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Research article

Effectiveness of Trauma-Focused Cognitive Behavioral Therapy in a community-based program☆

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ABSTRACT

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a widely used treatment model for trauma-exposed children and adolescents (Cohen, Mannarino, & Deblinger, 2006). The Healthy Coping Program (HCP) was a multi-site community based intervention carried out in a diverse Canadian city. A randomized, waitlist-control design was used to evaluate the effectiveness of TF-CBT with trauma-exposed school-aged children (Muller & DiPaolo, 2008). A total of 113 children referred for clinical services and their caregivers completed the Trauma Symptom Checklist for Children (Briere, 1996) and the Trauma Symptom Checklist for Young Children (Briere, 2005). Data were collected pre-waitlist, pre-assessment, pre-therapy, post-therapy, and six months after the completion of TF-CBT. The passage of time alone in the absence of clinical services was ineffective in reducing children's posttraumatic symptoms. In contrast, children and caregivers reported significant reductions in children's posttraumatic stress (PTS) following assessment and treatment. The reduction in PTS was maintained at six month follow-up. Findings of the current study support the use of the TF-CBT model in community-based settings in a diverse metropolis. Clinical implications are discussed.

Research has documented the negative sequelae of trauma in children (Black, Woodworth, Tremblay, & Carpenter, 2012; Cohen, Berliner, & Mannarino, 2003; Perry, 2009). Although children may engage in coping mechanisms to achieve a semblance of 'normality,' such strategies are unlikely to be healthy or sustainable (Cicchetti & Cohen, 1995). For example, a child who has been exposed to maltreatment from an adult may form a neural template which signals to the child to be fearful of all adults (Perry, 2009). Although such a response may serve a protective function in a maltreating environment, it is not helpful across all contexts (McCrory et al., 2011). Furthermore, the longer a child continues on a maladaptive pathway the more difficult it becomes to return to a normal developmental trajectory (Cicchetti & Cohen, 1995). Consequently, the provision of timely and effective trauma-focused intervention is essential. In 2009/2010, Victim Services in Canada reported that children and youth were the largest specially identified group in need of victim programs and so, optimizing clinical services provided to this population is vital (Munch, 2012).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment for trauma-exposed children and adolescents (Cohen, Mannarino, & Deblinger, 2006). The therapy model is based on the recognition that traumatized children

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present with a diverse set of emotional and behavioral difficulties (Cohen, Berliner, & Mannarino, 2000). Although TF-CBT is a structured intervention, the protocol allows for flexibility. Therapists are encouraged to adapt the model to accommodate the needs of individual families. Given the significant influence caregivers have on children's functioning (Cole & Tan, 2007; Grusec & Davidov, 2010; Sameroff, 1995), the inclusion of caregivers in treatment is believed to be an integral aspect of TF-CBT. Child and caregiver sessions are conducted in parallel. The content covered during the individual session with the child is shared with the caregiver(s) so that learning can be reinforced by the caregiver at home. Caregiver sessions may also address the caregiver's own difficulties related to the trauma, or the experience of vicarious trauma as a result of the child's experience (Cohen et al., 2006). The overarching goals of treatment are to reduce posttraumatic symptoms (PTS), help the family understand the child's reaction to the trauma, and restore normal developmental functioning (Cohen et al., 2006). Briere et al. (2001) further suggested the assessment of the symptom sub-clusters defining PTSD including: re-experiencing (e.g., intrusive thoughts about the trauma), avoidance (e.g., persistent avoidance of thoughts, feelings, and reminders of the trauma), and arousal (e.g., difficulty concentrating) for the purposes of increasing diagnostic utility and informing treatment.

