# Trauma Focused Coping (Multimodality Trauma Treatment)

Trauma Focused Coping (TFC), sometimes called Multimodality Trauma Treatment, is a school-based group intervention for children and adolescents in grades 4-12 who have been exposed to a traumatic stressor (e.g., disaster, violence, murder, suicide, fire, accident). The intervention targets posttraumatic stress disorder (PTSD) symptoms and other trauma-related symptoms, including depression, anxiety, anger, and external locus of control.

TFC uses a skills-oriented, peer- and counselor-mediated, cognitive behavioral approach. The intervention is delivered in 14 weekly, 50-minute sessions, providing youth with gradual exposure to stimuli that remind them of their trauma. The sessions move from psychoeducation, anxiety management skill building, and cognitive coping training to activities involving trauma narratives and cognitive restructuring. Implementation of TFC requires a master's-level clinician and should include a cofacilitating school counselor when administered in a school setting.

The study reviewed for this summary evaluated an 18-week version of TFC that was conducted with youth aged 10-15 in a school setting.

## Descriptive Information

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| **Areas of Interest** | Mental health treatment |
| **Outcomes** | **Review Date: August 2011**<br>1: PTSD symptoms<br>2: Symptoms of depression<br>3: Anxiety<br>4: Anger<br>5: Locus of control<br>6: General mental health functioning related to trauma and its treatment |
| **Outcome Categories** | Mental health<br>Trauma/injuries<br>Violence |
| **Ages** | 6-12 (Childhood)<br>13-17 (Adolescent) |
| **Genders** | Male<br>Female |
| **Races/Ethnicities** | American Indian or Alaska Native<br>Asian<br>Black or African American<br>White |
| **Settings** | School |
| **Geographic Locations** | Suburban |
| **Implementation History** | Trauma Focused Coping (Multimodality Trauma Treatment) was developed in 1998. Since then, it has been implemented in sites in Connecticut, Louisiana, Maine, North Carolina, Pennsylvania, and Tennessee, as well as in France and South Africa. |
| **NIH Funding/CER Studies** | Partially/fully funded by National Institutes of Health: Yes<br>Evaluated in comparative effectiveness research studies: No |

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| **Adaptations** | No population- or culture-specific adaptations of the intervention were identified by the developer. |
| **Adverse Effects** | No adverse effects, concerns, or unintended consequences were identified by the developer. |
| **IOM Prevention Categories** | IOM prevention categories are not applicable. |

## Quality of Research

**Review Date: August 2011**

### Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

**Study 1**

March, J. S., Amaya-Jackson, L., Murray, M. C., & Schulte, A. (1998). Cognitive-behavioral psychotherapy for children and adolescents with posttraumatic stress disorder after a single-incident stressor. Journal of the American Academy of Child and Adolescent Psychiatry, 37(6), 585-593. PubMed

**Supplementary Materials**

Amaya-Jackson, L., Reynolds, V., Murray, M. C., McCarthy, G., Nelson, A., Cherney, M. S., et al. (2003). Cognitive-behavioral treatment for pediatric posttraumatic stress disorder: Protocol and application in school and community settings. Cognitive and Behavioral Practice, 10(3), 204-213.

Fidelity checklist and coding metric sheet

Information on the measures used in Trauma Focused Coping

### Outcomes

| **Outcome 1: PTSD symptoms** | |
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| **Description of Measures** | PTSD symptoms were assessed using two instruments:<br>• Clinician-Administered PTSD Scale for Children (CAPS-C). The 33-item CAPS-C, modified from the adult CAPS, assesses the frequency and intensity of 17 PTSD symptoms over the past month, with items developed to be consistent with DSM-IV criteria.<br>• Child and Adolescent Trauma Survey (CATS). The CATS is a self-report screening tool that includes a PTSD symptom component and a scalar outcome measure. The CATS yields reexperiencing, avoidance, and hyperarousal subscale scores, as well as a total score. |
| **Key Findings** | Study participants were students aged 10-15 who completed TFC treatment. Data were collected at baseline, at posttreatment, and at the 6-month follow-up. Study results over time included the following:<br>• From baseline to the 6-month follow-up, participants had a reduction in the frequency and intensity of PTSD symptoms, as indicated by the CAPS-C ($p < .001$).<br>• From baseline to the 6-month follow-up, participants had a reduction in PTSD symptoms, as indicated by the CATS total score ($p < .001$) and scores for the reexperiencing ($p < .001$), avoidance ($p < .001$), and hyperarousal ($p < .001$) subscales. |
| **Studies Measuring Outcome** | Study 1 |
| **Study Designs** | Preexperimental |
| **Quality of Research Rating** | 3.0 (0.0-4.0 scale) |

