

HEALING ACROSS BORDERS: GLOBAL TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY INTERVENTIONS FOR CHILD SEXUAL ABUSE VICTIMS



JULY 2014

BY: EMILY BOWEN



Healing Across Borders: Global Trauma-Focused Cognitive Behavioral Therapy Interventions
for Child Sexual Abuse Victims

Copyright © 2014, International Centre for Missing & Exploited Children.

ABOUT US

The International Centre for Missing & Exploited Children (ICMEC) is leading a global movement to protect children from sexual abuse, exploitation and abduction. ICMEC's work brings promise to children and families by: establishing global resources to find missing children and prevent child sexual exploitation; promoting the creation of national operational centers based on a public-private partnership model; building an international network to disseminate images of and information about missing children; providing training to law enforcement, prosecutors, judges, legal professionals, non-governmental organizations, and government officials; advocating and proposing changes in laws, treaties, and systems to protect children worldwide; conducting international expert conferences to build awareness, encourage and increase cooperation and collaboration between and among countries; and leading a global financial coalition to eradicate commercial child pornography from the Internet.

The Koons Family Institute on International Law & Policy (The Koons Family Institute) is the in-house research arm of ICMEC. The Koons Family Institute conducts and commissions original research into the status of child sexual exploitation and child protection legislation around the world and collaborates with other partners in the field to identify and measure threats to children and ways ICMEC can advocate change to help make children safer. The Koons Family Institute works to combat child abduction and child sexual exploitation on multiple fronts: by creating replicable legal tools, building international coalitions, bringing together great thinkers and opinion leaders, and creating best practices on training and the use of technology.

TABLE OF CONTENTS

Table of Contents	i
Acknowledgements	ii
Acronyms	iii
Abstract	v
Introduction: Child Sexual Abuse on a Global Scale	1
Methodology	6
Trauma-Focused Cognitive Behavior Therapy: A World View	7
Canada	7
Norway	8
Singapore	10
Tanzania	11
TF - CBT Replication	14
Conclusion	18

ACKNOWLEDGMENTS

We wish to thank the following organizations and individuals for their outstanding assistance and guidance on this project:

- ❖ Emily Bowen, *Research Intern, International Centre for Missing & Exploited Children, Spring 2013, Master Graduate of Harvard University.*

- ❖ Staff of the International Centre for Missing & Exploited Children, in particular: Caroline Humer, *Program Director*; Sandra S. Marchenko, *Director, The Koons Family Institute on International Law & Policy*; and Naomi Van Treuren, *Program Coordinator, The Koons Family Institute on International Law & Policy.*

Points of view and opinions presented in this publication are those of the author and do not necessarily represent the views of the International Centre for Missing & Exploited Children.

ACRONYMS

ACE – Adverse Childhood Experience

CASAT – Central Agencies Sexual Abuse Treatment

CSA – Child Sexual Abuse

GB-CBT – Game-Based Cognitive Behavioral Group Therapy

PTSD – Post-Traumatic Stress Syndrome

DSM – U.S. Diagnostic Statistical Manual

TF-CBT – Trauma-Focused Cognitive Behavioral Therapy

TAU – Treatment As Usual

During therapy treatment various child measures are used to help with the diagnosis. Below some of the methods are described that are used in the countries that are highlighted in this report.

Child PTSD Symptom Scale (CPSS) – This self-report measure assesses the frequency of all DSM-IV-defined PTSD symptoms and was also designed to assess PTSD diagnosis.

Clinician-Administered PTSD Scale (CAPS) – The CAPS is the gold standard in PTSD assessment. The CAPS-5 is a 30-item structured interview that can be used to: Make current (past month) diagnosis of PTSD; make lifetime diagnosis of PTSD; and assess PTSD symptoms over the past week.

Screen of Child Anxiety Related Disorders (SCARED) – The SCARED is a child and parent self-report instrument used to screen for childhood anxiety disorders, including general anxiety disorder, separation anxiety disorder, panic disorder, and social phobia.

