity of the domestic violence. During the second TF-CBT session, Terry disclosed that JT had beaten him with a belt and showed Lynn belt marks on his back. Lynn reassured Terry and told him that she was going to meet with his mother. Lynn met alone with Sharon and told her about Terry's disclosure and that she was required by law to report this. Sharon became angry, denied that JT could have done this, and accused Lynn of "putting ideas in Terry's head".

Lynn tried to stay calm but inside she was seething. She thought, "What's wrong with her? Why isn't she upset that her boyfriend beat her son? Why is she mad at me?" The calmer she tried to remain the more angry Lynn got. Lynn thought to herself, "This lady is not a good mother. I probably should have seen this coming last week and done more then to protect Terry." Lynn felt protective of Terry and angry with Sharon. She had difficulty controlling these emotions. After several minutes of trying to explain and engage Sharon, Lynn said that perhaps it would be helpful if she got her supervisor, Lori, and they spoke with her together. Sharon said that she would rather speak with Lori without Lynn present.

Lori, a personal domestic violence survivor, spoke with Sharon while Lynn called Child Protection Services. Lori told Sharon that she understood that Terry had made an allegation of physical abuse, and that Sharon did not believe the claim was true. Sharon angrily said that she knew it was not true. Lori explained that she and Lynn did not know what was true or not, and that they were not making any judgment about Sharon, JT, or Terry, or who was telling the truth. Lori relayed that when anyone told the therapists that they had experienced violence, the therapists had the responsibility to let the authorities determine whether that had happened. In this case they would let Child Protection Services figure out what had happened.

Lori then told Sharon that she had been where Sharon was now. Lori said that she remembered how frightened she felt, how hard it was for her to hear that her child had been abused, and how helpless she felt about having to choose between believing her husband, whom she loved and needed, or her child whom she also loved and wanted to protect. Lori said "My husband hitting me and my kids never got

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

through to me. It took losing my kids for the truth to hit me."

Lori explained that she and Lynn were there to help her, and Lynn calling Child Protection Services was part of helping Sharon to protect Terry when she could not do it alone. Child Protection Service's job was to figure out who was telling the truth, so she did not have to make that difficult determination on her own. Sharon cried and said that she loved her son, that she wanted help and didn't want Lori or Sharon to think badly of her. Lori told Sharon that Lynn cared deeply about Terry and Sharon and that it had upset her to learn about JT abusing Terry, but that Lynn knew Sharon was a good mother. Sharon agreed to wait in Lori's office and to speak with Lori and Lynn together.

Lori met with Lynn and asked her to do a cognitive triangle about the thoughts, feelings and actions she experienced before she left Sharon and pulled Lori in. Her thought was "she is a bad mother" and she was feeling frustrated. Lori then asked Lynn to remember when she told her personal history to her. Lori asked Lynn whether she believed that Lori had been a terrible parent. Lynn said, "You couldn't protect yourself so you gave your children to your mother. I know how much that tore you to pieces." Lori said, "What about when my kids were being beat up by my husband? Was I a bad mother then?" Lynn said, "You couldn't help what happened. You did everything you could." Lori reminded Lynn that Sharon was in a similar situation now. Lori encouraged Lynn to do a new triangle with more helpful thoughts about the situation. Lynn apologized and said she was ashamed of not handling her own upset feelings more appropriately. Lori asked Lynn to meet with Sharon together with her to discuss what had happened and to reengage her in TF-CBT.

The three met together and Lynn validated Sharon on how much she knew she wanted to keep Terry safe, and how hard it was for Sharon to hear what Terry had alleged. Sharon and Lynn processed Sharon's feelings about Terry's disclosure by talking about thoughts and feeling she had when Lynn first told her. Lynn praised Sharon for being a good mother and Sharon became tearful again, asking for Lynn's support to help Terry in therapy and to support them through the Child Protection process. They agreed to continue TF-CBT.

TF-CBT Practical Strategy #3: Real Danger Versus Trauma Reminder

Many youth who experience continuing trauma have difficulty distinguishing the difference between real and perceived danger because they are in a state of continuous hyperarousal. Appropriate vigilance to danger serves an important protective function but hypervigilance diminishes protective capabilities. Through creating and processing a personal trauma narrative, youth gain the ability to differentiate between overgeneralized reminders and real ongoing danger, learning to use different skills to cope with each situation.

