NCTSN The National Child Traumatic Stress Network

CFTSI: Child and Family Traumatic Stress Intervention

GENERAL INFORMATION

Treatment Description

Acronym *(abbreviation)* **for intervention:** CFTSI

Average length/number of sessions: 4

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:** CFTSI has been successfully implemented and evaluated with clients representing a range of ethnic and racial backgrounds. CFTSI materials have been translated into Spanish.

Trauma type *(primary)*: CFTSI is not limited to one specific trauma type. Children who have received CFTSI have experienced and/or witnessed a wide range of traumas (i.e. sexual abuse, physical abuse, domestic violence, community violence, rape, assault, motor vehicle accidents, etc.), and many have experienced chronic and/or multiple traumatic events.

Trauma type *(secondary)*: Wide range of trauma types (i.e. see above)

Additional descriptors *(not included above)***:** CFTSI focuses on two key risk factors (poor social or familial support, and poor coping skills in the aftermath of potentially traumatic events) with the primary goal of preventing the development of PTSD. CFTSI seeks to reduce these risks in two ways: (1) by increasing communication between the affected child and his caregivers about feelings, symptoms, and behaviors, with the aim of increasing the caregivers' support of the child; and (2) by teaching specific behavioral skills to both the caregiver and the child to enhance their ability to cope with traumatic stress reactions.

Families who receive CFTSI are often psychosocially disadvantaged in multiple ways and have long-standing needs not directly related to the Potentially Traumatic Event (PTE) that brought them into care. Case management and care coordination are essential aspects of CFTSI, based on the rationale that helping the family to access needed services, navigate medical care and legal proceedings, establish safety plans, coordinate with school personnel and other providers, etc., will both (1) reduce distractions, so that caregivers can dedicate more time and attention to their children in the aftermath of PTE, and (2) alleviate stressful burdens that often complicate caregivers' posttraumatic adjustment. CFTSI practitioners also seek to learn about each family's resources, both to facilitate the recruitment of maximum support during a time of greatest need, and to address barriers that directly impede access to CFTSI and other services. Depending on the nature of the issues and available resources within the clinical agency, the clinician can either include a Case Manager in the intervention or provide the case management by him or herself.

Target Population

Age range: 7 **to** 18

Gender: ❒ **Males** ❒ **Females** ☒ **Both**

Ethnic/Racial Group *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Latino (Puerto Rican, Mexican, Central and South American) from a range of acculturation levels including recent immigrants; African Americans; Caucasians; Multiethnic

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Target Population continued	**Other cultural characteristics (e.g., SES, religion):** Wide income range, although predominantly lower-income families, where both parents and children may have complex trauma histories **Language***(s)*: English and Spanish **Region** *(e.g., rural, urban)*: urban; suburban; rural **Other characteristics** *(not included above)*: CFTSI is an early intervention, secondary prevention treatment model that involves individual sessions with the child and caregiver, as well as conjoint caregiver-child sessions. CFTSI is provided to children and adolescents who have experienced a Potentially Traumatic Event (PTE) within the past 30 days (including disclosure about prior sexual or physical abuse, or other PTEs that have only recently been revealed).
Essential Components	**Theoretical basis:** The targets of CFTSI are informed by findings that indicate the role of family support as a primary protective factor for children exposed to a PTE (Hill, Levermore, Twaite, & Jones, 1996; Kliewer, et al., 2004; Ozer, Best, Lipsey, & Weiss, 2003) Optimal support requires communication between caregivers and affected children (Kerr & Stattin, 1999, 2000; Kerr, Stattin, & Trost, 1999; Stattin & Kerr, 2000). CFTSI enhances communication by using wellestablished PTSD and Mood questionnaires as expeditious vehicles for identifying and discussing the child's difficulties and focusing on understanding and reviewing agreement and discrepancies between reported and observed symptoms of PTSD and Depression. Once symptoms are identified, CFTSI teaches caregivers and youth specific coping skills such as sleep hygiene and relaxation techniques to manage them. **Key components:** Goals of CFTSI: • Improve screening and identification of children impacted by traumatic stress • Reduce traumatic stress symptoms • Increase communication between caregiver and child about child's traumatic stress reactions • Provide skills to help master trauma reactions • Assess child's need for longer-term treatment • Reduce concrete external stressors
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 2

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Clinical & Anecdotal Evidence continued

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**

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No**

If YES, please include citation:

Marans, S., Hahn, H. Epstein, C, and Arnow, N. (2012). The Safe Horizon-Yale Child Study Center Partnership: Offering Hope for Abused Children. Presents outcome results of CFTSI cases completed in Safe Horizon Child Advocacy Centers that are consistent with the randomized controlled trial completed on CFTSI; presents caregiver satisfaction survey results that are overwhelmingly positive and indicate that families learn about the the impact of trauma through CFTSI.

