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## Trauma-Focused Cognitive Behavioral Therapy for Children Witnessing Domestic Violence: A Systematic Review

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Trauma-Focused Cognitive Behavioral Therapy for Children Witnessing  
Domestic Violence: A Systematic Review

by

Xia Thao, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members  
Kari Fletcher, Ph.D., LICSW(Chair)  
Chelle York, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

## Abstract

Trauma-Focused Cognitive Behavioral Therapy is an evidence based treatment. The primary use was with children and youth who has been or continues to be exposed to trauma. The objective of this systematic review was to focus on the effectiveness of Trauma-Focused Cognitive Behavioral Therapy to reduce post-traumatic symptoms of children. The study is inclusive of children ages three to 18 years old, who witnessed domestic violence. Ten empirical intervention studies were selected for inclusion in findings. The articles were obtained and analyzed from six databases. Evidence based practice was used as the conceptual framework. The purpose of the framework is to examine the aspects that makes Trauma-Focused Cognitive Behavioral Therapy an effective treatment for children who were exposed to domestic violence. Findings for this study supported that Trauma-Focused Cognitive Behavioral Therapy decreased the externalizing, internalizing, and post-traumatic symptoms. This study describes in depth in the discussion on limitations and recommendations for future research as the findings implied.

## Acknowledgments

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And a special thanks to my parents whom have motivated me through their stories. I know that life was a struggle and unfortunate events may have taken place. However, after a storm there is a rainbow. I have turned those events into a learning experience and even found a passion in youth who witnessed domestic violence.

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# Trauma-Focused Cognitive Behavioral Therapy for Children Witnessing Domestic Violence: A Systematic Review

## **Introduction**

Statistics from findings up to now estimated that about 15.5 million children live in domestically violent homes (Gustaffson, Coffman, & Cox, 2015, p. 266). In the United States, children who witnessed domestic violence are said to lack visibility as a population due to challenges associated with the fact of being underreported, underfunded, and underserved (Carter, Weithorn, & Behrman, 1999). Evidence to prove the extent of concerns for children witnessing domestic violence is slightly under estimated. The lack of evidence directly effects the accessibility of appropriate treatments and services (Carter et al., 1999). This deficiency implied that a larger problem was that children roughly ages three to 18 years old, continue to suffer the cost of witnessing domestic violence (Carter et al., 1999; Onyskiw, 2003).

Today, children ages five years or younger are more likely than children of any age to live in homes where domestic violence is present (Carter et al., 1999; Gustafsson, et al., 2015). According to research by Hutchinson and Hirschel (2001) during a violent domestic assault, children were present in 75% of the cases (as cited in Holden, 2003). Exposure is defined as more abstract than simply “seeing” or “hearing”. It is explained as “more complex than simply the dichotomy of whether the child observed or overheard the violence or not,” (Holden, 2003, p.

152). Exposure is a synonym of witnessing, but considered abstract experiences of witnessing the violence.

Children exposed to domestic violence are at a higher risk when compared to children who were not exposed to domestic violence. Main concerns and risks surround safety issues; which includes physical and emotional abuse, as well as derailed developmental processes, and later post-traumatic stress (PTS) symptoms (Cooley & Frazer, 2006; Gustafsson, et al., 2015; Onyskiw, 2003; Holden, 2003; Mabanglo, 2002).

In addition to PTS symptoms, children exposed to domestic violence often exhibit more adverse externalizing and internalizing behaviors (Onyskiw, 2003; Carter et al., 1999). Externalizing behaviors are physical aggressions that take place externally from the person's actions, whereas internal behaviors are thoughts and feelings inside the person (e.g. sad; angry). Instead of being assessed for possible traumatic exposure, these children would be considered inattentive, antisocial, and troublesome at school (Onyskiw, 2003).

Regardless the type of experience one has had, Prior (2012) recommended that due to the absence of a caretaker, children are not taught how to effectively communicate, build relationships, and learn desirable or undesirable behaviors. The parent-child relationship is parallel to the caregiver's violent and unsafe relationship (Gustafsson, et al., 2015). If the mother is restless, feels threatened, and/or does not have sense of self-control, she will be tuned out to the children (Gustafsson, et al., 2015). The caregiver's own traumatic experiences will negatively impact children.

Recent studies suggested that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an effective intervention for children who have witnessed domestic violence. Furthermore, research has shown that TF-CBT can effectively reduce symptoms of distress, adverse behaviors,

and PTS symptoms. The unique aspects that made this treatment effective is the emphasis on utilizing coping strategies, building safety skills, and rebuilding or establishing a trusting relationship with a non-offending caregiver (Cohen et al., 2012).

While studies have suggested that TF-CBT reduces distress and PTS symptoms, there are studies that have found the opposite to be true. This research intends to explore the use of TF-CBT with children exposed to domestic violence. In this systematic review, I will examine how TF-CBT is considered an appropriate and effective intervention based on the empirically-based practice (EBP) conceptual framework. In the process of analyzing the empirical intervention studies, I will search for themes that are consistent with TF-CBT as a treatment for children exposed to domestic violence.

## **Literature Review**

The current research available on Trauma-Focused Cognitive Behavioral Therapy is its effectiveness with children exposed to domestic violence, the participation of caregivers, and comparison to other treatments, to name only a few topics. Therefore, a literature review of the current subjects pertaining to children witnessing domestic violence and TF-CBT is essential to this study. The first part of the literature review will include children exposed to trauma. Then it will review some of the current treatments thus far for children who have witnessed domestic violence. It will also include the history and strategies of TF-CBT. Lastly the review will explain in-depth the effects of exposure to trauma and how evidence-based practice, such as TF-CBT, is a proper intervention.

### **Children Exposed to Trauma**

Domestic violence, more commonly known as interpartner violence (IPV), is considered a trauma-inducing event (Cohen et al., 2008; Cooley & Frazer, 2006; Gustaffsson et al., 2015; Nguyen et al., 2012; Prior, 1996). Inter-partner violence, is a general term that covers all mediums of violence such as stalking, penetration, and the physical, emotional, and sexual interactions two individuals who have a current or former intimate partnership (National Center for Injury Prevention and Control, 2015).

During trauma, children are vulnerable both mentally and physically. The cognition most impacted is executive functioning. Executive functioning according to Garon, Bryson, and Smith (2008), is defined as “adaptive, goal-directed behaviors that enable individuals to override more automatic or established thoughts and responses... regulating perceptions, thought, and behavior,” (p. 31). In Gustafsson et al.’s (2015) research on children’s executive functioning and

interpartner violence, they concluded that violence had a negative relationship with executive functioning.

Another study by Prior (1996) suggested that executive functioning is greatly altered when caretakers or primaries neglected emotional needs of children. Prior (1996) obtained a sample that consisted of six-year olds. It was suggested that children less than five years old lacked the ability to process trauma. Their reactions or affect response was described as adverse behaviors, tantrums, crying, and screaming. In other words the features displayed were best explained as post-traumatic stress disorder (PTSD). According to the DSM-5 (2014), the following are PTSD symptoms: scared, little to no affect regulation, startled easily, behavior abnormality (p. 145). The symptoms that are parallel to children witnessing domestic violence and PTSD symptoms are mainly related to affect regulation.

Holden (2003) had found a way to categorize the various emotional and physical adverse reactions from trauma specifically from witnessing domestic violence. The taxonomy of children's exposure to domestic violence, developed by Holden (2003), states that the first type of exposure for children is having been 'exposed prenatally'. Prenatal exposure is where a developing fetus, during pregnancy, suffered the effect of violent behaviors such as pushing of the victim. It is more common for the mother to be the victim of domestic violence. The last stage of exposure, involves participation, in which "the child is forced or 'voluntarily' joins in the assault," (Holden, 2003, p. 152).

The mother can make attempts to hide or protect the children from witnessing the abuse, but unfortunately they are never totally separate from the violence. Children will experience or witness the domestic violence in some way as suggested by Holden (2003). Even during the

aftermath, “the child faces changes in his or her life as a consequence of the assault,” (Holden, 2003, p. 152).

Overall, Holden (2003) points out that exposure can happen intermittently. Thus, to specify and determine the effects of violence on the child the following information should be identified: what type of domestic violence they were exposed to, how long they were exposed, age, and in what way they were exposed. For example, a younger child in preschool may perceive the same information differently than an adolescent. Adolescents can make abstract interpretations of the event, whereas a younger child may lack those skills.

Despite that their processing capabilities differ, there is a higher chance that children are still at risk regardless of age. The risks include psychological impact on the brain, suspect to future abuse, and neglect from both parents (Holden, 2003). Depending on how they cope, how long, and what type of exposure they have had, children may have no reaction at all. Stanley, Miller and Foster (2012) mentioned that “the amount of violence a child is exposed to is significantly associated with his or her level of adjustment.”

Mothers, who in most cases are the non-offending parent, will be naturally preoccupied with their domestic assault (Carter et al., 1999, p. 3). The assault, the concern for safety, and the depression involved monopolize the parent victim’s attention. Consequently, the parent is less available to provide care and guidance for children. The lack of care makes it difficult for children to process the violence they witness. Without the proper support of caregivers, children lose the appropriate way to process emotionally, physically, and mentally. Children commonly reacts by being distressed, tuning out, or developing a habit of substance abuse (Cohen et al., 2012).

Furthermore, a significant amount of evidence suggests that the lack of parental care and involvement in a child's academic endeavors can put him/her at risk for poorly developed academic skills (Carter et al., 1999; Gustafsson, et al., 2015; Onyskiw, 2003). "Chronic security concerns, in turn, can interfere with their ability to acquire age-appropriate skills in a variety of domains," (Gustafsson, et al., 2015, p.267). Children start to express post-traumatic symptoms (PTS) early on (Nguyen, Edleson, & Kimball, 2012). It is recommended by the American Academy of Child and Adolescent Psychiatry (2011) that children receive treatment earlier rather than later.

### **Interventions for Children**

Historically, intervention strategies for children exposed to domestic violence included crisis-oriented support such as an emergency shelter, short-term mental health services, and child protection services. The type of services range from federal to local levels. A discussion of all the various interventions available would expand beyond this research. It is still unclear which modality is the most appropriate and effective. All interventions are beneficial for any victims of domestic abuse, but most importantly to children. They are all effective to target children who have witnessed domestic violence.

