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Trauma-Focused Cognitive Behavior Therapy with Children and Adolescents
A Systematic Review

by

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MSW Clinical Research Paper

Presented to the faculty of the
School of Social Work
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Master of Social Work

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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 a 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.

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Abstract

This systematic review examines the efficacy of Trauma-Focused Cognitive Behavior Therapy (TF-CBT) as an intervention in the treatment of Posttraumatic Stress Disorder (PTSD) in children and adolescents. Upon thorough review of the present literature, 7 articles met criteria. Common themes identified throughout the reviewed studies include TF-CBT versus other interventions, use of an engagement intervention, outcome influences, reduction in PTSD symptoms, and integrating TF-CBT into practice. Results of this review conclude TF-CBT is an effective treatment intervention for reducing PTSD symptoms in children and adolescents, yet further research needs to be done to be able to properly integrate the program in foster care and in-home family therapy settings, as well as with the developmentally disabled population.

Introduction and Purpose Statement

Between 2005 and 2006, an estimated 1.25 million children were victims of maltreatment, including neglect, physical abuse, and sexual abuse (U.S. Department of Health and Human Services, 2010). As high as this number is, it does not account for all of the children worldwide who are experiencing other traumatic experiences such as war, natural disasters, or death of loved ones. Recent research suggests there are several protective factors that can influence a child's emotional health following exposure to trauma; including, the degree of the exposure; whether or not life was threatened to the child or a child's caregiving figure; availability of social support; past trauma history; the child's preexisting mental health history; presence of parental stress in response to the traumatic event; and the amount of time the child was exposed to the event after it happened, via internet, television, or hearing others tell stories about it (Cohen & Mannarino, 2008, p. 158). While it is true that some, or perhaps even *most* children who experience a traumatic event are resilient, some, in fact *many*, are not.

When considering how to help children that have developed posttraumatic stress symptoms following the experience of a traumatic event, trauma-focused cognitive-behavioral therapy (TF-CBT) is a child-centered, strengths-based manualized treatment approach (Cohen, Mannarino, & Deblinger, 2006) that has been proven as evidence based practice through extensive research over the past fifteen years. It is a "components-based hybrid approach that integrates trauma-sensitive interventions, cognitive-behavioral principles, as well as aspects of attachment, developmental neurobiology, family, empowerment, and humanistic theoretical models in order to optimally address the needs of traumatized children and families" (Cohen et al., 2006, p.32).

Research from Little and colleagues (2011) summarizes the psychological impact of trauma on children and systemic interventions that have been used throughout the world with

attention to the concept of post-traumatic growth. Their research and others explores the types of trauma that impact children throughout the world, and supports the contention that working with traumatized children using evidence-practice is a growing need. This systematic review will further the understanding of the use of Trauma-Focused Cognitive Behavior Therapy in treating Posttraumatic Stress Disorder in children and adolescents, and provide insight into future clinical interventions with this population.

Literature Review and Research Question

Trauma Experiences

In order to provide evidence-based practices in treating children with Posttraumatic Stress Disorder (PTSD), it is critical to first understand the various traumatic experiences children are exposed to. A common misconception is that a traumatic experience has to be abhorrently violent to be considered “trauma”, or that an experience can only be “traumatic” if it is experienced first-hand. In reality, research regarding children and adolescents in the United States find more than half of this population has “experienced a potentially traumatic event such as child abuse, sexual assault, domestic violence, community violence, bullying, serious accidents, fires, disasters, medical trauma, or the traumatic death of a loved one” (Copeland, Keeler, Anglod, & Costello, 2007), of which approximately a quarter of exposed children develop significant symptoms of PTSD (Copeland, Keeler, Anglod, & Costello, 2007). Little (2009) reiterates that children and adolescents may experience a number of different types of trauma including abuse, grief, community violence, domestic violence, natural disasters, or a combination of more than one of these experiences. Life threatening illness, witnessing or learning about a serious injury or death, and terrorist attacks are noted as traumatic events according to the American Psychological Association (2013). Cohen & Mannarino (2008) cite

motor vehicle accidents, school violence, war, and refugee status as additional potentially traumatic events that can result in “long lasting negative emotional sequelae” (p. 158).

Traumatic experiences related to domestic violence and various forms of abuse are undoubtedly the most likely associated with PTSD in children and adolescents due to common knowledge of these sort of events taking place. Puccia, et. al. (2012) discuss the emergence of trauma related to domestic violence as a major social and health policy concern over the past 40 years, and the recognition of long term mental health risk for children who experience these types of trauma. “Forms of domestic violence can include verbal abuse, financial manipulation, physical and sexual abuse and assault, intimidation, coercion, and threats (Puccia, et. al., 2012, p. 105), with 60% of women reporting that their children were in the room at least occasionally while violence occurred, and 30 to 60% of families reporting child in the home was also a victim. Another study found approximately 75% of children exposed to domestic violence were also involved in the violence through children as part of the precipitating event, children calling for help to outside sources (e.g., police), and children’s physical involvement, either intentional or unintentional (Puccia et. al., 2012, p.106).

Although instances of violence and abuse in the home are the most often discussed as the main source of childhood trauma, war, terrorism, and natural disasters are affecting just as many children both in the Unites States and abroad. This is of particular concern to the mental health field when considering how to provide evidence-based practice when working with children who are displaced due to natural disasters, or who have recently arrived to the Unites States as refugees. Consider, for example, the statistics that “more than *one million people* were displaced, at least temporarily, by Hurricane Katrina in 2005” (Little, 2009, p. 199), and “globally, just over 1 billion children under the age of 18 live in countries affected by war” (McMullen,

O’Callaghan, Shannon, Black, & Eakin, 2013, p. 12311). Furthermore, data compiled by UNICEF (2007) regarding the impact of war on children reports that over the last decade 20 million children have had to flee their homes, 1 million children have been orphaned or separated from family, 6 million children have been permanently disabled or seriously injured, and as many as 300,000 children have been forced to be soldiers. Knowing this, it should not be surprising then that “Posttraumatic stress disorder (PTSD) is the most researched mental health difficulty in war-affected children” (McMullen, O’Callaghan, Shannon, Black, & Eakin, 2013, p. 1231).

Sudden accidents account for yet another type of traumatic event children and adolescents may be exposed to. In fact, for children ages 3–7, the leading causes of death were motor vehicle accidents (38.1 %), drowning (22.5 %), and fire/burns (13.5 %) (National Vital Statistics System 2013), and for the children who survive these accidents the long lasting impact of the trauma can be significant. Single-incident and accidental injuries account for 2,500 per 100,000 children and adolescents experiencing a necessary hospital admission each year, and consequently, discrete traumas, particularly hospital admission trauma resulting from accidental injury, present a significant risk of posttraumatic stress disorder (PTSD) in children (Nixon, Sterk, and Pearce, 2012, p. 327).

When accidents result in the sudden loss of a parent or sibling, this “can dramatically impact the caring environment surrounding the child, and can potentially result in a complicated mix of trauma and grief with both PTSD and complicated grief reactions as a result” (Dyregrov and Yule, 2006, p. 176). In children and adolescents, unresolved complicated grief may also lead to manifestation of traumatic grief. Dickens (2014) describes traumatic grief as a “condition in which posttraumatic stress symptoms develop after the traumatic death of a loved one, and both

unresolved grief and PTSD are present” (p. 120). “Risk factors that may influence the development of complicated traumatic grief include the type and suddenness of the death, whether or not the survivor witnessed the death, self-blame, and emotional attachment to the deceased” (Dickens, 2014, p. 120). A final contributing factor is the level of violence in which the death occurred, with the likelihood of traumatic grief increasing in relation to the level of violence present in the death. As Dickens (2014) explains, “children are not small adults; they experience distress but manifest it in developmentally distinct ways” (p. 120).

