From Efficacy to Effectiveness: A Look at Trauma-Focused Cognitive Behavioral Therapy in a Community Setting

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ABSTRACT

Since the early 1990s, research has found that trauma-focused cognitive behavioral treatment (TF-CBT) is efficacious in treating children who were sexually abused. Since then a number of manualized treatments have been developed and determined efficacious as well. The purpose of this study was to examine the transportability of TF-CBT and determine whether it is effective in a real-world, clinic community setting.

Participants were children who were sexually abused and their nonoffending parents who were recruited to the study from the Child Advocacy Center at the Children's Hospital at Montefiore Medical Center. Therapists there were trained in the Deblinger and Heflin (1996) manualized treatment for sexually abused children and their nonoffending parents. Parents and children attended weekly sessions at the center. Parents and children completed measures at the start and end of treatment. Parents completed the *Child Behavior Checklist* (CBCL) and *Parenting Stress Index – Short Form* (PSI-SF). Children completed the *Trauma Symptom Checklist for Children* (TSCC) and *Children's Depression Inventory* (CDI). Therapists completed a checklist to record which component of treatment they engaged in after every session.

Results indicated a significant decrease in depressive and trauma-related symptoms in children from pre- to post-treatment. Additionally, results yielded some improvements in child behavioral difficulties from pre- to post-test. In terms of parent emotional distress, results yielded no significant improvements from pre- to post-treatment

Despite the small sample size and modifications made in treatment, there were still improvements in child depression and trauma-related symptoms from pre- to post- treatment, demonstrating a utility for TF-CBT in the clinic setting for children suffering from childhood

sexual abuse. Behavioral symptoms also showed improvements from pre- to post-treatment, further supporting the generalizability of the efficacy studies and utility in a community setting. Conversely, this study did not show improvements in parental symptoms for the nonoffending parents involved in treatment. This may demonstrate to clinicians the need to include parents on a more consistent basis in the treatment, in order to yield results that more closely match the efficacy studies.

CHAPTER I: INTRODUCTION

The purpose of this study was to examine the effectiveness of a manualized trauma-focused cognitive behavioral treatment (TF-CBT) in a clinic setting. There have been studies which have shown TF-CBT to be efficacious in research settings (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Knudsen, 2005; Deblinger, Mannarino, Cohen & Steer, 2006; Deblinger, Stauffer, & Steer, 2001; Deblinger, Steer, & Lippmann, 1999; Heflin & Deblinger, 2003; Stauffer & Deblinger, 1996); however, there have not been studies showing the effectiveness of this treatment in a real-world setting. This project reviews the research on generalizing efficacious findings to actual practice. Additionally, it reviews the efficacy research on TF-CBT. The goal of the study is to examine one of the trauma-focused manualized treatments and how it generalizes to a real-world setting.

Prevalence and Effects of Child Sexual Abuse

It is estimated that one out of three girls and one out of six boys suffer sexual abuse by the time they are 18 years old. The Third National Incidence Study of Child Abuse and Neglect, a congressionally mandated study designed to provide estimates of the incidence of child abuse and neglect in the United States, reported that approximately 300,200 children (4.5 per 1,000) experienced sexual abuse during 1993. This rate had more than doubled since the Second National Incidence Study which was conducted in 1986 (Sedlak & Broadhurst, 1996). More recently, the U.S. Department of Health and Human Services reported that 88,656, or 1.2 per 1,000 children, were sexually abused in 2002 (United States Administration for Children and Families, 2005). Common

emotional reactions to abuse include anger, hostility, shame, guilt, depression, and post-traumatic stress disorder (PTSD). Behavioral symptoms are also commonly reported for child victims of childhood sexual abuse (CSA) as are problematic sexualized behaviors. Researchers have found that abuse perpetrated by a family member and abuse that is more invasive result in increased negative impact (Adams-Tucker, 1981; Conte & Schuerman, 1987; Friedrich et al., 1986; Gomez-Schwartz, Horowitz, & Sauzier, 1985; McLeer et al., 1988). Conversely, the responses of the nonoffending parent(s) have a significant impact on the post-abuse adjustment of child victims. Friedrich (1990) notes that parental support is a crucial predictor for child victims' behavioral reactions to the abuse. Specifically, negative parental responses aggravate behavioral disturbances in child victims, whereas supportive responses positively influence child victims' adjustment. Thus, parental support may be a key factor in developing intervention programs for sexually abused children (Stauffer & Deblinger, 1996).

