Trauma-focused cognitive behavioral therapy and children with ptsd systems

Trauma-Focused Cognitive Behavioral Therapy and Children with Posttraumatic Stress Disorder Symptoms

Abstract

This paper will discuss the Posttraumatic Stress Disorder (PTSD) symptomatology within children, ages 4 to 8 years old, and the use of Trauma-Focused Cognitive Behavioral Therapy to treat it. PTSD has a wide range of symptoms for anyone who has experienced some type of trauma exposure. There is not copious amounts of research done regarding children and effects of PTSD symptoms, this may be due to misdiagnosis or lack of awareness about PTSD symptoms when related to trauma exposure. In this paper I plan on investigating the effectiveness of TF-CBT when treating PTSD symptoms in children, important aspects of what the manifestation of PTSD symptoms look like for youths, as well as what TF-CBT can accomplish for children.

Main Topics & Objectives

This paper will go into depth of why Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an effective treatment for children who have Post-Traumatic Stress Disorder (PTSD) symptomatology. I will provide information on the treatment process and the symptomatology that may occur within children exposed to trauma. The major talking points will be: an overview of PTSD and symptoms in children, an overview of risk factors of PTSD, peer-reviewed research studies that prove the effectiveness of TF-CBT along with what is involved throughout the treatment method, how TF-CBT is effective

in treating PTSD symptoms in children, and an idea into early intervention and prevention strategies.

Post-Traumatic Stress Disorder

Definition

Defining Post-Traumatic Stress Disorder (PTSD) can be difficult when an individual's reaction to a traumatic event can vary for many people. However, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has defined the categories in which symptoms of PTSD would fall under: arousal and reactive symptoms, negative thoughts and feelings, avoiding reminders, and intrusive thoughts. [1] These four categories of symptoms also need to be persistent for longer than a month. [1] Every individual category can differ in severity, but altogether resemble the same outcomes. [1] Trauma symptoms can be seen in a matter of months or arise years after experiencing the traumatic event. [1]

Symptoms for Children

As stated above the symptoms of PTSD can look different depending on the individual, especially when that individual happens to be of early school-age. The DSM-5 has similar yet slightly altered categories for PTSD symptoms when regarding children and how they are affected by traumatic events. The categories include: exposure, intrusive thoughts, avoidance, changes in cognition and mood, and arousal and hyperactivity. [2] Each class has criteria that require the children to demonstrate one, or two or more specific attributes relating to that category. [2]

Epidemiology

The estimate for the prevalence of PTSD among individuals eighteen and older is around 3. 5%, with rates for women at 9. 7% and men at 3. 6%. [3] On the other hand, there is no large scale epidemiological study that has measured the frequency of PTSD among youths. There have been small scale studies in which researchers have found the prevalence rates among adolescents but in terms of school-aged children, statistics have not been taken. This lack of evidence is startling when early childhood trauma is a very real and apparent issue facing this population.

PTSD Treatments

Treatment for PTSD is not always necessary, as individuals can have symptoms diminish or disappear as time goes on. However there are certain evidence-based practices that provide positive results in lower PTSD symptoms for those who are suffering. The gold standard treatment is usually a combination of psychotherapy, specifically Cognitive Behavioral Therapy (CBT), and medication. [1] CBT has many types of therapy that can be used in order to treat PTSD; Cognitive Processing Therapy, Prolonged Exposure Therapy, and Stress Inoculation Therapy are only a few of the types of CBT available for PTSD treatment. [1]

Complication of Diagnoses

Often times trauma experienced by children can go unnoticed and passed off as a behavioral disorder. There are many types of Trauma and Stressor-Related Disorders that can resemble and appear to be the diagnosis that

would fit the child in question, however there are stark differences that only thorough investigating of the child's behavior and responses would reveal. Diagnosis for Acute Stress Disorder for example that seems fairly the same as a PTSD diagnosis but is for a shorter length of time after a stressful event and features more dissociative tendencies in comparison. [4]

Another example being an Adjustment Disorder diagnosis, which follows more along the lines of a conduct issue that is milder and stress responsive. [4] These are only two possible diagnoses given to children who may exhibit PTSD symptoms. This misdiagnosis creates the lack of understanding when discussing childhood trauma and displays of PTSD symptoms in children. Without investigating the child client entirely and approaching from all aspects, a missed diagnosis for PTSD is very likely.

