Caregiver Behaviors and Child Distress in Trauma Narration and Processing Sessions of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Caroline A. Canale
Adele M. Hayes
University of Delaware

Charlotte Yasinski
Emory University

Damion J. Grasso
University of Connecticut School of Medicine

Charles Webb
State of Delaware Division of Prevention and Behavioral Health Services

Esther Deblinger
Rowan University School of Osteopathic Medicine

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an effective treatment for children impacted by trauma, and non-offending caregivers play an important role in this treatment. This study aims to identify correlates of four caregiver variables that have been identified as predictors of child outcomes in TF-CBT: support, cognitive-emotional processing, avoidance, and blame/criticism. Audio recorded sessions were coded from a community effectiveness trial of TF-CBT that included 71 child-caregiver dyads participating in the trauma narration and processing phase of treatment. Regression analyses were conducted to examine caregiver trauma history and child baseline symptoms (internalizing, externalizing, and post-traumatic stress disorder [PTSD] symptoms) as predictors of caregiver behavior during the trauma processing sessions. Caregivers who reported exposure to more trauma types exhibited more in-session avoidance and also processing during the trauma processing phase of treatment. Child symptoms at baseline did not predict caregiver in-session behaviors. Bivariate correlations were used to investigate concurrent associations between mean levels of in-session caregiver behaviors and in-session child distress (negative emotion, hopelessness, negative behaviors). More caregiver blame/criticism was associated with more in-session child distress on all three measures. Caregiver avoidance was associated with more child negative emotion and hopelessness. Findings may help identify therapeutic targets when working with caregivers to promote change and enhance TF-CBT outcomes.

Keywords: child trauma; caregiver; TF-CBT; therapy process; P-TSD

CHILDHOOD TRAUMA is associated with a variety of mental health outcomes, including internalizing symptoms, externalizing behaviors, and symptoms of posttraumatic stress disorder (PTSD; Ford et al.,

2010; McLaughlin et al., 2020; Sege et al., 2017). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2016) is a gold-standard treatment for traumatized youths ages 3–18 and their nonoffending caregivers. This treatment focuses on psychoeducation, skill building, gradual exposure to traumatic memories, and cognitive processing to help the child improve functioning in various domains impacted by trauma (e.g., affective, behavioral, cognitive, social). Caregivers learn to improve parenting and coping skills, prepare their child for experiencing trauma-related triggers and content, and better understand and support their child's needs (Appleyard & Osofsky, 2003; Sege et al., 2017).

TF-CBT has been evaluated in 22 randomized controlled trials (RCTs) that report significant improvement in symptoms of PTSD, depression, and anxiety, as well as reductions in behavioral difficulties and abuse-related attributions (e.g., Deblinger et al., 2011; Tebbett et al., 2018; Unterhitzenberger et al., 2020). Caregiver involvement in treatment is associated with more successful application of skills and more improvements in the child's behavioral problems and depressive symptoms (Deblinger et al., 1996, 1999; Dorsey et al., 2014). Although the primary focus is on the traumatized child, TF-CBT has also been shown to reduce caregiver psychopathology and negative posttraumatic cognitions more than wait-list and supportive therapy conditions (Martin et al., 2019; Tutus et al., 2019). These reductions in distress and negative beliefs may help caregivers to provide more encouragement and support of the child during the trauma processing phase of treatment, as they may be able to remain more focused and open to hearing about the child's experiences. Consistent with this, more caregiver support and processing and less avoidance and child blame/criticism during the trauma processing phase of TF-CBT have been found to predict better child treatment outcomes (Brown et al., 2020; Yasinski et al., 2016).

Little is known about how caregiver behaviors are associated with child levels of distress before treatment starts (initial symptom severity) and during the trauma narration and processing phase of TF-CBT, when the child develops a trauma narrative, and the caregiver is encouraged to process their own emotions and respond to the narrative in a helpful, supportive way. The focus of the current study is to examine the linkages between caregiver behavior and child distress before and during the trauma processing phase of treatment. This might reveal novel therapeutic targets for caregivers that can promote change and improve TF-CBT outcomes.

IMPORTANCE OF CAREGIVER SUPPORT FOR TRAUMATIZED YOUTHS

The TF-CBT model highlights that caregivers can buffer the impact of traumatic experiences on the child by providing support, which can be fostered by believing the child's experiences, modeling positive coping strategies, effectively examining and processing their own reactions to their child's trauma, and providing effective encouragement and parenting (Brown et al., 2020; Cohen & Mannarino, 2015). Social support following traumatic experiences can help children to feel a sense of connectedness/care and provide a safe context for processing the experience. Social support is one of the strongest predictors of better psychological and physiological outcomes after trauma in both children and adults (e.g., McLaughlin et al., 2020; Racine et al., 2020). Particularly important aspects of support are parental nurturance and responsiveness to their child's distress, which predict more prosocial behavior and less aggression after trauma (Dozier & Bernard, 2019). Supportive and responsive caregiving has been shown to buffer the adverse effects of childhood sexual abuse (Godbout et al., 2014) and violence exposure (Howell et al., 2010). However, it is important to note that research has also found that caregiver support might not be as strong or consistent a predictor of child functioning after sexual abuse disclosure as once thought because of different definitions and measures of social support, small effect sizes, and a lack of consideration of other possible contributing factors, such as abuse severity and demographic variables (Bolen & Gergely, 2015; Wamser-Nanney, 2017; Wamser-Nanney et al., 2020).

