Addressing mental health and trauma-related needs of sheltered children and families with Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Jamie A. Spiegel, Ph.D.[1], Paulo A., Graziano[1], Emily Arcia, Ph.D.[2], and Sundari Foundation[3]

[1]Florida International University - Center for Children and Families and Department of Psychology, 11200 SW 8th Street, Miami, Florida, United States, 33199

[2] Emily Arcia Consulting Co. emilyarcia@yahoo.com

[3]Sundari Foundation, Inc. dba Lotus House Women's Shelter (Lotus House), 217 NW 15th Street, Miami, FL 33136, Attn: Constance Collins, J.D., Executive Director, research@lotushouse.org

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Abstract

The purpose of this study was to 1) better understand and document the mental health and trauma-related needs of sheltered children and adolescents ("youth") ages 7-18 and their mothers, and 2) examine the feasibility and effectiveness of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) administered within the context of a women's homeless shelter. Two hundred and ninety-four youth (M_{age}=10.04 years, *SD* = 3.22 years, 56.1% female, 69.7% Black/African American, 34.6% Hispanic/Latinx) and their mothers were recruited from a homeless shelter and provided ten weeks of TF-CBT, with the option for up to eight additional weeks of therapy based on clinical need. Families completed pre- and post-intervention assessments including mother and youth self-reported measures of youth trauma symptoms, trauma exposures, and externalizing problem behaviors, and maternal self-reported stress. Results demonstrated clinically elevated PTSD symptoms and rates of exposure to potentially traumatic events in sheltered youth well above those previously reported in the general population. TF-CBT resulted in substantial reductions in both maternal and self-reported severity of youth PTSD symptomology. Reductions were largely attributable to reduced symptoms of re-experiencing and arousal. TF-CBT resulted in greater improvements for those individuals with fewer exposures to potentially traumatic/adverse events and improvements in externalizing behaviors were greater for younger than older youth. Overall, these findings illustrate the importance of assessing and addressing the mental health and trauma-related needs of sheltered youth and the feasibility and efficacy of embedding an evidence-based trauma-focused treatment protocol within a shelter environment. Additional implications of these findings for clinical practice are discussed.

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Homelessness is a global problem impacting over 100 million people worldwide (United Nations Economic and Social Council, 2015). As of January 2020, the Department of Education[1] reported that 1,508,265 children and youth[2], enrolled in public schools, experienced homelessness (United States Interagency Council on Homelessness, 2020). Retrospective data indicates that one in every 30 children/adolescents (youth) in the U.S., or 2.5 million children, experience homelessness annually (Bassuk et al., 2014). Although securing safe, adequate, and affordable access to basic needs, such as food and shelter are of primary importance, addressing the mental health needs of this marginalized and at-risk population is also essential. Studies completed over two decades ago found that up to 78% of youth experiencing homelessness have at least one mental health disorder (e.g., depression, behavior problems) and/or experience an academic or developmental delay (Committee on Community Health Services, 1996; Weinreb et al. 1998). However, an analysis by Bussuk and Friedman showed less than one-third of these youth receive mental health treatment (2005). Given the disproportionately high rates of trauma experienced by youth experiencing homelessness (Cowal et al., 2002; Keeshin & Campbell, 2011; Masten et al., 1993), it is particularly important to investigate the feasibility and

[1] The Department of Education broadly defines homelessness as, individuals who lack regular, fixed, and adequate nighttime residence, including youth who are: (i) sharing the housing of other persons; living in motels, hotels, trailer parks, or camping grounds; living in emergency or transitional shelters; or abandoned in hospitals; (ii) primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; (iii) living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory youth. Whereas the Department of Housing and Urban Development (HUD) has a more restrictive definition, defining homelessness as individuals/families who, a) lack fixed, regular, and adequate nighttime residence; b) will imminently lose their primary nighttime residence; c) are fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other life-threatening conditions that relate to violence against the individual or family member; and d) unaccompanied youth defined as homeless under other federal statutes. A 2020 HUD report revealed that 580,466 people experienced homelessness in the United States, of whom 171,575 were families and youth (U.S. Department of HUD, 2021)

[2] This data was collected for the 2017-2018 school year. This number *does not* reflect the totality of youth experiencing homelessness, as it only includes students enrolled in public school districts or local educational agencies.

effectiveness of delivering evidence-based treatments for trauma and mental health issues within this population. Further, with so many youth entering our nation's shelter systems (both domestic violence and homeless), shelter service providers that are appropriately resourced have an opportunity, through evidence-based assessment and therapeutic interventions, to provide targeted treatment for highly vulnerable, at risk youth, transforming what might otherwise be yet another layer of trauma in their young lives into a window of opportunity for healing and growth.

Mental Health and Trauma in Sheltered Youth

The DSM 5 defines a traumatic event as an instance in which an individual is directly or indirectly exposed to, witness to, or learns about a family member having been exposed to death or threat of death, actual or threat of serious injury, or actual or threat of sexual violence (American Psychiatric Association, 2013). In the general population, approximately 20% of youth are exposed to at least one potentially traumatic event and approximately half of these youth experience polyvictimization (Saunders, 2003). The prevalence rates of traumatic events vary based upon the nature of the event. Ranging from 8-10% of youth experiencing at least one sexual assault (of which approximately half are reported to have occurred prior to age 13) to 38-70% of youth witnessing household or community violence[3] prior to adulthood (Saunders & Adams, 2015). Within the population of youth experiencing homelessness, the prevalence rate of exposure to potentially traumatic events is substantially higher (e.g., Cowal et al., 2002; Keeshin & Campbell, 2011; Masten et al., 1993). However, studies to date have tended to focus on the prevalence of a single type of traumatic event exposure making it difficult to determine the range of prevalence rates across exposure types in youth and families experiencing homelessness.

[3] Estimates for witnessing violence varied substantially across samples based upon the criteria used to define violence across studies (e.g., whether physical injury was a required criteria).

Reactions to potentially traumatic events are highly variable and depend upon the individual's predispositions, the nature of the event, the duration and frequency of the event(s), and the reaction of the community (Caspi et al., 2002; Green et al., 1985; Toro et al., 1991). Exposure to potentially traumatic events is associated with varied reactions ranging from resiliency (Masten, 2011) to elevated symptoms or diagnosis of post-traumatic stress disorder (PTSD), separation anxiety, hyperactivity, inattention, and irritability (e.g., Bui et al., 2014). Responses to trauma exposure are also often pervasive impacting affect and mood (e.g., sadness, overly responsive to negative stimuli, lack of responsiveness to positive stimuli), behavior (e.g., avoidance, oppositionality, heightened fight or flight responses), cognition (e.g., self-blame, worthlessness, loss of trust; Cohen & Mannarino, 2008), and ability to meet developmental milestones including language development (e.g., Kaplan et al., 2016) and school readiness (Obradović et al., 2010). Even when full diagnostic criteria for PTSD are not met, partial PTSD symptomatology can result in substantial impairments (e.g., Cuffe et al., 1998). Approximately 36% of youth exposed to trauma develop symptoms consistent with a diagnosis of PTSD (Fletcher, 1996). Although lifetime incidence of PTSD tends to be greater for older as compared to younger youth (e.g., Grasso et al., 2013; Finkelhor et al., 2007), the rate at which individuals develop PTSD following exposure to a traumatic event are fairly consistent across development[4] (Fletcher, 1996). However, rates of PTSD do vary across types of traumatic events. For instance, 0-5% of children exposed to natural disasters develop PTSD (Earls et al., 1988; Handford et al., 1986; Lonigan et al., 1994; Shannon et al., 1994) whereas as many as 90% of youth exposed to sexual abuse develop PTSD (Kiser et al., 1988). Polyvictimization has also been shown to predict PTSD outcomes, with greater number of exposures to traumatic events being related to