Substantial numbers of children are subjected to traumatic experiences such as exposure to violence, natural disasters, car accidents, sudden death of parents or siblings, and physical and sexual abuse. Exposure to such events can result in significant psychological symptoms including PTSD or other anxiety disorders, depressive symptoms, or a variety of behavior problems (Finkelhor, 1998; Singer et al., 1995). Chaffin, Silovsky, and Vaughn (2005) found the lifetime prevalence rate for anxiety disorders among sexually abused children to be high, among a sample of 158 sexually abused children, with 87% meeting criteria for at least one anxiety disorder, excluding PTSD. Sixty-three percent of the children met criteria for separation anxiety, 31% for

overanxious disorder, 22% reported obsessions, 22% reported compulsions, and 68% met criteria for different phobias. Sixty-one percent reported CSA-related PTSD. Widom (1999) examined PTSD as part of a prospective study of long-term consequences of early childhood victimization (i.e., sexual abuse, physical abuse, and neglect) and found that childhood victimization increases a person's risk for PTSD. The odds of an abused or neglected child developing PTSD were 1.75 times higher than the odds for a matched comparison subject. The comparison subjects were nonvictimized children who were followed prospectively into young adulthood as well in order to allow causality to be examined to help separate the effects of childhood victimization from other confounding variables. In terms of the specific types of abuse, those children who had been sexually abused were 2.34 times more likely to develop PTSD, physically abused children were 1.90 times more likely, and neglected children were 1.72 times more likely to develop PTSD than those children in the comparison group.

Additionally, Johnson, Sheahan, and Chard (2003) found that 80.2% of their sample of 86 women, who had been sexually abused as children, met full diagnostic criteria for PTSD. Burnam et al. (1988) studied a large epidemiologic sample of adults and found that the experience of being sexually assaulted is associated with an increased risk for onset of major depression, substance use disorders, and anxiety disorders later in life. Gore-Felton, Koopman, McGarvey, Hernandez, and Canterbury (2001) found that sexual and physical abuse were significantly related to behavioral problems among a sample of 1008 incarcerated youth. If left untreated these difficulties may become

chronic, producing effects that can persist into adulthood (Green et al., 1994; Sack, Clarke, & Seeley, 1995).

Discovering that their child has been sexually abused can have a traumatic impact on the nonoffending parent as well. Historically, nonoffending mothers have been portrayed as being unsupportive of their children and partially to blame for their children's victimization. Due to this misconception, the therapeutic needs of nonoffending mothers have been largely ignored. However, since the beginning of the 1990s, the clinical and empirical literature has begun to recognize and examine the impact CSA can have on nonoffending parents (Stauffer & Deblinger, 1996).

Trauma-Focused Cognitive Behavioral Therapy

Theory

Several efficacy studies have been conducted on TF-CBT for children who have been sexually abused and their parents. Furthermore, cognitive-behavioral treatment approaches have been used to treat adults who have been sexually abused. In particular, cognitive restructuring and exposure have been used successfully in treating adult rape victims (Foa, Rothbaum, Riggs, & Murdock, 1991; Frank, Anderson, Stuart, Dancu, Hughes, & Wert, 1988; Resick & Schnicke, 1992). In the early 1990s researchers began to evaluate outcomes in the treatment of children exposed to sexual abuse. Most studies examined the efficacy of TF-CBT. From this work, a number of manualized treatments were developed and published. These interventions have been increasingly used and empirically evaluated (Cohen, Deblinger, & Mannarino, 2005).

Most of the treatments developed for trauma-related symptoms in children have been modified from treatments for traumatized adults or from interventions used to treat nontraumatized symptoms with similar symptoms, such as anxiety or depression. Of all of the interventions used to treat trauma-related symptoms in children, cognitive behavioral interventions have received the most empirical evaluation and many advocate for the use of cognitive behavioral techniques or treatments with traumatized children (Cohen, Mannarino, Berliner, & Deblinger, 2000).

Deblinger and Heflin (1996) developed a manualized treatment based on an abuse-focused cognitive behavioral treatment approach in order to alleviate the symptoms of sexually abused children. The model offers a social learning conceptualization of the development, maintenance, and treatment of abuse-related symptoms in children and adolescents who have been sexually abused. The development of the symptoms that the children experience can be explained by learning theory, incorporating both classical and operant conditioning principles. When children experience sexual abuse, they often instinctively experience negative emotions such as fear, shame, or anger. Classical conditioning occurs when otherwise neutral cues, such as certain clothes, a certain tone of voice, darkness, a certain room, to name a few, present at the time of the abuse become conditioned, so that they too elicit negative emotions, even though the cues themselves may seem harmless.

