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The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth

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ABSTRACT

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is one of the most widely disseminated mental health interventions for children and youth. The purpose of this study is to systematically review the evidence of TF-CBT's ability to reduce symptoms of post-traumatic stress, depression and behavior problems in children and youth who have survived trauma. A search was conducted to locate studies that evaluated TF-CBT or interventions highly similar to TF-CBT. Ten studies (twelve articles) were selected for inclusion in three sets of meta-analyses. Findings were consistent amongst meta-analyses; pooled estimates were similar whether we were analyzing the effects of interventions that were highly similar to TF-CBT, or if we were exclusively analyzing the effects of the branded intervention. Results show that there is a significant difference between the TFCBT condition and comparison conditions in its ability to reduce symptoms of PTSD ($g = .671$), depression ($g = .378$) and behavior problems ($g = .247$) immediately after treatment completion. This difference held for PTSD at twelve months after treatment completion (.389) but did not hold for depression or behavior problems. There was not a significant difference between the TF-CBT condition and alternative active control conditions immediately after treatment completion. Therefore, TF-CBT is an effective intervention for the treatment of PTSD in youth.

1. Introduction

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is one of the most widely disseminated mental health interventions for children and youth (Cohen and Mannarino, 2008; Cohen, Mannarino, and Deblinger, 2006; Saunders, 2011; Saunders, Smith, and Best, 2010). Despite its popularity, a systematic review of its effects has not yet been published. Systematic reviews are unique in their ability to reveal the overall effects of interventions, pooling and analyzing the results of every trial in which an intervention has been evaluated while considering the quality of each of those trials. The purpose of this study is to systematically review the evidence of TF-CBT's ability to reduce symptoms of post-traumatic stress, depression and behavior problems in children and youth who have survived at least one traumatic event.

2. Background

2.1. What is TF-CBT?

While there are a number of trauma-focused interventions for children that employ cognitive treatment components, clinicians who work with traumatized children tend to be most familiar with the trauma-focused cognitive behavioral intervention developed by Cohen et al. (2006). We refer to this as the branded version of TF-CBT because it has been manualized and widely disseminated in this form. It is a highly structured, conjoint parent/child intervention, consisting of sequential 90-minute weekly sessions. A trained clinician moves the client through a series of 8 components, pacing the progression of the treatment with the client's clinical readiness. The components include: psychoeducation and parenting skills (P), relaxation (R), affective expression and regulation (A), cognitive coping (C), trauma narrative development and processing (T), in vivo gradual exposure (I), conjoint parent/child sessions (C) and enhancing safety/future development (E). Together these components comprise the P.R.A.C.T.I.C.E. acronym.

This branded version has been actively disseminated. In addition to the hardback treatment manual published by Guilford (2006), there is a web-based training program maintained by the Medical University of South Carolina (TF-CBT.musc.edu) that, as of May 2011, had 90,970 registered users (Saunders, 2011), including clinicians from more than 111 countries (Saunders et al., 2010). The treatment developers have maintained an active training schedule for a number of years, supplemented by a cadre of sanctioned train-the-trainer clinicians and learning collaboratives (Cohen and Mannarino, 2008). Much of this work has been promoted and funded through the National Child Traumatic Stress Network (NCTSN), a program established by Congress in 2000 in the interest of linking traumatized

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children and their families with effective resources including evidence-based interventions.

This branded version of TF-CBT has a substantial history, as it is a combination of and expansion upon earlier trauma-focused interventions developed by the Cohen/Mannarino and Deblinger teams to treat child sexual abuse survivors (Cohen and Mannarino, 1993, 1996a, 1996b, 1998, 2000; Cohen, Mannarino, and Staron, 2005; Deblinger and Heflin, 1996; Deblinger, McLeer, and Henry, 1990; Deblinger, Stauffer, and Steer, 2001; Stauffer and Deblinger, 1996). The prior interventions used by the Cohen/Mannarino team went by a variety of names (Structured Parent Counseling–Child Psychotherapy (SPC–CP), Cognitive-Behavioral Therapy adapted for Sexually Abused Pre-school children (CBT-SAP) and Sexual Abuse-Specific Cognitive Behavioral Therapy (SAS-CBT)), but all of the earlier forms of this intervention were cognitive-behavioral in nature. While differing slightly, they shared a focus on (1) exploring the impact of sexual abuse on the family, (2) developing a sense of self-efficacy in the survivor of sexual abuse and (3) encouraging an understanding of how the experience of abuse was carried out in subsequent behaviors and relationships (Cohen et al., 2006). Their 1993 study employing SCP–CP provided the earliest foundation for the intervention as it exists today (Cohen and Mannarino, 1993). Their next round of trials (Cohen and Mannarino, 1996a, 1996b, 1997) used the same intervention, but with a new name (SBT-SAP). These interventions were largely based on cognitive reframing and included both psychoeducation and caregiver participation. Cognitive reframing remained the central element of SAS-CBT, the intervention tested in their 1998 trial, but this version also included a stress management component. The intervention did not, at that stage, include structured formalized exposure, although the abuse was discussed; the later inclusion of this important component was largely a result of Deblinger's earlier work.

