

Trauma-Focused Cognitive Behavioural Therapy

Review: September 2017

Note on provider involvement: This provider has agreed to EIF's terms of reference, and the assessment has been conducted and published with the full cooperation of the programme provider.

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a therapeutic intervention for children and families who have been exposed to a traumatic event.

Children and their parents attend between 12 and 18 sessions where they learn cognitive strategies for managing negative emotions and beliefs stemming from highly distressing and/or abusive experiences.

Evidence
rating: **3+**

Cost rating: **3**

EIF Programme Assessment

Trauma-Focused Cognitive Behavioural Therapy has evidence of a **short-term positive impact** on child outcomes from at least one rigorous evaluation.

Evidence
rating: **3+**

What does the evidence rating mean?

Level 3 indicates **evidence of efficacy**. This means the programme can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

This programme does not receive a rating of 4 as it has not yet replicated its results in another rigorously conducted study, where at least one study indicates long-term impacts, and at least one uses measures independent of study participants.

What does the plus mean?

The plus rating indicates that this programme has evidence from at least one level 3 study, along with evidence from other studies rated 2 or better.

Cost rating

A rating of **3** indicates that a programme has a **medium cost** to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of **£500–£999**.

Cost rating: **3**

Child outcomes

According to the best available evidence for this programme's impact, it can achieve the following positive outcomes for children:

Supporting children's mental health and wellbeing

Reduced PTSD

Based on study 1

2.68-point improvement on the PTSD section of the Kiddie Schedule for Affective Disorders and Schizophrenia-Epidemiological

Improvement index: **+31**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 81% and worse outcomes than 19% of their peers, if they had received the intervention.

3 months later

Based on study 3

Based on study 2a

Based on study 4

Reduced depression

Based on study 4

Based on study 1

4.73-point improvement on the Child Depression Inventory

Improvement index: **+27**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 77% and worse outcomes than 23% of their peers, if they had received the intervention.

3 months later

Based on study 5

Based on study 2a

Improved daily functioning

Based on study 4

Improved psychological functioning

Based on study 5

Improved cognitive distortions

Based on study 5

Increased perceived credibility and interpersonal trust

Based on study 2a

Reduced internalising behaviours

Based on study 2b

Reduced PTSD symptoms

Based on study 3

Based on study 3

Based on study 5

Based on study 5

Reduced anxiety

Based on study 3

Based on study 5

Preventing crime, violence and antisocial behaviour

Improved behaviour

Based on study 5

Based on study 2a

Reduced externalising behaviours

Based on study 2b

This programme also has evidence of supporting positive outcomes for couples, parents or families that may be relevant to a commissioning decision. Please see the 'About the evidence' section for more detail.

Key programme characteristics

Who is it for?

The best available evidence for this programme relates to the following age-groups:

- Toddlers
- Preschool
- Primary school
- Preadolescents
- Adolescents

How is it delivered?

The best available evidence for this programme relates to implementation through these delivery models:

- Individual

Where is it delivered?

The best available evidence for this programme relates to its implementation in these settings:

- Community centre
- Out-patient health setting

The programme may also be delivered in these settings:

- Primary school
- Secondary school
- Community centre
- In-patient health setting
- Out-patient health setting

How is it targeted?

The best available evidence for this programme relates to its implementation as:

- Targeted indicated
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Where has it been implemented?

Australia, Democratic Republic of Congo, Finland, Germany, Israel, Italy, Japan, Kenya, Netherlands, New Zealand, Singapore, Sweden, Tanzania, United Kingdom, United States, Zambia

UK provision

This programme has been implemented in the UK.

UK evaluation

This programme's best evidence does not include evaluation conducted in the UK.

Spotlight sets

EIF includes this programme in the following Spotlight sets:

- parenting programmes with violence reduction outcomes
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About the programme

What happens during delivery?

How is it delivered?

- TF-CBT is delivered to parents and their children via 12 to 16 weekly sessions depending on the severity of the child's symptoms and the family's needs.
- Parents and their children attend separate 30 to 45 minute sessions during which they engage in parallel educational, skill-building and trauma processing activities.
- Parents and their children attend conjoint sessions together (10-40 minutes) to practice skills and enhance general and trauma-related communication as needed.
- TF-CBT can also be delivered individually with the child when it is not possible to work with the parents or other caregivers.