In the context of treatment, Cohen and Mannarino (2000) found in a randomized controlled trial (RCT) of TF-CBT and supportive therapy that more caregiver support assessed before treatment predicted lower child-reported anxiety and depression at the end of treatment. TF-CBT also helps caregivers during treatment to effectively process their own reactions to their child's trauma so that they can better serve as supportive and helpful coaches for their children (Cohen & Mannarino, 2015). In previous analyses from the current TF-CBT trial (Yasinski et al., 2016), we found that more caregiver cognitive-emotional processing (extent to which the caregiver approaches issues related to the child's trauma and constructively explores, tries to understand,

challenge, and make meaning of it) during the trauma processing phase of TF-CBT trial was associated with more support of the child during that same period. In addition, both caregiver support and processing predicted child treatment outcomes. More caregiver processing predicted improvement in child internalizing and externalizing symptoms across the course of treatment, and more caregiver support had longer-term effects and predicted lower child internalizing symptoms over the follow-up at 12 months.

In contrast, breakdowns in caregiver support, such as avoidance or blaming and criticizing the traumatized child, can have detrimental effects on child treatment outcomes (Feeny et al., 2014). For instance, when caregivers engage in avoidance related to their child's traumatic experience (e.g., not talking about the child's trauma or avoiding trauma-related cues), the child may feel unsupported and invalidated. Caregiver avoidance is associated with higher levels of child trauma-related psychopathology, more child avoidance, poor treatment outcomes, and premature dropout from treatment (Ostrowski et al., 2007; Yasinski et al., 2018). Caregivers can also engage in blame, criticism, and invalidation. This can include viewing the child as at fault for the trauma, criticizing the child's trauma-related reactions (e.g., "Stop being a baby and just get over it."), or not believing or minimizing the trauma disclosure. These behaviors can inhibit trauma processing and negatively impact relationships throughout the lifetime (Doyle & Cicchetti, 2017; Feeny et al., 2014). These negative caregiver behaviors have been associated with both increased risk of child trauma-related psychopathology and poor treatment outcomes (Cohen & Mannarino, 1996, 1998, 2000; Ullman et al., 2007). For instance, more caregiver blame and criticism of the child during the trauma processing phase of the TF-CBT trial used in the current study predicted more internalizing and externalizing symptoms over the 12-month follow-up (Yasinski et al., 2016).

CAREGIVER TRAUMA HISTORY

Caregivers with their own trauma experiences can have difficulty providing support and nurturance when their child has also been traumatized. Poly-victimized adults, or those with exposure to numerous trauma types, experience more severe symptoms such as PTSD and depression, and overall functional impairment (Kiser et al., 2020; Mitchell et al., 2020) that can interfere with parenting and emotional availability. For instance, caregivers impacted by poly-victimization may unintentionally respond in nonsupportive ways when their child is distressed (Kiser et al., 2020). These caregivers may also struggle to regulate their own emotions, show less sensitivity to their child's needs, and more generally practice less effective parenting (Lai et al., 2019; Martin et al., 2018). However, other findings suggest that some trauma-exposed caregivers, relative to nonexposed caregivers, may show more support, protection, sympathy, and empathy when interacting with their child and responding to their distress (Jobe-Shields et al., 2018). Thus, an important task is to better understand how caregiver trauma history might be associated with their behaviors during TF-CBT sessions that focus on the child's traumatic experiences and involve children's expressed emotion and distress.

CHILD DISTRESS

Caregivers may face more parenting stress when caring for highly symptomatic children, such as those with externalizing problems (e.g., oppositional or aggressive behavior; Vanschoonlandt et al., 2013), internalizing problems (e.g., depression, anxiety; Rodriguez, 2011), and PTSD symptoms (Salloum et al., 2015). These types of problems can tax parenting resources and skills and may be associated with maladaptive caregiver behaviors (for a review, see Berg-Nielsen et al., 2002). While there is general information about how child symptomatology can be associated with parenting stress, there is much more limited work that examines specifically how child distress is associated with caregiver behaviors *during* treatment. For instance, more child externalizing symptoms have been associated with more caregiver blame/criticism in a self-report study (Yahav & Sharlin, 2002). During a joint trauma narrative task, more child internalizing symptoms have been associated with caregiver avoidance, which may be an attempt to reduce the child's distress and can be perceived as invalidating (McGuire et al., 2019). Although these studies identify linkages between child symptomatology and caregiver behavior, they are self-report studies and the temporal sequencing of child symptoms and caregiver behavior is not clear. In earlier analyses of the current TF-CBT trial (Yasinski et al., 2016), higher child PTSD scores at baseline predicted more subsequent caregiver avoidance early in the course of TF-CBT, although the direction of that association is still not clear. Overall, there is very little known about the association between child distress and caregiver behavior during TF-CBT.

In addition to examining caregiver behavior and associations with children's symptoms before treatment, it may be useful to examine caregiver

behavior during the sessions of TF-CBT that focus on reading and processing the child's trauma narrative. Therapeutic processing often involves a period of increased distress for the child and caregiver, as the child recounts trauma memories and develops the trauma narrative (Cohen & Mannarino, 2015). The child can express a range of negative emotions, including fear, sadness, anger, and hopelessness, as well as engage in maladaptive coping and externalizing behaviors. Child distress can be difficult for caregivers, who are also managing their own reactions to the child's trauma and in some cases to their own traumatic experiences. However, if managed properly, the child's distress during the trauma processing phase of TF-CBT can be therapeutic in that it reflects engagement with and processing of the traumatic experiences. For instance, we found in the current TF-CBT trial that an increase and then decrease (curvilinear, inverted U) in child trauma-related distress during the trauma processing phase predicted *more* improvement in PTSD and internalizing symptoms at the end of treatment (Alpert et al., 2021). Therefore, it is important how caregivers handle the child's distress during the trauma processing phase of TF-CBT. Problematic caregiver behaviors, such as less support and processing and more avoidance and blame/criticism, could interfere with the child's engagement in the trauma processing sessions and with a subsequent decrease in distress.

