Trauma focused cognitive behavioural therapy reduces PTSD more effectively than child centred therapy in children who have been sexually abused

Cohen JA, Deblinger E, Mannarino AP, *et al.* A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *J Am Acad Child Adolesc Psychiatry* 2004;**43**:393–402.

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Q Is trauma focused cognitive behavioural therapy more effective than child centred therapy for post-traumatic stress disorder in sexually abused children?

METHODS

Design: Randomised controlled trial.

Allocation: Concealed.

Blinding: Single blinded (clinicians).

Follow up period: 12 weeks.

Setting: One metropolitan and one suburban outpatient clinic, USA; timeframe not specified.

Patients: 229 children aged 8–14 years with post-traumatic stress disorder (PTSD) after contact sexual abuse (DSM-IV). Exclusions: active psychotic or substance use disorder; non-English speaking; taking psychotropic medication for less than two months; parent or primary carer unwilling or unable to participate; parent or primary carer with active psychotic or substance use disorder.

Intervention: Children were randomised to trauma focused cognitive behavioural therapy (TF-CBT; $n = 114$) or child centred therapy (CCT; $n = 115$). Treatments involved 12 weekly sessions with a trained CCT or TF-CBT therapist for each child and carer, except for three TF-CBT sessions that were joint carer-child sessions. TF-CBT included: skills in expressing feelings; training in coping skills; recognising the relation between thoughts, feelings, and behaviours; gradual exposure; cognitive processing of the abuse experience; parent management skills; and, in joint sessions, psychoeducation about child sexual abuse and body safety. CCT encouraged children and their parent or carer to direct the content and structure of the therapy, with the therapist providing support. Assessment interviews were carried out before and after treatment.

Outcomes: Primary outcome: PTSD (Schedule for Affective Disorders and Schizophrenia for School-Age Children). Secondary outcomes: other related behavioural and emotional problems (Children's Depression Inventory; State-Trait Anxiety Inventory for Children; Children's Attributions and Perceptions Scale).

Patient follow up: 88%.

MAIN RESULTS

At 12 weeks, TF-CBT significantly improved PTSD symptoms compared with CCT in children who had been sexually abused (see <http://www.ebmentalhealth.com/supplemental> for table). At least twice as many children in the CCT group had PTSD after treatment, compared with children in the TF-CBT group. TF-CBT significantly improved symptoms of depression, behavioural problems, shame, credibility, and trust.

CONCLUSIONS

Trauma focused cognitive behavioural therapy is significantly better than child centred therapy for post-traumatic stress disorder, emotional, and behavioural problems in sexually abused children. Trauma focused cognitive behavioural therapy also provides significant benefits for parents/carers in coping and dealing with the abuse of their child.

NOTES

Analysis was by intention to treat. Effect size for the adjusted mean difference between each treatment was calculated by dividing the mean difference in test score by the square root of the within mean square error for the adjusted post-test score. Sibling pairs were assigned the same treatment to ensure their primary carer only received one treatment.

Commentary

In addition to replicating earlier findings that symptom focused cognitive behavioural therapy treatments are superior to client centred therapies in the treatment of trauma symptoms, this study demonstrates that trauma focused cognitive behavioural therapy (TF-CBT) may be successfully applied to multiply traumatised populations. This is important as manualised treatments have often been criticised for being inflexible and deemed inappropriate for treating more complicated cases of abuse. Critics argue that manualised treatments are not flexible enough to accommodate the chaotic lives of some families and too brief to effect long term changes. It is not clear from these current data if TF-CBT will show significant long term benefits for these families. Although short term symptom management is important, the real test of treatment effectiveness in such disadvantaged populations is whether these changes hold up when support is removed.

The results of this study also suggest that such a treatment may be successfully conveyed to clinicians from a variety of training backgrounds and theoretical orientations. Ideally, such results will encourage more widespread training for community based clinicians who are on the "front line" in the treatment of childhood abuse. It is important that additional efficacy studies such as this one are undertaken with multitraumatised families (for example, domestic violence, drug abuse, economic hardship, community violence, etc). It is under these conditions that abuse of a child is most likely to occur. In addition, treatment effectiveness studies that allow for widespread application of validated treatments in the community are extremely critical.

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