TF-CBT is typically delivered individually to parents and their children. TF-CBT may also be provided in groups, however, the evidence presented here reflects delivery of TF-CBT an individual therapy format.

What happens during the intervention?

- During the initial phases of the therapy, the therapist works individually with the parents and child to establish a trusting therapeutic relationship that, in turn, provides the context in which difficult experiences and emotions can be discussed.
- Within this safe therapeutic environment, the child learns to manage a variety of negative feelings and behaviours, including reoccurring and intrusive thoughts, difficulty sleeping or concentrating, depression, anxiety and negative and/or aggressive behaviour.
- The parent sessions provide parents with strategies for managing any stress or anxiety they may experiences, as well as strategies for communicating with their child and managing their child's behaviour.
- Parents also receive homework assignments to practice concepts covered during treatment at home with their children.
- The joint parent-child sessions are designed to help parents and children practice and use the skills they learned and for the child to share the trauma narrative while also fostering effective parent-child interaction.

What are the implementation requirements?

Who can deliver it?

The practitioner who delivers this programme is a mental health professional with QCF 7/8 level qualifications.

What are the training requirements?

- The practitioner has 10 hours of programme training. Booster training of practitioners is recommended.
- The mental health professional receives a minimum of two days' face-to-face training with a minimum of 12 hours of case consultation during implementation.

How are the practitioners supervised?

It is recommended that practitioners are supervised by one host agency supervisor, with the same level of programme training as practitioners, for one hour per week.

What are the systems for maintaining fidelity?

- Supervision
- Self-reported checklist

Is there a licensing requirement?

There is no licence required to run this programme.

How does it work? (Theory of Change)

How does it work?

- TF-CBT is based on the assumption that children have difficulty processing complex and strong emotions that can result from exposure to a traumatic event.
- TF-CBT therefore aims to create an emotionally supportive environment in which children and their parents learn cognitive strategies for managing the difficult emotions that arise from a traumatic event.
- In the short term, the negative child emotions and associated behaviours stemming from traumatic events are reduced.
- In the longer term, children will be less likely to have ongoing mental health problems.

Intended outcomes

Supporting children's mental health and wellbeing
Preventing child maltreatment
Preventing crime, violence and antisocial behaviour
Preventing substance abuse
Preventing risky sexual behaviour & teen pregnancy

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About the evidence

Trauma Focused CBT's most rigorous evidence comes from an RCT which was conducted in the USA. This was a rigorously conducted (level 3) study, which has identified a statistically significant positive impact on a number of child outcomes. Additional evidence comes from multiple RCTs (level 2 studies) conducted in USA, Norway, and Germany.

A programme receives the same rating as its most robust study. This programme has evidence from at least one rigorously conducted RCT along with evidence from additional comparison group studies. Subsequently, the programme receives a 3+ rating overall.

Study 1

Citation: Deblinger et al., 1996

Design: RCT

Country: United States

Sample: 100 children and their parents

Timing: 3-months post-baseline; 6-months post-baseline; 12-months post-baseline.

Child outcomes:

- Reduced PTSD
 - Reduced depression
-

Other outcomes:

- Parent outcomes measured. However these findings do not meet EIF's level 3 quality standards.
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Study rating: 3

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, 1(4), 310-321.
<http://dx.doi.org/10.1177/1077559596001004003>

Available at <http://journals.sagepub.com>

Study design and sample

The first study is a rigorously conducted RCT.

This study involved random assignment of 100 children and their parents to a parent-only treatment group (n=25); child-only treatment group (n=25); child and parent treatment group (n=25); or a community control group (n=25). For the purposes of the EIF assessment we primarily focused on the findings for the child and parent treatment group as this is how the intervention is normally delivered (although it can be delivered to the child only if it is not possible to work with the parents).

This study was conducted in the USA, with a sample of sexually abused children aged 7-13 years (mean = 9.84). 83% were female and 17% male. 72% were Caucasian, 20% African American, 6% Hispanic, 2% other ethnic origin. 76% of the children's maternal caregivers were biological or adoptive, 4% were long-term foster mothers, 20% were other related female guardians (step-mothers, aunts, grandmothers, or older sister). The duration of the sexual abuse suffered by the children ranged from 1 day to more than 5 years of repeated abuse, 18% experienced 2-10 episodes, 22% experienced 11 to 50 abusive incidents.