CURRENT STUDY

While caregiver behaviors appear to be important for child outcomes across a wide variety of diagnoses, it is not yet clear what factors may be associated with these behaviors during TF-CBT. There is a particular dearth in information about the relationship between in-session child distress and caregiver behaviors. Yasinski et al. (2016) used an observational coding system (CHANGE; Hayes et al., 2007) and identified four caregiver behaviors during the trauma processing phase of TF-CBT that predicted child outcomes at post-treatment and/or 12-month follow-up: support, cognitive-emotional processing, avoidance, and blame/criticism. The current study builds on those findings by examining the associations between those four caregiver variables and caregiver trauma history, child symptoms at baseline (internalizing, externalizing, and PTSD symptoms), and child distress expressed in session (negative in-session emotion, hopelessness, negative behavior).

We hypothesized that higher baseline levels of child symptoms and more caregiver trauma history would predict less caregiver support and

processing and more avoidance and blame/criticism in the trauma processing sessions of TF-CBT. In addition, child distress during these sessions was expected to be associated with less caregiver support and processing and with more avoidance and blame/criticism in concurrent sessions.

Method

PARTICIPANTS

Participants included the traumatized child and the nonoffending caregiver, who were recruited as part of a larger treatment effectiveness study of TF-CBT for trauma-exposed youths in Delaware community mental health agencies (see Webb et al., 2014, for details on trial outcomes, informed consent procedures, and information on participant recruitment and retention; ClinicalTrials.gov Indentifier: NCT01649141). In the main trial, TF-CBT was associated with clinically and statistically significant decreases in PTSD, internalizing, and externalizing symptoms over the course of treatment (Ready et al., 2015; Webb et al., 2014).

Youths were required to score 17 or higher on the UCLA PTSD Reaction Index for DSM-IV Abbreviated (UPID-A; Steinberg et al., 2004) or endorse 3 of 9 PTSD symptoms to ensure elevated symptom severity. Eligible youths spoke English, qualified for publicly funded treatment, were age 7 years or older (to minimize developmental differences between participants), and had a caregiver willing to participant in treatment. Youths were ineligible if they had: (1) an intellectual disability, untreated psychosis, or untreated substance abuse, (2) frequent hospitalizations or need for a higher level of care, or (3) a sibling already in the study.

The effectiveness trial included 109 youth participants (including those without caregivers who participated in treatment). The current study included a subsample of youths with caregivers who participated in treatment (n = 71 dyads) and who completed at least one session of the trauma processing phase of treatment. Youths were ages 7-17 (M = 12.30, SD = 2.7), and most were female (69%). They were racially and ethnically diverse (56.3% White, 36.6% Black, 4.2% Hispanic/Latino, 2.8% multiracial). All had elevated scores on the UPID, and 69% met criteria for PTSD. Youths reported an average of 3.4 types of lifetime traumatic experiences (SD = 1.55, range = 1 – 7). This included sexual abuse (48%), physical abuse (58%), domestic violence (52%), traumatic loss of a loved one (49%), community violence (experienced: 23%; witnessed: 30%), traumatic

accident (25%), fire (4%), witnessed a disaster (6%), or other abuse (10%).

Caregivers were 90% female and averaged 43 years of age (SD = 12). The caregiver's relationship to the child varied (50.7% birth parent, 22.5% foster parent, 9.9% grandparent, 7% aunt, 2.8% caseworker, 5.6% other nonrelative caregiver). The average household income was $31,000/year ($SD$ = $33,600). Caregivers experienced an average of 1.85 types of traumatic experiences (SD = 1.26, range = 0 – 4) in their lifetime. This included physical abuse (60.3%), sexual abuse (45.6%), witnessed violence (34.9%), experienced a disaster (41.5%), and traumatic loss (7.4%). The number of trauma types experienced varied between none (14.7%), one type (29.4%), two types (25.1%), three types (17.6%), and four types (13.2%).

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a 12- to 15-session treatment for children with a history of trauma and their nonoffending caregiver(s) and can be summarized by the acronym PRACTICE (Psychoeducation; Parenting Skills; Relaxation Skills; Affective Modulation Skills; Cognitive Coping Skills; Trauma Narration & Processing; In vivo Mastery; Conjoint Child-Caregiver Sessions; Enhancing Safety; Cohen et al., 2015). The same therapist sees both the child and caregiver separately for 30–45 minutes each session (60–90 minutes total). Each visit begins with the child-therapist session and ends with the caregiver-therapist session.

The *stabilization and skills building* phase (Phase 1) focuses on psychoeducation, parenting skills, relaxation, affect modulation, and cognitive processing. The caregiver is taught coping and behavior management skills and guided on how to best support the child. The *trauma narration and processing phase* (Phase 2) focuses on the development and processing of the child's detailed trauma narrative, and the therapist helps the child challenge maladaptive beliefs about the trauma, its meaning, and the consequences. When clinically appropriate, the therapist shares the child's narrative with the caregiver in order to help the caregiver understand the child's perspective and process their own emotions, challenge cognitive distortions, and respond to the child's narrative in a helpful and supportive way. The *integration and consolidation phase* (Phase 3) helps to integrate learning from previous sessions through in vivo mastery (when appropriate), sharing of the narrative in conjoint caregiver-child sessions (when appropriate), and the development of

personal safety and other skills to reduce the risk of revictimization (enhancing safety and future development).

Treatment was delivered by 25 clinicians, who were either clinical psychology doctoral students or held professional degrees. Unlicensed therapists were supervised by a licensed psychologist. A co-author of the TF-CBT manual (the last author) trained a core group of five clinicians, who received 2 days of didactic training, weekly phone consultations, and expert review of at least one case. These core clinicians then trained and supervised the next cohort of therapists with the same process of didactic training, weekly phone consultations, and tape review.