Child Post-Traumatic Cognitions Inventory (CPTCI) – It measures the level of agreement with 25 trauma- and symptom-related appraisals. There are two subscales: “permanent and disturbing change” (items 4, 6, 8, 13, 14, 16, 17, 19, 20, 22, 23, 24); and “fragile person in a scary world” (items 1, 2, 3, 5, 7, 9, 10, 11, 12, 15, 18, 25).

Strengths and Difficulties Questionnaire (SDQ) – The SDQ is a brief child mental health questionnaire for children and adolescents ages 2 through 17 years old, developed by the UK child psychiatrist Robert N Goodman.

Mood and Feelings Questionnaire (MFQ) – The MFQ consists of a series of descriptive phrases regarding how the subject has been feeling or acting recently.

Quality of Life Questionnaire – The questionnaire called CAMPHOR is handed out at clinics and at hospital admission. It consists of questions about how a patient’s breathing has been and how they are feeling.

Therapeutic Alliance Questionnaire – The scale requires the participants to estimate the degree to which the therapeutic alliance with their therapist was helpful.

ABSTRACT

Child sexual abuse (CSA) is a form of childhood trauma that can produce symptoms of post-traumatic stress disorder (PTSD) and potentially lifelong debilitating effects for its victims. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been used and has proved to be an effective form of therapy for CSA victims around the world due to its short-term, goal-oriented, and often group-focused empowerment model. This paper reviewed several implementations of TF-CBT for CSA victims to discern the effectiveness of this therapy in different cultural settings and resource levels. The results indicate that CSA victims who undergo TF-CBT treatment tend to experience fewer PTSD symptoms but that this success is contingent upon several conditions of implementation being met, such as clinician training, commitment to the basic treatment plan, and participation of a parent or adult caregiver. In reviewing strategies for replicating TF-CBT programs in different cultural settings, the results indicated that successful treatments for CSA victims will involve trained, trustworthy clinicians using an apprenticeship model and partnerships with established organizations such as universities and non-governmental organizations, as well as replication strategies, to overcome potential implementation barriers.

INTRODUCTION: CHILD SEXUAL ABUSE ON A GLOBAL SCALE

Child sexual abuse (CSA) is a crime that knows no national border, impacting innocent victims in every country around the world. While the definition of CSA is widely debated, for the purpose of this report, the World Health Organization's (WHO) definition is used, which is "unwanted and inappropriate sexual solicitation of, or exposure to, a child by an older person; genital touching or fondling; or penetration in terms of oral, anal or vaginal intercourse or attempted intercourse."¹

CSA is committed without the consent of a child, sometimes occurs unexpectedly, and can occur in a single event or over the course of many years and therefore may not be fully comprehended by the victim.² Perpetrators can be anyone from a family member, a trusted older figure outside of the child's home, or a stranger. However, the majority of CSA victims know the perpetrators, with one third being family members.³ Because of its widely debated definition, CSA prevalence has been challenging to determine. For example, a national Norwegian survey on CSA prevalence indicated that rates were between 2.8% and 22% depending on the definition.⁴ In spite of this barrier, a 2011 study estimated that global incidence of CSA was around 11.8%⁵, and the Adverse Childhood Experience (ACE) Study, performed by the U.S. Centers for Disease Control and Prevention (CDC), found that 28% percent of women and 16 % of men will be sexually abused before they turn 18.⁶

CSA is considered a criminal act in many countries including Canada, India, the United Kingdom and the United States; however, there are still several nations that have yet to include

¹ Gavin Andrews et al., *Child Sexual Abuse*, 2 COMPARATIVE QUANTIFICATION OF HEALTH RISKS: GLOBAL AND REGIONAL BURDEN OF DISEASE ATTRIBUTABLE TO SELECTED MAJOR RISK FACTORS, WORLD HEALTH ORGANIZATION, at 1851 (2004), <http://www.who.int/publications/cra/chapters/volume2/1851-1940.pdf> (last visited Feb. 18, 2014).