Deblinger's cognitive behavioral treatment manual (Deblinger and Heflin, 1996) was centered around gradual exposure techniques, including in vivo exposure to reminders of the trauma and writing exercises in which traumatized children were encouraged to describe the details of the trauma as well as associated feelings and thoughts. Deblinger also focused on the therapeutic role of the parent (Cohen et al., 2006). Cohen and Mannarino and Deblinger merged their approaches to treating traumatized youth in 1997; the manual for the branded TF-CBT was available on the internet for a number of years and was published in 2006 in book form.

While the branded version of TF-CBT is the most well known and widely disseminated, other child-focused trauma treatments employing many of the same intervention components are available to clinicians, have been actively disseminated (to varying degrees), and have been evaluated in clinical trials. The most similar of these interventions is the Cognitive Behavioral Intervention for Trauma in Schools (CBITS). This intervention shares nearly all treatment components with the branded version of TF-CBT, but rotates between a group and individual format in the school setting and does not consistently include a caregiver component (Stein et al., 2003; Jaycox et al., 2010). A number of other Cognitive Behavioral Treatments that have been adapted to meet the needs of traumatized children similarly share the majority of treatment components (Berger, Pat-Horenczyk, and Gelkopf, 2007; Celano, Hazzard, Webb, and McCall, 1996; Deblinger, Lippmann, and Steer, 1996; King et al., 2000; Smith et al., 2007).

2.2. Evaluation and dissemination

Despite the fact that there has been no published systematic review of the branded or other versions of TF-CBT for children and youth, there are a number of reasons to expect that these interventions are effective at reducing symptoms of post-traumatic stress, depression and behavior problems following trauma. Firstly, a 2007 Cochrane Collaboration systematic review of trauma-focused cognitive behavioral interventions for *adults* concluded that both group and individual trauma-focused cognitive behavioral interventions outperformed waitlist/community treatment conditions in reducing posttrauma symptoms, performed as well as eye-movement desensitization and reprocessing therapy (EMDR) and outperformed other non-EMDR treatments (Bisson & Andrew, 2009). Second, there have been a number of randomized trials of both the branded TF-CBT and other trauma focused cognitive interventions that have shown positive outcomes. The TF-CBT website maintained at the Medical University of South Carolina lists nine randomized trials with positive outcomes (http://tfcbt.musc.edu/resources.php?p=5) and 3 trials of other interventions similar to branded TF-CBT. The TF-CBT book cites five randomized controlled trials with positive outcomes (Cohen et al., 2006), all of which were included on the website.

A number of organizations have given the branded version of TF-CBT their highest endorsements. In their report sponsored by the U.S. Department of Justice, Saunders, Berliner, and Hanson (2002) reviewed the research on 24 interventions for child maltreatment. Only one, TF-CBT, received their highest classification rating, "well-supported, efficacious". The Kauffman Best Practices Project, conducted by the Kauffman Best Practices (2004), similarly gave TF-CBT the most rigorous classification of all the interventions they evaluated, considering it the "best practice" in the field of child abuse treatment. The California Evidence Based Clearinghouse for Child Welfare gave TF-CBT it's most rigorous ranking, a 1, asserting that it is "strongly supported by research evidence" (California Evidence-Based Clearinghouse for Child Welfare, 2011). The National Registry of Evidence-Based Programs and Practices (NREPP), a sector of the US Dept of Health and Human Services (SAMHSA), gave TF-CBT between a 3.6 and a 3.8 out of 4.0 possible points on its ability to effectively treat PTSD, depression and behavior problems and a 3.6 out of 4.0 on its quality of research rating (SAMHSA, 2008).

Systematic reviews provide a number of advantages over examining studies one at a time and over the results of organizational endorsements such as those named above, even when these endorsements are based on the results of randomized trials. First, systematic reviews include all of the eligible trials conducted to date in their analyses; some rating systems award high marks to an intervention if two randomized controlled trials have shown significantly positive effects, even if other studies or better studies showed null effects. Secondly, implicit in a systematic review is an assessment of the quality of the included research studies, weighing when necessary the results of some studies over others. Rating organizations may include a study in their research base that is of questionable quality or has produced misleading results. Finally, numerous analyses can be conducted within a systematic review, which provides a more complete picture than a rating or endorsement. For example: systematic reviewers can assess the effectiveness of an intervention on a variety of measured outcomes, at a variety of times post completion, and against a variety of neutral or active conditions.

Systematic reviews can also reveal inconsistencies across studies and outcomes with practical implications for organizations and practitioners who are considering adopting the candidate intervention. These advantages were in play in Littell et al.'s review of Multi-Systemic Treatment (MST, Littell, 2005; Littell, Popa, and Forsythe, 2005), another child intervention that has been highly endorsed. They concluded that effects across studies were not consistent and that the most rigorous analyses found no significant differences between MST and usual services in reducing restrictive out-of-home placements, arrests or convictions. This finding resulted in a mild firestorm, with complaints from the treatment developers (Henggeler, Schoenwald, Swenson, and Borduin, 2006) and a response from the lead systematic reviewer (Littell, 2006). Our choice to conduct a systematic review of TF-CBT was based on our interest in looking across multiple studies and outcomes, pooling results, to evaluate the extent to which TF-CBT was having a positive impact on the lives of traumatized children.