[4] Based upon Fletcher's (1996) meta-analysis, PTSD was diagnosed in 39% of preschoolers (< 7 years old), 33% of school-aged children (6–12 years), and 27% of teenagers (> 12 years old).

greater severity of PTSD symptoms and impairment (Finkelhor et al., 2009; Finkelhor et al., 2007). Further, different profiles of traumatic event exposures are associated with different patterns of behavioral and emotional outcomes (Ford et al., 2010). These findings suggest that consideration of the frequency and nature of trauma exposure is important to the diagnosis and treatment of post traumatic reactions.

Mental Health Needs of Youth Experiencing Homelessness

Homeless youth are amongst the highest need children in our nation. Results of a recent meta-analysis indicate that 24% to 40% of school-age children experiencing homelessness had clinically significant symptoms of a mental health disorder; representing a rate of mental health disorders 2 to 4 times higher than those seen in low income homed peers (Bassuk et al., 2015). In fact, youth experiencing homelessness are up to three times more likely to experience PTSD than their homed peers (e.g., Stewart et al., 2004).

Although the DSM 5 does not recognize homelessness in and of itself as a criterion A stressor for PTSD (American Psychiatric Association, 2013), substantial research has demonstrated that homelessness is a complex life stressor which increases the risk of developing mental health difficulties (Goodman, Saze, Harvey, 1991). The majority of youth respond to the stress of homelessness with, at a minimum, worries about the safety of themselves and their families (National Center on Family Homelessness, 1999). Homelessness often results in a substantial disruption to daily routines and the removal of social supports as one leaves familiar surroundings, possessions, familial support systems, and communities. Additionally, transitioning to living in a shelter often results in a decreased sense of privacy, safety, predictability, and control (Kirkpatrick & Byrne., 2009). In addition to increasing the stress of

daily living, homelessness increases exposure to adverse childhood experiences (ACE; Kaiser & Permanente, 1998).

The ACES model of trauma posits that childhood exposure to events, including abuse, neglect, domestic violence, household mental illness or substance abuse, parental separation or divorce, economic hardship, community violence, bullying, and exposure to the foster care system has a direct negative impact on long-term mental and physical health (Cronholm et al., 2015; Felitti et al., 1998). Substantial evidence suggests that, although at least half of the population is exposed to one or more ACE (Felitti et al., 1998), youth exposed to four or more ACES are up to five times more likely to develop mental health disorders (e.g., Hunt et al., 2017; Merrick et al., 2017). Approximately 12.5%, or one in every eight youth, experience high levels of ACES ($\geq$ 4; Felitti et al., 1998). However, youth living in poverty, especially those experiencing homelessness, are at substantially greater risk of experiencing high levels of ACES. Living below the poverty line results in a four hundred percent increase in the risk of exposure to high levels of ACES ($\geq$ 4), as compared to peers from financially stable homes (Halfon et al., 2017).

In addition to exposure to poverty, youth experiencing homelessness have also experienced higher incidence of exposure to traumatic events (Anooshian, 2005; Cowan, 2007; Guarino & Bassuk, 2010; Hicks-Coolick et al., 2003; Perlman & Fantuzzo, 2010), complex trauma (i.e., polyvictimization or prolonged exposure to trauma), separation from caregivers and the foster care system (Zlotnick, 2009; Zlotnick et al., 1998), community violence, decreased access to health care and educational services (Masten et al., 1997; Panter-Brick, 2004; Shelton et al., 2015; Zlotnick, 2009), exposure to parental substance abuse (e.g., Stein et al., 2002), and parental incarceration (Casey et al., 2015; Wilderman, 2014). Combined, this increased exposure

to ACES culminates in an increased risk for the development of emotional disorders, amongst other medical and mental health difficulties. Indeed, the National Child Traumatic Stress Network reports that "more than one-fifth of homeless preschoolers have emotional problems serious enough to require professional care" (Bussuk & Friedman, 2005, p. 2) and approximately 18% of youth experiencing homelessness meet criteria for PTSD (Stewart et al., 2004).

In short, youth experiencing homelessness and their families represent a particularly vulnerable population for whom early assessment is critical and effective evidence-based treatments for addressing mental health and trauma are vital. Sadly, to date, there has been a dearth of literature on the efficacy of mental health and trauma treatments to address the needs of this young, at-risk, sheltered population. This study aimed to understand more deeply the mental health and trauma of sheltered youth and test the feasibility and effectiveness of Trauma Focused Cognitive Behavior Therapy (TF-CBT) to support youth and families in transition.

Trauma Informed Care in Children

Left untreated, youth responses to trauma exposure can follow a chronic course (Bolton et al., 2000; Morgan et al., 2003; Yule et al., 2000). A number of therapeutic approaches have been proposed for the treatment of post traumatic symptoms in youth including, TF-CBT, eye movement desensitization and processing (EMDR), parent training, and individual psychotherapy. Findings from systematic literature reviews and meta-analyses consistently indicate that TF-CBT is an effective treatment for symptoms of PTSD, depression, anxiety, and behavior difficulties that have emerged secondary to trauma exposure in 3-17 year old youth (Cary & McMillen, 2012; Guttermann et al., 2016; Kowalik et al., 2011; Morina et al., 2016; Silverman et al., 2008). Further, a recent meta-analysis found that TF-CBT outperforms all other commonly utilized forms of therapy (e.g., EMDR, supportive counseling family therapy, parent

training) in the treatment of post traumatic responses in youth, both at post treatment and at one- to four-month follow-ups (Mavranezouli et al., 2020). As such, TF-CBT is often considered a gold standard in the treatment of traumatic responses in childhood.

TF-CBT is largely based upon a gradual exposure model. Youth and their parents are taught coping strategies and then face exposures of gradually increasing intensity as they move through a phase-based manualized treatment. TF-CBT sessions follow a sequence summarized by the acronym PRACTICE: psychoeducation and parenting skills, relaxation skills, affective regulation skills, cognitive coping skills, trauma narrative and cognitive processing of the traumatic events, in vivo mastery of trauma reminders, conjoint child-parent sessions, and enhancing safety and future developmental trajectory. Sessions are conducted in separate child- and parent-sessions as well as conjoined child-parent sessions. Because youth's abilities to talk about and cope with challenging experiences are often dependent upon the adults in their lives (Fivush, 1998; Mash & Terdal, 1997) and because their emotional expression and coping strategies are largely dependent upon the behavior of adults in their lives (Eisenberg et al., 1996), each component of TF-CBT is provided to both the youth and their parent in parallel sessions.

