Research Proposal: Trauma-Focused CBT Effectiveness in Reducing Symptoms of PTSD in Children and Adolescents

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INTRODUCTION

Statement of the Problem

Children undergoing emotional stress may show symptoms of posttraumatic stress disorder (PTSD), which is a psychological disorder where the child feels as though he or she is experiencing or reliving the trauma, sometimes months or years after it occurred (American Psychological Association [APA], 2002). Risk factors that might increase the likelihood of PTSD in children exposed to trauma include environmental factors, such as low social support, low economic status, and individual factors such as comorbid genetics as well as psychological problems (Diagnostic & Statistical Manual of Mental Disorders, 5th edition). Equally important, Dalgleish et. al. (2015) suggest that some of the PTSD symptoms include trauma re-experiencing, avoidance, and hyper-arousal, which might be more specifically identified as flashbacks, nightmares, social withdrawal, emotional numbing, anger outbursts, and play disturbed play. These can impact children's and adolescents' biopsychosocial functioning and development if not treated on time.

Trauma and stress are experienced at least once in a person's lifetime. According to the *Diagnostic & Statistical Manual of Mental Disorders (DSM V)*, the following criteria must be applied to adults, adolescents, and children older than 6 years of age: A) exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: 1) experiencing the traumatic event, 2) witnessing in person the traumatic event 3) learning tat the traumatic event occurred to a close family member or friends (events must have been violent or accidental), 4) experiencing repeated or extreme exposure to aversive details of the traumatic events.

Statistics show that more than half of the children and adolescents in the U.S. have experienced a traumatic event, which includes child abuse, sexual assault, domestic violence,

community violence, bullying, serious accidents, medical trauma associated with medical procedures, or a traumatic death of a loved one (Cohen et. al., 2010). In the same way, Kaminer et. al. (2005) found that about 15% to 43% of girls and 14% to 43% of boys go through at least one traumatic event; of those children and adolescents who experience trauma, 3% to 15% of girls and 1% to 6% of boys go on to develop PTSD. With this in mind, Diehle et. al (2013) suggest that if PTSD is left untreated, it can lead to the development of other anxiety, mood, or substance abuse disorders.

Significance of the Study

Research studies have shown that children and adolescents who experience traumatic events such as sexual abuse, domestic violence, parent figure absence, or multiple traumas are particularly vulnerable to long lasting negative impacts ultimately leading to developing PTSD. Lenz and Hollenbaugh (2015), found that prior to adolescence, almost 90% of adults in the United States may have been subjected to a traumatic or stressful incident, creating consequences on their psychosocial functioning. Besides, we know that minority children are placed at a higher-risk of encountering mental health (PTSD, depression, anxiety, etc.) correlated with their exposure to traumatic experiences (Cohen and Mannarino, 2008).

Research has demonstrated that racial/ethnic minorities are at greater risk for developing PTSD, especially Hispanics/ Latinos and literature indicates that there is a consistently higher rate of PTSD among Hispanic/Latinos compared with non-Latino whites (Constantino et al, 2014). As noted by (Constantino et al, 2014), this is indicated by social-cultural elements that exist and elevated PTSD symptoms are associated with cultural factors such as low SES, self-blame and discrimination, making them more prone to PTSD, anxiety and depression. Similarly, unaccompanied refugee minors seeking asylum have shown high rates of

Posttraumatic Stress disorder (PTSD) due to post-migration stressors like an uncertain residence status and are in urgent need of interventions (Unterhitzenberger et. al., 2019). Similarly, American Indians as well as Alaska natives are vulnerable populations with significant levels of trauma exposure, given that multiple risks present in AI/AN communities, the prevalence of PTSD remains higher than in the general community (Bigfoot & Schmidt, 2010).

Given that the majority of research studies have focused on exploring adults who are diagnosed with PTSD, there is a lack of evidence and knowledge about the efficacy of trauma-focused cognitive behavioral therapy (TF-CBT) for mitigating PTSD symptoms in young children and adolescents. As a result, what we need to study is the importance of TF-CBT, and its effectiveness in reducing PTSD symptoms in young patients. There is also very limited empirical evidence on the effectiveness of TF-CBT for treating PTSD in these study groups, compared to other interventions and treatments. Also, we still need to research and implement the accessibility of effective interventions to minority children and adolescents in community-based settings (Cohen & Mannarino, 2008).

