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Comparison of trauma-focused cognitive-behavioral therapy and theory of mind on increasing social competence among abused children

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Abstract:

BACKGROUND: In recent decades, the use of psychological methods has been considered to improve the barriers and challenges of abuse adolescent females. This study focuses on comparing the efficacy of trauma-focused cognitive-behavioral therapy (TF-CBT) and theory of mind (ToM) on social competence among abused children.

MATERIALS AND METHODS: A clinical trial was performed with 39 abused children as the subjects of the study. Participants are residents in Ahvaz (Iran) host-family centers and were randomly divided into two groups of experimental subjects and control subjects. The data collection method utilized the Social Competence Questionnaire. Descriptive statistics, covariance analysis, and Tukey's *post hoc* test were used for the data analysis.

RESULTS: Comparison of the groups showed that the average behavioral and cognitive competence increased in both TF-CBT and ToM groups, but the average emotional, social competence is significantly higher in the ToM group. It is also found that the average social motivational competence is significantly higher in the TF-CBT group than in the ToM group.

CONCLUSION: TF-CBT and ToM can be effectively used to improve the social competence of abused adolescent females.

Keywords:

Abused children, social competence, theory of mind, trauma-focused cognitive-behavioral therapy

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Introduction

Many children are abused by their caretakers every year. The World Health Organization (2006) considers child abuse as behavior that involves any intentional means of physical, emotional, and sexual harassment of children or negligence and carelessness toward children. Abuse of children and teenagers has a severely negative impact on children and aggravates the future outlook of children. Substance abuse in the form of narcotics, alcohol, and prescription drugs, as well as abandoning and running away from home are more frequent in abused children.[1-3]

One of the problems often affecting abused children is lower social competence. Social competence includes a set of skills whose mastery would promote social awareness.[4-6] Social awareness focuses on the ability to understand others and establish effective communication and social responsibility. It enables maintaining a personal independence and managing relationships.[7] Damage to social competence can lead to vulnerabilities to interpersonal relationships in abused

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children. Accordingly, these children fall victim to psychological, social, and behavioral problems.[8] Recent research findings have established that children and teenagers with low social competence suffer more heavily from depression,[9] criminal tendencies,[10] aggression,[11] and other behavioral problems. Educational programs that enhance individual and social abilities can effectively prevent these behaviors and increase the social competence of these children.[12]

Of the existing and new therapies in helping abused children, considerable evidence suggests that trauma-focused cognitive-behavioral therapy (TF-CBT) to be a novel and effective approach. TF-CBT is derived from the cognitive-behavioral approach. TF-CBT is used to reduce the symptoms of posttraumatic stress disorder, depression, and anxiety, as well as trauma-related features.[13] This treatment is a combination of standard cognitive-behavioral techniques and supportive individual interventions.[14] In many studies, this treatment is compared with other commonly used treatments, such as supportive care, child-centered therapy, game therapy, or community-based treatment. It is shown that children who receive TF-CBT improve significantly.[15]

The issue of child abuse has been widely studied; however, due to many varying and complex challenges in this area, one standard cannot be utilized for the method for all children in this study. Therefore, another method is paired up in this study that is the theory of mind (ToM). The ToM is derived from social cognition theory. ToM is the ability to have mental states being different from reality or one's mental state and to motivate human actions by the internal mental state such as beliefs, desires, and intentions.[16,17] Teaching ToM may facilitate the creation of empathy and thus provides a broader insight into beliefs and emotions. Therefore, it is feasible that abused children could effectively benefit from ToM education that otherwise would have been further aggravating.[18,19]

In addition, given that the child abuse has become increasingly widespread in Iran in recent years, several researchers in Iran have focused on this critical issue. For example, Mikaeili in a study assessed 2000 students aged 11–14 years demonstrating that at least one type of child abuse was reported by 15% of students.[20] Regarding the at-risk population, the prevalence of childhood sexual abuse was 0.60 among male and 0.53 in women (for most of the cases abusive encounters possibly began from early years of primary school), which reported through a meta-analysis of 38 studies in 21 countries worldwide;[21] hence, dealing with effective therapy modalities to diminish abused children's suffering is noteworthy.

