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A Systematic Review Examining the Efficacy and Effectiveness of Trauma-Focused
Cognitive Behavioral Therapy

A Capstone Project
Presented to
The Faculty of the Clinical Psychology Masters Program
Western Kentucky University
Bowling Green, Kentucky

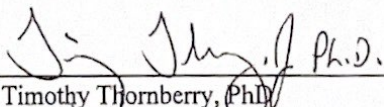
In Partial Fulfillment
Of the Requirements for the Degree
Master of Arts

By
Abigail Howerton


August 2021

EXAMINING THE EFFICACY OF TRAUMA-FOCUSED COGNITIVE BEHAVIORAL
THERAPY: A SYSTEMATIC REVIEW

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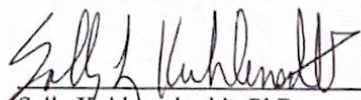


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A SYSTEMATIC REVIEW EXAMINING THE EFFICACY AND EFFECTIVENESS
OF TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

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More than two-thirds of children and adolescents experience a traumatic event by the age of 16. Trauma comes in many forms and affects people in many ways. Trauma can affect behavioral, cognitive, emotional, physical, and neurological development. Trauma-focused cognitive behavioral therapy (TF-CBT) is a type of therapy created to treat children and adolescents who have experienced trauma. TF-CBT is an evidence-based treatment (EBT) and is currently the only EBT whose focus is solely on treating trauma in children and adolescents. This article reviews the literature assessing studies using randomized controlled trials (RCT's) to determine the effectiveness and efficacy of TF-CBT in different countries and cultures, with different age groups, and across different settings. These studies suggest TF-CBT significantly and clinically reduces symptoms of post-traumatic stress disorder, trauma, anxiety, and depression, and improves the quality of life. Based on these results, as a provider, TF-CBT is a treatment worth investing time and money in learning about and becoming certified in when working with children and adolescents who have experienced trauma.

Introduction

In a 2015 study conducted by the National Child Traumatic Stress Network (NCTSN), research concluded that “more than two-thirds of children experience at least one traumatic event by 16” (Copeland et al., 2007, p. 579). These events can range from physical abuse, sexual abuse, neglect, community violence, domestic violence, natural disasters, loss of a loved one, or life-threatening illnesses (Becker-Blease, 2015). When a child or adolescent goes through a traumatic experience, the child’s development is affected and internalizing and externalizing problems may appear (Nader, 2011). Post-traumatic stress disorder (PTSD) is a diagnosis in the *Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-5)* given to those who have experienced a traumatic event and have adverse effects from the traumatic experience (American Psychiatric Association, 2013). Children, adolescents, and adults can be diagnosed with PTSD.

There are many different evidence-based treatment’s (EBT’s) for PTSD in adults, like cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), and prolonged exposure therapy (PET; Society of Clinical Psychology, 2020). For children and adolescents, one therapy has the most research supporting it: TF-CBT (Cohen et al., 2017). Trauma-focused cognitive behavioral therapy (TF-CBT) is a therapy created by Judith Cohen, Esther Deblinger, and Anthony Mannarino (TF-CBT Therapist Certification Program, 2021). TF-CBT is an established treatment for children and adolescents ages 3 through 17 who have experienced one or more traumatic events (Cohen et al., 2017). TF-CBT is a structured treatment with specific steps to be followed in a particular order. TF-CBT can be completed in 12 to 25 sessions, depending on the

provider and the complexity of the child or adolescent's trauma history (Ramirez de Arellano et al., 2014).

What is Trauma?

Trauma has many definitions. According to the NCTSN, "trauma is a frightening or dangerous event that threatens a child's life or bodily integrity" (National Child Traumatic Stress Network, n. d., para. 1). The American Psychological Association (APA) defines trauma as "an emotional response to a terrible event like an accident, rape, or natural disaster" (American Psychological Association, n.d., Trauma section). The DSM-5 describes a traumatic event as exposure to actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2013). The exposure can either be through a direct experience to the event, a person who witnesses an event, when someone hears about an event that happened to someone close to him, or repeated secondhand exposure, also known as vicarious trauma (American Psychiatric Association, 2013).

Although there are different definitions for trauma, all the definitions have common themes. Experiencing, witnessing, or hearing about an event that produces harm, injury, or even death are common themes in trauma. There are many different types of traumatic experiences someone can go through. Examples are as follows: sexual abuse, physical abuse, emotional abuse, neglect, severe accident or illness, domestic violence, community violence, school violence, natural or artificial disasters, war, traumatic grief or separation, system-induced trauma, and divorce (Becker-Blease, 2015).

Research shows it is common for people to experience one or more traumatic events in their lifetime (Greeson et al., 2011). There are three categories traumatic events

can be classified in and they are, an acute traumatic event, a chronic or pervasive trauma, or complex trauma (Allarakha, 2021). Acute trauma occurs after a single traumatic event, and the event is severe enough for the person to feel threatened (Allarakha, 2021). An example of acute trauma would be someone involved in a car accident that resulted in the loss of a loved one. Chronic trauma is when someone experiences a traumatic event over a long period of time (Allarakha, 2021). An example of chronic trauma is someone who is sexually abused repeatedly over many years. Finally, complex trauma is where someone experiences multiple different traumatic events, and some of them can be single events or multiple exposures (Allarakha, 2021). An example of complex trauma would be if someone experiences sexual abuse, physical abuse, and was removed from the home and placed in foster care.

Trauma affects people differently (Shore, 2020). The child maltreatment report for 2018 showed an increase for the first time since 2015 in the number of victims who experienced maltreatment (Children's Bureau Administration on Children, Youth, and Families, Administration for Children and Families of the U.S. Department of Health and Human Services, 2020). They said that abuse and neglect rates are highest among infants and children, which has been the theme for many years (Children's Bureau Administration on Children, Youth, and Families, Administration for Children and Families of the U.S. Department of Health and Human Services, 2020). They found that in 2018, 3,534,000 million children were involved in a child maltreatment investigation, and 678,000 were confirmed victims of maltreatment (Children's Bureau Administration on Children, Youth, and Families, Administration for Children and Families of the U.S. Department of Health and Human Services, 2020). This was a 4,000 person increase from

2017 (U.S. Department of Health and Human Services, 2020). Of the 678,000, 60.8% were neglected, 10.7% were physically abused, 7.0% were sexually abused, and 15% experienced more than one type of trauma (Children's Bureau Administration on Children, Youth, and Families, Administration for Children and Families of the U.S. Department of Health and Human Services, 2020).

How Trauma Impacts Children and Adolescents

Trauma affects a large portion of children and adolescents worldwide, and the effect of the trauma varies (Shore, 2020). There is a high likelihood for those who experience a traumatic event to be distressed right after the event or even days after (American Psychological Association, 2008). For some people, the distress does not go away on its own, but for others it does. Resiliency is what helps determine the extent of the effect of the trauma and resiliency is the ability to adapt well in the face of adversity (Lee et al., 2020). An important note is that everyone who experiences trauma, whether the trauma type is acute, chronic, or complex trauma, experiences different reactions (Lee et al., 2020). No two people respond the same way, and trauma has different impacts on different people. Some people are very resilient and can “bounce back” from the trauma over time without help from medical or mental health professionals (Shore, 2020). There are a variety of factors that can help predict someone's response to trauma including the child's developmental level, age of the child or adolescent at the time of the trauma, social support, ethnicity or cultural factors, trauma history, availability of resources, and family factors (American Psychological Association, 2008).

Although some display resilience in the face of trauma, others experience long-lasting negative effects (Curran et al., 2018). Children and adolescents who experience

trauma may develop diagnoses of PTSD, depression, anxiety, panic disorder, behavioral disorders, and/or substance use disorders (Curran et al., 2018). Some children and adolescents may experience severe emotional or behavioral problems and not meet the full diagnostic criteria for the disorders mentioned above (Curran et al., 2018).

Long-term exposure to stress can affect a child's ability to regulate their emotions or cope with those intense emotions (Lubit et al., 2003). Trauma also activates our sympathetic nervous system (fight or flight system), which aids in survival. When someone experiences a traumatic event, afterward, the individual may be hypervigilant, meaning that their sympathetic nervous system may be activated unnecessarily during various situations that remind one of the trauma (Lubit et al., 2003). Being under intense amounts of stress for an extended period can alter a person's brain development, specifically in children and adolescents whose brains are not fully developed (Lubit et al., 2003).

Trauma reactions tend to differ across age or developmental period (Lubit et al., 2003). The researchers noted that preschool children might experience separation anxiety, more severe temper tantrums, avoidance of activities, sleepwalking, anxiety, somatic complaints, and aggressive behavior (Lubit et al., 2003). School-aged children may exhibit hypervigilance, increased aggression, concentration problems in class, nightmares, anxiety, and a preoccupation with danger (Lubit et al., 2003). Adolescents may be oppositional or aggressive, engage in substance use, risky behaviors, sleep problems, concentration problems, and may enter adult activities quickly (Lubit et al., 2003).

A study conducted in 2018 used data from the U.S. National Epidemiology Survey on Alcohol and Related Conditions to look at the effect trauma has on psychopathology (Curran et al., 2018). The researchers found that childhood trauma can interfere with normal development and impair cognitive function, social function, and emotional development (Curran et al., 2018). The authors categorized the results into three classes of trauma. Class three showed either no trauma symptoms or low trauma symptoms, class two showed people who experienced multi-victimization, and class one experienced situational trauma (Curran et al., 2018). Class three made up 86 percent of the population, class two was at six percent, and class one with nine percent (Curran et al., 2018). This study found that specific early traumatic experiences can have distinct psychiatric outcomes. Interpersonal (violence and abuse) versus situational (accident, illness, or loss) trauma helped determine if there was an increase in certain psychopathology (Curran et al., 2018).

