

Child and Family Traumatic Stress Intervention

The Child and Family Traumatic Stress Intervention (CFTSI) is a brief, early acute intervention for families with children (ages 7-18) who have either recently experienced a potentially traumatic event or have recently disclosed the trauma of physical or sexual abuse. CFTSI aims to reduce early posttraumatic stress symptoms, to decrease the likelihood of traumatized children developing long-term posttraumatic psychiatric disorders, and to assess children's need for longer term treatment. The intervention focuses on increasing communication between the caregiver and child about the child's traumatic stress reactions and on providing skills to the family to help cope with traumatic stress reactions.

CFTSI is delivered by a trained clinician (master's, Ph.D., or M.D. level) over four to eight sessions, which are held weekly and last 45-60 minutes each. In session 1, the clinician meets with the caregiver to provide education about trauma and children's typical reactions to traumatic exposure and to explain the protective role of communication and family support. After first assessing the caregiver's level of traumatic stress reactions and case management and care coordination issues, the clinician uses standardized assessment instruments as clinical tools to initiate and structure discussion with the caregiver to gather the caregiver's assessment of the child's traumatic stress reactions related to the traumatic event. In session 2, the clinician first meets with the child alone to provide education about trauma and children's typical reactions to traumatic exposure and to use standardized assessment instruments to gather the child's assessment of his or her traumatic stress reactions. Next, the clinician meets with the caregiver and the child together. In this session, the clinician uses the child's and caregiver's responses to the standardized assessment instruments as a basis for discussion. The discussion focuses on ways of improving communication, including encouraging greater awareness of when traumatic stress reactions are occurring; helping the child to better communicate with and inform his or her caregiver about feelings, symptoms, and behaviors; and helping the caregiver to be more aware, receptive, and supportive of the child. The clinician works with the child and caregiver to collaboratively identify specific traumatic stress reactions as the areas of focus, which are based on symptom clusters identified by the child and caregiver as being the most problematic (e.g., anxiety, sleep disturbance, depressive withdrawal, intrusive thoughts, oppositionality, tantrums, aggressive behaviors). The clinician then introduces skills, techniques, and behavioral interventions for the child and caregiver to practice to help the child cope with and master traumatic stress reactions. Sessions 3 and 4 are held with the child and caregiver together, and the clinician focuses on continuing to improve communication between the child and caregiver and on practicing the skills introduced in session 2. Sessions 5-8 are provided on an as-needed basis and may be used for additional meetings with the child and caregiver together or with the caregiver or child alone.

In the study reviewed for this summary, participants received a four-session version of CFTSI.

Descriptive Information

Areas of Interest	Mental health promotion Mental health treatment
Outcomes	Review Date: July 2012 1: Posttraumatic stress symptoms 2: Anxiety symptoms 3: Posttraumatic stress disorder diagnostic symptoms
Outcome Categories	Mental health
Ages	6-12 (Childhood) 13-17 (Adolescent)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified

Settings	Outpatient
Geographic Locations	Urban Suburban
Implementation History	CFTSI was first piloted at the Yale Child Study Center in 2005, and in 2007, CFTSI was implemented in multiple child advocacy centers as part of a partnership with Safe Horizon in New York City. A national learning collaborative has been developed and conducted, and several organizations have implemented CFTSI through this training methodology. Since its inception, CFTSI has been implemented with more than 1,000 caregiver-child dyads at 13 sites in California, Connecticut, Illinois, Kentucky, Mississippi, Missouri, Montana, New York, Ohio, Pennsylvania, and South Carolina.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	The intervention has been adapted for use with children in foster care who are wards of the state, children in domestic violence shelters, and children with physical injuries (seen in emergency rooms and hospital settings). Program materials have been translated into Spanish.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Indicated

Quality of Research

Review Date: July 2012

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

[Berkowitz, S. J., Stover, C. S., & Marans, S. R. \(2011\). The Child and Family Traumatic Stress Intervention: Secondary prevention for youth at risk of developing PTSD. *Journal of Child Psychology and Psychiatry*, 52\(6\), 676-685.](#) 

Supplementary Materials

Berkowitz, S. J., Marans, S., Berkman, M., Epstein, C., & Hahn, H. (n.d.). CFTSI manual I: (Version 7). Implementation guide for providers.

CFTSI Fidelity Support Tool

DioGuardi, R. J., & Gilbert, A. (2005). Review of Trauma Symptom Checklist for Children (TSCC). N. Taylor, R. Igelman, M. Kulkami, & C. G. Ippen (Eds.). National Child Traumatic Stress Network Measure Review Database.