Concurrent with the recognition of the psychological problems and symptoms among the abused children, the issue of their treatment was raised. The dominant approach among the psychotherapy ones in the area of the treatment of behavioral and emotional problems caused by child abuse was CBT approach in recent years. However, the application of this method in different studies resulted in different effects, and it was reported that the method contributes to varying effects in the treatment of psychological symptoms relevant to the child. This inconsistency and limitation led researchers to seek other approaches in the field.

Furthermore, TF-CBT and ToM have not yet been compared in terms of analyzing the social competence escalation among the abused children. Therefore, it has not been feasible to determine which one is more effective in this area. For these reasons, the present study aimed to compare the effectiveness of trauma-based CBT and ToM on enhancing the social competence of abused children.

Materials and Methods

Study design

This was a randomized controlled clinical trial. The statistical population includes all participants referred to the Ahvaz Welfare Organization. The first sampling includes 49 abused girls who were admitted to the family-like (foster home placement centers) centers of the Ahvaz Welfare Organization. Of them, 43 participants have entry criteria. Of 43 admitted people, one of the participants refused to cooperate with us, and three participants were discharged (two girls were admitted by parents and one of them was admitted by grandfather). Finally, 39 participants were chosen. Of those, 26 participants were randomly put in two experimental groups (TF-CBT and ToM) and 13 participants were randomly put in the control group [Figure 1].

Selection criteria

The entry criteria of the study include (a) gender (girls), (b) referral and admission to pseudo-family centers due to physical and psychological abuses and ignorance, (c) ages range of 9–12 years, and (d) failure to receive psychological treatments at the time of conducting research. The exit criteria of the study are obvious symptoms of psychosis in the child, chronic illness or other simultaneous psychical disorders, and mental retardation observed in children. It should be noted that criteria to recognize child abuse are referral and admission of children to the Ahvaz Welfare Organization due to the report of child abuse. This study was conducted and overseen by the Research Committee of Shahid Chamran University of Ahvaz, Iran.

Procedure

The general procedure was that after the approval of

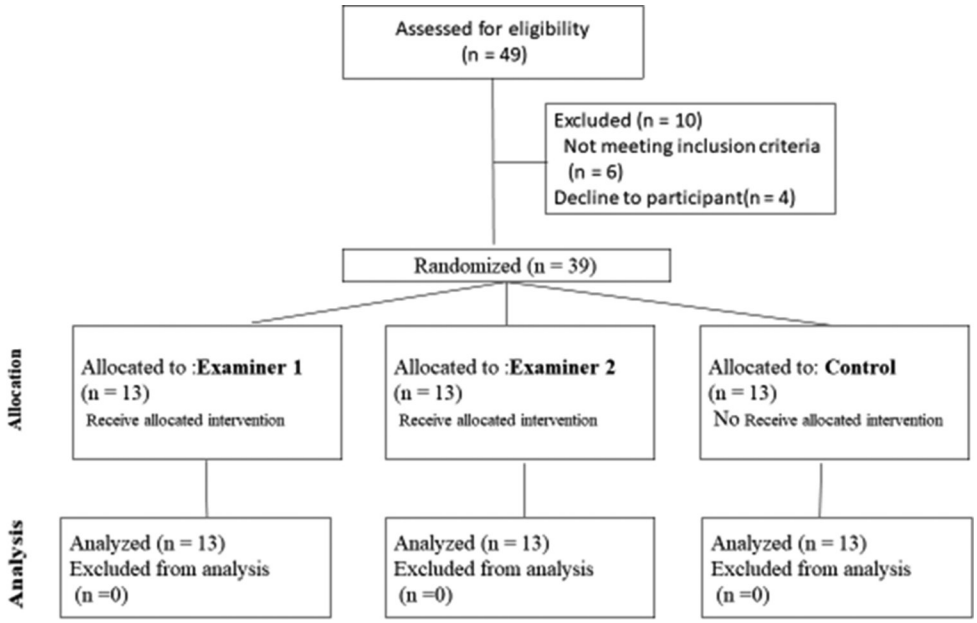

Figure 1: Consort flow diagram of the participants

the Research Committee in Shahid Chamran University, Ahvaz, the necessary coordination was carried out with the social affairs deputy and the expert responsible for the foster-family affairs in the Welfare Organization, and the researcher referred to foster-family centers after obtaining the consent and performing the above steps. Then, the objective underlying the present study was explained to the experts based in these centers, and the children were selected according to the inclusion and exclusion criteria.

