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The Efficacy of Trauma Focused Cognitive Behavior Therapy on Treatment of PostTraumatic Stress Disorder among Youth Traumatized by Domestic Violence

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ABSTRACT **Published Online: October 28, 2023**

Trauma Focused Cognitive Behavior Therapy (TF-CBT) is an evidence- based therapy that was specifically designed for the treatment of post-traumatic stress disorder (PTSD) among victims of sexual abuse. Due to its efficacy and ease of application, researchers have continued to assess its effectiveness in the treatment of PTSD resulting from other varied traumatic experiences.

Objective: This study sought to confirm the efficacy of TF-CBT in reducing PTSD symptoms among adolescents who had undergone various forms of domestic violence. The participants were drawn from two selected mixed sex public day secondary schools in Kajiado County, Kenya.

Method: Purposive sampling was employed to select 93 adolescents (13-18 years) into the study, based on a self-report social demographic questionnaire where they affirmed to having been exposed to various forms of domestic violence. A Quasi-experimental design was applied where respondents from one of the schools (Kerarapon) were assigned to the control group and the other school (Ngong Township) was the experimental group. PTSD was assessed using the Harvard Trauma Questionnaire at baseline, midline, and, endline. The experimental group received a 12-week TF-CBT intervention, for one hour once a week in group format, but no intervention was given to the control group for the 12 weeks. The midline assessment was done after the 12 weeks and an endline assessment was done 3 months post-treatment in both groups. The Statistical Package for Social Sciences (SPSS) version 29 was used for data analysis, utilizing means, analysis of variance (ANOVA) and the paired samples t-test.

Results: The comparison of means from baseline, midline to endline showed a marked decline in PTSD symptoms in the experimental group (M= 86.44 to 80.63 and 74.20) but in the control group, the PTSD means continued to increase (M= 77.18 to 79.02 to 79.26). The paired samples ttest indicated a statistically significant decline in symptoms from baseline to endline in the experimental group (p=0.033) but in the control group, no statistically significant change in PTSD symptoms was observed from baseline to endline (p=0.986). Based on the effect sizes in the experimental group, the greatest effect of the intervention was at midline to endline phase (*d*=.454, 95%CI: .102-.799) showing that participants continued to improve posttreatment. Nevertheless, the effect sizes were not large (<.5) showing that probably, the ongoing domestic violence could have slowed down treatment effects.

Conclusion: TFCBT was found efficacious in the treatment of PTSD among adolescents who had undergone domestic violence, with continued improvement maintained 3-months post treatment. Ongoing domestic violence nonetheless slowed down the treatment effects.

Recommendation: TFCBT can effectively be used for the treatment of PTSD among adolescents undergoing various forms of domestic violence. However, there is need for additional parental education to create awareness on the impacts of domestic violence which would hopefully improve on parenting practices.

KEYWORDS:
Adolescents, Domestic violence, TFCBT, PTSD.

INTRODUCTION

Post traumatic stress disorder (PTSD) mainly results from direct exposure or witnessing a traumatic event(s) resulting in thought intrusion symptoms; circumvention of traumatic incentives and negative transformations in thoughts and feelings (APA,2013). Domestic violence whether physical, sexual and psychological abuse or children witnessing violence between their parents adversely affects offspring socially, mentally and psychologically (Papalia et al., 2017). Homes with various forms of domestic violence thus become dangerous environments for children and adolescents (Dillon et al., 2013). The exposure to emotional, physical, and/or sexual violence can prompt harrowing constant worry, which could lead to PTSD and other mood disorders (Devries et al., 2017). Efficacious treatments must thus be offered for youth who have experienced domestic violence to promote mental well being and life outcomes.

Trauma Focused-Cognitive Behaviour Therapy (TF-CBT) was originally developed by Anthony Mannarino, Judith Cohen, and Esther Deblinger to address the needs of children who had experienced sexual abuse. In recent years, it has been studied for many other populations of traumatized youth (Cabrera et al., 2020; O,Callaghan et al., 2013; Okamura et al., 2020). TF-CBT is a form of Cognitive Behavioural Therapy (CBT) and it stands out amongst other therapies since it is specific to the unique challenges of mood problems arising from traumatizing experiences. It thus aids clients to process their experiences by concentrating on the memory of the traumatic occurrence and what it means to them. (Morgan-Mullane, 2018).

The therapy is preferred by clinicians due to its flexibility and clearly outlined procedures. It follows eight main protocols summarized in the acronym PRACTICE. These represent; Psychoeducation, Relaxation skills, Affective modulation skills, Cognitive coping skills, Trauma narrative and processing, In-vivo mastery of trauma reminder, Conjoined parent-child sessions and Enhancing safety and future development (Cohen et al., 2006 as cited by Murray et al., 2015).