Coders were trained to use a 10-item adherence checklist for child and caregiver sessions developed by the last author. Coders achieved good to excellent interrater agreement (dichotomous ratings of present or absent) on all categories (median κ = 0.92, range κ = 0.89 to 1.00). Therapists were rated as having high levels of adherence in each of the phases of treatment for the child sessions and caregiver sessions, which suggests that therapists delivered the TF-CBT components in the correct sequence. Overall, children completed an average of 5.4 sessions (SD = 2.1) in the trauma narration and processing phase, and caregivers completed an average of 4.8 sessions in this phase (SD = 2.0).

MEASURES

Child Behavior Checklist (CBCL)

The CBCL is used to assess child emotional and behavioral problems and captures a broad scope of symptoms. The 113-item parent-report measure rates items on a Likert scale from 0 (*not true*) to 2 (*very true or often true*). This study used child baseline internalizing and externalizing scores to assess emotional and behavioral symptom severity before treatment began. The CBCL is a well-established measure with good reliability and validity (Achenbach, 1991; Achenbach & Rescorla, 2001). Reliability in this trial was excellent across treatment and follow-up for the internalizing (Cronbach's α =.89 to .90) and externalizing scales (Cronbach's α = .92 to .95) (Ready et al., 2015).

UCLA PTSD Reaction Index for DSM-IV (UPID)

The UPID (Steinberg et al., 2004) is a child self-report measure used to assess PTSD symptoms. This measure assesses various trauma types and severity of DSM-IV PTSD symptoms in youths ages 7 to 18. The UPID shows good test-retest reliability, convergent validity, sensitivity, and speci-

ficity in diagnosing PTSD (Steinberg et al., 2004). The UPID demonstrated good reliability in this study across treatment and follow-up (Cronbach's α = .87 to .90; Ready et al., 2015).

Caregiver Trauma History
Caregiver Trauma History was measured using the Child Wellbeing Initiative Caretaker Interview designed for this study. This 41-item semi-structured interview was administered to the caregiver during the baseline session to assess lifetime trauma exposure. It was adapted from a standard intake interview used at the Child Abuse Research and Education Service (CARES) Institute. Caregiver trauma data were separated into trauma domains (physical abuse, sexual abuse, witness of violence, disaster, and traumatic loss) in order to give each trauma type equal weight and to serve as a proxy for extent of poly-victimization (Grasso et al., 2016) and cumulative trauma exposure (Petruccelli et al., 2019). The total number of trauma domains experienced was used in analyses.

Session Coding: CHANGE Coding System
Caregiver behaviors and child distress variables during the trauma narration and processing phase of TF-CBT were coded using the CHANGE (Hayes et al., 2007), a coding system designed to study the process of change in psychotherapy (see Table 1). The CHANGE has been used to code written narratives and audiotaped sessions in cognitive behavioral treatments for depression (Abel et al., 2016; Hayes et al., 2005; Hayes, Laurenceau, et al., 2007), PTSD (Alpert et al., 2020; Alpert et al., 2021; Hayes et al., 2017), and personality disorders (Hayes & Yasinski, 2015). A team of 19 undergraduate and graduate students coded audio recordings of sessions during the trauma processing phase of TF-CBT. Coding was done in pairs, and weekly meetings were held to reach consensus on coding discrepancies of two or more points on the 4-point scale of the CHANGE and to maintain inter-rater agreement across time. Consensus ratings replaced discrepancies, and the ratings of both coders were averaged.

Session content was coded only if it related to the child's trauma and was reported or experienced in the session. This study included four caregiver codes (support, cognitive-emotional processing, avoidance, blame/criticism) and three codes to capture child distress (in-session emotion, hopelessness, and negative behavior). Each variable was coded from 0 (*absent to very low*) to 3 (*high*). Coding categories are not mutually exclusive and can occur simultaneously. Interclass correlation coefficients (ICC; Shrout & Fleiss, 1979) were calculated for each coding pair and averaged

across pairs. ICCs ranged from .73-.88 (see Table 1), which falls within the good to excellent range of agreement (Cicchetti, 1994). Codes were averaged across sessions in the trauma processing phase to allow for information from all available sessions to contribute to analyses.

DATA ANALYTIC PLAN
Data from the 71 caregiver-youth pairs were analyzed with linear regression analyses and bivariate correlation analyses using SPSS. Analyses that included caregiver trauma history included 68 caregiver-youth pairs (three caregivers did not complete a baseline interview). The averages for each of the in-session caregiver behaviors and child distress scores over the trauma processing sessions were used in all analyses. The unit of analysis was the treatment phase to maintain consistency with the Yasinski et al. (2016) study, which the current study builds on, and to understand what happened *on average* across the processing sessions rather than from one session to the next.

Regression analyses were conducted to examine baseline variables (child symptoms and caregiver trauma history) as predictors of caregiver behaviors (support, processing, avoidance, and blame/criticism) during the trauma processing sessions. Separate models were run for baseline symptom variables (CBCL internalizing, CBCL externalizing, and UPID PTSD scores; entered simultaneously) and caregiver trauma history predicting each caregiver behavior. Child age was included as a covariate because it was significantly correlated with caregiver behaviors, whereas child sex was not included in the models because it was not significantly associated with any of the caregiver behaviors. Bivariate correlations were used to examine associations between child distress (negative in-session emotion, hopelessness, negative behavior) and caregiver variables (support, processing, avoidance, blame/criticism) across the trauma processing sessions.

