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Trauma-Focused CBT in the Context of Parental Chronic Medical Conditions: A Case Report

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Parental chronic medical conditions (CMCs) are relatively common and have been shown to impact children's psychosocial functioning. Previous research suggests that, for some youth, parental CMCs may be conceptualized as a form of traumatic stress. Trauma-focused cognitive behavioral therapy (TF-CBT) is a multicomponent, evidence-based intervention that is designed to reduce symptoms of posttraumatic stress, depression, and anxiety, as well as behavioral problems, among children and adolescents. Despite its robust empirical support, however, no known studies have utilized this treatment approach to address the mental health needs of youth affected by parental CMCs. The purpose of this article is to describe the application of TF-CBT to treat an adolescent male whose mother was diagnosed with a CMC, which had resulted in continuous family stressors since his birth. Results suggest that TF-CBT offers a promising approach for treating symptoms of posttraumatic stress, anxiety, and depression among children of parents with CMCs, and clinical trials to investigate its effectiveness among this population may be warranted.

Approximately 50% of adults living in the United States have a diagnosis of at least one chronic medical condition (CMC; Ward et al., 2014), which can be defined as an illness, disease, or injury that is continuing or ongoing and causes impairment to health (Bernell & Howard, 2016). Common CMCs include heart disease, cancer, diabetes mellitus, and arthritis (Centers for Disease Control and Prevention, 2017). CMCs not only cause impairments in physical health but they can also negatively affect the mental health of the adults with the conditions (e.g., Moussavi et al., 2007) as well as their family members (e.g., Hickman & Douglas, 2010). In particular, it is important to consider potential psychosocial effects on children, as estimates indicate that between 4 and 15% of youth live with a parent who has a CMC (Barkmann et al., 2007; Sieh et al., 2013).

Keywords: parental chronic medical conditions; posttraumatic stress symptoms; internalizing symptoms; trauma-focused cognitive behavioral therapy; case report

Parental CMCs and Youths' Psychosocial Functioning

The literature examining the impact of parental CMCs on youth's functioning is somewhat mixed, likely due to variations in samples, measurement, and consideration of moderators and mediators. For example, some studies have shown no differences between children of parents with and without CMCs (e.g., Pakenham & Cox, 2014a; Smith & Chambers, 2006), and other research has found positive or adaptive outcomes among children with parental CMCs (e.g., use of effective coping strategies, high levels of resilience, strengthened family relationships; Kennedy & Lloyd-Williams, 2009; Moberg et al., 2016). However, the preponderance of evidence suggests that youth of parents with CMCs are at greater risk for psychosocial difficulties compared to youth of healthy parents (Chen, 2017; Hartman et al., 2020; Morris et al., 2016; Pakenham & Cox, 2014b). Results from one meta-analysis revealed small but significant effect sizes for internalizing symptoms and externalizing problems (Sieh & Meijer et al., 2010). Another review found that, in comparison to adolescents with healthy parents,

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those with a parent diagnosed with cancer had higher levels of distress, anxiety, depression, irritability, and behavioral problems, in addition to lower levels of self-esteem and social competence (Phillips, 2014). Parental CMCs have also been associated with lower grade point averages, activity restrictions (e.g., missing out on activities same-age peers are doing), increased household chores, and caregiving responsibilities among adolescents (Sieh et al., 2013). Children of parents with CMCs are also at increased risk for parentification, whereby the boundaries between parent and child roles are blurred in developmentally inappropriate and often harmful ways (Mayseless et al., 2004). Recent work suggests that adolescents of parents with CMCs may be particularly susceptible to psychosocial maladjustment when exposed to higher levels of emotional parentification (Chen & Panebianco, 2020).

The links between parental CMCs and youths' psychosocial functioning can be viewed within a transactional model of stress and coping (Lazarus & Folkman, 1984). This model posits that children of parents with CMCs experience continuous stressors (e.g., chronicity of the illness, repeated acute events, decreased parental availability, parentification), which may be perceived as challenging, threatening, and/or harmful. Some youth may even perceive the CMC as a traumatic event (or repeated traumatic events), given their exposure to potential or actual serious injury or death (Houck et al., 2007). When children interpret their parent's CMC as life-threatening and do not have adequate coping skills to manage such situations, their stress is exacerbated;this may, in turn, lead to psychosocial impairment.

In fact, several studies have examined symptoms of posttraumatic stress (PTS) in children of parents with CMCs. Houck et al. (2007) found that adolescents of parents with various CMCs reported average levels of anxiety, depression, and behavior problems, but approximately one third of the sample endorsed clinically significant PTS symptoms. In another investigation of adolescents and young adults whose parents were diagnosed with cancer, 35% of daughters and 21% of sons endorsed clinically significant PTS symptoms (Huizinga et al., 2005). Similarly, mothers diagnosed with cancer have also reported greater perceived symptoms of PTS in their children as compared to mothers without cancer (Foran-Tuller et al., 2012). Another recent study revealed that 46% of youth whose parents had an acquired brain injury endorsed elevated PTS symptoms, whereas 10% of youth of parents with diabetes mellitus had elevated symptoms (Kieffer-Kristensen et al., 2011). Therefore, it appears that PTS symptoms might capture the distress experienced by some children of parents with CMCs, and assessment and intervention efforts targeting these symptoms are warranted.

There are likely a number of factors related to the parental CMC itself that may impact the course of a child's PTS symptoms. For example, among children of parents with cancer, prior research indicates that the highest rates of PTS symptoms are present in the first few months after the diagnosis, which could be attributed to initial fear of poor prognosis and possible death (Huizinga et al., 2010). Over the first year after diagnosis, however, distress seems to decline, possibly in response to improved prognosis, positive response to treatment, and/or habituation to the stressor. More specifically, one study found that 30% of youth had clinically elevated PTS symptoms in the first few months following parental diagnosis, 16% had elevated symptoms at 6 months, and 14% had elevated symptoms at 12 months. Further, Kieffer-Kristensen et al. (2011) suggested that children of parents with acquired brain injury may experience higher rates of PTS symptoms than children of parents with diabetes mellitus because they are regularly reminded of the traumatic event due to their parent's physical, cognitive, and personality changes that resulted from it. Taken together, there is a paucity of prior research clarifying the specific aspects of parental CMCs that may increase risk, but fear of death and reminders of traumatic events related to the CMC may impact youths' PTS symptoms.

Intervention Approaches for Children of Parents With CMCs

Although a number of mental health interventions for youth PTS symptoms exist, findings from several systematic reviews suggest that trauma-focused cognitive behavioral therapy (TF-CBT) has the most significant empirical support (e.g., Cary & McMillen, 2012; de Arellano et al., 2014). TF-CBT has undergone extensive investigation, including multiple randomized clinical trials that have demonstrated reductions in PTS symptoms for children and adolescents both inside and outside of the United States (e.g., Konauer et al., 2015; O'Callaghan et al., 2013). No known studies, however, have utilized this treatment modality to address PTS symptoms in children of parents with CMCs.