Risk Factors for PTSD

Psychological

Studies have shown that psychological distress and symptoms of PTSD are the result of victimization. [5] A child who endures victimization during early childhood can carry the psychological distress with them into adulthood facing chronic victimization. [5] A child may witness an act of violence, be mistreated, or have sibling or peer issue which can lead to psychological distress that results in the child being more likely to experience PTSD symptoms due to revictimization. [5]

Genetic

Genome-wide association studies (GWAS) are used in order to get a close and scientific look to identify what genes may be at risk for PTSD. [6] It has been found that there is a genetic link between exposure to trauma and how that can impact the heritability throughout the generational line. [6] A specific study working with veterans determined that, through DNA methylation, analyses proved there was an association between certain cytosine–phosphate–guanine dinucleotide sites and the severity of PTSD symptoms experienced by the individual. [7] In other words, specific areas of one's genetic code can determine how severe they may experience PTSD symptoms.

Environmental

When thinking about external forces, there are adverse childhood experiences that predict how likely one can be to develop a mental disorder or experience certain somatic disorders as well. Lack of education and social supports are significant indicators of the likelihood that a child will be exposed to trauma. [8] Lower socioeconomic status and previous trauma exposure have been linked to an increase in the probability of one experiencing PTSD symptoms at any early age. [8]

Trauma-Focused Cognitive Behavioral Therapy

Definition

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence based practice that has been implemented and refined over the course of twenty-five years. [9] TF-CBT works on reducing negative behavioral responses

to trauma and has been highly effective in reducing PTSD symptoms in children. [9] This therapy treatment is short-term that produces positive outcomes within eight to twenty-five sessions by correcting maladaptive beliefs related to the traumatic event. [9] Caregivers are also relieved from personal distress and educated in strategies on supporting the child cope effectively. [9]

Process of TF-CBT

There are far too many variables for each client that would facilitate a strict guideline to follow but TF-CBT has a general model that most clinicians follow. The PRACTICE Model is a set of procedures that dictate what a clinician should do to effectively implement TF-CBT. [9] Each letter in the PRACTICE Model stands for the type of work the clinician should be doing throughout the process of implementation: Psychoeducation and parenting, Relaxation, Affect modulation, Cognitive coping, Trauma Narrative, In-vivo exposure, Conjoint parent-child sessions, and Enhancing safety and development. [10] These core steps in TF-CBT are what helps make the evidence based practice effective and when implemented by a trained clinician can produce positive outcomes for the child and family.

Effectiveness of TF-CBT

SAMHSA has determined this practice to be top tier because of the widespread positive outcomes in randomized controlled trials. [9] The practice itself is effective in treating many different children who come from a variety of cultural backgrounds as well as children at different stages of

development. [9] Over the course of fifteen years, TF-CBT has been studied and researched across multiple populations of youth who have experienced some type of trauma. [9] TF-CBT has proven its effectiveness time and time again which is no surprise as to why is it used often in a clinical setting.

TF-CBT and PTSD Symptoms

Effectiveness

In one study conducted with three to eight year olds, TF-CBT has been proven to reduce PTSD symptoms not only for sexual abuse, but also for a variety of possible traumatic occurrences. [11] Children who received TF-CBT treatment for their PTSD symptoms were better able to conceptualize their PTSD, identify emotions through discussion, and able to understand what events were upsetting to them. [11] Another randomized controlled trial found that TF-CBT improved symptoms of depression, anxiety, and sexual concern in a follow up of a year. [12] In comparison to other treatments TF-CBT also had better outcomes in PTSD dissociative symptoms after one year follow up. [12]

There is also proof that in studies done comparing TF-CBT treatment alone to TF-CBT treatment with the addition of medication, that there is not significant difference. [13] TF-CBT is just as effective without the need to additionally introduce medication into the treatment process. [13] TF-CBT alone, children can improve behavioral problems that are related to PTSD

symptoms as well as improvements on the relationship with the child's parents. [13]