A very common type of resource for children and their families suffering from domestic violence are shelters. Shelters for such families are located across the United States and are the most highly sought out support, given their accessibility and the services provided. The primary support available to victims and their children is advocacy and safety support (Carter et al., 1999). In fact, half of the population in shelters for domestic violence survivors and their families consists of children (Carter et al., 1999). Majority of the time, victims and their children only stay in shelters temporarily.

The least favorite but most common intervention throughout history with children exposed to domestic violence is law enforcement and Child Protective Services (CPS) (Carter et al., 1999). The strategy of intervention is based on public laws that grants state the right to intervene and ensure that the child is not endangered (Hester, 2011). Spratt (2001) suggests that “a child protection orientation is characterized by a primary concern to protect children from abuse, usually from parents who are often considered morally flawed and legally culpable”, (p. 934). The primary intent of these two intervention is to ensure the safety of children. A service provided by CPS is a family assessment which ultimately defines needs and strengths of the family (Department of Human Services, 2015).

Despite the intervention strategies targeted at children endangered and suffering from harm, CPS and law enforcement are the least preferred when seeking help. Caregivers and victims have a flawed perception of protection workers. Victims of domestic abuse fear law enforcement due to threats from the offending partner (Antle, Barbee, Yankeelov, & Bledsoe, 2010; Humphreys & Absler, 2011). Therefore, to lessen their fear of these threats, victims try to get involved with authorities as little as possible. Another flawed perception is that CPS workers remove children from homes with domestic violence present (Humphreys & Absler, 2011). Consequently, CPS is the least preferred resource.

Psychosocial treatments are empirically-based practices that have proven by research its effectiveness (Carter et al., 1999). Whereas the former interventions’ (e.g. shelters and CPS) effectiveness were supported by very limited data. The limited knowledge exists because children do not reside long enough in shelters to collect data. However, for psychosocial treatments, it was slightly more convenient to obtain data. The treatments are usually conducted, at clinics, where children are referred or voluntarily participated due to identified exposure to

trauma. Once children who have witnessed domestic violence seek treatment, they either continue to participate or decide to drop out early. Despite the fact that this intervention is guaranteed to have the most impact it is underutilized. Researchers Stein et al. (2003) mentioned that no “randomly controlled trials have been conducted to date [2003] of interventions,” (p. 604). The exact reason why is still unclear.

### **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

Trauma-focused cognitive behavioral therapy is one of the most recently found evidence-based treatments and has existed for approximately 24 years. The founders are Dr. Esther Deblinger, Judith Cohen M.D., and Dr. Anthony Mannarino. Initially, TF-CBT was only practiced with children who identified that their traumatic exposure related to sexual abuse. It was then expanded to children who suffered traumatic events or those going through continuous trauma (Murray, Cohen, & Mannarino, 2013). It was approximately 12 or more years ago when cognitive behavioral therapy, TF-CBT, began its course with children exposed to trauma such as domestic violence. TF-CBT is most effective specifically for children ages 3-18 years old.

These children can vary in demographics and they can also have more than one trauma identified (Cohen et al., 2010; Feldman, n.d.; Mannarino, 2012). TF-CBT emphasizes psychoeducation as a vital piece of treatment (Murray, Cohen, & Mannarino, 2013; Holt, Jensen, & Larsen, 2014; Cohen & Mannarino, 2008). However, after close clinical observation of this therapy it was highly not recommended to youth and children “whose primary problems are not trauma-related” (Cohen & Mannarino, 2008, p. 159). Therefore, all therapists and specialists should assess the children further for qualifications before delivering treatment.

The targeted population of this intervention is children, although it is essential to have a non-offending parent or caregiver’s consent to participate with the child (Cohen, Mannarino, &

Deblinger, 2012). Children and their caregivers participated in this therapy. Initially, parents and children would have separate sessions with the therapist (Cohen & Mannarino, 2008). As mentioned by Cohen and colleagues (2006), parent sessions are heavily focused on enhancing parenting skills (as cited in Holt, Jensen, & Wentzel-Larsen, 2014). During joint sessions, they would get the chance to work with their children and implement these skills.

Caregivers attended a separate session in which they learned positive parenting and response skills (Cohen et al., 2012). Both parties were separated for the first two stages. During later sessions, caregivers and children participate in the same session with the therapist. The caregivers will get to practice the behavior management skills that they learned if undesired behaviors arise. Thus, it was vital that both the child and caregiver were present for all sessions.

TF-CBT's successfulness also depended on the therapist. The therapist's role in this intervention was ingrained in values such as listening, teaching relaxation skills, and acknowledgement (Cohen & Mannarino, 2008). The skills that therapists have are highly sought out by children witnessing domestic violence. It was also suggested by Stanley, Miller, and Foster (2012) that child witnesses of domestic abuse most expected professionals who listened, acknowledged their accounts of events, and did not make them feel helpless or ineffective. Professionals who enact powerlessness only further contribute to victims' feelings of hopelessness (Stanley et al., 2012). Therefore, therapists play a critical role in guiding children, survivors and their families from the impact of domestic violence.

TF-CBT is carried out in the following stages and is also known by the acronym PRACTICE as suggested by Cohen, Berliner, and Mannarino (2010, p. 216):

1. Psychoeducation
2. Parenting
3. Relaxation skills
4. Affect regulation

5. Coping skills
6. Trauma narrative and processing
7. In vivo mastery
8. Conjoint sessions
9. Enhance future safety

The first five components make up the first stage: coping skills (Cohen et al., 2012). First, children build a relationship with the therapist. This is essential to the child's establishing trust in the therapist, especially given that relationships with adults in their lives have been or may be broken during exposure to trauma. Then the child will learn coping and relaxation skills. Meanwhile, their caregivers are in a separate session learning parenting skills.

In the next phase, children will have to tell a narrative of the trauma. This causes gradual re-exposure to the trauma, which in turn is used to help the child apply the learned skills. When therapists identify inaccurate ways of thinking about trauma, children will be encouraged to use strategies of coping learned from the first stage. During this stage, children will work on their in vivo mastery. In vivo mastery is defined as gradual exposure to the innocuous relationships to the trauma (Cohen et al., 2010). Children may identify a certain activity (e.g. sleep) as anxiety inducing because it brought back bad memories of the trauma. If so, with the application of their learned skills, they will be encouraged to separate the link between the traumas and the activity. Meanwhile, parents will be taught how to support children in their environment.

The last phase of the PRACTICE model, consolidate and closure, unites both parties (Cohen et al., 2012). It is where the caregiver and child implements the skills they have learned. The work thus far between the therapist and child is transferred from the therapist to the caregiver. The therapist transferred positive support strategies, a trusting relationship, and relaxation skills to the caregiver. The ultimate goal after this stage was to reduce the child's PTS symptoms as well as internal and external behaviors. The caregivers will learn to be advocates

for children as they recover from the trauma. Lastly, the therapist will work closely to ensure that they are prepared to continue these skills in the child's environment.

Currently, there are three unique settings where TF-CBT takes place: schools, foster care, and residential programs. These settings are the most popular due to the high participation rates of children. The settings may impact the successfulness of treatment. However, studies have not suggested yet which setting impacted the effectiveness of treatment. Despite the limited knowledge of the setting's impact, the important thing is that if the participating adult is not a biological parent, then it can be a current caregiver. This does not affect the outcome of treatments as long as the caregiver is also present during therapy.

### **The Importance of Research Informing Clinical Practice**

Clinical practice was reliable in research. Research defined what social injustices were present and what needs still needed to be addressed. According to the National Association of Social Workers, one of the values of social workers was to be competent. Social workers "continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledgebase of the profession," (National Association of Social Workers, 2015). A common way to contribute to the pool of knowledge and awareness is research. It also guides intervention strategies within the population of interest.

## **Conceptual Framework**

A conceptual framework help organize the thoughts and descriptions of an empirical study. In other words, it is a way to explain what was being done and what it meant. The conceptual framework included in this study is evidence-based practice (EBP). EBP is often recommended for treatment since extensive research has found its effectiveness. This theory can be applied to support the research on the intervention of TF-CBT with children who currently witness or have witnessed domestic violence. The end of the conceptual framework will conclude with my personal and professional motivations in choosing this topic for the current research.

### **Evidence-Based Practice (EBP)**

EBP was developed around the early 1970s by Archibald Cochrane (Leach, 2006). Prior to EBP, the best treatment was chosen by the practitioner. The practitioner rationale relied on “tradition, intuition, authority, unsystematic clinical experience and pathophysiological rationale,” (Leach, 2006, p. 248). There was no concrete evidence to support these decisions. Therefore, EBP would help them make a more evidence-informed decision.

Medical professionals slowly adapted this model. Treatments slowly gained popularity and recommendations based on the increase of the evidence-based practices (EBP) model. EBP was defined as “the process by which decisions about clinical practice are supported from research using scientific models and theoretical paradigms,” (Hurley et al., 2011, p. 30). EBPs are guides that clinicians and practitioners should consider for the patient’s treatment (see *Figure. 1*). EBP is essentially “a formal, problem-solving framework” (Leach, 2006, p.248).