Typical goals of the trauma narrative and cognitive processing include: (a) desensitizing youth to feared memories of past traumatic experiences and thus, mastering avoidance of these memories; (b) identifying and reprocessing maladaptive or unhelpful cognitions related to past traumas; (c) contextualizing past trauma into one's entire life experience; and (d) preparing the caregiver to be supportive to the youth in regard to these past traumatic experiences. Because youth experiencing ongoing traumas are continually resensitized to fear-inducing memories related to these new traumas, therapists have questioned whether creating narratives about past traumatic experiences could effectively decrease learned fear and avoidance for these youth, and whether creating narratives might even be harmful to these youth. TF-CBT therapists and trainers have anecdotally expressed that creating narratives are particularly helpful in some ways for youth experiencing ongoing traumas. First, hearing youths' detailed narration of their trauma experience results in many caregivers more fully acknowledging the "real danger" situations and how they are impacting youths' current behaviors, emotions, and reactions to triggers. Second, describing traumatic experiences within the safety of the therapy session, even if traumatic episodes continue to recur, allows youth to engage in some perspective taking, cognitive processing, and contextualization. This aids in differentiating real versus perceived or overgeneralized danger cues. Finally, youth gain increased ability to

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

distinguish between real danger and trauma reminders by including descriptions of both types of situations in their narratives and their thoughts and feelings related to this. Each of these is described in more detail below.

Caregivers more fully acknowledging the "real danger" situations. Caregivers who are experiencing ongoing personal traumas such as domestic violence often struggle to accept the degree to which their children are experiencing and/or impacted by these and whether they are real or perceived danger (e.g., Melissa and Sharon in the above examples). As the narratives are shared, caregivers hear details about what youth have heard and seen, and what they continue to hear and see in the present, which starkly contrasts with what parents are trying to convince themselves is true (e.g., "my child has barely seen anything;" "staying together as a family is best for my children"). Hearing the youth describe scenes of horrific domestic or community violence in their own words is extremely powerful and often successfully breaks through parental minimization about the youth's experiences. This process challenges some of the caregivers' unhelpful thoughts, allowing the caregiver to more appropriately validate the youth's trauma experiences and perhaps take different approaches to safety. This validation is an extremely important step in empowering youth. It is also critical to improving parental support and insight into the impact of ongoing trauma on youths' behavior and emotions, and ultimately to improving parents' own views of themselves as good parents.

Case example: Melissa and Ron continued in TF-CBT. Although the therapist encouraged Ron to implement new coping skills, he continued to worry about his mother and was only moderately successful at remaining in school throughout the school day. The therapist believed this was largely due to the mother's continued tendency to minimize the ongoing domestic violence and the degree to which Ron was aware of it. Ron did implement his new safety plan, going to his room as soon as his father began to yell at his mother (a usual prelude to physical violence). Melissa would typically deny that any violence occurred after Ron was in his room.

Ron created a trauma narrative with the therapist's encouragement, which included graphic descriptions of two domestic violence episodes. One had occurred before TF-CBT began, and the other occurred during therapy. Although Ron had gone to his room, he had watched some of the episodes through a crack in the door and so was able to describe what occurred. In both cases Ron described what each parent said, his mother's pleas to his father not to hurt her, and his father's brutal physical abuse. The second narrative included the following: "My mom was lying on the floor with her busted nose. There was blood squirting out of her nose and her eyes and everywhere. My dad kicked her in the face and the stomach, over and over again, saying, 'die, die.' I prayed for my mom not to die but I wished my dad would. All men treat women so badly." The therapist worked with Ron to differentiate which of these thoughts were indicative of real danger, and which may be overgeneralizations.

Previously when Melissa had discussed domestic violence with the therapist she had become tearful, saying that the episodes were infrequent, not that serious, and that the children were better off living with their father. When the therapist shared Ron's narrative with Melissa including the above graphic details, Melissa was silent and ashen-faced. She said, "I never knew he saw that. I thought he—I thought he loved his father." She struggled to accept how angry Ron was at his father. In reading his entire description, the enormity of what Ron had witnessed struck her and she said, "I'm an idiot. He saw what his father did. This is a 'real danger.' Of course he hated him. How could I not see that?" Melissa later told the therapist, "It was like a light bulb went on in my head. I finally got what it was like for Ron. Until I saw it in his own words, I never got that all this time he's been living through this just like me as a real danger."

