Trauma focused cognitive behavioral therapy with children

By 16 years of age, 25 percent of children and youth “ in the United States are exposed to at least one traumatic event” (Silverman et al., 2008). Studies show that children as a group are especially at high risk for developing Posttraumatic Stress Disorder (PTSD) after a traumatic event. Furthermore, “ clinical and population studies” indicate that “ children who have” developed PTSD due to experiencing child abuse are also susceptible to learning problems, “ medical problems, substance abuse, interpersonal violence and other serious” health and “ social problems” (Feather & Ronan, 2006). Therefore, it is of top priority to insure that there is an efficient and effective psychotherapy available to abused children who are at risk of developing, have already developed some symptoms, or are currently diagnosed with PTSD in order to both alleviate the present symptoms of PTSD and prevent further psychological and other disturbances.

Cognitive-Behavioural therapies have been the most frequently researched and empirically supported treatments for children suffering from PTSD due to traumatic experiences, such as child abuse. Typically, Cognitive-Behavioural therapies and techniques are adapted to be used with children based on their performance with other clients. For instance, Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) was adapted to traumatized children suffering from PTSD on the basis of its success with adult clients diagnosed with PTSD and children who have not suffered trauma but who display PTSD symptoms. Some TF-CBT techniques that have been successfully adapted to children who have experienced child abuse and are suffering from PTSD include direct discussion of specific aspects of the traumatic event(s), correction of cognitive distortion, cognitive coping, and exposure techniques

among others (Cohen, Mannarino, Berliner, & Deblinger, 2000). The main goal of TF-CBT with abused children suffering from PTSD is “ to help children develop skills in order to manager the symptoms of PTSD and to process trauma as a time-limited past event that can be managed effectively by the child and his/her family”, while they “ focus on current and future concerns” (Feather & Ronan, 2009; Silverman et al., 2008).

Just as with any other Cognitive-Behavioural Therapy, a major principle that underlies TF-CBT with children is a collaborative client-therapist relationship (Feather & Ronan, 2009). “ A collaborative” therapeutic “ relationship between the child and the therapist” not only insures that the client’s goals and needs are understood and not ignored, but, it also is a way of insuring ethical treatment of the child in therapy with regards to consent. Moreover, “ working with the child in an individual format” is another principle of TF-CBT with children (Silverman et al., 2008). This type of format provides the child with a safe environment where s/he can express concerns and talk freely without external judgment from parents or caregivers. A third principle that is most often applied in the first sessions of TF-CBT is the focus on the strengthening of the “ child’s psychosocial” environment “ as a basis for” subsequent “ treatment” intervention. This principle is important because abused children are often taken away from their parents; this may add more trauma to the children’s lives. As a result, an aim of TF-CBT is to develop the child’s interpersonal skills so that positive relationships and attachments can be formed between child and caregiver (Feather & Ronan, 2009). Furthermore, it is becoming more and more common in TF-CBT to include the parent/caregiver in the therapy. For instance, in a treatment session that

lasts 90 minutes it is now common to dedicate a 45 minute session to working individually with the child and a 45 minute session to individual therapy with the parent/caregiver or with both child and parent/caregiver together (Silverman et al., 2008; Feather & Ronan, 2009). This not only provides the therapist with a second source of information on how the child is progressing, it also empowers the parent to better deal with and understand his/her child's trauma and symptoms while providing the child with the necessary support and encouragement. Lastly, TF-CBT holds that the best strategy for reducing PTSD symptoms is through gradual exposure. Additionally, throughout research there seems to be a concrete emphasis on applying TF-CBT techniques in a creative way when working with children. Some such techniques include sand-play " as a medium for processing abuse and violence" and the use of " creative media" to produce a coherent " trauma narrative for desensitization in a safe environment" (Feather & Ronan, 2009). While these principles and techniques seem logical and sound it is important to consider evidence from scientific research in order to evaluate whether or not this particular type of therapy is both efficient and successful with the targeted group of clients.

When evaluating a treatment it is important to look at research studies that examine the treatment in a number of different settings. TF-CBT is considered to be the most " well-established treatment for children exposed to traumatic events" because both effectiveness and efficacy studies have been done on this form of treatment (Silverman et al., 2008). This is a crucial point for the generalizability of the treatment's effects to the real world. For instance, a treatment that was only studied under perfectly controlled

conditions in a laboratory setting cannot be expected to generalize to the less than perfect conditions of the real world and the diverse populations/ types of clients that are encountered there. In a meta-analysis of 21 studies testing the effectiveness of different therapeutic techniques on children and youth who have experience trauma, TF-CBT was shown to be statistically significantly superior in treatment with trauma exposed children and adolescence in both efficacy and effectiveness studies (Silverman et al., 2008). It is also important to note that both efficacy and effectiveness studies find TF-CBT to be especially useful in treating PTSD in children who experienced child abuse or multiple trauma (Feather & Ronan, 2009). The regular duration of TF-CBT with abused children being treated for PTSD is 12 sessions where each session lasts approximately 90 minutes in total. Treatment results, reduction or elimination of PTSD symptoms, are shown to be well maintained for at least 6 months past treatment. These results are reported by only 4 out of the 21 studies in the meta-analysis because only 4 studies conducted a “ 6 month follow up assessment” (Silverman et al., 2008). Lastly, the results of the meta-analysis indicate that including parental training into TF-CBT is very common and proves to be statistically significantly effective in enhancing and maintaining the results of treatment (Silverman et al., 2008). Therefore, it is safe to conclude that although studies should include more long term follow up assessments, TF-CBT is effective in treatment for PTSD in children who have been victims of child abuse since this therapy has been studied in detailed both by effectiveness and efficacy studies.

However, there are a number of considerations that are taken into account in TF-CBT with children. For instance, the therapy must take a “ developmentally appropriate” and culturally sensitive approach to treatment when working with children (Feather & Ronan, 2009). That is, in order to act in an ethical manner the therapist must insure that the therapy is “ developmentally appropriate” for the child’s age and that the techniques used are sensitive to and respectful of any cultural values and norms that may exist within the child’s family. Doing so is also likely to increase the child and his/her family’s adherence to and agreement with the treatment plans. Another related ethical and political issue that exists in many therapies, including TF-CBT, is the very noticeable lack of therapy techniques that are adapted and available to minority populations. For instance, “ American Indian and Alaska Native children are more likely to receive” mental health treatment for PTSD and other trauma related mental health problems “ through the juvenile justice system than non-Indian children” (Bigfoot & Schmidt, 2010). This is obviously a major problem since these children are forced by the system to become delinquents in order to get at least some kind of mental health services, if any at all.

In conclusion, TF-CBT includes various techniques for treating PTSD in abused children and therapists are encouraged to apply these techniques in creative ways when working with children. Moreover, TF-CBT is proven to be a well-established and effective treatment method for PTSD in abused children. However, both ethical and political issues must be taken under consideration when looking at the adaptation, application and availability of TF-CBT for minority group children who are suffering from PTSD due to child

abuse. Thus, for future research it would be useful to look at how it would be possible to increase availability of and accessibility to TF-CBT services in minority communities.