To date, the efficacy of TF-CBT has been demonstrated in samples of youth exposed to sexual abuse (Cohen et al., 2004a; Cohen & Mannarino, 1996; Cohen et al., 2005; Deblinger et al., 1996; King et al., 2000), domestic violence (Cohen, 2005), violence outside the home (Stein 2003), death of a loved one (Cohen et al., 2004b; Cohen et al., 2006), terrorist attacks and wars (Ertl et al., 2011; Hoagwood et al., 2006; Ruf et al., 2010), natural disasters (Berger et al., 2009; Pityaratstian et al., 2015), motor vehicle accidents (Meiser-Stedman, 2008; Smith et al., 2007) and polivictimization (Auslander et al., 2017). However, to date, research on the effectiveness of TF-CBT in the treatment of youth experiencing homelessness is fairly limited. Wenocur et al.

(2016) reported on the practicality of implementing TF-CBT in an emergency family housing setting, however the sample of 29 children who completed treatment within a three-year period was small. Nonetheless, they reported that 86% self-reported reduced trauma-related symptomatology and 97% were reported to have reduced problem behaviors by their mothers. Although these findings offer preliminary support for utilizing TF-CBT with sheltered populations, the Wenocur study reports on a small sample size and largely relies on qualitative reports of treatment efficacy. To our knowledge, no other study has examined the effectiveness of TF-CBT in reducing trauma-related symptoms in sheltered youth.

Present Study

Taken together, it is clear that in addition to poverty and homelessness, sheltered youth are faced with a wide range of traumatic and environmental stressors which place them at a substantially elevated risk for mental health difficulties. However, to date, the prevalence of exposure to various potentially traumatic events in sheltered youth is unclear. The life circumstances and events occurring prior and leading to homelessness, the overall elevated risk of trauma exposure in youth experiencing homelessness, the long-term effects of trauma, and the lack of research on how best to address trauma-responses in this population, culminate in an urgent need to better understand the mental health and trauma experiences of sheltered children and to establish evidence-based intervention practices for this vulnerable population. Thus, as part of a larger community-based service driven research project, the current study sought to 1) determine the mental health difficulties and prevalence of exposure to potentially traumatic events within a large sample of youth experiencing homelessness at entry into a women's homeless shelter, 2) determine the feasibility and effectiveness of implementing TF-CBT within the context of a homeless shelter, and 3) examine child-level constructs (i.e., age/grade,

race/ethnicity, and number of exposures to potentially traumatic events/ACES) which may moderate treatment effectiveness. Following a clinical assessment (detailed below), youth were assigned to receive TF-CBT based upon clinical need. We hypothesized that the prevalence rates of exposure to trauma and PTSD diagnoses would be higher for youth experiencing homelessness as compared to the prevalence rates found in the general population. We also hypothesized that both trauma and externalizing symptoms in youth would improve substantially from TF-CBT and parental stress would decrease substantially, subsequent to completion of TF-CBT. Based upon evidence that youth across development respond similarly to exposure to trauma (Fletcher, 1996), we hypothesized that TF-CBT would be equally effective for youth regardless of age. Finally, we hypothesized that greater exposure to potentially traumatic events would be associated with poorer treatment response.

Method

Participants and Recruitment

The present study was part of a larger service driven, community-based, research project conducted at (masked for review), the largest women's shelter in the state of (masked for review) and one of the largest in the nation, with a nightly capacity to shelter over 500 women and children. All families were offered clinical assessments and based on clinical needs, therapeutic services promptly upon admission. Families were permitted to receive clinical services without participating in research; however, almost all mothers whose children received services provided consent to participate in research. Exclusionary criteria, for the current study, included youth a) outside the target age range (ages 5-17) or b) already receiving therapeutic services elsewhere.

The sample for the present study consisted of **318** youth between the ages of 5 and 17 (M_{age}=10.06, *SD* = 3.25) whose mothers provided consent to participate in the study. The sample

was comprised of mostly females (56.3%) and Black/African Americans (70.4%). Of these youth, 24 never attended treatment; leaving **294** youth who received at least one session of TF-CBT (intent to treat sample). Of these 294 participants, **212** completed treatment (i.e., 10 or more sessions). The breakdown of treatment attendance and dropout is depicted in Figure 1.

Of the 294 participants in the intent to treat sample, the mean age was 10.04 years (*SD* = 3.22 years), and most were female (56.1%) and Black/African American (69.7%), and 34.6% were Hispanic/Latinx. See Table 1 for other descriptive sample data. Descriptive data for the 218 treatment completers can also be found in Table 2. Chi square difference tests indicate no demographic differences between those children and adolescents who completed treatment as compared those who dropped out of treatment prior to completion (i.e., prior to completing at least 75% of the intervention).

The 294 youth included in this study were from 221 families, with 58 sets of siblings within the sample. The number of youth in the families ranged from one to seven, with an average of 2.7 children in each family (although not all children qualified for intervention). In the majority of families, the home language was English (72.8%); another 25.9% spoke Spanish exclusively or were bilingual. Mother/guardian age ranged from 23-66 years (*M* = 35.09, *SD*=8.31). The majority of mothers were unemployed at the onset of treatment and the modal family income was less than 10,000 annually, with only 2% of mothers reporting income greater than 25,000 annually.

Study Design and Procedure

This study was approved by the University's Institutional Review Board. Clinicians at (masked for review) who delivered the interventions, in the family's preferred language, were master's level clinical staff or therapists, licensed or registered for licensure, and certified or in

the process of receiving their certification in TF-CBT. Counselors received weekly supervision by the shelter's program clinical director, a state qualified psychologist and social worker trained and certified in TF-CBT.

Upon admission to the shelter, clinicians and trained staff administered an assessment protocol that lasted approximately two hours and included: a) a biopsychosocial interview of mothers that gathered relevant background information on the child and family, b) questionnaires on youth's externalizing behavior problems, trauma histories, and symptoms, c) questionnaires on maternal stress, and d) videotaped observations of three 5-minute standard parent-child interaction situations that varied in the degree of parental control expected (child-led play, parent-led play, and clean-up; for children ages 6 months to 12 years 11 months). See below for a description and names of assessments. Families completed a similar post-intervention assessment upon completion of intervention (i.e., 10 sessions) or four months after the start of the intervention (mean time to complete intervention = 3.67 months, *SD* = 1.25 months). Families were given small incentives such as a small toy to the youth, or a small gift to the parent upon completion of the assessments, and all interventions were provided at no cost.

