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Parents' and children's perception of parent-led Trauma-Focused Cognitive Behavioral Therapy☆

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ABSTRACT

This study explored parent and child experiences of a parent-led, therapist-assisted treatment during Step One of Stepped Care Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Seventeen parents/guardians and 16 children who were between the ages of 8 and 12 years were interviewed after Step One and six weeks after the completion of a maintenance phase about their perceptions of the parent-led, therapist-assisted treatment. Participants were asked what they liked and disliked about the treatment as well as what they found to be most and least helpful. Generally, parents and children liked the treatment and found it helpful. In terms of treatment components, children indicated that the relaxation exercises were the most liked/helpful component (62.5%) followed by trauma narrative activities (56.3%). A few children (18.8%) did not like or found least helpful the trauma narrative component as they wanted to avoid talking or thinking about the trauma. Parents indicated that the parent–child meetings were the most liked/helpful (82.4%) followed by the *Stepping Together* workbook (58.8%) and relaxation exercises (52.9%). Some parents (23.5%) noted that the workbook seemed too repetitive and some parents (17.6%) at times were uncertain if they were leading the parent–child meetings the best way. Parent-led, therapist-assisted TF-CBT may be an acceptable type of service delivery for both parents and children, although more research is needed.

Introduction

Approximately one in four children will experience a traumatic event such as domestic, community or school violence, child abuse and neglect, death of a loved one, accidents and/or disasters (Costello, Erkanli, Fairbank, & Angold, 2002). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an empirically based treatment (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Iyengar, 2011; Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012), addresses the child's symptoms and parent's concerns related to the trauma. There are three main treatment components of TF-CBT: (1) skill-building techniques for the child and parent, (2) trauma narrative (TN) (i.e., child describes and cognitively processes his/her trauma), and (3) treatment closure (e.g., conjoint parent–child sessions and safety plans) (Mannarino et al., 2012). Gradual

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exposure to trauma reminders for the child is included throughout the components of TF-CBT (Cohen & Mannarino, 2008a, 2008b). Research suggests that the skill-building techniques and the trauma narrative are important components and are considered effective ways to reduce child symptomology (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011).

While both skill-building techniques and developing a coherent trauma narrative are important (Deblinger et al., 2011), some therapists may be reluctant to help children develop trauma narratives. Studies have found that the trauma narrative component is frequently under-utilized by clinicians (Allen & Johnson, 2011; Becker, Zayfert, & Anderson, 2004; Sprang, Craig, & Clark, 2008). In a study on the use of TF-CBT components with 132 mental health clinicians within child advocacy centers, Allen and Johnson (2011) found that the implementation of TN is one of the least used techniques along with behavioral child management skills and cognitive restructuring. The most frequently implemented techniques were relaxation/coping skills and pyschoeducation, which are both part of the TF-CBT skill-building component. Similarly, in a sample of 217 mental health professionals (e.g., licensed psychologists and trauma specialists), Becker et al. (2004) found that the majority of the professionals did not use exposure-based techniques. While studies on therapists' use of exposure-based techniques and skill-building with traumatized children have been explored, research on parents' and children's perceptions of these components is limited.

During all of the TF-CBT components, parents/caregivers are actively included in the treatment for the child. Family and child involvement in mental health treatment holds an important role in the child's treatment and recovery (Bernardon & Pernice-Duca, 2010; McKay & Bannon, 2004). In fact, most recent forms of treatment involve education, support, and participation of family members (Bernardon & Pernice-Duca, 2010). Thus, when a parent or caregiver takes part in the child's trauma-focused treatment, the child's traumatic experience often becomes a shared event. During the conjoint child–parent sessions of TF-CBT, the child shares his/her trauma narrative directly with the parent allowing the parent and child to strengthen their ability to discuss additional parts of the child's traumatic experience (Cohen & Mannarino, 2008a, 2008b). Family members learn how to express empathy during the trauma narrative, promote healthy coping skills, and develop a form of positive support. Having a family member or caregiver involved can also lead the child to re-constructing his/her view of the parent as more of a "protective shield," seeing that the parent is able to withstand hearing the child's traumatic experience (Bernardon & Pernice-Duca, 2010).

While parents play an important role in the child's treatment, many treatment barriers still exist (Bringewatt & Gershoff, 2010; McKay & Bannon, 2004; Owens et al., 2002). For many parents, barriers to treatment may include lack of information about services available, when care should be sought, benefits to which their child is entitled, fear of the stigma linked with accessing care, and a distrust of systems (Bringewatt & Gershoff, 2010). Thurston and Phares (2008) found that the most frequently recognized barriers that parents reported for themselves and their child were "I would want to solve the problem or my child's problem on my own," "mental health services are not in my budget or my budget for my child," and "I would be scared about my child being put into a hospital against my will." These findings suggest that treatments are needed that decrease treatment barriers such as costs and increase parents' willingness to utilize mental health services (Thurston & Phares, 2008). Implementing treatments that address perceived barriers could also improve the family's involvement in early sessions (Saxe, Ellis, Fogler, & Navalta, 2012; Thurston & Phares, 2008).

Considering the prevalence of trauma, barriers to treatment, and the important role of parental involvement in the child's treatment, new service delivery approaches are needed. TF-CBT is a therapist-led treatment that requires the parent and child to attend weekly in-office visits for three or more months (Cohen, Mannarino, & Deblinger, 2006). In-office, therapist-led weekly treatments do not address common barriers. Stepped Care TF-CBT has been developed to improve the accessibility, efficiency, and cost of delivering treatment to children after trauma (Salloum, Scheeringa, Cohen, & Storch, 2014). Stepped Care TF-CBT consists of two steps. Step One is a parent-led, therapist-assisted treatment where the majority of the treatment occurs at-home with the parent leading the treatment, without the therapist present. There are three in-office therapist-directed sessions. Step One provides an alternative approach for parents who have difficulty with scheduling or keeping weekly office-based sessions. Stepped Care TF-CBT also addresses the parent's desire to solve the child's problem on his/her own as the parent leads the trauma-focused meetings with the child at home, and it is less costly than standard treatment. Step One includes all of the components of TF-CBT including an emphasis on trauma-focused exposures. Children needing more intensive care "step up" and receive Step Two, which consists of weekly TF-CBT in-office sessions with the therapist leading the treatment.

TF-CBT presents as an ideal basis for a stepped care model given its wide dissemination and training infrastructure (Cohen & Mannarino, 2008a, 2008b; Sigel et al., 2013). Using CBT throughout treatment steps, rather than using various practices that require different trainings and certifications, facilitates dissemination and uptake in community practice. However, there are other considerations regarding uptake of a treatment, such as feasibility, acceptability from the user's perspective, and effectiveness (Drake, 2014). The current study provides the initial steps to elucidating parents' and children's perceptions of the acceptability of a parent-led trauma-focused treatment. Findings from this study could be used to further adapt the treatment to be acceptable to parents and children. In terms of effectiveness of Stepped Care TF-CBT, preliminary data are encouraging (Salloum, Small, et al., 2014) and warrant additional research on the development and efficacy of the treatment. Results from a case study with a 4-year-old boy found improvements in posttraumatic stress symptoms and the parent reported high levels of treatment credibility and satisfaction (Salloum & Storch, 2011). Similarly, in a small pilot study with nine young children (ages 3–7 years) approximately 56–83% (intent-to-treat sample and completers, respectively) responded to Step One and most parents reported high levels of treatment satisfaction (Salloum, Robst, et al., 2014).