Foundations
What Works Centre for Children & Families

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Intervention website: www.musc.edu/tfcbt

GUIDEBOOK INTERVENTION INFORMATION SHEET

Trauma-Focused Cognitive Behavioural Therapy

Please note that in the 'Intervention Summary' table below 'child age', 'level of need', and 'race and ethnicities information is **as evaluated in studies**. Information in other fields describes the intervention as **offered/supported by the intervention provider**.

Intervention summary	
Description	Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a therapeutic intervention for families with a child aged between 3 and 18 years old who has been exposed to a traumatic event, including child maltreatment and domestic abuse. TF-CBT is delivered by therapists through 12 to 18 sessions to children individually or to children and their parents together. During these sessions, family members learn cognitive strategies for managing negative emotions and beliefs stemming from highly distressing and/or abusive experiences.
Evidence rating	3+
Cost rating	3
Child outcomes	• Supporting children's health and wellbeing - Improved emotional wellbeing - Improved mental health - Reduced anxiety - Reduced depression. • Preventing crime, violence and antisocial behaviour - Improved behaviour.
Child age (population characteristic)	7 to 18 years old

Intervention summary	
Level of need (population characteristic)	Targeted Indicated
Race and ethnicities (population characteristic)	• African American • Asian • Black • Hispanic • Mixed racial background • White.
Type (model characteristic)	Individual
Setting (model characteristic)	• Out-patient health setting • Community centre.
Workforce (model characteristic)	Master's (or higher) qualified psychologist, family therapist, or social worker
UK available?	Yes
UK tested?	No

Model description

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a therapeutic intervention for children and families who have been exposed to a traumatic event.

TF-CBT is delivered by a single therapist to parents and their children via 12 to 16 weekly sessions depending on the severity of the child's symptoms and the family's needs.

- Parents and their children attend separate 30- to 45-minute sessions during which they engage in parallel educational, skill-building, and trauma-processing activities.
- Parents and their children attend conjoint sessions together (10 to 40 minutes) to practise skills and enhance general and trauma-related communication as needed.
- TF-CBT can also be delivered individually with the child when it is not possible to work with the parents or other caregivers.

During the initial phases of the therapy, the therapist works individually with the parents and child to establish a trusting therapeutic relationship that, in turn, provides the context in which difficult experiences and emotions can be discussed.

Within this safe therapeutic environment, the child learns to manage a variety of negative feelings and behaviours, including reoccurring and intrusive thoughts, difficulty sleeping or concentrating, depression, anxiety, and negative and/or aggressive behaviour.

The parent sessions provide parents with strategies for managing any stress or anxiety they may experience, as well as strategies for communicating with their child and managing their child's behaviour. Parents also receive homework assignments to practise concepts covered during treatment at home with their children.

The joint parent–child sessions are designed to help parents and children practise and use the skills they learned and for the child to share the trauma narrative while also fostering effective parent–child interaction.

TF-CBT can also be delivered individually with the child when it is not possible to work with the parents or other caregivers.

TF-CBT is typically delivered individually to parents and their children. TF-CBT may also be provided in groups; however, the evidence presented here reflects delivery of TF-CBT on an individual therapy format.

Target population

Age of child	3 to 18 years old
Target population	Children and families who have been exposed to a traumatic event.

Please note that the information in this section on target population is as **offered/supported by the intervention provider**.

Theory of change

Why		Who	How	What		
Science-based assumption	**Science-based assumption**	**Science-based assumption**	**Intervention**	**Short-term outcomes**	**Medium-term outcomes**	**Long-term outcomes**
• Unresolved emotions stemming from traumatic experiences in childhood and adolescence • Increases the risk of physical and mental health problems occurring in adulthood.	• The re-examination of traumatic events within a psychologically safe, therapeutic environment can help children process and manage difficult emotions associated with traumatic events • Supportive parenting practices further helps children process the difficult emotions associated with traumatic experiences.	Children and families who have been exposed to a traumatic event.	TF-CBT aims to create an emotionally supportive environment in which children and their parents learn cognitive strategies for managing the difficult emotions that arise from a traumatic event.	• Parents are better able to support the needs of their child • Family relationships improve • Children are better able to manage the negative feelings associated with traumatic experiences.	• Children are better able to manage their emotions • Children have fewer behavioural problems.	Children experience greater emotional wellbeing and improved mental health as they develop.