Personal communication (2010) from Carla Stover to Steven Marans and Carrie Epstein. Satisfaction survey results indicating that those receiving CFTSI were much more satisfied than clients receiving comparison treatment.

A study of 64 cases completed at the Safe Horizon Child Advocacy Centers in New York City indicates high levels of caregiver satisfaction with the CFTSI. In 2011, 64 caregivers who completed CFTSI at a Safe Horizon CAC completed a client satisfaction survey; these caregivers expressed an extraordinary level of satisfaction with the help they received. 96.7% of respondents reported that they had learned new skills, and 98.4% said they would recommend CFTSI to a friend.

Marans, S., Hahn, H, Epstein, C and Arnow, N. (2012). The Safe Horizon-Yale Child Study Center Partnership: Offering Hope for Abused Children. [White Paper]. Retrieved from http://www.safehorizon.org/images/uploads/misc/1333460124_ChildAbuse_CFTSI_WhitePaper_Final.pdf

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

If YES, please include citation*(s)* **from last five presentations:**
Berkowitz, S., Brymer, M., Kassam-Adams, N. and Marans, S. (March 2012). Early Interventions That Aim to Prevent PTSD. Pre-Meeting Institute at the All Network Meeting of the National Child Traumatic Stress Network, Baltimore, MD.

Marans, S. and Epstein, C. (June 2011). CFTSI: A Brief Evidence-Based Treatment and It's Implementation in Settings that Serve Traumatized Youth.

Marans, S., Epstein, C. & Arnow, N. (September 2010). *The Child and Family Traumatic Stress Intervention: An Evidence-Based Brief Intervention for Child Victims in a Child Advocacy Setting*. Presented at the National Conference of the National Center for Victims of Crime, New Orleans, LA.

Epstein, C., & Arnow, N. (2010). *The Child and Family Traumatic Stress Intervention: Secondary Prevention for Abused Children and Youth.* Presented at the National Children's Advocacy Center's National Symposium on Child Abuse, Huntsville, AL.

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Marans, S., & Berkman, M. (2010). *The Child and Family Traumatic Stress Intervention: Introduction to a Promising Approach to Preventing PTSD in Children.* Paper presented at Healing the Generations Conference on Trauma. Ledyard, CT

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

If YES, please include citation:
Berkowitz, S., & Marans, S. (2011). The Child and Family Traumatic Stress Intervention: Implementation Guide for Providers

Has the intervention been replicated anywhere? ☒ Yes ❒ No

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies	**N=**106 The mean age of youth in the sample was 12 with 48% males, 32% Caucasian, 37% African American, 22% Hispanic, 7% Multi-ethnic, 2% other ethnicities.	Berkowitz, S., Stover, C.S. & Marans, S. (2010). The Child and Family Traumatic Stress Intervention: Secondary Prevention for Youth at Risk Youth of Developing PTSD. *Journal of Child Psychology and Psychiatry, 52(6)*, 676-685.
Pilot Trials/Feasibility Trials *(w/o control groups)*	A chart review of 124 CFTSI cases completed at Safe Horizon Child Advocacy Centers was completed in 2012. The sample for this chart review project included 124 caregiver-child dyads referred for the Child and Family Traumatic Stress intervention (CFTSI) at four Child Advocacy Centers in New York City following a child's disclosure of sexual abuse. The children in the sample ranged in age from 5-16 (M = 10.72, SD = 2.69), were predominantly female (85%) and predominantly Latino (53%) and Black (36%). The vast majority of caregivers participating in the intervention were the child's mother.	

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Randomized Controlled Trials	**N=**106 The mean age of youth in the sample was 12 with 48% males, 32% Caucasian, 37% African American, 22% Hispanic, 7% Multi-ethnic, 2% other ethnicities. The results of the randomized controlled trial will be presented in an article accepted for publication in the Journal of Child Psychology and Psychiatry.	

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

A unique aspect of the CFTSI is that measures traditionally used as research and diagnostic tools have been adapted to serve as clinical tools for increasing recognition of, and communication about, the impact of PTE, and are used throughout the intervention. While the primary use of these instruments is to serve as the basis for discussion between parents, the child, and the clinician, they also provide a way of monitoring the child's functioning on a weekly basis during the post-traumatic period. This approach to following the experiences of children and their parents in the aftermath of a PTE also affords a systematic means of assessing need for further psychiatric evaluation and mental health treatment. Measures used include a Trauma History Questionnaire and adaptations of the PTSD-RI, and the Mood & Feelings Questionnaire. The CPSS is used as an outcome measure.

