



ADVANCING HEALTH EDUCATION & RESEARCH

AVA Research Reviews provides AVA members with recent published, peer-reviewed articles in a broad array of violence and abuse topics. The goal is to highlight and disseminate violence and abuse research in a timely fashion, and to enhance healthcare providers' practice by fostering the educational mission of AVA

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# AVA Research Review

## ADVANCING HEALTH EDUCATION & RESEARCH

**Review Title:** Trauma-Focused Cognitive Behavioral Therapy – Is it effective for children exposed to ongoing intimate partner violence?

**Reviewer:** Brooks R. Keeshin, MD, Mayerson Center for Safe and Healthy Children, Cincinnati Children's Hospital Medical Center

#### **Articles:**

1. Cohen JA, Mannarino AP, Iyengar S. Community Treatment of Posttraumatic Stress Disorder for Children Exposed to Intimate Partner Violence. *Arch Ped Adol Med* 2011; 165 (1): 16-21.
2. Cohen JA, Mannarino AP, Murray LK. Trauma-focused CBT for youth who experience ongoing traumas. *Child Abuse & Neglect* 2011; 35 (8): 637-646.

#### **Article Summaries:**

##### *Brief Overview*

Children are often witness to, and victim of, parental intimate

partner violence (IPV) and community violence. In contrast to histories of physical or sexual abuse, where often times a safety plan has been implemented and the cessation of violence exposure has occurred prior to treatment, there is little research on the implementation of evidence based treatments for trauma exposed youth who continue to live in environments where there is the potential for ongoing exposure to violence. The following articles describe a prospective, randomized controlled trial of trauma focused cognitive behavioral therapy (TF-CBT) among a group of children exposed to IPV with symptoms of posttraumatic stress as well as expert opinion on how to effectively manage issues of ongoing traumatization while providing TF-CBT. Aims/ hypotheses of the articles

Combined, the following articles address two primary

questions: 1. What is the effectiveness of TF-CBT among children exposed to IPV; and, 2. What are common clinical barriers, safety issues and effective solutions to treating children with ongoing exposure to violence?

**Cohen JA, Mannarino AP, Iyengar S. Community Treatment of Posttraumatic Stress Disorder for Children Exposed to Intimate Partner Violence. *Arch Ped Adol Med* 2011; 165 (1): 16-21.**

#### **Relevant findings**

One hundred and forty children between the ages of 7-14 years were recruited to participate from a community based IPV program. Of the 140 recruited children, 124 met study criteria, that included at least 5 symptoms of posttraumatic stress, normal development and IQ, and the absence of psychosis. Children were randomized to 8 weeks of TF-CBT or child-centered therapy (CCT), a supportive psychotherapy. All families received a structured PTSD assessment interview, as well as anxiety, depression and behavior measures at the beginning and end of the study. Baseline and dropout rates did not differ significantly between the groups.

Eighty-nine percent of all the children witnessed physical IPV, and the duration of IPV

was >2 years in 95% of the parents of participants. Children who participated in the study reported multiple other types of victimization, including significant accidents (38%), witness to violent crime (18%), history of physical abuse (36%) and sexual abuse (8%). At least half the population had ongoing contact with the IPV perpetrator during the study, including 7% who continued to live with the perpetrator. Forty percent of children reported ongoing traumatization during treatment, including 14% reporting ongoing exposure to IPV.

Results from the intent to treat analysis compared to children who completed the 8-week program demonstrated similar findings. Specifically, children who participated in TF-CBT demonstrated significantly lower overall posttraumatic stress symptoms that were primarily driven by reductions in re-experiencing and hyperarousal scores compared to CCT participants. Children in the TF-CBT group also demonstrated decreased anxiety as measured by the SCARED assessment tool. Finally, there were 10 serious adverse events, (including exposure to serious physical IPV, child abuse, child self-injury and child psychiatric hospitalization,) among CCT completers (n=32 children)

compared to 2 serious adverse events among TF-CBT completers (n=43), a difference that was significant ( $p<.005$ ).

#### **Authors' conclusions**

TF-CBT was both statistically and clinically superior to CCT in the treatment of children with symptoms of posttraumatic stress exposed to IPV, and was associated with increased remission of symptoms and decreased serious adverse events. The treatment effects observed in the TF-CBT group were not as strong as previous studies treating children with a history of sexual abuse or multiple traumas. The ongoing exposure to violence and truncated version of TF-CBT (8 weeks instead of 12-16) are possible reasons for the decrease in effectiveness.

#### **Potential Limitations of the article/findings:**

The TF-CBT was both truncated as well as modified in this study. Specifically, safety issues were addressed at the onset rather than towards the end of therapy, including increased communication between child and non-offending parent. The trauma narrative focused less on mastery of the traumatic experience and decreasing the response to posttraumatic triggers, but rather more emphasis was placed on

learning to discriminate between real danger and a more general sense of fear. Because of the multiple variations, it is difficult to infer why the effect sizes demonstrated in this study differ from previous TF-CBT studies.