Implementation requirements

Who is eligible?	Children and families who have been exposed to a traumatic event.
How is it delivered?	TF-CBT is delivered to parents and their children via 12 to 16 weekly sessions depending on the severity of the child's symptoms and the family's needs. Parents and their children attend separate 30- to 45-minute sessions during which they engage in parallel educational, skill-building, and trauma-processing activities. Parents and their children attend conjoint sessions together (10 to 40 minutes) to practise skills and enhance general and trauma-related communication as needed. TF-CBT can also be delivered individually with the child when it is not possible to work with the parents or other caregivers.
What happens during the intervention?	During the initial phases of the therapy, the therapist works individually with the parents and child to establish a trusting therapeutic relationship that, in turn, provides the context in which difficult experiences and emotions can be discussed. See the model description for further details.
Who can deliver it?	The practitioner who delivers this intervention typically has a master's qualification or higher in a mental health profession, such as psychology, family therapy, or social work.
What are the training requirements?	The practitioner has 10 hours of intervention training. Booster training of practitioners is recommended. The mental health professional receives a minimum of two days' face-to-face training with a minimum of 12 hours of case consultation during implementation.
How are practitioners supervised?	It is recommended that practitioners are supervised by one host-agency supervisor, with the same level of intervention training as practitioners, for one hour per week.
What are the systems for maintaining fidelity?	Intervention fidelity is maintained through the following processes: • Supervision • Self-reported checklist.

Is there a licensing requirement?	No
***Contact details**	Organisation: Trauma Focused CBT Email address: tfcbt@musc.edu Websites: www.musc.edu/tfcbt www.tfcbt.org *Please note that this information may not be up to date. In this case, please visit the listed intervention website for up to date contact details.

Evidence summary

TF-CBT qualifies for a Level 3+ rating, as it has evidence from at least one level 3 study, along with evidence from other studies rated 2 or better.

The first study was conducted in the United States and has evidence consistent with Foundations' Level 3 evidence strength criteria. This study observed statistically significant improvements in TF-CBT parents' reports of their children's symptoms of PTSD and depression three months post-treatment in comparison to families not receiving the intervention.

The second study was also conducted in the United States and has evidence consistent with Foundations' Level 2+ criteria. This study observed statistically significant improvements in TF-CBT parents' reports of their children's symptoms of PTSD and anxiety in comparison to parents whose children did not receive TF-CBT.

A third study was conducted in Norway and has evidence consistent with Foundations' Level 2+ evidence strength criteria. This study observed statistically significant improvements in diagnostic assessments of TF-CBT children's symptoms of PTSD immediately after intervention completion compared to children not receiving the intervention. Additionally, this study observed significant improvements in TF-CBT children's self-reported anxiety symptoms compared to children not receiving the intervention.

A fourth study was conducted in Germany and has evidence consistent with Foundations' Level 2+ evidence strength criteria. This study observed statistically significant improvements in independent assessments of TF-CBT children's psychological functioning compared to children not receiving the intervention. These assessments were confirmed by TF-CBT children's self-reports of PTSD symptoms, as well as their reports of depression, anxiety and cognitive distortions. TF-CBT parents also reported improvements in their child's behaviour compared to parents not receiving the intervention.