Depending on the client's needs, TF-CBT constitutes 12-18 sessions of outpatient healing (Finkelhor et al., 2013). Currently, there exists shortened sessions with equal effects meaning improvements are ongoing. During treatment, clients are directed to process their memories, thoughts, and the feelings connected with their traumatic experience(s) (Last et al., 2021). These may include intrusive reflections and affections related to the trauma, such as thought alterations, guilt, and shame (Finkelhor et al., 2013). To inhibit post-traumatic stress, and behavioral challenges, cognitive-behavioral principles and exposure techniques are utilized (de Arellano et al., 2014). The primary goal of treatment is to lessen post-traumatic stress warning signs, diminish anguish and undertake maladaptive thoughts related to trauma within a restricted period. A key advantage of TF-CBT is that group- based interventions can produce desired results and be administered by non- mental health practitioners, thus reaching out to large numbers of clients within a short time (Davis et al., 2023). Several randomized control studies globally find that youth attached to a group-based treatment show meaningfully lower PTSD symptoms after intervention compared to the control group. Group PTSD interventions, particularly using TFCBT interventions, are effective at focusing on post trauma anguish in children and adolescents (Dorsey et al. 2022; Jensen et al., 2022). Meta analytic studies confirm that TFCBT benefits persist after 6 months, 1 year and 2 years after treatment follow-up (Syros, 2017). Cultural sensitivity in both assessments and interventions is nevertheless critical and there is need for counselors to be receptive to the respondents' customs, beliefs, and socioeconomic circumstances (Dorsey et al., 2022).

Kenya rates third highest in Africa regarding child abuse (United Nations Children's

Fund [UNICEF], 2020), a silent epidermic with enormous negative impacts on their mental well being (Castro et al., 2017). Nevertheless, the accessibility for adequate mental health care remains a challenge due to a plethora of factors. While ignorance and lack of awareness could lead victims to not seeking treatment, there are additional challenges regarding the accessibility of the mental health services (Kamau et al., 2017; Memial et al., 2022; Meyer & Ndetei, 2016). Low funding of mental health services by the Government contributes to poor service provision in the designated mental health facilities due to constrained human resource and services (Marangu et al., (2021). Particularly in rural areas, distance from the available services may be a tall order and additionally, they may face financial obstacles to access the mental health care professionals and services (Arzamarski et al., 2021). Youth in low and medium income settings hence experience the brunt created by the variance between the basic necessity for access to mental health services, and the intervention gap (de Menil, 2014).

It is thus critical for researchers to fill this gap by looking into efficacious interventions that can maximize accesibility and be offered in non-clinical settings such as schools. The current syudy thus focuses on assessing the efficacy of TF-CBT for treatment of PTSD among adolescents from poor backgrounds who have gone through domestic violence.

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The sample are derived from two schools located within the informal settings of Kajiado County, Kenya. The County has experienced speedy urbanization as many people from the capital city of Nairobi migrate towards Kajiado which is opening up to more settlement opportunities. The speedy ubanization may be a risk factor to the family stability thus propagating domestic violence (Gama et al., 2021). Ngong Sub-County in Kajiado County has several informal settlements such as Mathare, Gishagi and Jua kali. With the increase in population, more slums are burgeoning because Ngong Town's expansion has outrun the construction of adequate infrastructure, and services, particularly housing to satisfy the growing population needs. This poses a risk to the adolescents' exposure to domestic violence in the eventuality that it occurs. The schools selected by this study are frequented by adolescents who come from the low socioeconomic backgrounds in the crowded settlements within Ngong Sub-county. There is rampant alcoholism and poverty, which are some of the risk factors for DV (National Center for for Injury Prevention and control Division of Violence Prevention , n.d; Orindi et al., 2020).

Given that TFCBT model has been found efficacious in treating trauma-related disorders, there is need to assess its efficacy in a setting such as the current study where there are issues of low social economic status and ongoing abuse among the adolescents. It may hopefully offer a community- based solution to the recurrent poor state of mental health interventions for youth in Kenya.

METHODOLOGY

The research was conducted in two selected mixed sex public secondary schools in Kajiado County, Kenya, with a sample size of 93 adolescents (13-18 years) who had undergone various forms of domestic violence. A quasi-experimental design approach was applied, with an experimental and control groups established. The respondents from one of the schools (Kerarapon secondary school) were assigned to the control group while respondents from Ngong Township were assigned to the experimental group. The assessment of PTSD symptoms utilized the Harvard Trauma Questionnaires (HTQ) (α=.952). The HTQ is a universally used screening instrument that records trauma exposure. It is comparatively short, simple to administer and score, easy to adapt and interpret for different populaces. The participants had to grade whether they experienced each of 40 symptoms in the last one month. The items were scored on a 4-point Likert scale (1= not at all, 4= extremely) giving a total raw score of 160.