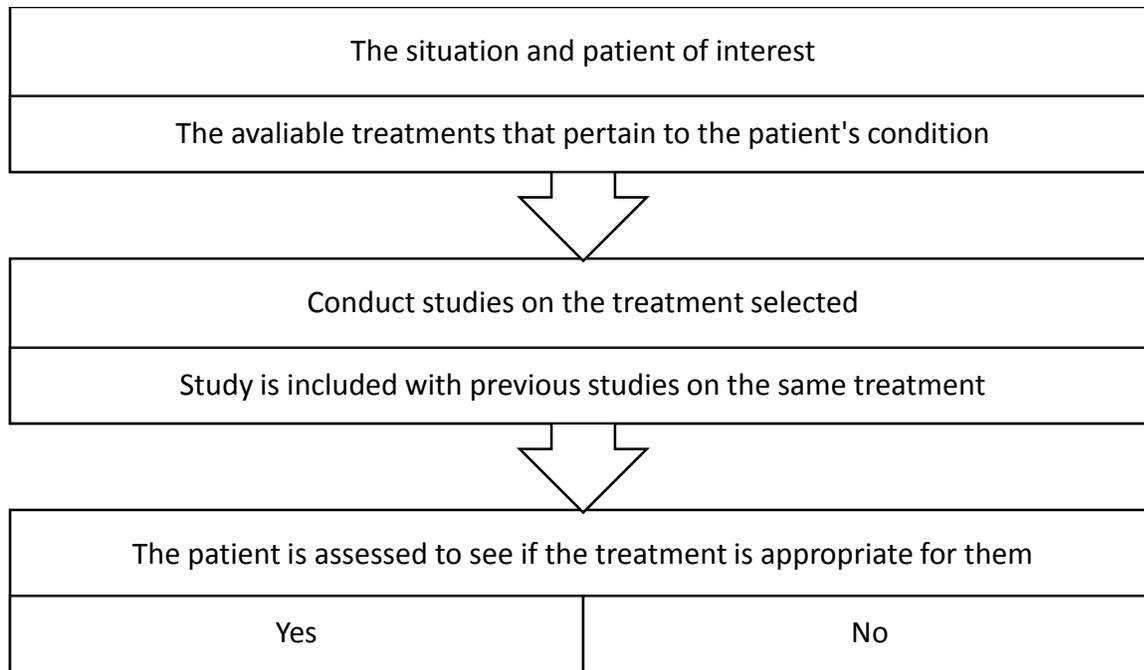


Figure 1. Evidence-based Practice (EBP) Framework

The first step of EBP is to clarify what the issue of interest is (e.g. diagnose, health issue) and then compile the most relevant treatments or interventions. From there, the clinician can analyze the solution with tests and research. Furthermore, one can make the final conclusions about the treatments. It will be processed with the all the compiled data from studies surrounding the same treatment (Leach, 2006).

Over the developmental course of EBP, professionals have been on both ends of the spectrum. Those that implement the model recognized that the advantages were in theirs' and their patient's favor. The greatest advantage for practitioners was that this framework is both time and cost efficient (Leach, 2006). Likewise, patients have the advantage of knowing the research contributing to the EBP has undergone clinical scrutiny and has been implemented in more than just randomly controlled trials (RCT).

Despite these advantages, criticism to the EBP model exists. Some disapprove of EBP because it “oversimplifies or inadequately addresses complex patient situations,” (Leach, 2006, p. 250). The paradigm may not address the unique needs or care of each person. Another argument is that it will trump clinician’s judgements with scientific evidence (Hurley Denegar, Hertel, 2011, p. 32). EBP should be used alongside of these judgements, instead of being the sole determination of patients’ treatments.

EBP essentially creates a framework for medical professionals to establish the best treatment or care. It requires close evaluation of interventions prior to applying it. The substantial studies of EBP suggests that they were treatments based on individuals not clinical judgements. Consequently, this meant that clinicians would be patient centered if they applied this theory. And most importantly it will also assist medical professionals when trying to obtain the best and effective treatment.

### **Personal Motivation**

I have the passion to do this research due to personal reasons. As a child I was chronically exposed to domestic violence. I had no support throughout the whole time. Till this day, I still do not fully understand how my lived experience of domestic violence has impacted my life. Additionally, neither am I still aware of the full scope of interventions available for children in these situations. My research aims to bring awareness and understanding to the support of TF-CBT as a suggested intervention for this population. It is neither the preferred solution nor the worst, but the effectiveness has been suggested by various empirical studies. Therefore, through this research I want to bring hope that children experiencing domestic violence can be saved from further trauma.

## **Professional Motivation**

My professional motivation intends to shine a light on empirical intervention studies that address domestic violence among children. Social workers come into contact with children more often than not. As social workers, it is one of our ethical principles to “pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people,” (NASW Code of Ethics, 2015). Rarely do we hear of how kids are surrendered to foster care or adoption facilities due to exposure to domestic violence. Therefore, by understanding more about how violence has impacted these children and the support of TF-CBT, social workers can better serve this population.

As a social worker, I want to address gaps within this population. I know that about three to 15 million children were exposed to domestic violence every year (Carter et al., 1999; Onyskiw 2003). This number more than convinces me that we cannot turn a blind eye to this issue anymore. We as clinical social workers need to enforce our social justice ethics and be part of the solution. There are many issues out there, but if domestic violence can be prevented, it would feel like we can solve almost any problem within the child population. Knowing that exposure to domestic violence can cause psychological, behavioral, and cognitive issues, is it not worth a tackle? And knowing that most of that population consists of children ages five or younger, is that not enough to convince us to pay attention to this issue? Social workers are a hope for these children, we just need to know where to fit in the puzzle.

## **Methods**

The purpose of this study is to investigate the use of TF-CBT with child witnesses of domestic violence. The age range includes children and youth ages 3-18. Through analysis, the study uncovers common themes in the intervention as well as the significant findings that makes it an empirically-based practice.

### **Systematic Reviews**

Systematic reviews were conducted based on close analysis of empirical studies. Due to the substantial empirical studies and research on the impact of TF-CBT for this population a systematic review will be conducted to explore these issues. According to Petticrew and Roberts (2008):

“Systematic literature reviews are a method of making sense of large bodies of information, and a means of contributing to the answers to questions about what works and what does not -- and many other types of question too. They are a method of mapping out areas of uncertainty, and identifying where little or no relevant research has been done, but where new studies are needed,” (, 2008, p.2).

A systematic review of Trauma- Focused Cognitive Behavioral Therapy is an appropriate approach to understanding its efficacy. A systematic review is appropriate, given that the substantial yet lacking body of research on TF-CBT and its impact on children exposed to domestic violence is still developing.

### **Search Strategies**

Articles for this research were extracted from computer searches conducted on six online databases: ERIC, JURN, PsychINFO, Pubget, Child development & Adolescent Studies, and SocINDEX. The boundaries of these empirical studies are within the interest of Trauma-Focused

Cognitive Behavioral Therapy on children exposed to domestic violence. Articles that will be selected for this research have the following terms: trauma, children or youth, CBT, domestic violence, family violence, violence, and inter-partner violence.

The key terms “domestic violence” or “family violence” will be paired with CBT or “cognitive behavioral therapy” and “trauma”. The pairing of key terms for each search was in this order for all databases: su (“domestic violence” or “family violence”) AND (cbt OR “cognitive behavioral therapy”) and trauma. Studies that sampled children between three to 18 years old as the focus of the intervention will be included. Only studies assessing some attributes of TF-CBT on children who have been exposed to domestic violence will be included.

### **Selection Criteria**

The search strategies produced a total of 1,610 articles that were established from all six databases during the initial round of selection. JURN yielded 87 results, PsycINFO generated 60 articles. Pubget generated 800 articles, ERIC only established 16 articles, and SocINDEX yielded 647 articles. Studies of English or non-English international studies will be accepted for the systematic review.

The secondary round of selection was administered. A total of 1,610 articles were selected during the first stage, and after applying the second round of selection, only 30 articles remained. The abstracts were read and excluded if the studies were conducted from samples of ages 18 and older, domestic violence was not the trauma experienced, did not implement TF-CBT as treatment, and not available in full-text.

During the last stage of selection, a total of 10 articles remained. The 10 articles were examined again and found to be relevant to the goal of this research. Table 1 below illustrates a complete list of empirical studies included.

Table 1.

*Empirical Studies: Trauma Focused CBT for Children Witnessing Domestic Violence*

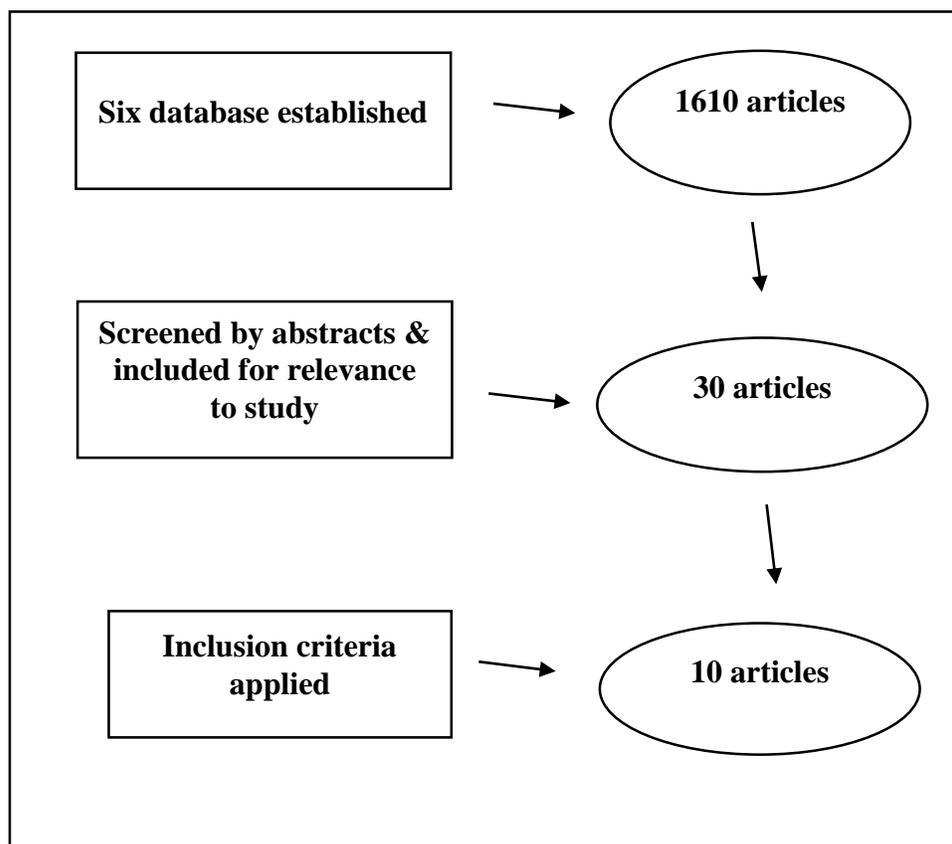
	Author	Year	Title
1	Holt, Jensen, Larsen	2014	The Change And The Mediating Role Of Parental Emotional Reactions & Depression In The Treatment Of Traumatized Youth: Results From Randomized Controlled Study
2	Webb, Hayes, Grasso, Laurenceau, Deblinger	2014	Trauma-Focused Cognitive Behavioral Therapy For Youth: Effectiveness In A Community Setting
3	Cohen, Mannarino, Kliethermes, Murray	2012	Trauma-Focused CBT For Youth With Complex Trauma
4	Westerman, Cobham, McDermott	2016	Trauma-Focused Cognitive Behavior Therapy: Narratives Of Children And Adolescents
5	Smith, Yule, Perrin, Tranah, Dalgleish, Clark	2007	Cognitive-Behavioral Therapy For PTSD In Children & Adolescents: A Preliminary Randomized Controlled Trial
6	Thornback & Muller	2015	Relationships Among Emotion Regulation And Symptoms During Trauma-Focused Cbt For School—Aged Children
7	Dorsey, Pullman, Berliner, Koschmann, McKay, Deblinger	2014	Engaging Foster Parents In Treatment: A Randomized Trial Of Supplementing Trauma-Focused Cognitive Behavioral Therapy With Evidence-Based Engagement Strategies
8	Ready, Hayes, Yasinski, Webb, Gallop, Deblinger, & Laurenceau	2015	Overgeneralized Beliefs, Accommodation, And Treatment Outcome In Youth Receiving Trauma-Focused Cognitive Behavioral Therapy For Childhood Trauma
9	Kameoka, Yagi, Arai, Nosaka, Saito, Miyake, Takada, Yamamoto, Asano, Tanaka, Asukai	2015	Feasibility Of Trauma-Focused Cognitive Behavioral Therapy For Traumatized Children In Japan: A Pilot Study
10	Holstead & Dalton	2013	Utilization Of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) For Children With Cognitive Disabilities