Instead, traditional cognitive-behavioral therapy (CBT) approaches have previously been utilized, which have not focused on the potentially traumatic nature of parental CMCs. For example, prior work has used CBT to address the psychosocial functioning of children of parents with human immunodeficiency virus (HIV; Keypour et al., 2011; Rotheram-Borus et al., 2003). Components of these treatment approaches included

providing psychoeducation about the disease and teaching relaxation strategies, thought challenging, problem solving, communication skills, and self-expression. In contrast, a systematic review of interventions for children of parents diagnosed with cancer—one of the leading causes of death globally (World Health Organization, 2018)—found that the majority of studies rarely utilized evidence-based techniques (Ellis et al., 2017). Rather, interventions for this parental CMC commonly used informal approaches (e.g., holiday camps, art and play activities) to provide age-appropriate information about the disease, teach communication skills, and facilitate emotional expression and normalization. Given the robust literature supporting the use of TF-CBT to address symptoms related to other traumatic stressors in children and adolescents, including the death of a parent (e.g., O'Donnell et al., 2014), it may be a useful approach for addressing PTS symptoms in children of parents living with CMCs.

Overview of TF-CBT Components

TF-CBT is a multicomponent intervention designed to address PTS, depressive, and anxiety symptoms, as well as moderate behavioral problems, among youth between the ages of 3 and 18 (see Cohen et al., 2017, for a detailed overview). Treatment typically lasts 12–16 sessions, although a longer duration may be required for individuals with complex trauma histories or problems. TF-CBT consists of nine components that comprise the acronym PPRACTICE and are divided into three phases: stabilization, trauma narrative, and integration/consolidation.

The stabilization phase includes (a) **p**sychoeducation, (b) **p**arenting skills, (c) **r**elaxation skills, (d) **a**ffective expression and modulation skills, and (e) **c**ognitive coping and processing skills. The psychoeducation component aims to provide information about the index trauma(s); common emotional, behavioral, and physical responses; the child's diagnosis; trauma reminders; and the TF-CBT model of treatment. In the parenting skills component, information regarding developmental expectations is provided, functional analyses are conducted, and behavior management strategies are taught to address behavioral problems and depressive symptoms. The relaxation skills component includes a range of strategies—focused breathing, progressive muscle relaxation, and mindfulness—to help children and parents manage physiological responses to trauma and stress. The affective expression and modulation skills component focuses on expanding children's emotional vocabulary, teaching coping strategies (e.g., positive imagery, positive self-talk, problem solving), and building social skills. The cognitive coping and processing skills component aims to help children identify their thoughts and understand their connection to feelings and behaviors, as well as address inaccurate or unhelpful cognitions.

The trauma narrative phase includes one component divided between two parts: (f; Part 1) **t**rauma narration and (Part 2) cognitive processing. Trauma narration is a form of gradual exposure in which children are guided in developing a detailed account of the traumatic event(s) they experienced. A central goal is to break the links between thoughts or reminders of the traumatic event(s) and the physiological reactions and negative thoughts/emotions associated with them. Thus, the goal is for the trauma to be integrated as "only one part of the child's life experience and self-concept, rather than the defining aspect of both" (Cohen et al., 2017, p. 173). The trauma narrative provides opportunities for the therapist to identify, challenge, and restructure inaccurate or unhelpful trauma-related cognitions during the processing phase.

The integration/consolidation phase comprises three components: (g) **i**n vivo mastery of trauma reminders, (h) **c**onjoint child–parent sessions, and (i) **e**nhancing future safety and development. The in vivo mastery component is optional; it is used with youth actively avoiding trauma cues that are objectively safe. Although TF-CBT includes multiple opportunities for conjoint child–parent sessions (e.g., psychoeducation, practicing skills, safety planning), a critical goal in this component is to increase children's comfort in sharing their trauma narratives with their caregivers. While children develop the narrative, therapists meet individually with parents in parallel sessions to review their children's narratives, support parents' processing, and teach them skills to support their children. During conjoint sessions, children may read the narratives (in some instances, therapists may help read them), while parents listen reflectively and provide support and praise. Enhancing future safety and development is devoted to personal safety skills training. Therapists teach strategies to reduce children's risk of revictimization and increase their sense of safety and self-efficacy. This component also focuses on reviewing skills learned during treatment, identifying plans for the future, and discussing signs that may indicate the need for a booster session.

Current Case Report

The current paper presents a case report of an adolescent male whose mother was diagnosed with a CMC that resulted in continuous family stressors since his birth. It aims to illustrate the process of implementing TF-CBT to address his PTS and internalizing symptoms. Although case reports are inherently limited in their generalizability, we believe this provides a

valuable example of the benefits and challenges of utilizing an evidence-based, trauma-focused treatment for this population.

Method

Client Description

EJ was a 13-year-old male referred by his primary care physician for mental health services to an outpatient trauma treatment center at an academic medical center in the Southeastern United States.[1] When the case was assigned, the clinic coordinator provided the following information:

> [EJ]'s mother is currently fighting an illness that may take her life. Though there is some question whether it is terminal, there appears to be an expectation that she will pass as a result. . . . The youth does have a history of exposure of domestic violence, but we have been asked to engage in trauma-focused work around the mother's medical troubles. Please place focus on assessing fit in regard to TF-CBT.

Initial Intake

During the initial intake with the case therapist, EJ's mother reported particular concern regarding his adjustment to her CMC. She indicated that he often worried about her health, and he would become upset, cry, and "shut down" when there was a medical emergency that required her to go to the hospital. EJ's mother reported experiencing frequent seizures and undergoing repeated medical testing that had yielded inconclusive results regarding the nature of her CMC. At intake, she stated her doctors had suggested she may be in the first stage of congestive heart failure. EJ's mother indicated that their family was supported through her disability benefits, as she was unable to work due to her CMC.

EJ stated that he was angry about his mother's illness, and he endorsed worrying most days about what could happen to her, including that she could "go away" (i.e., fear of death). He also reported that he frequently thought about what he could do to make his mom feel better, and he avoided talking with her about his feelings related to her illness so as to not create added stress. Due to his mother's CMC, EJ would often help with chores and tasks at home (e.g., cooking dinner, cleaning), and assist his mother with medical equipment (e.g., oxygen tank) used to maintain her daily health.

EJ's mother noted he had witnessed one incident of domestic violence between her and his stepfather approximately 2 years prior to the intake. Child protective services became involved, and as a result, the stepfather was living out of the house while he engaged in individual treatment services with the goal of reunification. Immediately following this incident, EJ, his mother, stepfather, and younger sister (age 6) had engaged in family therapy. EJ reported that the incident did not continue to cause him distress, and he had a generally positive relationship with his stepfather. He also indicated that he had a close relationship with his sister despite some occasional conflict that stemmed from her frequent desire to play together. EJ's mother noted she had one sister (i.e., EJ's aunt) who lived nearby and helped supervise EJ and his sister whenever she had medical emergencies.

His mother also indicated that EJ had been bullied on a daily basis for several months during the previous school year. Specifically, she reported that he was physically attacked, his property was destroyed, and he was exposed to frequent teasing. As a result, she was afraid to send him to school, and she encouraged EJ to defend himself. He was subsequently involved in a physical altercation with two other students, and according to EJ, the bullying stopped after this incident. At the time of the intake, EJ had an individualized education plan (IEP) for a specific learning disorder, and he was involved in several extracurricular activities. EJ had no prior history of individual therapy services.