Early Intervention and Prevention Strategies

Early Intervention Strategies

Integration of trauma-informed care should be included within the child welfare system. There is ability for child welfare workers to be able to meet this need to intervene when necessary. [14] If screenings are implemented within the child welfare system, there is a greater likelihood that child welfare workers could intervene and get children who experience PTSD symptoms the proper treatment. [14] While trauma screening is a practice with trauma-exposed youth, it is not a standard when children are entering the system to be have a universal mental health screening. [14]

Children may not be exactly " trauma exposed" in the specific definition, but can experience maltreatment and disruption in their lives that can result in the forming of PTSD. [14] Having a universal screening regardless of the types of qualifications for " trauma exposed" youth, would further decrease the percentage of children suffering with PTSD symptoms and allowing them access to treatment. [14] If all individuals working with, as well as within, the child welfare system became trauma-informed then children's PTSD could be addressed much earlier.

Being trauma-informed in this context means one is able to recognize how trauma can impact children, knowing of potential trauma triggers, and how

the system can make symptoms of trauma more intense. [15] It has been proven that implementing training of trauma-informed care for those involved with the child welfare system has positive outcomes in improving the knowledge thus increasing the use of trauma-informed are when dealing with children. [15] This type of training allows staff members to slowly become more comfortable in responding to children when PTSD symptoms are brought to light. [15]

Prevention Strategies

There is no possible way to prevent any traumatic events happening or prevent a child from being exposed to a traumatic event. The types of environment and certain factors for the child are impossible to control prior to traumatic events, so the best option is to prevent the PTSD symptoms from continuing long-term and addressing the symptoms early on. Studies have shown that if a cognitive behavioral therapy is administered shortly following a traumatic event, then there is a decrease in PTSD symptoms in future months. [16] Prevention can work by educating parents and caregivers on what PTSD symptoms may look like and how to move forward when there is acknowledgment of an issue. [16]

If parents and caregivers are able to spot the changes that could be an indication of trauma exposure, then the child will be able to receive treatment faster than parents who are uneducated on the matters of trauma exposure. Encouraging protective factors as well as providing support for resiliency and recovery work towards preventing PTSD symptoms from

manifesting in harsher long-term problems. [16] If parenting classes or hospital departure procedures for children focused on adding information about PTSD that allowed caregivers to become more aware, there would be a decreased likelihood for the need for treatment.

Conclusion

TF-CBT has proven its effectiveness throughout years of practice and an abundance of randomized clinical trials. Not only has TF-CBT been effective on its own, it has proven to be better in comparison to other treatments in reducing trauma responses. TF-CBT can be applied to a wide variety of children from all types of backgrounds and altered in a way that best suits the client. The malleable treatment implementation allows TF-CBT to produce positive results across many varying clients in reducing PTSD symptoms.

TF-CBT can work towards aiding in early intervention strategies, as well as decreasing PTSD symptoms quicker which reduces the need for ongoing treatment. Since TF-CBT can work in early stages of appearance of PTSD symptoms, being able to implement this treatment process earlier can decrease the likelihood of treatment for unresolved symptoms in the future. TF-CBT is effective for children age’s four to eight, but in reality can be used for individuals age four and older.

Through frequent use of TF-CBT in children who display PTSD symptoms, positive outcomes will continue to increase. When using TF-CBT in conjunction with prevention and early intervention strategies, children will

see better outcomes in processing trauma along with decreased PTSD symptoms. Although it is difficult to prevent children from being exposed to traumatic events, working with the child welfare system and caregivers in TF-CBT procedures can aid in the likelihood that children will have an easier experience with processing their traumatic experience.

Implications for Behavioral Health

Finding all the research that I did with the work that TF-CBT does for children was astounding and relieving to know that there are practices out there that truly have an immensely positive impact for children. While I was not very surprised by how effective TF-CBT was, since I have previous knowledge about the treatment, I was shocked that in comparison to other treatments it was more effective. This is important information as we move forward with the child welfare system and as a large amount of students are expecting to become clinicians one day.