² WORLD HEALTH ORGANIZATION, *Child Sexual Abuse: A Silent Health Emergency*, 2004, <http://apps.who.int/iris/bitstream/10665/1878/1/AFR.RC54.15%20Rev.1.pdf> (last visited Feb. 18, 2014); Macdonald et al., *Cognitive-behavioral interventions for children who have been sexually abuse*, CAMPBELL SYSTEMATIC REVIEWS, 14 (2012 ed.).

³ Macdonald et al., *Cognitive-behavioral interventions for children who have been sexually abuse*, CAMPBELL SYSTEMATIC REVIEWS, at 10 (2012 ed.).

⁴ *Trauma-focused cognitive-behavioural therapy for children: a study of process and outcome*, NASJONALT KUNNSKAPSSENTER OM VOLD OG TRAUMATISK STRESS, at 3, http://www.nkvt.no/fu/documents/tfcbt_prosjektskisse.pdf (last visited May 18, 2014).

⁵ Mariji Soltenborgh et al., *A Global Perspective on Child Sexual Abuse*, 16 J. OF CHILD MALTREATMENT 79, 87 (2011).

⁶ Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults*, 14 AM. J. OF PREVENTATIVE MEDICINE 245, 256 (1998).

a specific provision on CSA offenses in their legislation. While the U.S. first passed CSA legislation in 1973, other countries have adopted laws against CSA only recently. For example, India passed its Protection of Children Against Sexual Offences Act in 2012⁷ and the United Kingdom included definitions of child sexual abuse offenses in its Sexual Offences Act of 2003. Other countries, such as Syria or Yemen, have yet to pass any legislation criminalizing child sexual abuse as shown in reports issued in 2014 by the United Nations (UN) that detailed government-sanctioned detainment and sexual abuse of children in these two countries.⁸ CSA is culturally sanctioned in several African and Caribbean countries where child victims have far fewer rights and the age of consent for sexual activity is much lower than in Europe or the United States.⁹ For example, in Jamaica, male perpetrators of CSA often believe they have the right to engage in sexual acts with girls in their care.¹⁰ In addition, many countries focus on female CSA victims, despite the fact that male CSA victims are also common. Cases of male CSA victims are often underreported, and in several countries such cases are not considered as crimes.

The effects of CSA have been widely documented through numerous studies and victim accounts, but the impact on the victims varies depending on several factors including the child's age, socioeconomic status, frequency, duration, and severity of the abuse, and the relationship of the perpetrator to the child.¹¹ Many child victims suffer deteriorating mental health symptoms including anxiety, depression, behavioral issues, sexualized behavior, and other symptoms commonly associated with post-traumatic stress disorder (PTSD).¹² *Table 1* provides a more comprehensive view of the impact of CSA and demonstrates the length of time the symptoms can last following the abuse incident, especially if left untreated. The U.S. Diagnostic Statistical Manual (DSM) V divides sexual abuse-related PTSD symptoms into four clusters: 1) re-experiencing (i.e., spontaneous memories or recurring dreams of abuse), 2) avoidance (i.e.,

⁷ *Tough law on sexual offences against children comes into force*, THE HINDU, Nov. 15, 2012, <http://www.thehindu.com/news/national/tough-law-on-sexual-offences-against-children-comes-into-force/article4095666.ece> (last visited 18 February 2014).

⁸ *Yemen*, BUREAU OF DEMOCRACY, HUMAN RIGHTS, AND LABOR, <http://www.state.gov/j/drl/rls/hrrpt/2007/100610.htm> (last visited July 8, 2014); Somini Sengupta, *U.N. Report Details Abuse of Children in Syrian War*, N.Y. TIMES, Feb. 4, 2014, http://www.nytimes.com/2014/02/05/world/middleeast/at-least-10000-children-killed-in-syria-un-estimates.html?_r=0.

⁹ Andrews, *supra* note 1.

¹⁰ Tamar Hahn, *Fighting child sexual abuse in the Caribbean*, UNICEF, May 18, 2012, http://www.unicef.org/infobycountry/jamaica_62479.html (last visited Feb. 19, 2014).

¹¹ Macdonald, *supra* note 3, at 11.