Procedure

EJ and his mother completed pretreatment and end-of-treatment assessments to objectively evaluate change in EJ's symptoms of PTS, anxiety, and depression. Therapy services were provided through two supervised clinical programs. The first program focuses on community-based treatment services for youth who have experienced trauma, with the goal of reaching populations that have traditionally been underserved by office-based mental health care programs (e.g., rural communities, low-income families, racial/ethnic minorities). Through this program, treatment was initially delivered at EJ's home. Services were transferred to an integrated behavioral health program within a pediatric primary care clinic after Session 10 so that EJ could complete TF-CBT with the therapist when he began working in this setting. In order to maintain access to care, a case manager provided transportation to sessions for EJ and his family during their participation in the second program. EJ's mother provided writ-

[1] Details from this case have been de-identified and changed to protect the identity of the patient and his family.

ten informed consent, and he provided verbal assent for the completion of this case report.

Therapist Training

The therapist (i.e., JLC) was a male Ph.D. candidate in an American Psychological Association (APA)-accredited clinical psychology internship program. Prior to treatment onset, the therapist completed two 3-hour TF-CBT workshops and TF-CBT *Web*, a 10-hour online training course. The course of treatment was guided by the second edition of the TF-CBT manual, which was written by the intervention developers (Cohen et al., 2017). Two doctoral-level, licensed clinical psychologists, who were certified as TF-CBT trainers, supervised the case (one per each clinical program). The therapist met with them individually or with one additional psychology intern for weekly clinical supervision. Supervision focused on reviewing each session to ensure fidelity to the TF-CBT protocol, practicing skills via role plays, addressing treatment barriers, and planning for upcoming meetings. Treatment sessions were also audio recorded and reviewed periodically by the case supervisors for training and fidelity purposes. All session documentation was reviewed and co-signed by the supervising psychologists.

Measures

PTS Symptoms

The University of California at Los Angeles Child/Adolescent Posttraumatic Stress Disorder Reaction Index for DSM-5 (UCLA-RI-5) is a widely used semi-structured interview that assesses trauma history and symptoms, as well as posttraumatic stress disorder posttraumatic stre diagnostic criteria (Pynoos & Steinberg, 2015). Importantly, among the traumatic stressors screened, the UCLA-RI-5 includes questions related to illness/medical trauma (i.e., Did you ever see someone you really care about get so sick that you were scared they might die?) and an impaired caregiver (i.e., Was there ever a time when someone who was supposed to take care of you couldn't, like they were too sick, they were so sad they stayed in bed?). The interview then assesses the frequency of symptoms during the past month for the trauma that bothers the youth most at the present time using a 5-point scale (0 = *none*, 1 = *little*, 2 = *some*, 3 = *much*, 4 = *most*). The 31-item symptom checklist maps onto the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) intrusion, avoidance, and arousal criteria, as well as dissociative symptoms. Finally, clinically significant distress and impairment are assessed. Self- and parent-report versions of the UCLA-RI-5 are administered separately. Preliminary research on the DSM-5 version supports its reliability and validity, and one recent study found that a total score of 35 for the self-report version provides excellent diagnostic classification accuracy (Kaplow et al., 2020). No known clinically significant cutoff scores currently exist for the parent-report version.

Internalizing Symptoms and Externalizing Problems

The Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher et al., 1997) is a 41-item multidimensional inventory that maps onto diagnostic criteria for anxiety disorders. Self- and parent-report versions exist, and items are rated based on the previous 3 months on a 3-point scale (0 = *not true/hardly ever true*, 1 = *somewhat true/sometimes true*, 2 = *very true/often true*). The scale comprises five subscales that each have identified clinically significant cutoff scores (panic disorder/somatic symptoms = 7, generalized anxiety disorder = 9, separation anxiety disorder = 5, social anxiety disorder = 8, school avoidance = 3). These subscales are summed to create a total score, which has a cutoff of 25. The SCARED has been examined extensively and has demonstrated sensitivity to treatment effects in both clinical and research settings (e.g., Birmaher et al., 1997; Muris et al., 2001).

The Short Mood and Feelings Questionnaire (SMFQ; Angold et al., 1995) is a 13-item measure that assesses youths' symptoms of depression over the past 2 weeks. Self- and parent-report versions exist, and items are rated on a 3-point scale (0 = *not true*, 1 = *sometimes*, 2 = *true*). This measure has demonstrated good psychometric properties (e.g., Sharp et al., 2006), and research suggests that a combined score of 10 between the child- and parent-report versions provides the best diagnostic classification accuracy (Rhew et al., 2010).

The Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) is a 113-item parent-report measure that assesses youths' psychosocial functioning over the previous 6 months. Items are rated on a 3-point scale (0 = *not true*, 1 = *somewhat/sometimes true*, 2 = *very true/often true*). The CBCL provides internalizing problems, externalizing problems, and total problems scores along with eight syndrome scale scores. As a standardized measure, *T* scores are calculated, with scores of 70 and above in the clinical range, and scores of 65–69 in the borderline clinical range. The CBCL has been extensively examined in clinical and research contexts and demonstrated good psychometric properties (e.g., Aschenbrand et al., 2005).

Results

DSM-5 Diagnosis

Based on results from the clinical interview and the self- and parent-report measures, EJ met DSM-5 criteria for Adjustment Disorder with Mixed Anxiety and Depressed Mood, Persistent. On the UCLA-RI-5 (see Figure 2), both EJ and his mother reported he was most bothered by his mother's illness/medical trauma, which had resulted in continuous stressors since he was 5 years old, and they endorsed elevated PTS symptoms for EJ. Specifically, they noted he was experiencing intrusion symptoms (i.e., psychological distress and physiological reactivity), negative alterations in cognitions and mood (i.e., distorted cognitions and persistent negative emotional state), and marked alterations in arousal and reactivity (i.e., irritable behavior and angry outbursts, hypervigilance, exaggerated startle response, problems with concentration, sleep disturbance). EJ and his mother reported that these symptoms were causing clinically significant distress, and his mother stated that these had created functional impairments for EJ at home and in his developmental progression. Neither EJ nor his mother reported significant avoidance symptoms, and EJ's self-report score did not exceed the clinically significant cutoff on the UCLA-RI-5. Thus, he did not meet full diagnostic criteria for posttraumatic stress disorder. However, EJ and his mother endorsed clinically significant symptoms of anxiety and depression, but not externalizing problems, on the SCARED, SMFQ, and CBCL (see Table 2). They attributed these symptoms to his mother's CMC, and EJ did not meet diagnostic criteria for another anxiety or depressive disorder. EJ and his mother reported that his emotional symptoms had been present since the age of 5 when he first witnessed his mother have a medical emergency that left her unconscious for a long period of time. Taken together, the therapist and supervisor determined that TF-CBT would be an appropriate intervention approach for addressing EJ's PTS and internalizing symptoms.