What is Trauma-Focused Cognitive Behavioral Therapy?

TF-CBT is an EBT designed for children and adolescents who have experienced trauma (Cohen et al., 2017). TF-CBT is a type of therapy created to address the adverse effects trauma can have on children. Judith Cohen, Anthony Mannarino, and Esther Deblinger were each working independently on treating children who experienced trauma, and in 1997, the creators came together to integrate their treatment models into what is now known as TF-CBT (Cohen et al., 2017). Their first study of TF-CBT was with children who had experienced sexual abuse, traumatic loss, complex trauma, or domestic violence. TF-CBT is a components-based treatment model that integrates trauma-sensitive interventions, cognitive-behavioral techniques, and different

components like attachment, development, family, and humanistic approaches (Cohen & Mannarino, 2017).

TF-CBT uses many different acronyms to explain different concepts. CRAFTS is an acronym used twice, once to list the difficulties addressed by TF-CBT and the other to address the core values of TF-CBT (Cohen et al., 2017). The problems addressed with TF-CBT are cognitive, relationship, affective, family, traumatic behavior, and somatic problems (Cohen et al., 2017). These difficulties are common in children and adolescents with a trauma history and are incorporated into TF-CBT to alleviate these adverse problems. The core values of TF-CBT are just as crucial as the difficulties addressed. The CRAFTS values are the following: components based, respectful of cultural values, adaptable and flexible, family-focused, the therapeutic relationship is central, and an emphasis on self-efficacy (Cohen et al., 2017)).

History and Theories Behind Trauma-Focused Cognitive Behavioral Therapy

TF-CBT is unique because it integrates many different theories to explain each section of the treatment. Looking just at the name of TF-CBT, two of the theories included are the cognitive theory and the behavioral theory (Cohen & Mannarino, 2017). The cognitive theory looks at someone's mind and focuses on their thoughts or their perception of events (Kuther, 2019). The cognitive theory seeks to identify unhelpful or maladaptive thoughts causing distress and replace them with new healthy thoughts (Cohen & Mannarino, 2017). One cognitive theory is the information processing theory. This theory states that information is received, manipulated, stored, and used for future problem solving (Kuther, 2019). Those who experience a traumatic event store information about the event and use this information later in their life. When maladaptive

memories are stored, the memories create an obstacle for how future information is rationalized (Kuther, 2019). Children and adolescents who have experienced trauma may have maladaptive thoughts related to the traumatic event that carry into other parts of their life post-trauma (Hill, 2020).

Another theory TF-CBT draws from is the behavioral theory. This theory seeks to focus on identifying challenging or problematic behaviors and implement ways to change those behaviors (Cohen & Mannarino, 2017). Behavioral therapy may also work to identify involuntary responses to trauma-related stimuli (Cohen & Mannarino, 2017). Social learning theory by Albert Bandura talks about how thoughts and feelings influence behavior, and it also says people learn behaviors by observing others in the environment around them (Kuther, 2019). Children and adolescents who have gone through a traumatic event can exhibit challenging behaviors. Social learning theory assumes that children learn these behaviors from observing how people interact with themselves and others around them (McRae et al., 2017). For example, someone who is physically abused may display aggressive behaviors because of the trauma (McRae et al., 2017).

Classical conditioning is another principle used. Classical conditioning is a form of learning when a conditioned stimulus is paired with an unconditioned stimulus that produces a conditioned response (Kuther, 2019). When a child or adolescent experiences a traumatic event, the event now causes a strong association to form between stimuli that once elicited no response but now elicits a negative response (Carrion & Hull, 2009). The child or adolescent pairs certain stimuli with the trauma and then actively works to avoid the trauma reminder (Carrion & Hull, 2009).

Operant conditioning is another form of learning. Operant conditioning states that consequences of a response determine the probability of it being repeated (Iwata, 1987). This theory helps to explain the maintenance of PTSD symptoms, and why PTSD can last over time (Nijdam & Wittmann, 2015). When someone experiences trauma, they avoid trauma reminders. The avoidance is negatively reinforced, which means you get rid of something unpleasant to increase the likelihood of continuing the avoidance behavior (Iwata, 1987). This avoidance causes challenging behaviors and maladaptive thoughts that are targeted during TF-CBT (Carrion & Hull, 2009).

TF-CBT incorporates individual therapy with the child or adolescent and parent sessions later in treatment (Cohen et al., 2017). More than one person from the family is involved in treatment; therefore, TF-CBT draws from family therapy (Cohen et al., 2017). When a child or adolescent is referred for TF-CBT, one of the first tasks is to find a non-offending caregiver who can participate in treatment with the child (Cohen et al., 2017). The caregiver can be a parent, grandparent, aunt, uncle, foster parent, and in residential facilities, a primary staff member. The only rule for the selection of the caregiver is they cannot be the offender (Cohen et al., 2017). For example, if their biological father sexually abused the child, the biological father could not be the caregiver involved in treatment. The caregiver does not receive treatment for themselves, but rather is involved in the child or adolescent's treatment to learn how to help them through the trauma (Cohen et al., 2017). If the caregiver experiences adverse side effects as well, then they can be referred to another provider for individual therapy, while still being involved in TF-CBT (Cohen & Mannarino, 2008). If no one is available to sit in as

the caregiver, then TF-CBT can still be effective, even if there is no caregiver involvement (Cohen & Mannarino, 2008).

Who is Trauma-Focused Cognitive Behavioral Therapy For?

TF-CBT is a therapeutic intervention designed for children and adolescents aged 3 to 17 (Cohen et al., 2017). TF-CBT therapists go by these age guidelines when deciding if someone is a good fit for TF-CBT. The only time someone over 18 participates in TF-CBT will be if the child was 17 at the start of treatment and has already started treatment or if the child or adolescent's developmental level is lower than 18 (Cohen et al., 2017).

The requirements for participation in TF-CBT are the following: the child or adolescent is between the ages of 3 and 18; there is a trauma history, which can be due to acute, chronic, or complex trauma; and the symptoms are a result of the trauma history (Cohen et al., 2017). The child or adolescent's symptoms either were not present before the traumatic event or were heightened post-trauma (Cohen et al., 2017). The child or adolescent does not have to meet full criteria for PTSD to qualify for TF-CBT. Some people who do not meet criteria still exhibit symptoms called post-traumatic stress symptoms (PTSS), and these children and adolescents are eligible for TF-CBT (Cohen et al., 2017).

As mentioned, one of TF-CBT's values is being a culturally sensitive treatment. This value means TF-CBT has been studied in many different countries and within many different cultures. Some studies have included Caucasian, African American, Latino, European, Australian, and African youth (Cohen et al., 2004; Cohen et al., 2011; O'Callaghan et al., 2013). TF-CBT has a treatment book with translations in Chinese,

Spanish, German, Dutch, Polish, Japanese, Korean, English, and soon will include French and Russian translations (Cohen et al., 2017).

The creators of TF-CBT have also tested TF-CBT in many different settings. TF-CBT can be implemented in outpatient therapy centers, schools, residential facilities, and the home (TF-CBT Therapist Certification Program, 2021). A study completed by Cohen and colleagues (2016) looked at how effective TF-CBT was if implemented in residential treatment facilities. Youth in residential facilities statistically have higher rates of trauma exposure. This study looked at the effectiveness of the treatment and the effectiveness based on the provider's training and experience (Cohen et al., 2016). The study showed that youth who completed TF-CBT had statistically and clinically significant improvements in PTSD, PTSS, and depressive symptoms (Cohen et al., 2016). Standardized measures were used at pre-and post-treatment to assess for these symptoms (Cohen et al., 2016). The study shows that providers who attended the web-based training and live training were more effective in implementing TF-CBT than the providers who only completed the web-based training (Cohen et al., 2016).

Fitzgerald and Cohen (2012) looked at school systems as an ideal location to screen children who have experienced trauma. Fitzgerald and Cohen discussed the critical role schools could play in treating children while at school. School psychologists trained in TF-CBT can provide the treatment in the school setting (Fitzgerald & Cohen, 2012). Utilizing this treatment in schools is important because some children who experience trauma have symptoms that directly correlate to school-related academic and behavioral problems.

The creators of TF-CBT wanted to ensure children in multiple settings in multiple countries and from multiple different ethnic backgrounds could benefit from TF-CBT. In order to ensure the creators attained this goal, specific manuals were designed for implementing TF-CBT in the following settings and populations: sexually exploited children, implementation for military, residential facilities, via telehealth, and foster care (TF-CBT Therapist Certification Program, 2021).

How to Implement Trauma-Focused Cognitive Behavioral Therapy

TF-CBT is a therapeutic intervention intended for trained providers to implement (Cohen et al., 2017). In order to implement TF-CBT, providers need to be competent in the therapy. The APA ethics code says in Standard 2.01 psychologists must practice within the boundaries of their competence, which is determined by studies, supervised experiences, education, and training (American Psychological Association, 2010). To become competent, providers need to participate in the necessary training to become certified TF-CBT providers.

TF-CBT is a phase-based intervention with three distinct phases and the components of TF-CBT make up the three phases (Cohen et al., 2017). All three phases are close to equal in length, and on average, each phase is one-third of the overall treatment (Cohen et al., 2017). TF-CBT can be completed anywhere from 12 to 25 sessions. How long treatment lasts typically depends on both the therapist's skills and how complex the trauma history is. TF-CBT sessions are typically once a week for 60 to 90 minutes in length (Cohen et al., 2017). The treatment's success is heavily dependent on how consistent in attendance the child or adolescent and families are (Cohen et al., 2017).