¹² Judith A. Cohen et al., *A multi-site, randomized controlled trial for children with abuse-related PTSD symptoms*, 43 J. OF AM. ACADEMY OF CHILD ADOLESCENT PSYCHIATRY 393 (2004).

distressing memories, thoughts, or feelings of the abuse), 3) negative cognitions (i.e., self-blame, estrangement from others, reduced interest in activities, memory loss), and 4) hyper-arousal (i.e., aggressive, reckless, or self-destructive behavior).¹³

Table 1. CSA-related Symptoms	
Acting Out	Poor coping skills, substance abuse, tobacco use, overeating, addiction, lying/stealing, poor academic performance, expectation of early death, poor adherence to medical treatment, suicide, anger, prostitution, increased risk of sex crimes
Relationship Problems	Increased risk of intimate partner violence, low self-esteem, intimate relationship problems, divorce, interpersonal problems, victim-perpetrator cycle, superficial idealization of sexual relationships, lack of trust
Somatic Symptoms	Increased sensitivity in the pelvic or abdominal region, various bowel symptoms, musculoskeletal disorders, back pain, severe headaches, gastrointestinal problems, sleep disorders, asthma, pseudocyesis
Sexual Disorders	STIs, compulsive sexual behaviors, early sexual activity, extreme masturbation, sexual promiscuity, poor sexual adjustment, poor contraceptive use, teen pregnancy
Functional Amnesia/Dissociative Disorders	Can develop after severe trauma, especially among children experiencing severe sexual trauma or in those aged 5 years or younger. If the abuse occurred in middle childhood, ages 6-12, the victim may: 1) develop false memories that the abuse ever occurred; 2) be in denial; or 3) be unaware that the type of experience was determined to be CSA
<i>Source: County of Los Angeles Public Health Newsletter in Medical Professions in Los Angeles County, 2009.</i>	

While there are several methods of treatment for CSA victims, one evidence-based method that has demonstrated success with child sexual abuse victims is Trauma-Focused Cognitive Behavior Therapy (TF-CBT). Originally developed in the 1980s to treat children exposed to traumatic events, TF-CBT is a short-term therapy intervention with 12-15 sessions that “integrates cognitive, behavioural, interpersonal, and family therapy principles with trauma

¹³ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed.) (2013).

interventions...that specifically target PTSD symptoms.”¹⁴ TF-CBT can be completed with the victim (adult or child), the child victim and his or her parent(s)/caregivers, or just the victim’s parents(s). Over the years, this treatment method has been used specifically to treat CSA victims. In addition, a form of TF-CBT is now being used to treat CSA perpetrators as a means to stem the incidence of CSA, as well as reduce recidivism.¹⁵

Over the course of TF-CBT sessions, the clinician can help a CSA victim establish a “trauma narrative,” the re-creation of the victim’s trauma experience through words, pictures, and/or music in books written and/or illustrated by the victims, which enables the clinician to discern any cognitive distortions (an irrational thought pattern) and assist the victim in overpowering these traumatic reminders.¹⁶ While quite structured, TF-CBT does allow clinicians flexibility in tailoring treatment (i.e., number of sessions; group or individual sessions) to the needs of the victims and their families and determining how and when the trauma narrative is created. Specific skills built through TF-CBT include building social-emotional and coping skills; learning to identify the connections between thoughts, feelings, and behaviors; processing traumatic experiences; and psycho-education on abuse and body awareness, as well as safety training.¹⁷

The parenting aspect of TF-CBT seeks to equip the victim’s parents with increased support and evidence-based tools to support their children. Joint parent-child sessions tend to focus on communication, personal safety training, and a conversation about the child victim’s trauma narrative.¹⁸ TF-CBT can also be implemented within group sessions with multiple victims and their caregivers working together with a clinician to discuss their experience and leverage group support to minimize symptoms.

There have been several studies over the past 20 years regarding the effectiveness of TF-CBT for CSA victims. The results overwhelmingly indicate that victims who undergo TF-CBT and similar therapies are more likely to decrease PTSD symptoms.¹⁹ However, most of the studies

¹⁴ *Trauma-focused cognitive-behavioural therapy for children: a study of process and outcome*, supra note 4, at 3.