After identifying the children and before any intervention, the children completed a self-report social competency questionnaire. Data obtained from this stage were considered as pretest scores. Then, the training was conducted in groups, twice a week, and individually for each group. Due to the use of two different methods, the first and second experimental groups were selected from two different dormitories to avoid the effects of the intervention. Interventions were conducted by psychologists at the centers where these children were kept, and the interventions were performed in Persian.

Selective protocol

Trauma-focused cognitive-behavioral therapy protocol

In the first session, the goal of treatment along with expectations was explained. A brief summary of TF-CBT and the rules of the group were presented. Managing emotional responses to trauma, identifying types of emotions through games and images, managing the physiological responses to trauma, deep muscle relaxation, and diaphragmatic breathing are taught from the second session to the fourth session. Stopping thought technique, communication between thought, emotion, and behavior, and investigation of the daily thoughts through writing or painting are taught in the 5th and 6th sessions. We focused on the identification of negative thoughts, cognitive coping, familiarity with and cognitive distortions, and their challenges in 7th and 8th sessions. Furthermore, the trauma narrative was performed by storytelling techniques. In the 9th and 10th sessions, we discuss the trauma reminders, and then, overcoming the fear associated with the trauma and increasing environmental protection were considered.[22]

Theory of mind protocol

The first session consists of familiarization and general explanation of the educational plan. We teach the identification of emotional states by means of images while teaching situational emotion by a combination of images and stories from the 2nd session to the 4th session. Images depicting different situational emotions are offered to children, and the emotion of the character in the image and story is taught in the 5th and 6th sessions. A set of images is presented to the child and the desire and thought of the character in the story are taught to them in the 7th and 8th sessions. Finally, in the final sessions, (9th and 10th), a set of cartoon images is presented to children so that the thoughts and beliefs of characters in the story can be taught.[23]

Measurements

Social Competence Questionnaire was used to collect the data**.** The questionnaire is constructed and normalized by Parandine (2006) based on Felener's four-dimensional social competence model (1990). This questionnaire is composed of 47 questions with Likert scale. The scores of overall social competence range from 47 to 329.

Social competence questionnaire includes behavioral skills (negotiation, role play, self-expression, and conversational skills, social skills, and learning to be friendly with others), cognitive skills (information warehouse, high social knowledge, perceptions proportion to perspective of others, understanding how to establish interpersonal relationships, processing skills and information acquisition, and decision-making ability), emotional skills (establishment of effective communication with others, development of mutual trust and mutual support, and identification of or proper response to emotional symptoms in social events), and motivational competence (including individual worth, moral development level, feeling of effectiveness, self-efficacy, effective communication with others, and relationship management). The estimation of reliability and validity of this test is performed by Parandin in Tehran Province (Iran) on 450 people. To estimate the scale reliability coefficient, Cronbach's alpha method was used to investigate the internal consistency of the scale and subscales. The alpha coefficient obtained from omitting the items that had little correlation with the total score was 88%, indicating that the questionnaire has acceptable internal consistency coefficient. In addition to the alpha coefficient, test–retest was used to estimate the reliability. Retest coefficient between two runs was obtained to be 0.89. The total correlation with the subscales is very high and is significant at the 99% level. In addition, the construct validity of the scale was investigated via factor analysis. On the other hand, all correlation values between the items and the total questionnaire score for analyzing the principal components were above 0.50, indicating a high correlation between each item with the whole test.[24]

Data analysis

To analyze the descriptive data, the statistical methods (i.e., Chi-square method) are used by utilizing SPSS statistical software version 17.0 (IBM Corp.: Armonk, NY, USA). Inferential data are investigated through the analysis of covariance and Tukey's *post hoc* test.