Once the referral is made and the non-offending caregiver has been identified, treatment can begin. The sessions are structured where each 60 to 90-minute session has the provider see both the child and the caregiver (Cohen et al., 2017). At the beginning of the session, the provider always sees the child or adolescent first and the caregiver at the end to ensure the child or adolescent knows this treatment is for them, not the caregiver (Cohen et al., 2017). The time spent with both the child or adolescent and the caregiver needs to be equal throughout treatment, which means some weeks more time might be spent with the child versus the caregiver or vice versa (Cohen & Mannarino, 2015). Overall, balance is needed.

All sessions are structured similarly. At the beginning of the session, the provider will check in with the child or adolescent and review any assigned homework. Then a new skill is introduced, or a previously learned skill is reviewed (Cohen et al., 2017). The child or adolescent practices the skill in session, and the provider teaches how to apply the skill. Each session builds off one another, so what the child or adolescent learns in one session is used in future sessions (Cohen et al., 2017). Providers always integrate the skills the child or adolescents have been learning previously and explain how the skills can apply to what the child or adolescent is currently learning in treatment (Cohen et al., 2017). Finally, the provider assigns homework. Once the child's portion ends, the caregiver comes in, and the child or adolescent leaves. The caregiver's portion of the session is like the child portion, where there is a check-in, review of skills, practice of new skills, and a discussion of plans for homework (Cohen et al., 2017). The homework typically overlaps, and the provider goes over what the child learned with the caregiver

so the caregivers can help with homework for the week and assist in practicing the skills learned outside of the session (Cohen et al., 2017).

The first session is typically an assessment session where the provider gathers background information, trauma history, trauma symptoms, and other relevant information (Cohen et al., 2017). This first session can vary by the provider's setting, as some places like community mental health centers have specific intake procedures for new child or adolescents. The child or adolescent and caregiver then complete assessments in the intake session or the following session (Cohen et al., 2017). These specific assessments are structured and specifically designed to assess for PTSD and trauma. The following are the most used assessments: University of California Los Angeles (UCLA) PTSD Reaction Index (UCLAP-RI; Pynoos & Steinberg, 2013), which has both child or adolescent and caregiver versions, the Trauma Symptom Checklist (TSC) for both children and young children (Briere, 1995), the Child PTSD Symptom Scale (CPSS; Foa & Capaldi, 2013), and the Child and Adolescent Trauma Scale (CATS; Goldbeck & Berliner, 2014). Providers choose which assessment method to use and are not required to give them all. After the intake and assessments, the next session includes a review of the results and diagnoses as well as supplying an overview of the treatment and the expectations for all parties involved (Edna Bennett Pierce Prevention Research Center, 2020).

After the provider completes the intake and reviews the assessments, treatment can begin. The acronym for the components of TF-CBT is PRACTICE: Psychoeducation and parenting skills, relaxation, affective regulation, cognitive coping one, trauma narrative and cognitive processing two, in vivo mastery of trauma reminders, conjoint

processing of trauma, and enhancing future safety (Cohen et al., 2017). The components exist to provide a framework to implement TF-CBT. TF-CBT is a very structured treatment, but there is some room for modification within the structured framework (Cohen et al., 2017). PRACTICE is an acronym describing the order of the components. However, the provider incorporates gradual exposure and parenting skills throughout the entire length of treatment (Cohen et al., 2017). In vivo mastery and conjoint processing of trauma are the only two components providers can skip, varying by case (Cohen et al., 2017). If the child or adolescent does not have a caregiver involved in treatment, then the conjoint sessions can be skipped. In vivo mastery is a component only necessary if, post-trauma narrative, the child or adolescent is still exhibiting trauma symptoms (Cohen et al., 2017).

In order to understand how TF-CBT works, there must be a basic understanding of how the different components are incorporated into the different phases. Phase 1 of treatment includes the PRAC components: psychoeducation, relaxation, affective regulation, and cognitive coping one. Psychoeducation is used to help normalize the trauma responses the child or adolescent is experiencing and the caregiver's reaction (Cohen et al., 2017). This component aims to provide information about the specific type of trauma or traumas the child or adolescent experienced and the child or adolescent's physiological reaction to stress (Cohen & Mannarino, 2008). This education allows the family to learn about the cause of some of the problematic behaviors or symptoms. Knowing this information can help increase treatment engagement. The provider incorporates psychoeducation as often as needed, specifically whenever the provider introduces a new component of treatment (Cohen & Mannarino, 2008). Psychoeducation

helps explain why the child or adolescent is doing what they are doing and shows how the skill can benefit them (Cohen & Mannarino, 2008). This component is for both the child or adolescent and the caregiver.

Parenting skills are the second part of the “P” component. Like psychoeducation, parenting skills are necessary throughout the entire treatment process. This section is only for the caregiver. Here the provider teaches skills like labeled praise, active ignoring, selective attention, implementing consequences, using time-outs effectively, and other techniques (Cohen & Mannarino, 2015). What skills to teach will be determined based on the age of the child or adolescent. The most important factor is consistency, regardless of the skill (Cohen et al., 2017). These skills teach parents how to handle their child or adolescent’s trauma symptoms in a helpful way to the child or adolescent and themselves (Cohen & Mannarino, 2015).

Relaxation is the next component. In this section, the provider teaches relaxation techniques to help reduce physiological stress. Some of the common relaxation strategies taught for all ages are deep breathing, progressive muscle relaxation, and guided imagery (Cohen & Mannarino, 2015). These skills are taught early on in treatment; so, in the future, once the child or adolescent begins to talk more openly about the traumatic event, the child or adolescent will have already learned the tools necessary to help calm them down in the moment (Cohen et al., 2017). These techniques are taught early on in treatment, so when the child or adolescent has a trauma reminder and is in distress, the child or adolescent has skills to use to help calm down. The age of the child or adolescent will determine how the skills are taught (Cohen et al., 2017). Skills like stress balls, yoga, music, and books can also be taught and be effective. However, calming down their body

physiologically, progressive muscle relaxation, guided imagery, and deep breathing have more research support (Cohen et al., 2017). This section is for both the child or adolescent and the caregiver. The caregiver can learn the same techniques as the child or adolescent in order to help them practice and learn techniques themselves to help as the caregiver processes the trauma (Cohen & Mannarino, 2008).

Affective regulation is the next component addressed in treatment. This component focuses on being able to identify and label different emotions (Cohen et al., 2017). Children or adolescents who have experienced trauma may experience multiple feelings at once and may have a hard time understanding or expressing them. This section works to increase their knowledge of emotion vocabulary and their ability to identify and express different emotions (Cohen et al., 2017). This component is helpful when trauma reminders occur because the skill teaches them to label the emotion felt. This section is for both the child or adolescent and caregivers. This component is essential for the caregiver because it allows the caregiver to express and label their emotions towards the trauma and their child or adolescent's behavior (Cohen & Mannarino, 2008).

Cognitive coping has two sections. Cognitive coping one is the final section of phase 1. The goal of this stage is to help the child or adolescent become more aware of their thoughts. Using cognitive behavioral therapy (CBT) interventions like the cognitive triangle allows them to learn how their thoughts affect their feelings and behaviors (Cohen et al., 2017). In this section, the provider focuses on non-trauma-related examples to help them learn the concept. This component is where dysfunctional thought patterns will begin to reveal themselves (Cohen et al., 2017). The provider avoids addressing and correcting the distorted thoughts until later in treatment. Using CBT techniques, this stage

teaches the child or adolescent to become more aware of their thoughts and helps explain and label different thoughts like automatic thoughts (Cohen et al., 2017). In the caregiver portion of the session, providers also introduce the cognitive triangle but focus the conversation on the caregiver's thoughts about the child's trauma and keep it child-focused (Cohen & Mannarino, 2015).

Phase 2 of treatment consists of the trauma narrative component, part 2 of the cognitive coping component, and, if needed, in-vivo mastery of trauma reminders. The trauma narrative is where the focus shifts to the trauma the child or adolescent experienced. This section aims to desensitize them from the trauma and disclose all the details of the traumatic event (Cohen et al., 2017). This component allows the child or adolescent to gain mastery over their trauma reminders and identify any avoidance. The provider writes down everything the child or adolescent says word for word, then re-reads the narrative multiple times to give the child or adolescent repeated exposure (Cohen et al., 2017). At this point in treatment, the child or adolescent is revealing the details of the trauma. The caregiver portion of these sessions will allow the provider to read the narrative to the caregiver to allow them a chance to react and process their reactions before they hear about the trauma from the child or adolescent (Cohen & Mannarino, 2008). If the child or adolescent is hesitant about the caregiver hearing portions of the trauma narrative, the provider will address those concerns and seek to gain the child's assent before continuing (Cohen et al., 2017).

Cognitive coping two is similar to cognitive coping part 1. However, now, the provider identifies cognitive distortions related to the trauma, unpacks them, and helps the child or adolescent replace those thoughts (Cohen & Mannarino, 2008). The caregiver

goes through the same process here, and the provider works with them to identify their cognitive distortions (Cohen & Mannarino, 2008).

In vivo mastery is the final component of phase 2 and is not a component everyone must complete. This component focuses on real-life exposure if a particular situation is still causing the child or adolescent distress post-trauma narrative (Cohen et al., 2017). This component will be helpful if the child or adolescent is experiencing distress about a future event or place the child or adolescent might find themselves in. In this component, the caregiver's job is to work with the provider to develop a plan and then carry out the plan outside the session (Cohen et al., 2017).

The final phase is conjoint sessions and enhancing safety. Conjoint parent-child sessions are the first time both the caregiver and child or adolescent are together with the provider (Cohen et al., 2017). This component aims to allow the child or adolescent to share the trauma narrative with the caregiver and create a place for communication. The provider can skip this component if there is no caregiver involved in treatment (Cohen & Mannarino, 2008).