| **Outcome 2: Symptoms of depression** | |
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| **Description of Measures** | Symptoms of depression were assessed using the Child Depression Inventory, a 27-item self-report instrument. Participants responded to statements (e.g., "I am sad once in a while," "I am sad |

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| | many times," "I am sad all the time") to describe how they felt in the past 2 weeks. Response options are associated with scores ranging from 0 (absence of symptoms) to 2 (definite symptoms). The total score ranges from 0 to 54, with higher scores indicating more symptoms of depression. |
| **Key Findings** | Study participants were students aged 10-15 who completed TFC treatment. Data were collected at baseline, at posttreatment, and at the 6-month follow-up. Over time, from baseline to the 6-month follow-up, participants had a decrease in symptoms of depression ($p < .001$). |
| **Studies Measuring Outcome** | Study 1 |
| **Study Designs** | Preexperimental |
| **Quality of Research Rating** | 2.9 (0.0-4.0 scale) |

| **Outcome 3: Anxiety** | |
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| **Description of Measures** | Anxiety was assessed using the Multidimensional Anxiety Scale for Children, a 39-item self-report instrument. Participants responded to items (e.g., "I feel tense or uptight," "I stay away from things that upset me") using options ranging from 0 (never true about me) to 3 (often true about me). |
| **Key Findings** | Study participants were students aged 10-15 who completed TFC treatment. Data were collected at baseline, at posttreatment, and at the 6-month follow-up. Over time, from baseline to the 6-month follow-up, participants had a decrease in anxiety ($p < .001$). |
| **Studies Measuring Outcome** | Study 1 |
| **Study Designs** | Preexperimental |
| **Quality of Research Rating** | 3.0 (0.0-4.0 scale) |

| **Outcome 4: Anger** | |
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| **Description of Measures** | Anger was assessed using the Strait-Trait Anger Expression Inventory, a 57-item self-report instrument that consists of six scales measuring intensity of anger and disposition to experience angry feelings. Respondents rated each item with a 4-point scale to assess the intensity of anger at a particular moment and the frequency of anger experience, expression, and control. |
| **Key Findings** | Study participants were students aged 10-15 who completed TFC treatment. Data were collected at baseline, at posttreatment, and at the 6-month follow-up. Over time, from baseline to the 6-month follow-up, participants had a reduction in intensity of anger and frequency of anger experience, expression, and control ($p = .004$). |
| **Studies Measuring Outcome** | Study 1 |
| **Study Designs** | Preexperimental |
| **Quality of Research Rating** | 3.0 (0.0-4.0 scale) |

| **Outcome 5: Locus of control** | |
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| **Description of Measures** | Locus of control was indexed as external or internal using the Nowicki-Strickland "What I Am Like" scale, a 40-item self-report instrument. Respondents answered each question (e.g., "Do you believe that most problems will solve themselves if you just don't fool with them?") with "yes" or "no."<br><br>It has been suggested that an external locus of control is characteristic of children with PTSD, and the investigators hypothesized that effective treatment would result in locus of control changing from external to internal. |
| **Key Findings** | Study participants were students aged 10-15 who completed TFC treatment. Data were collected at baseline, at posttreatment, and at the 6-month follow-up. Over time, from baseline to the 6-month follow-up, participants had a shift in locus of control from external to internal ($p < .001$). |