**Article Analysis and Data Extraction**

Empirical studies that were analyzed and included from the selection criteria were carefully evaluated for content. The intervention studies were each read twice and their “finding sections” analyzed three to four times. Article analysis and data extraction was conducted more

than once and is as illustrated in *Figure 2* below. The taxonomy of empirical studies included were not categorized in any specific format.

The headings of the chart directed the type of data to be extracted. The headings included in the chart were study, year, study question, evaluation aim, location, sample size, age, inclusion criteria, intervention, treatment, design, selection; measures, statistical analysis, fidelity, findings, limitations, and recommend.



*Figure 2.* Studies Inclusion & Selection Process

## **Findings**

The findings in this section were developed from the 10 empirical intervention studies that met the inclusion criteria. This section will start with an overview summary of all 10 empirical studies. Components that will be specifically outlined in the overview included (but were not limited to) age range, year, treatment, designs, and inclusion criteria. Lastly, the empirical articles will be assessed according to the relevant theory that makes it an effective treatment. The following overview and findings can be reviewed as illustrated in Table 2.

Table 2.

*Summary: Trauma Focused CBT Interventions for Children Witnessing Domestic Violence*

<b>Study</b>	Holt, Jensen, Larsen	Webb, Hayes, Grasso, Laurenceau, Deblinger
<b>Study question</b>	How did the parent’s emotional reaction and depressive symptoms change through therapy, and if the changes mediate children’s PTS symptoms and depressive symptoms	How effective is TF-CBT when implemented in a community setting?
<b>Evaluation aim</b>	Parents’ decrease of depressive symptoms during therapy and how it affects children’s post-traumatic stress symptoms & depressive symptoms	TF-CBT can be implemented effectively in community settings.
<b>Location</b>	Norway: 8 child and adolescent mental health clinics	United States
<b>Sample size</b>	135 caregivers, 135 children & youth	72 youths & 1 non-offending caregiver
<b>Age</b>	Children & youth: 10 – 18 y/o	7-16 y/o
<b>Inclusion criteria</b>	Experiencing at least 1 traumatizing event & suffering from PTS symptoms as screened by the clinics’ psychologist	Met DSM-IV PTSD, including at least 1 criteria from ea. of PTSD clusters, English speaking; 1 caregiver willing to participate
<b>Intervention</b>	Therapy as Usual (TAU), Trauma-focused CBT (TF CBT)	TF-CBT
<b>Treatment</b>	TF-CBT - 12-15 sessions, TAU – not specified	60-90 mins weekly sessions; 10 sessions
<b>Design</b>	Pre-test, mid-test & post-test	Pre-test, mid-test & post-test
<b>Selection</b>	Parent and children who provided written, active consent	Referrals from clinics and voluntary participation
<b>Measures</b>	PERQ, CES-D, CAP-CA, MFQ	K-SADS-PL; UPID-A; UPID; CBCL; 10-item adherence checklist developed by Dr. Deblinger for coding
<b>Statistical Analysis</b>	Mixed effect models, Multiple mediation models, Intra-class correlation (ICC)	Mplus software
<b>Fidelity</b>	TF-CBT Fidelity Checklist	Therapists had a professional degree and licensed or supervised by licensed practitioner; 4 coders trained by developer to use adherence checklist
<b>Findings</b>	TF-CBT reduce caregiver’s depression scores; caregiver’s reduction mediated child depressive symptoms but not PTS symptoms	Symptoms of PTSD decreased but externalizing symptoms increased
<b>Limitations</b>	Bigger time frame, more adolescents than young children, exclusion of participants who did not speak Norwegian	No control group, only generalizable to ages 6 and up, therapists volunteered to learn & use TF-CBT
<b>Recommend</b>	Parental and children reactions over time, mechanisms of change in treatments, differences of emotional reactions b/w fathers and mothers,	Identify predictors of early dropouts, treatment outcomes, find factors that enhance TF-CBT’s effect on externalizing symptoms

Table 2. (continued)

*Summary: Trauma Focused CBT Interventions for Children Witnessing Domestic Violence*

<b>Study</b>	Cohen, Mannarino, Kliethermes, Murray	Westerman, Cobham, McDermott
<b>Study question</b>	How does the strategies for applying TF-CBT for youth (proportion stages, implementing safety early on, titrating gradual exposure, unifying trauma themes, extending treatment) with complex trauma make it an effective treatment?	How does the progress of narratives relate to the decrease of distress from children and youth during TF-CBT?
<b>Evaluation aim</b>	The practical skills utilized to implement TF-CBT	Clarity and less distress of narratives and decrease in stressful or PTSD symptoms
<b>Location</b>	United States	Queensland, Australia
<b>Sample size</b>	30 youth	20 primary students, 6 highschool students
<b>Age</b>	3-18 y/o	6 – 17 y/o
<b>Inclusion criteria</b>	Complex trauma: exposure to more than one traumatic events; secondary adversities that occur related to trauma	Exposed to 1+ traumatic event
<b>Intervention</b>	TF-CBT	TF-CBT
<b>Treatment</b>	14-20, 50 minute sessions	Caregivers - 2 sessions, Children & youth – 8 sessions
<b>Design</b>	Pre- to post- treatment scored on UCLA PTSD & narrative from participants	Depth and clarity of narratives through progress of sessions
<b>Selection</b>	Referrals from residential treatment facilities (RTF)	3 stage screening process
<b>Measures</b>	Analysis of narrative and progress notes from therapist; UCLA PTSD Reaction Index; CANS	ADIS-IV-C/P
<b>Statistical analysis</b>	UCLA PTSD Reaction Index; Child and Adolescent Needs and Strengths (CANS)	Software Atlas.ti; simple coding system: coherence, elaboration, evaluation' Narrative Form Index and Matrix; Narrative Processes Coding System; JAKOB system
<b>Fidelity</b>	Licensed therapists in TF-CBT	Review after each session
<b>Findings</b>	“practical strategies greater improvement in emotional and behavioral problems & PTSD symptoms”	Narratives were told hesitantly at first and highly distressed; later they were more comfortable with the narratives by giving more information and a clearer sequence
<b>Limitations</b>	Limited sample	Isolating stories, no combination of coping skills for youth with more severe behaviors, not identifying resolution patterns
<b>Recommend</b>	“provide a longer coping skills phase & allow for adequate treatment closure phase to enhance ongoing trust & safety”	More details on participant variables, develop a baseline to verify the efficacy of the coding system, focus on lexical information

Table 2. (continued)

*Summary: Trauma Focused CBT Interventions for Children Witnessing Domestic Violence*

<b>Study</b>	Smith, Yule, Perrin, Tranah, Dalgleish, Clark	Thornback & Muller
<b>Study question</b>	How effective is TF-CBT in treating PTSD in children & young people?	How does emotion regulation (ER) improve throughout TF-CBT and how does that effect improvement in symptoms?
<b>Evaluation aim</b>	Decrease of PTSD symptoms	Improvement in emotion effects improvement in PTS symptoms
<b>Location</b>	London	Canada
<b>Sample size</b>	24 & 1 non-offending caregiver	108 children & 1 non-offending parent
<b>Age</b>	8 – 18 y/o	7-12 y/o
<b>Inclusion criteria</b>	age related, main presenting problem is PTSD relating to a traumatic event, & fluent in English	Referrals from 2 outpatient clinics; no substance use or psychotic disorder, not suicidal, no developmental disorder, & no previous trauma-related treatment
<b>Intervention</b>	TF-CBT; Randomized controlled trial (RCT); Wait listed (WL)	TF-CBT
<b>Treatment</b>	10 weekly individual sessions	17.05 sessions
<b>Design</b>	Experimental pre & 6 mos. post test	Pre-assessment, pre-treatment; post-treatment, & 6 mos. follow-up
<b>Selection</b>	Recruit from National Health Service trauma clinic in London	Referrals from 2 outpatient clinics
<b>Measures</b>	ADIS-C/P, CAPS-CA, CPSS, C-RIES, DSRS, RCMA scale, C-PTC inventory	CEMS, TERC, TSCC, TSCYC, CBCL
<b>Statistical analysis</b>	Independent <i>t</i> tests & $\chi^2$ ; parametric & nonparametric tests, Multivariate analyses of covariance (MANCOVAs), MANOVAs	SPSS v.20.0
<b>Fidelity</b>	“Monthly supervision, viewing videotapes of sessions which addressed treatment adherence as well as clinical issues”	An adherence checklist for therapists
<b>Findings</b>	Significantly lower measures of PTSD symptomology & better functioning	Inhibition, liability/negativity, and dysregulation improved. Improvement in liability/negativity is consistent with symptom improvement. Poor ER skills did not improve.
<b>Limitations</b>	Small number of participants & inclusion criteria were deliberately broad	“All variables assessed through Paper-and-pencil measure”, Limitations on child’s ability to monitor emotions, Inclusion of siblings
<b>Recommend</b>	Effectiveness of individual CBT; “use a monitoring v. no monitoring comparison design”	“Evaluate how adaptive and maladaptive ER strategies impact child symptomology”

