Treatment of Children Who Have Suffered Sexual Abuse and Other Traumas: Lessons Learned
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Literature Review

- Psychiatric Difficulties
- Substance Abuse
- Risky Sexual Behaviors
- Interpersonal Difficulties
- Re-victimization and/or Violent Behavior
- Suicide Risk

Most Common Diagnosis
Among Children Who Have Experienced Child Sexual Abuse

PTSD symptoms specific to a history of child sexual abuse


Literature Review – Nonoffending mothers

- Clinical literature very harsh
- Characterizing mothers in negative light
- Holding mothers responsible for incestuous abuse

“Unconscious homosexuality may well characterize these mothers”  
(1966)
“The mother seems to experience no guilt during or after the discovery of the incestuous relationship since the relationship is structured by her and continues with her collusion to satisfy her own unmet dependency needs” (1975)

“Whatever justification for physical absence, however, the effect is the same with respect to the incestuous relationship: mother manages to avoid setting limits for others and fails to fulfill her own role responsibilities by being elsewhere” (1982)

MOTHER-BLAMING IN MAJOR CLINICAL JOURNALS
Paula J. Caplan, Ph.D., and Ian McConnochie, B.Sc.
Ontario Institute for Studies in Education, Toronto

The incidence of mother-blaming in major clinical journals was investigated for the years 1970, 1976, and 1982 to determine whether reductions have resulted from the efforts of the women’s movement. Very few changes were found across the target years, and mother-blaming was only slightly affected by type of journal and by sex of author.
Understanding the Nonoffending Mothers


Literature Review
Treatment of Child Sexual Abuse

- Descriptive clinical literature existed
- In 1987, no empirically based literature on treating children who suffered CSA existed
Lessons learned

- Nonoffending mothers are often victims of domestic violence themselves and need a great deal of non-judgmental support.
- PTSD and age inappropriate sexual behaviors are important targets of treatment.

Developing evidence based treatment for children who suffered sexual abuse

- Reviewed the adult treatment literature.
- Modeled treatment for children on empirically based treatment designed for adult rape victims.
- Significant treatment modifications to address developmental differences and parent involvement.

Empirical Support for TF-CBT: Pre-post findings

Empirical Support: Randomized Controlled Trials


Lessons learned........

- TF-CBT showed greater benefits to preschool and school age children in overcoming PTSD, depression, sexual and general behavior problems as compared to passage of time, nondirective, community txs
- Parent involvement as well as behavior rehearsal and homework improved children's acquisition of personal safety skills (Deblinger, et al., 2001)
- Parental levels of distress and support influence children's overall outcomes (Cohen & Mannarino, 1996; 1997)
- Parental participation critical to helping children overcome depression and behavior problems (Deblinger, et al., 1996)

Follow-up and replication studies


Lessons learned...

- Symptoms improvements maintained over one and two year follow up periods (Deblinger, et al., 1999; Cohen & Mannarino, 1996; 1997)
- Findings were replicated and generalized across racial, ethnic, and geographic boundaries (King et al., 2000)

A Multisite Randomized Controlled Trial For Sexually Abused Children With PTSD Symptoms (2004).

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Design

- Multisite randomized controlled treatment trial
- Sexually abused children 8-14 yo and their non-offending parents/primary caretakers
- Had to have ≥ 5 PTSD sx., ≥ 1 in each cluster (89% met full diagnostic criteria)
- 12 individual treatment sessions
- Rigorous training, supervision and adherence monitoring
- Pretreatment, posttreatment, 6- and 12-month follow-up assessments
Treatment

SUPPORTIVE CHILD-CENTERED THERAPY (CCT)
- Rogerian, supportive empowerment model
- Representative of a commonly provided treatment in our communities
- Content and pace of treatment direct by parent/child, not therapist
- Active listening, accurate empathy, unconditional positive regard, interpretation of feelings
- Therapist asks about sexual abuse at specified points but child/parent decide how, whether and when to discuss sexual abuse.