Operant conditioning occurs when sexually abused children learn to avoid abuse-related cues in order to reduce the likelihood of experiencing conditioned fear. Abuse-related memories and thoughts may also become conditioned stimuli that automatically

elicit negative emotions. Though children and their parents may feel that avoidance is an effective coping response because it leads to immediate reduction in anxiety, there is evidence that such behavior is associated with long-term symptomatology. Gradual exposure, a cognitive-behavioral technique, is designed to assist sexually abused children to gradually confront these anxiety-provoking reminders of the abuse experience. Through gradual, but repeated attempts to confront abuse-related cues, children learn that thoughts, memories, and reminders of the abuse are not harmful and do not need to be avoided (Deblinger & Heflin, 1996).

Sexual abuse may impact children's developing cognitive view of the world. CSA victims are prone to developing cognitive distortions, particularly with relationships, sexuality, and personal safety. Dysfunctional thoughts about interpersonal relationships at a young age may hinder the development of satisfying relationships later on in life. In fact, there is considerable evidence that survivors of CSA suffer greater difficulties in interpersonal relationships than individuals without that history. The treatment model, therefore, incorporates a component on cognitive coping skills that aims to assist children and their parents in effectively identifying and disputing dysfunctional, abuse-related thoughts. Due to the fact that one's cognitive view of the world is in a constant state of development, it can be influenced by new information and experiences. Therefore, this model includes a large educational component designed to provide accurate information about sexual abuse, healthy sexuality, and body safety skills (Deblinger & Heflin, 1996).

Thirdly, the treatment model helps to explain the role of the nonoffending parents in the maintenance and treatment of their children's difficulties. Evidence (Seligman, 1991) shows that children's coping resources are significantly influenced by models of coping presented by their parents. In addition, the reaction of the nonoffending parents to their children's abuse-related problem behavior may significantly influence the improvement or exacerbation of the symptoms. The treatment, therefore, aims to teach parents effective behavioral skills for responding to their children's abuse-related disclosures and difficulties and to help parents learn more effective coping skills for managing their own distress, so they can model the skills for their children (Deblinger & Heflin, 1996).

Description of Manualized Treatment

Deblinger and Heflin's (1996) manualized treatment for TF-CBT provides 12 parallel individual sessions to children and their nonoffending parents or primary caretakers. In each session, parents and children address similar issues, with the exception of behavior management training, which is only provided to parents. The behavior management component was designed to assist parents in strengthening children's positive behaviors and minimize abuse-related difficulties. Effective parenting practices based on cognitive behavioral principles are taught and modeled by the therapist and practiced throughout treatment. The other major components in the TF-CBT protocol include: identification of feelings, stress management, cognitive coping, gradual exposure, cognitive processing, and psychoeducation (Cohen, Deblinger, & Mannarino, 2005).

The child's individual sessions are structured as follows. The initial sessions are generally devoted to building rapport with the child, completing the evaluation, and presenting assessment findings and treatment rationale. Afterward, the child's therapeutic work begins, which can be categorized into three components. The first component is coping skills training, including: emotional expression, cognitive coping skills training, and relaxation training. The second component is gradual exposure and cognitive and affective processing. The third component is education regarding child sexual abuse, healthy sexuality, and personal safety skills. The number of sessions devoted to each of these components can vary as well as the order in which they are presented to the child. Often, more than one component can be integrated into the same session. Following the completion of the therapy components, the final sessions are used to evaluate treatment progress, review skills developed, and discuss ways to continue the therapeutic process at home (Deblinger & Heflin, 1996). It should be noted that in the treatment studies (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1998; Deblinger, Lippmann & Steer, 1996) each session was devoted to a specific skill and all the therapists followed the same order (Cohen, Deblinger, & Mannarino, 2005).

The individual sessions with the parents aim to provide support, as well as provide information and skills that will assist the parents in coping with their own emotional reactions and their child's potential difficulties. Like the child intervention, the parent sessions can be categorized into three components. The initial component is coping skills training, to provide parents with skills for coping with their own thoughts and feelings. During this component, parents are often provided with educational

information about child sexual abuse. The second component is gradual exposure. This provides the parent with gradual exposure, as well as teaches the parent how to help the child with gradual exposure. Included in this component is information regarding how to present sex education and personal safety skills to the child. The third component focuses on behavior management skills that may be used to manage behavioral problems that arise, particularly any problems that may develop in response to the abuse experience. Like the child intervention, the amount of time devoted to each component and order in which it is presented should be flexible and address the needs of the parent and the child (Deblinger & Heflin, 1996).