The final component is enhancing future safety. This component focuses on creating a safety plan the child or adolescent uses to identify safe adults and make sure the child or adolescent knows the difference between what is appropriate and inappropriate (Cohen et al., 2017). The caregivers in this component help develop the safety plan. After this component, the child or adolescent has graduated from TF-CBT. The provider administers standardized assessments showing the progress made during treatment (Cohen & Mannarino, 2015). The assessments the child or adolescent completed at the beginning of treatment will be administered again before the trauma

narrative begins and then for a third time at the end of treatment (Cohen & Mannarino, 2015).

How to Become Certified in Trauma-Focused Cognitive Behavioral Therapy

According to the APA Ethics Code Standard 2.01, those in the providing services to child or adolescents must practice within their bounds of competence. Education, training, professional experience, and studies determine the provider's competence (American Psychological Association, 2010). The creators of TF-CBT have developed very detailed criteria for providers to become certified to implement TF-CBT. The certification process requires providers to have a master's degree or above in mental health and have a professional license to practice in their state (TF-CBT Therapist Certification Program, 2021). The creators of TF-CBT created an online training course used as a pre-requisite to any in-person training. Once providers complete the web training, they register for a two-day TF-CBT training hosted by a certified TF-CBT trainer (TF-CBT Therapist Certification Program, 2021). The next step is to participate in consultation calls where the providers apply the information learned in training and beginning TF-CBT with child or adolescents. The consultation calls are held either twice a month for 6 months or once a month for 12 months (TF-CBT Therapist Certification Program, 2021). Before providers can become fully certified, they have to complete three cases of TF-CBT, use standardized assessments to monitor progress before, during, and post-treatment, and complete the TF-CBT Therapist Certification Program Knowledge-Based Test (TF-CBT Therapist Certification Program, 2021). Once the provider completes the above steps, an application is submitted verifying completion of the necessary steps to become certified, and then a post-test is taken.

According to the NCTSN, the cost for agencies, like community mental health clinics, can range between \$4,000 and \$6,000 for the 2-day training and an additional \$150 to \$200 dollars for each consultation call (The National Child Traumatic Stress Network, n.d.). The online web training can cost as little as \$35 dollars (Medical University of South Carolina, 2017).

The creators of TF-CBT and certified trainers in TF-CBT emphasize that providers who only complete the web training are not certified in TF-CBT, which means implementing TF-CBT with child or adolescents after completing the web training alone would be unethical. Providers can use TF-CBT with child or adolescents after the completion of the two-day training (Cohen et al. 2017).

Is Trauma-Focused Cognitive Behavioral Therapy an Evidence-Based Treatment?

According to the APA, evidence-based practice (EBP) is when the best research combines clinical expertise and patient values (American Psychological Association, 2002). EBP allows providers to choose interventions, techniques, and therapy styles that have been empirically studied and proven to work for a specific population or diagnosis. For a treatment to be considered an EBP, there must be at least two randomized controlled trials (RCT) showing the therapy is effective with a specific population or diagnosis (Cohen & Mannarino, 2017). Providers who use EBP use the best practices or preferred practices within the field. There are many EBP, and not all of them work to treat the same problems.

APA created the Society of Clinical Psychology, Division 12, and within Division 12 there are many resources for providers to access to aid in their practice. One of the resources looks at psychological treatments and lists treatments by diagnosis with the

evidence-based label or treatments with solid research behind them (Society of Clinical Psychology, 2016). This website provides the latest articles and developments regarding treating different adult disorders and providing information on where to find clinical resources and training opportunities for a specific type of therapy (Society of Clinical Psychology, 2020). Division 12 focuses specifically on adults, so Division 53 compiles a list of EBP for treating children and adolescents. This website lists many different EBP therapies, one of which being TF-CBT (Society of Clinical Child and Adolescent Psychology, 2012).

Purpose of this Systematic Review

According to the NCTSN, TF-CBT has the most substantial research support for treating trauma in children and adolescents than any other model currently available (e.g., Cohen et al., 2004; Deblinger et al., 2006; McMullen et al., 2013; O’Callaghan et al., 2013; Scheeringa et al., 2011). The purpose of this systematic review is to review studies that examined the efficacy and effectiveness of TF-CBT for use with children and adolescents who have experienced trauma. Efficacy and effectiveness were both incorporated into the review to provide a more comprehensive overview of TF-CBT.

Efficacy and effectiveness studies are both important in terms of research but answer two different questions. Studies that examine efficacy seek to answer, does this produce a desired result under ideal conditions and are high in internal validity (Stricker, 2000). Ideal conditions refer to very controlled environments. Efficacy studies are used in the field of psychology to determine whether a treatment works (Stricker, 2000). These studies often help determine what treatments are considered evidenced based (Stricker, 2000). On the other hand, effectiveness studies evaluate if a treatment produces a desired

effect in real-world conditions and are high in external validity (Stricker, 2000). For this review, the efficacy studies that are included answer the question is TF-CBT an effective treatment for treating the populations and symptoms for which it was created? The effectiveness studies evaluate if TF-CBT can be generalized across different settings like community settings and still produce the same results. As a clinician, evaluating both types of evidence is useful; efficacy results show the clinician if the treatment they are considering works, and the effectiveness studies can show if it will work for the population they are considering using the treatment with.

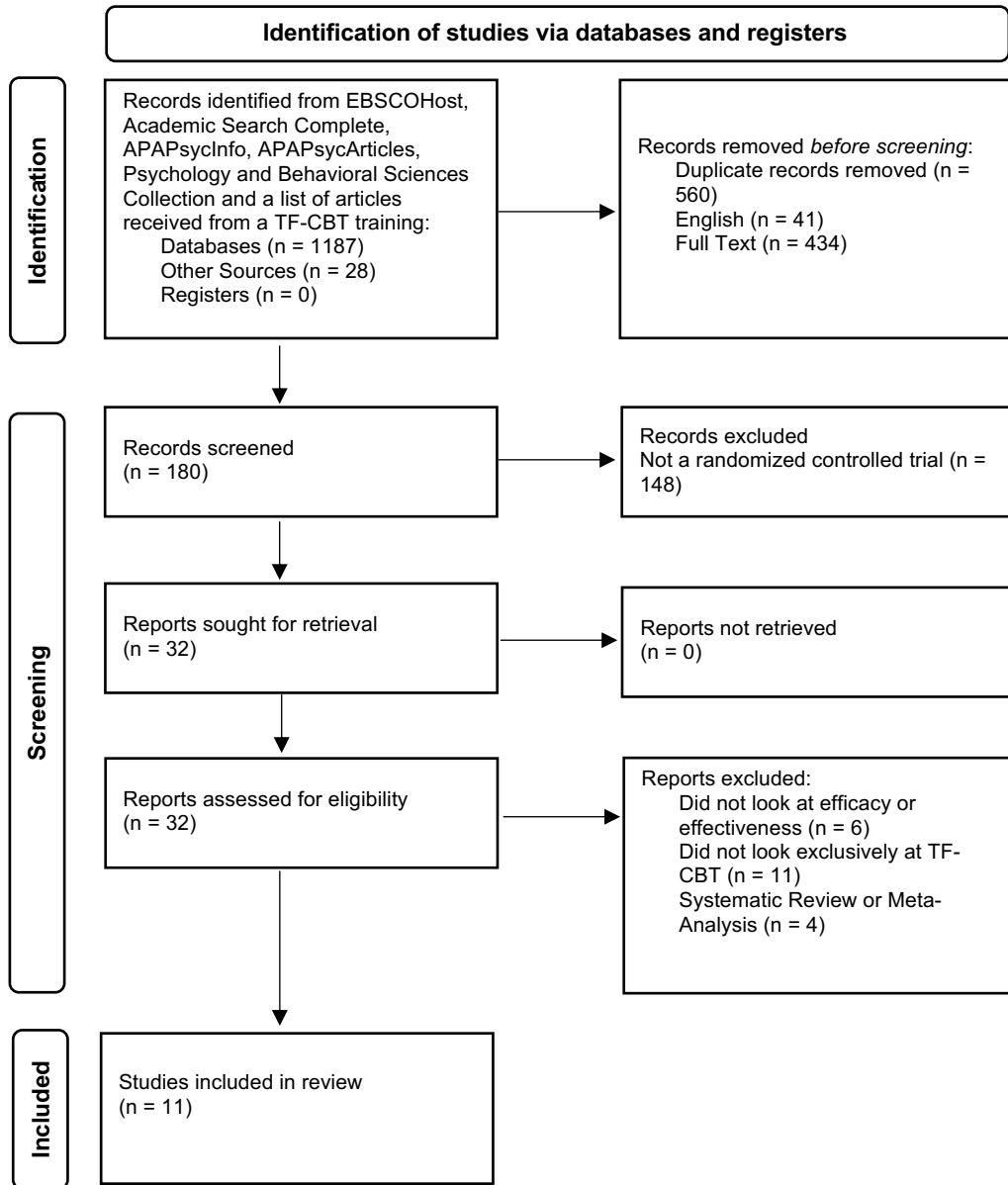
Methods

Studies included in this review were found by using the MYWKU library databases. This study followed the PRISMA method for systematic reviews (Figure 1; Page et al., 2021) The databases used included EBSCOHost, PsycInfo, PsycArticles, Academic Search Complete, and Psychology and Behavioral Sciences Collection. A resource that was provided at a trauma-focused cognitive behavioral therapy (TF-CBT) training was included as well. The resource was a document listing references for different research articles that have been published about TF-CBT. This resource was obtained during a TF-CBT training conducted by a certified trainer (Risk, 2021). Search terms included TF-CBT (written out and abbreviated), trauma, children, adolescents, and randomized controlled trial (RCT). The search terms were combined in the following ways: TF-CBT, trauma, children, RCT and TF-CBT, trauma, adolescents, and RCT. Combining the search results from the library databases and the list of articles on the resource handout yielded 1,215 results. The following exclusionary criteria were used to filter out articles: not written in English, did not have full-text availability, not RCT design, if TF-CBT was not the main focus of the study, if determining efficacy or effectiveness was not the goal of the study, and if the article was a systematic review or meta-analysis not specific to TF-CBT. After filtering through the articles, 11 RCT's were left, two of which were follow-up studies to two of the included articles. This study looks at RCTs because RCTs are considered a gold standard in determining causal relationships and are also one of the criteria used to determine if a practice is considered evidence-based (Hariton & Locascio, 2018). RCT's were also chosen because this study is evaluating TF-CBT compared to other types of therapy, which would require TF-CBT to

be compared to a control group. Out of the 11 articles selected for inclusion, four evaluate efficacy and seven evaluate effectiveness.