Table 2. (continued)

*Summary: Trauma Focused CBT Interventions for Children Witnessing Domestic Violence*

<b>Study</b>	Dorsey, Pullman, Berliner, Koschmann, McKay, Deblinger	Ready, Hayes, Yasinski, Webb, Gallop, Deblinger, & Laurenceau
<b>Study question</b>	“What is the impact of supplementing TF-CBT with evidence based foster parent engagement strategies?”	What is the association between overgeneralization (perception of broad, abstract, and global patterns) and accommodation beliefs (concrete, factual information that enhance discrimination b/w stimuli & increase specificity of trauma related beliefs) and symptom reduction for youth who received TF-CBT?
<b>Evaluation aim</b>	Increase the engagement of foster parent in TF-CBT	Accommodation beliefs will predict better outcome and weaken overgeneralization over course of treatment
<b>Location</b>	Washington (WA)	United States
<b>Sample size</b>	47 children & 1 of their foster parents	81 youth & 1 non-offending caregiver
<b>Age</b>	6-15 y/o	7 – 17 y/o
<b>Inclusion criteria</b>	Resided in foster placement for 1+ months; 1+ traumatic event; 1 symptom criteria for PTSD	3 – 18 y/o, English speaking, qualified for publically funded treatment, and caregiver willing to participate
<b>Intervention</b>	TF-CBT	TF-CBT
<b>Treatment</b>	unspecified	11+ sessions
<b>Design</b>	Pre-test & post-test	Pre- & post test at 3, 6, 9, 12 mos
<b>Selection</b>	Random assignment	Recruited as part of a larger treatment effectiveness trial
<b>Measures</b>	UCLA-PTSD-RI, CSQ-8, Tolan Process Measures, 27-item CDI, CBCL, BERS 2nd ed.	UPID-A, UCLA-PTSD Reaction Index for DSM-IV Abbreviated (UPID-A)
<b>Statistical analysis</b>	2-level Hierarchical Linear Models (HLM)	T-scores; Hierarchical Linear Modeling 7 software (HLM-7)
<b>Fidelity</b>	Audio review, direct feedback to clinicians, and weekly group consultations; checklist	10-item adherence checklist for coding videotape; 25 clinicians who had a professional or doctoral degree; licensed or supervised by licensed practitioner
<b>Findings</b>	Youth in engagement condition were more likely to attend more sessions thus decrease in PTS, emotional & behavioral symptoms	Reduction in PTSD symptoms, internalizing, externalizing. Youths with higher levels of accommodation and lower overgeneralizations were associated with lower internalizing, externalizing symptoms.
<b>Limitations</b>	Small sample size, children screened before meeting with TF-CBT clinician; used community based clinicians	Not utilize both parent and child report t measure PTSD symptoms; no control group; self-report
<b>Recommend</b>	Larger foster care sample size with a more rigorous design	“more detailed analysis of self-monitoring; include untreated comparison group”

Table 2. (continued)

Summary: Trauma Focused CBT Interventions for Children Witnessing Domestic Violence

<b>Study</b>	Kameoka, Yagi, Arai, Nosaka, Saito, Miyake, Takada, Yamamoto, Asano, Tanaka, Asukai	Holstead & Dalton
<b>Study question</b>	How feasible is TF-CBT for children in Japan?	“How effective is manualized TF-CBT than Applied Behavior Analysis approaches with Intensive Behavioral Interventions for youth with developmental conditions in a RTF?”
<b>Evaluation aim</b>	TF-CBT is a treatment that can be used with youths exposed to trauma in Japan	Youth with cognitive disabilities with trauma would demonstrate less response to TF-CBT
<b>Location</b>	Japan	Indianapolis, Indiana
<b>Sample size</b>	32 youth & 1 of their caregiver	88 children
<b>Age</b>	3 – 17 y/o	12-17 y/o
<b>Inclusion criteria</b>	At least 1 symptom in each of 3 PTSD clusters, caregiver’s consent to participate, at least 5 criteria for PTSD in DSM-IV	Dx PTSD/ trauma based symptoms; at least 4-6 adverse childhood experiences (ACE); mild cognitive abilities; intelligence score 58-69
<b>Intervention</b>	TF-CBT	Mandated TF-CBT, Applied Behavior Analysis approaches with Intensive Behavioral Interventions (ABA/IBI)
<b>Treatment</b>	12 – 25 sessions, 60-90 mins parallel and joint sessions	TF-CBT: 3 sessions/ wk along with ABA/IBI as necessary; ABA/IBI (for only control group): 3 sessions/wk
<b>Design</b>	Pre-treatment & post-treatment measures	Quasi-experimental study; pre-/post treatment measures
<b>Selection</b>	Recruit from 4 sites in Japan: Morioka, Kobe, Tokyo, Osaka	Damar Services, Inc. 200 youths from RTF treated with ABA/IBI
<b>Measures</b>	UPID; Children’s Global Assessment Scale (C-GAS)	Teacher Report Form of the Achenbach System of Empirically Based Assessment (ASEBA)
<b>Statistical analysis</b>	2 tailed paired <i>t</i> tests’ Cronbach’s alpha	T scores; paired sample <i>t</i> test
<b>Fidelity</b>	Brief Practice Checklist (BPC); 2-day introduction training sessions by certified TF-CBT trainers	Masters level behavioral therapists
<b>Findings</b>	RI scores lower & C-GAS scores higher; 23 participants exhibited 50% reduction in RI scores	“Children with cognitive disabilities demonstrate less response to TF-CBT as compared to traditional ABA/IBI training”
<b>Limitations</b>	No culture specific modifications to treatment; uncontrolled pilot study	Small sample size, subjects were matched to groups, no random assignment; ABA/IBI frequency not equal
<b>Recommend</b>	“Randomized controlled trial with independent assessments to evaluate effectiveness of TF-CBT”	Conduct more research on efficacy of TF-CBT for developmentally disabled population, larger sample size, trauma measures in addition to other scales measuring psychopathology

## **Results**

**Participants.** In TF-CBT only the children were considered as participants; although the parents participated too, they were not counted as a participant. The children included in these studies ranged in age from 3 to 18 years old. The smallest study had only a total of 24 participants. Compared to the largest study, it had 135 participants.

In the last phase of TF-CBT children and parents interacted and participated in the same session. During this stage, the goal was to build a trusting relationship in addition to practicing coping and relaxation skills. Only one study (n=88) did not include a non-offending parent or caregiver. Participants in the corresponding study resided in the care of a residential treatment facility. They were limited to the participation of their caregivers. If caregivers were inaccessible, they were exempted and participants continued the treatment alone.

**Location and selection.** A little over than half of the studies were conducted in the United States, while the other five studies were conducted out of the country such as Japan, Norway, Australia, Canada and London. Despite that these studies were out of the country, they utilized the same strategies as in the United States. The study in Japan was the only one that considered changing TF-CBT therapy to accommodate cultural differences. However, they decided to conduct therapy exactly to how it was being done in the United States given that cultural differences were not controlled for in the study.

The method of recruitment varied: from clinics to, referrals, and residential treatment facilities. Specifically, half of the studies recruited participants. Majority of the studies selected participants from referrals and self-enrollments.

**Year and design.** The empirical studies were conducted from as early as 2007 to as late as 2016. Three empirical interventions were randomly controlled trials. All nine empirical

studies, except one were qualitative and included a quantitative design of pre-test and post-test measures. The one intervention study that was not quantitative was primarily qualitative.

The study that was only qualitative evaluated narratives. The narratives were assessed thoroughly right after session. The therapists reviewed these narratives with a licensed therapist in TF-CBT.

**Inclusion criteria.** The inclusion criteria in the studies were necessary for participants to meet the requirements of the research. Overall, the main identified inclusion criteria were the experience of at least one traumatizing event, consent to participate from a non-offending caregiver, and symptoms from one of each of the PTSD clusters as stated in the DSM-IV or DSM-5 based on the year of the study. Participants across all studies had an average range of approximately eight to 25 sessions.

**Measures.** The most common measures utilized to measure progress and outcomes of researched were: UCLA-PTSD Reaction Index for DSM-IV Abbreviated (UPID-A), UCLA-PTSD Reaction Index (UPID), Clinician-Administered PTSD Scale for Children and Adolescents (CAP-CA), Child Behavior Checklist School-Aged Version (CBCL), and Anxiety Disorders Interview Schedule for Children (ADIS-IV-C/P). The measurements most commonly utilized were UPID (n=3) and CBCL (n=3).

**Fidelity.** The fidelity part of each research was slightly different from study to study. Out of 10 empirical studies, three of the studies employed therapists who were licensed to supervise. If a licensed therapist was not available, four of the studies implemented supervision by a licensed TF-CBT therapist. In five of the overall studies included, they implemented an adherence checklist for therapists. The checklists were specifically to code narratives during the narrative process and the therapy session.

Another common strategy for fidelity is consultation and training. Five of the intervention studies implemented this strategy. These two specific components were implemented if the research required videotaping or narrative analysis. Researchers utilized the fidelity requirement so that therapy interventions were valid. Additionally, many of the therapists conducting therapy would be the one in session with the participant, and thus, supervision was a necessity.

### **Theories Implicated in Articles**

Theories are used to describe an abstract concept and in this finding, help organize the empirical studies, according to the applicable theory. The theories also categorize the empirical studies in a format that makes it evident as an effective treatment for children who have witnessed domestic violence. The theories identified for the empirical studies included in this research are:

- Psychoanalytic Theory (two studies)
- Attachment Theory (one studies)
- Family Systems Theory (two studies)
- Strength Based Theory (five studies)

### **Psychoanalytic Theory (two studies)**

Psychoanalytic theory was founded by the Austrian psychoanalyst Sigmund Freud (Robbins, Chatterjee, & Canda, 2012). Freud believed that human behaviors were beyond just nature. He assessed that behaviors were driven by universal structures of the mind and social control (Johnson, 2011; Robbins et al., 2012). The central focus of psychoanalytic theory is that human behavior is driven by three distinct psychic structures: the id, ego, and superego (Robbins et al., 2012).

