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Child Abuse & Neglect



Factors related to attrition from trauma-focused cognitive behavioral therapy

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ABSTRACT

Attrition from child trauma-focused treatments such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is common; yet, the factors of children who prematurely terminate are unknown. The aim of the current study was to identify risk factors for attrition from TF-CBT. One hundred and twenty-two children (ages 3–18; $M = 9.97$, $SD = 3.56$; 67.2% females; 50.8% Caucasian) who received TF-CBT were included in the study. Demographic and family variables, characteristics of the trauma, and caregiver- and child-reported pretreatment symptoms levels were assessed in relation to two operational definitions of attrition: 1) clinician-rated dropout, and 2) whether the child received an adequate dose of treatment (i.e., 12 or more sessions). Several demographic factors, number of traumatic events, and children's caregiver-rated pretreatment symptoms were related to clinician-rated dropout. Fewer factors were associated with the adequate dose definition. Child Protective Services involvement, complex trauma exposure, and child-reported pretreatment trauma symptoms were unrelated to either attrition definition. Demographics, trauma characteristics, and level of caregiver-reported symptoms may help to identify clients at risk for premature termination from TF-CBT. Clinical and research implications for different operational definitions and suggestions for future work will be presented.

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1. Characteristics of attrition in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Decades of research have documented strong associations between trauma exposure during childhood and a plethora of adverse outcomes. Following trauma exposure, a significant subset of children develop difficulties that are of public health concern including posttraumatic stress disorder (PTSD), anxiety and mood disorders, substance use, and behavioral and interpersonal problems (Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Cicchetti & Toth, 1995; Copeland, Keeler, Angold, & Costello, 2007; Putnam, 2003). As these symptoms are unlikely to remit if untreated (Scheeringa & Zeanah, 2008), it is paramount to intervene with these children. Fortunately, there are a variety of evidence-based trauma-focused treatments for children exposed to traumatic events (Cohen, Mannarino, & Deblinger, 2006; Jaycox, 2003; Scheeringa, Zeanah, Myers, & Putnam, 2005).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2006) is one of the most commonly used interventions for trauma-exposed children, and arguably, the most widely disseminated (Allen & Johnson, 2012). TF-CBT has extensive empirical support in treating trauma-related symptoms in children (Cary & McMillen, 2012; Cohen et al., 2010).

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These results instill optimism that children can recover from trauma exposure. Yet, TF-CBT will only be effective if it is received, and between 20–75% of children prematurely terminate from therapy (Armbruster & Kazdin, 1994; Olfson et al., 2009; Wierzbicki & Pekarik, 1993). Without access to TF-CBT or other effective services, these children may continue to exhibit distressing symptoms that impair their ability to function. To prevent attrition from trauma-focused therapy, it is critical to determine if there are pretreatment factors related to premature termination from commonly employed interventions such as TF-CBT.

Trauma-exposed families may have more difficulty completing treatment than those seeking treatment for other disorders. Avoidance of trauma-related content is part of the clinical presentation of PTSD; therefore, due to the nature of their difficulties, some trauma-exposed children and their caregivers may be ambivalent about treatment or may struggle to persist in therapy when trauma-related content becomes a more central treatment focus. Further, as caregivers may also experience PTSD following their child's trauma exposure, there is a double risk for attrition in this population as either or both the child's and the caregiver's trauma-related avoidance may result in premature termination. Some caregivers may initially seek out therapy following a recommendation by a professional (i.e., law enforcement, pediatrician, case worker) after the child's disclosure, but may not perceive that intervention is necessary and fail to "buy in" to the importance of completing treatment. Other families may recognize the importance of treatment, but are vulnerable for attrition due to the numerous secondary adversities that can follow trauma exposure including legal involvement, placement in child protective custody, and increased family stress (e.g., moving, financial strain if perpetrator provided economic support). In the presence of multiple stressors, families may prioritize environmental security over completing a child trauma therapy protocol (Cohen, Mannarino, & Iyengar, 2011). Thus, trauma-exposed families may have unique trauma-focused factors that may interfere with treatment completion.

2. TF-CBT

TF-CBT is the most researched child-trauma intervention and has extensive empirical support in reducing PTSD, depressive symptoms, and behavioral problems among children ages 3–18 who have experienced different traumas in samples across the globe (Cohen et al., 2012; Cohen, Mannarino, Deblinger, & Berliner, 2009; Cohen, Mannarino, & Knudsen, 2005). The primary goals of TF-CBT are to reduce trauma-related symptoms in children and increase the caregiver's ability to support the child's recovery from trauma. This is accomplished through several components, which are summarized by the PRACTICE acronym: Psychoeducation and Parenting Skills, Relaxation; Affect Modulation and Expression; Cognitive Coping; Trauma Narrative; *in vivo* exposure; Conjoint sessions for child and parent; and Enhancing Future Safety and development (Cohen et al., 2006). Treatment lasts between 8 and 24 weekly 60–90 min sessions. TF-CBT content is delivered using individual sessions with the caregiver and child. Upon the completion of each component, the caregiver and child meet together with the therapist for a conjoint session to review the content in the completed component and facilitate the relationship between the caregiver and child.

Despite numerous studies supporting the efficacy of TF-CBT (Cohen et al., 2011; Cohen, Deblinger, Mannarino, & Steer, 2004; Silverman et al., 2008), attrition remains a concern (Cary & McMillen, 2012; de Arellano et al., 2014). Some TF-CBT studies have reported attrition rates of between 33 and 77% (Cohen et al., 2011; Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011), which is consistent with other pediatric PTSD treatments (Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2013). However, surprisingly little research has been devoted to investigating predictors of dropout from TF-CBT. Of the few studies that have examined predictors of dropout, most consisted of small sample sizes, several with less than 20 participants, making them inadequately powered to detect group differences (e.g., Cohen & Mannarino, 1996; Cohen, Mannarino, Perel, & Staron, 2007; Deblinger, McLeer, & Henry, 1990; King et al., 2000; Murray et al., 2013; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013). Perhaps partially due to this issue, many TF-CBT studies that examined attrition factors did not observe differences between completers and non-completers (Cohen et al., 2004, 2011; Cohen & Mannarino, 2000; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Mannarino et al., 2012). Of studies that did identify significant predictors, one study found that socioeconomic status (SES) differed between non-completers and completers such that the non-completers tended to be of a lower SES than completers (Cohen & Mannarino, 1996). Another study found that children who prematurely terminated were more likely to be older and have experienced more traumatic events (Jensen et al., 2014). These findings provide some guidance as to potential predictors of attrition in TF-CBT, but the limited evidence base means that few conclusions can be drawn.

As noted, TF-CBT is empirically supported by several randomized clinical trials (RCT). Despite the importance of these RCTs, studies utilizing samples from community mental health centers may shed light on attrition factors specific to those settings (Warnick, Gonzalez, Weersing, Scahill, & Woolston, 2012), where most clinical services are delivered (Miller et al., 2008). Trauma-exposed children may receive trauma-focused therapy from a Child Advocacy Center (CAC), which are trauma-informed multidisciplinary mental health centers that provide trauma-focused services such as forensic interviews and trauma-focused therapy. Yet, to our knowledge, no published studies have examined attrition from TF-CBT at a CAC, which represents a significant gap in the child trauma attrition research literature.

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