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| **Studies Measuring Outcome** | Study 1 |
| **Study Designs** | Preexperimental |
| **Quality of Research Rating** | 3.0 (0.0-4.0 scale) |

| **Outcome 6: General mental health functioning related to trauma and its treatment** | |
|---|---|
| **Description of Measures** | General mental health functioning related to trauma and its treatment was assessed with the Global Improvement subscale of the Clinical Global Impressions instrument. Using a scale ranging from 1 (very much improved) to 7 (very much worse), the study's psychologist rated each participant's change in general mental health functioning over time as indicated by the general improvement or worsening of trauma-related symptoms (e.g., anxiety, depression, trauma-related anger). |
| **Key Findings** | Study participants were students aged 10-15 who completed TFC treatment. Data were collected at baseline, at posttreatment, and at the 6-month follow-up. Over time, from baseline to the 6-month follow-up, participants had an improvement in general mental health functioning related to trauma and its treatment ($p < .001$). |
| **Studies Measuring Outcome** | Study 1 |
| **Study Designs** | Preexperimental |
| **Quality of Research Rating** | 3.0 (0.0-4.0 scale) |

### Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

| Study | Age | Gender | Race/Ethnicity |
|---|---|---|---|
| **Study 1** | 6-12 (Childhood)<br>13-17 (Adolescent) | 58.8% Female<br>29.4% Male | 47.1% White<br>41.2% Black or African American<br>5.9% American Indian or Alaska Native<br>5.9% Asian |

### Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

| Outcome | Reliability of Measures | Validity of Measures | Fidelity | Missing Data/Attrition | Confounding Variables | Data Analysis | Overall Rating |
|---|---|---|---|---|---|---|---|
| **1: PTSD symptoms** | 3.7 | 3.8 | 2.5 | 2.6 | 2.1 | 3.5 | **3.0** |
| **2: Symptoms of depression** | 3.8 | 3.1 | 2.5 | 2.6 | 2.1 | 3.5 | **2.9** |
| **3: Anxiety** | 3.6 | 3.8 | 2.5 | 2.6 | 2.1 | 3.5 | **3.0** |
| **4: Anger** | 3.8 | 3.8 | 2.5 | 2.6 | 2.1 | 3.5 | **3.0** |
| **5: Locus of control** | 3.5 | 3.6 | 2.5 | 2.6 | 2.1 | 3.5 | **3.0** |

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|---|---|---|---|---|---|---|---|
| **6: General mental health functioning related to trauma and its treatment** | 3.3 | 3.8 | 2.5 | 2.6 | 2.1 | 3.5 | **3.0** |

**Study Strengths**

The study used measures with good to excellent psychometric properties for the outcomes. The intervention is theory based and manualized, and a senior member of the research team reviewed audiotapes to establish intervention fidelity using the Trauma Focused Coping Fidelity Checklist. Intent-to-treat analysis was performed in an effort to compensate for attrition. Appropriate statistical analyses were used with the data.

**Study Weaknesses**

Although the study article states that procedures for evaluating intervention integrity were implemented, no data on treatment fidelity were reported. Although appropriate analyses were used, the small sample size limited the investigators' ability to conduct a number of analyses or to find group differences, owing to a lack of power. The already-small sample had high attrition. Because of the lack of a comparison group, it could not be determined whether there were additional threats to internal validity. Students selected for treatment were those whom the investigators believed would likely benefit from treatment, and students with severe disruptive behaviors were excluded.

## Readiness for Dissemination

**Review Date: August 2011**

### Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

March, J. S., & Amaya-Jackson, L. (1999). Trauma Focused Coping manual: Treatment of pediatric post traumatic stress disorder after single-incident trauma. Durham, NC: Division of Child Psychiatry, Duke University Medical Center. Retrieved from http://epic.psychiatry.duke.edu/sites/epic.psychiatry.duke.edu/files/documents/TRauma%20Focused%20Coping%20Manual%2012.19.08-1.pdf

March, J. S., & Amaya-Jackson, L. (n.d.). Trauma Focused Coping (multimodality treatment model): Research development and efficacy/effectiveness of screening and treatment of traumatized youth [PowerPoint slides]. Durham, NC: Duke Evidence-based Practice Implementation Center.