Understanding how to provide effective treatment while not being extremely intrusive is imperative when it comes to children. Children are a very vulnerable population, so treatment should reflect in cautious and positive procedures. Overall with the information of how impressive TF-CBT works in reducing PTSD symptoms, it is upsetting to recognize how little of trauma-informed care is implemented in child welfare systems effectively. A need to increase the use of trauma-informed care to all staff in child welfare, as well as parents, is very clear.

If there is more work done in prevention and early intervention, it would have a positive impact on decreasing the suffering a child will endure due to

trauma exposure. I want to work on creating more trauma-informed individuals in the workplace, for children and for adolescents. The goal would be to educate adults who have the most contact with children on recognizing signs of PTSD symptoms. If there are more educated individuals that can make a change in the child's life, then there will be less distress for the child in their future.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. Arlington, VA: American Psychiatric Association; 2013.
2. Foa EB, Asnaani A, Zang Y, Capaldi S, Yeh R. Psychometrics of the Child PTSD Symptom Scale for DSM-5 for Trauma-Exposed Children and Adolescents. *Journal of Clinical Child & Adolescent Psychology* . 2017; 47(1): 38-46.
3. Gradus JL. Epidemiology of PTSD. *National Center for PTSD (United States Department of Veterans Affairs).* 2007.
4. Friedman MJ, Resick PA, Bryant RA, Strain J, Horowitz M, Spiegel D. Classification of trauma and stressor-related disorders in DSM-5. *Depression and Anxiety* . 2011; 28(9): 737-749.
5. Cuevas CA, Finkelhor D, Clifford C, Ormrod RK, Turner HA. Psychological distress as a risk factor for re-victimization in children. *Child Abuse & Neglect* . 2010; 34(4): 235-243.
6. Cornelis MC, Nugent NR, Amstadter AB, Koenen KC. Genetics of Post-Traumatic Stress Disorder: Review and Recommendations for Genome-

Wide Association Studies. *Current Psychiatry Reports* . 2010; 12(4): 313-326.

7. Mehta D, Bruenig D, Carrillo-Roa T, et al. Genomewide DNA methylation analysis in combat veterans reveals a novel locus for PTSD. *Acta Psychiatrica Scandinavica* . 2017; 136(5): 493-505.
8. Brewin CR, Andrews B, Valentine JD. Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology* . 2000; 68(5): 748-766.
9. TF-CBT Therapist Certification Program. About Trauma-Focused Cognitive Behavior Therapy (TF-CBT). *Trauma-Focused Cognitive Behavioral Therapy* . https://tfcbt. org/about-tfcbt/. Accessed November 9, 2018.
10. Syros I. Cognitive behavioral therapy for the treatment of PTSD. *European Journal of Psychotraumatology* . 2017; 8(4): 1351219.
11. Scheeringa MS, Weems CF, Cohen JA, Amaya-Jackson L, Guthrie D. Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: a randomized clinical trial. *Journal of Child Psychology and Psychiatry* . 2010; 52(8): 853-860.
12. Cohen JA, Mannarino AP, Knudsen K. Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse & Neglect* . 2005; 29(2): 135-145.
13. Cohen JA, Mannarino AP, Perel JM, Staron V. A Pilot Randomized Controlled Trial of Combined Trauma-Focused CBT and Sertraline for Childhood PTSD Symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry* . 2007; 46(7): 811-819.

14. Whitt-Woosley A, Sprang G, Royse DG. Identifying the trauma recovery needs of maltreated children: An examination of child welfare workers' effectiveness in screening for traumatic stress. *Child Abuse & Neglect* . 2018; 81: 296-307.

15. Conners-Burrow NA, Kramer TL, Sigel BA, Helpenstill K, Sievers C, Mckelvey L. Trauma-informed care training in a child welfare system: Moving it to the front line. *Children and Youth Services Review* . 2013; 35(11): 1830-1835.

16. Foa EB, Hearst-Ikeda D, Perry KJ. Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault victims. *Journal of Consulting and Clinical Psychology* . 1995; 63(6): 948-955.