Course of Treatment

A summary of EJ's course of treatment is provided in Table 1, and a timeline is provided in Figure 1. All treatment sessions, with one exception (noted below), lasted approximately 60 minutes. Prior to *Session 1*, EJ's mother called to inform the therapist that they were running late due to an unforeseen doctor's appointment. When they arrived, she requested to meet with the therapist individually to discuss recent stressors their family was experiencing, including her ongoing medical problems, unstable housing, and a recent trauma EJ's sister had experienced. The therapist provided support around these issues, reviewed the results from the initial evaluation, and provided an overview of the TF-CBT model. The therapist subsequently met with EJ individually to review the results from the initial evaluation and provide an overview of the TF-CBT model; both EJ and his mother endorsed a desire to participate in therapy.

Session 2 initially had to be rescheduled, as EJ's mother had a medical emergency due to harmful levels of chemicals in their home following repairs. When the session occurred, the therapist met with EJ individually to provide psychoeducation about the prevalence of CMCs, their impact on families, and common reactions among children of parents with CMCs. The therapist inquired about the extent of EJ's knowledge about his mother's illness and worked collaboratively to generate a list of questions he would like to ask her. The therapist then met with his mother individually to review the aforementioned topics.

At the beginning of *Session 3*, EJ's mother requested to meet individually with the therapist and reported that she had just been notified that he had sent an inappropriate photo to a girl at school, who then shared it with their peers. His mother endorsed very high levels of stress due to this incident and the other issues their family was facing. The therapist asked permission to discuss aspects of healthy relationships and sexuality with EJ, which she agreed to. Next, the therapist met individually with EJ, who endorsed feelings of confusion, anxiety, sadness, and anger about what had transpired. The therapist validated his feelings and worked with EJ to identify a list of coping strategies he could engage in to help manage his distress. Focused breathing was introduced as a relaxation skill, which he was instructed to practice daily. The therapist and EJ subsequently discussed aspects of healthy relationships, reasons why people decide to engage and refrain from sexual activity, physical health considerations, age of consent, and potential consequences of risky behavior.

Due to his mother's elevated distress, an individual meeting with her was scheduled for the following day. *Session 4* began by introducing focused breathing and mindfulness as relaxation skills for EJ's mother and then reviewing the questions he developed about her CMC. Due to periodically having medical emergencies that left her unconscious for long periods of time, the therapist worked with EJ's mother to develop a safety plan clearly outlining the steps he should take in such instances. Behavior management skills were then reviewed, including praise, reflective listening, selective attention, and removal of privileges. Finally,

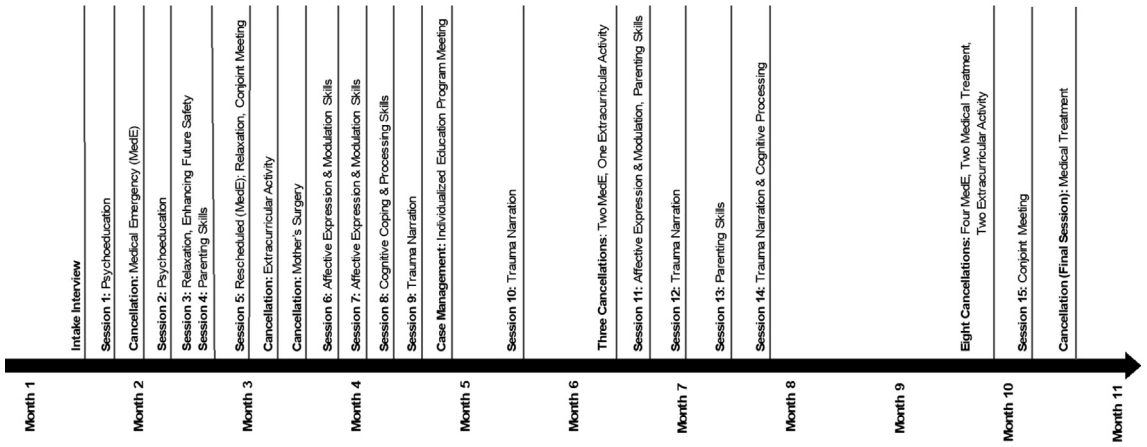

Figure 1. Treatment timeline.

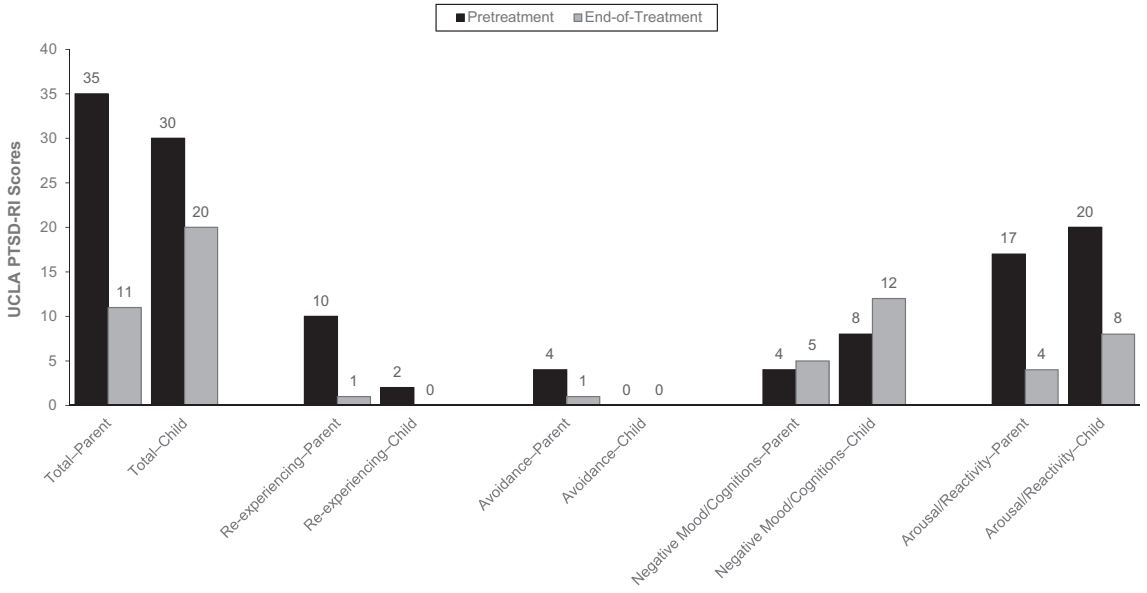

Figure 2. Change in posttraumatic stress symptoms from pretreatment to the end of treatment. *Note.* UCLA PTSD-RI = University of California at Los Angeles Child/Adolescent Posttraumatic Stress Disorder Reaction Index for DSM-5.

the therapist worked with her to problem solve around their housing situation—local resources were identified along with avenues for finding temporary accommodations and a new home.