Measures

- Behavioural problems were measured using Child Behaviour Checklist (CBCL) (parent report).
- Situational specific anxiety was measured using the State/Trait ANXIETY Inventory for Children (STAIC) (Self-report).
- PTSD was measured using the Kiddie Schedule for Affective Disorders and Schizophrenia K-SADS (diagnostic interview).
- Child depression was measured using the Child Depression inventory (CD) (parent report).
- Parenting Practices were measured using the Parenting Practices Questionnaire (PPQ) (parent self-report).

Findings

This study identified statistically significant positive impact on a number of child and parent outcomes. This includes reduced PTSD (K-SADS), reduced child depression (CDI), and improved parenting practices (PPQ) for the parent and child intervention group. Reduced PTSD (K-SADS) for the child-only intervention group.

An additional paper (Deblinger et al., 1999) reported on the long term findings from this study. These outcomes did not however contribute to the overall programme rating as the study was not as robust as the Deblinger et al., (1996) study.

Study 2a

Citation: Cohen et al., 2004

Design: RCT

Country: United States

Sample: 229 children aged between 8 and 14 (mean age 10.76 years) and their parents or carers

Timing: Post-intervention.

Child outcomes:

- Reduced depression
 - Increased perceived credibility and interpersonal trust
 - Reduced PTSD
 - Improved behaviour
-

Other outcomes:

- Reduced depression Reduced emotional distress Improved parenting practices Increased parental support
-

Study rating: 2

Cohen, J., Deblinger, E., Mannarino, A. & R. Steer (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(4), 393-402. <http://dx.doi.org/10.1097/00004583-200404000-00005>

Available at <http://www.sciencedirect.com>

Study design and sample

The second study is an RCT.

It involved random assignment of children and their carers to trauma-focused, cognitive behavioural therapy (TF-CBT) or Child Centred Therapy (CCT). The study took place in the United States. Participants were 229 children aged between 8 and 14 (mean age, 10.76 years) who were confirmed as having experienced contact sexual abuse. A parent or carer of each child participated in the parental treatment component of the study. All children met at least 5 criteria for sexual abuse-related DSMIV- defined posttraumatic stress disorder (PTSD). 180 (89%) met full criteria for current PTSD. 79% were female. 60% were Caucasian, with the next largest group represented (28%) being African American.

Measures

- PTSD was measured using the Kiddie Schedule for Affective Disorders and Schizophrenia Present and Lifetime Version (K-SADS-PL) (diagnostic interview).
- Child depression was measured using the Child Depression inventory (CD) (child self-report).
- Present (state) and trait anxiety symptoms were measured using the State-Trait Anxiety Inventory for Children (STAIC) (child self-report).
- Children's stigmatization, interpersonal trust, self-blame for negative events, and perceived credibility were measured using the Children's Attributions and Perceptions Scale (CAPS) (child self-report).
- Behavioural problems were measured using Child Behaviour Checklist (CBCL) (parent report).
- Normative as well as inappropriate sexual behaviours were measured using the Child Sexual Behaviour Inventory (CSBI) (parent report).
- Parental depression was measured using the Beck Depression Inventory II (BDI) (parent self-report).
- Parental emotional distress related to their children's sexual abuse experience was measured using the Parent's Emotional Reaction Questionnaire (PERQ) (parent self-report).
- Parental support of their sexually abused child and attributions about responsibility for the abuse was measured using the Parental Support Questionnaire (PSQ), (parent self-report).
- Parenting practices were measured using the Parenting Practices Questionnaire (PPQ) (parent self-report)

Findings

This study identified statistically significant positive impact on a number of child and parent outcomes. At post-intervention, child outcomes included reduced PTSD (K-SADS), reduced behavioural problems (CBCL), reduced symptoms of depression (CDI), increased perceived credibility and interpersonal trust (CAPS).

Parent outcomes include reduced parental depression (BDI), reduced parental emotional distress (PERFQ), improved parenting practices (PPQ), increased parental support (PSQ).

Study 2b

Citation: Deblinger et al., 2006

Design: RCT

Country: United States

Sample: 229 children aged between 8 and 14 (mean age 10.76 years) and their parents or carer

Timing: 6-months post-intervention; 12-months post-intervention.

