### Treatment Description

- **Acronym (abbreviation) for intervention:** TG-CBT
- **Average length/number of sessions:** 12-16 session, 60-90 minutes per session
- **Aspects of culture or group experiences that are addressed** (e.g., faith/spiritual component, or addresses transportation barriers): Cultural beliefs and practices related to bereavement are addressed.
- **Trauma type (primary):** Childhood traumatic grief
- **Trauma type (secondary):**
- **Additional descriptors** *(not included above)*: The goal of this intervention is to improve PTSD, childhood traumatic grief (CTG), and depressive, anxiety, and behavior problems in children with CTG as well as to improve PTSD, depressive, and CTG symptoms in their parents or primary caretakers.

### Target Population

- **Age range:** *(lower limit)* to *(upper limit)* 6 to 18
- **Gender:** □ Males □ Females □ Both
- **Ethnic/Racial Group** *(include acculturation level/ immigration/refugee history—e.g., multinational sample of Latinos, recent immigrant Cambodians, multigenerational African Americans)*: TG-CBT has been used in diverse cultural groups and been empirically evaluated in Caucasian and African American samples.
- **Other cultural characteristics** *(e.g., SES, religion)*:
- **Language(s):** The TG-CBT manual is being translated into Dutch and German.
- **Region** *(e.g., rural, urban)*: TG-CBT has been used in urban, suburban, and rural regions, and is being adapted for use in different countries *(e.g., Zambia, Pakistan, Russia, The Netherlands, Germany, etc.)*
- **Other characteristics** *(not included above)*:

### Essential Components

- **Theoretical basis:** TG-CBT is based on the TF-CBT model, which has a cognitive-behavioral, family, and empowerment basis, integrated with grief-focused interventions.
- **Key components:** Parallel individual child and parent trauma- and grief-focused sessions; joint parent-child sessions, provided over 12-16 sessions (first eight are typically trauma focused and subsequent sessions are typically grief-focused)

### 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).* 5
- **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
- Has this intervention been presented at scientific meetings? [ ] Yes [ ] No  

- Are there any general writings which describe the components of the intervention or how to administer it? [ ] Yes [ ] No  

- Has the intervention been replicated anywhere? [ ] Yes [ ] No  
  [Other countries? (please list) It is being used and adapted in Zambia, Russia, Israel, The Netherlands, Germany, those affected by the 2004 tsunami and the 2005 earthquake in Pakistan. It is also being used by several other NCTSN sites for CTG. It has been used by a number of NYC programs related to CTG secondary to September 11, 2001.]

- Other clinical and/or anecdotal evidence (not included above):

<table>
<thead>
<tr>
<th>Research Evidence</th>
<th>Number of Participants</th>
<th>Sample Breakdown</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Published Case Studies</td>
<td>[ ] Yes [ ] No</td>
<td>N =</td>
<td>By gender: By ethnicity: By other cultural factors:</td>
</tr>
<tr>
<td>Pilot Trials/Feasibility Trials</td>
<td>[ ] Yes [ ] No</td>
<td>N = 61</td>
<td>By gender: 38 female, 23 male By ethnicity: 43 Caucasian, 15 African American, 3 Biracial By other cultural factors:</td>
</tr>
<tr>
<td>Clinical Trials (w/ control groups)</td>
<td>[ ] Yes [ ] No</td>
<td>N =</td>
<td>By gender: By ethnicity: By other cultural factors:</td>
</tr>
<tr>
<td>Randomized Control Trials</td>
<td>[ ] Yes [ ] No</td>
<td>N = 40</td>
<td>By gender: By ethnicity: By other cultural factors:</td>
</tr>
<tr>
<td>Studies describing modifications</td>
<td>[ ] Yes [ ] No</td>
<td>N =</td>
<td>By gender: By ethnicity: By other cultural factors:</td>
</tr>
</tbody>
</table>
• **Outcomes**: What assessments or measures are used as part of the intervention or for research purposes, if any? 
  **Child Measures**: Expanded Grief Inventory (EGI); Child PTSD Symptom Scale (CPSS); Mood and Feelings Questionnaire (MFQ); Screen for Children’s Anxiety Related Emotional Disorders (SCARED). **Parent Measures**: PTSD Diagnostic Scale (PDS); Beck Depression Inventory II (BDI-II); UCLA PTSD Index-Parent Version, Child Behavior Checklist (CBCL).