Even though researchers have conducted studies on the effects of TF-CBT for treating PTSD symptoms, little is known about the relevance of approaching PTSD symptoms at early ages (if diagnosed). In other words, researchers have missed research on the age groups that TF-CBT has the highest probability of reducing the symptoms of PTSD and alleviating trauma because they have focused on studying vague age groups or populations with no specific characteristics. Additionally, research should be done on minority youth diagnosed with PTSD, regarding how their access to TF-CBT interventions in different settings might be affected due to their race or ethnicity, as researchers have not been able to find a relatedness between these two factors.

LITERATURE REVIEW

Trauma-Focused Cognitive Behavioral Therapy

The trauma-focused CBT model is a brief (8-25 session), cognitive-behavioral, resiliency building, components and phase-based model for children and adolescents impacted by trauma. Trauma-focused CBT consists of a short term psychotherapy that involves 45-50 minute sessions with the child and then 45-50 minutes with the caregiver or parent. According to a study conducted by Cohen et al (2018), the trauma-focused CBT model is an evidence based treatment for traumatized individuals, adolescents and families and has been tested in various settings and has strong evidence for improving trauma symptoms across different populations. The model consists of nine components contained within three phases that are provided in equal length. Phase 1 consists of psychoeducation about how trauma impacts individuals, parenting skills to address children's traumatic behavior responses; relaxation skills to reverse physiological trauma responses; affective skills to address trauma dysregulations and cognitive processing skills. Phase 2 consists of trauma narration and processing while Phase 3 consists of consolidation. Phase 3 usually consists of three components: *In vivo mastery* to address overgeneralized fear as well as avoidance of trauma reminders; *conjoint child-parent* sessions to enhance communication about the child's trauma experiences and parental communication; finally enhancing safety and future development to address issues with each client.

The Trauma-Focused CBT was developed by Deblinger, Cohen and Mannarino and is based on cognitive-behavioral principles and exposure techniques in order to prevent as well as treat post-traumatic stress, depression and behavioral problems (Arrellano et. al., 2014). As noted by Cohen et al (2006), trauma involves loss of safety and loss of trust, therefore the therapeutic relationship is essential to Trauma-Focused CBT in enabling the child and parent to optimally

recover after trauma. As emphasized by Arellano et al (2014), a central focus of TF-CBT is to ensure an approach that is developmentally appropriate for the needs of children as well as their caregivers which includes a developmentally sensitive assessment and fostering of coping skills in order to allow children to manage trauma-related distress as well as emotional reactions. After learning coping skills, children undergo exposure based therapy which includes a gradual exposure and cognitive processing; for example the creation of a trauma narrative which is meant to reduce stress and maladaptive cognitions associated with traumatic events (Arrellano et al, 2014).

A research conducted by Feather & Ronan (2009), examined the effectiveness of trauma focused behavioral therapy (TF-CBT) program for maltreated children with PTSD in a child protection clinic setting. Four studies were conducted where eight 9-13 year old abused children with PTSD were treated with TF-CBT. A single multiple-baseline across participants was used to evaluate the controlling effects for treatment on PTSD symptoms and child coping. Both intra-participant and inter-participant replications showed that levels of PTSD symptoms reduced and child coping increased across baseline as well as treatment. The results of the study concluded that the majority of the children in the study demonstrated relief from symptoms and an increase in coping as a result from symptoms and an increase in coping as a result of TF-CBT.

TF-CBT in Children and Adolescents

When it comes to children and adolescents who are diagnosed with PTSD, the efficiency and reliability of TF-CBT is still uncertain as the evidence base and randomized trials done in this population are very limited. Therefore, researchers explored its feasibility, and the efficacy of the techniques implemented in this therapy by focusing on three main aspects: treatment versus wait list, measures of efficacy, and the feasibility of TF-CBT techniques. A total of 77

children (between 3 and 6 years old) diagnosed with PTSD, the majority identified as minority races, were randomly selected. In this longitudinal study, findings showed that the intervention group improved substantially on PTSD symptoms, and the impact size for this condition increased at a six-month follow-up. Similarly, the frequency at which children were able to comprehend and complete complex strategies demonstrated that TF-CBT was feasible in this age range. In sum, TF-CBT was effective for assessing PTSD symptoms in young children (Michael et. al., 2011).

Limited empirically evidence-based research on the same issue motivated researchers to examine TF-CBT efficacy in young children (3 to 8 years old). Aiming to explore if children diagnosed with PTSD experienced symptom reduction by receiving TF-CBT interventions, and compare its feasibility with treatment as usual or TAU (psychotherapy or medicine), Dalgleish et. al. (2015) conducted an exploratory randomized controlled research study, where the key targets of the intervention are trauma memory, traumatic event meaning, and symptom-management. 44 children with PTSD were randomly assigned to receive either TF-CBT or TAU interventions for 12 weeks (1 session per week), and the findings supported the need for TF-CBT as it is the most appropriate and feasible treatment for young children's PTSD symptoms.