Trauma and Development

For young children, “exposure to violence in the first years of life can engender profound helplessness and terror which are causally linked to the shattering of the child’s trust in the parent’s competence as protector” (Puccia et. al., 2012, p.106). Even in the absence of violence, “psychic trauma occurs when a sudden, unexpected, overwhelmingly intense emotional blow or a series of blows assaults the person from outside. Traumatic events are external, but they will quickly become incorporated into the mind” (Terr, 1990, p.8). Regardless of age, children exposed to trauma may develop personality changes, or other psychiatric disturbances in response to effects on the central nervous system and neuroendocrine systems following exposure to trauma in formative years (Dyregrov and Yule, 2006, p. 176).

Bruce Perry, MD, a highly respected leader in the field of child psychiatry, goes into great depth in his 2006 publication *The Boy Who Was Raised as a Dog and Other Stories from a Psychiatrist’s Notebook* regarding the developmental impacts of trauma on a developing child’s brain. Perry (2006) explains that for the developing brain, “being harmed by the people who are supposed to love you, being abandoned by them, being robbed of the one-on-one relationships that allow you to feel safe and valued and to become humane- these are profoundly destructive

experiences” (p. 231). In most cases, when a child experiences trauma, the brain will respond with hyperarousal or dissociation, and if these patterns are activated repeatedly long enough, due to the intensity, duration, or pattern of the trauma, there will be ‘use dependent’ changes in the neural systems that mediate these responses (Perry, 2006, p. 50). These responses help the child survive the immediate trauma, but overtime they can become overactive and sensitized, manifesting into serious emotional, behavioral, and cognitive issues long after the trauma has passed (Perry, 2006).

Throughout the text, Perry (2006) describes how an individual processes, stores, retrieves, and responds to the world based upon their current physiological state, and for a child who has been exposed to trauma, or the pervasive threat of trauma, he or she may respond to ordinary experiences as though they are threatening, moving primarily along the aforementioned dissociative or the arousal continuum, reducing his or her ability to learn cognitive information, such as schoolwork. Discussing a young female patient, Tena, and her history of sexual abuse, Perry (2006) states:

Repeated activation of the stress response from trauma at a young age, while the brain is still developing, causes a cascade of altered receptors, sensitivity, and dysfunction throughout the brain. This developmental trauma is seen in sleep and attention problems (brainstem), difficulties with fine motor control and concentration (diencephalon and cortex), social and relational delays and deficits (limbic and cortex), and speech and language problems (cortex) (Perry, 2006, p.22).

Affective, behavioral, cognitive, and physical (elevated resting pulse and blood pressure, muscle tension, hypervigilance) symptoms are all related to the chronic stress these children are experiencing and have been found to decrease brain size and functioning if the exposure to

trauma is prolonged (Little, 2009). Perry (2006) reports “research continues to show how even seemingly purely ‘physical’ problems like heart disease, obesity and cancer can be more likely to affect traumatized children later in their lives” (p.3). Cohen and Mannarino (2008) provide further insight into the types of affective, behavior, and cognition problems we may see in children exposed to trauma noting affective problems can include sadness, fear, anxiety or anger, excessive moodiness, or difficulty in controlling or regulating moods and emotional states (affective dysregulation). Behavioral problems may take the form of avoidance of trauma reminders (any person, place, thing or situation that reminds the child of the original trauma), new oppositional behaviors (which may result from anger or feelings of betrayal in reaction to the unfairness of the traumatic event), difficulty in separating from adults (school refusal, wanting to sleep with parents), regressive behaviors, manifestations of anxiety, or re-experiencing the original trauma by means of sexualized behavior, bullying, or abuse of others (Cohen & Mannarino, 2008).

While avoidance of trauma reminders may be an effective short-term coping mechanism for these children, if these behaviors generalize, it may have a severe negative impact on the child’s participation in normal age-appropriate activities, exacerbating the affective symptoms. “Cognitive problems following trauma may include distorted ideas about why the traumatic event happened, or who was responsible (including self-blame), in an attempt to provide an explanation for the traumatic event” (Cohen, Mannarino, & Deblinger, 2006). These beliefs are generally dogmatic, rigid musts and imperative demands to help the child develop a sense of control or predictability over the environment. (Cohen, Mannarino, & Deblinger, 2006; Cohen & Mannarino, 2008).

This dysregulation of neurobiological, cognitive, and affective processes will differ with each child and is not a one-size-fits-all scenario. Rather, the stage of development the child is in at the time of the trauma, and the level of trauma, need to be taken into consideration all the while remembering that each child will react to trauma differently; and aggression, hyperarousal, emotional withdrawal, attention problems, and psychiatric disturbances will vary in degree of severity, or not occur at all. Following exposure to traumatic stressors, children display a wide range of stress reactions that will vary with age, and to some extent, by gender (Dyregrov & Yule, 2006). Young children generally display more overt aggression and destructiveness, repetitive play (and drawing) about the traumatic event, as well as behavioral re-enactments; while with preschool children, their reactions are more determined by parental reactions to the event (if the parents respond calmly, the child feels protected and secure) (Dyregrov & Yule, 2006). After the age range of 8-10 years old, the child's reactions are more similar to those manifested by adults due to the child's ability to understand more of the situation, see more long-term consequences of the traumatic event, and reflect more on their own role in the event (Dyregrov & Yule, 2006).

Ultimately, when working with children who have been exposed to trauma, it is crucial to remember the developing brain is malleable and sensitive (Perry, 2006). "Children become resilient as a result of the patterns of stress and of nurturing that they experience early on in life. Consequently, we are also rapidly and easily transformed by trauma when we are young" (Perry, 2006, p. 39).

Posttraumatic Stress Disorder

Abuse, severe accidents, life-threatening illness, natural disasters, war, terrorism, community violence, school violence, or the sudden death of a parent, sibling, or peer *may* result

in the development of PTSD, “however, it should also be noted that not every child exposed to a traumatic event will develop trauma symptoms. Many children demonstrate resiliency, the ability to thrive and excel, even when exposed to severe stressors (Little, 2009, p. 200). For the children in which resiliency is not protecting them from the effects of their trauma, “gender differences are often reported, with more girls than boys qualifying for the diagnosis of PTSD, while boys show higher rates of behavior symptoms” (Dyregrov and Yule, 2006, p. 176), although overall “children appear to be the demographic group at highest risk for PTSD” (Feather & Ronan, 2006, p. 132).

In 1980, the diagnosis of Posttraumatic Stress Disorder (PTSD) due to the psychological effects of trauma exposure was acknowledged by the American Psychiatric Association, and in 1987 it was recognized that PTSD can also occur in children (Feather & Ronan, 2006). “Like adults, children show the cardinal tripartite grouping of symptoms: re-experiencing, avoidance and increased arousal” (Feather & Ronan, 2006, p. 132.), “however symptoms of PTSD in children may manifest differently at different ages, and other reactions can also occur” (Feather & Ronan, 2006, p. 132). Examples of these symptoms can include separation anxiety and oppositional defiant disorder as predominating comorbidity, in addition to irritability and anger with parents and peers, blaming selves for events, depression, anxiety, and grief reactions (American Psychiatric Association, 2013, p. 280; Feather & Ronan, 2006, p. 132-133).