Ethical consideration

This study was reviewed and approved by the Ethical Committee of the Vice Chancellery of Research and Technology, Shahid Chamran Ahvaz University. Each participant was informed and their written consent form was obtained from all participants.

Results

In the current study, 39 abused children who refer to the family-like center are selected. They are randomly divided into two experimental groups and one control group. Table 1 shows that the three groups have relatively similar attributes and properties. As shown in Table 1, among the participants aged 9–12 years, the highest frequency of child abuse was related to physical child abuse (33.33%) and the lowest frequency belonged to child neglect (20.51%). Parental education was mostly at the high school level (61.54%), and family history of addiction was often positive (69.23%).

Table 2 presents the statistical indices relevant to the social competence score and its subscales for each group. According to the table, in the preintervention phase, the mean and standard deviation of social competence scores in the groups were similar. However, in the postintervention phase, a significant difference was observed.

As shown in Table 2, the mean score of social–behavioral competence before and after intervention in TF- CBT group is 114.923 and 133. In the ToM and control groups, this score is 112 and 127.153 and 114.076 and 111.384, respectively. The mean score of social cognitive competence before and after the intervention in TF-CBT group is 5.461 and 9, and in the ToM and control groups, it is 6.769 and 8.846 and 6.384 and 6.615, respectively.

In addition, the mean score of social motivational competence before and after intervention in the group TF- CBT is 16.38 and 19.076, and in the ToM and control groups, it is 15.153 and 17.230 and 16.30 and 14.538, respectively. On the other hand, the mean score of emotional–social competence before and after intervention in TF- CBT group is 6.615 and 7.384, and in the ToM and control groups, it is 7.461 and 7.615 and 7.615 and 7.461, respectively. The mean of total social competence before and after the intervention in TF-CBT group is 143.384 and 168.461, and in the ToM

Table 1: Demographic properties of abused children in the study groups

	n (%) or mean (SD)			
Groups	**TF-CBT**	**Theory of mind**	**Control**	**Total**
Kind of child abuse				
Physical	7 (53.84)	6 (46.15)	5 (38.46)	18 (46.16)
Emotional	3 (23.07)	4 (30.76)	6 (46.15)	13 (33.33)
Negligence	3 (23.07)	3 (23.07)	2 (15.38)	8 (20.51)
Father's educational level				
High school	9 (69.23)	7 (53.84)	8 (61.53)	24 (61.54)
Advanced degree	4 (30.76)	6 (46.15)	5 (38.46)	15 (38.46)
Father's job				
Employed	5 (38.46)	6 (46.15)	8 (61.53)	19 (48.72)
Unemployed	8 (61.53)	7 (53.84)	5 (38.46)	20 (51.28)
History of addiction in family				
Yes	8 (61.53)	10 (76.92)	9 (69.23)	27 (69.23)

TF-CBT=Trauma-focused cognitive-behavioral therapy, SD=Standard deviation

and control groups, it is 141.384 and and 163.923 and 140, respectively.

According to the present research design which was of a pretest and posttest type, covariance analysis was used to analyze the data and to control the effect of pretest. In addition, prior to using this method, the prerequirements to perform covariance test including variance–covariance matrix homogeneity, variance homogeneity, and regression coefficients homogeneity were evaluated, and then, this method was used.

Based on the analysis summarized in Table 3, the value of F relevant to the social–behavioral competence is $F = 1625.154$ ($P < 0.005$), and the value of F relevant to the cognitive and total social competence are $F = 4.280$ ($P < 0.022$) and $F = 8.313$ ($P < 0.001$), respectively. This indicates that there is a significant difference between the posttest scores of social–behavioral, cognitive, and general social competences in the two groups of the experiment and control. However, there is little to no difference between the posttest scores of motivational and emotional social competence in the experimental and control groups based on the value of F when comparing the social–motivational competence ($F = 2.957, 0.065$) and social–emotional competence ($F = 4.806, 0.014$).