The Healthy Coping Program (HCP) was a multi-site community-based intervention designed to evaluate the effectiveness of TF-CBT with school-aged children (Muller & DiPaolo, 2008). Research on treatment outcome distinguishes between treatment efficacy and treatment effectiveness. TF-CBT was developed based upon randomized, controlled trials evaluating the efficacy of the model in decreasing psychopathology in children and adolescents following trauma exposure (e.g., Cohen, Deblinger, & Mannarino, 2005; Cohen, Deblinger, Mannarino, & Steer, 2004; King, Tonge, Mullen, Myerson, & Heyne, 2000). Studies of treatment efficacy focus on methodological design which maximizes internal validity, including, ensuring that all participants have the condition the therapeutic model was designed to treat and that all therapists are competent in delivering the intervention being studied (Hunsley, 2007). In the HCP, this was addressed by verifying that all children had experienced trauma as corroborated by police and/or child welfare services. Participating therapists read *Treating Trauma and Traumatic Grief in Children and Adolescents* (Cohen et al., 2006) and completed the TF-CBT web-based training; attended monthly clinical consultation meetings moderated by a model expert; received ongoing TF-CBT group supervision; and attended TF-CBT training workshops over the duration of the research study.

Studies of treatment effectiveness maximize external validity while striving to maintain internal validity (Hunsley, 2007). Previous research has supported the successful use of TF-CBT with multiple types of trauma such as terrorism (Cohen & Mannarino, 2008); natural disasters (Jaycox et al., 2010); and traumatic exposure in refugee youth (Murray, Cohen, Ellis, & Mannarino, 2008). TF-CBT has been found effective when delivered by therapists from clinical (Feather & Ronan, 2009) and school settings (Little, Akin-Little, & Gutierriez, 2009) and with children ranging from preschool-age to adolescence (Cohen & Mannarino, 1997; Cohen et al., 2006; Hebert & Daignault, 2015). The model has been shown to be more effective when compared to nondirective supportive therapy (Cohen & Mannarino, 1996) and child-centered therapy (Cohen et al., 2004), in the treatment of trauma. A study comparing a TF-CBT condition with TF-CBT in combination with a selective serotonin reuptake inhibitor, found no significant differences in treatment outcome (Cohen, Mannarino, Perel, & Staron, 2007). It has also been demonstrated to be effective with culturally diverse populations, for example, a study of foster care youth found no racial differences in treatment outcome (Weiner, Schneider, & Lyons, 2009). Follow-up studies have found that post-therapy reductions in children's PTS, shame, and abuse-specific parental distress were maintained at 6 and 12 months following therapy (Cary & McMillen, 2012; Deblinger, Mannarino, Cohen, & Steer, 2006).

Prior research supports the robustness of TF-CBT in treating trauma-related symptomatology; however, these studies have largely been conducted by the model developers in academic settings. Community-based settings often have more heterogeneous populations and fewer resources for carrying out interventions than programs carried out in the context of efficacy trials (Marchand, Stice, Rohde, & Becker, 2011). Furthermore, relatively few studies have examined the effectiveness of TF-CBT with Canadian populations (e.g., Hebert & Daignault, 2015; Madigan, Vaillancourt, McKibbon, & Benoit, 2015). The HCP was designed to extend the external validity of the TF-CBT model by evaluating its effectiveness in community agencies operating within a multicultural Canadian metropolis (Statistics Canada, 2008). Based on previous research, the main hypothesis of this study was that children would report reductions in PTS following TF-CBT. There exists a paucity of research examining the effect of TF-CBT on the symptom sub-clusters of PTS (i.e., intrusion, avoidance, and arousal). As such, an additional goal of the current study was to explore these symptom domains in order to obtain a more nuanced understanding of children's PTS as perceived by caregivers.

Method

Data were collected from March '06 to March '12, through the HCP (Muller & DiPaolo, 2008; Muller, Padoin, & Lawford, 2008). The study received funding from the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario (Muller & DiPaolo, 2008). Additional funding was obtained from the Hedge Funds Care Canada Foundation. University and community center ethics committees approved this study.

Participants

Children. Of the 113 children who completed at least one data collection in the HCP, 80 were female and 33 were male. Children ranged in age from 6 years, 10 months to 12 years, 10 months (M = 10 years, 0 months, SD = 1 year, 8 months). Ethnic backgrounds were reported as European-Canadian (39.3%), African/Caribbean-Canadian (17.9%), Asian Canadian (11.6%),