**Reviewer's Comment:**

This study provides data that begins to answer a clinical question of many TF-CBT practitioners, specifically is TF-CBT effective even in the face of ongoing exposure to violence and abuse? Although it is difficult to compare this modified TF-CBT to previous studies, this study does demonstrate the effectiveness of a modified, truncated TF-CBT in a population that continues to experience ongoing trauma. As such, it supports the idea that TF-CBT should continue to be disseminated among community providers who treat children who have experienced previous violence and abuse, even when there is still the potential for future exposure/victimization. More research is needed in assessing the effectiveness of the specific components designed to increase the child's safety.

**Cohen JA, Mannarino AP, Murray LK. *Trauma-focused CBT for youth who experience ongoing traumas.***

***Child Abuse & Neglect 2011; 35 (8): 637-646.***

***Relevant findings***

Multiple studies on the effectiveness of TF-CBT have recently been completed among populations that experienced ongoing violence. Specifically, the authors included a study in Zambia that primarily worked with IPV and sexual abuse exposure in the context of the HIV epidemic and a cohort of families in a large, U.S. city exposed to IPV and ongoing interpersonal and community violence. During both studies, the authors worked with local therapists to make modifications to TF-CBT to appropriately meet the ongoing safety concerns and violence exposure of study participants. These modifications were based on feedback from therapists and families from previous studies as well as a result of problem solving safety issues as they arose during the intervention.

The primary area of increased focus was in adapting TF-CBT to enhance the safety of participants early during the course of treatment. During the normal TF-CBT model, the current safety of the child is assumed, and safety education is usually reviewed during the final stages of therapy. Modifications included having therapists routinely ask parents

about potential or known violence exposure prior to the start of individual sessions with the child. Safety plans, with developmentally appropriate role-playing was often used depending on the risk and severity of potential violence. In situations of IPV with ongoing contact with the perpetrator, efforts were made by the therapist, with the permission of the non-offending parent, to directly contact the perpetrator. The rationale behind informing the perpetrator of the goals and format of therapy was to decrease any potential risk of the perpetrator trying to coerce information from the child.

Another area of focus in families with ongoing exposure to interpersonal violence was the engagement with the non-offending parent. Especially in cases of IPV, therapists increased the use of psychoeducation, discussing the common experience of non-offending parents (i.e. feeling torn between competing interests in the family, the pattern that many parents will return to the perpetrator numerous times over the course of IPV.) Additionally, confronting issues of countertransference, especially when therapists felt like the parent was recklessly placing the child at risk, was addressed as an issue that might compromise the

therapeutic relationship between the provider and family.

A third component was a clinical need to modify the goals and highlight unique benefits of the trauma narrative in children with ongoing violence exposure. For some families, hearing the trauma narrative became a motivating factor in improving the safety of the child. Even with ongoing victimization, children were able to engage in the normal goals of the narrative, including cognitive processing and contextualization. Importantly, teaching the child and parent to decipher between real danger and trauma reminders can be a unique and valuable focus for the trauma narrative in children with ongoing violence exposure.

#### ***Authors' Conclusions***

Through the implementation and study of TF-CBT in families and communities with ongoing exposure to violence and abuse, methods were developed to adapt and build in added safety enhancing strategies for the child. This was done through collaboration between program developers and the clinicians directly working with the affected families. As a result of these strategies and adaptations, children demonstrated an improvement in symptoms of traumatic

stress, even when there continued to be exposure, or the risk of exposure, to violence and abuse.

#### ***Potential limitations of the article/ findings***

The data supporting the TF-CBT modifications/adaptations to ongoing trauma were based on clinical experiences and case scenarios. And, although the previous paper demonstrated the efficacy of the IPV TF-CBT program, no systematic effort was made to determine which modifications were most effective, and in which violence exposures were modifications most appropriate. Furthermore, the two populations (Zambia and Pittsburg) are quite different, and have communities with different needs and strengths; therefore it is unclear how generalizable the clinical scenarios would be to different populations.

#### ***Reviewer's Comment:***

This account of clinical experiences and proposed interventions in adapting TF-CBT to children with ongoing trauma is a helpful guide for clinicians who are regularly confronted with episodes that would otherwise interfere with therapy. Although not a complete list of possible scenarios, the themes of improving current safety, enforcing the parent/therapist alliance and enhancing the

child and family's ability to be able to recognize and differentiate between real danger and trauma reminders are general categories that are likely to benefit a diverse array of patients and families.

#### ***Reviewer's Summary:***

These articles complement each other, providing both quantitative and case-based data for practitioners who work with children with an ongoing risk of violence exposure. Although clinicians would agree that cessation of violence is an essential piece of treatment, there are many real life scenarios where complete cessation is either impractical or legally impossible. However, there continues to be honest debate among clinicians as to when is the appropriate time to initiate therapy, with some clinicians favoring waiting until the threat of violence and abuse is removed before engaging in the therapeutic process. These studies, when taken together, demonstrate that TF-CBT is both modifiable and effective in both the reduction of symptoms related to traumatic stress and in enhancing the safety of children who are at risk for further victimization.