Intervention Description and Adaptation

TF-CBT (Kliethermes et al., 2017) is an evidence-based program designed for the treatment of trauma-related symptoms in youth ages three to eighteen years. In TF-CBT youth and their parents are taught coping strategies and face exposures of gradually increasing intensity as they move through treatment. Therapy sessions follow a preset PRACTICE sequence: psychoeducation and parenting skills, relaxation skills, affective regulation skills, cognitive coping skills, trauma narrative and cognitive processing of the traumatic events, in vivo mastery of trauma reminders, conjoint child-parent sessions, and enhancing safety and future

developmental trajectory. Treatment is broken down into three phases (a) stabilization, (b) integration, and (c) consolidation. Sessions are conducted in separate child- and parent-sessions as well as conjoined child-parent sessions and each component of TF-CBT is provided to both the youth and their parent in parallel sessions. TF-CBT is traditionally completed within 12-15 sessions with approximately equal sessions for each of the three phases. In cases of more complex trauma, treatment can be extended to up to 16-25 sessions (Cohen & Mannarino, 2016). For this study, given the transient nature of the sheltered population (Culhane et al., 2007), every effort was made to complete TF-CBT within 10-12 sessions. During the tenth session or four months after initiating treatment (whichever was earlier), youth, their mothers, and their therapist met to determine whether treatment goals were met or if additional sessions were needed. If therapeutically necessary, youth received additional sessions (n=46), not exceeding 18 sessions.

Measures of Feasibility and Acceptability

Intervention Completion and Attendance. Attendance for each session was measured from therapists' notes within the shelter's electronic medical records. Intervention completion rates were calculated based on the completion of at least 10 sessions.

Consumer/intervention satisfaction. Parents and youth provided ratings of satisfaction at post-intervention by completing selected items from the Therapy Attitude Inventory (Brestan et al., 1999). Raters indicated on a five-point Likert scale their degree of satisfaction of a) improvements in the parent-child relationship b) progress the youth made in general behavior, c) progress the youth made in trauma symptoms, d) general feeling about the program, and e) how likely they were to recommend the program to others. The mean level of satisfaction was calculated across these five items ($\alpha = .75$ for maternal report and $\alpha = .67$ for youth self-report).

Child Outcomes

Grade. Grade was dichotomized into a) kindergarten through sixth grade and b) seventh through twelfth grade to allow for comparisons between elementary and junior high/high school.

Child and Adolescent Trauma Screen (CATS). Mothers completed the CATS-caregiver for all children and adolescents ages eight and older completed the CATS-youth at pre- and post-intervention. The CATS assesses for exposure to 14 potentially traumatic events (and allows for short response of any additional potential traumas) as well as the frequency of each of the 20 post-traumatic stress symptoms (PTSS; only 16 PTSS symptoms were assessed for children under 7 years old), based upon the DSM-5 criteria (American Psychiatric Association, 2013). The total number of potentially traumatic events endorsed by the youth or their mother served as a proxy for adverse childhood events (ACES), with scores ranging from 0-14. It is important to note that although homelessness and poverty are adverse events of childhood/ childhood risk factors, these were not counted amongst participant ACES in this study because all participants in the sample experienced both.

PTSS symptoms were rated on a 4-point Likert-scale ranging from 0 (never) to 3 (almost always); resulting in a single total severity score, with higher scores indicating greater severity of PTSS (Parent CAT $\alpha = .83$; Self CAT $\alpha = .86$). Endorsement rates of a) reexperiencing, b) avoidance, c) negative mood and cognitions, and d) arousal symptoms (which coincide with criterion B-E of the DSM 5 PTSD symptom criterion, respectively) were also calculated by summing the number of items within each domain rated as occurring half the time (2) or almost always (3). Higher scores indicate greater presence of symptomology.

Eyberg Child Behavior Inventory (ECBI). Mothers completed the ECBI (Eyberg & Ross, 1978), a 36-item questionnaire designed to assess externalizing behavior problems in youth

ages 2-16 years, at pre- and post-intervention. The raw score from the total intensity scale was used in the present study as a measure of externalizing behavior problems (α =.94).

Parent Outcomes

Parenting Stress Index-Short Form (PSI-SF). Mothers completed the PSI-SF (Abidin, 1983) a 36-item questionnaire designed to assess parental stress for parents of children ages 1 month to 12 years. As such, this measure was not administered to parents of participants over the age of twelve. The total raw score was used to measure overall parenting stress (α = .89).

Data Analytic Plan

All analyses were conducted using Statistical Package for the Social Sciences, version 20 (SPSS 26). At pre-intervention 6.76% of data were missing. At post-intervention 39.71% of data were missing, primarily due to families exiting the shelter prior to completion. Based upon Little's Missing Completely at Random test, data at pre-intervention $\chi 2(14) = 38.06$, $p < .001$ and post-intervention $\chi 2(8) = 19.19$, $p < .05$ were not missing at random. Therefore, as recommended in clinical trials, intent to treat analyses with the use of multiple imputation was used (Little & Yau, 1996; Rubin, 1988; Von Hippel, 2020) in addition to analyses for youth who completed treatment.

In an effort to provide updated incidence/prevalence rates within a sample of youth currently experiencing homelessness, initial analyses focused on describing the percentage of youth who were clinically elevated in terms of behavior problems and trauma symptoms as well as the percentage of youth who experienced potentially traumatic events at pre-intervention. Paired-sample t-tests were utilized to examine whether prevalence rates varied by reporter (i.e., self- versus maternal-repot). Next, we examined completion, and attendance, and intervention satisfaction. For the primary analyses, multiple repeated measures ANCOVAS, controlling for

age, were conducted to examine pre- post-intervention changes for youth and parenting outcomes, including changes in diagnostic status. Other demographic variables were not included as covariates, as age was the only variable consistently significantly correlated to the outcomes of interest[5]. Finally, a series of repeated measures ANOVAS and ANCOVAS controlling for age were conducted to examine the potential moderating effect of grade level and ACES on pre- post-intervention outcomes, respectively.

Results

Profiles of Symptomatology and Trauma Exposure at Pre-Intervention

With regard to externalizing behavior symptoms, 25.96% of youth had a total score in the clinical range on the ECBI (i.e., score of 131 or higher), based upon maternal report. In terms of trauma symptoms, 53.46% of the youth had total raw scores in the clinically elevated range (i.e., score of 12 or higher for ages 5-6 years and 15 or higher for ages 7 and older on PTSD severity) as reported by mothers on the CATS. Based on self-report, 69.52% of youth had scores in the clinically elevated range on the CATS.

Rate of exposure to potentially traumatic events are outlined in Table 2. Overall, the results indicate that regardless of reporter, the most commonly experienced traumatic events were witnessing violence (at home or in the community) and sudden or violent death of a loved one. Self-report consistently indicated a higher rate of exposure to potentially traumatic events than did maternal report, with the exception of witnessing someone in the family get slapped, punched or beat up, which mothers endorsed more often than did youth. Paired-sample t-tests were conducted to determine whether discrepancies between maternal and self-reports were

[5] Correlations between sex, maternal education, child race and ethnicity with maternal report of trauma severity (.02, .08, .01, -.07, respectively), self-report of trauma severity (.04, .07, -.03, .08 respectively), ECBI raw score (.09, .07, -.03, -.02, respectively), and parenting stress total score (.02, .02, -.01, .00, respectively) at post-intervention were all not significant ($p > .05$).

significantly different. Given the number of analyses conducted Holm's Step-Down Procedure (Holm, 1979) was implemented to minimize Type 1 error. Results, depicted in Table 2, indicated that mothers reported significantly greater incidence of witnessing violence in the home than did youth, but youth reported significantly greater witnessing of community violence than did their mothers. Youth also reported great incidence of physical abuse, emotional abuse, separation from a caregiver (including abandonment by father), and serious accident or injury as compared to maternal report.