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

CFTSI appears to prevent the development of Chronic PTSD in children and adolescents 3 months post-intervention. After intervention, the CFTSI group was significantly less likely to have PTSD at F/U (B=-1.063, p=.046), reducing the odds of PTSD by 65%. There was a significant Group by Time interaction for TSCC Posttraumatic Stress F(2,163)= 3.25, p=.04, and Anxiety F(2,163)=4.89, p=.009, Indices. Youth in the CFTSI group had significantly lower posttraumatic scores post-treatment and at 3 months; anxiety scores were lower post-treatment.

Logistic regression was performed to examine group differences in PTSD diagnosis at F/U based on child self-reports on the PTSD-RI. Intervention group and total number of trauma types experienced since the baseline interview were simultaneously entered into the models for Full PTSD and then for Full or Partial PTSD.

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Outcomes continued	At F/U the overall model was significant, X2(2, 81) = 6.25, p=.04, and accounted for 10.8% of the variance (Nagelkerke R2 = .108). After intervention, the CFTSI group was significantly less likely to have PTSD at F/U (B=-1.063*, p=.046) reducing the odds of PTSD by 65%. The reference group is the individual psychoeducation-focused comparison group. The overall model assessing Full or Partial PTSD diagnosis at 3-month follow-up was significant, X2(2, 81) =12.65, p=.002) and accounted for 18.9% of the variance (Nagelkerke R2 = .189). CFTSI reduced the odds of Partial or Full PTSD by 73% (B=-1.32, p=.008). Additionally, there were significant differences between groups at 3-month follow-up in severity of PTSD symptoms on the PTSD-RI, F(2, 81)=6.55, p=.01, with means for CFTSI and Comparison 8.70 and 14.74 at F/U respectively. Chi-square analyses were used to determine which PTSD criteria resulted in significant differences between CFTSI and Comparison groups in PTSD diagnosis. At F/U, there were significant group differences in Re-experiencing, with 85% of comparison and 57% of CFTSI, X2(1, 83) =8.04, p=.005, and Avoidance with 37% comparison and 17% CFTSI, X2(1, 83) =4.23, p=.04, meeting criteria, but not Hyperarousal X2(1, 83) =2.57, p=.11. **odds ratio for a logistic regression*
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** CFTSI is a four session intervention that can be provided in the clinician's office. Materials required include copies of the measures, and copies of the Parent/Child Handouts. There are no equipment requirements. **Supervision requirements** *(e.g., review of taped sessions)***?** Clinical supervisors trained and experienced in CFTSI. Weekly group supervision is the minimum requirement. **To ensure successful implementation, support should be obtained from:** Child's parent or caregiver.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Berkowitz, S., & Marans, S. (2011). The Child and Family Traumatic Stress Intervention: Implementation Guide for Providers. Marans, S. Berkowitz, S. & Epstein, C. (2011) The Child and Family Traumatic Stress Intervention: Adaptation for Children in Foster Care. Both manuals are available in conjunction with training. **How/where is training obtained?** Training can be obtained from the intervention developers and location depends upon the needs of participants. **What is the cost of training?** Contact Carrie Epstein, CFTSI Training Director to discuss training costs. Carrie.epstein@yale.edu

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Training Materials & Requirements continued	**Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Spanish (Parent handouts) **Other training materials &/or requirements** *(not included above)*: Training sessions are appropriate for supervisors and mental health providers with a master's degree or higher (who will act as the primary CFTSI provider), as well as case managers (who will play a vital role in collaboration with the primary CFTSI provider).
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)***?** Many agree that the development of PTSD constitutes a "failure of recovery" as the majority of individuals, both adults and youth, exposed to a PTE typically experience transient symptoms and subsequently return to their previous level of functioning (Foa & Meadows, 1997; Rothbaum & Davis, 2003). While multiple non-modifiable factors contribute to suboptimal recovery, it should be possible, when providing early interventions following a PTE, to target and optimize protective factors such as social and family support and coping skills. One of the ways we measure our success in improving communication is by comparing the child's report of symptoms he/she is experiencing to the caregiver's report. Prior to CFTSI, children typically report symptoms of which their caregivers are not aware. By the end of the CFTSI process, we see a significant improvement in the agreement between the child and parent's reports on the CPSS. A recent review of 124 CFTSI cases completed at the Safe Horizon Child Advocacy Centers indicated that the discrepancy between child and caregiver reports of the child's traumatic symptoms was reduced by 53% following CFTSI. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** None currently identified
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