TF-CBT can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

Child outcomes			
Outcome	**Improvement index**	**Interpretation**	**Study**
Reduced PTSD	+31	2.68-point improvement on the PTSD section of the Kiddie Schedule for Affective Disorders and Schizophrenia-Epidemiological (3 months later)	1
Reduced PTSD	N/A	N/A	2, 3
Reduced depression	27	4.73-point improvement on the Child Depression Inventory	1
Reduced depression	N/A	N/A	3, 4
Improved daily functioning	N/A	N/A	3
Improved psychological functioning	N/A	N/A	4
Improved cognitive distortions	N/A	N/A	4
Reduced PTSD symptoms	N/A	N/A	2, 4
Reduced anxiety	N/A	N/A	2, 4
Improved behaviour	N/A	N/A	4

Search and review

	Number of studies
Identified in search	26
Studies reviewed	5
Meeting the L2+ threshold	3
Meeting the L2 threshold	1
Meeting the L3 threshold	1
Contributing to the L4 threshold	0
Ineligible	21

Individual study summary: Study 1

Study 1	
Study design	RCT
Country	United States
Sample characteristics	100 children aged 7 to 13 years old with experience of sexual abuse and PTSD and their parents.
Race, ethnicities, and nationalities	• 72% White • 20% African American • 6% Hispanic • 2% Other ethnic origins.
Population risk factors	None reported
Timing	• Baseline • Three months post-baseline.

Study 1	
Child outcomes	• Reduced PTSD symptoms (diagnostic interview) • Reduced depression symptoms (Child report) • Reduced externalising problems (Parent report).
Other outcomes	None
Study Rating	3
Citation	Deblinger, E., Lippmann, J. & Steer, R. (1996) Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*. 1 (4), 310–321.

Brief summary

Population characteristics

This study was conducted in the United States, with a sample of 100 sexually abused children and their parents. All children had a total of three post-traumatic stress symptoms, including at least one symptom of avoidance or re-experiencing phenomenon.

Ninety of the 100 sexually abused children completed pre- and post-treatment assessment. They ranged in age from 7 to 13 (mean = 9.84). 83% were females and 17% were males. 72% were White, 20% African American, 6% Hispanic, 2% other ethnic origin. 76% of the children's maternal caregivers were biological or adoptive, 4% were long-term foster mothers, 20% were other related female guardians (step-mothers, aunts, grandmothers, or older sister).

The duration of the sexual abuse suffered by the children ranged from one day to more than five years of repeated abuse. 18% experienced one sexually abusive incident, 47% experienced 2 to 10 episodes, 22% experienced 11 to 50 episodes, and 13% experienced more than 50 abusive incidents. 32% of the children were sexually abused by fathers or stepfathers, 19% were abused by other adult relatives, 22% were abused by adult nonrelatives, 20% were abused by older peers, and 7% suffered abuse by multiple offenders. The type of the abuse ranged from sexual touching (45%) to simulated intercourse (7%) to oral-genital contact (17%) to penile penetration of the vagina or anus (33%).

The children were diagnosed with the following DSM-III-R disorders: 71% post-traumatic stress, 29% major depression, 30% oppositional, 20% attention deficit, 11% separation anxiety, 10% overanxious, 6% conduct, 5% specific phobia, and 1% obsessive-compulsive disorder.

Study design

The first study is a rigorously conducted RCT. This study involved random assignment of 100 children and their parents to:

- Parent-only treatment group (25 families), with nonoffending parents participating in treatment sessions that lasted approximately 45 minutes.
- Child-only treatment group (25 families), with children participating in treatment sessions that lasted approximately 45 minutes. Parents received occasional updates on their child's progress.
- Child and parent treatment group (25 families), with children and parents participating in treatment sessions that lasted approximately 80 to 90 minutes.
- Community control group (25 families), with standard community care.

For the purposes of our assessment we primarily focused on the findings for the child and parent treatment group as this is how the intervention is normally delivered (although it can be delivered to the child only if it is not possible to work with the parents).