Child outcomes:

- Reduced internalising behaviours
 - Reduced externalising behaviours
-

Other outcomes:

- Reduced emotional distress Improved parenting practices Increased parental support
-

Study rating: 2

Deblinger, E., Mannarino, A. P., Cohen, J. A. & Steer, R. A. (2006). Follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms: Examining predictors of treatment response. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45, 12. <http://dx.doi.org/10.1097/01.chi.0000240839.56114.bb>
Available at<http://www.sciencedirect.com>

Deblinger et al., 2006 describes long term outcomes from study 2a described above. In this case:

- The study reported on 6 and 12-month follow-up findings.
- Positive findings for child outcome include reduced child internalising behaviour (CBCL), Reduced child externalising behaviour (CBCL).
- Positive findings for parent outcomes include reduced parental emotional distress (PERQ), improved parenting practices (PPQ), increased parental support (PSQ).

This study therefore identified statistically significant positive impact on a number of child and parent outcomes, at post-intervention, 6-month post-intervention and 12-month post-intervention. The conclusions that can be drawn from this study are limited by methodological issues pertaining to lack of ITT, unequal groups, and high attrition, hence why a higher rating is not achieved.

Study 3

Citation: Cohen et al., 2011

Design: RCT

Country: United States

Sample: 124 children and their parents

Timing: Post-intervention.

Child outcomes:

- Reduced PTSD
 - Reduced PTSD symptoms
 - Reduced PTSD symptoms
 - Reduced anxiety
-

Other outcomes:

- None measured
-

Study rating: 2+

Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: A randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine*, 165(1), 16-21. <http://dx.doi.org/10.1001/archpediatrics.2010.247>

Available at <https://jamanetwork.com/journals>

Study Design and Sample

The third study is an RCT.

This study involved random assignment of 124 children to a treatment group (n=64; TF-CBT) and a control group (n=60; child centred therapy).

This study was conducted in the USA, with a sample of children aged 7-14 who have been exposed to intimate partner violence and were experiencing symptoms of PTSD. To be included, children had to have at least 5 IPV-related PTSD symptoms, including at least 1 in each of 3 PTSD symptom cluster on the Kiddie Schedule for Affective Disorders and Schizophrenia. 49% of the sample as male, 51% of the sample were female. 56% were white, 33% were Black, and 11% were biracial.

Measures

- Total child PTSD symptoms were measured using Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (K-SADS-PL) (Diagnostic interview).
- Child anxiety was measured using the Screen for Child Related Emotional Disorders (SCARED) (child self-report).
- Cognitive functioning was measured using The Kaufman Brief intelligence test (intelligence test).
- Total Behaviour Problems was measured using the Child Behaviour Checklist (parent report).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes reduced PTSD (K-SADS-PL) and anxiety (SCARED). This study identified statistically significant positive impact on a number of child outcomes. The conclusions that can be drawn from this study are limited by methodological issues pertaining to unequal groups post-attrition, and where attrition was over 10% these differences not being controlled for in the analyses.

Study 4

Citation: Jensen et al., 2013

Design: RCT

Country: Norway

Sample: 156 children and their parents

Timing: Post-intervention.

Child outcomes:

- Reduced depression
 - Improved daily functioning
 - Reduced PTSD
-

Other outcomes:

- None measured
-

Study rating: 2+

Jensen, T. K., Holt, T., Silje, M., Ormhaug, K. E., et al. (2013). A randomized effectiveness study comparing Trauma-Focused Cognitive Behavioral Therapy with therapy as usual for youth. *Journal of Clinical Child & Adolescent Psychology*.
<http://dx.doi.org/10.1080/15374416.2013.822307>

Available at <http://www.tandfonline.com>

Study Design and Sample

The fourth study is an RCT.

This study involved random assignment of 156 children to a treatment group (n=79, TF-CBT) or a control group (n=77, treatment as usual). This study was conducted in Norway, with a sample of children aged 10-18 years who were experiencing PTSD symptoms. 79.5% of the sample were girls, 20.5% were boys. 73.7% were Norwegian, 10.9%.

Measures

- PTSD symptoms were measured using CPSS (self-report) and the CAPS-CA (self-report, clinical judgement).
- Depression symptoms were evaluated using the Mood and Feelings Questionnaire (MFQ, child self-report).
- Anxiety symptoms were measured using the Screen for Child Anxiety-Related Disorders (SCARED) (child self-report).
- General mental health and conduct problems were measured using the Strengths and Difficulties Questionnaire (SDQ, parent report).