• **If research studies have been conducted, what were the outcomes?** The above instruments were used to assess outcomes for children and parents. Pilot effectiveness studies which have required clinical levels of CTG have shown that children receiving TG-CBT have experienced significant improvement in CTG, PTSD and other related symptoms, and their participating parents have experienced significant improvement in PTSD symptoms as well. A small randomized controlled trial compared TG-CBT to Child Centered Therapy (CCT) among children whose uniformed service parents died in the September 11th terrorist attacks in New York City. Due to the service requirements of the funding agency, this project did not require clinical levels of CTG in participants. At pretreatment children did not have clinically significant levels of CTG or other outcome measures and no differences were found between the two treatment groups in outcomes at post-treatment. Mothers participating in this project did have clinically significant levels of PTSD, depression and general psychopathology at pretreatment, and those mothers who participated with their children in receiving TG-CBT experienced significantly greater improvement in all of these domains than those receiving CCT. Randomized trials of children with clinically significant levels of CTG are needed to further evaluate the efficacy of TG-CBT.

• **Citations**:

• **Implementation Requirements and Readiness**
  - Space, materials or equipment requirements? Private treatment rooms
  - Supervision requirements (e.g., review of taped sessions)? Trained supervisors able to provide supervision following initial training or the availability of ongoing consultation when needed.
In order for successful implementation, support should be obtained from: web-based training (CTGWeb will be launched in 2007), reading the treatment manual, and consultation from trained consultants or ongoing supervision.

<table>
<thead>
<tr>
<th>Training Materials &amp; Requirements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The treatment manual has been revised in response to suggestions from multicultural therapists. It is being translated into Dutch and German.</td>
<td></td>
</tr>
<tr>
<td>How/where is training obtained? From NCTSN Learning Collaboratives, Train the Trainer Programs, or from privately arranged trainings.</td>
<td></td>
</tr>
<tr>
<td>What is the cost of training? Training through the NCTSN is available at cost. Otherwise training costs approximately $3000/day per trainer, plus expenses.</td>
<td></td>
</tr>
<tr>
<td>Are intervention materials (handouts) available in other languages?</td>
<td>XYes ☐No</td>
</tr>
<tr>
<td>If YES, what languages? The manual is being translated into Dutch and German. Some instruments are currently available in Spanish.</td>
<td></td>
</tr>
<tr>
<td>Other training materials &amp;/or requirement (not included above):</td>
<td></td>
</tr>
</tbody>
</table>

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)? The TG-CBT treatment is based on TF-CBT which has strong efficacy evidence and is being successfully disseminated to other countries and cultures.
- What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)? Some therapists may not want to use a structured treatment which encourages children to talk about the specific ways the significant other died.
- Other qualitative impressions: Client satisfaction (child and parent) are high.

Contact Information

Name: Judy Cohen, MD, Allegheny General Hospital, Anthony Mannarino, PhD, Alleghany General Hospital, and Elissa Brown, PhD
Address: Alleghany General Hospital Center for Traumatic Stress in Children and Adolescents, Pittsburgh, PA and St. John’s University
Phone number: please contact via e-mail
Email: jcohen1@wpahs.org, amannari@wpahs.org, browne@stjohns.edu
Website: [www.pittsburghchildtrauma.org](http://www.pittsburghchildtrauma.org) and [www.musc.edu/tfcbt](http://www.musc.edu/tfcbt)