¹⁵ See DUNKELFELD PROJECT, <https://www.dont-offend.org/> (last visited May 20, 2014).

¹⁶ *Creating a Trauma Narrative*, SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION, http://www.samhsa.gov/samhsanewsletter/Volume_18_Number_4/TraumaNarrative.aspx (last visited May 18, 2014).

¹⁷ Esther Deblinger et al., *Trauma-Focused Cognitive Behavioral Therapy for Children: Impact of the Trauma Narrative and Treatment Length*, 28 DEPRESSION AND ANXIETY 67, 69 (2011).

¹⁸ *Id.* at 69.

¹⁹ *Ibid.*

regarding TF-CBT treatment of CSA victims have been done in the United States in a non-clinical setting, and not studied in conjunction with cases of no treatment or other therapeutic treatment methods.²⁰ Therefore, it is difficult to empirically state how TF-CBT improves the experience of CSA victims outside of an American clinical setting. However, despite the lack of empirical international evidence, several global implementations of TF-CBT have indicated preliminary success.

The objective of this report is to look beyond the scope of U.S. research and mental health practice to examine several iterations of TF-CBT treatments for CSA victims in different cultural settings around the world (Canada, Norway, Singapore, and Tanzania). In light of the examples presented, the goal is to offer guidance on how to replicate successful TF-CBT programs in settings that may have cultural differences as well as geographic and resource barriers.

²⁰ *Trauma-focused cognitive-behavioural therapy for children: a study of process and outcome*, *supra* note 4, at 3.

METHODOLOGY

Information was gathered over a four-week period in the Spring of 2014 from online databases, reference lists, and specialized journals. Online databases such as ERIC, PsychINFO, and ScienceDirect were searched using key search terms related to CSA and TF-CBT. In addition, specific journals – *Child Abuse & Neglect*, *Child Maltreatment*, and *Journal of Child Sexual Abuse* – were used to inform the analysis presented in this paper. Studies were considered if they contained the following criteria:

- Any study that examined CSA victims (with a particular focus on research outside of the United States);
- Any study that examined TF-CBT treatment of CSA victims;
- Any study published in the last 25 years; and
- Meta-analyses of original search results.

The initial sample included approximately 31 articles. Due to time restrictions, the author was unable to conduct a more extensive search. In addition, due to the lack of research on TF-CBT for CSA victims in a global context, many of the studies referenced focused on programs in the United States and many of the reviewed international studies were unfinished at the time of compiling and writing this report and focused not only on CSA, but on child trauma in general. This paper will also enumerate how the popular therapy translates in a variety of cultural settings with differing levels of resources. While no Canadian study of TF-CBT intervention for CSA victims could be found, the author of this paper believes that the referenced Canadian program is an important aspect in the report.

TRAUMA-FOCUSED COGNITIVE BEHAVIOR THERAPY: A WORLD VIEW

TF-CBT treatment for CSA victims has been proven to successfully minimize PTSD symptoms and other evidence of abuse impact. The overwhelmingly positive results of this treatment method have caught the eye of many, prompting universities and governments to attempt their own execution of TF-CBT in areas of the world where CSA is highly prevalent. Because CSA knows no national borders, the American Psychological Society has called for more evidence-based mental health treatments for CSA victims that meet the needs of more culturally, ethnically, and socioeconomically diverse groups.²¹

Canada

The Central Agencies Sexual Abuse Treatment (CASAT) in Toronto, Ontario is an innovative consortium of more than 30 agencies that provides evidence-based services for children and youth (ages 4 to 18) and families impacted by the trauma of sexual abuse. CASAT is described as a “city-wide initiative to further the goal of providing collaborative, comprehensive, coordinated, specialized and responsive services to children and their families in Toronto.”²² CASAT organizations include children and youth service organizations, hospitals, women’s health care centers, the Toronto District School Board, and the YWCA of Greater Toronto. Clinicians employed by CASAT utilize TF-CBT, which many learned via a free web-based training from the Medical University of South Carolina, which was introduced to accommodate the individual schedules and learning paces of CASAT mental health professionals.²³