The cut off points for the presence of PTSD symptoms was set at a mean score greater than ≥ 1.8. The HTQ was successfully used in a prior study in Kenya with an internal consistency of Cronbach's α =.75 (Dorsey et al., 2019). Data was collected in three stages: baseline, midline and endline, and analysed using SPSS version 29.

The intervention was administered by two TF-CBT trained psychologists. The intervention in the experimental group lasted for 12 weeks after which a midline assessment was done and an endline assessment at 3 months post-treatment. The control group did not receive any intervention from baseline to endline.

Data was collected in three stages: baseline, midline and endline, and analysed using SPSS version 29. Descriptive and inferential statistics were utilized to explain the findings relating to the efficacy of the intervention.

RESULTS

Table 1: Comparisons of PTSD Means at Different Timelines in the Experimental and Control Groups

Group		Baseline	Midline	Endline
Experimental	Mean	86.44	80.63	74.20
	N	43	43	35
	Std. Deviation	24.71	28.72	24.63
Control	Mean	77.18	79.02	79.26
	N	50	42	39
	Std. Deviation	23.15	24.86	27.22
Total	Mean	81.46	79.84	76.86
	N	93	85	74
	Std. Deviation	24.20	26.734	25.98
	ANOVA	.065	.784	.407

Table 1 shows the comparison of means in the experimental and control groups at different timelines. In the experimental group, the means declined from 86.44 to 80.63 and 74.20 at baseline, midline and endline respectively. Conversely, in the control group, the means increased and they were 77.18 to 79.02 to 79.26 at baseline to midline to end line respectively. The analysis of variance was conducted to test for PTSD mean differences between the control and

experimental groups. None of the mean differences between the control and experimental group were statistically significant (Baseline: p=0.65, Midline=0.784, Endline: p=0.407) and this could have been because the experimental group started at higher PTSD means at baseline (M=86.44) compared to the control group (M=77.18). The findings further demonstrate that recovery in the experimental group was slow, which may be probably due to the ongoing domestic violence within the family environment. The paired samples test was also conducted to compare the impact of the intervention at baseline to midline, midline to endline and baseline to endline in both arms of the study as shown in table 2.

Table 2. The Paired Samples Test in the Experimental and Control Group

Timeline Pairs		Mean	S.D	S.E	95% C.I		T	df	P
					Lower	Upper			
		E xperimental group							
Pair 1	Baseline- midline	5.814	26.6	4.06	-2.38	14.01	1.43	42	.160
Pair 2	Midline – endline	8.829	19.5	3.29	2.14	15.51	2.68	34	.011*
Pair 3	Baseline- endline	10.69	28.5	4.82	.891	20.48	2.22	34	.033*
		Control group							
Pair 1	Baseline – midline	1.024	23.3	3.588	-6.22	8.270	.285	41	.777
Pair 2	Midline – endline	-.154	16.3	2.614	-5.45	5.139	-.059	38	.953
Pair 3	Baseline – endline	.077	28.2	4.509	-9.05	9.204	.017	38	.986

Table 2 shows the paired samples test in the experimental and the control group. Findings indicate that in the experimental group, the difference in baseline to midline intervention was not statistically significant (p=.160) but the midline to endline intervention was statistically significant (p=0.011) and similarly the baseline to endline intervention was statistically significant (p=0.033). This implies that TFCBT was efficacious in alleviation of
PTSD symptoms from baseline to endline where the most impact was at midline to endline. In the control group, the findings indicate that there was no alleviation of PTSD symptomatology at baseline to midline (p=0.777), from midline to endline (p=0.953) and baseline to endline (0.986). Hence, the respondents maintained their PTSD symptomatology status from baseline to end line, even though seemingly showing an upward trend.

The Effect Sizes

A comparison of the effect size of the intervention in both arms of the study using
Cohen's d and Hedges correction is shown in table 3.

Table 3: Paired Samples Effect Sizes in the Experimental and Control Group

Timeline Pairs			Standardizer	Point Estimate	95% C.I	
					Lower	Upper
		Experimental Group				
Pair 1	Baseline- Midline	Cohen's *d*	26.632	.218	-.085	.520
		Hedges' correction	27.119	.214	-.084	.510
Pair 2	Midline – Endline	Cohen's *d*	19.460	.454	.102	.799
		Hedges' correction	19.902	.444	.100	.781
Pair 3	Baseline- Endline	Cohen's *d*	28.514	.375	.029	.715
		Hedges' correction	29.163	.366	.029	.699
		Control Group				
Pair 1	Baseline – Midline	Cohen's *d*	23.253	.044	-.259	.346
		Hedges' correction	23.690	.043	-.254	.340
Pair 2	Midline – Endline	Cohen's *d*	16.327	-.009	-.323	.304
		Hedges' correction	16.658	-.009	-.317	.298
Pair 3	Baseline – Endline	Cohen's *d*	28.156	.003	-.311	.317
		Hedges' correction	28.727	.003	-.305	.310

Table 3 shows the effect sizes of the intervention (mean differences) in the experimental and control groups. It is clear that in the intervention group Cohen's *d* values were larger (baseline-endline *d*=.375; 95% CI -.085-.520)

compared to those in the control group (baseline-endline *d*=.003; 95% CI -.311-..317) where in the experimental group, the largest effect of the intervention was noted at midline to end line (*d*=0.454; 95% CI .102.799). Hence, the results show a marked improvement in PTSD symptoms in the experimental group compared to the control group.