Session 5 had to be rescheduled because EJ's mother had a medical emergency that required a trip to the hospital. When the session occurred, the therapist met individually with EJ and introduced several progressive muscle relaxation exercises. He agreed to practice these on a nightly basis before bedtime, and the therapist guided EJ in exploring other times in which he could use these relaxation skills in his day-to-day life. EJ's mother then joined the session, and he taught her the relaxation skills he had learned to date. Finally, the therapist facilitated a discussion about her CMC; that is, EJ asked her the previously generated questions, and his mother reviewed the safety plan she had developed. The therapist inquired about each step of the plan to ensure EJ's understanding, and his mother decided the plan would be posted on their refrigerator so that it was easily accessible at all times.

Session 6 was rescheduled twice due to a conflict with one of EJ's extracurricular activities followed by his mother undergoing surgery. Prior to the appointment, the therapist was informed by his mother via phone that EJ had four recent altercations—two physical and two verbal—with other students at school. During the individual session, EJ reported that he had been

Table 1
Summary of Treatment Sessions

Session #	TF-CBT component(s)	Session content
1	Psychoeducation	Feedback from initial evaluation, overview of TF-CBT model, support for patient's mother
2	Psychoeducation	Review of prevalence of CMCs, their impact on families, and common reactions among children of parents with CMCs; development of questions regarding mother's illness
3	Relaxation Skills, Enhancing Future Safety	Focused breathing, identification of coping strategies, discussion of healthy relationships and sexuality
4	Parenting Skills	Focused breathing and mindfulness with mother, review of questions patient developed regarding her CMC, development of safety plan, behavior management skills, problem solving regarding housing
5	Relaxation Skills, Conjoint Child–Parent Meeting, Enhancing Future Safety	Progressive muscle relaxation, child–parent discussion about her CMC, review of safety plan
6	Affective Expression and Modulation Skills	Problem-solving approach, effective responses to bullying, identification of additional coping strategies
7	Affective Expression and Modulation Skills	Emotion identification, awareness, and expression; rating emotional intensity and emotion triggers
8	Cognitive Coping and Processing Skills	Cognitive triangle, distinction between accurate/inaccurate and helpful/unhelpful thoughts, generation of alternative thoughts
9	Trauma Narration	Psychoeducation regarding trauma narration process, development of first "about me" chapter
10	Trauma Narration	Development of second chapter about "most frightening memory" related to mother's CMC
11	Affective Expression and Modulation Skills, Parenting Skills	Problem-solving approach, effective responses to bullying, development of behavioral contract with patient's mother
12	Trauma Narration	Development of third "impact statement" chapter
13	Parenting Skills	Defining household expectations and rules, reinforcers, consequences for misbehavior, development of behavioral plan
14	Trauma Narration and Cognitive Processing	Cognitive processing regarding patient's guilt, development of final chapter about "what I learned in therapy" and what advice patient would give another child, review of trauma narrative with mother
15	Conjoint Child–Parent Meeting	Review of trauma narrative separately with patient and mother, review of each chapter during conjoint meeting

Note. TF-CBT = trauma-focused cognitive behavioral therapy; CMC = chronic medical condition.

provoked in each of these incidents but responded in ways that escalated the conflict. The therapist introduced a problem-solving approach, which included (a) say what the problem is, (b) think of solutions, (c) examine the solutions, (d) pick one and try it out, and (e) see how it worked. Next, they worked together to apply this approach to the recent bullying incidents. The therapist and EJ discussed the ineffectiveness (and potential harm) of responding to such interactions aggressively. Finally, they worked to identify additional coping strategies EJ could employ when he is upset. EJ was assigned homework of utilizing his relaxation and coping strategies and implementing the identified problem-solving plan as needed.

At the beginning of *Session 7*, EJ reported one incident of bullying with a peer on the bus during the previous week but that he had used the previously discussed problem-solving approach, which helped to de-escalate the situation. The affect expression and modulation skills component was continued by having EJ identify as many emotions as possible during a 2-minute period. The therapist and EJ then played a game of emotion charades. Further, they discussed the last time each emotion was experienced (note that many occasions involved his mother's CMC), described how it physically impacted the body, rated the emotion on a 0–10 scale, and suggested what could have changed in the situation to increase or decrease the

Table 2
Change in Internalizing Symptoms From Pretreatment to the End of Treatment

	Pretreatment	End of treatment
SCARED Scores		
Total–Parent	33-C	11
Panic–Parent	6	1
Generalized Anxiety–Parent	9-C	3
Separation Anxiety–Parent	6-C	2
Social Anxiety–Parent	10-C	4
School Avoidance–Parent	2	1
Total–Child	19	16
Panic–Child	1	1
Generalized Anxiety–Child	9-C	6
Separation Anxiety–Child	4	3
Social Anxiety–Child	3	5
School Avoidance–Child	2	1
SMFQ Scores		
Combined Parent and Child	14-C	5
CBCL Scores		
Internalizing Problems	70-C	52
Externalizing Problems	53	50
Total Problems	66-C	53
Anxious/Depressed	66-B	50
Withdrawn/Depressed	66-B	54
Somatic Complaints	74-C	58
Social Problems	69-B	54
Thought Problems	67-B	66-B
Attention Problems	67-B	55
Rule-Breaking Behavior	50	52
Aggressive Behavior	57	51

Note. SCARED = Screen for Child Anxiety Related Emotional Disorders; SMFQ = Short Mood and Feelings Questionnaire; CBCL = Child Behavior Checklist; C = clinical range; B = borderline clinical range.

emotion's intensity. EJ's homework involved completing a daily emotion log. Next, the therapist met separately with his mother and stepfather, who had just reintegrated with the family. The therapist provided him with an overview of treatment to date and inquired about his perspective and goals for EJ.

Session 8 focused on introducing the cognitive triangle and illustrating how thoughts, emotions, and behaviors are connected. Several hypothetical scenarios were reviewed, and the therapist explained the distinction between accurate/inaccurate thoughts and helpful/unhelpful thoughts. Several examples relevant to EJ, including conflicts with peers and worries about his mother's health, were discussed to demonstrate how changing patterns of thinking by focusing on more accurate or helpful thoughts can change one's subsequent emotions and behaviors. Finally, EJ's mother joined the session, and he explained these concepts to her. Homework for the week involved EJ tracking his thought patterns and utilizing these cognitive coping skills.

During *Session 9*, the therapist provided psychoeducation to EJ about the rationale for and process of creating the trauma narrative. EJ decided to create a book for his narrative, and began working with the therapist to create the first chapter, which focused on information about his family, interests, goals, and best qualities. EJ endorsed a desire to become a doctor in the future so that he could help take care of his mom or a scientist so he could create a machine that could heal her. The therapist then met with his mother to provide an overview of the trauma narration process and review EJ's first chapter. EJ was instructed to continue to use the relaxation and cognitive coping skills during the upcoming week. Following this session, the therapist attended EJ's annual IEP meeting at his mother's request. Note that IEP meetings are attended by children, parents, general education teachers, special education teachers, school psychologists, and school district representatives to review special education services that are being provided, discuss children's educational progress, and develop new goals for the upcoming year. At the end of this meeting, the therapist worked with the school team to address EJ's experiences of bullying by identifying the process for reporting incidents in the classroom and on the school bus, as well as adults that EJ could talk to when they occurred.