In order to educate parents and caregivers about how to cope with the aftermath of CSA and the treatment options for their children, CASAT created a handbook that defines CSA in English, Mandarin, Punjabi, and Spanish. The comprehensive handbook explains the signs to identify child abuse, the proper caregiver response including maintaining control of their emotions, the legal process for reporting CSA, the investigation (including forensic interviewing) and potential court proceedings, and the available treatment options for child

²¹ Justin R. Misurell & Craig Springer, *Developing Culturally Responsive Evidence-Based Practice: A Game-Based Group Therapy Program for Child Sexual Abuse (CSA)*, 22 J. OF CHILD AND FAMILY STUDIES 137 (2013).

²² *Central Agencies Sexual Abuse Treatment (CASAT)*, CHILD DEV. INST., <http://www.childdevelop.ca/programs/family-violence-services/central-agencies-sexual-abuse-treatment-casat> (last visited Mar. 14, 2014).

²³ TF-CBT WEB: A WEB-BASED LEARNING COURSE FOR TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY, <http://tfcbt.musc.edu/> (last visited Mar. 12, 2014).

victims and their families.²⁴ The handbook explains that, under the provincial law, the Child and Family Act of Ontario of 1990, a child is defined as a person between the ages 0-16, and that any person who suspects child abuse should report the evidence of abuse to a Children's Aid Society office.²⁵ Canadian individuals who work with children are mandated to report abuse or be fined up to \$1,000.

In its recommendation of treatment for CSA victims, CASAT proposes the use of TF-CBT, describing it as "abuse-focused assessment."²⁶ In outlining therapy options, CASAT unpacks TF-CBT by using less clinical terms for caregivers of differing education backgrounds. They describe individual, group, and family therapy options. For example, for group therapy, CASAT describes this option as allowing "the participant to explore issues, share information, and learn from a small group of people with similar experiences," while family therapy is described as assisting family members in understanding and coping with the abuse, with a note that "careful consideration" must be given as to whether or not to include the offender if he or she is a family member.²⁷

Norway

Established in 2004 at the University of Oslo, the Norwegian Centre for Violence and Traumatic Stress is a research and development organization that studies violence and trauma in relation to both children and adults. The Centre was established with support from the Norwegian Ministries of Health and Care Services, Defense, Labour and Social Inclusion, Justice and the Police, and Children and Equality.²⁸ Much of the Centre's work has focused on CSA and possible treatment therapies. In 2013, the Centre published research that measured the effectiveness of TF-CBT in comparison with Treatment As Usual (TAU) in regular clinics for traumatized children (while they were not purely CSA victims, the non-American application of TF-CBT is worth noting).²⁹ The random control study was implemented from 2008 to 2011 in a

²⁴ Loree Beniuk & Pearl Rimer, *Understanding Child Sexual Abuse: A Guide for Parents & Caregivers*, Central Agencies Sexual Abuse Treatment Program (2006), at <http://www.childdevelop.ca/sites/default/files/files/Understanding-Child-Sexual-Abuse.pdf> (last visited Mar. 12, 2014).

²⁵ Child and Family Services Act R.S.O. 1990, Chapter 5, amended 1994-95, c. 7, ss. 11-15, 150; 1996, c. 10; 1996, c. 3, ss. 37, 38; 2001, c. 3, s. 4; 2002, c. 5, ss. 2, 3; 2005, c. 15; 2008, c. 12 (Can.).

²⁶ Beniuk & Rimer, *supra* note 24, at 43.

²⁷ *Id.* at 44.

²⁸ Organization, NORWEGIAN CENTRE FOR VIOLENCE AND TRAUMATIC STRESS, <http://www.nkvts.no/en/Pages/Aboutthecentre.aspx> (last visited July 9, 2014).