To determine the exact difference between the test and control groups, Tukey's *post hoc* test was used, and the results are summarized in Table 4.

The results of Table 4 suggest that the average score of overall social, behavioral, cognitive, and motivational competence in TF-CBT group has a more significant difference as compared to the control group ($P < 0.005$). In contrast, this difference in the emotional–social competence is not significant ($P < 0.998$). Furthermore, it is clear that ToM has a significant effect on the overall social, behavioral, cognitive, and emotional competence ($P < 0.005$). This, however, does not translate to a significant effect on the motivational competence ($P < 0.334$).

The other findings suggest that there would be no significant differences between TF-CBT and ToM in the overall social competence ($P < 0.818$). In short, both methods have a significant effect in increasing the overall social competence.

Discussion

Data analysis shows that there is a measurably significant difference in favor of TF-CBT group between average posttest score of social competence in TF-CBT and control groups.

This study further supports the findings of Deblinger *et al*., based on the effectiveness of CBT on the improvements in the personal resiliency among youth.[25] Furthermore, the results of this study are in agreement with the findings of de Arellano *et al*., showing that TF-CBT leads to reducing behavior problems or symptoms of depression.[13] To explain this finding further, in the TF-CBT sessions, we helped the participants restructure the abused children's cognitive properties including belief and mental imagery, and then, we attempted to alleviate the emotions associated with their harassment during the sympathy process. Furthermore, attempts were made to reduce the social problems of these children, which continues due to irrational thoughts, using diverse behavioral, emotional, and cognitive techniques through carrying out assignments.[26,27]

There is also a significant social competence difference in favor of ToM group when ToM and control groups with pretest control are compared. This finding is consistent with the results of Le based on the effect of ToM on the

Table 2: Mean and standard deviation of social competence before and after intervention

Variables	Mean (SD)	
	Before intervention	After intervention
Social competence		
Behavioral		
TF-CBT	114.92 (18.98)	133 (15.737)
Theory of mind	112 (18.533)	127.15 (17.367)
Control	114.07 (13.972)	111.38 (15.840)
Cognitive		
TF-CBT	5.46 (1.506)	9 (1.779)
Theory of mind	6.76 (2.087)	8.84 (1.675)
Control	6.38 (2.785)	6.61 (3.302)
Motivational		
TF-CBT	16.38 (4.03)	19.07 (5.267)
Theory of mind	15.15 (4.450)	17.23 (3.833)
Control	16.30 (4.479)	14.53 (5.125)
Emotional		
TF-CBT	6.61 (2.631)	7.38 (3.500)
Theory of mind	7.46 (2.933)	10.69 (3.425)
Control	7.61 (3.302)	7.46 (2.221)
Total		
TF-CBT	143.38 (17.91)	168.46 (18.581)
Theory of mind	141.38 (17.918)	163.92 (18.607)
Control	144.38 (18.305)	140 (20.337)

TF-CBT=Trauma-focused cognitive-behavioral therapy, SD=Standard deviation

Table 3: The results of the multivariate covariance analysis on the mean posttest scores in the experimental and control groups

Variables	Sum of square	DF	Mean square	*F*	*P*
Social competence					
Behavioral	3250.308	2	1625.154	6.093	0.005
Cognitive	46.308	2	23.154	4.280	0.022
Motivational	135.436	2	67.718	2.957	0.065
Emotional	92.667	2	46.33	4.806	0.014
Total	6079.538	2	3039.769	8.313	0.001

Table 4: The results of Tukey's *post hoc* test to compare the averages of groups in posttest step