The beginning of *Session 10* was devoted to discussing plans for treatment moving forward, as the therapist was approaching the end of his rotation at the community-based program. EJ and his mother were provided with the option of continuing services with a new provider through this program or to transitioning their services to an integrated behavioral health program within a pediatric primary care clinic; they both requested a transfer to the new setting so that EJ could complete TF-CBT with the current therapist. Next, the therapist met individually with EJ and worked to develop the second chapter of his trauma narrative, which focused on the most frightening memory related to his mother's CMC. This involved an occasion when

EJ was 5 years old and his mother had a medical emergency that left her unconscious for a long period of time. He reported that he did not know what to do, and she was hospitalized overnight. After he recounted the event, the therapist inquired about his thoughts and feelings during that time. EJ's subjective units of distress scale (SUDS) rating began at 1 out of 10 and peaked at 5 during the creation of this chapter before decreasing again to 2. Homework for the week involved EJ continuing to utilize relaxation and cognitive coping skills.

When the therapist arrived at the home for the next appointment, he was met by EJ's stepfather, who reported that EJ's mother had gone to the hospital for a medical emergency, and the session would need to be rescheduled. It was rescheduled twice more due to issues related to her CMC and then a schedule conflict with one of EJ's extracurricular activities. *Session 11* occurred at the pediatric primary care clinic, where all remaining sessions were conducted. At the onset of it, his mother reported that EJ had been suspended from school twice in recent weeks—once for fighting with a peer and another time for swearing at his teacher. She expressed concern that he was continuing to be bullied, and there was one peer who was consistently victimizing him (e.g., taking his possessions, putting him in a headlock). She suggested that EJ had responded to these experiences by misbehaving at school. The therapist then met individually with EJ and explored his perceptions of the effectiveness of his tendency to respond aggressively to bullies at school and the consequences of these actions. This exploration was done using Socratic questioning, which involves asking a series of open-ended questions in order to foster critical thinking, help patients develop new perspectives, and guide them in implementing the skills introduced in treatment (Braun et al., 2015). Moving forward, EJ expressed that he would use other strategies for managing future conflict, including telling the peer to stop, not responding to the provocation, removing himself from the situation, telling an adult at school, and telling his mother. Homework for the week involved utilizing the identified strategies for managing bullying victimization. Next, the therapist worked individually with EJ's mother to develop a behavioral contract whereby he could earn back access to his electronics, which she had removed, for appropriate behavior at school.

At the beginning of *Session 12*, EJ reported that things had gone well over the previous week. Specifically, he indicated that he had disclosed his experiences of bullying during a school meeting, and this had led the administrators to open an investigation and take action. EJ stated that he had not experienced any bullying since that time, and he had earned back access to electronics at home. The therapist praised EJ for talking with adults at his school about the bullying and utilizing his identified problem-solving strategies. Next, they reviewed the portion of the trauma narrative generated to date and worked to create an impact statement regarding how his mother's CMC had affected his life and his concerns for the future. While working on this portion of the narrative, EJ's SUDS rating peaked at 5 out of 10. Accordingly, the therapist facilitated focused breathing at the end of the session, which reduced his SUDS rating to 1. It is important to note that relaxation activities were not implemented until the *end* of each exposure exercise (i.e., the creation and review of the trauma narrative) throughout treatment, so as to not disrupt the therapeutic mechanisms and inadvertently reinforce avoidance (see Blakely & Abramowitz, 2016). Instead, these activities were used to reinforce previously introduced strategies that EJ could utilize in his day-to-day life and so that he did not leave sessions with heightened distress. This approach is consistent with the TF-CBT manual, which states that sessions should end with calming, fun activities (Cohen et al., 2017). Homework for the week involved EJ continuing to utilize his relaxation and cognitive coping skills.

EJ's mother and stepfather reported at the outset of *Session 13* that they wanted to address his recent misbehavior at home. In particular, they expressed frustration related to EJ's difficulty following instructions, waking up in the morning, and completing daily chores. The therapist worked with them to define their household expectations (e.g., following parent's instructions) and rules (e.g., clean your room once a day, wake up by 6 a.m.). The therapist reviewed potential reinforcers and consequences for misbehavior and worked with his parents to establish a consistent behavioral plan for minor and major violations of household expectations. The therapist emphasized the importance of consistency and predictability in implementing this plan. Finally, EJ joined the session, and his parents explained the behavioral plan to him.

Session 14 focused on cognitive processing of the trauma narrative. The therapist began by reviewing the previously generated portions individually with EJ; while doing so, his SUDS rating peaked at 2 out of 10. The therapist then engaged in cognitive processing around EJ's guilt about his mother's CMC and his beliefs about the future. Specifically, complications during EJ's birth had contributed to his mother's medical problems, for which he consistently blamed himself. EJ also expressed in his impact statement that if his mother were to die prematurely due to complications stemming from her CMC, he would "be nothing."

The therapist engaged in Socratic questioning to address the inaccurate/unhelpful nature of these thoughts and help EJ focus on more accurate/helpful cognitions. Next, EJ created the final chapter of the narrative, detailing what he learned in therapy and what advice he would give to another child whose parent had a CMC. No additional homework was assigned. The therapist subsequently met individually with EJ's mother and reviewed his trauma narrative with her. She became tearful while it was read aloud, expressing she had always worried about the impact of her CMC on EJ, and it was difficult to hear his perspective about it. Finally, the therapist engaged EJ's mother in cognitive processing around her thoughts and feelings about the narrative and discussed having a conjoint meeting with EJ. At the end of the session, the therapist facilitated her use of relaxation skills (i.e., focused breathing).

The next appointment had to be rescheduled on numerous occasions due to EJ's mother being out of town for medical treatment, ongoing complications with her CMC, and scheduling conflicts with one of EJ's extracurricular activities. When it occurred approximately 2 months later, self- and parent-report measures were readministered during the initial hour. *Session 15* then focused on the conjoint child–parent meeting, which lasted 90 minutes. The therapist began by reviewing the trauma narrative individually with EJ and discussing a plan for sharing it with his mother. EJ initially reported high levels of anxiety—a SUDS rating of 8 out of 10—about the conjoint meeting but indicated he was willing to do so. EJ and the therapist played a brief game together, which reduced his SUDS to 5; this relaxation activity was implemented at the conclusion of the first exposure exercise (i.e., individual review of the trauma narrative and preparation for the conjoint meeting) prior to the second exposure exercise (i.e., sharing the trauma narrative with his mother) in order to maintain consistency with the expectations established during prior sessions. Next, the therapist met with EJ's mother individually and reviewed the trauma narrative with her. Although she became tearful, she appeared considerably calmer than the previous occasion when it was shared, and she expressed the need to be strong for her son. Finally, EJ rejoined the session. He was visibly nervous, but his mother helped to calm him down. EJ shared his trauma narrative with her by alternating reading chapters with the therapist (per EJ's request). After each chapter, his mother reflected what EJ had expressed and provided him with labeled praise. She addressed his fear of losing her due to her illness, expressed how proud she was of him, and highlighted his strengths and goals for the future.