Poly-victimization was examined by summing the domains in which youth and their mothers endorsed exposure to a potentially traumatic event on the CAT. The CAT lists 14 potentially traumatic events, meaning that possible scores for poly-victimization ranged from 0-14; however, in this sample no youth endorsed experiencing exposures in more than ten domains. Based upon maternal report, the mean number of traumatic events was 2.26 and the majority of mothers endorsed exposures in between one and three domains, with 22% of mothers reporting exposure to potentially traumatic events in $\geq$4 domains. Self-report indicated that the mean number of traumatic events was 3.14, with the majority of youth endorsing exposures within two and four domains. Approximately 38% of youth endorsed exposure to potentially traumatic events in $\geq$4 domains.

Treatment Completion and Satisfaction

In terms of intervention completion, it is important to note that 7.55% of families never initiated TF-CBT after assessment and assignment (see Figure 1). Of the families that initiated intervention, 72.11% of families in (n = 212) completed all intervention sessions (i.e., 10 or more sessions). The primary reason for treatment dropout (96.7%) was leaving the homeless shelter.

Maternal (*M* = 4.27, *SD* = .69) and self-report (*M* = 4.31, *SD* = .63) indicated high levels of satisfaction with treatment.

A random 40% of sessions (10 sessions each for 60 participants who completed TF-CBT) were selected and scored on treatment fidelity. Specifically, treatment notes were reviewed to determine adherence to treatment protocol (i.e., covering PRACTICE sequence) and to ensure parents were seen by the therapist in addition to youth. Results indicated that in all but one session for one participant therapists met with parents to instruct them on topics covered within session, in addition to meeting individually with the youth. With regard to adherence to the treatment protocol, the PRACTICE sequence was adhered to in 96% of sessions reviewed.

Treatment Efficacy

As indicated in Table 3, TF-CBT resulted in significant reductions in the severity of PTSD-related symptoms, such that there was a significant reduction in youth who fell within the clinically elevated range on the CAT from pre- to post-intervention, both based on maternal and self-report. Based on maternal and self-report, TF-CBT was most effective at reducing criterion B (reexperiencing) symptoms. Maternal report also indicated a significant reduction in criterion E (arousal) symptoms. With regard to parent-level outcomes, results indicated that TF-CBT resulted in significant reductions in overall parenting stress, based upon maternal self-report.

As indicated in Table 4, grade level (i.e., K-6th versus 7-12th grade) significantly moderated the effects of TF-CBT on externalizing behavior, but not for trauma-related symptoms. Specifically, although adolescents in junior high and high school ended treatment with a lower average ECBI scores than did children in elementary school, children in elementary school demonstrated greater pre-post changes in ECBI scores. In contrast, the total number of ACES/exposures to potentially traumatic events, moderated the effects of TF-CBT on all child-

level outcomes. Specifically, both youth experiencing less than four and four or more ACES demonstrated improvements pre- to post- intervention, but youth with exposure to four or more ACES consistently benefited less from TF-CBT than did youth with exposure to less than 3 ACES.

Discussion

The current study provides updated estimates of the clinical needs and prevalence of exposure to potentially traumatic events in sheltered youth. To our knowledge, the present study represents the first large scale quantitative investigation of the mental health needs and trauma histories and symptoms of sheltered homeless youth and the feasibility and efficacy of providing Trauma-Focused CBT (TF-CBT) to address those needs. The findings demonstrate both the magnitude of the needs sheltered youth, the feasibility of providing evidence-based interventions within the context of a homeless shelter, and the value of providing such services to sheltered youth and their families. Further, the time-limited adaptation of TF-CBT, a necessary adaptation given the transient nature of the homeless population (Culhane et al., 2007), was found to be efficacious at reducing trauma-related symptomology. This offers a promising blueprint for other shelters and community mental health providers to follow in their provision of clinical services in the future. Finally, although TF-CBT resulted in a significant reduction of symptomology across youth, it was more effective at reducing externalizing behaviors in children as compared to adolescents and was more effective at reducing symptomology in youth who had experienced fewer adverse/potentially traumatic events (ACES). These findings are discussed in greater detail below.

Profiles of Symptomatology and Trauma Exposure at Pre-Intervention

Whereas previous studies have indicated that the prevalence rate of exposure to potentially traumatic events is substantially higher for youth experiencing homelessness, findings from this study suggest that a more nuanced examination of prevalence rates is needed. Specifically, as compared to prevalence rates reported by Saunders and Adams (2015), in the present study youth experiencing homelessness reported experiencing similar rates of exposure to physical abuse, sexual abuse, natural disasters, and serious accidents (e.g., car accidents) prior to being sheltered. However, the prevalence of witnessing physical violence in the home or community and exposure to bullying were reported at greater rates in this study than in studies with homed youth. The fact that the study was conducted at a women's homeless shelter, rather than a gender-neutral shelter, may have impacted the reported rates of witnessing violence in the home, as violence is a lead cause of homelessness for women–with fifty-seven percent (57%) of all women experiencing homelessness reporting domestic violence as the immediate cause of their homelessness (National Alliance to End Homelessness, 2019). The prevalence of violence for women at the women's shelter was nearly ubiquitous as ninety-nine percent (99%) of the incoming women and children at [masked for review] report victimization from domestic and/or intimate partner violence, gender-based violence, trafficking and other crimes and serious trauma. However, it is important to note that this study did not include a homed comparison group, and as such comparisons rely on prevalence rates reported in previous studies.

Consistent with previous studies (Saunders, 2003), maternal report in this study indicated that approximately two thirds (63.8%) of youth experiencing homelessness experienced two or more potentially traumatic events. These rates were substantially higher when self-report was examined. Specifically, 85.6% of youth reported exposure to two or more potentially traumatic events. Importantly, these rates may underestimate polyvictimization in this population.

Specifically, we only allowed for endorsement of experiencing each category of potentially traumatic event once, whereas individuals may have experienced multiple instances of each type of event (e.g., multiple instances of witnessing violence). With regards to reactions to these potentially traumatic events, approximately half of maternal report (53%) and just shy of three quarters of self-report (70%) indicated clinically elevated rates of PTSD symptomology. These rates are substantially higher than rates of PTSD symptomology following potentially traumatic events in the general population (i.e., 36% of youth exposed to trauma develop symptoms consistent with a diagnosis of PTSD; Fletcher, 1996). Taken together, these findings highlight the elevated need for evidence-based interventions to address trauma-related symptomology within this population.