Figure 1

PRISMA Flowchart of Article Selection



Results

Efficacy Versus Effectiveness of Trauma-Focused Cognitive Behavioral Therapy

Looking at both the efficacy and effectiveness of trauma-focused cognitive behavioral therapy (TF-CBT), common themes were found among the articles included in this review. Table 1 refers to the articles included in the study and the order the articles are listed in the table is the order they appear below. All the reviews showed that TF-CBT was effective in reducing post-traumatic stress disorder (PTSD) diagnosis or post-traumatic stress symptoms (PTSS; Cohen et al., 2004; Deblinger et al., 2006; Kameoka et al., 2020; Scheeringa et al., 2011). However, not all of the studies were statistically significant when compared to the control groups. For example, cognitive behavioral intervention for trauma in schools (CBITS) and eye movement desensitization and reprocessing (EMDR) were two treatments that when compared to TF-CBT, did not yield statistical differences (Diehle, et al., 2015 & Jaycox et al., 2010). Overall, nine of the 11 articles showed a statistically significant decrease in general mental health symptoms like depression and anxiety. Two of the articles showed a reduction in anxiety symptoms, but the difference was not significant when compared to the control group (Jensen et al., 2014 & Kameoka et al., 2020). Overall, there are some mixed results found in terms of TF-CBT addressing comorbidities or symptoms of comorbidities, but in terms of treating PTSD and trauma symptoms, TF-CBT is effective and efficacious.

Table 1*Overview of Studies Examining the Efficacy and Effectiveness of TF-CBT*

Study	Comparison Group	Type of Trauma	Type of Study	Relevant statistics
Cohen, Deblinger, Mannarino, and Steer (2004)	Child-Centered Therapy	Sexual Abuse	Efficacy	Statistically significant difference between PTSD diagnoses post-treatment; $\chi^2_{Yates}(1, N = 180) = 11.28, p < .001, \phi = 0.26$.
Deblinger, Mannarino, Cohen, and Steer (2006)	Child-Centered Therapy	Sexual Abuse	Efficacy	TF-CBT group-maintained improvements at post-treatment ($d = -0.19$) 6 ($d = -.03$) and-12-month ($d = -0.18$) follow-up and maintained reduction in PTSD symptoms. TF-CBT ($M = 6.46$ $SD = 2.46$ post-treatment, $M = 6.44$ 6-month $SD = 2.49$, $M = 6.00$ $SD = 1.94$ 12 month). CCT ($M = 7.24$ $SD = 2.89$ post-treatment, $M = 6.51$ $SD = 2.58$ 6-month; $M = 6.4$ $SD = 2.55$ 12-month)
Scheeringa, Weems, Cohen, Amaya-Jackson, Guthrie (2011)	Waitlist Condition	Any Type of Trauma	Efficacy	TF-CBT showed an 82.4% reduction in PTSD diagnoses post-treatment and maintained at 6-month follow-up; $F = 29.01, df = 2,44, p < 0.0001$.
O'Callaghan, McMullen, Shannon, Rafferty, & Black (2013)	Waitlist Condition	Sexually Exploited War-Affected Girls	Efficacy	TF-CBT showed significantly greater reductions in trauma symptoms; $F(1, 49) = 52.708, p < 0.001, \chi^2_p = 0.518$. TF-CBT showed significant reduction in depression, anxiety, conduct problems, and prosocial behaviour.
McMullen, O'Callaghan, Shannon, Black, Eakin (2013)	Waitlist Condition	Child Soldiers and War Affected Boys	Effectiveness	TF-CBT showed highly significant reduction in PTSS [$F(1, 45) = 89.27, p < .001, \eta_p^2 = .665$]; Psychosocial distress [$F(1, 45) = 72.47, p < .001, \eta_p^2 = .617$]; depression/anxiety symptoms [$F(1, 45) = 58.82, p < .001, \eta_p^2 = .567$]; conduct problems [$F(1, 45) = 18.18, p < .001, \eta_p^2 = .288$]; and increase in prosocial behaviour [$F(1, 45) = 34.18, p < .001, \eta_p^2 = .432$].
Jaycox, Cohen, Mannarino, Walker, Langley, Gegenheimer, Scott, and Schonlau (2010)	Cognitive Behavioural Intervention for Trauma in Schools	Natural Disaster	Effectiveness	Both CBITS and TF-CBT led to significant improvement of PTSD symptoms and an improvement in depressive symptoms (CBITS; $n = 37$; 65%) and (TF-CBT; $n = 6$; 43%). However, CBITS difference was statistically significant in depressive symptoms (TF-CBT; difference (t) = -1.37; CBITS; difference (t) = -4.30).
Kameoka, Tanaka, Yamamoto, Saito, Narisawa, Arai, Nosaka, Ichikawa, & Asukai (2020)	Waitlist Condition	Any Type of Trauma	Effectiveness	TF-CBT showed significantly greater reduction in symptoms and PTSD diagnosis, 70% remission compared to 10%, and on the K-SADS-PL (TF-CBT: baseline $M = 12.64, SD = 2.34$, 1 month $M = 7.07$ $SD = 4.38$, pre-post reduction 44.1% $d = 1.59$; Waitlist: baseline $M = 11.56, SD = 3.05$, 1 month $M = 9.69, SD = 3.84$, pre-post reduction 16.2% $d = .54$) but did not show significant difference in anxiety symptoms between group $d^2 = .35, 95\%CI = -.38, 1.09$].
Cohen, Mannarino, & Iyengar (2011)	Child-Centered Therapy	Intimate Partner Violence	Effectiveness	TF-CBT showed significantly greater reduction in PTSD diagnostic remission $\chi^2 = 4.67, p = .03$ and reported fewer adverse events $n = 2, z = 2.9, p < .005$.
Jensen, Holt, Ormhaug, Egeland, Granly, Hoas, Hukkelberg, Indregard, Stormyren, & Larsen (2014)	Therapy As Usual	Any Type of Trauma	Effectiveness	TF-CBT reported significantly less PTSS (TF-CBT) $M = 10.33; SD = 1.99$ (TAU) $M = 9.22; SD = 2.09; d = -0.55, t(154) = -3.32$, depression and general mental health symptoms (TF-CBT) $M = 14.40, SD = 13.67$ $d = -0.54, t(154) = -2.79$ and (TAU) $M = 22.67, SD = 16.24$. Anxiety was reduced, but the difference was not statistically significant.
Jensen, Holt, & Ormhaug (2017)	Therapy As Usual	Any Type of Trauma	Effectiveness	Symptom improvement was maintained at the 18-month follow-up and for TF-CBT symptom reduction was quicker than the TAU group. On the CPSS for TF-CBT: Time 1 $M = 26.82, SD = 7.46$; Time 5 $M = 10.42, SD = 12.07$. For TAU: Time 1 $M = 26.88, SD = 7.90$; Time 5 $M = 13.28, SD = 11.13$.
Diehle, Opmeer, Boer, Mannarino, & Lindauer (2015)	Eye Movement Desensitization and Reprocessing	Any Type of Trauma	Effectiveness	No statistical difference in PTSD diagnoses between groups. TF-CBT: fisher's exact test $p = 0.45$; EMDR: Fisher's exact test $p = 0.45$).

Note. PTSD = post-traumatic stress disorder; TF-CBT = trauma focused-cognitive behavioural therapy; CCT: Child-Centered Therapy; CBITS = cognitive behavioural intervention for trauma in school; PTSS = post-traumatic stress symptoms; TAU = therapy as usual; EMDR = eye movement desensitization and reprocessing; CPSS: Child PTSD Symptom Scale, K-SADS-PL: Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children.

Efficacy Studies

Cohen, Deblinger, Mannarino, and Steer (2004) examined the efficacy of TF-CBT and compared TF-CBT with child-centered therapy (CCT) for children who have PTSD symptoms due to sexual abuse. In this study, 229 children between the ages of 8 and 14 and their non-offending caretaker participated in a screening (Cohen et al., 2004). The 229 children were included in the screening because child protective services confirmed the children experienced sexual abuse (Cohen et al., 2004). Referrals for this study were obtained from child protective services, police, primary care doctors, mental health clinics, and advocacy centers. Exclusion criteria for the study were if the child had a psychotic disorder or was already receiving therapy for the abuse (Cohen et al., 2004).

Multiple assessments were utilized to evaluate the two groups. The Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children present, and Lifetime (K-SADS-PL; Kaufman et al., 2016) was given to the parent and child to assess for psychiatric disorders. The Children's Depression Inventory (CDI; Kovacs, 2015) was used to monitor depressive symptoms. The State-Trait Anxiety Inventory for Children (STAI; Spielberg, 1989) monitored anxiety symptoms. The Children's Attribution and Perceptions Scale (CAPS-CA; Mannarino et al., 1994) assessed if there was any self-blame for adverse events. The caretakers completed the K-SADS-PL (Kaufman et al., 2016), the Child Sexual Behavior Inventory (CSBI; Friedrich, 1997), the Beck Depression Inventory (BDI; Beck et al., 1996), the Parent Emotional Reaction Questionnaire (PERQ; Cohen & Mannarino, 1996), and finally, the Parental Support Questionnaire (PSQ; Mannarino & Cohen, 1996).