According to the most recent diagnostic criteria presented in the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5 (American Psychiatric Association, 2013), in children older than 6 years of age, PTSD is diagnosed when a child meets the following criteria:

- a. Exposure to actual or threatened death, serious injury or sexual violence through direct experience, witnessing the event, learning the event occurred to a close family

- member or friend, or experiencing repeated or extreme exposure to aversive details of the traumatic event(s).
- b. Presence of recurrent, involuntary, and intrusive memories of the traumatic event(s), recurrent distressing dreams related to the traumatic event(s), dissociative reactions (e.g. flashbacks) where in the individual feels or acts as if the event is recurring, intense or prolonged psychological distress in response to internal or external cues that resemble part of the event, or marked physiological reactions to internal or external triggers that symbolize or resemble a part of the event(s).
 - c. Persistent avoidance of stimuli associated with the traumatic event(s) beginning after the event occurred, such as avoiding or efforts to avoid memories, thoughts, feelings, or external reminders that arouse distressing memories, thoughts, or feelings about the event(s).
 - d. Negative alterations in cognitions and mood associated with the traumatic event(s) (i.e. inability to remember important aspects of the event; persistent negative beliefs and/or cognitions about self, others, or the world; persistent negative emotional state; markedly diminished interest in activities; feeling detached or estranged from others; persistent inability to experience positive emotions).
 - e. Increased arousal after the event(s) has occurred including irritability, anger outbursts, reckless or self-destructive behavior, hypervigilance, exaggerated startle response, problems with concentration, and sleep disturbance.
 - f. Duration of symptoms is greater than 1 month.
 - g. Disturbance causes significant distress and impairment to functioning.
 - h. Disturbance is not due to effects of a substance.

In children 6 years of age and younger, PTSD is diagnosed when the child is exposed to the event(s) directly, indirectly, or learn a traumatic event occurred to a parent or caregiving figure; presents recurrent, involuntary and intrusive distressing memories, dreams, or dissociative reactions in regards to the traumatic event(s); experiences intense or prolonged psychological distress at exposure to internal or external cues that resemble an aspect of the event; and/or display marked physiological reactions to reminders of the traumatic event(s). Additionally, persistent avoidance of stimuli associated with the event(s) or negative alterations in cognitions and mood associated with the event(s), must be present, beginning after the event(s) or worsening after the event(s) (American Psychiatric Association, 2013).

Without effective treatment, childhood PTSD persists over time (Scheeringa et al. 2005), but various researchers have identified adverse reactions in the short- and long- term effects of trauma in developing children, reporting early comprehensive intervention may effectively reverse and considerably lessen the long-term risks (Feather, J. & Ronan, K., 2006). Unfortunately, many traumatized children and youth are not found in mental health clinics but rather in law enforcement, substance abuse treatment, criminal justice and other systems where providers have not been trained to identify the origins of the problems, or to deal with remediation (Puccia, et. al., 2012, p.106-107).

Trauma-Focused Cognitive Behavior Therapy

Empirically supported in the trauma field as a fundamental intervention for children and adolescents with PTSD is Trauma-Focused Cognitive Behavior Therapy (TF-CBT), and although most of the research has supported the use TF-CBT with children following sexual abuse, this intervention has also proved efficacious for other types of trauma (Little, 2009, p. 199). Combining cognitive therapy, behavioral therapy, and family therapy, TF-CBT is a client-centered, strengths-

based, manualized treatment approach that serves to reduce children's negative responses to trauma, change children's maladaptive beliefs about the trauma experience, provide support and skills for parents to use in coping with their own issues about trauma, and help the parents develop skills to help support their children (Child Welfare Information Gateway, 2007; Green, S.A., Pruitt, D.K., 2013). TF-CBT has been recognized consistently in literature as the treatment of choice for childhood PTSD (Nixon, Sterk, & Pearce, 2012, p. 327) and has been used effectively with children who have experienced a variety of traumatic events, including multiple traumas, with children from a variety of backgrounds (Child Welfare Information Gateway, 2007).

TF-CBT therapy has six core values, spelled out in the acronym CRAFTS: component-based skill development, respect, adaptability, family participation, therapeutic relationship, and self-efficacy (Cohen, Mannarino, & Deblinger, 2006). The overarching purpose of TF-CBT is for children to be able to talk about their traumatic experiences in an open and supportive environment, allowing parents and children to communicate about these traumatic events (Puccia, et. al, 2012, p.114). A search of academic databases will result in several randomized controlled treatment trials for sexually abused and multiply traumatized children, all supporting the efficacy of TF-CBT for improving PTSD, depression and other emotional and behavioral difficulties in children from 3–17 years of age (Cohen and Mannarino, 2008, p. 161). One report on this intervention model states:

TF-CBT—a hybrid treatment model integrating cognitive behavioral, interpersonal, and family therapy principles with trauma sensitive interventions—has been superior to other treatments in improving PTSD and depressive symptoms in comparative trials, this may suggest effective treatment models may target specific symptom clusters, developmental level, and/or level of severity/chronicity more than specific types of trauma experiences. In addition to its use with sexually abused children, TF-CBT has also been tested with

children who have been exposed to community violence, traumatic grief, and domestic violence (Cohen, Mannarino, & Iyengar, 2011).

In this same randomized control trial, the authors go on to report that when working with children who have witnessed violence in the home they “found that clients who participated in TF-CBT saw significantly more progress with their PTSD symptoms than did clients who participated in traditional child-centered therapy, especially with respect to hyperarousal and avoidance” (Cohen, Mannarino, & Iyengar, 2011).

A primary tool in TF-CBT is a narrative intervention where a child writes about his or her trauma. The reasons for creating a trauma narrative include: overcoming avoidance of traumatic memories; identifying cognitive distortions through his or her own words; contextualizing the traumatic experience into the larger framework of the child’s whole life: through telling the story in context (before, when, since this happened to me...), the child is able to see that he or she is more than just a victim of trauma (Cohen and Mannarino, 2008, p. 160). Before the narrative intervention takes place, it is imperative for psychoeducation to be provided by the therapist regarding the rationale of the intervention for both the child and the parents.

Narratives within TF-CBT provide a way for children to voice specific experiences, explore cognitive dysfunctions, and reduce feelings of embarrassment, self-blame, and posttraumatic stress symptoms. The later sharing of the narrative allows for open, honest communication about the abuse and helps the parent to move into a supportive, therapeutic role, which can continue after termination from counseling (Foster, 2014, p. 334).

Through use of evidence based practices like narratives that have components well suited to a strengths-based framework, TF-CBT principles include a focus on the provider using a

strengths-based approach to further clients' self-efficacy (Sabalauskas, Ortolani, & McCall, 2014, p.123). In individual work with children and adolescents, clinicians focus on the thought processes that lead the client to act out, rather than focusing on the acting out behavior itself; develop strategies with the client, not for them, to shift their thinking to something more positive; and help clients transform their reactions. (Sabalauskas, Ortolani, & McCall, 2014, p.124).

The components of TF-CBT are summarized by the acronym PRACTICE (see table 1), not only to symbolize the TF-CBT components, but to also stress the hope that children and parents or caregivers will practice what they learn in therapy between treatment sessions (Cohen & Mannarino, 2008, p. 159). Standing for Psychoeducation and Parenting skills; Relaxation skills; Affective regulation skills; Cognitive coping skills; Trauma narrative and cognitive processing of the traumatic event(s); In vivo mastery of trauma reminders; Conjoint child-parent sessions; and Enhancing safety and future developmental trajectory (Cohen & Mannarino, 2008, p. 159), PRACTICE follows a core principle of gradual exposure, with each TF-CBT component “including graded exposure to the child’s traumatic experience; the intensity of the exposure incrementally increasing as the child and parent systematically move through the hierarchy” (Cohen & Mannarino, 2008, p. 159).

Table 1

PRACTICE (Cohen and Mannarino, 2008; Green, S.A., Pruitt, D.K., 2013).