Results of exploratory analyses highlighted substantial discrepancies between maternal and self-reported severity of PTSD symptoms and rates of exposure to most categories of potentially traumatic events. Self-report consistently indicated greater severity and rates of exposure, except for witnessing violence within the family and emotional abuse which mothers rated as occurring more often than did youth. One possible explanation, for these findings is that parental report of potentially traumatic events that are witnessed by parents (those events which are most likely to occur in the home) are influenced by the parent's own feelings of distress, either because they also experienced the trauma or because witnessing their child distressed is itself upsetting (Shemesh et al., 2005; Shemesh et al., 2003). In contrast, potentially traumatic events which occur outside the home are less likely to be witnessed by parents and therefore may only be reported if the youth informed their parent of the exposure. Mothers may also minimize youth's prior exposure to traumatic events for fear of child welfare involvement for failure to protect their children. Alternatively, it is possible that these discrepancies are due to different

parent and youth severity thresholds of what constitutes an exposure to potentially traumatic events. For example, a fender-bender might constitute a serious accident to a youth, but a parent may not consider an accident "serious" unless the youth went to the hospital. Regardless of the reason, the substantial discrepancies between maternal and self-reported PTSD symptomology highlight the importance of thorough multi-informant ratings of youth symptomology. This is in line with previous evidence that youth self-report of PTSD symptomology is a better predictor of PTSD diagnostic status than is parental report (Shemesh et al., 2005) and that self-report of internalizing symptoms offers unique information beyond that obtained from parental report (e.g., Hope et al., 1999).

Treatment Completion and Satisfaction

The access to and transportability of evidence-based interventions to those individuals with the greatest needs are significant issues in the intervention field (Hershell et al., 2004; Silverman et al., 2004). Families experiencing homelessness are arguably the population with the greatest physical, medical, and mental health needs (Arangua et al., 2005; Bussuk & Friedman, 2005; Lee et al., 2010). Specifically, 12.5% of youth experiencing homelessness have high levels ($\geq$4) of ACES (Felitti et al., 1998), 20% have clinically significant emotional problems (Bussuk & Friedman, 2005), and 18% meet criteria for PTSD (Steward et la., 2004). Despite this, in the past 20 years there has been a gap in the literature as to how best to address the mental health needs of sheltered youth and their families (Hershell et al., 2004; Silverman et al., 2004). This study represents a critical step towards identifying and addressing the elevated needs of youth experiencing homelessness by examining the feasibility, acceptability, and efficacy of administering both assessments and TF-CBT treatment within a shelter environment.

Completion rates of TF-CBT in the present study (72%), delivered within a homeless shelter, were comparable to slightly or better than those of previous trials of the TF-CBT which have typically documented completion rates ranging from 55% to 75% (Cohen et al., 2005; Eslinger et al., 2014; Yasinski et al., 2018). Furthermore, both maternal and self-report indicated high rates of satisfaction with treatment, with the majority of families reporting that they would recommend the treatment to others. Thus, an appropriately resourced shelter which is trained and staffed to provide evidence-based services in-house has the substantial advantage of bypassing common barriers to providing interventions to this population, including familial transportation to and from services, familial engagement in the face of multiple complex life stressors, and parental time limitations. Providing free in-house services allowed for flexibility with regard to scheduling and rescheduling sessions, greater insight into the needs of the families, and a greater ability to build rapport as shelter staff were engaged with families on a daily basis outside of sessions; each of which helped address the well documented attendance difficulties of families participating in clinical services (e.g., Axford et al., 2012; Baker et al., 2011; Nock & Ferriter, 2005). Finally, the use of time-limited intervention (i.e., time-limited to 10-18 sessions, with a check-in at session 10 to evaluate clinical need for additional sessions) also likely contributed to the reduced dropout rates. Specifically, the time-limited format addressed difficulties associated with sustaining proximity to therapeutic services for families in transition (Culhane et al., 2007) and associated with the burden of extensive time commitments from parents who were already overburdened. Taken together, the feasibility of training shelter staff to administer assessments and treatment with fidelity and obtaining relatively high completion rates given the at-risk nature of this population highlight the transportability of TF-CBT to a shelter setting for this vulnerable population of youth and families.

Treatment Efficacy

Consistent with our original hypothesis TF-CBT resulted in a reduced severity of PTSD symptomology based on both maternal and self-report as well as a reduction in the number of youth who fell within the clinically elevated range for PTSD. Further investigation revealed that these reductions were largely attributable to reduced symptoms of reexperiencing and arousal. Overall, these results offer promising evidence that even amongst this most at-risk population, TF-CBT can result in substantial improvements in trauma-related symptomology. With regard to the symptoms of reexperiencing, research indicates that these symptoms typically follow the presence or recall of stimuli after the trauma, which during the trauma signaled the onset of trauma or a "turn for the worse" (Ehlers et al., 2004). These stimuli trigger reexperiencing if the individual has not put the trauma memories within temporal context (e.g., "this stimuli/memory occurred within the context of my broader trauma narrative and is not a warning signal for danger presently"; e.g., Ehlers & Clark, 2000). Given the attention paid to the trauma narrative within TF-CBT, which allows the individual to process the events that occurred in detail and within a temporal context, it follows that substantial reductions would be seen in reexperiencing symptoms. With regards to symptoms of arousal, these symptoms are the most external of the PTSD symptoms (e.g., angry outbursts, reckless behavior, sleep disruption) and therefore the easiest for parents to monitor without insight from their child. As such, it is possible that mothers were more likely to notice reductions in arousal symptoms in their child than symptoms which are more internalizing or emotion and thought related.

Contrary to our original hypothesis, TF-CBT did not result in improvements in externalizing behaviors in the intent to treat group. However, follow-up analyses indicated that elementary school-aged children, but not older adolescents, had a significant reduction in

externalizing symptoms following TF-CBT. These findings are likely attributable to differences in the presentation of trauma-related symptoms across development. In fact, at pre-intervention elementary school-age children had a substantially lower mean score on the ECBI than did junior high and high school-age adolescents (*M*=105.56, *SD*= 43.30 and M=84.91, *SD*=40.92, respectively). Suggesting that older youth are less likely to express trauma-related reactions through externalizing behaviors than are younger youth, and therefore may require less focus on such symptoms in treatment. This finding is consistent with the DSM 5 accommodations which allow for different presentations of symptoms of PTSD in young children (American Psychiatric Association, 2013). However, the DSM 5 makes such accommodations for children under the age of 6 and findings from this study suggest that throughout elementary school clinical presentation of trauma-reactions may continue to differ substantively from those of adolescents (and adults). As such, future research would benefit from continued investigation of the developmental trajectory of trauma-related symptomology.

As hypothesized, greater exposure to ACES was associated with less treatment response, such that youth who experienced less than three ACES consistently benefited more from TF-CBT than did children with exposure to 4 or more ACES. These findings are particularly important given that youth experiencing poverty are at a substantially increased risk for exposure to high levels of ACES (Halfon et al., 2017). In this study specifically, 22% of children were reported by their mothers to have experienced four or more ACES (not including homelessness or low SES as an ACES[6]). As such, although TF-CBT offers an efficacious treatment option and should be strongly considered for sheltered youth with trauma-related symptoms, future research would benefit from exploration of more intensive treatment options for those individuals with the

[6] 63.2% of children would have qualified for experiencing four or more ACES if homelessness and low SES were considered ACES. In this study we did not include these as ACES as 100% of the sample experienced them.

greatest degree to ACES exposures. In other words, although we have made strides towards meeting the elevated clinical needs of these youth, there continue to be opportunities to improve and better address their needs.