T-tests and chi square tests were used to compare subjects across the treatment conditions with respect to sex, age, ethnicity, identity of the perpetrator, frequency and type of child sexual abuse, use of force, and the pre-treatment measures. No significant differences were found across the conditions on any of these variables.

Measurement

Measurement took place at baseline and three months post-baseline.

- **Child report measures** included Child Depression Inventory (CDI) and State/Trait Anxiety Inventory for Children (STAIC).
- **Parent report measures** included Child Behaviour Checklist (CBCL) and Parenting Practices Questionnaire (PPQ).
- **Researcher-led assessments** included Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-E).

Study retention

90% (90) sexually abused children recruited for participation in this study completed the pre- and post-treatment assessment, representing:

- 88% (22) participants in parent-only treatment group
- 96% (24) participants in child-only treatment group (note that only 23 participants completed PPQ)
- 88% (22) participants in child and parent treatment group
- 88% (22) participants in community control group (note that only 21 participants completed CBCL and PPQ).

Results

Data-analytic strategy

Two-by-two least-squares analyses of covariance (ANCOVA) were used to compare the treatment outcome measures. The pre-test score for each measure was used as a covariate to adjust the post-test measure. Any missing data was excluded from the analyses.

Findings

This study identified statistically significant positive impact on a number of child and parent outcomes. Participants in child only and parent–child treatment groups were found to have significantly reduced PST symptoms. In addition, children assigned to parent only and parent–child treatment groups were found to have significantly fewer externalising behaviours and less depression. Their mothers were found to have significantly greater use of effective parenting skills.

Parents in the three treatment groups were significantly more satisfied with the treatment than those in the community control group.

An additional paper (Deblinger et al., 1999) reported on the long-term findings from this study. These outcomes did not, however, contribute to the overall intervention rating as the study was not as robust as the Deblinger et al. (1996) study.

Study 1: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Internalising problems	Child Behaviour Checklist (CBCL), Parent report	Not reported	No	89	Three-month post-baseline
Externalising problems	Child Behaviour Checklist (CBCL), Parent report	Not reported	Yes	89	Three-month post-baseline
Depression symptoms	Child Depression Inventory (CDI), Child report	Not reported	Yes	90	Three-month post-baseline

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Situationally specific anxiety	State/Trait Anxiety Inventory for Children (STAIC) - State, Child report	Not reported	No	90	Three-month post-baseline
Anxiety as a relatively stable characteristic of the individual	State/Trait Anxiety Inventory for Children (STAIC) - Trait, Child report	Not reported	No	90	Three-month post-baseline
PTSD symptoms	Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-E), Diagnostic interview	Not reported	Yes	90	Three-month post-baseline
Parent outcomes					
Parenting practices	Parenting Practices Questionnaire (PPQ), Parent report	Not reported	Yes	88	Three-month post-baseline

Individual study summary: Study 2

Study 2	
Study design	RCT
Country	United States
Sample characteristics	124 children aged 7 to 14 years old with intimate partner violence (IPV)-related post-traumatic stress disorder (PTSD) symptoms
Race, ethnicities, and nationalities	• 55.6% White • 33.1% Black • 11.3% Mixed racial background.
Population risk factors	• Most children (76.6%) experienced IPV for more than five years, the most severe type of IPV being physical violence. • They experienced on average three to four different types of traumas. • The most common types of past trauma experiences include traumatic death, physical abuse, and witness to violent crime. • Around half of the children still had contact with IPV perpetrator.
Timing	Post-intervention
Child outcomes	• Reduced child PTSD symptoms (total, hyperarousal, and avoidance) • Reduced child anxiety.
Other outcomes	None
Study Rating	2+
Citation	Cohen, J. A., Mannarino, A. P. & Iyengar, S. (2011) Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: A randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine*. 165 (1), 16–21.