A post hoc power analysis was conducted using G*Power. For the correlation analyses, using a medium effect size (r = .30) and two-tailed test with alpha = .05, the power estimate for our sample size of 71 is .73. Using a large effect size (r = .50) and alpha =.05, the power estimate for this sample is .99. For the regression analyses, using a medium effect size (f^2 = .15), alpha = .05, and four predictors (child age, child internalizing, child externalizing, child PTSD symptoms at baseline), the power estimate is .89. In our final regression analyses, using a medium effect size (f^2 = .15), alpha =.05, and one predictor (caregiver trauma history), the power estimate was .99. Thus, this

Table 1
CHANGE Coding Categories With Descriptions, Examples of High Levels of Each Variable, and Intra-Class Correlations (ICCs) of Inter-Rater Agreement

Coding Category	Description	Example	ICC
CAREGIVER CODES			
Support	Concern, empathy, and care expressed for the child in relation to the trauma, trauma responses, and positive gains that he/she makes.	"We went out to eat, and he was nervous being in front of other people. I used the thought changing technique to try and help him. Thoughts are running his life, and I can understand that because it happened to me."	.80
Cognitive-Emotional Processing	Extent to which the caregiver approaches issues related to the child's trauma and constructively explores, tries to understand, challenge, and make meaning of it.	"I realize that I raised my kids the way I did as a defense mechanism. I started integrating it together, like 'that's why I do that.' It makes sense. I'm finally understanding why."	.73
Avoidance	Attempts to protect or defend oneself by pulling away from problems, issues or emotions related to the trauma.	"'Come climb in bed with your father.' I will never forget those words. And I don't want to face it. I want to push it back. That's how I deal with things."	.86
Blame/Criticism	Blame or criticism of the child for the trauma and trauma-related difficulties.	"She's just using the abuse as an excuse for acting out. We're the ones paying for it. She's the problem in this family"	.78
CHILD CODES			
Negative In-Session Emotion	Rated based on the number and intensity of negative emotion words (e.g., anxious, sad, angry, ashamed, guilty) and quality of the emotional tone (e.g., crying) in session.	"I'm hurting so badly right now. I feel guilty that my dad got arrested because of me, and I'm so embarrassed."	.82
Negative Behavior	Maladaptive actions that are inconsistent with therapeutic goals. Rated based on number of behaviors and their intensity.	"Then I lost it and started screaming at him [brother]. I just kept yelling and telling him he didn't know what he was talking about – how could he? He wasn't there when the assault happened."	.88
Hopelessness	Feelings of being stuck or having no way out, feeling tired of trying, or holding negative beliefs about the future.	"I feel so horrible, and it's always going to be like this. I can't see a way out."	.76

Note. ICC = intra-class correlation.
Content in each category must be related to the trauma or its impact to be coded.

Table 2
Intercorrelations and Descriptive Statistics for Primary Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12
1. Child Age Baseline	—											
2. INT Baseline	.09	—										
3. EXT Baseline	.09	.63***	—									
4. PTSD Baseline	.09	.35**	.17	—								
5. CG Trauma History	−.05	.25*	.24*	.03	—							
6. Child Neg Emotion	.37**	.20	.04	.00	.14	—						
7. Child Neg Behavior	.33**	.16	.05	.28*	.19	.28*	—					
8. Child Hopelessness	.29*	.25*	.04	.10	.15	.59***	.32**	—				
9. CG Support	−.05	.05	.06	.15	−.02	−.13	.00	−.16	—			
10. CG CEP	−.01	.24*	.21	.05	.26*	.02	−.14	−.17	.33**	—		
11. CG Avoidance	.23	.17	.20	.08	.26*	.28*	.18	.37**	−.35**	.01	—	
12. CG Blame/Criticism	.28*	.29*	.32**	.09	.20	.25*	.31**	.43***	−.42***	−.11	.52***	—
Mean	12.3	14.24	15.74	34.42	1.85	1.55	.38	.40	1.96	.48	.33	.42
SD	2.74	9.07	12.48	12.84	1.26	.58	.49	.50	.59	.47	.48	.51
Range	7.73–17.02	0–36	0–44	8.60–65	0–4	.40–2.67	0–2	0–2.10	.50–3	0–1.75	0–1.83	0–1.83

Note. Neg = negative; CG = caregiver; CEP = cognitive-emotional processing; INT = Child Behavior Checklist Internalizing score; EXT = Child Behavior Checklist Externalizing score; PTSD = Posttraumatic Stress Disorder.
* p < .05. ** p < .01. *** p <.001.

study is powered to detect medium effect sizes for the regression analyses and large effect sizes for the correlational analyses.

Results

Intercorrelations and descriptive statistics for study variables are presented in Table 2. Associations between caregiver in-session variables and child baseline symptoms, caregiver trauma history, and child in-session variables are presented below. All associations fall into the small to moderate effect size range.

BASELINE VARIABLES PREDICTING CAREGIVER BEHAVIOR IN THE TRAUMA PROCESSING PHASE OF TF-CBT

Child Baseline Symptoms

Contrary to study hypotheses, none of the child baseline symptoms (CBCL internalizing, CBCL Externalizing, UPID PTSD) predicted the later caregiver in-session variables (support, processing, avoidance, blame/criticism) during the trauma processing phase of TF-CBT (see Table 3). Only older child age predicted more caregiver blame/criticism during these sessions, β = .25, $t(66)$ = 2.19, p = .03.

Caregiver Trauma History

On average, caregivers reported an average of 1.85 types of traumatic experiences (SD = 1.26, range = 0–4) in their lifetime. As predicted, a greater number of caregiver trauma types (i.e., polyvictimization) predicted their behavior in the trauma processing phase of TF-CBT (see Table 4). An intriguing finding was that number of trauma types at baseline predicted more caregiver avoidance (β = .26, $t(66)$ = 2.23, p = .03) and also more cognitive-emotional processing (β = .26, $t(66)$ = 2.15, p = .04) during the trauma processing sessions. Caregiver trauma history did not predict caregiver support or blame/criticism.