The results also indicated a substantial reduction in overall parenting stress following TF-CBT, based upon maternal self-report. This finding is consistent with our hypothesis and consistent with previous research indicating that TF-CBT results in reductions in parental psychopathology (Martin et al., 2019, Tutus et al., 2019). Although the exact mechanism of this reduction in maternal stress is unknown, as part of TF-CBT caregivers learn to improve their own coping skills, aide in preparing their child for experiencing trauma-related triggers in and outside session, learn to better understand their child's symptomology, and how to support their child's needs as they pertain to their trauma (Appleyard & Osofsky, 2003; Sege et al., 2017). It is therefore possible that through learning these skills, parental symptomology is reduced. It is also possible that seeing improvements in their child's distress results in maternal reductions in stress. Although the primary focus of TF-CBT is on the reduction of symptoms in youth, reductions in parental stress are particularly important as, parental involvement in treatment has been found to be associated with greater skills use and greater improvements in behavior and emotional symptomology in youth (Deblinger et al., 1996; Deblinger et al., 1999; Dorsey et al., 2014). Parental reductions in distress are likely to help parents engage more in their child's treatment, behave more encouragingly, and be more supportive during treatment (in particular during the trauma processing portion of TF-CBT wherein parents hear details of their child's trauma narrative). This is particularly salient as previous research has demonstrated that greater parent support and less parental avoidance during the trauma narrative portion of TF-CBT predict better treatment outcomes for youth (Brown et al., 2020; Yasinski et al., 2016).

Limitations

In terms of our limitations, first, it is important to note that the study did not include a waitlist control. Given the high clinical needs of this population, we deemed it unethical to withhold treatment for a waitlist control. In particular, we were concerned that given the transient nature of the homeless population, asking families to wait for treatment would have been prohibitive, such that many families would have relocating before services became available to them. Now that the efficacy and feasibility of implementing TF-CBT within the context of a shelter has been established, future research would benefit from comparing TF-CBT to alternative treatment options within the homeless shelter context. Second, it is important to acknowledge that we cannot speak to the long-term maintenance of TF-CBT improvements in outcomes, as no follow-up data was collected in the present study. This was due to families exiting the shelter as well as limitations with regard to shelter resources.

Clinical Implications

In terms of clinical implications, the current study demonstrates the importance of offering evidence-based assessments to detect and address the clinical needs of youth experiencing homelessness. Further, it demonstrates the feasibility, acceptability, and effectiveness of embedding evidence-based treatment programs within the context of a homeless shelter and other shelter environments, such as domestic violence shelters and transitional housing. The findings indicate that sheltered youth and their families can see substantial benefits from time limited TF-CBT. While it is important to acknowledge that most homeless shelters face high staff turnover, limited resources, and minimal access to evidence-based programs (Gewirtz & August, 2008), the results from the present study are promising in that they suggest that evidence-based programs to address the mental health needs and trauma of youth can

feasibly be implemented if shelters are appropriately resourced, staffed and trained. There is growing awareness of the elevated mental health needs of youth experiencing homelessness (Committee on Community Health Services, 1996; Weinreb et al. 1998) as well as the lack of access to quality mental health interventions (Bussuk & Friedman 2005). The results of the present study demonstrate the potential for building community-university partnerships to develop evidence-based programs and better meet the needs of this most at-risk and underserved population. The implications for other community providers serving at-risk, marginalized youth and families to address the trauma of racial, ethnic, gender, and social and economic inequities and improve community health are broader still.

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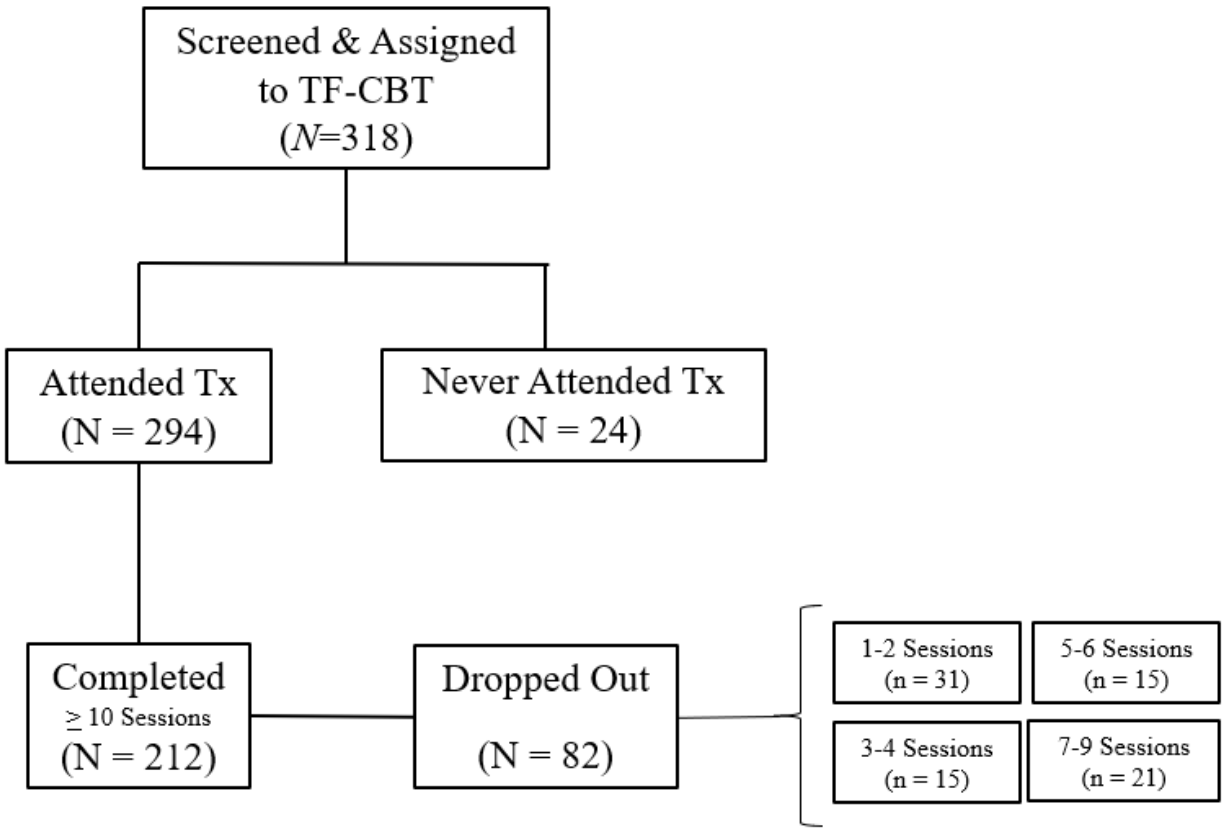