A final appointment was scheduled for treatment termination, but unfortunately, EJ's mother had to cancel it due to complications with her CMC. The therapist spoke with her via phone to review EJ's treatment progress and emphasize his and the family's strengths. EJ's mother expressed high levels of satisfaction with the improvements EJ demonstrated and the therapy services they received. Although she stated that she was disappointed not to be able to attend a final session (rescheduling was not possible due to the therapist ending his predoctoral internship), she stated she was comfortable ending services for EJ, and she thanked the therapist for their work together.

Treatment Outcomes

EJ demonstrated decreases in PTS symptoms according to both self- and parent reports on the UCLA-RI-5 over the course of treatment (see Figure 2). In particular, there were substantial reductions in his symptoms of arousal and reactivity. EJ did show a minor increase in his self-reported negative mood and cognitions related to his mother's CMC, but this was driven by his ratings of anger that doctors were not able to help her and his belief that the world is a dangerous place. Neither EJ nor his mother, however, endorsed clinically significant distress or functional impairment on the UCLA-RI-5 at the completion of treatment. Moreover, EJ no longer exhibited clinically significant symptoms of anxiety or depression on the SCARED, SMFQ, and CBCL at the end of treatment (see Table 2). Thus, he no longer met DSM-5 criteria for adjustment disorder with mixed anxiety and depressed mood, persistent. When EJ was asked what advice he would give to another child whose parent had a CMC, he stated:

> A therapist can help you talk about your feelings to them about your mom, dad, or your family. What's going wrong with you. They help you. It helped me. I used to worry about my mom's illnesses. They helped me feel better and change my ways during school.

Discussion

The current case report highlights the potential utility of TF-CBT when working with children of parents with CMCs, as it yielded significant reductions in PTS and internalizing symptoms for EJ. Relatively little research to date has investigated treatment approaches for this population, and many of the existing interventions have not utilized evidence-based techniques (Ellis et al., 2017);this is a notable omission in the literature considering the prevalence of parental CMCs and their demonstrated impact on children's psychosocial functioning (e.g., Sieh & Meijer et al., 2010). There is also

evidence to suggest that, for some youth, parental CMCs may be conceptualized as a form of traumatic stress given their exposure to potential or actual serious injury or death (Houck et al., 2007). This case report is the first known paper to detail the application of an evidence-based, trauma-focused treatment to address the mental health needs of children affected by parental CMCs.

TF-CBT was a particularly good fit for this patient and his family for a number of reasons. EJ had been exposed to a continuous series of medical traumas since the age of 5;that is, his mother would occasionally have medical emergencies that would leave her unconscious and require hospitalization. As a result, EJ exhibited elevated PTS symptoms, including intrusion symptoms, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. He also experienced substantial guilt stemming from the impact of his birth complications on her health. Due to the ongoing nature of his mother's CMC, it is unsurprising that EJ did not endorse symptoms of avoidance (i.e., it would have been difficult to avoid thoughts, feelings, or reminders related to the traumatic events). Although EJ did not exceed the clinical cutoff of PTS symptoms, he and his mother stated at the onset of treatment that these symptoms had caused clinically significant distress and impairment. Further, they both indicated that he was experiencing clinically significant symptoms of anxiety and depression, which they attributed to her CMC. Importantly, the developers of TF-CBT indicate that children do not need to meet full diagnostic criteria for PTS disorder in order to benefit from this intervention (Cohen et al., 2017).

There are several factors related to his mother's CMC that may have impacted EJ's psychosocial functioning. First, the CMC had been present for the majority of EJ's life, and there was an ongoing threat that she could have a medical emergency that would leave her unconscious. Second, EJ was continually reminded of these traumatic events due to the medical equipment that his mother required at all times to manage her illness. Third, there was a great deal of uncertainty regarding the nature of her CMC and whether or not it would be terminal, and EJ endorsed frequent worry about this. In fact, it has been suggested that fear of death and reminders of traumatic events related to parental CMCs may be a source of chronic stress that impacts youths' PTS symptoms (Huizinga et al., 2010; Kieffer-Kristensen et al., 2011).

As previously noted, EJ showed significant reductions in PTS and internalizing symptoms over the course of TF-CBT. According to both self- and parent reports, EJ no longer exhibited clinically significant distress, impairment, or symptoms of anxiety and depression at the end of treatment. No alterations to the TF-CBT model of treatment were required. Certain core components were tailored, however, to EJ's presenting needs. For example, psychoeducation focused on parental CMCs; safety planning primarily involved his mother's medical emergencies; and trauma narration focused on addressing EJ's most frightening memory related to her CMC, guilt about his contribution to her CMC, and beliefs about how her CMC had and would continue to affect his life. We believe there are a number of important takeaways from this case, each of which are consistent with the TF-CBT model of treatment but may be unique to this population.

One key component of therapy with EJ involved increasing communication with his mother regarding her CMC. Previous research has shown that children often lack information about their parent's condition (Schrag et al., 2004), and this was certainly true for EJ. His confusion about her CMC exacerbated his worry and anxiety, so the therapist had EJ develop a list of questions he had about it. During a subsequent session (and after reviewing the list individually with his mother and discussing her responses), the therapist facilitated a conversation between the two of them, wherein EJ was given an opportunity to ask his questions and obtain additional information about her CMC. This may have contributed to the positive clinical outcomes, as better child–parent communication has been associated with lower PTS and anxiety symptoms (Houck et al., 2007).

Safety planning was also needed early in treatment due to the fact that EJ's mother would periodically have medical complications that would leave her unconscious for long periods of time. The therapist worked with her to develop a clear series of steps EJ should take when these emergencies occurred; these included calling 911, calling an identified family member to come to the house when his mother was transported to the hospital, watching for the ambulance, letting the emergency responders into the house, and waiting with his younger sibling until the family member arrived. This safety plan was reviewed in detail with EJ and posted in a prominent location in their home, and he utilized the plan on multiple occasions following this session.

Moreover, preparation for the conjoint meeting in which EJ shared his trauma narrative with his mother resulted in his highest SUDS rating during TF-CBT, which is not uncommon when treating youth exposed to trauma. EJ reported hesitation about sharing it out of a desire to protect her. It is important to note that responsibilities of caregiving tend to be redistributed in families affected by parental CMCs, and children often feel overwhelmed by the need to care for a

chronically ill parent (Schrag et al., 2004). Indeed, EJ took a major role in helping with chores and tasks at home, as well as assisting his mother with her medical equipment. Addressing this "parentification" by increasing EJ's comfort in talking directly with his mother about his thoughts and feelings related to her CMC was a major goal of the conjoint meeting. His mother did experience elevated emotional distress when the narrative was reviewed individually with her, but the therapist introduced relaxation skills and engaged in cognitive processing to improve her ability to tolerate hearing EJ's perspective about her CMC. Further, she expressed the need to be strong for her son. Then, during the conjoint child–parent meeting, she was able to listen reflectively, make supportive statements, provide labeled praise, and assuage his fear of losing her due to her illness.