DISCUSSION

This study sought to confirm the efficacy of TF-CBT intervention on PTSD among adolescents traumatized by different forms of DV from selected schools in Kajiado County, Kenya. Based on the paired samples t-test, the intervention was found efficacious for the treatment of PTSD where the experimental group showed statistically significant remission of PTSD symptoms compared to the control group from baseline to endline (p=0.033). The intervention positive outcomes were maintained three months post treatment where the Cohen's d value also showed a larger effect size from midline to endline [d=0.454(95% C.I =.102 to.799] in the experimental group. The experimental group had higher PTSD means at baseline and showed a steady albeit slow decline of symptomatology up to the endline but the control group control group increased in the symptomatology. This shows that TFCBT was critical in reducing the PTSD despite the ongoing domestic violence.

The efficacy of TF-CBT has been confirmed in several other global studies for youth undergoing various kinds of trauma. Davis et al. (2023) meta-analytic study confirmed that group- based interventions using TFCBT can produce desired results even when administered by non-mental health practitioners, and are additionally beneficial as they focus on large numbers of youth. Findings on the 9, 5650 children and adolescents in the study revealed that they had meaningfully lower PTSD symptoms after intervention, compared to the control group. This was despite the intervention being delivered in highly complex and limited resource settings and to a variety of groups exposed to trauma, including war/conflict, natural disasters, domestic violence and abuse.

Similarly, Syros (2017) meta analytic study in Athens, Greece studied in 10 random control trials (RCTs) utilizing TF-CBT, comprising a total of more than 900 children. Reports indicated significant recuperation and the benefits were maintained after 6 months, 1 year and 2 years after treatment follow-up. On the same line, Mavranezouli et al. (2020) found that TFCBT treatment with 1-4 months follow up yielded successful results. TF-CBT revealed steadily large effects in decreasing PTSD symptoms post-treatment compared with waitlist.

Another study in China randomly allocated 234 children aged 9-12 showing symptoms of PTSD to group-based TF-CBT or treatment as usual (TAU). The experimental group (n=118) was assigned lay counselors who administered 10-12 sessions of group-based TF-CBT for 9 consecutive weeks. Results indicated that the TFCBT group scored considerably lower than the TAU group on PTSD after the intervention. Hence, it confirmed the efficacy of group-based TF-CBT in line with other researchers (Li et al., 2023).

A study based in Kenya and Tanzania compared TF-CBT to Usual care (UC) among 320 children and adolescents aged 10-16 years who were traumatized (Dorsey et al., 2022). Findings unveiled that TF-CBT was more effective than UC for PTSD in 3 of 4 sites after treatment at the end of 3-months.

CONCLUSION

TF-CBT was found efficacious in the treatment of PTSD among adolescents who had undergone domestic violence, with continued improvement maintained 3-months post treatment. Ongoing domestic violence nonetheless slowed down the treatment effects. Treatment of PTSD for those undergoing domestic violence is therefore important to reduce PTSD symptomatology. TFCBT can effectively be used for the treatment of PTSD in school settings among adolescents who have undergone various forms of domestic violence.

LIMITATIONS

The respondents faced major challenges given that the intervention was within a school setting where attendance of therapy was not confidential and was also interfered with by school events and activities. Nevertheless, the study was successfully completed but it is critical that the stakeholders must consider allocating time and resources for effective mental health services to be offered in schools. The intervention can be effectively instituted for the reduction of PTSD symptoms among students who have undergone domestic violence but the right therapeutic environment is extremely critical to enhance the adolescents' sense of trust and safety.

RECOMMENDATION

TFCBT can effectively be used for the treatment of PTSD among adolescents undergoing various forms of domestic violence. Hence, it is recommended that schools should consider incorporation of mental health services constituting assessments and interventions with TFCBT for youth traumatized by different forms of abuse including domestic violence. However, there is need for additional parental education to create awareness on the impacts of domestic violence which would hopefully improve on parenting practices.

ETHICS

The study was approved by Daystar University Ethics and Review Board, Daystar University Department of School of Applied Human Science, (SAHS) National Commission for Science and Technology in Kenya (NACOSTI) and the Ministry of education, Kenya. Adolescents aged 18 years

provided informed consent while those below 18 years provided parent informed consent.

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