Figure 1. Consort flow diagram for children who were assigned to TF-CBT based upon clinical need

Table 1. *Participant Baseline Demographic Variables by Initial Intervention Assignment*

	Total Sample (N = 294)	Completers (n = 212)
Demographic Variables		
Child sex (% female)	56.1	56.6
Child mean age	10.04 (3.22)	10.18 (3.23)
Education (%)		
Preschool	1.0	0.9
Elementary School (K-6)	71.9	70.2
Junior High-High School	23.7	14.1
GED	1.0	11.4
Child Race (%)		
Black	69.7	68.4
White	29.9	31.1
Biracial/other	0.3	0.5
Child Ethnicity (%)		
Latinx	34.6	33.5
Non-Latinx	64.6	65.6
Maternal Education (%)		
Some High School	32.3	32.1
High School Diploma/GED	45.3	47.2
Technical Degree	3.1	3.3
Some College	12.9	11.3
Associate's Degree	1.0	0.5
Bachelor's Degree or higher	5.4	5.2
Maternal Employment Status (%)		
Unemployed	72.4	73.6
Employed	27.6	26.4
Home language (%)		
Monolingual (English only)	72.8	74.1
Monolingual (Spanish only)	10.9	9.4
Monolingual (Other Language)	0.3	0.5
Bilingual (Spanish/English)	15.0	15.1
Bilingual (English/Other Language)	1.0	0.9
Department of Child and Families Involvement (%)		
Present	13.3	13.7
Past	33.0	32.1

Note. Values enclosed in parentheses represent standard deviations.

Table 2. *Number of children and adolescents exposed to potentially traumatic events based on maternal and self-report at pre-intervention*.

Trauma Type	Parent CAT All Ages (N=294)	Parent CAT 8-17years (N=214)	Self CAT 8-17years (N=214)	t-test
Burglary/robbed	2	1	5	-1.64, *p* =.10
Natural disaster	67	49	63	-2.43*
Serious accident/injury	67	50	80	**-4.16*** **
Death of loved one	161	126	123	0.60, *p* = .55
Scary medical	42	31	29	0.50, *p* = .62
War	1	1	1	---
Any Physical Abuse	56 (19%)	37 (17.3%)	78 (36.4%)	**-3.67*** **
Physical abuse – family	28	19	32	**-3.04** **
Physical abuse – nonfamily	21	13	45	**-5.10*** **
Attacked	8	6	15	-2.53*
Any Witnessed Violence	169 (57.5%)	123 (57.5%)	163 (76.2%)	**-4.89*** **
Witness physical violence family	129	93	69	**3.28*** **
Witness community violence	64	49	135	**-10.15*** **
Witness others attacked	52	38	49	-1.99*
Any Sexual Abuse	22 (7.5%)	21 (9.8%)	24 (11.2%)	-0.83, *p* =.41
Forced sexual touching	20	19	22	-0.90, *p* =.37
Forced sexual pressure	6	5	7	-0.82, *p* =.42
Other Traumatic Event				
Emotional Abuse	34 (11.6%)	24 (11.2%)	20 (9.35%)	**-7.08*** **
Separation from parent	65 (22.1%)	43 (20.1%)	64 (29.91%)	**-3.28*** **
Bullying	102	71	85	-2.04*
PTSD Severity Score Mean (*sd*)	17.15 (10.66)	17.18 (10.86)	21.76 (11.77)	**-7.08*** **

Note. Any Physical Abuse = experienced at least one instance of either physical abuse from a family member or nonfamily member or has been attacked; Any Witnessed Violence = witnessed at least one instance of either physical abuse of a family member or nonfamily member or has witnessed an attack; Any Sexual Abuse = experienced at least one instance of either forced sexual touching or sexual pressure. Other Traumatic Event = events endorsed as part of an open-ended question of other traumatic events not traditionally listed by the CATS. T-tests compare maternal- and self-reports on the CAT for participants 8-17 years old. Bold = significant after Holm's stepdown correction procedure.

* = p <.05, ** = p <.01, *** = p <.001

Table 3. *Repeated measures ANCOVAs examining pre-post intervention scores covarying for age.*

	Intent to Treat F	Completers F
Parent CATS		
Symptom Severity	**11.73*** **	**12.44*** **
Reexperiencing Sx	**7.69** **	3.74*
Avoidance Sx	6.25*	**8.44** **
Neg Mood/Cog Sx	0.32, p = .57	0.62, p = .43
Arousal Sx	**12.29*** **	**9.95** **
Self-report CATS		
Symptom Severity	**7.15** **	**5.76***
Reexperiencing Sx	**7.53** **	5.89*
Avoidance Sx	0.21, p = .65	0.01, p = .91
Neg Mood/Cog Sx	0.45, p = .50	0.04, p = .85
Arousal Sx	0.09, p = .77	0.04, p = .85
ECBI		
Intensity Raw	0.72, p = .40	**21.59*** **
Parenting Stress Index		
Total Stress	**12.16*** **	5.27*
CAT Scores in PTSD Range		
Maternal report	**6.81** **	4.97*
Self-report	**7.58** **	**7.00** **

Note. Sx = symptom count. Effects in bold remained significant after Holm's stepdown procedure.

* = p <.05, ** = p <.01, *** = p <.001

Table 4. *Results of repeated measures ANOVA Analyses Examining the Effects of Grade on Parent and Child Outcomes of TF-CBT in Intent to Treat Sample.*

	Elementary *M* (SE)	Junior High/ High School *M* (SE)	Time Effect F	Time x Group Effect F
Parent CATS Symptom Severity	14.33 (.47)	15.93 (.79)	25.54***	.04, $p = .84$
Self-report CATS Symptom Severity	17.75 (.60)	17.87 (.82)	51.23***	.001, $p = .97$
ECBI Intensity Raw	96.64 (1.96)	92.93 (3.57)	.39, $p = .53$	14.77***
Parenting Stress Index Total	82.41 (1.04)	89.36 (5.34)	2.80, $p = .10$	1.16, $p = .28$

*** = $p < .001$

Table 5. *Results of repeated measures ANCOVA Analyses Examining the Effects of Number of ACES on Parent and Child Outcomes of TF-CBT Controlling for Age in Intent to Treat Sample.*

	Homelessness Only *M* (SE)	1-3 ACES *M* (SE)	$\geq$ 4 ACES *M* (SE)	Time Effect F	Time x Group Effect F
Parent CATS Symptom Severity	11.80 (1.22)	14.50 (.47)	16.57 (.83)	13.13***	5.67**
Self-report CATS Symptom Severity	15.17 (1.68)	17.28 (.57)	20.16 (1.00)	7.67**	6.26**
ECBI Intensity Raw	90.67 (5.01)	94.21 (2.07)	103.21 (3.65)	28.01***	3.21*
Parenting Stress Index Total	80.76 (2.76)	81.55 (1.26)	86.52 (2.21)	7.50**	2.82, $p = .06$

* = $p < .05$, ** = $p < .01$, *** = $p < .001$