The 229 participants were randomly assigned to the TF-CBT group ($n = 114$), and the CCT group ($n = 115$; Cohen et al., 2004). Treatment for both groups included 12 weekly sessions with the parent and child individually, each party getting 45-minute sessions. The mean number of TF-CBT sessions attended was 10.47 ($SD = 2.89$), and the mean number of CCT sessions attended was 10.75 ($SD = 2.44$; Cohen et al., 2004). There was no significant difference in the dropout rate between the TF-CBT group ($n = 89$) and the CCT group ($n = 91$; Cohen et al., 2004). There was also no significant difference between completion rates for either group. The authors then compared pre- and post-treatment assessment results. A X^2 test for independence was utilized to compare PTSD diagnosis post treatment (Cohen et al., 2004). At pre-treatment, the difference in PTSD diagnosis was not significant for either the TF-CBT group ($n = 75$; 84%) and the CCT group ($n = 83$; 91%; Cohen et al., 2004). Post-treatment, there was a statistical difference in PTSD diagnosis between the TF-CBT group ($n = 19$; 21%) and the CCT group ($n = 42$; 46%; $X^2_{Yates}(1, N = 180) = 11.28, p < .001, \phi = 0.26$; Cohen et al., 2004).

A follow-up study was completed in 2006 to assess for 6-and 12-month follow-up results. Using a repeated analysis of covariance (ANCOVA), those who received TF-CBT still had reduced PTSD symptoms and less self-blame at both the 6-month and 12-month follow-up compared to the CCT treatment (Deblinger et al., 2006). The TF-CBT group-maintained improvements from post-treatment, $d = -0.19$, to the 6-month follow-up, $d = -.03$, and the 12-month follow-up, $d = -0.18$. TF-CBT results were as follows: $M = 6.46$ $SD = 2.46$ at post-treatment, $M = 6.44$ $SD = 2.49$ at 6-months, $M = 6.00$ $SD = 1.94$ at 12 months. CCT results were as follows: $M = 7.24$ $SD = 2.89$ at post-treatment, $M = 6.51$ $SD = 2.58$ at 6-months; and $M = 6.4$ $SD = 2.55$ at 12-months; Deblinger et al., 2006)

A study by Scheeringa, Weems, Cohen, Amaya-Jackson, and Guthrie (2011), evaluated TF-CBT versus a waitlist condition for children between the ages of three and six-years-old who met the criteria for PTSD. This study was the first to look specifically at this age range who experienced any trauma, not just sexual abuse. Before this study, studies done with this age group primarily looked at sexual abuse as the only trauma type (Scheeringa et al., 2011). Inclusion criteria were the following: the child or adolescent experienced any traumatic event, were between three and six years of age, and met at least four criteria for PTSD (Scheeringa et al., 2011). There were 90 participants in the study, but the study was interrupted by Hurricane Katrina, and only 25 completed treatment. The participants received 12 sessions of TF-CBT. At pretreatment, 17 out of 25 participants had a PTSD diagnosis, and at post-treatment, only three did (82.4% reduction; Scheeringa et al., 2011). At the 6-month follow-up, 16 of the 25 participants were reassessed using a follow-up test with a random-effects model for PTSD symptoms, and the difference was significant, which means TF-CBT was more efficient in treating trauma-related symptoms than the waitlist group ($F = 29.01$, $df = 2,44$, $p < 0.0001$; Scheeringa et al., 2011). This study was the first to show that TF-CBT was adequate for a young population in treating multiple types of trauma, not just sexual abuse (Scheeringa et al., 2011).

The following study is critical because the study focused on a population who experienced war and sexual violence and included people from the Democratic Republic of the Congo. This study is also significant because the researchers used a culturally modified version of TF-CBT (O'Callaghan et al., 2013). The hypothesis was TF-CBT would show much more progress in the four domains of anxiety, depression, prosocial

behavior, and conduct problems than those in the control group (O'Callaghan et al., 2013).

The participants from this study were girls between the ages of 12 and 17 who had been war-affected, victims of rape, or sexual abuse (O'Callaghan et al., 2013). Fifty-two girls rescued by a non-government organization qualified for this study. The participants were given a screener with added questions about rape and sexual abuse (O'Callaghan et al., 2013). Exclusion criteria were having a psychotic disorder, an intellectual disability, or other intense emotional or behavioral problems; but out of the 52 girls, no one met exclusion criteria (O'Callaghan et al., 2013).

The TF-CBT group used a culturally modified version of TF-CBT. The treatment still included psychoeducation, stress management, feelings, cognitive coping, and identifying unhelpful cognitions but incorporated these sections culturally appropriate to these girls (O'Callaghan et al., 2013). Some of the ways the treatment was adapted was a female talked about reducing the risk for revictimization specific to their environment using culturally relevant songs and games, and the social workers visited the girl's families to help establish trust and foster acceptance (O'Callaghan et al., 2013). The girls in the TF-CBT group received 15 sessions in a group format, with three individual sessions in the middle of treatment. The groups lasted 2 hours a day and were held three times a week for 5 weeks. There were also three caregiver sessions to help talk about the child's rights, the impact of the trauma, and to help establish safety (O'Callaghan et al., 2013).

The results in this study were measured by looking at specific symptoms, not the diagnosis as a whole. The University of California Los Angeles (UCLA) PTSD Reaction

Index (UCLAP-RI; Pynoos & Steinberg, 2013) and the African Youth Psychosocial Assessment (Betancourt et al., 2009) were used to assess symptom reduction (O’Callaghan et al., 2013). These assessments were translated into Swahili by two translators, then reviewed by an expert in Swahili to ensure the measures were culturally appropriate. An ANCOVA assessed the outcome. Twenty-four girls were in the TF-CBT experimental group, and 28 were in the waitlist control group (O’Callaghan et al., 2013). The ANCOVA showed the TF-CBT group had a highly significant reduction in trauma symptoms ($F_{1,49} = 52.71, p < .001$) depression and anxiety symptoms ($F_{1,49} = 52.37, p < .001$), conduct problems ($F_{1,49} = 17.12, p < .001$), and a significant increase in prosocial behavior ($F_{1,49} = 5.39, p < .05$; O’Callaghan et al., 2013). The reduction in symptoms was maintained or even improved at the three-month follow-up session. This article is significant because this was the first study including those from low-income countries. It also was the first study on a population who had been war-affected and exposed to rape and sexual abuse. The study showed that TF-CBT was successful in reducing trauma symptoms (O’Callaghan et al., 2013).

Effectiveness Studies

The following study, conducted in 2013, is similar to the study above. However, this study focuses on former child soldiers and other boys affected by war in the Democratic Republic of the Congo. Like the previous study, the goal was to determine the effectiveness of TF-CBT in reducing PTSD symptoms along with anxiety, depression, conduct problems, and increasing prosocial behavior (McMullen et al., 2013).

To find participants for this study, the authors utilized the International Committee of the Red Cross who were helping boys who were previously child soldiers

(McMullen et al., 2013). The child had to be below 18-years-old, a former child soldier, and had to be evaluated using the War Experiences Checklist to evaluate the types of traumatic events the boys experienced (McMullen et al., 2013). The total number of participants was 50 between the ages of 13 and 17, and all the participants spoke Swahili. McMullen and O'Callaghan were authors of the previous study who were involved in translating the measures used for the war-affected girls in the Congo from English to Swahili, so the same assessments were used (McMullen et al., 2013).

Cultural adaptations included treatment lasting for 15 sessions but using a group format versus individual, parent and conjoint, using culturally appropriate metaphors, songs, and games (McMullen et al., 2013). The control group was a waitlist group. The two groups were randomly assigned and evenly matched in terms of symptom severity (McMullen et al., 2013). The authors utilized an ANCOVA to look at the data. The TF-CBT group had a significant reduction in PTSD symptoms ($F_{1,45} = 89.27; p < .001$), overall distress ($F_{1,45} = 72.47; p < .001$), depression and anxiety ($F_{1,45} = 58.82; p < .001$), conduct problems ($F_{1,45} = 18.18; p < .001$), and showed an increase in prosocial behavior compared to the control group ($F_{1,45} = 34.18 p < .001$; McMullen et al., 2013). This study is significant because this was the first RCT evaluating a mental health treatment for child soldiers. The study is also significant because it showed that TF-CBT could be done in low-income places with limited resources and group settings (McMullen et al., 2013).

One type of trauma is experiencing a natural disaster. A school system impacted by Hurricane Katrina participated in a study conducted by Jaycox et al., (2010). This study examined students who had elevated trauma symptoms and randomly assigned them to receive TF-CBT or CBITS. Three schools participated in the study for a total of

195 students in fourth through eighth grade. Of the 195 screened, 118 had elevated PTSD symptoms and 77 were excluded. Students were randomly assigned to the TF-CBT group ($n = 60$) and the CBITS group ($n = 58$; Jaycox et al., 2010).

Involved parties completed assessments at the beginning of treatment, after 5 months, and again after 10 months. The Child PTSD Symptom Scale (CPSS; Foa & Capaldi, 2013), the UCLAP-RI (Pynoos & Steinberg, 2013), and the CDI (Kovacs, 2015) were administered. The format of the CBIT sessions was 10 sessions with both group and individual sessions, and TF-CBT's format was 12 conjoint sessions with parent and child. CBITS sessions were at school, and TF-CBT sessions were in a community mental health center (Jaycox et al., 2010). There was a significant difference in the completion numbers between the TF-CBT group ($n = 9$) and the CBITS group ($n = 57$). Both treatments showed significant improvement in PTSD symptoms at the 10-month post-treatment. Both the CBITS group ($n = 37$; 65%) and the TF-CBT group ($n = 6$; 43%) remained in the at risk range (Jaycox et al., 2010). Both CBITS and TF-CBT led to significant improvement of PTSD symptoms and an improvement in depressive symptoms (CBITS; $n = 37$; 65%) and (TF-CBT; $n = 6$; 43%). However, the CBITS group's difference was statistically significant in depressive symptoms (TF-CBT; difference (t) = -1.37, $p < .01$; CBITS; difference (t) = -4.30, $p < .01$; Jaycox et al., 2014).

