

THE BEHAVIOUR INSTITUTE

Diploma in Trauma-Informed Psychotherapy

UNIT 4 • CORE READING 1 OF 6

01

# Trauma-Focused CBT

*The most extensively researched approach, and often the first port of call*

## What This Document Covers

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This document introduces Trauma-Focused Cognitive Behavioural Therapy, generally abbreviated TF-CBT, one of the most extensively studied and widely used approaches to trauma treatment currently available. Understanding its structure and mechanism provides a useful reference point for the other approaches covered later in this unit.

## Where TF-CBT Comes From

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TF-CBT developed as an adaptation of standard cognitive behavioural therapy, specifically designed to address trauma directly, initially developed for children and adolescents before being adapted further for adult use. It combines cognitive behavioural techniques with trauma-sensitive components, and carries one of the strongest evidence bases of any trauma treatment currently in use, with a substantial body of controlled research supporting its effectiveness.

## The Core Structure

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TF-CBT is typically delivered as a structured, phased treatment, often summarised using the acronym PRACTICE, though the specific components and their sequencing can vary somewhat depending on the individual case and practitioner.

### Psychoeducation and Parenting Skills

Early sessions focus on providing clear, accurate information about trauma and its effects — closely related to the trauma-informed foundation covered in Unit 1 — helping the client understand that their symptoms are a recognised, common response, not a sign of something being fundamentally wrong with them.

### Relaxation and Stress Management Skills

Before any direct trauma processing begins, TF-CBT places real emphasis on building concrete self-regulation skills — breathing techniques, grounding strategies, and other tools for managing physiological activation. This connects directly to the window of tolerance concept covered in Unit 2: these skills are aimed at helping a client stay within their window as more difficult material is introduced later in treatment.

### Affective Expression and Regulation

Building on the previous phase, this stage develops a client's capacity to identify, tolerate, and communicate a broader range of emotional experience, including emotions connected to the trauma itself.

### Cognitive Coping and Processing

This phase addresses the connection between thoughts, feelings, and behaviours, helping a client identify and gently challenge unhelpful or inaccurate trauma-related beliefs — echoing the negative alterations in cognition covered in Unit 3's PTSD material.

## Trauma Narrative and Processing

Often considered the core of TF-CBT, this phase involves the client constructing a detailed narrative account of the traumatic event, gradually, and with real attention to pacing. This is where the exposure-based mechanism of TF-CBT does its central work — processing feared or avoided material directly, under safe, structured conditions.

### Pause and Consider

*TF-CBT places considerable emphasis on building coping skills before any direct trauma narrative work begins. Why do you think that sequencing matters, given what Unit 2 covered about the window of tolerance?*

## In Vivo Mastery of Trauma Reminders

For clients who have developed significant avoidance of specific, genuinely safe reminders of the trauma, this phase involves gradual, supported exposure to those reminders, aimed at reducing avoidance that may otherwise persist indefinitely.

## Conjoint Sessions and Enhancing Future Safety

Particularly relevant in work with children and families, this phase can involve sessions bringing in caregivers directly, alongside broader planning for future safety and continued support beyond the end of formal treatment.

## Why the Structure Matters

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TF-CBT's phased, sequential structure reflects a deliberate clinical philosophy: build genuine capacity and safety before asking a client to engage directly with the most difficult material. This connects directly to the window of tolerance concept from Unit 2 — introducing detailed trauma narrative work too early, before adequate coping skills are established, risks pushing a client well outside their window, with the processing becoming overwhelming rather than genuinely therapeutic.

## Who TF-CBT Tends to Suit Well

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Given its strong evidence base, particularly with single-incident or relatively contained trauma, TF-CBT is often a strong first consideration for straightforward PTSD presentations, as covered in Unit 3's Document 1. Its structured, skills-building approach can also work well for clients who find a clear, predictable treatment structure genuinely reassuring. It may require thoughtful adaptation for Complex PTSD presentations, given the additional clusters covered in Unit 3's Document 2, though adapted versions for complex presentations do exist and continue to develop.

## What's Next

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The next document turns to EMDR, an approach with a considerably different underlying mechanism, despite addressing much of the same clinical territory.

## A Few Things to Take With You

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- TF-CBT is one of the most extensively researched trauma treatments currently available, originally developed for children and adolescents
- It follows a phased structure, often summarised as PRACTICE, building coping skills before direct trauma narrative processing begins
- The trauma narrative phase, involving gradual, structured exposure to the traumatic memory, sits at the core of the approach
- Careful sequencing reflects the window of tolerance concept from Unit 2 — building capacity before processing difficult material directly

- TF-CBT tends to suit single-incident or relatively contained presentations particularly well, though adapted versions for complex presentations exist

## Before You Move On

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- Why do you think TF-CBT's strong evidence base developed initially with children and adolescents specifically?
- What risks might arise from skipping the early coping-skills phases and moving straight to trauma narrative work?
- How does the PRACTICE structure reflect the trauma-informed principles covered in Unit 1?