Brief summary

Population characteristics

This study was conducted in Greater Pittsburgh in the United States, with a sample of 124 children aged 7 to 14 years old who have been exposed to intimate partner violence and were experiencing

symptoms of PTSD. To be included, children had to have at least five IPV-related PTSD symptoms, including at least one in each of three PTSD symptom cluster on the Kiddie Schedule for Affective Disorders and Schizophrenia.

49% of the sample were male, 51% of the sample were female. 55.6% were White, 33.1% were Black, and 11.3% were biracial.

Most children (76.6%) experienced IPV for more than five years, the most severe type of IPV being physical violence. They experienced on average three to four different types of traumas. The most common types of past trauma experiences include traumatic death, physical abuse, and witness to violent crime. Around half of the children still had contact with IPV perpetrator.

Study design

64 children were randomly assigned to a TF-CBT treatment group and 60 to a control group who received child-centred therapy. Participants were randomised using a computer-generated random number series.

At baseline, the two groups did not differ significantly regarding demographic characteristics or initial scores on assessment measures.

Measurement

Measurement occurred at post-intervention.

- **Child report** measures include University of California at Los Angeles PTSD Reaction Index (RI), Children's Depression Inventory (CDI), and Screen for Child Anxiety Related Emotional Disorders (SCARED).
- **Parent report** measures include Child Behaviour Checklist (CBCL).
- **Researcher-led assessment** include Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (K-SADS-PL) which is a diagnostic interview, and Kaufman Brief Intelligence Test (KBIT) which is a clinical assessment of cognitive functioning.

Study retention

60.5% (75) children participated at post-intervention, representing 67.2% (43) treatment group children and 53.3% (32) control group children.

100% of the data was included in last observation carried forward (LOCF) intent-to-treat analysis. Dropouts did not differ from treatment completers regarding demographics or initial scores on outcome measures except that race differed significantly between dropouts and completers.

Results

Data-analytic strategy

A mixed-model analysis was carried out to examine treatment effects. An intent to treat design was used, using last observation carried forward approach for missing data. Further analysis was conducted with multiple imputation.

Findings

This study identified statistically significant positive impact on a number of child outcomes. The TF-CBT children were found to have reduced anxiety and PTSD symptoms at post-intervention.

Limitations

The conclusions that can be drawn from this study are limited by methodological issues pertaining to inequivalent groups post-attrition, and where attrition was over 10% these differences were not being controlled for in the analyses.

Study 2: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
PTSD symptom - Reexperiencing	Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (K-SADS-PL), Diagnostic interview	Not reported	No	124	Post-intervention
PTSD symptom - Avoidance	Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (K-SADS-PL), Diagnostic interview	Not reported	Yes	124	Post-intervention
PTSD symptom - Hyperarousal	Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (K-SADS-PL), Diagnostic interview	Not reported	Yes*	124	Post-intervention

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child PTSD symptoms	Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (K-SADS-PL), Diagnostic interview	Not reported	Yes*	124	Post-intervention
Child PTSD symptoms	University of California at Los Angeles PTSD Reaction Index (RI), Child report	Not reported	Yes	124	Post-intervention
Depression	Children's Depression Inventory (CDI), Child report	Not reported	No	124	Post-intervention
Anxiety	Screen for Child Anxiety Related Emotional Disorders (SCARED), Child report	Not reported	Yes*	124	Post-intervention
Child behavioural problems	Child Behaviour Checklist (CBCL), Parent report	Not reported	No	124	Post-intervention
Cognitive functioning	Kaufman Brief Intelligence Test (KBIT), Clinician assessment	Not reported	No	124	Post-intervention
*Confirmed by multiple imputation results.					