CORRELATIONS BETWEEN CAREGIVER AND CHILD IN-SESSION VARIABLES

Although none of the pretreatment child symptom levels (internalizing, externalizing, PTSD) predicted negative caregiver behaviors in the trauma processing sessions of TF-CBT, more negative caregiver behaviors were associated the level of distress expressed by the child in these sessions. As predicted, more caregiver avoidance and blame/criticism were associated with more child expression of negative emotion [avoidance: $r(69)$ = .28, p = .02; blame/criticism: $r(69)$ = .25, p = .03] and also hopelessness [avoidance: $r(69)$ = .37, p = .001; blame/criticism: $r(69)$= .43, p < .001]. More caregiver blame/criticism was also

Table 3
Regression Results for Child Baseline Symptoms and Age Predicting in-Session Caregiver Variables in Trauma Narration and Processing Sessions of TF-CBT

Predictor (Child Baseline)	Outcome	B	SE	β	t	p	95% Confidence Interval		R^2
							Lower	Upper	
Model 1									.03
Child Age Baseline	CG Support	−.01	.03	−.07	−.54	.59	−.07	.04	
INT Baseline		.00	.01	−.05	−.29	.77	−.02	.02	
EXT Baseline		.00	.01	.07	.43	.67	−.01	.02	
PTSD Baseline		.01	.01	.16	1.22	.22	.00	.02	
Model 2									.07
Child Age Baseline	CG CEP	−.01	.02	−.04	−.30	.76	−.05	.04	
INT Baseline		.01	.01	.20	1.22	.23	−.01	.03	
EXT Baseline		.00	.01	.10	.62	.54	−.01	.02	
PTSD Baseline		.00	.01	−.03	−.24	.81	−.01	.01	
Model 3									.09
Child Age Baseline	CG Avoidance	.04	.02	.21	1.74	.09	−.01	.08	
INT Baseline		.00	.01	.05	.29	.78	−.01	.02	
EXT Baseline		.01	.01	.16	1.02	.31	−.01	.02	
PTSD Baseline		.00	.01	.02	.12	.91	−.01	.01	
Model 4									.17
Child Age Baseline	CG Blame/Criticism	.05	.02	.25	2.19	.03*	.00	.09	
INT Baseline		.01	.01	.14	.92	.36	−.01	.03	
EXT Baseline		.01	.01	.21	1.47	.15	.00	.02	
PTSD Baseline		.00	.01	−.02	−.13	.90	−.01	.01	

Note. CG = caregiver; CEP = cognitive-emotional processing; INT = Child Behavior Checklist Internalizing score; EXT = Child Behavior Checklist Externalizing score; PTSD = Posttraumatic Stress Disorder.
* p < .05.

Table 4
Regression Results for Caregiver Trauma History Predicting In-Session Caregiver Variables in Trauma Narration and Processing Sessions of TF-CBT

Model	Outcome	B	SE	β	t	P	95% Confidence Interval		R^2
							Lower	Upper	
1	CG Support	−.01	.06	−.02	−.14	.89	−.12	.11	.00
2	CG CEP	.10	.05	.26	2.15	.04*	.01	.19	.07
3	CG Avoidance	.10	.05	.26	2.23	.03*	.01	.19	.07
4	CG Blame/Criticism	.08	.05	.20	1.66	.10	−.02	.18	.04

Note. Caregiver Trauma History examined as a predictor of each caregiver behavior in separate regression equations, CG = caregiver; CEP = cognitive-emotional processing.
* p < .05.

associated with more child reported negative behavior, $r(69) = .31$, $p = .01$. There were no significant associations between positive caregiver in-session behaviors (support and processing) and child distress variables during the trauma processing phase sessions.

Discussion

This study sought to better understand four caregiver variables (support, cognitive-emotional processing, avoidance, and blame/criticism) expressed in sessions from the trauma narration and processing phase of TF-CBT and their associ-

ations with baseline child symptoms, caregiver trauma history, and child in-session distress. Unexpectedly, child symptoms at baseline (internalizing, externalizing, PTSD symptoms) did not predict caregiver behaviors in the processing phase of TF-CBT. This may be because child symptoms changed from baseline, improving over the early skills-building phase of treatment (Deblinger et al., 2011; Webb et al., 2014) before the processing phase began and caregiver behavior was measured. This TF-CBT trial did not include symptom measures immediately before the trauma processing phase, but the level of child distress expressed in the sessions was measured concurrently with caregiver behaviors, which might give a more proximal assessment of how caregivers respond to their child's trauma-related reactions.

Consistent with the literature, older child age predicted more caregiver blame/critical parenting behavior during the trauma processing sessions. Caregivers may see older children as more culpable or responsible for their traumatic experiences and thus engage in more blameful behavior (Back & Lips, 1998; Rogers & Davies, 2007). Although developmentally it is appropriate for parents to have higher expectations for older children in terms of maturity and responsibilities, the limits of the control teens have over the dynamics of abusive interactions are often not fully appreciated by caregivers (Davies & Rogers, 2009; Maynard & Wiederman, 1997). Future research should examine the impact of age on caregiver behaviors during TF-CBT with a larger sample that includes more evenly distributed ages and perhaps measures of caregivers' perceived attributions for the traumatic experiences. Our sample included children from the ages of 7 to 17, but most of the sample (72%) was in the 10–17 age range. In addition, it would be useful to examine therapist behaviors in the first phase of treatment, when psychoeducation is designed to help caregivers understand the dynamics associated with child sexual abuse, physical abuse, exposure to domestic violence, and other victimization experiences as a function of the child's developmental stage. It is possible that caregivers could benefit from additional information on behaviors that facilitate support and those that inhibit processing than are currently standard in TF-CBT.