Although his mother's CMC was the primary focus of treatment (and the original reason for referral), addressing EJ's experiences of bullying victimization at school was another critical aspect of his therapeutic progress. Bullying is a prevalent issue among school-age youth that may have a long-lasting impact on psychosocial functioning (see McDougall & Vaillancourt, 2015). Relevant to this case, internalizing problems have been identified as both a risk factor for and a consequence of bullying victimization (Reijntjes et al., 2010). Thus, it is likely that EJ's symptoms of depression and anxiety contributed to and were impacted by his experiences of bullying. EJ and his mother reported a history of bullying victimization during the initial intake, but it was several months into treatment before this became a major issue again. EJ responded to his aggressors by fighting back, but consistent with previous research (e.g., Cooley et al., 2018), this only escalated the problem. The need to directly address EJ's bullying victimization became apparent when it led to disruptions in his social and academic functioning. He was suspended on several occasions for fighting back, and the physical nature of the bullying incidents became a safety concern. Accordingly, the therapist introduced an approach to problem solving and worked with EJ to identify alternative strategies for responding to aggressive peers; these included telling the peer to stop, not responding to the provocation, removing himself from the situation, telling an adult at school, and telling his mother. The therapist also advocated for EJ by addressing his experiences of bullying during an IEP meeting at school. Ultimately, the pattern of bullying had become so stable that it required major action from the school administrators, which helped to disrupt the established dynamic between EJ and the aggressors. Both EJ and his mother reported that bullying victimization was no longer an issue at the end of treatment.

Several other factors likely contributed to EJ's treatment success. First, clinical services were provided in EJ's home for the majority of treatment. Evidence suggests that community-based interventions, particularly those in children's natural environments, may increase generalizability and duration of treatment gains (e.g., Henggeler et al., 1995). For example, by engaging in TF-CBT in the home, the therapist was able to help the patient engage in ecologically valid imaginal exposures and establish a connection between introduced skills and location (i.e., EJ was able to practice focused breathing and progressive muscle relaxation in his natural environment). These factors might have been especially salient for a child whose index trauma was his mother's CMC and her medical emergencies that often occurred in their home.

Second, when EJ transitioned to the pediatric primary care clinic, the program was able to provide transportation for his family to attend sessions. Transportation is typically rated as a significant barrier to health care for underserved, low-income populations (Flores et al., 1998). Thus, for EJ, whose mother may not have been able to consistently bring him to visits (e.g., due to feeling too ill to drive, affordability of gas and parking, and/or distance between home and clinic), this service undoubtably helped to facilitate consistent engagement in therapy. If transportation was unavailable, perhaps EJ could have benefited from participating in TF-CBT through telehealth, which has been shown to yield comparable treatment effects to in-person therapy (e.g., Stewart et al., 2017).

Third, in the process of providing therapy services to EJ, significant attention was given to addressing his family's basic needs and his mother's ability to manage her own stress. The therapist helped to address their unstable housing situation by exploring avenues for finding temporary accommodations and a new home, as well as by providing information on multiple occasions about local resources. Prior work has shown that therapy services that address basic needs help to increase access, retention, and adherence to mental health treatment (e.g., Berkowitz et al., 2016). Focused breathing and mindfulness were also introduced as relaxation skills for EJ's mother and were practiced throughout treatment in order to help her cope with their multiple ongoing family stressors.

One consistent barrier to therapy in this case involved repeated appointment cancellations. On virtually every occasion, this was due to the mother's medical emergencies and doctor's appointments, which were unavoidable. However, the family had to reschedule several sessions due to conflicts with one of EJ's

extracurricular activities. Considering his ongoing experiences of bullying, the therapist was supportive of these decisions, as EJ was in need of positive social interactions and connections with his peers. Research has also shown that children of parents with CMCs are often restricted in their daily activities and isolated from peer groups (Earley & Cushway, 2002). Thus, the therapist determined that involvement in extracurricular activities provided a necessary outlet for EJ.

There are several limitations to the current case report that may be important to consider when interpreting its findings. Despite the fact that a semi-structured interview was used to assess PTS symptoms (i.e., UCLA-RI-5), additional mental health diagnoses were not assessed using a structured diagnostic interview. Further, although a formal fidelity rating procedure was not utilized, other strategies were implemented to support treatment adherence. These included weekly supervision with doctoral-level, licensed clinical psychologists who were certified as TF-CBT trainers, periodic review of audio-recorded treatment sessions, and weekly review of session documentation. Studies indicate that supervision is an important resource to support quality implementation of evidence-based practices (e.g., Dorsey et al., 2017). Finally, there were a number of potential confounding variables that may have impacted treatment progress and outcomes. These included changes in family dynamics when EJ's stepfather moved back in, the family's unstable housing situation, and EJ's ongoing experiences of bullying at school. It is our belief, however, that the complexity the presenting problems and family circumstances adds to the ecological validty of the paper.

Moreover, the current case maintained a high degree of adherence to the TF-CBT model. Each core component was implemented over the course of treatment, with the exception of in vivo mastery. This component is only needed if a child is experiencing trauma-related avoidance in their "real-world" environment (Cohen et al., 2017). Since EJ was not engaging in behavioral avoidance related to trauma cues, this component was omitted. As noted above, one deviation involved the temporary prioritization of a stressor (i.e., bullying victimization) other than the presenting trauma in order to address EJ's more proximal needs. Another aspect of treatment that was not ideal involved the continual disruption of the trauma narration and processing component due to appointment cancellations and reschedulings. Unfortunately, this was largely due to medical emergencies stemming from his mother's CMC, making these unavoidable. Of note, this disruption did not appear to adversely impact the overall treatment outcomes.

Conclusions

Although additional research is needed to examine the effectiveness of trauma-focused interventions for children of parents with CMCs, the current case report suggests that TF-CBT is a promising treatment approach for this population. Through our work with this family, we have learned that early safety planning for medical emergences may be necessary, conjoint child–parent meetings focused on increasing communication about the CMC (e.g., prognosis, symptoms to expect) are needed, addressing parentification is an important goal of the trauma narration process, and flexibility in scheduling and alternative approaches to reduce barriers to care (e.g., home-based services, provision of transportation) are required.

Further, it may be beneficial for clinicians working with families impacted by parental CMCs to consider the importance of addressing traumatic grief. Depending on the prognosis, there may be a need in some cases to help children prepare for the potential loss of their parent. Importantly, TF-CBT also comprises four grief-focused components (Cohen et al., 2017), the first of which involves psychoeducation and may be particulary useful in this regard. It is also possible that the child could be experiencing grief—aside from the possibility of early mortality—related to the loss of functions that his or her parent can engage in. That is, the parent may be less able to engage in previously normative activities, such as playing games, going to the park, or attending extracurricular events. As their CMC progresses, there may also be higher rates of doctor visits, hospitalizations, and increased limitations. All of these may represent losses to the child and exacerbate feelings of grief. In cases where the parent does ultimately pass away, the child may also benefit from the remaining three TF-CBT components that are focused on grieving the loss and resolving ambivalent feelings, preserving positive memories, and redefining the relationship and commiting to present relationships. In summary, there are needs for increased attention to the potentially traumatic nature of parental CMCs and additional investigations of TF-CBT for this population.

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