The following study evaluates the most recent RCT in this review. The study took place in 2020 in Japan, and the study sought to evaluate TF-CBT's effectiveness in community settings in Japan. The hypothesis this study examined was that receiving TF-CBT is better than receiving minimal services in reducing PTSD symptoms, anxiety,

depression, behavioral problems, and dysfunction in Japanese children and adolescents (Kameoka et al., 2020).

Inclusion criteria for the study were the following: being between the ages of 6 and 18, were referred to a psychiatric or another treatment facility, have experienced at least one traumatic event, and have dysfunction in their daily life due to the trauma symptoms. Exclusion criteria are the following: having a psychotic disorder, substance use disorder, suicidal ideation, antisocial behavior, or impaired intellectual/cognitive functioning. Based on these criteria, 100 children were initially screened, and only 30 children and adolescents were included in the study (Kameoka et al., 2020).

The treatment for the TF-CBT group was 12 individual weekly sessions lasting between 90 and 100 minutes in length (Kameoka et al., 2020). The therapists were certified and completed the necessary TF-CBT training. In the control group, those in the waitlist condition received 12 individual weekly sessions lasting 90 to 100 minutes in length, but the therapists decided on a treatment to use and had more of a direct child or adolescent approach (Kameoka et al., 2020). The following assessments were used in the study: KSADS-PL (Kaufman et al., 2016), Children's Global Assessment Scale (CGAS; Schaffer et al., 1983), UCLAP-RI (Pynoos & Steinberg, 2013), the Child Behavior Checklist (CBCL; Achenbach, 1991), Depression Self-Rating Scale for Children (DSRSC; Birlleson, 1995), Spence Children's Anxiety Scale (SCAS; Spence, 1998), BDI (Beck, 1996), STAI (Speilberg, 1989), and the World Health Organization Quality of Life Scale (WHOQOL; World Health Organization, 2004).

The TF-CBT group had 14 participants, and the waitlist group had 16. The results were the TF-CBT group showed an improvement in symptoms on all assessment scales.

PTSD diagnoses in the TF-CBT group went from 10 to three (70% remission) and in the control group from 10 to 9 (10% remission). The following are the results of the K-SADS-PL: TF-CBT at baseline $M = 12.64$, $SD = 2.34$, at one month $M = 7.07$ $SD = 4.38$, with a pre-post reduction of 44.1% $d = 1.59$; Waitlist: at baseline $M = 11.56$, $SD = 3.05$, at one month $M = 9.69$, $SD = 3.84$, with a pre-post reduction of 16.2% $d = .54$). The results did not show significant difference in anxiety symptoms between group $d^3 = .35$, $95\%CI = -.38, 1.09$. This study is significant because no RCT looking at TF-CBT had been conducted in Asia. The study showed TF-CBT was superior in terms of the waitlist group. However, results did not show significant differences for anxiety, depression, behavioral problems, and psychosocial functioning like previous studies have (Kameoka et al., 2020). Another significant finding is this study showed that the western version of TF-CBT was effective in an Asian culture. The only cultural adaptation that was made was using materials that were translated into Japanese (Kameoka et al., 2020).

Another study by Cohen, Mannarino, and Iyengar (2011) looked specifically at PTSD resulting from intimate partner violence (IPV). IPV is violence between two caregivers, and this study looks at how a child witnessing IPV can be diagnosed with PTSD. The researchers chose to evaluate TF-CBT and CCT. They hypothesized that TF-CBT would decrease PTSD-related symptoms and anxiety, depression, and other behavioral problems more than CCT (Cohen et al., 2011).

Participants in this study were between the ages of 7 and 14-years-old, had to meet criteria for at least five PTSD symptoms directly related to the IPV, and spoke English (Cohen et al., 2011). Exclusion criteria were intellectual ability less than 80, having a psychotic disorder, and living in the IPV shelter (Cohen et al., 2011). Those

living in an IPV shelter were excluded (Cohen et al., 2011). One hundred forty participants were referred, and after a screening, 124 met inclusion criteria to join the study. The participants were randomly assigned to either the TF-CBT ($n = 64$) group or the CCT ($n = 60$) group (Cohen et al., 2011).

Both the CCT and the TF-CBT groups received individual sessions lasting 45 minutes long for 8 weeks. CCT's goal is to allow the therapist to empower the child or adolescent to direct their treatment, whereas TF-CBT aims to decrease trauma reminders and the distress those bring by desensitizing the child to the trauma (Cohen et al., 2011). The participants completed the following assessments at pre-and post-treatment: The K-SADS-PL (Kaufman et al., 2016), the UCLAP-RI (Pynoos & Steinberg, 2013), the Screen for Child's Anxiety Related Emotional Disorders (SCARED; Birmaher, 1995), the CDI (Kovacs, 2015), and the CBCL (Achenbach, 1991).

The study results showed before treatment that children in both groups did not differ statistically in initial assessment scores. The TF-CBT group scores ($n = 8$; 75% remission) were significantly lower than the CCT scores ($n = 10$; 43% remission $\chi^2 = 4.67, p = .03$) on the K-SADS-PL and showed more overall improvement (Cohen et al., 2011). There was also a significant difference in the number of adverse events reported post-treatment from the CCT group ($n = 10$) than in the TF-CBT group ($n = 2, z = 2.9, p < .005$; Cohen et al., 2011).

Jensen and colleagues (2014) designed a study to show the effectiveness of TF-CBT in a community setting compared to therapy as usual (TAU). The researchers used eight different community clinics for children and adolescents in Norway. Knowing any treatment can be beneficial, the researchers hypothesized both the TAU and TF-CBT

groups would improve (Jensen et al., 2014). However, the TF-CBT group was expected to show more significant symptom reduction, fewer PTSD diagnoses post-treatment, and better daily functioning (Jensen et al., 2014).

The 156 participants were between the ages of 10 and 18 and referred by the community mental health centers. The inclusion criteria were experiencing at least one traumatic event, and the trauma is causing distress or negative emotions that interrupt their ability to function in daily life (Jensen et al., 2014). The researchers used the following assessments: The Traumatic Events Screening Inventory for Children (TESIC; Ribbe, 1996), the CPSS (Foa & Capaldi, 2013), the Clinician-Administered PTSD Scale for Children and Adolescents (CA-PSCA; National Center for PTSD, 2015), the Mood and Feelings Questionnaire (MFQ; Angold & Costello, 1987), the SCARED (Birmaher, 1995), and the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). Random assignment placed the participants in either the control group (TAU; $n = 77$) or the experimental group (TF-CBT; $n = 79$). Certified TF-CBT trainers trained the TF-CBT therapists, and the TAU therapists provided a treatment of their choice (Jensen et al., 2014).

A power analysis was used to analyze the results. One hundred fifty-six participants started treatment, and 122 completed the posttreatment assessment. At the end of treatment, results indicated for the TF-CBT group, trauma impacted daily functioning significantly less than in the TAU group ($M = 10.33$; $SD = 1.99$; $M = 9.22$; $SD = 2.09$; $d = -0.55$, $t(154) = -3.32$). Depressive symptoms and general mental health symptoms were significantly lower in the TF-CBT group ($M = 14.40$, $SD = 13.67$ $d = -0.54$, $t(154) = -2.79$) than in the TAU group ($M = 22.67$, $SD = 16.24$). However, there

was no significant difference between groups in anxiety symptoms (Jensen et al., 2014). This study is significant because the researchers evaluated the effectiveness of TF-CBT in community mental health settings, and this study showed no significant improvement compared to the control group for a reduction in anxiety-related symptoms (Jensen et al., 2014).

Jensen et al., (2017) completed a follow-up study to the study above. After an 18-month follow-up, symptom reduction for the TF-CBT group was maintained and continued to show evidence of decline (Jensen et al., 2017). CPSS results for both groups are as follows: TF-CBT group at Time 1 $M = 26.82$, $SD = 7.46$; at Time 5 $M = 10.42$, $SD = 12.07$; TAU group at Time 1 $M = 26.88$, $SD = 7.90$; at Time 5 $M = 13.28$, $SD = 11.13$. The TAU group received many more sessions than the TF-CBT group, suggesting TF-CBT is more efficient.

As established earlier in the literature, trauma affects many people, and there are many different treatments for trauma for adults, one of them being EMDR. This next article analyzes whether TF-CBT or EMDR is more effective in treating children who have symptoms of PTSD (Diehle et al., 2015). The study was completed in a Dutch outpatient facility. This study design is unique because it evaluated the overall effectiveness of TF-CBT and EMDR determined by how many sessions each therapy requires and evaluating the effectiveness of the treatment in an outpatient setting (Diehle et al., 2015).

A trauma center referred participants for this study. Inclusion criteria were the following: being between the ages of 8 and 18, speaking Dutch, having experienced at least one traumatic event within four weeks of baseline assessment, and experiencing

PTSS (Diehle et al., 2015). Exclusion criteria were suicidality, psychotic disorders, substance use, and developmental disorders or autism. Seventy-one participants were screened, 48 were selected based on the inclusion criteria, 23 received TF-CBT, and 25 received EMDR (Diehle et al., 2015). The following assessments were used: CAPS-CA (National Center for PTSD, 2015), Anxiety Disorder Interview Schedule for DSM-IV (ADIS C/P; Brown & Barlow, 2014), Children's Revised Impact of Event Scale (CRIES; Children and War Foundation, 1998), the SDQ (Goodman, 1997), and the Revised Child Anxiety and Depression Scale (RCADS; Chorpita et al., 2021).