Freud further formulated a process that made it easier to understand how all three personalities were interconnected by the consciousness of the mind. The id was described as the personality that acts on instinctual needs or basic desires, whose actions were initiated by the unconscious mind (Robbins et al., 2012). The unconscious mind is a storage area that contained memories. The ego was the construct defined as the more rationale personality; creating a balance between the two personalities. The ego's actions were initiated by the preconscious state of mind where thoughts were currently being put on hold (Robbins et al., 2012). And the superego was stated as the more ethical, ideal ego personality and was fully instated in the conscious state of mind.

Psychoanalytic theory attempted to emphasize how experiences from the past influences present behaviors (Johnson, 2011). Therapies that implemented this theory tried to deconstruct the individual's state of mind in order to help them break down their defensive approach. The defense mechanism was defined as intentions from the ego to: "safeguard the mind against feelings and thoughts that are too difficult, such as inappropriate or unwanted thoughts and impulses, from entering the conscious mind," (Johnson, 2011).

One of the studies that applied this theory was the empirical study conducted by Smith, Yule, Perrin, Tranah, Dalgleish, and Clark (2007). This study's research aimed to evaluate how effective TF-CBT is for treating PTSD in children and youth. The research focused on a sample of 24 participants and one of their non-offending caregivers. The design of the research compared the outcome measures of participants who were randomly assigned to either TF-CBT treatment or Waitlist (WL), where they received no treatment.

In Smith et al.'s study, they discovered that children who were administered TF-CBT treatment displayed significantly lower measures of PTSD symptomology and better functioning.

TF-CBT, specifically for this effectiveness, resulted from modifying the misappraisals that were usually missed for children with PTSD (Smith et al., 2007). Adults were disengaged during traumatic incidents like domestic violence. What resulted from that was the lack of attention and effort for appraisals; when appraisals were missed it took a negative toll on the children (Smith et al., 2007).

In this empirical research, missed appraisals directly related to the needs that children ask for from their instincts (id), rational needs (ego), or from a pure lack of the former two (superego). When the parent does not praise, the children do not get the proper response to their needs. When children do not receive appraisals, there is no help to process or evaluate the experience of witnessing domestic violence. Their trauma continually gets stored in the unconscious mind due to the associated grief.

In Smith et al.'s (2007) research, the part that assisted the child's process of trauma was in vivo mastery. Again, the aim of in vivo mastery was to expose them again to the trauma slowly by narratives and psychoeducation for parents. Parents learned positive behavior management, therefore learning about the importance of appraisals.

The next intervention study conducted by Thornback and Muller (2015) suggested that improvements in emotional regulation led to positive changes in symptoms from trauma. In order to evaluate the child's ability to regulate emotions, the study used scales such as The Children's Emotion Management Scales (CEMS), which was a self-report emotional regulation of sadness; and Emotion Regulation checklist. The scales were administered as a pre- and post-test measure in order to track the development in regulation.

Emotion regulation was defined as "a set of processes that monitor, evaluate, and modify emotional reactions," (Thornback & Muller, 2015). Children's personalities were affected by

how a child could manipulate the emotional regulation. The intervention study found that although inhibition and dysregulation greatly improved, their maladaptive emotional regulation did not (Thornback & Muller, 2015).

The two previous intervention studies implemented the theory of psychoanalytic theory. Psychoanalytic theory aims to reinstate the individual's mental health by assessing the personality. The goal was to "unmask the repressed memories and bring them to the conscious level," (Robbins et al., 2012). In psychoanalytic theory, the trauma is stored back to the unconscious state of mind but it is not forgotten. In the superego the trauma resurfaces as the conscious mind starts thinking about the memories again.

### **Attachment Theory (one study)**

Attachment theory was established by John Bowlby and Mary Ainsworth. It established from the work of Bowlby in a children's hospital during World War II. Bowlby collected data from children in the hospital and those statistics contributed to his research on the development attachment theory. Inspired by Sigmund Freud's theory about the unconscious mind and personality, Bowlby developed the attachment theory. Attachment theory was defined as "proximity to an attachment figure as a predictable outcome and whose evolutionary function is protection of the infant from danger," (Bretherton, 1992). This definition stemmed from Bowlby's study of the children's attachment to caregiver when they were in the hospital. Additionally to his studies, he collected observations of mother-children dyads during play (Bretherton, 1992).

The essential role that caregivers played was a safety net. In other words caregivers were used as a secure base of exploration. Children felt safe and explored with the thought of knowing that they could return to their caregiver for comfort (Bretherton, 1992; Robbins et al., 2012).

Their behaviors were interrelated: mothers played the independent role, meanwhile children were dependent on them.

In attachment theory, Bowlby established three patterns of relationships that were identified between the dyads: resistant, avoidant, and disorganized. The first one, resistant, defined the relationship when the child were physically resistant to the parent. The child would demonstrate, at first resistance in the form of anger, while at the same time expressing the need for comfort. The next attachment pattern, avoidant, children avoided their caregivers. These children identified were emotionally distant from their caregivers. In fact, when caregivers were nearby they actively attempted to distance themselves from the caregiver. During disorganized attachment behaviors, children remained indifferent to the presence of caregivers and their absence. Disorganized attachment was described as a confused look on the child's face when being held; or the child had no affect at all (Schoore & Schoore, 2008).

One of the studies that implemented this theory was the research conducted by Webb, Hayes, Grasso, Laurenceau, and Deblinger (2014). The focus of the study was to test the treatment of TF-CBT in a community setting. Participants for the research were recruited from clinics and via voluntary participation. Children were administered the UPIS to “assess changes in DSM-IV PTSD symptoms” (Webb et al., 2014). Caregivers that participated with their children were given the CBCL. The measure was a “self-report measure used to assess changes in children's emotional and behavioral problems” (Webb et al., 2014).

Webb and his colleagues did not exclude parents that had substance abuse problems. This empirical study implemented the importance of relationships between children and caregivers as they receive TF-CBT. The results suggested that the essence of the parenting principle was not fully absorbed for parents who had substance abuse problems. The parents were usually

disengaged with children and may be less sensitive to children's needs compared to their peers. As Bowlby would conclude from the attachment theory, the child would be more withdrawn and the two would have a less secure relationship (Bretherton, 1992).

Webb and his colleagues (2014) did find consistent with prior research that "TF-CBT on behavioral outcomes could be enhanced by focusing more on parenting skills, extending treatment length, providing follow-up sessions, provide more parental, community, or institutional support," (p. 9). According to Webb et al.'s conclusion, positive parenting skills were essential to the progress of children's reduction in emotional and behavioral problems.

In TF-CBT, this study implemented the approach of attachment theory. It closely evaluated parent involvement and children's progress in a community setting where TF-CBT was administered. Therefore, both caregivers (either offenders or non-offenders in the relationship) was invited to participate in the therapy. As their findings suggested, dyads that were closely involved with one another had more progress. The intervention study also concludes that additional assistance should be available to families who did not see changes in symptoms.

### **Family Systems Theory (two studies)**

Family system theory is defined by Rosenbusch and Cseh (2012): "the family as a whole and the members as interdependent... Each member is strongly influenced by the structure, organization, and the transactional patterns of the family system," (p. 64). The members of a family were unique in that they had different counterparts that differentiated them. For example, the father is an adult and goes to work, so his contribution and effect on the family would be different from that of his daughter.

A family can also be thought of as a closed group. Members who participate in this closed group, bring and take different parts of the group. Therefore, the group continues to function. If members do not contribute, the system slows or even stops. This was also identified as a non-functional family (Rosenbusch & Cseh, 2012).

In any groups, there are healthy and unhealthy families. The term health was used to define the functionality of the family: healthy is a functional family whereas unhealthy is not functional. A healthy family is functional when they are “complex, open, adaptive, and an information-processing system,” (Rosenbusch & Cseh, 2012, p. 65). By contrast an unhealthy, dysfunctional family system may be closed, strict, lacking the ability to adapt, or dominated by one person. The general family functions can be classified as such: assertiveness, leadership discipline, negotiation, roles, and rules (Rosenbusch and Cseh, 2012).

If one considers this family system theory in terms of this paper’s research the empirical studies that really implemented this theory were Holt, Jensen, and Wentzel-Larson (2014) including the research by Dorsey and his colleagues (2015). Holt et al.’s objective for their study was to identify the changes of parent, caregivers, or adoptive parents’ emotional reactions and depressive symptom changes overall through TF-CBT (Holt, Jensen, & Wentzel-Larsen, 2014). The second objective was whether the children’s PTSD symptoms and depressive symptoms was mediated by changes in the parent’s emotional reactions and depressive symptoms.

The design of the study was random selection to either Therapy as Usual (TAU) or TF-CBT. The 71 participants that did receive the latter treatment reported lower levels of distress. And children also reported being less depressed. The researchers suggested that the focus on targeting maladaptive appraisals or positive parenting component of TF-CBT caused such

results. However, it was noted that participants' results from TAU were only slightly less than those from TF-CBT.

In the second study conducted by Dorsey and her colleagues, the focus was to “examine the impact of supplementing TF-CBT with evidence-based engagement strategies on foster parent and foster youth engagement,” (Dorsey et al., 2014, p. 1508). This unique research design created by one of the researchers, implemented an engagement strategy called the McKay engagement intervention. The engagement intervention was solely a “strong perceptual focus, implemented during the first telephone contact with the caregiver and during the first in-person visit,” (Dorsey et al., 2014, p. 1510). The engagement strategy was described as:

(1) direct discussion of perceptual barriers, including prior negative experiences with mental health treatment and lack of confidence in treatment effectiveness, and (2) identification of the caregiver's own greatest concern about the child... And the clinician elicits potential concrete barriers and assists with problem-solving. (Dorsey et al., 2014, p. 1510).

The engagement strategy was only implemented during the first phone contact and the first in-person visit. Foster parents who received the engagement intervention attended two more sessions and were less likely to drop out of the study. The same parents also reported less PTS symptoms at the end of the study. Meanwhile foster parents from the standard group, did not receive the engagement strategy. These parents dropped out early on in the treatment. In the standard group, 27.3% dropped out of the study, versus 0% who dropped out and received the engagement intervention (Dorsey et al., 2014).