Findings

This study identified statistically significant positive impact on a number of child outcomes.

This includes PTSD symptoms (CPSS, fCPSS), and depression symptoms (MFQ).

This study identified statistically significant positive impact on a number of child outcomes. The conclusions that can be drawn from this study are limited by methodological issues pertaining not reporting on equivalence between groups post-attrition, hence why a higher rating is not achieved.

Study 5

Citation: Goldbeck et al., 2016

Design: RCT

Country: Germany

Sample: 159 children and their parents

Timing: 4 months post-baseline.

Child outcomes:

- Reduced depression
 - Improved psychological functioning
 - Improved cognitive distortions
 - Reduced PTSD symptoms
 - Reduced PTSD symptoms
 - Reduced anxiety
 - Improved behaviour
-

Other outcomes:

- None measured
-

Study rating: 2+

Goldbeck, L., Muche, R., Sachser, C., Tutus, D., & Rosner, R. (2016). Effectiveness of Trauma-Focused Cognitive Behavioral Therapy for Children and Adolescents: A Randomized Controlled Trial in Eight German Mental Health Clinics. *Psychotherapy and Psychomatics* 16, 159-170. <http://dx.doi.org/10.1159/000442824>
Available at <https://www.karger.com>

Study Design and Sample

The fifth study is an RCT.

This study involved random assignment of 159 children to a treatment group (TF- CBT, n = 76) or a control group (waitlist; n = 83). It was conducted in Germany, with a sample of children aged 7-17 with PTSD symptoms. 28% of the sample was male, 72% were female. 90% were German natives, 6% were non-German natives, and 1% was unknown.

Measures

PTSD Symptoms were measured using the PTSD Scale for Children and Adolescents (CAPS-CA) (independent assessor).

- The presence of comorbid mental disorders according to DSM-IV criteria was determined using the Schedule of Affective Disorders and Schizophrenia for School-Age Children Revised for DSM IV (K-SADS) (diagnostic interview).
- The level of psychosocial functioning was assessed using the Children's Global Assessment Scale (CGAS) (independent assessor).
- PTSD symptoms was reported on the child and adolescent and caregiver versions of the UCLA-PTSD Reaction Index.
- The patients' cognitive distortions related to the trauma were assessed by self-reports on the Child Posttraumatic Cognitions Inventory (CPTCI) (self-report).
- Symptoms of anxiety were assessed by self-reports and caregiver reports on the Screen for Child Anxiety-Related Emotional Disorders (SCARED) with repeatedly reported excellent psychometric properties (self-report).
- Symptoms of depression were assessed by patients' self-reports on the Children's Depression Inventory (CDI) (self-report).
- Child behaviour was measured using The Child Behaviour Checklist 4–18 (CBCL/4–18) [30] (parent report)
- The patients' quality of life was assessed by self-reports and caregiver-reports on the Inventory of Quality of Life for Children (ILK) (parent and child reports).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes:

- Reduced PTSD symptoms (CAPS-CA: total score, re-experiencing, avoidance, and hyperarousal; UCLA: self, care)
- Reduced cognitive distortions (CPTCI)
- Improved psychological functioning (CGAS)
- Reduced depression (CDI)
- Reduced anxiety (SCARED: self, care)
- Improved child behaviour (CBCL: Total, externalising, internalising).

This study identified statistically significant positive impact on a number of child outcomes. The conclusions that can be drawn from this study are limited by methodological issues pertaining to not reporting on equivalence between groups post-attrition, hence why a higher rating is not achieved.

Other studies

The following studies were identified for this programme but did not count towards the programme's overall evidence rating. A programme receives the same rating as its most robust study or studies.