Psychoeducation and Parenting Skills	Starts at first contact with the family. Family is educated on the TF-CBT approach. Provides important message of hope. Normalizing and validating. Continues throughout treatment regarding impact of trauma on children and family, nature of PTSD and other diagnoses/symptoms, normalizes feelings.
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	Parents receive parallel sessions that address PRACTICE components: interventions to optimize parenting skills (e.g. praise, selective attention to positive behaviors, contingency reinforcement). Interventions must be individualized for each family. Instruction is through role plays, behavioral vignettes, discussion, and supplemental materials.
Relaxation	Aim to reverse physiologic changes that occurred due to trauma. Helps the child gain mastery. Provides a toolkit of different age-appropriate methods to self-soothe (e.g. progressive muscle relaxation, deep breathing, blowing bubbles, yoga, mindfulness, music, sports, knitting, singing, reading, writing, praying, relaxation tapes). Goal is to create options that will work in various settings (i.e. school, friend's house, church, home).
Affect Regulation	Individualized to each family. Identify areas of difficulty. Work with child to expand range of affective expression. Importance of practice between sessions. Skills taught include: identifying feelings; thought interruption and positive imagery; positive self-talk; developing a sense of safety; enhancing social skills; improving problem solving skills.
Cognitive Coping and Processing	Help child and parents recognize connections between thoughts, feelings, and behaviors as related to everyday situations. Evaluate which thoughts are helpful or harmful. Explore feelings and behaviors associated with these thoughts. Work toward reframing traumatic event.
Trauma Narrative	This is done AFTER completion of the skill-building components. Child gradually tells story of what occurred during trauma through book, poem, song, or other written narrative. Not uncommon for parents to hear some aspects of the trauma for the first time. Parents may need individual sessions to process what they hear. Through this process, traumatic symptomology should decrease.
In Vivo Mastery of Trauma Reminders	Further desensitizes child to trauma reminders, memories, and avoidant behaviors.

	Gradually eliminates behaviors and responses that have developed as an overgeneralization. Allows child to tolerate previously feared situations. Decreases traumatic symptomology. Increases sense of safety, competency, and mastery.
Conjoint Child-Parent Sessions	Occurs after processing of trauma narrative. 1 hour sessions become 15 min child, 15 min parent, and 30 min together. Goal is to enhance parent/child relationship and discuss unresolved or newly developed issues or concerns.
Enhancing Future Safety and Development	General safety planning and skills are taught (identifying safe people and places; difference between secrets and surprises; boundaries). Parental involvement is crucial.

This systematic review will serve to further explore how TF-CBT can be essential in treating PTSD in children and adolescents, through preventing and decreasing negative impacts on development, and providing a framework for improving future resiliency.

Conceptual Framework

The lens of this systematic review is the use of evidence-based practice as a conceptual framework in working with this fragile population. There is no debating that trauma has long lasting, harmful, and sometimes detrimental effects on the lives of children and adolescents. Knowing this, it is imperative that clinicians are implementing structured, empirically supported practices that have been thoroughly researched and proven effective in reducing symptoms associated with child trauma, and continue to have long lasting effects after the course of treatment has been reduced or ended, this is the basis of evidence-based practice.

Child trauma is common, complex in nature and response, and often leads to serious and long-lasting mental health problems, with most traumatized children dependent on routine providers for mental health services, such as those in schools or public mental health

organizations (Cohen, 2013, p. 344). In order for these children receive the best possible care, it is imperative to provide child trauma evidence-based practice into these settings (Cohen, 2013, p. 344). Without an evidence-based practice intervention, the symptoms associated with trauma may persist into adolescence and adulthood, continuing to negatively impact the victim's life. "Ameliorating the short- and long-term sequelae of child maltreatment requires developing, disseminating, and implementing effective treatment approaches" (Allen and Johnson, 2012, p.80).

Evidence-based treatments exist for behavior problems associated with child and adolescent trauma, with substantial literature documenting the effectiveness of a variety of approaches (Woody et. al., 2015). These interventions are primarily behavioral, target parenting skills, and are fully parent-mediated, but do not address emotional problems that children with behavior problems related to trauma may have (Woody et. al., a2015). In contrast, TF-CBT addresses both trauma-related emotional and behavior problems (Cohen, Berliner, and Mannarino, 2010, p. 216), and TC-CBT specifically is empirically supported and has been proven to be effective in working with children displaying serious symptoms related to child trauma (Woody et. al., 2015).

Over the past decade, many researchers have explored the efficacy of TF-CBT when working with children and adolescents. A systematic review published by Cary and McMillen (2012) compares the use of TF-CBT with youth, along with other models that include four or five of the TF-CBT components, and ultimately suggests "that TF-CBT is more effective than attention control, standard community care, and waitlist control. ... Therefore, enthusiasm for this intervention appears to be justified" (p. 756). In a meta-analysis of psychosocial treatments for children and adolescents exposed to traumatic events, Silverman et. al. (2008) report TF-CBT

was the only treatment meeting the “well-established criteria” threshold. Furthermore, Allen and Johnson (2012) cite numerous trials that suggest TF-CBT has greater efficacy than nondirective approaches for reducing posttraumatic stress, anxiety, depression, and sexual behavior problems, particularly for sexually abused children (p.80), and state their own research has shown “maintenance of treatment gains for up to 2 years after treatment completion” (p. 80).

The implementation of evidence-based practices, such as TF-CBT, has been a primary focus in the child maltreatment field over the past 10 years, and organizations are taking notice. The National Children’s Alliance’s (NCA), for example, revised standards in 2008 for accrediting children’s advocacy centers (CACs) to require they “integrate evidence-based practices into mental health services” (National Children’s Alliance [NCA], 2008). Additionally the National Child Traumatic Stress Network (NCTSN), in collaboration with the NCA, “developed a handbook of information regarding evidence-based practices specifically designed for directors of CACs to encourage dissemination and implementation efforts” (Child Welfare Committee, NCTSN & NCA, 2008).

Various efforts have been employed to disseminate TF-CBT research and training, including “a free online training program (TF-CBTWeb, accessible at www.musc.edu/tfcbt), numerous conference presentations worldwide, state collaborations, and intensive learning collaborative methodologies that utilize multiple in-person trainings and ongoing consultation and supervision” (Cohen & Mannarino, 2008). In 2012 a “TF-CBT learning collaborative only enrolling clinicians from CACs was commenced with the cooperation and collaboration of the Southern Regional CAC, which is responsible for the oversight of CACs in 16 states and the District of Columbia” (Allen and Johnson, 2012, p.81), and in response to these efforts, TF-CBT

is likely the most widely disseminated evidence-based practice for the treatment of symptoms resulting from child trauma (Allen and Johnson, 2012).

Methods

Multiple databases have been examined to review past research regarding the use of TF-CBT as an evidence based practice, and will be presented in the following pages through a systematic review. Petticrew (2005) describes a systematic review as 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” (p. 2). Sometimes mistaken for simply a large literature review, a systemic review is different in that it serves to answer a specific question (as opposed to a literature review that is “comprehensive” based) that will assist researchers in reducing bias, assessing the quality of past studies, and summarizing past studies objectively (Petticrew, 2005).

The review process begins with determining whether or not it is actually needed, and if so, assessing if the resources to complete the review are available. Completing a systemic review requires a significant investment of time, energy, information, and funds for articles and books, all of which are to be balanced with the overall need for the review to be completed. Who will use the results, and for what? Why is the review needed? (Petticrew, 2005). If it is determined to be a need that is worthy of the work, it will require to complete the review. Then, the researcher can start the process of designing the question, forming an advisory group, writing the protocol and submitting it for review, conducting the literature search, screening references, assessing studies against the inclusion/exclusion criteria, data extraction, appraisal of results, synthesis of primary studies, examining bias, and finally, writing the report (Petticrew, 2005).