These two studies demonstrated the implementation of family systems theory. Parents in the first study showed much more progress given the focus of positive parenting. As family systems theory suggests, all members were interdependent on each other. Their function and

interaction modalities create the system. Parents from this study demonstrated that their progress in the depressive symptoms created a domino effect to the children's overall report of depression.

Dorsey and her colleagues utilized the theory by trying to use an engagement intervention for foster parents. Engagement is essential for both biological and non-biological parents. However, amidst foster and adopted families, there are more notable struggles with engagement. These families lacked characteristics that often correlate with functional family systems. For example, these families tend to exhibit less coherent behaviors, have minimal to no regular interaction, and can rarely depend on one another (Robbins et al., 2012). It is especially difficult for a child to depend on foster families given that, most of them, are placed in foster care based on unfortunate events (i.e. witnessing domestic violence) from their biological families.

The two empirical studies validate the theory's aspect of functional families. For example, Holt et al. claim that it was also the TF-CBT's component of targeting maladaptive appraisals that contributed to the progress. And similarly, Dorsey et al. suggested that caregivers who took the time to participate with children for the entire therapy were more likely to care about the child. They also had a more positive relationship with the child. Therefore, families that were functional can be distinguished as flexible with changes (Rosenbusch & Cseh, 2012).

### **Strength Based Theory (five studies)**

Empowerment efforts, which transpired because of the events of social reform, established strength-based theory. Empowerment can be thought of as "the process by which individuals and groups gain power to access resources and to control the circumstances [in their own] lives," (Robbins, Chatterjee, & Canda, 2012, p. 87). There were subjective and objective dimensions to this theory. The subjective piece was self-efficacy. Badura (1982) translates self-

efficacy to a belief that one has “the ability to produce and regulate events in life” (as cited by Robbins, Chatterjee, & Canda, 2012). The objective component is the individual’s own strength and helping themselves.

Another way to think of the strength-based theory was that individuals get to take part in helping themselves and discovering more about themselves. As Herman-Stahl and Peterson (2010) suggested “when we have experts solve issues, we deny and limit the individual an opportunity to explore strengths and capacities they might have in the process of exploring, participating, taking control, and learning” (as cited in Hammond & Zimmerman, 2010, p. 2). It is an opportunity that allows individuals or groups to problem solve with the very tools that they already possessed. When applying this theory, the participant is cued to find their own strengths in order to resolve their issues.

Majority of the studies that implemented the strength-based theory used social activities. The activities intended to make participants use their own strengths to diminish their trauma. For instance, four of the five studies embedded a narrative as the social activity. During times that internal or external behaviors escalated, the therapist would suggest the child to apply their skills. The skills that they used were either learned in session or of their own such as singing, drawing, and writing. As Kameoka and his colleagues (2015) discovered, one of the main reason for three participants who dropped out early, was due to resisting the creation and process of the narrative. Meanwhile, participants that did stay showed improvements to PTS symptoms and social functioning (Kameoka et al., 2015).

In research conducted by Holstead and Dalton (2013) they explored how youth with cognitive and developmental disabilities who have identified complex trauma; would show decrease of symptoms in TF-CBT or Applied Behavior Analysis. The findings suggested that

TF-CBT was ineffective. Children with complex trauma lacked affective vocabulary and had difficulty implementing coping strategies. Therefore, both Kameoka et al. and Holstead and Dalton's research suggest that the ability to apply one's strength within narrative processing is very essential for positive results.

Narrative processing only accounted for one third of the treatment process (Cohen et al., 2012). It is the second stage in TF-CBT where individuals process trauma through narratives. However, the work within deconstructing the narrative shows either improvement or regression in the children's current symptoms. Children who witnessed domestic violence retold their stories when prompted by therapists. As Westerman and his colleagues (2016), interpreted this narrative stage, therapists approach the narrative as a "written piece on a computer," through which children can be taught "the skill of seeking alternative plausible appraisals for events to reduce anxiety, and to broaden the narrow parameters of explanations that often occur in response to trauma," (Westerman, 2016, p. 3).

Children are given the tools to concurrently activate a more accommodated reasoning when approached with trauma or distress induced situation (Ready et al., 2015, p.683). In Ready et al.'s empirical study, accommodated beliefs can be thought of as a way to think more critically about the situation. For example, a participant loved music so the therapist suggested that she writes her narrative in a song. The participant not only found it easier to process the trauma, but also found a relaxation skill (Cohen et al., 2012). This example is similar to the strength-based framework where individuals were empowered to control their own circumstances.

Overall, all studies that implemented the strengths based theory drew out participant's potential. The importance of strengths based theory is that individuals are encouraged to solve their own issues with tools they already possess. For example, participants used hobbies such as

writing lyrics to process their trauma. All five studies that implemented this theory suggested that the participants did show progress in PTS symptoms and undesired behaviors.

## Discussion

This study examined themes that were embedded in the effectiveness of TF-CBT as a treatment to reduce post-traumatic symptoms of children who had witnessed domestic violence. The findings were compiled from 10 empirical studies that were found on various databases. In nine of the studies, it was suggested that TF-CBT did decrease adverse or PTS symptoms that stemmed from being exposed to the trauma. The article to this exception, found that components such as coping strategies and trauma processing may be harder for children with developmental and cognitive disability.

TF-CBT was initiated for children who suffered from sexual abuse but was later extended to children exposed to one or more types of trauma. Therefore, studies in the future should focus more on children who have witnessed domestic violence. The studies included in this research lead us to assume that as the popularity of this treatment surfaces, more and more therapists will be licensed to carry out this therapy.

The empirical studies suggested that the implied frameworks psychoanalytic, attachment, family systems, and strength-based break down the empirical studies in a way that we can see how they contribute to the effectiveness of TF-CBT. Half of the articles focused intently on the strength-based theory for their progress in desired results. Researchers across all studies noticed reduction in reactions to trauma such as internal and external behaviors, social functioning, PTS symptoms for both caregivers and youths, distress (also for both), and depression.

The recent findings of this treatment suggest that more research needs to be conducted. Many of these studies were the first of its kind to use TF-CBT in depth. Although the statistics were reliable and valid, there needs to be more randomized controlled studies. Randomly controlled studies are true experiments and data from such studies are highly valid. However, the

limited empirical studies do not diminish the fact that TF-CBT is an evidence-based practice. The studies contributed to a better understanding of TF-CBT for children who have witnessed domestic violence. TF-CBT shows progress for many individuals and has earned its name among other CBT utilized among children witnessing domestic violence. The future hope is that knowledge will be more substantial with more empirical studies.

TF-CBT is not effective for everyone who had been exposed to this trauma. The study has limitations that are inevitable: the difficulty in recruiting children exposed to domestic violence, getting consent from caregivers, lack of participation from a caregiver, and no EBP for children with cognitive disabilities. These are some of the many reasons that TF-CBT is not a resource for children who may identify with this population. It is the therapist's responsibility to assess the patients before suggesting this intervention. It is also their duty to suggest another mode of treatments if TF-CBT does not address their needs.

## **Strengths and Limitations**

### **Strengths**

One strength for this study is the summary table of all empirical studies. The table is a chart with detailed information regarding all the studies. It was used as a review of each study. This tool saved the researcher time from reading the abstracts and checking the entire study again. If needed, it is helpful to have it a part of this research so readers can reference back to it. The summary table contains results which the researcher extracted for findings.

Another strength of this research is the variety of databases. This study used six databases. All databases produced empirical studies relevant to this research. In all, there were a total of 1610 articles that were relevant to the research. It was easier to compile at a minimum of 10 studies with the substantial amount of relevant studies.

### **Limitations**

One of the limitations of this study was that it was conducted over a short duration of time. The study was only allotted a total of nine months to complete this project. The research project began in September and it had to be completed by May and presented to the public. Therefore, the shortage of time highly impacted this research project. More allotted time would further the findings for this research. It would also give the researcher more time to develop a more in-depth systematic review of TF-CBT.

Another limitation is the lack of empirical studies conducted specifically on children who have witnessed domestic violence. It is hard to collect data within this population because children have a short length of stay in shelters, parents do not always give consent, and there is a lack of reporting. Overall, this impacts the available empirical studies. Researchers have a harder

time with the selection process for participants. Therefore it was hard for me to locate articles that were conducted just on children witnessing domestic violence receiving TF-CBT.

## **Implications**

In this section, implications are suggestions for future studies, clinical social work and practice. Implication sections entail what was learned from the research. The whole research up to this point can teach similar research in the future what to caution when doing an empirical study. These suggestions were not formulated by any theory; they are merely information for studies to consider.

**Implications for future research.** It is recommended for future studies to focus on how domestic violence can affect the parents too. In most of these studies, the focus or the participant was referred to as the child, not the parent. There was little to no work done with parent regarding their own traumatic experiences. Depending on the severity of experiences, it can affect their participation as well as their child's participation in TF-CBT.

Future research needs to conduct randomized controlled trials. Randomized controlled trials are true experimental designs. The validity of these study designs are highly valid and reliable. The sample tends to be larger and diverse, hence a true experiment. Another neat thing about it is that participants are randomly selected to either treatment groups or control groups.

**Implications for clinical social work.** What this study suggests for clinical social work is that more therapists should be trained in TF-CBT. It is an EBP, yet these findings demonstrated that there were more unskilled TF-CBT therapists. If clinical social work can start utilizing this intervention it will increase their knowledge of it. It will also increase the public's awareness of this therapy too.

Children who experience or have experienced trauma should be treated earlier rather than later. It is essential for clinical social workers to provide the necessary assessment and treatment for these children. The research suggests that when implementing any therapy, especially TF-CBT, therapists should assess first. Assessment not only ensures that the treatment is appropriate for children witnessing domestic violence. The treatment is not suggested for children with complex trauma or intellectual disabilities given the complexity of relaxation and coping skill building. In order to adhere to the children's health early on clinical social workers must evaluate the appropriateness of this intervention.

Social worker's as a front line of defense are well poised to support children who experience domestic violence due to the level of neglect that this population has received from caregivers and professionals. Social workers can address the concern by advocating, educating, and detecting for children exposed to domestic violence (National Association of Social Workers, 2015). Social workers can get involved in intervention programs aimed at victims and abusers (i.e. parenting, therapy, safety planning) (Carter, Weithorn, & Behrman, 1999). A responsibility of the social worker to the broader society is social welfare (NASW Code of Ethics, 2015). Domestic violence is a harm to social welfare; every individual is negatively impacted by the violence. By educating the public about domestic violence, social workers repair the basic human needs that domestic violence impacts.