Youth engage in perspective taking, cognitive processing and contextualization. Ongoing traumatic experiences provide new opportunities for perpetrators or others to reinforce youths' maladaptive or unhelpful cognitions. For example, after a new domestic violence episode the perpetrator might say, "If your mother only did what I told her I wouldn't have to punish her." After new community violence, a nonoffending parent might say, "If you hadn't been walking on that street you wouldn't have gotten attacked." Creating trauma narratives can help youth and caregivers become more adept at

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

accurately identifying proximal causes of specific traumatic experiences and minimizing such maladaptive cognitions. Changing unhelpful thoughts can help a child better differentiate real and perceived danger, and improve the youth's ability to effectively implement safety plans.

Case example: There was a report with Child Protection Services that indicated physical abuse by JT but he remained at home with Sharon and Terry. Sharon remained engaged with Lynn in TF-CBT treatment and she became more assertive about protecting Terry, such as not leaving him alone in JT's care but bringing Terry to her sister's house when she went to work. However, JT was furious about having to attend mandated anger management classes and during subsequent domestic violence episodes he made comments like, "ask your damn son about my anger problem, he's the one who shot off his mouth about it." Terry heard these comments and Sharon was too intimidated to respond to them.

Terry initially included two trauma episodes in his narrative: the time when JT physically abused him (that led to the Child Protection Services report), and a recent episode of domestic violence during which JT made comments blaming Terry, such as the one above. Terry then included maladaptive cognitions in which he blamed himself for the domestic and physical abuse. He dictated the following to Lynn: "If I was a good kid and always did what JT wanted, he wouldn't have beat me." "It's my fault that he hits my mom. I know because he says so all the time." "He gets mad because I told on him and now he has to go to class and that makes him even madder." "It's all because of me that he hurts my mom. If I just kept my mouth shut about the abuse and everything, maybe everything would just be okay and my mom would be happy again." "If I was never born JT would never have hurt my mom and my mom would be better off." Terry's self-blame underscores the particular vulnerability of youth who experience ongoing traumas to continuous reinforcement of maladaptive cognitions.

Lynn encouraged Terry to add another episode of domestic violence to his trauma narrative, in which he described the first time he remembered JT abusing his mother. Terry was able to describe that this occurred when Terry was much younger and Sharon had made a birthday cake for JT. Terry had made JT a birthday card and was very excited about the party they were going to have for JT. JT "smelled funny" when he came home and he started yelling at Terry's mother "for no reason." Terry tried to show JT the birthday card but JT threw the cake across the table and it landed on the floor. JT then yelled at mother to "clean up the mess she made." By describing the details of this episode Terry was able to identify that he and his mother had been doing a lot of very nice things for JT and he still became mean and violent for no reason. Despite this, JT tried to blame it on Sharon. This helped Terry to start thinking about other times when JT became violent and blamed it on his mother or him. Writing these narrative also helped Terry begin to understand the cues for real danger when JT was around (e.g., "smelling funny").

Lynn shared Terry's narrative with Sharon during individual parent sessions as Terry was writing it. Sharon was stunned to read Terry's words. His self-blame impacted Sharon more than anything in TF-CBT treatment. She said to Lynn, "That hit me like a ton of bricks. That he could blame himself—that changed everything for me." Sharon asked to meet with Terry even before Lynn introduced the conjoint sessions, so that she could reassure Terry that he was not responsible for any of JT's violence. Lynn agreed to bring them together for this purpose, and Sharon for the first time validated Terry's version of both his and her abusive experiences. She then said that what JT did was due to his problems and had nothing to do with Terry. Sharon said that she had made a lot of mistakes but that she was going to do everything she could to make it up to Terry from then on. This proved to be a turning point for the family. Sharon asked for a referral to individual therapy and by the end of TF-CBT treatment she and Terry had moved in with her sister.

Youth include descriptions of both types of situations (real and perceived danger) in their narratives. Youth who experience ongoing trauma have valid reasons to be sensitive to ongoing threats in their environments. However, excessive vigilance to trauma reminders that are inherently benign often causes hyperarousal symptoms that impinge on adaptive functioning. It is, therefore, crucial to help these youth differentiate real threats from trauma re-

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

minders that do not pose a real danger, and to help them use coping skills in response to the latter while using safety strategies in response to the former.