Psychometric Properties for the UCLA PTSD Reaction Index

Rodriguez, N., Steinberg, A., & Pynoos, R. S. (1999). UCLA PTSD Index for DSM IV (revision 1) instrument information: Child version, parent version, adolescent version. Los Angeles: UCLA Trauma Psychiatry Service.

[Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. \(2004\). The University of California at Los Angeles Post-traumatic Stress Disorder Reaction Index. *Current Psychiatry Reports*, 6\(2\), 96-100.](#) 

Outcomes

Outcome 1: Posttraumatic stress symptoms

Description of Measures

Posttraumatic stress symptoms were measured with the Posttraumatic Stress clinical scale of the Trauma Symptom Checklist for Children (TSCC). The TSCC is a 54-item self-report instrument that measures the frequency of posttraumatic stress symptoms and other symptom clusters found in some traumatized children and adolescents. The TSCC consists of six clinical scales: Anxiety, Depression, Posttraumatic Stress, Sexual Concerns, Dissociation, and Anger. Using a 4-point scale ranging from 0 (never) to 3 (almost all of the time), each youth rates the frequency of the symptom

described in each item. Scores for each of the clinical scales are summed, with higher scores indicating more frequent symptomatology.

Key Findings	<p>In a randomized clinical trial, youth (ages 7-17) who were recently exposed to a potentially traumatic event and endorsed at least one new, distressing posttraumatic stress symptom in the prior 30 days were assigned, along with a caregiver, to the intervention or comparison condition. Participants in the intervention group received four weekly sessions of CFTSI, and those in the comparison group received four weekly sessions of psychoeducation with relaxation training and supportive therapy. Assessments occurred at baseline, 4 weeks after baseline (at the end of treatment), and 3 months after treatment (follow-up).</p> <p>From baseline to the 3-month follow-up assessment, youth in the intervention group had a greater improvement in scores on the TSCC Posttraumatic Stress clinical scale relative to youth in the comparison group ($p = .04$).</p>
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 2: Anxiety symptoms

Description of Measures	<p>Anxiety symptoms were measured with the Anxiety clinical scale of the Trauma Symptom Checklist for Children (TSCC). The TSCC is a 54-item self-report instrument that measures the frequency of anxiety symptoms and other symptom clusters found in some traumatized children and adolescents. The TSCC consists of six clinical scales: Anxiety, Depression, Posttraumatic Stress, Sexual Concerns, Dissociation, and Anger. Using a 4-point scale ranging from 0 (never) to 3 (almost all of the time), each youth rates the frequency of the symptom described in each item. Scores for each of the clinical scales are summed, with higher scores indicating more frequent symptomatology.</p>
Key Findings	<p>In a randomized clinical trial, youth (ages 7-17) who were recently exposed to a potentially traumatic event and endorsed at least one new, distressing posttraumatic stress symptom in the prior 30 days were assigned, along with a caregiver, to the intervention or comparison condition. Participants in the intervention group received four weekly sessions of CFTSI, and those in the comparison group received four weekly sessions of psychoeducation with relaxation training and supportive therapy. Assessments occurred at baseline, 4 weeks after baseline (at the end of treatment), and 3 months after treatment (follow-up).</p> <p>At 4 weeks after baseline, youth in the intervention group had lower scores on the TSCC Anxiety clinical scale relative to youth in the comparison group ($p < .05$). From baseline to the 3-month follow-up assessment, youth in the intervention group had a greater improvement in scores on the TSCC Anxiety clinical scale relative to youth in the comparison group ($p = .009$).</p>
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 3: Posttraumatic stress disorder diagnostic symptoms

Description of Measures	<p>Posttraumatic stress disorder (PTSD) diagnostic symptoms were assessed with the UCLA PTSD Reaction Index for DSM IV (PTSD-RI). The PTSD-RI is a self-report instrument of 20 items (child version for youth ages 7-12) or 22 items (adolescent version for youth ages 13-18) designed to evaluate the respondent's frequency of exposure to a variety of traumatic events. The PTSD-RI includes the DSM-IV criteria for evaluating objective and subjective features of a traumatic experience and the DSM-IV criteria for evaluating diagnostic symptom clusters of reexperiencing, arousal, and avoidance. Using a 5-point scale ranging from "none of the time" to "most of the time," youth rate the frequency of their symptoms over the past month.</p> <p>For youth who meet the DSM-IV criteria for objective and subjective features of a traumatic</p>
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experience, a full PTSD diagnosis is coded if the youth acknowledges all three symptom clusters with a frequency of "much of the time" or "most of the time" over the past month, and a partial PTSD diagnosis is coded if the youth acknowledges two of the three symptom clusters with a frequency of "much of the time" or "most of the time" over the past month.