Individual study summary: Study 3

Study 3	
Study design	RCT
Country	Norway
Sample characteristics	156 children aged 10 to 18 years old who have experienced at least one traumatising event and suffered from significant PTSD reactions.
Race, ethnicities, and nationalities	• 73.7% Norwegian • 10.9% Asian • 8.3% One parent Norwegian • 1.9% African countries • 1.3% Western European countries • 1.3% Eastern European countries • 1.3% South/Central American countries • 0.6% Nordic countries • 0.6% Other.
Population risk factors	• Child participants had on average 3.6 traumatic experiences, ranging from 1 to 10. • The most common types of traumatic experiences included sudden death/injury of a close person, violence outside the family, witnessed/exposed to physical abuse inside/outside the family, sexual abuse outside the family, and accident.
Timing	• Baseline • Mid-treatment • Post-intervention.
Child outcomes	• Reduced child PTSD symptoms (Child report) • Reduced influence of PTSD on daily functioning (Child report) • Reduced child depression (Child report) • Improved child mental health (Child report).
Other outcomes	None
Study Rating	2+
Citation	Jensen, T. K., Holt, T., Silje, M., Ormhaug, K. E., et al. (2013) A randomized effectiveness study comparing Trauma-Focused Cognitive Behavioral Therapy with therapy as usual for youth. *Journal of Clinical Child & Adolescent Psychology*. 43 (3), 356–369.

Brief summary

Population characteristics

This study was conducted in Norway, with a sample of children aged 10 to 18 years who were experiencing PTSD symptoms. 79.5% of the sample were girls, 20.5% were boys. 73.7% were Norwegian.

Child participants had on average 3.6 traumatic experiences, ranging from 1 to 10. The most common types of traumatic experiences included sudden death/injury of a close person, violence outside the family, witnessed/exposed to physical abuse inside/outside the family, sexual abuse outside the family, and accident.

Study design

79 children were randomly allocated to a TF-CBT treatment group, and 77 were allocated to a treatment as usual group. Randomisation was computer generated, allocating participants into random blocks of four or six, and half assigned to TF-CBT and the other to the control desk.

There were no significant differences between participants in the two treatment conditions at baseline in terms of age, gender, ethnicity, living/care situation, total number of traumas experienced, household income, or the parent's level of education. The two groups also had comparable scores on outcome measures.

Measurement

Measurement occurred at baseline (Time 1), mid treatment after the sixth session (Time 2), and post-intervention (Time 3).

- **Child report** measures included Child PTSD Symptom Scale (CPSS), Mood and Feelings Questionnaire (MFQ), Screen for Child Anxiety-Related Disorders (SCARED), and Strengths and Difficulties Questionnaire (SDQ).
- **Researcher-led assessment** included Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA).

Study retention

78.2% (122) children participated at post-intervention, representing 74.7% (59) TF-CBT children and 81.8% (63) control group children.

There were no significant differences between the attrited and the retained with regards to demographic characteristics, such as gender, parent/background information, or primary and secondary outcome variables. However, the attrition group was significantly older than the retention group, and the attrition group reported being exposed to significantly high numbers of different traumatic events.

Results

Data-analytic strategy

A mixed effects model was performed to evaluate the effects of the intervention which can account for the nested nature of the data and handle missing data under the missing at random assumption. Intent-to-treat analyses were conducted.

Findings

The study found significant intervention effect on child outcomes. TF-CBT children were found to have reduced PTSD symptoms, reduced influence of PTSD on daily functioning and reduced depression in comparison to the control group. They were also found to have improved mental health.

Limitations

The conclusions that can be drawn from this study are limited by methodological issues pertaining not reporting on equivalence between groups post-attrition, hence why a higher rating is not achieved.