Search strategy

The research design presented will be a systematic review of prior research focusing specifically on the use of Trauma-Focused Cognitive Behavior Therapy in treating Posttraumatic Stress Disorder in children and adolescents. The purpose of this review is to examine the efficacy of TF-CBT in treating PTSD symptoms in children and adolescents, taking into account various traumatic experiences, treatment settings, and ages.

Criteria of Inclusion

For the systematic review, the following databases will be used: SocINDEX, Child Development and Adolescent Studies, Social Work Abstracts, Family Studies Abstracts, and Sciencedirect.com. The research articles found on these databases will be reviewed, and data will be extracted and synthesized. Strengths and weaknesses of the research will be discussed in the discussion section. Inclusion criteria for this systematic review includes research from 2010 – 2015, reported in English. With over 2000+ hits following a search of TF-CBT, the terms “PTSD”, “child”, “adolescent”, and “youth” were added. In order to be considered as useful for this review, the research must provide discussion on the use of TF-CBT specifically, regardless of whether or not this is compared to other treatment modalities.

Criteria of Exclusion

Criteria of exclusion included any research prior to 2010, and research that used TF-CBT in treating PTSS (Posttraumatic Stress Symptoms, not a diagnosis) as opposed to PTSD. Research involving adolescents over the age of 17 was also excluded, in addition to research regarding very specific trauma history (i.e. child soldiers), and alternative forms of TF-CBT (i.e. stepped-care TF-CBT). Journal articles that required purchasing and that were not published in English were excluded as well.

Data Abstraction

Upon completion of the initial search of existing literature and determining which studies met inclusion and exclusion criteria, the remaining articles were reviewed in a thorough, methodological process consisting of comprehensive examination of the research sample, design, outcomes, and limitations. Initially 10 studies met inclusion criteria; however, upon further review of the text, two were excluded for studies involving research that was conducted pre 2010 and published at a later date, and another was excluded for being a systematic review itself. This information is concisely summarized and presented in a table to be later included in findings section of this review.

Table 2
Search Strategy

DATABASES SEARCHED: SocINDEX, Child Development and Adolescent Studies, Social Work Abstracts, Family Studies Abstracts, and Sciencedirect.com

INITIAL SEARCH TERM: TF-CBT.

2000+ARTICLES

CRITERIA OF INCLUSION ADDED: published between 2005 - 2015 written in English language, "PTSD", "child", "adolescent", and "youth".

200+ ARTICLES

CRITERIA OF EXCLUSION ADDED: research prior to 2010, treatment of PTSS (Posttraumatic stress symptoms, not an official PTSD diagnosis), participants over the age of 17, "child soldiers", "refugee", "war", "stepped-care TF-CBT", journals requiring purchase.

20 ARTICLES

**REVIEW FULL TEXT TO FURTHER ASSES
INCLUSION/EXCLUSION CRITERIA:**

Findings

The goal of this systemic review was to examine current literature exploring the effectiveness in using Trauma-Focused Cognitive Behavior Therapy in treating Posttraumatic Stress Disorder in children and adolescents ages 4 – 17. Seven articles met inclusion criteria and were examined for the purpose of this systematic review. Common themes identified throughout the examined research include research participants receiving services through community health clinics/organizations, comparison studies to other interventions, long term nature of the research, and the expectation that some clients will discontinue services for various reasons. Table 3 outlines the examined studies in further detail.

Table 3*Study Comparison*

Article	Participants	Design	Data Analysis	Results	Limitations
Engaging Foster Parents in Treatment: A Randomized Trial of Supplementing TF-CBT with Evidence-Based Engagement Strategies. Dorsey, et. al. (2014).	47 children and adolescents between the ages of 6-15 in foster care, and one of their foster parents.	Small scale Randomized, controlled trial of TF-CBT standard delivery compared to TF-CBT plus evidence based strategies.	Attendance, engagement, and clinical outcomes assessed at 1 month of treatment, end of treatment, and 3 months post treatment. Data came from foster parents, children and adolescents, and clinicians via in-person and telephone interviews, and web-based surveys	Children who received at least four sessions of TF-CBT had significant decreases in emotional and behavioral symptoms and increased strengths.	Obtaining referrals from child welfare for this therapy was challenging; small sample size; children were screened by research team prior to contact with TF-CBT clinician which could have impacted attendance of first session; improvements may reflect change over time.
A Randomized Trial of Cognitive behavior Therapy and Cognitive Therapy for Children with Posttraumatic Stress Disorder Following Single	34 children and youth ages 7-17 years old, who had been victim to single incident trauma and met criteria for PTSD, and whose families self-referred from	Randomized, control trial of either TF-CBT or CT administered individually to children and their parents. Participants received 9 one and	ANOVAs were used as the primary method of determining symptom change. Last observation carried forward (LOCF) was used for missing data.	Out of the original sample, 5 never returned for the first session, and 10 received partial therapy. 18 completed all therapy sessions. At posttreatment, 65%	Exclusions criteria included exposure to chronic trauma, a traumatic brain injury resulting from the trauma, developmental delay, sexual abuse history, and

<p>Incident Trauma. Nixon, Sterk, and Pearce (2011).</p>	<p>mental health centers, hospitals, and police.</p>	<p>a half hour sessions provided individually on a weekly basis.</p>		<p>of TF-CBT and 56% of the CT group no longer met criteria for PTSD, and gains were maintained at a 6 month follow up. PTSD secondary to single-incident trauma can be successfully treated with trauma-focused cognitive behavioral methods. TF-CBT and CT were successful, with the mothers' own symptoms of PTDS and depression improving significantly as well.</p>	<p>inadequate comprehension-n of English. The waitlist control group was never used, but there is evidence that some natural remission of PTSD Symptoms in children can occur. Small sample size.</p>
<p>Article</p>	<p>Participants</p>	<p>Design</p>	<p>Data Analysis</p>	<p>Results</p>	<p>Limitations</p>
<p>Trauma-Focused Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder in 3-6 Year Old Children: A</p>	<p>64 children (mean age 5 years) were randomly assigned to either a 12 session manualized TF-CBT, or a 12 week wait list. The majority of the</p>	<p>Randomized trial. Participants were recruited for three types of trauma exposures: acute single blow trauma, chronic repeated events, and</p>	<p>-Preschool Age Psychiatric Assessment (PAPA) -Adverse Events Checklist (AEC) - Treatment Fidelity Checklist (TFC)</p>	<p>The intervention group improved significantly on more symptoms of PTSD, but not on depression, separation anxiety, oppositional</p>	<p>- Attrition was unusually high in this study. - study was conducted in a very young population that was mostly minority and single</p>