Case example: Linn was a 10 year-old girl from Cambodia who experienced several episodes of community violence. These were often preceded by angry confrontations or loud disruptive activity in the brothel where she was kept. Linn, now living in a safe shelter, was very reactive to arguments and raised voices and became very frightened when these occurred at the shelter or at school. She had no tolerance for anyone using stern voices and when this happened she would scream at the housemothers or teachers and run from the room, and sometimes the shelter. This had happened on multiple occasions leading to ongoing traumatic exposure to community violence and almost being picked up by another brothel. She also had an extreme reaction to peers arguing, feeling that she needed to escape and not being able to tolerate these situations. Linn had limited success in using coping skills when faced with innocuous trauma reminders, such as stern voices of teachers or housemothers correcting her, until she created her trauma narrative. The adults in Linn's life were unhappy at her outbursts and frustrated with her running away due to the high risk. Many had trouble viewing these as trauma-related behaviors. As a result, many staff found themselves continuing to use stern voices due to concern for her unsafe behaviors. They would say "the last thing I want is for her to end up back in a brothel. I know it was terrible for her—why would she put herself back in that situation?"

With the local counselors' help, Linn developed a trauma narrative in which she described her two scariest episodes of violence. In one of these Linn had witnessed the rape and beating of another very young girl while she hid, paralyzed with fear. The shelter staff had not previously heard the details of this episode. She also described several episodes in which her teachers had used stern or loud voices and this had triggered the same fearful feelings as the violent episodes she saw in the brothel. Linn's counselor worked with her to identify differences between the angry confrontations she heard before the serious violence and the stern voices she heard at the shelter or school. In the narrative, Linn identified differences between what happened when dangerous people in certain settings started to become violent versus when her housemother or teachers used stern voices to correct behavior, including what she thought and how she felt internally and physically. When scary people in the community started to speak loudly, it escalated to saying derogatory or threatening things, then to pushing, punching, beating, or other forms of physical violence including using knives. When these events occurred Linn thought that something terrible would happen such as someone dying, maybe even her, her friends or family members. This made her muscles tense up and her head hurt, and she felt "trapped, like I have to get out but I can't."

In contrast, at the shelter or school, when adults used stern voices that made her feel like "something terrible might happen," she was able to recognize that nothing terrible ever really happened in these situations. Through her therapy, Linn saw that the stern voices were just reminding her of what happened at the brothel. When adults raised their voices, no one got hit, beaten up, or physically hurt. Similarly, when Linn's peers argued, they never ended up physically fighting. Linn was then able to acknowledge that "kids argue all the time and nothing that bad happens." Linn said that she knew these situations were not dangerous, but it was still really hard for her to not feel the "need to get out" feeling at the time they were happening.

When the housemother and one other shelter staff heard the details of Linn's traumatic experiences, they gained a different perspective. They now recognized the similarity between what Linn had been through at the brothel, and some of what was just part of "normal child care." The therapist validated their desire to assure that Linn was a well-behaved and respectful young girl, and that they had simply misunderstood what her behaviors meant. Now that Linn had told them her story, they could help her even more. They were very eager to help Linn so the counselor discussed how staff could start implementing positive parenting strategies, including how they could support Linn in recognizing the difference between innocuous trauma reminders and real danger.

TF-CBT Practical Strategy #4: Providing Advocacy

Therapists often advocate for youth to receive other needed community services (e.g., educational, health, shelter, food, sanitation, etc.) that contribute to their safety and well-being. This varies in many settings within the United States depending on how many service providers are involved with the family. For example, some therapists are able to leave most of the "searching and finalization" of advocating different services to a caseworker or other individual with this role. However, at times, the therapist is the only person involved and, thus, advocacy might take on a small portion of the session time and would be focused on skill building and empowering the youth or family to learn how to gain access to other services. For example, a therapist may help a client write a list of all the little steps needed to finding a suitable home for her and her child. They may do step 1 together (e.g., making a phone call in session and arranging an appointment), and agree which steps the client can do on his or her own during the week. In low-resource settings, this advocacy may include obtaining, or in some cases creating, a list of organizations that provide different services, such as shelter (a community-based organization or church that takes families in for a short period of time), or food (a World Food Program site).