Caregiver poly-victimization predicted more caregiver processing. This is consistent with findings that TF-CBT helps caregivers challenge their negative posttraumatic cognitions and change perspectives (Tutus et al., 2019). Caregivers with complicated trauma histories might also have more material to process, especially if these past experiences interfere with their ability to support their child. Additionally, trauma-exposed caregivers have been found to show high levels of support, protection, sympathy, and empathy when responding to their child's distress (Jobe-Shields et al., 2018). It is possible that this effect is amplified for caregivers with more trauma history, possibly contributing to the association between caregiver poly-victimization and processing. In addition, caregivers may vary in the degree to which they have processed their personal history of trauma, and this may moderate how caregiver trauma history impacts their behavior in session. For example, caregivers who have processed and come to terms with past trauma, perhaps through their own therapy, may be optimally positioned to support their child through this process. On the other hand, caregivers who have not processed past trauma or have actively avoided it may not have the resources to support their child's recovery, as they struggle with their own trauma-related symptoms. In line with this possibility, our findings revealed that caregiver poly-victimization predicted more in-session avoidance during trauma processing sessions.

While TF-CBT is designed to help caregivers cope with and process their children's traumatic experiences, it does not directly target caregivers' own trauma or associated psychopathology. However, therapists can help the caregiver work through these responses as they relate to their ability to support the child. When interpreting these seemingly contradictory findings, it is also critical to note that the coding system used is not mutually exclusive, and the values used in this study are averages across sessions. This means that it is possible that the same caregiver can have high levels of avoidance in the first few trauma processing sessions and then be able to move through the avoidance into healthy processing. In other words, cognitive-emotional processing is a dynamic process that can involve moving from avoidance to working through the trauma responses, and it can even be punctuated with other spikes in avoidance as the caregiver works through more difficult material.

It is interesting to note that caregiver processing and avoidance are not significantly correlated with each other, which suggests the possibility of a moderating variable, such as caregiver trauma-related symptoms, which might influence the relationship between trauma exposure and in-session behavior. However, this trial of TF-CBT did not include a measure of caregiver symptoms to examine this possibility. Future studies that account for caregiver symptomatology and that measure

session-by-session change (rather than averages) in caregiver behavior and symptoms across the trauma processing phase of TF-CBT can help to clarify the relationship between processing and avoidance in caregivers with a trauma history.

An intriguing set of findings suggested that neither caregiver support nor processing were significantly related to child baseline symptoms or to the level of child distress during the trauma processing phase. This is congruent with previous findings that caregiver support may not be as strongly related to child functioning after trauma as previously thought (Bolen & Gergely, 2015). Instead, it was the in-session negative caregiver behaviors, avoidance and blame/criticism, that were associated with child distress. This is in line with the idea that a *lack* of support may have more impact than the presence of support (Feeny et al., 2014). It is also possible that other factors influence the positive caregiver behaviors, such as personality factors, the type of trauma experienced by the child and caregiver, and/or the preexisting quality of the dyad's relationship. Future research could examine the associations between positive caregiver behaviors and positive child variables during treatment (e.g., hope, adaptive behaviors, positive in-session emotion) to attempt to understand what may be associated with these important behaviors.

Problematic caregiver behaviors (avoidance and blame/criticism) were associated with more child distress. These negative caregiver behaviors might interfere with or short-circuit the therapeutic distress associated with the child's processing of the experiences (Alpert et al., 2021). Importantly, this distress can be an indicator of positive treatment outcomes if handled well, but problematic caregiver behaviors may interfere with this process. Caregiver avoidance was correlated with more child in-session negative emotion and hopelessness. Although directionality is not clear in this correlational design, children may experience more distress when their caregivers are avoidant, and/or caregivers may be overwhelmed by the child's emotions and concerned about causing further distress, or unsure how to reduce the distress. Such avoidance could also reflect a lack of optimal caregiver processing and the need for additional skills building in caregiver-therapist sessions, as they learn how to best support the child. Future research might examine therapist behaviors in terms of how they might prepare and model such behaviors for caregivers, both in early individual sessions and in conjoint caregiver child sessions.

Caregiver blame/criticism was associated with all three measures of in-session child distress:

negative emotion, hopelessness, and negative behavior. Children may experience more distress, or get stuck in that distress, when they are blamed/criticized. Caregivers may also become frustrated by the child's distress and engage in blame/criticism. This behavior may indicate a need for more caregiver-therapist sessions, particularly psychoeducation about harmful reactions to trauma and the importance of support in the context of trauma. It is possible that caregivers engaging in blame and criticism do not see the harm in their actions and truly believe their child is at fault or needs negative feedback and criticism. These beliefs should be addressed by the therapist in individual sessions to ensure that caregivers can best support their child during the trauma processing phase of TF-CBT. It is important to highlight that blame/criticism can be detrimental to child outcomes, even in the presence of adequate support (Feeny et al., 2014), so this caregiver behavior is a key target in therapy and for future research. There are instances in which conjoint caregiver child sessions are contraindicated due to a caregivers' inability to acknowledge the abuse or manage their own emotions. Thus, the caregivers' coping responses and their ability to emotionally process trauma material is important to examine prior to possible conjoint sessions. Although causality is not clear because we examined mean values of caregiver and child in-session variables across the trauma processing phase of TF-CBT, the findings suggest that negative caregiver behavior and child in-session distress go hand in hand.

IMPLICATIONS FOR TF-CBT

This study identifies possible risk factors for poor child treatment outcomes by elucidating associations between caregiver behaviors, child in-session distress, and caregiver trauma history. The caregiver behaviors that we examined were predicters of both posttreatment and long-term child outcomes in a previous study of this dataset (Yasinski et al., 2016), which highlights the importance of better understanding these behaviors. If therapists notice that the caregiver is engaging in avoidance or blame/criticism, they may choose to focus more on supporting the caregivers' processing and responsive parenting. However, distress in the caregiver is not the same as avoidance or blame, so if therapists notice distress (e.g., negative emotion), they can help the caregiver overcome the tendency to blame or avoid by encouraging the use of effective coping skills. This may include focusing more on helping the caregiver understand abuse dynamics, as well as processing the care-

givers' dysfunctional thoughts about the child's trauma through the use of Socratic questioning. Therapists may also help the caregiver to work on approaching rather than avoiding trauma-related issues and on becoming more aware of their blame and criticism of the child and the negative impact of this. If therapists are able to assist and prepare the caregiver for conjoint work by helping them process their own trauma-related thoughts and behaviors, caregivers may be better able to support the child in doing the same.

