FUNCTION BEHAVIORAL ANALYSIS

If the child has severe behavioral problems, then these should be addressed prior to undertaking TF-CBT intervention. If the child has behavioral issues that are not overwhelming and also shows symptoms of trauma, the TF-CBT intervention can be utilized. The first procedure is to conduct a functional behavioral analysis (FBA). The basic principle of this analysis is to determine the function, or reason for, the child's behavior. The proponents of TF-CBT believe that a child's behavior either obtains a reward (such as attention, privileges, or influence), or avoids a negative consequence (for example, distress, punishment, or unpleasant activity). Behavior that is rewarded will persist even if the behavior is not desirable. Problem behaviors that are trauma-related tend to involve avoidance of memories or avoidance of reminders that result in distress.

In order to conduct a FBA, Cohen et al. (2010) instructs clinicians to evaluate what contexts and what settings are associated with the child's behaviors. When did the behaviors onset (prior to the trauma, immediately after the trauma, sometime later)? If problem behaviors predate the trauma, did the traumatic event(s) change the behaviors in any way? The clinician should consider the severity of the child's behaviors, what antecedents exist and what consequences typically occur, and whether the responses to the child's behaviors have been consistent. The clinician should also explore what prior treatment has been offered and what the response was to that treatment.

Gathering the information for a FBA can help the clinician determine the relationship between the problem behaviors and the trauma. For example, behaviors such as refusal to separate from a parent, school avoidance, restricting activities, or trouble falling asleep may be connected to avoidance of trauma-related distress. Sexual behavioral problems may be self-soothing, they can exert power over others, or they can gain attention for the child. Aggression resulting from ineffectively-managed anger about the trauma can be a strategy to prevent re-victimization. Self-harm behaviors can reduce

immediate high levels of internal distress. Cohen et al. note that a behavior may have started as trauma-related and then may persist because of reinforcement. While not every behavior can be analyzed, making some connections and helping parents understand the connections can facilitate implementing parenting interventions.

Cohen et al. (2010) caution that ensuring the child's safety is necessary in order to achieve a positive treatment response. Clinicians need to know whether the child's safety from exposure to further abuse is assured or whether the child remains in the violent environment. Some trauma-related behaviors such as hyper-vigilance may be legitimate responses and would not be expected to resolve if the child remains in the dangerous situation. If the child remains in a dangerous environment, clinicians can help the child 'fine-tune' vigilance to danger, learning to differentiate between dangerous situations and innocuous situations. The clinician can teach skills for both types of situations. The goals of the intervention would be to both reduce symptoms and enhance adaptive coping.

The FBA will help decide what treatment options are best to address a specific behavioral problem. The results of the assessment and the possible treatment options are explained to the parents or caretakers. If TF-CBT is also appropriate, the clinician should explain to parents that the treatment focus will be jointly on the child's behavioral issues and the trauma issues. It is important that parents be fully informed and be in agreement to addressing both issues before the treatment proceeds.

Motivation and engagement are important change components. The key is to address ambivalence and move the parent towards agreement about the problem. Several successful motivational interventions are to: clarify service options; define the **relationship as collaborative; identify concrete and practical issues that can be addressed immediately;** state the methods that will be utilized in the treatment plan; and develop a plan for potential attendance barriers. Cohen et al. (2010) suggest eliciting commitment to the change process from the start. Clinicians can convey

confidence about the success of the treatment and provide education to caretakers about the connection between behavior problems and trauma.

If behavior problems persist, the therapist's task is to ascertain why. Generally, if there is not behavioral improvement, the behavioral interventions are not being implemented consistently or they are being implemented improperly (Cohen et al., 2010). It is best to ask parents to implement just one single component per week (such as praising the child when he or she behaves). If the parent is not implementing the behavioral strategy, the therapist can return to the motivational mode instead of persisting in trying to encourage the parent to implement the behavioral component. Offering other options such as home-based therapy leaves choice to the parent. The therapist should remind the parent that a change in the child's status will require a change in the environmental response.

Focus on emotional regulation can also be helpful. Standard components of TF-CBT include: recognition of the physical signs of anger; use of a calming or interrupting strategy (such as controlled breathing, counting backwards, tensing and relaxing muscles); and taking alternative actions (distraction, leaving the room, talking to someone).

The cognitive component can correct misattribution, reduce shame and guilt, and provide factual information about abuse and its causes (Damashek & Chaffin , 2012). Cognitions that fuel anger or other emotions can be modified. For example, the child may believe that parents are being unfair or deliberately hurtful. The child may believe that the parent does not care. Even if the child's thoughts are accurate (for example, a foster child might know that the parent has not completed child welfare requirements so that he or she can return home), the cognitions can be shaped. The child who is disappointed in the parent might become aware that the parent has problems that are not related to the child.

Cohen et al. (2010) caution that therapists should maintain the focus of the evidence-based therapy and should avoid being derailed or distracted by trying to deal with family crisis. Effective treatments are structured and systematic. Problems that cannot be addressed by the psychotherapy should be referred to others. Therapists should clearly communicate about what trauma-based therapy can and cannot accomplish.