Case Example: Elizabeth, her five siblings, and their mother were living in a small hut in a compound in Zambia. Elizabeth began TF-CBT after disclosing that an older neighbor raped her. Elizabeth's father had recently passed away after being ill for a long time with HIV/AIDS. The family was struggling to survive with limited resources, and Elizabeth and two other older siblings had to stop attending school to work. It was on her way to work each day that Elizabeth came into continuous contact with this older neighbor. From the beginning, the mother explained to the counselor that she wanted to be involved, but mostly she wanted to move away from the area where they lived, or at least have Elizabeth move away for a time so she would not have to see this neighbor every day on the way to work. The mother had other goals such as allowing her children to return to school, and selling more of the textiles she made. In addition to spending time on a detailed safety plan for Elizabeth, the counselor also provided some advocacy for the family. Specifically, the counselor was able to give the mother a list of local resources that provided different help to families in need. They went through the list together with the counselor asking the mother to circle the ones that she felt may be able to help her achieve her goals. One of the places on the list was a church sponsored shelter with a school at its location. The counselor and mother discussed whether that may be a place that Elizabeth could stay at for some time to enhance her safety while we completed TF-CBT. The mother was hesitant to ask for help and said she didn't know when she "would get around to doing that." The counselor helped her come up with a list of small steps she would need to do first including: (a) call the shelter to arrange a visit, (b) request a visit on a Wednesday since this was the only day her auntie could help with the other children, (c) save minibus fare this week to assure she had the money to get to the shelter and back, and (d) once she had the date, speak to her auntie to watch the other children. The mother said, "ok, this seems easier now and I would very much like Elizabeth to be safe, and go to school again. She is such a clever child." The counselor and mother did the first step together, and the mother completed the others on her own. The following week, Elizabeth was at the shelter and not having to see the neighbor each day. The counselor continued her advocacy and helped the mother throughout TF-CBT to find other services she needed, and break these tasks down into small steps.

TF-CBT in Contexts of Continuous Trauma

This article outlined four strategies for applying TF-CBT in cases where there is continuous trauma. Our projects, research, and clinical work have found that even in the face of continuing trauma, TF-CBT along with such applications can contribute to improvement in mental health, resilience, and adaptive functioning. Contrary to concerns about using exposure-based treatments for youth experiencing ongoing trauma, with strategies like those above, TF-CBT led to significantly greater improvement in anxiety and PTSD symptoms for youth experiencing domestic violence in the CRAFT Project (Cohen et al., 2011), multiply trauma- AQ: 4

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

tized youth across California (CIMH, 2010), and youth experiencing domestic violence, sexual abuse, and multiple traumas in the Zambia projects (Murray et al., 2010).

Data from the CRAFT Project (see details in Cohen et al., 2011) offer potential explanations for mechanisms through which these strategies may aid in the effectiveness of TF-CBT in cases with continuous trauma. Three significant predictors of treatment outcome were found in this study (Cohen & Mannarino, 2010; Cohen, 2011). Each is discussed here briefly in the context of the strategies that have been described above. For all, TF-CBT treatment predicted greater improvement in both the mediator and youth outcome, relative to Child-Centered Therapy (Cohen et al., 2011).

First, improvement in parental depression as measured by the Beck Depression Inventory-II significantly predicted improvement in youth anxiety as assessed by the Scale of Children's Anxiety Related Emotional Disorders ($p < .01$; Cohen & Mannarino, 2010; Cohen, 2011). The strong focus in TF-CBT on parental engagement, helping parents to acknowledge and support their youth, and on correcting parental maladaptive cognitions, may have empowered parents to more effectively validate, protect and support their youth, thus decreasing youth anxiety.

Second, improvement in youth's trauma-related maladaptive cognitions as measured by the Children's Attributions and Perceptions Scale significantly predicted improvement in youth depressive symptoms as assessed by the Children's Depression Inventory ($p < .01$; Cohen, 2011; Cohen & Mannarino, 2010). The emphasis during the trauma narrative on addressing maladaptive cognitions related to ongoing traumas is likely critical in this regard; but we believe that some of the other strategies described above may also have contributed to correcting youth's maladaptive cognitions and, thus, to resolving depressive symptoms. The initial focus on safety is often critical in at least starting the process of challenging more global or permanent beliefs about danger. The extent to which parental engagement contributes to increased parental acknowledgment, validation of the youth's reality and correction of parental maladaptive cognitions, can also critically support more adaptive youth cognitions and, thus, diminish youth depression.