Key Findings	<p>In a randomized clinical trial, youth (ages 7-17) who were recently exposed to a potentially traumatic event and endorsed at least one new, distressing posttraumatic stress symptom in the prior 30 days were assigned, along with a caregiver, to the intervention or comparison condition. Participants in the intervention group received four weekly sessions of CFTSI, and those in the comparison group received four weekly sessions of psychoeducation with relaxation training and supportive therapy. Assessments occurred at baseline, 4 weeks after baseline (at the end of treatment), and 3 months after treatment (follow-up).</p> <p>At the 3-month follow-up assessment, youth in the comparison group were almost 3 times as likely as youth in the intervention group were to meet DSM-IV criteria for a full PTSD diagnosis ($p = .046$) and more than 3.5 times as likely as youth in the intervention group were to meet DSM-IV criteria for a partial or full PTSD diagnosis ($p = .008$). These group differences were associated with medium effect sizes (odds ratios = 2.90 and 3.73, respectively). Also at the 3-month follow-up assessment, the percentage of youth in the comparison group was higher than the percentage of youth in the intervention group who reported DSM-IV reexperiencing symptoms (85% vs. 57%; $p = .005$) and avoidance symptoms (37% vs. 17%; $p = .04$).</p>
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	6-12 (Childhood) 13-17 (Adolescent)	52% Female 48% Male	37% Black or African American 32% White 22% Hispanic or Latino 9% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see [Quality of Research](#).

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Posttraumatic stress symptoms	3.5	3.5	2.0	3.0	2.8	3.5	3.0
2: Anxiety symptoms	3.5	3.5	2.0	3.0	2.8	3.5	3.0
3: Posttraumatic stress disorder diagnostic symptoms	3.5	3.5	2.0	3.0	2.8	3.5	3.0

Study Strengths

The TSCC has good internal reliability for the Posttraumatic Stress and Anxiety clinical scales, which are also sensitive to change over time; it also has good face, concurrent, and discriminant validity. The PTSD-RI has high test-retest reliability and face validity, with convergent validity supported by agreement of PTSD-RI cutoff scores with the diagnosis of PTSD by DSM-IV criteria. The intervention is manualized and was delivered by trained clinicians who kept progress notes. Clinicians participated in weekly group supervision meetings with one of the CFTSI developers, who reviewed each case and used a detailed fidelity instrument to check that the main elements of each session were delivered as designed, taking corrective action when key elements were not implemented or only partially implemented. The study used a randomized block design, which controlled for many confounding factors, and statistically tested potential confounding factors between groups to establish baseline equivalence; where group differences were found, the confounding factors were entered into the statistical models. Statistical modeling of the data was appropriate and adequately incorporated missing data. The models used a Holm-Bonferroni correction to the experiment-wise alpha level (i.e., the statistical significance level at which a difference is considered to be beyond a chance occurrence) associated with multiple statistical comparisons.

Study Weaknesses

There was no description of interrater reliability for the full or partial diagnosis of PTSD with the PTSD-RI. Although an intervention fidelity instrument was used, the psychometric properties of this instrument are unknown. The use of the PTSD-RI as part of the intervention and as an outcome measure to establish change in PTSD diagnosis was a potential confound, as noted by the investigators. The small sample randomized from eligible participants may have confounded the results by introducing a selection bias toward less traumatized youth participants.

Readiness for Dissemination

Review Date: July 2012

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Implementation materials:

- Assessment tools:
 - CPSS (Pre-CFTSI): The Child PTSD Symptom Scale (CPSS)--Part I--Caregiver
 - CPSS (Pre-CFTSI): The Child PTSD Symptom Scale (CPSS)--Part I--Child
 - MFQ (CFTSI Modification)--Caregiver: Session 1
 - MFQ (CFTSI Modification)--Child: Session 2
 - PCL-C/SR
 - Trauma History Questionnaire: THQ Caregiver Revised
 - Trauma History Questionnaire: THQ Child Revised

- Coping skills handouts for caregivers:
 - Anxiety. (2011).
 - Depressive withdrawal. (2011).
 - General information about typical reactions to upsetting events. (2011).
 - Intrusive thoughts and traumatic reminders. (2011).
 - Sleep hygiene. (2011).
 - Tantrums and oppositional behavior. (2011).
 - Understanding and managing children's sexualized behavior. (2011).

- Coping skills handouts for children:
 - How to improve sleep habits... [Child and teen versions]. (2011).
 - How to reduce anxiety... [Child and teen versions]. (2011).
 - How to reduce depressive symptoms... [Child and teen versions]. (2011).
 - How to reduce intrusive thoughts... [Child and teen versions]. (2011).
 - When upsetting things happen to kids. (2011).
 - When upsetting things happen to teens. (2011).