<p>Randomized Clinical Trial. Scheeringa, Weems, Cohen, Amaya-Jackson, and Buthrie (2011).</p>	<p>children were minority race (African American) and without a biological father in the home. Inclusion criteria included experiencing a life threatening traumatic event between 36-83 months of age, and currently exhibiting 4 or more PTSD Sx.</p>	<p>survivors of hurricane Katrina. Therapists followed highly structured 12 session protocol.</p>	<p>-Adaptability Checklist Child (ACC).</p>	<p>defiant, or ADHD disorders. TF-CBT is feasible and more effective than a wait list condition for PTSD symptoms, and the effects appear lasting. - PTSD did not improve with the Passage Of time in the WL group in the randomized design</p>	<p>parent, and few prior efficacy studies have been conducted in this population with which to compare. - small size of the samples and the attrition of the six-month follow-up.</p>
<p>TF-CBT for Youth with Complex Trauma. Cohen, Mannarino, Kliethermes, & Murray (2012).</p>	<p>TF-CBT provided to 30 youth with complex trauma. -Case study: 13 year old female with chronic trauma (sexual abuse, domestic violence, multiple foster placements) -Case Study: 14 year old male with chronic trauma (severe neglect, domestic violence, traumatic death of grandmother,</p>	<p>Practical strategies to incorporate into TF-CBT practices to successfully treat youth with complex trauma: dedicating more of the model to the TF-CBT coping skills phase; implementing the safety component early and often; extending closure phase to include traumatic grief.</p>	<p>Outcomes assessed using Child and Adolescent Needs and Strengths (CANS) and UCLA PTSD Reaction Index, comparing TF-CBT to Systems of Care (SOC). (SOC is the common form of treatment for youth in foster care).</p>	<p>Compared to Systems of Care (SOC) treatment as usual, TF-CBT led to significantly greater improvement in emotional and behavioral problems and PTSD symptoms, as well as ranking superior in preventing placement disruption and running away.</p>	<p>Only two specific cases were discussed concerning how the TF-CBT process was helpful. Authors did not discuss many limitation to their study. Focused on a specific style of TF-CBT, a slight change to the model.</p>

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TF-CBT v. Other Intervention

Nixon and Sterk compared two groups of children ages 7-17 who were all victims of single-incident trauma and whose families were self-referred from mental health centers, hospitals, and police. Half of the children were provided with TF-CBT, and half of the children were provided with Cognitive Therapy (CT), eliminating the exposure component from all sessions. At the start of the study, all 34 of the children met diagnostic criteria for PTSD and “were comparable in terms of demographic and trauma characteristics and symptom severity, with the exception that the TF-CBT group reported significantly higher pretreatment general anxiety” (Nixon and Sterk, 2012, p. 331). Post treatment, 65% of the children who received TF-CBT and 55% of the children who received CT no longer met criteria for full or subthreshold PTSD (Nixon and Sterk, 2012, p. 331); and at a 6-month follow up, 91% of the children who received TF-CBT and 90% the children who received CT and had completed treatment no longer met criteria for PTSD (Nixon and Sterk, 2012, p. 331).

Scheeringa et al. (2011) compared a group of 3-6 year old children receiving TF-CBT, all of whom had experienced a life threatening traumatic event and were positive for display of four or more PTSD symptoms, with another group of children who met the same criteria, but were on a wait list for services. End results indicated that TF-CBT was more effective in reducing PTSD symptoms than the same amount of time on a waiting list (used to control the passage of time), in relation to symptoms decreasing (Scheeringa et al., 2011) Overtime, the children in the “wait list group showed no significant decrease in symptoms at all” (Scheeringa et al., 2011, p. 858).

Finally, Cohen, Mannarino, Kliethermes, and Murray (2012) compared TF-CBT to Systems of Care (SOC) treatment as usual for youth in foster care with complex trauma (associated with attachment, affect and behavior regulation, dissociation, cognition) and found

“TF-CBT led to significantly greater improvements in emotional and behavioral problems and PTSD symptoms, and it was significantly superior in preventing placement disruptions and running away” (p. 540). The use of TF-CBT in this study in replacement of SOC treatment was further proved successful through quantitative data on the UCLA PTSD Reaction index yielding drops in scores from 52 to 21 (Cohen, Mannarino, Kliethermes, and Murray, 2012, p. 540).

Engagement Intervention

In each study reviewed, a common theme was participants discontinuing services for various reasons (i.e. Hurricane Katrina derailed participants in one study, and in another the length of treatment seemed to be a barrier). Dorsey et al. (2014) addressed this concern for premature treatment exit by engaging study participants in an engagement intervention before the first appointment. The purpose of the engagement interventions was to involve participants in a 15 min phone call discussing perceptual barriers, prior negative experiences with mental health treatment, lack of confidence in treatment effectiveness, and the foster parent or caregivers primary concern for the child and how that might contrast the original reason for the referral to services (Dorsey et al, 2014). Implementing this “brief engagement interaction made a significant difference in improving treatment retention and completion for children and their foster parents” (Dorsey et al., 2014, p. 1517), with results demonstrating that “those who received the engagement intervention were significantly more likely to receive an active dose of TF-CBT (i.e. attend 4 or more sessions) and were less likely to have a premature treatment exit” (Dorsey et al., 2014, p. 1517). While this engagement intervention did serve its purpose to decrease premature exit from treatment, they authors do note that this intervention did not relate to treatment effectiveness, impact the therapeutic relationship, contribute to satisfaction with

treatment, or prevent the biggest engagement challenge for these study participants: placement disruption in foster care.

Outcome Influences

Similar to how Dorsey et al. (2014) identified placement disruption as an outcome influence when using TF-CBT with children and adolescents, the other studies analyzed in this review cited outcome influences as well. Cohen, Mannarino, Kliethermes, and Murray (2012), for example, reported the necessity of having an adult who will attend regularly with child. Unfortunately, this is not always possible in studies where the child or adolescent is living in foster care and is assigned to a new placement in the middle of treatment. In these cases, outcomes are generally unknown due to losing the ability to contact the child or adolescent, or the foster parent choosing not to engage in the caregiver portion of the TF-CBT model. If however, the foster parent is willing and able to engage in several TF-CBT conjoint sessions and the youth is able to share “their narrative directly with the caregiver, they can communicate about the trauma experiences and the youth gains confidence that the caregiver will respond supportively to communication like this in the future” (p. 538). This not only helps foster a healthy attachment between the foster parent and the child or adolescent, but it also paves the road for future success in the management of the PTSD symptoms when the child or adolescent believes they have been heard and understood.

Another outcome influence identified by Nixon, Sterk, and Pearce (2011) is the contributing factor of maternal depression. One of their research hypotheses speculated that higher levels of depression in the caregiver of the child or adolescent would restrict their ability to support child or adolescent through therapy, resulting in potentially reduced engagement or inability to assist the children in applying techniques taught in therapy. This research also

described the possibility that “children of mothers with higher levels of depression may be vulnerable to developing PTSD that is somewhat resistant to treatment...highlighting the impact of maternal adjustment on children’s ability to gain benefit from therapy” (Nixon, Sterk, and Pearce, 2011 p. 333). Through this study, Nixon, Sterk, and Pearce determined “maternal posttraumatic stress did not moderate children’s outcomes at any assessment point, however maternal pretreatment levels of depression and unhelpful trauma beliefs did” (p. 333).

In addition to placement disruption and maternal depression, Scheeringa et al. (2011) found the age of children and their ability to engage in the TF-CBT curriculum as a predictor of treatment outcomes. Already discussing attrition being unusually high in their study with the loss of 6 participants due to Hurricane Katrina, Scheeringa et al. (2011) reported attrition may be higher with young children due to less extreme externalizing behaviors and less verbalized internalized behaviors in comparison to adolescents, leading parents to feel less motivated to return for future appointments. Their research also brought to attention the initial difficulty displayed by 3-4 year old children with the narrative portion of TF-CBT (i.e., understanding PTSD, verbal discussion of feelings, identifying aspects of trauma), yet the authors describe the use of visual aids and drawings as being helpful with this (Scheeringa et al., 2011).

Throughout the review of the studies, other authors took time to mention unhelpful beliefs about therapy due to past negative experiences, and the TF-CBT clinician being a trainee versus as seasoned therapist, as influencing factors for TF-CBT outcomes and overall reduction in PTSD symptoms.