Study 3: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Child PTSD symptoms	Child PTSD Symptom Scale (CPSS), Child report	d = 0.51	Yes	122	Post-intervention
Influence of PTSD on daily functioning	Child PTSD Symptom Scale (CPSS), Child report	d = -0.55	Yes	121	Post-intervention
Trauma exposure and PTSD intensity and frequency	Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA), Clinical interview	d = 0.46	Not reported	116	Post-intervention
Child depression	Mood and Feelings Questionnaire (MFQ), Child report	d = 0.54	Yes	119	Post-intervention
Child anxiety	Screen for Child Anxiety-Related Disorders (SCARED), Child report	d = 0.3	No	115	Post-intervention
Child mental health	Strengths and Difficulties Questionnaire (SDQ), Child report	d = 0.45	Yes	115	Post-intervention

Individual study summary: Study 4

Study 4	
Study design	RCT
Country	Germany
Sample characteristics	159 children aged 7 to 17 years old with PTSD symptoms.
Race, ethnicities, and nationalities	• 89.9% German native • 6.9% non-German native • 3.1% Missing information.
Population risk factors	• Participants experienced on average 6.35 traumatic events • Most participants (75.5%) fulfilled DSM-IV criteria for PTSD diagnosis • 34% children had more than one comorbid DSM-IV disorder • 15.1% children were on psychotropic medication.
Timing	• Baseline • 2-month follow-up • 4-month follow-up.
Child outcomes	• Reduced PTSD symptoms (Total, Reexperiencing, Avoidance, Hyperarousal) (Clinical interview) • Reduced PTSD symptoms (Child and caregiver report) • Reduced trauma-related cognitive distortions (Child report) • Improved child psychosocial functioning (Clinical interview) • Reduced child depression (Child report) • Reduced child anxiety (Caregiver report) • Improved child behaviour (total, externalising and internalising behaviour) (Caregiver report)
Other outcomes	None
Study Rating	2+
Citation	Goldbeck, L., Muche, R., Sachser, C., Tutus, D. & Rosner, R. (2016) Effectiveness of Trauma-Focused Cognitive Behavioral Therapy for children and adolescents: A randomized controlled trial in eight German mental health clinics. *Psychotherapy and Psychomatics*. 16, 159–170.

Brief summary

Population characteristics

The study was conducted in Germany, with a sample of children aged 7 to 17 with PTSD symptoms. 28.3% of the sample was male, 71.7% were female. 89.9% were German natives, 6.9% were non-German natives, and 3.1% was unknown.

Participants experienced on average 6.35 traumatic events. Most participants (75.5%) fulfilled DSM-IV criteria for PTSD diagnosis. 34% children had more than one comorbid DSM-IV disorder. 15.1% children were on psychotropic medication.

Study design

76 children were randomly assigned to a TF-CBT group and 83 to a control group. The allocation to groups was stratified by severity of PTSD.

Measurement

Measurement occurred at baseline, two-month follow-up, and four-month follow-up.

- **Child report** measures included UCLA-PTSD Reaction Index, Child Posttraumatic Cognitions Inventory (CPTCI), Children's Depression Inventory (CDI), Screen for Child Anxiety-Related Emotional Disorders (SCARED) and Quality of Life for Children (ILK).
- **Caregiver report** measures included UCLA-PTSD Reaction Index, Screen for Child Anxiety-Related Emotional Disorders (SCARED), Child Behaviour Checklist 4–18 (CBCL/4–18) and Quality of Life for Children (ILK).
- **Researcher-led assessment** included Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA), Children's Global Assessment Scale (CGAS) and Schedule of Affective Disorders and Schizophrenia for School-Age Children Revised for DSM IV (K-SADS).

Study retention

100% (159) of the data was analysed in LOCF ITT analysis, including the data of 76 TF-CBT children and 83 control group children.

Two-month follow-up

88.1% (140) children participated at two-month follow-up, representing 86.8% (66) TF-CBT children and 89.2% (74) control group children.

Four-month follow-up

84.9% (135) children participated at four-month follow-up, representing 81.6% (62) TF-CBT children and 88% (73) control group children.

Results

Data-analytic strategy

The study used a repeated-measures analysis of variance (ANOVA) to evaluate treatment effects. Dichotomous variables were analysed by z tests. An intent to treat design was used and a Last observation Carried Forward (LOCF) approach was used to address missing data.