Third, improvement in general parental distress as assessed by the Brief Symptom Inventory led to significant improvement in youth cognitive functioning as assessed by the Kaufmann Brief Intelligence Test ($p < .002$) and improvement in parents' use of effective parenting strategies as measured by the Parenting Practices Questionnaire (Cohen, 2011; Cohen & Mannarino, 2010). These significantly predicted improvement in youth PTSD hyperarousal symptoms as assessed by the Schedule for Affective Disorders and Schizophrenia for Children and Adolescents, Present and Lifetime Version ($p < .007$). These findings reinforce the critical role of parents in generally improving youth outcomes. In particular, the strategy of attending to effective parental engagement by validating that parents experiencing ongoing trauma are also victims, and providing effective safety and coping strategies to parents as well as to youth, may all be important in reducing parents' general distress. The exact connection between parental distress and youth cognitive functioning is unclear, but as noted above, acute emotional arousal is incompatible with optimal cognitive functioning. Youth who are acutely worried or believe they must be hypervigilant due to extreme parental distress are unlikely to function well cognitively or to prioritize schoolwork. When parental functioning improves, their children often do better as well. TF-CBT routinely develops specific parenting strategies for problematic trauma-related behaviors. For youth with ongoing traumas, the additional focus during safety, parental engagement, and the trauma narrative components to help parents recognize their youths' trauma-related behaviors as such rather than signs that the youth is a "bad kid" or future perpetrator, may be particularly critical to enabling parents (such as Sonkwe's) to implement appropriate rather than harsh parenting strategies and, thus, to decrease youth hyperarousal symptoms.

It is important to note that this article represents a collection of thoughts and perspectives from ongoing work of community agencies, therapists, and trainers. Case examples are useful to highlight ideas and techniques. Future research may include a scientific evaluation of outcomes when particular strategies are used or not incorporated. Qualitative studies done within projects or studies focused on populations experiencing continuous trauma would

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

provide more formal insight into the therapists and clients' perspectives on how TF-CBT functions with ongoing traumas.

Summary

Through collaborating with local community members, stakeholders, and therapists, TF-CBT applications specific to continuous trauma cases have been implemented. The strategies discussed in this article include: (a) prioritizing safety, (b) enhancing engagement, (c) helping to differentiate real danger from trauma reminders, and (d) providing advocacy. With the help of these strategies, youth and their families experienced significant improvement in mental health symptoms and functioning. Utilizing such techniques allows us to maintain safety (and perhaps enhance it) while simultaneously offering efficacious treatment to families that find themselves in "stably unstable" situations. As opposed to "waiting" for unstable situations to change, therapists and counselors should continue to be creative about how to use various applications in continuous trauma cases, while still providing an evidence based treatment like TF-CBT that reduces mental health symptoms and increases functioning.

References

BigFoot, D. S., & Schmidt, S. (2010). Honoring children–mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy children. *Journal of Clinical Psychology, Special Issue: Culture-Sensitive Evidence-Based Practices, 66,* 847–856.

CIMH Trauma Focused Cognitive Behavioral Therapy Program Performance Report. (2010). *Retrieved from* http://www.cimh.org/LinkClick.aspx?fileticket=9EBpREVmRYs%3D&tabid=836&mid=1784

Cohen, J. A. (2011, March). *Trauma-focused CBT for children exposed to intimate partner violence: A community-collaborative application of an evidence-based treatment model*. Paper presented at Children Exposed to Violence: Evidence Based Interventions. Administration on Children, Youth and Families, Baltimore, MD.

Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment findings. *Child Maltreatment, 3,* 17–26. doi:10.1177/1077559598003001002

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York, NY: Guilford Press.

Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment for PTSD in children exposed to intimate partner violence: A randomized controlled trial. *Archives of Pediatrics and Adolescent Medicine, 165,* 16–21. doi:10.1001/archpediatrics.2010.247

Cohen, J. A., Mannarino, A. P., & Murray, L. K. (2011). Trauma-focused CBT for youth who experience ongoing traumas. *Child Abuse & Neglect, 35,* 637–646. doi:10.1016/j.chiabu.2011.05.002

Cohen, J. A., Mannarino, A. P., & Navarro, D. (2012). Residential treatment. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), *Trauma-focused CBT for children and adolescents: Treatment applications* (pp. 73–102). New York, NY: Guilford Press.