Variables	Comparison	Mean difference	Standard error	*P*
Social competence				
Behavioral	1st and 2nd groups	5.846	6.406	0.636
	1st and 3rd groups	21.615	6.406	0.005
	2nd and 3rd groups	15.769	6.406	0.048
Cognitive	1st and 2nd groups	0.153	0.912	0.984
	1st and 3rd groups	2.384	0.912	0.034
	2nd and 3rd groups	2.230	0.912	0.050
Motivational	1st and 2nd groups	1.846	1.877	0.592
	1st and 3rd groups	4.538	1.877	0.053
	2nd and 3rd groups	2.69	1.877	0.334
Emotional	1st and 2nd groups	3.307	1.217	0.027
	1st and 3rd groups	0.076	1.217	0.998
	2nd and 3rd groups	3.230	1.217	0.031
Total	1st and 2nd groups	4.538	7.500	0.818
	1st and 3rd groups	28.461	7.500	0.002
	2nd and 3rd groups	23.923	7.500	0.008

social competence of schizophrenia.[28] Further, this study supports the findings of Washburn *et al*. which show the effect of ToM on social anxiety disorder.[29]

Expanding on our findings, it can be said that the abused children are helped to find the ability to understand and predict the social behavior of others during the sessions of the ToM. By emphasizing the application of the ToM, abused children's awareness of their and other's emotions improves their relationships with others and helps them cope with their emotion.[30,31] Coping with their and other's emotion and improvement of interpersonal relationship usually positively results in the increase of social competence and enables proper confrontation in interpersonal interactions. Social competence allows abused children to behave efficiently in social settings. This is because children should have an awareness of their and other's traits, and this awareness is the requirement of the ToM. Therefore, the social competence is improved for abused children applying the method of ToM.[32,33]

The findings of the current study indicate that there is no significant difference between the total score of social competence in the group, in which TF-CBT method is used and the group in which ToM is used. Given that there is no study conducted to compare both methods and their effect on the social competence, it was not possible to compare them with other studies.

There are no significant differences between the two methods with regard to the increase in social competence. In both the methods, the outcomes are contributed to the children modifying their inefficient beliefs. Indeed, the main components in both TF-CBT and ToM methods are social competence and emotional, cognitive, and behavioral dimensions. It is strongly recommended that during these therapy sessions, the children are thought techniques to recognize and control their emotions. Recognition of theirs and others' thought and emotion is emphasized in the ToM method similarly to the TF-CBT method.

Furthermore, in both TF-CBT and ToM methods, children were thought to recognize their own emotions and understand that others may have differing interests, goals, feelings, and beliefs from them. By increasing their social and emotional interactions, these children have an opportunity to expand their social competence and communicate to attain their reasonable intent. In such a way, they gradually become familiar with different emotional states and different types of communication and find a greater understanding of social clues and form patterns of interactions in their minds to influence their environment and others. The basis of social competence is formed through these models. Equipped with these models, abused children assume the power of predicting the behavior of others as a consequence of their behaviors and of gaining control over the environment. In total, it can be argued that using these two methods can help to improve the social competence of abused children.

Limitations of the study

The current study is limited as it draws on self-reporting questionnaires which raises the possibility of response bias. Furthermore, the limited statistical population pool of the research prevents us to assess the impact of the aforementioned methods on other types of child abuse. Finally, due to time constraints and prediction of sample drop, following up effectiveness of TF-CBT and ToM methods was not possible in intervals of several months after the treatment.

Conclusion

As these abused children are parents of next generation, their problem often has consequences extending beyond to families and the society. Timely intervention during childhood can prevent a more severe mental harm and can reduce the possibility of violent behaviors during adulthood. Therefore, due to the effects of TF-CBT and ToM methods in improving the social competence of abused children, these methods can be used in psychotherapy practices and centers such as the State Welfare Organization used for keeping such children.

The strength of the present study was that it used novel approaches to help abused children since it is of high significance to focus on the consequences of child abuse and on effective methods and treatments to reduce the problems of these children. The disadvantage of the present

study was that the therapeutic methods were used only for girls and that child sexual abuse was not investigated because of the research limitations. The ultimate message of the present study is that TF-CBT and ToM can promote the social competence of abused children. Thus, such methods can be utilized in rehabilitation centers, psychology clinics, and crisis intervention centers based on the welfare organizations that accept these children.

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Conflicts of interest

There are no conflicts of interest.

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