Findings

The study found significant intervention effects on child outcomes. TF-CBT children were found to have reduced PTSD symptoms, reduced trauma-related cognitive distortions and improved child psychosocial functioning. They were also reported to have reduced child depression and anxiety, as well as improved child behaviour at four-month follow-up compared to the control.

Limitations

The conclusions that can be drawn from this study are limited by methodological issues pertaining to not reporting on equivalence between groups post-attrition, hence why a higher rating is not achieved.

Study 4: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
PTSD symptoms	Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA), Clinical interview	d = 0.5	Yes	159	Four-month follow-up
PTSD symptoms - Reexperiencing	Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA), Clinical interview	d = 0.46	Yes	159	Four-month follow-up

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
PTSD symptoms - Avoidance	Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA), Clinical interview	d = 0.44	Yes	159	Four-month follow-up
PTSD symptoms - Hyperarousal	Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA), Clinical interview	d = 0.4	Yes	159	Four-month follow-up
PTSD symptoms	UCLA-PTSD Reaction Index, Child report	d = 0.4	Yes	156	Four-month follow-up
PTSD symptoms	UCLA-PTSD Reaction Index, Caregiver report	d = 0.54	Yes	149	Four-month follow-up
Trauma-related cognitive distortions	Child Posttraumatic Cognitions Inventory (CPTCI), Child report	d = 0.48	Yes	157	Four-month follow-up
Child psychosocial functioning	Children's Global Assessment Scale (CGAS), Clinical interview	d = −0.55	Yes	150	Four-month follow-up

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child depression	Children's Depression Inventory (CDI), Child report	d = 0.32	Yes	157	Four-month follow-up
Child anxiety	Screen for Child Anxiety-Related Emotional Disorders (SCARED), Child report	d = 0.2	No	157	Four-month follow-up
Child anxiety	Screen for Child Anxiety-Related Emotional Disorders (SCARED), Caregiver report	d = 0.31	Yes	150	Four-month follow-up
Child behaviour	Child Behavior Checklist 4–18 (CBCL/4–18), Caregiver report	d = 0.42	Yes	154	Four-month follow-up
Externalising behaviour	Child Behavior Checklist 4–18 (CBCL/4–18), Caregiver report	d = 0.29	Yes	154	Four-month follow-up
Internalising behaviour	Child Behavior Checklist 4–18 (CBCL/4–18), Caregiver report	d = 0.56	Yes	154	Four-month follow-up
Quality of life	Quality of Life for Children (ILK), Child report	d = –0.18	No	159	Four-month follow-up

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Quality of life	Quality of Life for Children (ILK), Caregiver report	d = –0.36	No	154	Four-month follow-up
PTSD	Schedule of Affective Disorders and Schizophrenia for School-Age Children Revised for DSM IV (K-SADS), Clinical interview	Not reported	Not reported	159	Four-month follow-up

Other studies

The following studies were identified for this intervention but did not count towards the intervention's overall evidence rating. An intervention receives the same rating as its most robust study or studies.

Cohen, J. A. & Mannarino, A. P. (1996) A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*. 35 (1), 42-50.

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Cohen, J. A. & Mannarino, A. P. (1997) A treatment study for sexually abused preschool children: Outcome during a one-year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry*. 36 (9), 1228–1235.3.

Cohen, J. A. & Mannarino, A. P. (1998) Factors that mediate treatment outcome of sexually abused preschool children: Six- and 12-month follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry*. 37 (1), 44–51.

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Diehle, J., Opmeer, B. C., Boer, F., Mannarino, A. P. & Lindauer, R. J. L. (2014) Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: What works in children with posttraumatic stress symptoms? A randomized controlled trial. *European Child & Adolescent Psychiatry*. 24 (2).

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Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., et al. (2010) Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*. 23, 223-231.

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Note on provider involvement: This provider has agreed to Foundations' terms of reference (or the Early Intervention Foundation's terms of reference), and the assessment has been conducted and published with the full cooperation of the intervention provider.