Cohen, J. A., & Mannarino, A. P. (2010). *National Institute of Mental Health Grant R01MH 72590, Final Progress Report. December 28, 2010.*

Cutajar, M. C., Mullen, P. E., Ogloff, J. R., Thomas, S. D., Wells, D. L., & Spataro, J. (2010). Psychopathology in a large cohort of sexually abused children followed up to 43 years. *Child Abuse & Neglect, 34,* 813–822. doi:10.1016/j.chiabu.2010.04.004

de Arellano, M. A., & Danielson, C. K. (2005, January). *Culturally-modified trauma-focused therapy for treatment of Hispanic child trauma victims*. Paper presented at the Annual San Diego Conference on Child and Family Maltreatment, San Diego, CA.

Deblinger, E., Mannarino, A., Cohen, J., & Steer, R. (2006). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 45,* 1474–1484. doi:10.1097/01.chi.0000240839.56114.bb

Deblinger, E., McLeer, S. V., Atkins, M. S., Ralphe, D., & Foa, E. (1989). Post-traumatic stress in sexually abused, physically abused, and nonabused children. *Child Abuse & Neglect, 13,* 403–408. doi:10.1016/0145-2134(89)90080-X

Deblinger, E., Steer, R. A., & Lippmann, J. (1999). Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. *Child Abuse & Neglect, 23,* 1371–1378. doi:10.1016/S0145-2134(99)00091-5

Dorsey, S., Briggs, E. C., & Woods, B. A. (2011). Cognitive behavioral treatment for posttraumatic stress disorder in children and adolescents. *Child and Adolescent Psychiatric Clinics of North America, 20,* 255–269. doi:10.1016/j.chc.2011.01.006

Huey, S. J., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth:

tapraid5/pac-pac/pac-pac/pac00313/pac0070d13z | xppws | S=1 | 3/15/13 | 11:34 | Art: 2013-0059

A review and meta-analysis. *Journal of Clinical Child and Adolescent Psychology, 37,* 262–301. doi:10.1080/15374410701820174

Kliethermes, M., & Wamser, R. (2012). Adolescents with complex trauma. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), *Trauma-focused CBT for children and adolescents: Treatment applications* (pp. 175–196). New York, NY: Guilford Press.

Murray, L. K., Skavenski, S., Familiar, I., Bass, J., Bolton, P., & Jere, E. (2010). *Catholic relief services, SUCCESS return to life, Zambia TF-CBT pilot project report to USAID*. ●●●: USAID. AQ: 7

National Child Traumatic Stress Network. (n.d.) *Retrieved from* http://www.nctsn.org

Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., et al. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child and Adolescent Psychology, 37,* 156–183. doi:10.1080/15374410701818293 AQ: 8

AUTHOR QUERIES

AUTHOR PLEASE ANSWER ALL QUERIES 1

AQau—Please confirm the given-names and surnames are identified properly by the colors.
■= Given-Name, ■= Surname
The colors are for proofing purposes only. The colors will not appear online or in print.

AQ1—Author: Please provide running head of 50 characters or less including spaces.

AQ2—Author: For Cohen et al., 2011, there are two possible references. Please check text and cite Cohen et al., 2011's with the correct one.

AQ3—Author: For Cohen et al., 2011, there are two possible references. Please check text and cite Cohen et al., 2011's with the correct one.

AQ4—Author: For Cohen et al., 2011, there are two possible references. Please check text and cite Cohen et al., 2011's with the correct one.

AQ5—Author: For Cohen et al., 2011, there are two possible references. Please check text and cite Cohen et al., 2011's with the correct one.

AQ6—Author: For Cohen et al., 2011, there are two possible references. Please check text and cite Cohen et al., 2011's with the correct one.

AQ7—Author: Please provide location for publisher in Murray, L. K., Skavenski, S., Familiar, I., Bass, J., Bolton, P., & Jere, E. (2010).

AQ8—Author: The APA does not allow the use of "et al." in the reference list. For Author, Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., et al. (2008), if author names total 7, please provide all 7; if there are 8 or more, list the first 6 and add the last author name after the ellipsis.