Sullivan, K., Amaya-Jackson, L., Briggs-King, E., Murphy, R., Burroughs, J., Vreeland, E., et al. (2011). How to implement Trauma Focused Coping: A trauma focused cognitive behavioral treatment for youth. Durham, NC: Center for Child & Family Health and Duke Evidence-based Practice Implementation Center. Retrieved from http://epic.psychiatry.duke.edu/sites/epic.psychiatry.duke.edu/files/documents/TFC-Implementation-Manual-UPDATED.pdf

### Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

| Implementation Materials | Training and Support Resources | Quality Assurance Procedures | Overall Rating |
|---|---|---|---|
| 3.8 | 4.0 | 3.4 | **3.7** |

**Dissemination Strengths**

How To Implement Trauma Focused Coping is a detailed manual that addresses the needs of multiple stakeholders during the implementation process by providing comprehensive program information in a step-by-step manner. A program overview and organizational readiness assessment tool are also provided to support implementers. The Trauma Focused Coping Manual guides clinicians' delivery of treatment sessions by detailing the preparation of session materials, the implementation of sessions, and the application of clinical skills. Sample scripts, helpful considerations, and additional resources are also provided. Several training options are offered to accommodate implementers with varying levels of clinical skill and experience. The developer offers consultation, peer support, and fidelity monitoring for implementers who do not have the means to provide supervision or would like their clinicians to have additional assistance and learning opportunities. A range of standardized outcome measures is provided to support quality assurance. A fidelity

checklist reinforces the developer's emphasis on supervision to ensure quality and adherence to the model.

**Dissemination Weaknesses**

Guidance for engaging students' families is limited. No guidance is provided for the use of the supervision tool. No information is provided on using outcome tools and interpreting outcome data to determine program success.

## Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

| Item Description | Cost | Required by Developer |
|---|---|---|
| How To Implement Trauma Focused Coping: A Trauma Focused Cognitive Behavioral Treatment for Youth (manual) | Free | Yes |
| Trauma Focused Coping Manual: Treatment of Pediatric Post Traumatic Stress Disorder After Single-Incident Trauma | Free | Yes |
| 2-day, on- or off-site training | $2,400 per trainer plus travel expenses if necessary | No |
| 2-day, on- or off-site advanced training | $2,400 per trainer plus travel expenses if necessary | No |
| Trauma Focused Coping Learning Collaborative (includes 6 days of in-person training, monthly conference calls, and twice-monthly 30-minute individual consultations over the duration of the learning collaborative [9-12 months]) | $150,000-$180,000 for 30-60 participants | No |
| Learning Collaborative Toolkit | Included in the cost of the learning collaborative | No |
| Consultation (by phone or in person for sites local to the developer) | $150 per call or in-person session | No |

## Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Amaya-Jackson, L., Reynolds, V., Murray, M. C., McCarthy, G., Nelson, A., Cherney, M. S., et al. (2003). Cognitive-behavioral treatment for pediatric posttraumatic stress disorder: Protocol and application in school and community settings. Cognitive and Behavioral Practice, 10(3), 204-213.

Berthiaume, C., & Turgeon, L. (2004). Application d'un traitement cognitivo-comportemental auprès d'un enfant présentant un trouble de stress post-traumatique. Symposium au Congrès de l'Association française des thérapies cognitivo-comportementales, Paris, France.

Michael, K. D., Hill, R., Hudson, M. L., & Furr, R. M. (2002, October). Adjunctive manualized treatment of sexually traumatized youth in a residential milieu: Preliminary results from a small randomized controlled trial. Paper presented at the Kansas Conference in Clinical Child and Adolescent Psychology, Lawrence, KS.

## Contact Information

**To learn more about implementation or research, contact:**

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

**Web Site(s):**

- **http://epic.psychiatry.duke.edu/our-work/projects/trauma-focused-coping**