Avoidance and Sharing Trauma Experiences

In addition to the environmental factors that were discovered to influence the outcome of treatment (i.e. mother’s mental health status, foster care placement, natural disasters, feelings

regarding therapy services, clinician experience) Dittman and Jensen (2014) discussed their experience working with 11-17 year old adolescents who had experienced a single incident trauma, and how sharing their trauma story proved to be a barrier many of the adolescents had to overcome. For the majority of the youth receiving care, their traumatic experiences (e.g., sexual abuse) resulted in feelings of shame that made it difficult for the youth to discuss their trauma. Some of the youth were reluctant to share experiences due to still living with the parent who was the victim in a domestic violence situation, and were therefore fearful that discussing their experience of the trauma could cause additional hurt to their parent. Other youth harbored self-blame for their trauma, feeling responsible for what happened and anxious about talking about their trauma history with a person they did not know.

“Many traumatized youths have experienced a breach in their core conception of adults as trustworthy and capable of protecting them from harm” (Dittmann and Jensen, 2014, p. 1228) explain, stating “they may be more sensitive in areas related to trust and alliance than are other young people seeking help.” (Dittmann and Jensen, 2014, p. 1228). For most youth in their study, the TF-CBT protocol that emphasizes the importance of providing continuing psycho-education regarding symptoms, the normalization of reactions, and the rationale behind the interventions, diminished their reluctance and opened them up to willingness to engage in the treatment process (Dittmann and Jensen, 2014). The continued explanation of the what, why, and how behind what the clinician was doing served to strengthen the therapeutic alliance. Dittmann and Jensen (2014) describe their methodology: “Particularly, it seems that explaining to youth why it is important to talk about the traumatic incident and how this can lead to symptom reduction can motivate them to endure discomfort during the exposure process” (p. 1228). In the

end, the avoidance of the youth could be managed by understanding their need for control and autonomy, while successfully balancing encouraging the youth to talk without pressure.

As well as experiencing avoidance in sharing trauma experience from the youth who are receiving care, Puccia et al. (2012) noted the parents of children who have witnessed domestic violence also struggle with sharing their trauma experience due to guilt regarding the violence. “As a result, the parenting skill offered with TF-CBT seem to be more difficult for them to implement because they involve setting limits, being consistent with consequences, and actively ignoring unwanted behavior” (Puccia et al., 2012, p. 124). The guilt and shame over the history of violence, and fear of adding additional conflict to their relationship creates negative feelings about setting limits, leading the parent to avoid the crucial part of therapy that involves implementing safe limits within the home. This avoidance is something that can be worked through with continued psycho-education and normalizing of feelings, just as one would do with adolescents.

Reduction in PTSD Symptoms

Despite the many outcome influences that can reduce the effectiveness of the TF-CBT intervention, Murray, Cohen, and Mannarino (2013) report children who experience domestic violence, and who completed at least 4 sessions of TF-CBT, displayed significant decrease in PTSD symptoms. An interesting component of this study is that Murray, Cohen, and Mannarino (2013) were reviewed the impact of TF-CBT on children who were living in environments with ongoing trauma and domestic violence while receiving services through the Children Recovery after Family Trauma Project (CRAFT) that took place in a women’s shelter in Pittsburgh or the California Institute of Mental Health (CIMH). Both of these programs rolled out pilot programs using TF-CBT curriculum and trainers that consult with the organizations working with families

living with domestic violence, the threat of domestic violence, or continuous trauma (e.g. gang activity, street violence). Through their reported discussions with supervisors, counselors and TF-CBT trainers, the authors learned TF-CBT “has been demonstrated to be effective across multiple sites” (Murray, Cohen, Mannarino, 2013, p.181), leading to significant improvement in both PTSD and anxiety symptoms compared to other previously used child-centered approaches.

Puccia et al (2012) corroborate this data, reporting measurements from the Post Traumatic Stress Disorder Reaction Index (PTSD-RI) and the Trauma Symptom Checklist for Children alternate version (TSCC-A) confirm 100% of clients exposed to domestic violence show improvement in assessment scores for overall post-traumatic stress following TF-CBT treatment (p. 125).

Integrating TF-CBT into Practice

Sabalaukas, Ortolani, and McCall (2014) describe the implementation of TF-CBT as a strength-based practice in a child welfare agency in Boston, MA. The authors discuss the benefits and challenges of this agency wide change, as well as the evaluation of the practice model and client outcomes. Two years after the implementation of TF-CBT training, staff members provided feedback in a 12 item survey. In regards to obstacles that prevented the use of TF-CBT, staff members noted using TF-CBT techniques with children who have developmental challenges and children who were young, due to the cognitive nature and structure of the intervention. Other staff felt they did not receive adequate training and TF-CBT based consultation. Additional concerns included disbelief that TF-CBT would have a positive impact on practice due to having to follow a particular model as opposed to preferred alternative clinical interventions (130), concerns about how TF-CBT would fit within family therapy, and how the intervention would work with different subsets of clients.

Discussion

The purpose of this systematic review was to examine current literature on TF-CBT and its effectiveness in the treatment of PTSD when working with children and adolescents. Seven studies were reviewed with results indicating TF-CBT is in fact a child-centered, strengths-based manualized treatment approach (Cohen, Mannarino, & Deblinger, 2006) that is being utilized in outpatient mental health clinics and other community based organizations throughout the country. A comprehensive review of the research provides evidence to support the notion that TF-CBT “affords clinicians some flexibility in treatment planning, especially for children or parents who have concerns or are unwilling to engage in exposure methods requiring children to retrieve and engage in memories of their trauma” (Nixon, Sterk, and Pearce, 2011, p. 9).

Results of this review also suggest that like other evidence based practices, TF-CBT is vulnerable to outside factors and environmental influences the client is exposed to. Chronic trauma that is continuing in the home environment (i.e. domestic violence) can be successfully treated with TF-CBT, however the Cognitive Coping and Processing, and Trauma Narrative skills may present as points of resistance due to the child or adolescent not wanting to make the parent-victim feel worse for what has or is still occurring. Likewise, when a child or adolescent, and therefore their parent, are still living in a traumatic environment, or experience another single-incident trauma while receiving treatment (such as some study participants who were unable to finish due to hurricane Katrina), this can significantly slow the treatment process, or end it prematurely. These same parents might also have difficulty engaging in the caregiver portion of the TF-CBT process if they have not yet received care for their own trauma history, making TF-CBT sometimes difficult to implement in an in-home family therapy setting.

Despite this, every study participant who completed the TF-CBT treatment protocol, despite the setting or modifications to the plan to best fit client needs, did in fact present at their exit interview and follow up interviews with symptoms that were reduced to the point of no longer meeting PTSD diagnosis criteria. Furthermore, in studies where a wait list was used as a control group, researchers were able to prove the decrease in PTSD symptoms was due to TF-CBT treatment, and not to the natural propensity for symptoms to decrease over time, because the children and adolescents in the control group did not display any significant decrease in symptoms.

Limitations

The authors reviewed were forthcoming in sharing the limitations of the use of TF-CBT in social work practice, providing the framework for future discussion and research studies. Dorsey et al. (2014) noted it was challenging obtaining referrals to TF-CBT, even though the treatment was fully supported by Medicaid, a good fit for the population (i.e., given the high rates of trauma exposure), and available in geographically disparate locations. In addition, despite offers to assist in linking potential referrals to TF-CBT, there was little caseworker follow up from child welfare social workers who have a wide-ranging span of job duties, of which addressing child mental health needs is only one (Dorsey et al., 2014).

There appears to be clear leaders in the area of TF-CBT who publish the majority of research, thus in turn limiting the diversity of opinions and research designs to be reviewed, however, this is not a limitation that is significant enough to prevent a review as there are other authors examining TF-CBT as well. The research is limited by no two studies reviewed being the same, and it would be helpful to see the same study model conducted with the same population

to see if it works consistently, what changes need to be made to the model, and also identify the most beneficial parts of the model.