Further research on international guidelines for assessing PTSD, conducted by Diehle, Opmeer, Boer, Mannarino, and Lindauer (2015), suggests that TF-CBT is the primary and most accurate treatment to reduce the symptoms in children and adolescents. Nevertheless, researchers studied its effectiveness and viability on reducing posttraumatic stress symptoms compared to another therapy known as the eye movement desensitization and reprocessing (EMDR), which addresses traumatic memories and focuses on alleviating the distress caused by these. They [researchers] pointed to exploring the effects of each treatment and which was more effective for

reducing PTSD symptoms. For this longitudinal research study, 48 randomly selected participants, ages 8 to 18, who presented PTSD symptoms were allocated to receive one of the two interventions for a 12-month period. Both TF-CBT and EMDR were successful in treating children and adolescents with PTSD, according to the findings (Diehle et. al., 2015).

In their meta-analysis of 21 studies evaluating TF-CBT effectiveness for decreasing PTSD symptoms, Lenz and Hollenbaugh (2015) reviewed previously collected data of 1,860 participants diagnosed with PTSD, with an average age of 10.96 years, where 1,009 participants had received TF-CBT as their primary intervention, 631 had received alternative treatments, and 220 had not received any treatments (yet). Findings indicated that receiving TF-CBT interventions had a greater impact on reducing PTSD symptoms in these populations when compared to receiving alternative or no treatments. Most importantly, participants had positive responses and attitudes towards this intervention.

Culturally Sensitive TF-CBT in Children and Youth

Culturally adapting the TF-CBT model in order to work with children and youth of different cultures has been proven to be successful. As mentioned in a research study conducted by Bigfoot and Schmidt (2010), CBT principles that involve cultural practices that rely on thoughts, feelings, behaviors as well as emotions are core components of TF-CBT. Research conducted by Bigfoot et. al. (2010) emphasized how cultural affiliations and values associated with the well-being framework can enhance healing by culturally adapting the TF-CBT model. As described in their case study with one subject, Schmidt et. al. (2010) adopted spiritual sayings, prayers to the TF-CBT model which includes affect management, relaxation, cognitive coping and enhancing safety as well as developing parent-child relationships.

Developing a treatment for maltreated children involves special considerations that include the essential need to take a developmental and culturally sensitive informed perspective as well as family-centered approach. As noted by (Feather & Ronan, 2009), child maltreatment and neglect always affects the relationships that children have with family members since many children who come to the attention of child protective services are placed in case to ensure their safety. Culturally sensitive TF-CBT involves making sure that parents and caregivers are included, and a choice of child developmentally age appropriate activities and needs is provided. Recommendations are made to ensure that the approach used is culturally appropriate and respectful. That being said, TF-CBT interventions should allow the therapist to take into consideration antecedents as well as consequences of the child and adolescents' problems being presented which may include the interactive effects of his/her history and development, family relationships, attachments, social as well as cultural contexts (Feather & Ronan, 2009).

TF-CBT in Community Settings

Trauma-focused cognitive behavioral therapy has been established as one of the prominent evidence-based practice models that have been effective in treating children with posttraumatic stress disorder symptoms. Cohen and Mannarino (2008) primary concerns articulated were how to adequately disperse and execute Trauma Focused-Cognitive Behavioral Therapy in traditional care settings. Clinicians, in various settings, having access to TF-CBT training and learning materials to treat children with PTSD symptoms are crucial to ensuring the appropriate treatment is provided by competent providers. Substantial strategies are used to disperse and execute TF-CBT. Cohen and Mannarino (2008) discussed four general approaches (1) distance or Web-based learning, (2) training and ongoing consultation models, (3) learning collaborative models, and (4) mixed models. Each model holds strengths and limitations with the

diversity of each model being eminent to particular situations and care settings. In order for TF-CBT dissemination and implementation to be overseeing training should begin at the graduate level which would allow for face-to-face training, address the issue of cost-effectiveness, and reach a diverse population of clinicians.