## **Conclusion**

Children exposed to domestic violence are at a higher risk when compared to children who were not exposed to domestic violence. Main concerns surrounded safety issues, psychological impact, and behavioral tolls for the future. A significant amount of evidence suggested that the lack of parental care and involvement in the child's process of the trauma increases the risk for these concerns. It was recommended that children receives treatment earlier rather than later.

This study explored the effectiveness of TF-CBT as a treatment for children who are witnessing or have witnessed domestic violence. Literature reviews suggested that TF-CBT was an appropriate intervention for children identified with this population. It is an effective treatment given the therapy model of PRACTICE. This model showed that therapy is carried out in three unique stages. The result is to reduce PTS symptoms, reestablish trust between caregivers and children, and for children to learn coping skills. The aim of TF-CBT to intervene with children exposed to trauma or experiencing trauma has gained popularity as an EBP.

After a literature review of children witnessing domestic violence and TF-CBT, the next focus of the research was on the methods of the study. The method was to conduct a selection process. The selection process was conducted through three stages. An empirical study analysis and extraction for 10 intervention studies were conducted. Then the intervention studies were compiled for results.

Finally, the findings started with the overview of all 10 empirical studies. The studies were further broken down based on applicable theories. The theories identified for the articles included in this research are: Psychoanalytic Theory, Attachment Theory, Family Systems Theory, and Strength Based Theory. Theories were used to identify how intervention studies

further demonstrated the effectiveness of TF-CBT. After reviewing the relevance to these theories, it was concluded that TF-CBT is an effective treatment for children witnessing domestic violence.

## References

- American Academy of Child and Adolescent Psychiatry. (2011, March). *When to seek help for your child*. Retrieved April 24, 2016, from [http://www.aacap.org/AACAP/Families\\_and\\_Youth/Facts\\_for\\_Families/FFF-Guide/When-To-Seek-Help-For-Your-Child-024.aspx](http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/When-To-Seek-Help-For-Your-Child-024.aspx)
- Antle, B., Barbee, A., Yankeelov, P., & Bledsoe, L. (2010). A qualitative evaluation of the effects of mandatory reporting of domestic violence on victims and their children. *Journal of Family Social Work, 13*(1), 56-73. November 20, 2015
- Carter, L. S., Weithorn, L. A., & Behrman, R. E. (1999). Domestic violence and children: Analysis and recommendations. *The Future of Children, 9*(3), 4. October 16, 2015
- National Association of Social Workers. (2015). *Code of Ethics (English and Spanish)* - Retrieved from <http://www.socialworkers.org/pubs/code/code.asp>
- Cohen, J. A., & Mannarino, A. P. (2008). Trauma-focused cognitive behavioral therapy for children and parents. *Child and Adolescent Mental Health, 13*(4), 158-162.
- Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect, 36*(6), 528-541.  
doi:10.1016/j.chiabu.2012.03.007
- Cohen, J., Berliner, L., & Mannarino, A. (2010, April 1). TF-CBT components: PRACTICE [Digital image]. Retrieved April 3, 2016. p. 216
- Cooley, B., & Frazer, C. (2006). Children and domestic violence: A system of safety in clinical practice. *Australian Social Work, 59*(4), 462-473.
- Daniel, B., & Bowes, A. (2010). Re-thinking harm and abuse: Insights from a lifespan perspective. *British Journal of Social Work, 41*(5), 820-836. October 5, 2015

- American Psychiatric Publishing. *Desk reference to the diagnostic criteria from DSM-5*. (2013).  
Washington, DC:
- Dorsey, S., Pullmann, M. D., Berliner, L., Koschmann, E., McKay, M., & Deblinger, E. (2014).  
Engaging foster parents in treatment: A randomized trial of supplementing trauma-  
focused cognitive behavioral therapy with evidence-based engagement strategies. *Child  
Abuse & Neglect*, 38(9), 1508-1520. doi:10.1016/j.chiabu.2014.03.020
- Edleson, J. L., Gassman-Pines, J., & Hill, M. B. (2006). Defining child exposure to domestic  
violence as neglect: Minnesota's difficult experience. *Social Work*, 51(2), 167-174.  
November 13, 2015
- Folsom, W. S., Christensen, M. L., Avery, L., & Moore, C. (2003). The Co-Occurrence of child  
abuse and domestic violence: An Issue of Service Delivery for Social Service  
Professionals. *Child and Adolescent Social Work Journal*, 20(5), 375-387. November 2,  
2015
- Garon, N., Bryson, S. E., & Smith, I. M. (2008). Executive function in preschoolers: A review  
using an integrative framework. *Psychological Bulletin*, 134(1), 31-60.  
doi:10.1037/0033-2909.134.1.31
- George, H. W. (2003). Children exposed to domestic violence and child abuse: terminology and  
taxonomy. *Clinical Child and Family Psychology Review*, 6(3), 151-160.
- Gustafsson, H. C., Coffman, J. L., & Cox, M. J. (2015). Intimate partner violence, maternal  
sensitive parenting behaviors, and children's executive functioning. *Psychology of  
Violence*, 5(3), 266-274. October 29, 2015

- Holstead, J., & Dalton, J. (2013). Utilization of trauma-focused cognitive behavioral therapy (tf-cbt) for children with cognitive disabilities. *Journal of Public Child Welfare, 7*(5), 536-548.
- Holt, T., Jensen, T. K., & Wentzel-Larsen, T. (2014). The change and the mediating role of parental emotional reactions and depression in the treatment of traumatized youth: Results from a randomized controlled study. *Child and Adolescent Psychiatry and Mental Health Child Adolescent Psychiatry Mental Health, 8*(1), 11. doi:10.1186/1753-2000-8-11
- Humphreys, C., & Absler, D. (2011). History repeating: Child protection responses to domestic violence. *Child & Family Social Work, 16*(4), 464-473.
- Johnson, A. L. (2011). *Psychoanalytic theory: Counseling and psychotherapy* (5th ed.). (pp. 59-76) Alexandria, VA.
- Kameoka, S., Yagi, J., Arai, Y., Nosaka, S., Saito, A., Miyake, W., Asukai, N. (2015). Feasibility of trauma-focused cognitive behavioral therapy for traumatized children in Japan: A pilot study. *International Journal of Mental Health Systems, 9*(1). doi:10.1186/s13033-015-0021-y
- Leach, M. J. (2006). Evidence-based practice: A framework for clinical practice and research design. *International Journal of Nursing Practice, 12*(5), 248-251. doi:10.1111/j.1440-172x.2006.00587.x
- Mabanglo, M. A. (2002). Trauma and the effects of violence exposure and abuse on children: A review of the literature. *Smith College Studies in Social Work, 72*(2), 231-251.

- Melchiorre, R., & Vis, J. (2012). Engagement strategies and change: An intentional practice response for the child welfare worker in cases of domestic violence. *Child & Family Social Work, 18*(4), 487-495. November 29, 2015
- Murray, L. K., Cohen, J. A., & Mannarino, A. P. (2013). Trauma-focused cognitive behavioral therapy for youth who experience continuous traumatic exposure. *Peace and Conflict: Journal of Peace Psychology, 19*(2), 180-195.
- Nguyen, H. T., Edleson, J. L., & Kimball, E. (2012). Honor Our Voices: A strengths-based approach to supporting children exposed to domestic violence. *Relation Child and Youth Care Practice, 25*(4).
- Onyskiw, J. E. (2003). Domestic violence and children's adjustment. *Journal of Emotional Abuse, 3*(1-2), 11-45. October 29, 2015
- Prior, S. (1996). Object relations in severe trauma: Psychotherapy of the sexually abused child. Northvale, NJ: J. Aronson.
- Ready, C. B., Hayes, A. M., Yasinski, C. W., Webb, C., Gallop, R., Deblinger, E., & Laurenceau, J. (2015). Overgeneralized beliefs, accommodation, and treatment outcome in youth receiving trauma-focused cognitive behavioral therapy for childhood trauma. *Behavior Therapy, 46*(5), 671-688. doi:10.1016/j.beth.2015.03.004
- Rosenbusch, K., & Cseh, M. (2012). The cross-cultural adjustment process of expatriate families in a multinational organization: a family system theory perspective. *Human Resource Development International, 15*(1), 61-77. doi:10.1080/13678868.2011.646895
- Schore, J., & Schore, A. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal, 36*(1), 9-20.

- Smith, P., Yule, W., Perrin, S., Tranah, T., Dalgleish, T., & Clark, D. M. (2007). Cognitive-behavioral therapy for PTSD in children and adolescents: A preliminary randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(8), 1051-1061. doi:10.1097/chi.0b013e318067e288
- Stanley, N., Miller, P., & Foster, H. R. (2012). Engaging with children's and parents' perspectives on domestic violence. *Child & Family Social Work*, 17(2), 192-201.
- Thornback, K., & Muller, R. T. (2015). Relationships among emotion regulation and symptoms during trauma-focused CBT for school-aged children. *Child Abuse & Neglect*, 50, 182-192. doi:10.1016/j.chiabu.2015.09.011
- Visser, M. M., Telman, M. D., Schipper, J. C., Lamers-Winkelmann, F., Schuengel, C., & Finkenauer, C. (2015). The effects of parental components in a trauma-focused cognitive behavioral based therapy for children exposed to interparental violence: Study protocol for a randomized controlled trial. *Boston Medical Center of Psychiatry*, 15(1).
- Webb, C., Hayes, A. M., Grasso, D., Laurenceau, J., & Deblinger, E. (2014). Trauma-focused cognitive behavioral therapy for youth: Effectiveness in a community setting. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6(5), 555-562. doi:10.1037/a0037364
- Westerman, N. K., Cobham, V. E., & McDermott, B. (2016). Trauma-focused cognitive behavior therapy: Narratives of children and adolescents. *Qualitative Health Research*. doi:10.1177/1049732315627795
- Zeanah, C. H., Berlin, L. J., & Boris, N. W. (2011). Practitioner Review: Clinical applications of attachment theory and research for infants and young children. *Journal of Child Psychology & Psychiatry*, 52(8), 819-833. doi:10.1111/j.1469-7610.2011.02399.x