- Learning collaborative documents:
 - CFTSI agenda for initial supervisor call. (2011).
 - CFTSI case presentation format. (2011).
 - CFTSI learning collaborative change package. (2011).
 - CFTSI learning collaborative 1st all collaborative call agenda. (2011).
 - CFTSI learning collaborative model diagram. (2012).
 - Conducting consultation calls: Quick tips. (2011).
 - Yale Childhood Violent Trauma Center change package: For a learning collaborative on the adoption and implementation of the Child and Family Traumatic Stress Intervention (CFTSI). (2011).

- Other implementation materials:
 - Berkowitz, S. J., Marans, S., Berkman, M., Epstein, C., & Hahn, H. (n.d.). CFTSI manual I: (Version 7). Implementation guide for providers.
 - CFTSI family log [Handout]. (2011).
 - CFTSI progress note [Tracking sheet]. (2011).

- CFTSI sessions [Implementation document]. (2011).
- Supervision of an evidence-based practice [PowerPoint slides]. (2011).

Training and support materials:

- Berkowitz, S., & Marans, S. (2011). The Child and Family Traumatic Stress Intervention: Secondary prevention for at-risk children and youth [PowerPoint slides].
- Case vignette--Depression
- CFTSI faculty training agenda: CFTSI training at Yale, September 12-13, 2011. (2011).
- CFTSI role play: Background information (to be used in role plays for CFTSI sessions 2 part B and session 3). (2011).
- CFTSI session 2A--Small group discussion: Case examples. (2011).
- Child and Family Traumatic Stress Intervention (CFTSI): Faculty training agenda. (2012).
- Evaluation form: Child and Family Traumatic Stress Intervention--Learning collaborative training, learning session 1: October 13-14, 2011. (2011).
- Experiential exercise: CFTSI session 1--Case vignette--Caregiver interview. (2011).
- Experiential exercise: CFTSI sessions 2B and 3--CFTSI role play instructions for faculty use only
- Experiential exercises: CFTSI sessions 2B and 3--Short Mood and Feelings Questionnaire (CFTSI modification) adult version. (2011).
- Experiential exercises: CFTSI sessions 2B and 3--Short Mood and Feelings Questionnaire (CFTSI modification) child version. (2011).
- Sessions 2B and 3: Allison role play--UCLA PTSD Index for DSM IV (child version, revision 1). (2011).
- Sessions 2B and 3: Allison role play--UCLA PTSD Index for DSM IV (parent version, revision 1). (2011).
- Time remaining cards for training
- Yale Childhood Violent Trauma Center Facebook site, <https://www.facebook.com/pages/Yale-Childhood-Violent-Trauma-Center/248182175252362>

Quality assurance materials:

- CFTSI collateral progress note. (2011).
- CFTSI fidelity support tool. (2011).
- CFTSI fidelity support tool: Foster care adaptation. (2011).
- CFTSI learning collaborative monthly metrics. (2011).
- CFTSI provider survey. (2011).
- CFTSI satisfaction survey: Caregiver. (2011).
- Rodriguez, N., Steinberg, A., & Pynoos, R. S. (1999). UCLA PTSD Index for DSM IV (revision 1) instrument Information: Child version, parent version, adolescent version. Los Angeles: UCLA Trauma Psychiatry Service.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see [Readiness for Dissemination](#).

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.5	3.8	4.0	3.8

Dissemination Strengths

The implementation guide provides an overview of the intervention, including background information, instructions for each session, suggested scripts, assessments, case vignettes, and guidance for clinical scenarios. A learning collaborative approach to training and supervision is available for new implementers, who are required to participate in an introductory 2-day training and consultation calls. The training curriculum includes a variety of didactic presentations, interactive case discussions, and role-play. Interactive opportunities on the social media site offer support from the developer as well as peers. Many outcome monitoring and fidelity support tools, along with a detailed protocol for the administration of tools, are available to support quality assurance.

Dissemination Weaknesses

Potential implementers may find it challenging to understand how all of the implementation materials and training resources are used together, since no overarching document provides these details.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
CFTSI Manual: Implementation Guide for Providers	Free electronic copy or \$15 for hard copy (made available once the developer has been contracted for training)	Yes
2-day, on- or off-site training provided by CFTSI staff	\$3,000 per day for up to 30 participants, plus travel expenses if necessary	Yes
6 months of biweekly consultation calls with CFTSI master trainers	\$200 per hour for up to 15 participants per call	Yes
CFTSI Fidelity Support Tool	Included with implementation guide and training	Yes

Replications

No replications were identified by the developer.

Contact Information

To learn more about implementation, contact:

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Consider these [Questions to Ask](#) (PDF, 54KB) as you explore the possible use of this intervention.