Research conducted by Cohen et. al. (2011) discussed the comparison of community-provided trauma-focused cognitive behavior therapy (TF-CBT) as opposed to traditional community treatment for children (CCT) with intimate partner violence (IPV) related posttraumatic stress disorder (PTSD) symptoms. They believed that TF-CBT would enhance intimate partner violence PTSD symptoms considerably more than child centered therapy in children. As well as TF-CBT being dominant for enhancing PTSD symptom clusters, anxiety, depression, cognitive functioning, and behavior problems (Cohen et al., 2011). This research study was a randomized controlled study that completely took place in an intimate partner violence community setting at the Women's Center and Shelter of Greater Pittsburgh (WCS) between September 1, 2004, and June 30, 2009. Inclusion criteria for participants included the 124 children being between 7-14 years of age, having minimally five IPV related PTSD symptoms, containing at least 1 in each of 3 PTSD symptom clusters on the Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (K-SADS-PL)16; children and mothers spoke English, mother was a direct IPV victim, child agreed, and mother consented to participate in 8 therapy sessions (Cohen et al., 2011).

The interventions used by Cohen et al (2011), consisted of children and parents randomly receiving 45-minutes individual therapy sessions for 8 sessions. With the TF-CBT being altered to be adaptive to the length of time CCT is used in community settings. There were three master's level social workers who provided the interventions and were trained and supervised by

competent staff. Each provider saw the same children and mothers for the duration of the study. Children who received TF-CBT, as opposed to CCT, in the community setting were found to have substantial increased PTSD diagnosis reduction.

The elevated risk for trauma related symptoms developing among children and adolescents of incarcerated parents requires research and implementation about constructive interventions and treatments. Research conducted by Morgan-Mullane (2018) focused on implementing TF-CBT in a community-based environment treating one child, experiencing trauma symptoms associated with parental incarceration, and her mother. The initial traumatic incident of a child with an incarcerated parent is the arrest however, the child continues to face traumatic incidents up until the parent is released. This case study examines the correlation between the advancement of trauma-related symptoms and parental incarceration, treatment circumstances expressed through the TF-CBT intervention, preliminary findings from treatment, and suggestion for TF-CBT usefulness for children impacted by parental incarceration (Morgan-Mullane, 2018).

Both the child and mother participated in a treatment plan of 18 weeks including individual therapy for the mother and child as well as family therapy, and group therapy for the child. Morgan-Mullane (2018) research study consisted of three phases: the stabilization phase, trauma narrative phase, and integration/consolidation phase. The stabilization phases consisted of psychoeducation to examine trauma and domestic violence, which lead to the mother's incarceration, with the child and mother. The trauma narrative phase consisted of the child expressing her story related to her mother being incarcerated and their separation opposed to the domestic violence that led to the mother's incarceration. The integration/consolidation phase consisted of improvement of communication, in addition to the development and practice of a

safety plan to oversee the child's emotional and social behaviors. The conclusion of the study indicated parental incarceration paired with additional high risk factors implies that children could benefit from TF-CBT as an intervention to address their trauma.

Overall, past research literature found on trauma-focused CBT, which has been shown to be an evidence based treatment for treating PTSD symptoms for both children and adolescents who have been impacted by trauma in different settings ranging from hospitals to community settings. TF-CBT should be implemented using a culturally sensitive adaptation of the TF-CBT model in order to work with children and youth of different cultures which has been proven to be successful when working with individuals of different cultures. The majority of literature reviewed on alternative treatments and interventions such as TAU (traditional psychotherapy and medicine approaches), that have been formulated as possible solutions to reducing PTSD symptoms in children and adults has suggested that TF-CBT is a quite adequate intervention, producing positive responses and outcomes in patients. In fact, TF-CBT being accessible to children and adolescents, in community-based settings, is crucial in the reduction of PTSD symptoms. That being said, this research study will be further explored and developed.

PURPOSE OF THE STUDY

Considering that other alternative models studied such as eye movement desensitization and reprocessing (EMDR) and treatment as usual (TAU), which involves traditional psychotherapy approaches, have not been supported by researchers as the most efficient and feasible treatments to assess PTSD symptoms in youth, the purpose of this study is to explore the effectiveness of TF-CBT for reducing the symptoms of PTSD in both children and adolescents. In order to accomplish this, we formulated two research questions: (1) Does TF-CBT intervention reduce the symptoms of PTSD for diagnosed children and adolescents? (2) Does

satisfaction with TF-CBT intervention contribute to reducing PTSD symptoms for children and adolescents who are diagnosed with this disorder? Our hypotheses are that TF-CBT intervention will reduce PTSD symptoms in children and adolescents who are part of the intervention in comparison to children and adolescents who are part of the traditional psychotherapy and medicine intervention; TF-CBT children and adolescents will be satisfied with this intervention which will cause reduction in PTSD symptoms.

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