The treatment for both TF-CBT and EMDR included a total of eight weekly sessions, each with a duration of 60 minutes. The therapists in this study were trained and certified in both therapies and received supervision throughout the process (Diehle et al., 2015). TF-CBT sessions followed the manual but were changed to fit into eight sessions instead of 12 by shortening the number of sessions spent on each component (Diehle et al., 2015). Parents were also involved in portions of the session individually or with the child. The EMDR sessions followed the published EMDR manual, and parents had the opportunity to spend part of the session with the child and therapist or with the therapist individually (Diehle et al., 2015).

Results showed that EMDR and TF-CBT improved symptoms with a difference in improvement of 0.69 in favor of EMDR (Diehle et al., 2015). Looking at PTSD diagnoses after treatment for both conditions, there was no statistical significance in favor of either, but both showed a decrease in symptoms (TF-CBT: fisher's exact test $p = 0.45$; EMDR: Fisher's exact test $p = 0.45$; Diehle et al., 2015). Parents who had children involved in the TF-CBT group reported improvements on all subscales on the RCADS,

all but the prosocial scale on the SDQ, and a significant improvement in the major depressive disorder subscale and the hyperactivity subscale (Diehle et al., 2015). Parents from the EMDR group indicated improvement on most RCADS subscales besides the Separation Anxiety Disorder subscale and the Social Phobia Subscale. For the EMDR group, scores worsened on the SDQ Hyperactivity scale and only minor improvements were seen on the other scales (Diehle et al., 2015). This study evaluated another intervention specifically designed to treat trauma and tested how effective each therapy is for children. The researchers found both TF-CBT and EMDR are effective in treating trauma but found EMDR did not reduce any comorbid symptoms as TF-CBT did (Diehle et al., 2015).

Discussion

The focus of this systematic review was to review the research conducted on trauma-focused cognitive behavioral therapy and evaluate the efficacy and effectiveness of the treatment when compared to other treatment options for trauma. TF-CBT has been found to be very efficacious and effective in treating post-traumatic stress disorder (PTSD) symptoms in children and adolescents between the ages of 3 and 17 (Cohen et al., 2017). There is currently no other evidence-based treatment specifically designed for treating trauma in children and adolescents (Society of Clinical Child and Adolescent Psychology, 2012). TF-CBT has research support showing the benefits not only immediately at post treatment, but 3, 6, 10, and 18 months post treatment completion (Deblinger et al. 2006). This shows that TF-CBT has not only immediate, but lasting effects on the overall quality of living for the child or adolescents who receive this treatment (Deblinger et al., 2006).

Although TF-CBT is effective and efficacious in treating trauma, mixed findings were revealed across the studies in terms of treating anxiety. Like with any treatment, TF-CBT is not a one size fits all. It was specifically designed for treating PTSD and trauma symptoms in children and adolescents. The studies showed that anxiety symptoms were reduced, but the reductions were not statistically significant. This suggests that TF-CBT may help treat trauma related anxiety symptoms, but other treatment options may be warranted for someone who is still experiencing anxiety after completing TF-CBT.

TF-CBT has research support showing the efficacy for treating acute, complex, and chronic trauma (Jensen et al., 2014). TF-CBT showed clinically and significantly better outcomes when compared to child-centered therapy (CCT) as evidenced by several

studies showing the PTSD diagnosis post treatment for those who received CCT was twice as likely when CCT is compared to TF-CBT (Cohen et al., 2004). Many who experience a traumatic event take on shame and self-blame, and the TF-CBT group had greater improvements regarding trust, interpersonal experience, perceived credibility, and shame (Cohen et al., 2004).

Research has been completed in many non-western countries like the Democratic Republic of the Congo, Japan, and Norway. These studies all showed how TF-CBT can be adapted to be culturally appropriate and still be beneficial as long as the key components of the treatment are still implemented (McMullen et al., 2013).

Future Research and Limitations

With any study done there are personal limitations. One limitation to this study is limited access to databases. The search for articles included in the review were limited to full-text availability and resources like inter-library loan were not utilized. The study was also limited to only include articles that were available in the MYWKU databases, and if alternative search engines were used, more articles may have been able to be found to be included in the study. Another potential limitation to this study is bias towards TF-CBT. As a clinician, it is easy to see the value TF-CBT can offer as a treatment option for future clients. As clinicians, it is important to remain objective. In including articles for this review, given my personal bias towards TF-CBT, it is possible that effected what articles were included, specifically articles that frame TF-CBT in a positive light.

There are also other limitations in terms of the articles themselves. Out of the 11 studies that were reviewed, five of the studies had one or more of the TF-CBT creators as an author, which can create bias (Ramirez de Arellano et al., 2014). Future studies on TF-

CBT need to be conducted without the involvement of the creators Cohen, Deblinger, and Mannarino. Replication is an important component to research. Replication studies need to be done by people other than the TF-CBT creators to see if different people's results would match with the results the creators concluded.

Although many of the reviewed studies were done with different populations from different cultures, further research needs to be done. Different cultures have different values, which means a western version of TF-CBT may not be the most efficacious or effective for certain populations. More studies need to be conducted in Asian and African cultures. TF-CBT needs to be studied on how it is adapted with different populations. The articles included in the review mentioned some ways the treatment was adapted, but further research is needed on what specific components need to be adapted across cultures. APA's multicultural competency guidelines are a resource that seeks to explain how providers can develop multicultural competence in the profession. Using these standards in future research will allow the implementation of TF-CBT to be more culturally aware (American Psychological Association, 2017).

A final limitation to the above studies is that they all look at TF-CBT as a whole to determine if the treatment is effective for certain populations. The studies do not look into which specific components are the most efficacious or effective and if certain components are more effective given the population or comorbid disorders. Comorbid disorders are common with trauma, and more in-depth research on how to target certain symptoms brought on by comorbid disorders will be essential in furthering trauma treatments. Some studies utilized assessments that looked at anxiety or depression

symptoms specifically, but further research needs to be done on ways to address certain comorbidities within TF-CBT.

An area for future research is looking into telehealth for TF-CBT. After the 2020 Coronavirus pandemic, telehealth became the only option for many providers to still see child or adolescents and provide therapeutic services. Telehealth has its advantages and disadvantages, but given the convenience the service provided many people, telehealth will more than likely be a part of normal practice for many places in the future. Additional research about doing TF-CBT virtually in the place of face-to-face therapy will be needed to see if virtual therapy changes the treatments effectiveness.

Some of the studies found had replication studies, but many did not. Another benefit would be to see replication studies done, specifically replication of the studies dealing with implementation in other countries. A final area needing more research is EMDR therapy compared to TF-CBT. A study was done looking at which therapy was more efficient, but the results were not significant. Future research should be done in order to look at what specific factors of treatment affect who benefits most from which treatment.

Conclusion

TF-CBT is an evidenced based treatment for treating acute, chronic, or complex trauma in children and adolescents. TF-CBT has the most research support in the category of interventions specifically designed for treating trauma within this specific age range. Trauma is something impacting many, but not all truly understand the impact trauma can have on all different aspects of development and functioning. Most former research done on trauma has specifically been done in adults, so having a treatment like

TF-CBT which has been studied and shown multiple times to decrease trauma symptoms and improve the quality of living in children and adolescents should be utilized.

Evidenced based practices are the golden standards within the field of psychology and, as providers, part of our job is to ensure we are learning the best techniques and therapies for the population and disorders we specialize in treating. Research shows TF-CBT is a treatment worth investing in for those who work with children and adolescents, because regardless of the setting, trauma will be present one way or another.

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ABBREVIATIONS

ADIS-C/P: Anxiety Disorder Interview Schedule for DSM-IV

ANCOVA: Analysis of Covariance

APA: American Psychological Association

BDI: Beck Depression Inventory

CA-PSCA: Clinician-Administered PTSD Scale for Children and Adolescents

CAPS-CA: The Children's Attribution and Perceptions Scale

CATS: Child and Adolescent Trauma Scale

CBCL: Child Behavior Checklist

CBITS: Cognitive Behavioral Therapy for Trauma in Schools

CBT: Cognitive Behavioral Therapy

CCT: Child-Centered Therapy

CDI: Children's Depression Inventory

CGAS: Children's Global Assessment Scale

CPSS: Child PTSD Symptom Scale

CPT: Cognitive Processing Therapy

CRIES: Children's Revised Impact of Event Scale

CSBI: Child Sexual Behavior Inventory

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth edition

DSRS-C: Depression Self-Rating Scale for Children

EBP: Evidence Based practice

EBT: Evidence-based treatment

EMDR: Eye Movement Desensitization and Reprocessing therapy

IPV: Intimate Partner Violence

K-SADS-PL: Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children

MFQ: Mood and Feelings Questionnaire

NCTSN: National Child Traumatic Stress Network

PET: Prolonged Exposure Therapy

PERQ: Parent Emotional Reaction Questionnaire

PSQ: Parental Support Questionnaire

PTSD: Post-Traumatic Stress Disorder

PTSS: Post-Traumatic Stress Symptoms

RCADS: Revised Child Anxiety and Depression Scale

RCT: Randomized Controlled Trial

SCARED: Screen for Child's Anxiety Related Emotional Disorders

SCAS: Spence Children's Anxiety Scale

SDQ: Strengths and Difficulties Questionnaire

STAI: State-Trait Anxiety Inventory for Children

TAU: Therapy as Usual

TESIC: Traumatic Events Screening Inventory for Children

TF-CBT: Trauma Focused-Cognitive Behavioral Therapy

TSC: Trauma Symptom Checklist

UCLA: University of California Los Angeles

UCLAP-RI: University of California Los Angeles PTSD Reaction Index

WHOQOL: World Health Organization Quality of Life Scale