Limitations to the study include the refusal to participate, narrowing the participants in any given study, and high attrition rates. Two families that were referred to TF-CBT treatment and assessed by Nixon, Sterk, and Pearce, (2012), refused participation due to hesitancy to engage “in exposure methods requiring children to retrieve and engage in memories of their trauma...highlighting the impact of maternal adjustment on children’s ability to gain benefit from therapy” (p. 336). This provides insight into how impactful maternal depression and unhelpful thinking are on the children’s therapy process, serving as a significant limitation to victims of childhood trauma receiving necessary treatment, and therefore the ability to compare the effectiveness of TF-CBT is compromised when maternal depression is not taken into account.

Additional areas of limitation include the long nature of the research and the ethical considerations that need to be considered when placing some research participants on a wait list in order to compare the reduction of symptoms over time. Scheeringa, Weems, Cohen, Amaya-Jackson, and Guthrie (2011) compared a wait list participants to active treatment participants, and found the children and adolescents in the wait list group showed no decrease in symptoms over time, causing concern for the use of wait list control groups in regards to ethical and professional considerations.

Implications for Social Work Practice

An area of emphasis in the TF-CBT research is with youth in foster care or temporary housing, due to the need for caregiver participation in this model. Many youth in foster care receive non-specific, long-term therapy in which caregivers are not involved, making community

collaborators crucial (police officers, schools, domestic violence shelters, hospitals, mental health providers, integrated referral systems) for the TF-CBT model to be most effective (Puccia et al., 2012). Macro level development of a system wide referral protocol needs to be in place if community organizations and TF-CBT practicing clinicians hope to provide treatment to children and adolescents as soon as possible following trauma exposure.

Along with creating a system of care that allows community providers to recognize the need for TF-CBT and refer for care, the organizations and clinicians providing care need to evaluate practical strategies needed to tailor the detailed TF-CBT curriculum to family needs. As previously mentioned, adaptable interventions for use with children and/or parents with developmental delays, how to best utilize interventions in programs focused on case management, how to implement in TF-CBT in a family treatment model, and how to use TF-CBT at the time of trauma (by social workers, first responders, hospital staff, educators) along with crisis management and de-escalation techniques (Sabalauskas, et al, 2014), are all necessary for future practice. This might take place through

extending the TF-CBT coping skills phase to address the needs of complex trauma; including overarching trauma themes throughout TF-CBT treatment; progressing to the trauma narrative and processing phase even when absolute stability has not yet been attained; and as indicated, allowing for a somewhat longer treatment consolidation and closure phase that includes TF-CBT traumatic grief components (Cohen, et al, 2012, p. 540).

Likewise, providing a longer coping skills phase including appropriate gradual exposure, combined with emphasis on relevant unifying themes, and allowing for an adequate treatment closure phase, are shared by Cohen, Mannarino, Kliethermes, and Murray (2012) to enhance

ongoing trust and safety. Cohen, a leading researcher in the use of TF-CBT emphasizes how TF-CBT implementation can be conceptualized in the Cohen, Mannarino, Kliethermes, and Murray, (2012) research focusing on youth with complex trauma. Their research reiterates the importance of remaining attentive to the needs of youth presenting with complex trauma history by using a phase based approach that maintains the structure of TF-CBT, but allows for additional time to work in the coping skills phase, include overarching themes throughout treatment, progress to the trauma narrative even if stability has not yet been achieved, and allow for a longer closure phase.

In a paper addressing the practical strategies for applying TF-CBT for youth with ongoing traumas, Cohen, Mannarino, and Murray (2011) share three strategies for utilizing the TF-CBT. First, they describe focusing early and as needed, on an ongoing basis, to identify priorities and safety planning, with the goal of enhancing safety for the youth and the non-offending parent, that is appropriate to the youth's developmental, emotional, and situational context (Cohen, Mannarino, and Murray, 2011). Second, clinicians must enhance parental engagement strategies for parents who are experiencing ongoing personal trauma exposure, through validating and psychoeducation, acknowledging the parents desire to protect their children along with their fear of leaving the situation (Cohen, Mannarino, and Murray, 2011). Third, by focusing the trauma narration and processing on enhancing parental acknowledgement and support of the child's ongoing trauma experiences while addressing maladaptive cognitions about these experiences, this can help prepare the parent to directly support the youth in dealing with past, present, and future traumas (Cohen, Mannarino, and Murray, 2011). Desensitizing the youth to their feared memories of past trauma, and desensitizing the parents to the discussion of

the past trauma, can create mastery in no longer experiencing a phobic avoidance to the traumatic memories (Cohen, Mannarino, and Murray, 2011).

Implications for Research

One future area of emphasis for research could include the use of TF-CBT when working within family systems, perhaps for use by clinicians who conduct in-home therapy services where there is multigenerational or transgenerational trauma. The current TF-CBT model emphasizes the importance of caregiver involvement, and future research into the effectiveness of this model when used with a family system, instead of an individual, could provide the information needed in order to implement TF-CBT in in-home family services. Family-focused CBT is an evidence based practice that has proven successful for the treatment of manifestations of anxiety (e.g. obsessive–compulsive disorder) resulting from a families inability to process difficult life circumstances (Dickens, 2014). Specifically, when considering using TF-CBT for work with families who are navigating complicated traumatic grief following a death in the family, future research in this area “seems like a natural next step in promoting awareness of these conditions for parents, school counselors, medical professionals, and psychotherapists” (Dickens, 2014, p. 125).

Also beneficial for future research would be an examination of how this intervention can be useful with young children ages 3-6, or children with developmental delays. Previous studies show “3 and 4 year old children initially had difficulty with tasks that required narratives” (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011, p. 860), therefore “attrition may be higher with younger children because their externalizing behaviors are relatively less extreme and their internalizing behaviors are relatively less verbalized, so their parents may feel less motivated to return for appointments” (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie,

2011, p. 860). When considering using the TF-CBT model with children who have developmental delays this same concern for the termination of services exists, unless future research can determine how to tailor this model to the needs of the developmentally delayed children, or even their developmentally delayed parent, in a way that is more conducive to their learning style and abilities.

Regarding attrition rates in general, future research could build the specific challenges of working with a trauma-focused intervention, and the best means of dealing with these challenges (Dittmann and Jensen, 2014). Learning more from youth and parents who choose to drop-out of treatment can provide valuable information on how to tailor treatment interventions” (Dittmann and Jensen, 2014), with more focused questions regarding the different phases of TF-CBT and how to overcome specific challenges. Interviews throughout the course of treatment instead of at the end, aiming to evaluate treatment satisfaction, severity of symptoms, readiness to move on to the next step, and outside factors influencing treatment, may provide insight into how this concrete model can be more flexible when working around various barriers. Scheeringa, Weems, Cohen, Amaya-Jackson, and Guthrie (2011) question how to better work with young, single, minority parents of children receiving TF-CBT. What if they received the treatment first, then the kids. Could the outcome be different? Are young parents ready to engage in such a program, and if not, is this model the best fit for the children?

Conclusion

As demonstrated through this review and the examined past clinical research regarding TF-CBT, there is evidence to support the use of this intervention in the treatment of PTSD with children and adolescents. Not included however were the many studies examining the use of TF-CBT with children from war torn countries, and child victims of sex trafficking and slavery, two

sub-subgroups in which TF-CBT has been regarded as highly effective in the treatment of PTSD and continued ongoing trauma symptoms. As continued research about the prevalence and pathology of PTSD in children emerges, and with integration of TF-CBT into practice by more child and adolescent therapists, this model can continue to grow and develop into a widely used, evidence based practice, trusted by clinicians and regarded as useful for work with individuals and families.

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