Treatment (Cont’d)

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY (TFCBT)
- Trauma sensitive cognitive behavioral model
- Modified version of evidence based model used with adults
- Content and pace directed by therapist, in context of a collaborative therapeutic relationship
- Therapist structures sessions such that there is a focus on skill building and direct discussion and processing of the abuse experience

Subjects

- 229 sexually abused 8-14 yo children and parents (203 completed >3 sessions)
- 79% female, 21% male, mean age 10.76 years
- 60% Caucasian, 28% African American, 4% Hispanic American, 7% Biracial, 1% Other
Multiple Traumas (Mean = 3.6 Types)

- 100% sexually abused
- 70% received traumatic news (e.g., sudden death of family member)
- 58% domestic violence
- 37% serious accident
- 26% physical abuse
- 17% community violence
- 13% fire/natural disaster
- 25% other PTSD-level traumas

Lessons learned......

- Both TF-CBT and CCT produce significant improvements
- TF-CBT more effective than CCT in helping parents overcome depression and abuse specific distress (Cohen, et al., 2004)
- TF-CBT more effective than CCT in helping children overcome feelings of PTSD, depression, behavior problems, shame and dysfunctional attributions (Cohen, et al., 2004)
- At 1 year follow up TF-CBT preferable over CCT in treating PTSD and shame and for children with higher levels of depression and multiple traumas (Deblinger, et al., 2006)
- TF-CBT appears to be effective with children who have suffered other forms of trauma including traumatic grief (Cohen et al., 2004, 2006) and children exposed to domestic violence (Cohen et al., randomized trial underway)

National Registry of Effective Programs & Practices (NREPP)

U. S. Department of Health and Human Services - SAMHSA
A Learning Resource for TF-CBT

TF-CBTWeb

Access at:
www.musc.edu/tfcbt

TF-CBTWeb Learners
- 12,000 registered learners
- New registrations average ~30/day
- Over 4,000 learners have completed the course
- Social workers, professional counselors and psychologists comprised 88% of learners
- Most learners take 12 days to complete course
- Learners come from every state in the U.S.
- Learners from 60 countries outside the U.S.

TF-CBT is based on art and science
- Adaptable and flexible
  (to address developmental, gender, initial presentation)
- Respectful of cultural, family values
- Therapeutic relationship is central
Encourage humor and fun!

In laughter there is always a kind of joyousness that is incompatible with contempt and indignation.

Voltaire

A good time to smile is any time you can.

Breast Cancer Survivor

If you’re not laughing – you’re not doing it right!

Barbara Bonner (2005)

Importance of Strong “Therapy” Skills

- Centrality of therapeutic relationship
- Establish a collaborative relationship with clients
- Importance of therapist judgment, skill, humor, and creativity in implementing TF-CBT

Applying Proven Treatments in “Real Life”

- First things first
- Provide crisis response (usually for parents)
- Know what your setting can do
- Triage for priority focus
  - Basic needs (e.g., place to live)
  - Response to system activities (e.g., placement, legal processes)
  - Psychiatric emergencies/active substance abuse
  - Acting out and sexual behavior problems
PRACTICE components
- P sychoeducation and parenting skills
- R elaxation
- Affective expression and regulation
- C ognitive coping
- T rauma narrative development & processing
- I n vivo gradual exposure
- C onjoint parent child sessions
- E nhancing safety and future development

TF-CBT Sessions Flow

- Entire process is gradual exposure

1/3 1/3 1/3

Sessions 1 - 4
- Psychoeducation
- Parenting Skills
- Relaxation
- Affective Expression and Regulation
- Cognitive Coping

Sessions 5 - 8
- Trauma Narrative Development and Processing
- In vivo Gradual Exposure

Sessions 9 - 12
- Conjoint Parent Child Sessions
- Enhancing Safety and Future Development

Trauma focused Cognitive Behavioral Therapy – TF-CBT

Child’s Treatment
- Education
- Skill Building
- Exposure/Processing
- Preparation for Joint Sessions

Parent’s Treatment
- Education
- Skill Building
- Exposure/Processing
- Behavior Management
- Preparation for Joint Sessions

Joint Sessions

Family Sessions

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Specifcs of Treatment

- Individual sessions for both child and caregiver
- Caregiver sessions - generally parallel child sessions
- Same therapist for both child and caregiver
- Joint caregiver-child sessions

Developing the Treatment Plan

- Individually tailor treatment to family presentation
- Utilize PRACTICE components with both children and parents
- Link treatment to assessment findings
- Order and time devoted to each PRACTICE component will reflect the needs of individual child and family

The world is changed one person at a time.
-Maya Angelou