Additionally, it appears that child hopelessness is most strongly associated with caregiver avoidance and blame, so if therapists notice child distress (particularly hopelessness), they may consider intervening with the caregiver (in addition to the child) and preparing the caregiver to address the child's concerns in conjoint sessions, when clinically appropriate. Hopelessness and negative behavior might serve as signals that the therapist needs to intervene, whereas negative emotions that reflect engagement with the traumatic memories and experiences may be an important step towards productive processing (Alpert et al., 2021; Foa et al., 2006). Finally, in some instances, a referral for caregiver-specific treatment can be useful for caregivers who have their own history of trauma and unresolved PTSD, depression, or other mental health difficulties that may interfere with their ability to best support their child.

Each TF-CBT component is critically important for caregivers to master so they can optimally serve as effective coping role models, while also responding to children's emotions and behaviors with a greater understanding of the dynamics and impact of the traumatic experiences. Ultimately, most caregivers who participate in treatment have a desire to help and support their children, but their own emotional reactions and coping difficulties (e.g., avoidance) may undermine their efforts to do so optimally. Thus, the first phase of TF-CBT treatment may also be an important phase to study, as it is often during this phase that caregivers develop effective coping skills and begin to process their own thoughts and feelings about the child's trauma(s).

STRENGTHS, LIMITATIONS, AND FUTURE DIRECTIONS

This study has several strengths. The TF-CBT effectiveness study was implemented in community settings with a low income, racially/ethnically diverse sample. An observational coding system, CHANGE (Hayes et al., 2007), was used to measure behaviors and distress, which may allow for greater objectivity than self-reports. This study focused on sessions in the trauma narration and processing phase of TF-CBT, which is hypothesized to be where much of the clinical change occurs (Cohen et al., 2012). Very little research has been conducted on what happens in-session during TF-CBT, particularly in terms of caregiver behavior.

Several limitations also must be considered when interpreting the findings. First, it would be beneficial to have a larger sample size. The effect sizes of the findings from this study ranged from small to moderate, and we were powered to detect moderate to large effects with a sample size of 71. It is possible that some smaller effects would have been revealed with a larger sample. However, it is also important to note that this sample was from a state-wide effectiveness trial in community mental health centers with underserved populations. We were able to audiotape and code the content of the sessions in this trial, which yields a unique and valuable dataset and can generate hypotheses to test further in larger trials of TF-CBT.

Caregivers and children were majority female (90% and 69%, respectively), and 72% of children were age 10 years or older, which might limit the generalizability of the findings. In addition, the CBCL is a caregiver-report measure that can be subject to bias, as caregiver trauma can influence the lens through which child functioning and symptoms are viewed (Valentino et al., 2010). It is possible child symptoms changed during the first phase of TF-CBT (the stabilization and skills building phase) such that baseline measures were not predictive of caregiver behavior in the later trauma processing phase. Unfortunately, the TF-CBT trial upon which the current study is based did not include symptom measures at the end of the first phase of treatment, so it was not possible to evaluate the role of early child symptom change on caregiver behavior. However, we did include observational coding of in-session child distress to capture level of child distress *during* the trauma processing work. Notably, the CHANGE (Hayes et al., 2007) coding system relies on verbalizations and audible nonverbal information (e.g., crying). Thus, some important nonverbal information may not have been captured. Finally, this trial did not include a measure of caregiver psychopathology at baseline. Caregiver distress can affect caregiver behavior and child distress (Charuvastra & Cloitre, 2008); therefore, a measure of caregiver psychopathology would have been informative.

Future research may benefit from investigating session-by-session changes in caregiver and child processes over time to understand the direction of effects, such as whether caregiver behaviors precede child distress or child distress precedes caregiver behaviors. Unfortunately, there were not enough sessions (particularly caregiver sessions) to conduct these types of analyses with this sample. In addition, it could be valuable to examine observational data on child, caregiver, and therapist interactions throughout treatment, given therapists' role as the bridge between caregiver and child sessions. Therapists may relay information about caregiver behavior that impacts child distress, or vice versa. Additional data could objectively identify means by which therapists could more effectively facilitate optimal youth and caregiver outcomes. As noted above, the initial skill building and stabilization phase of treatment may hold the key to understanding caregiver and child emotional and behavioral responses to this critical aspect of treatment. It would also be useful to examine in-session child and caregiver processes in conjoint caregiver-child sessions and also over the follow-up period, without the support and scaffolding of the therapist. Ecological momentary assessment (Shiffman et al., 2008) methods could be harnessed to allow for more frequent assessments and to assess interactions in the daily lives of dyads, both between sessions and over the follow-up period. Additionally, it would be helpful to better understand the relationship between caregiver trauma and in-session behavior, particularly examining what factors may serve as a moderator of trauma and avoidance/processing during treatment. These data could highlight points of intervention to increase supportive caregiver behaviors and decrease negative behaviors.

Overall, the current study highlights potentially important associations between caregiver behaviors and child distress as they attempt to process the child's traumatic experiences. More intensive, longitudinal data can be collected in future research to begin to examine the temporal sequencing and interactions of caregiver and child variables that can influence treatment outcomes. Together, current and future research findings could help therapists identify factors that facilitate better and worse TF-CBT outcomes not only at the end of treatment, but also in the important period after treatment ends.

Conflict of Interest Statement

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