- 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(12), 1371-1378. [http://dx.doi.org/10.1016/S0145-2134\(99\)00091-5](http://dx.doi.org/10.1016/S0145-2134(99)00091-5)
- Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(1), 42-50. <http://dx.doi.org/10.1097/00004583-199601000-00011>
- Cohen, J. A., & Mannarino, A. P. (1997). A treatment study for sexually abused preschool children: Outcome during a one-year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(9), 1228-1235. <http://dx.doi.org/10.1097/00004583-199709000-00015>
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- King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. H. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(11), 1347-1355. <http://dx.doi.org/10.1097/00004583-200011000-00008>
- Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment outcome findings. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*, 3(1), 17-26. <http://dx.doi.org/10.1177/1077559598003001002>
- Deblinger, E., Stauffer, L. & Steer, R. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for children who were sexually abused and their nonoffending mothers. *Child Maltreatment*, 6(4), 332-343. <http://dx.doi.org/10.1177/1077559501006004006>
- Cohen, J. A., Mannarino, A. P., Perel, M.D. & Staron, V. (2007). A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46, 811-819. <http://dx.doi.org/10.1097/chi.0b013e3180547105>
- Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused Cognitive Behavioral Therapy for Children: Impact of the trauma narrative and treatment length. *Depression and Anxiety*, 28, 67-75. <http://dx.doi.org/10.1002/da.20744>
- Mannarino, A. P., Cohen, J. A., Deblinger, E., Runyon, M. K., & Steer, R. A. (2012). Trauma-focused Cognitive Behavioral Therapy for children sustained impact of treatment 6 – 12 months later. *Child Maltreatment* 17(3) 231-241. <http://dx.doi.org/10.1177/1077559512451787>
- O'Callaghan, P., McMullen, J., Shannon, C., Rafferty, H., Black, A. (2013). A randomized controlled trial of Trauma-focused Cognitive Behavioral Therapy for sexually exploited, war-affected Congolese girls. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(4), 359-369. <http://dx.doi.org/10.1016/j.jaac.2013.01.013>
- McMullen, J., O'Callaghan, P., Shannon, C., Black, A., & Eskin, J. (2013). Group Trauma-focused Cognitive-Behavioural Therapy with former child soldiers and other war-affected boys in the DR Congo: A randomized controlled trial. *Journal of Child Psychology and Psychiatry*, (Epub ahead of print). <http://dx.doi.org/10.1111/jcpp.12094>
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<http://dx.doi.org/10.1007/s00787-014-0572-5>

Murray, Laura K., Skavenski, Stephanie, Kane, Jeremy C., Mayeya, John, Dorsey, Shannon, Cohen, Judy A., Michalopoulos, Lynn T., Imasiku, Mwyla, and Bolton, Paul A. (2015). Effectiveness of Trauma-Focused Cognitive Behavioral Therapy among trauma-affected children in Lusaka, Zambia – A Randomized Clinical Trial. *JAMA Pediatrics* (online). <http://dx.doi.org/10.1001/jamapediatrics.2015.0580>

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Salloum, A., Wang, W., Robst, J., Murphy, T. K., Scheeringa, M. S., Cohen, J. A., & Storch, E. A. (2015). Stepped care versus standard trauma-focused cognitive behavioral therapy for young children. *Journal of Child Psychology and Psychiatry* (online). <http://dx.doi.org/10.1111/jcpp.12471>

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Guidebook

The EIF Guidebook provides information about early intervention programmes that have at least preliminary evidence of achieving positive outcomes for children. It provides information based on EIF's assessment of the strength of evidence for a programme's effectiveness, and on detail about programmes shared with us by those who design, run and deliver them.

The Guidebook serves an important starting point for commissioners to find out more about effective early interventions, and for programme providers to find out more about what good evidence of impact looks like and how it can be captured. As just one of our key resources for commissioners and practitioners, the Guidebook is an essential part of EIF's work to support the development of and investment in effective early intervention programmes.

Our assessment of the evidence for a programme's effectiveness can inform and support certain parts of a commissioning decision, but it is not a substitute for professional judgment. Evidence about what has worked in the past offers no guarantee that an approach will work in all circumstances. Crucially, the Guidebook is not a market comparison website: ratings and other information should not be interpreted as a specific recommendation, kite mark or endorsement for any programme.

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EIF

The Early Intervention Foundation (EIF) is an independent charity and a member of the What Works network. We support the use of effective early intervention for children, young people and their families: identifying signals of risk, and responding with effective interventions to improve outcomes, reduce hardship and save the public money in the long term.

We work by generating evidence and knowledge of what works in our field, putting this information in the hands of commissioners, practitioners and policymakers, and supporting the adoption of the evidence in local areas and relevant sectors.

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