In most cases, the culmination of treatment should include joint sessions with the child and the nonoffending parent or primary caretaker. These sessions provide an opportunity for the parent to serve as a positive role model for the child, particularly in terms of coping effectively with the sexual abuse experience. For example, parents can model how to express emotions effectively by expressing themselves verbally during the session. Similarly, they can model discussing the abuse openly in a calm manner, rather than being in distress or avoiding the topic. The sessions help the parent and child communicate about the abuse openly and prepare the parent to continue discussing it even after therapy has been terminated. The sessions also allow the child and parent to become comfortable discussing issues of healthy sexuality and personal safety skills. Prior to a joint session, the therapist must assess whether both the child and parent are ready for such a session as well as discuss and prepare both parties for such a session (Deblinger & Heflin, 1996).

CHAPTER II: LITERATURE REVIEW

Research Studies

Stauffer and Deblinger (1996) examined the impact of a cognitive behavioral group treatment approach on the adjustment of CSA victims and their nonoffending mothers. The children and their parents participated in two separate groups for 2 hour sessions for a period of 11 weeks. They were given pretreatment measures and then posttreatment measures were given at the 10th group session. The purpose of the parent group was to (a) assist parents in coping with their own emotional reactions in order to enable them to be more supportive of their children, (b) to educate parents about ways to initiate and maintain open parent-child communication regarding their child's sexually abusive experiences as well as healthy sexuality issues, and (c) to provide parents with behavior management skills to assist them in handling behavioral difficulties their children may experience as a result of the abuse. The children's group intervention also used cognitive behavioral techniques to help children develop skills and to manage children's behavior (Stauffer & Deblinger, 1996).

Parents were administered a structured interview in order to obtain demographic information, abuse characteristics, context and nature of the child's disclosure, parental reactions to the allegations, and mother's history of victimization. Additionally, parents completed the following measures: the Child Behavior Checklist (CBCL; Achenbach & Edelbrook, 1991) in order evaluate the impact of the treatment on the children's emotional and behavioral difficulties; the Child Sexual Behavior Inventory

(CSBI; Friedrich, Grambsch et al., 1992) in order to assess the impact of the treatment on the children's sexualized behavior; the Symptom Checklist 90-Revised Global Severity Index (SCL-90 GSI; Derogratis, 1983) to evaluate the mothers' self-reported level of general distress; the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979) used to evaluate the impact of the parents' group on mothers' level of distress related to their children's sexual abuse; and the Parent Practices Questionnaire (PPQ; Strayhorn & Weidman, 1988), which examined the impact of treatment on mothers' interactions with their children. Mean scores for the CBCL and the CSBI decreased from pre- to post-treatment indicating a decrease in symptomatology from pre-treatment.

Significant changes over time were noted on several of the measures utilized. Scores on the SCL-90 GSI and the IES avoidance subscale decreased significantly from pre- to post-treatment, supporting the notion that after treatment maternal distress decreases as does maternal avoidance of talking about and dealing with the child sexual abuse. Additionally, according to maternal report children's sexualized behavior decreased significantly from pre- to post-treatment and mothers felt that their parenting skills significantly increased from pre- to post-treatment. There was significant change in the IES intrusive scale as well; however, statistical analyses were unable to show that the change was a function of treatment. It is possible that decreases in maternal reports of intrusive thoughts may be a function of time elapsed since disclosure of the abuse and not due to treatment alone (Stauffer & Deblinger, 1996).

The results of this study suggest that cognitive behavioral group interventions may be effective in decreasing symptomatology exhibited by sexually abused children

and their nonoffending mothers. Furthermore, the interventions were perceived by the patients as highly satisfactory. In addition, the parent intervention seemed to be effective in assisting nonoffending mothers to improve their self-reported parenting practices. The significant results indicate that nonoffending mothers were reporting lower levels of general distress, less avoidance of abuse-related thoughts and feelings, and more appropriate responses to their children's behaviors and abuse-related issues following participation in the group program. These maternal changes may also have an important impact on the child's adjustment. When nonoffending mothers are less distressed, they may be better able to respond appropriately to their children's needs and difficulties. Additionally, the less avoidant they are, the more they can assist their children in coping with the confusing, often traumatic, experience of sexual abuse (Stauffer & Deblinger, 1996). Furthermore, maternal support and emotional distress have not only been linked to children's and parents' postabuse symptomatology, but also to children's response to treatment, with higher levels of support and lower levels of maternal distress predicting a more positive response to treatment by children (Cohen & Mannarino, 1996a, 1998; Friedrich, Lueke et al., 1992).

Deblinger, Steer, and Lippmann (1999) examined whether the effects of a cognitive behavioral treatment for CSA and their nonoffending parents were sustained over a 2 year period of time. They examined whether pre- to post-treatment gains that had been found by Deblinger, Lippmannn, and Steer (1996), in a sample of 100 sexually abused children, would be sustained 2 years after treatment. Sexually abused children and their nonoffending mothers were randomly assigned to one of four conditions: a child