²⁹ Tine K. Jensen et al., *A Randomized Effectiveness Study Comparing Trauma-Focused Cognitive Behavioral Therapy With Treatment as Usual for Youth*, 43 J. OF CLINICAL AND CHILD & ADOLESCENT Psychology 356 (2013).

clinical setting with 71 therapists (84.5% female) from eight different Norwegian community mental health clinics. The TF-CBT therapists ($n=26$) had completed TF-CBT training, like CASAT, from the Medical University of South Carolina web-based TF-CBT model and learning course.³⁰ In addition to using the online version of TF-CBT training, the Norwegian therapists were continually supervised and underwent training with American mental health practitioners and researchers, Dr. Judith A. Cohen and Dr. Anthony P. Mannarino – authors of the online TF-CBT training module and leaders in the field of child traumatic stress for almost 30 years. The majority (80.8%) of the therapists in this Norwegian study were psychologists; 66.7% described their theoretical orientation as cognitive-behavioral, and their average experience level was 12.5 years.³¹

Through normal referral procedures, victims aged 10 to 18 were recruited until the sample size reached 156 cases (M age=15.1 years, 79.5% female), which were divided evenly into TF-CBT and regular treatment groups. The study consisted of normal therapy procedures with a pre-treatment assessment where victims were selected based on having experienced at least one traumatic event (which was assessed with an adapted version of the Traumatic Events Screening Inventory for Children) and presenting with PTSD symptoms (victims with severe psychosis, suicidal behavior, and mental retardation were excluded for the purposes of the study).³² Selected victims were randomly assigned to TF-CBT or TAU groups and the trained clinicians continued to perform computer-assisted mental health assessments. After the sixth session of therapy (or after the fifteenth session for those that lasted less than 15 minutes), symptoms were reassessed to see if any changes had occurred in the victims. At the end of therapy (15 sessions), post-treatment assessments were taken for both groups; one year later, in 2012, further post-treatment assessments were made, and another round was made 3 years later in 2014. Around 28% of the victims ($n=43$) had experienced sexual abuse outside of their family and about 8% ($n=12$) had experienced sexual abuse within their family.³³ Child measures used the Child PTSD Symptom Scale, the Clinician-Administered PTSD Scale, the Screen of Child Anxiety Related Disorders, the Child Post-Traumatic Cognitions Inventory, the Strengths and Difficulties Questionnaire, the Mood and Feelings Questionnaire, the Quality of Life Questionnaire, and the Therapeutic Alliance Scale. In addition, other measures were used for

³⁰ Jensen, *supra* note 29, at 360.

³¹ *Id.*

³² *Id.* at 358.

³³ *Id.* at 359.

the victim's parents to assess the presence of any PTSD symptoms, as well as other behavioral and emotional issues.

Of the 156 victims, 122 completed the entire study, and the results demonstrated that the victims receiving TF-CBT reported lower levels of PTSD symptoms, depression, and overall mental health symptoms than those receiving TAU.³⁴ The study suggests that TF-CBT has proven to be successful in treating children with complex trauma, including CSA, with a wide range of symptoms. The results highlight the first successful randomized study of this kind of treatment in a clinical setting outside of the United States, implying that TF-CBT can be implemented in other countries around the world.

Singapore

A 2012 UNICEF report cited that approximately 16% of Singaporean children have experienced sexual abuse.³⁵ That same year, the Singaporean Ministry of Social and Family Development implemented a pilot study of TF-CBT for CSA victims to determine if the treatment can effectively be administered to a culturally diverse group of CSA victims.³⁶ Like previous studies, the investigators hypothesized that CSA victims receiving TF-CBT would exhibit significantly reduced PTSD symptoms. The small study sample ($n=22$) from Child Protective Services consisted of children who had experienced physical, sexual, and/or emotional abuse, scoring at least a 25 on the UCLA PTSD Index. 82% of the sample was female, 55% were of Chinese origin, and 41% Malaysian. 59% were 8-12 years of age and 41% were 13-16 years of age. 46% had eight or more prior traumas and 59% of the prior traumas were sexual abuse.³⁷

The therapies were free, held in non-Child Protective Services sites, and held weekly or bi-weekly, depending on the needs of the victims. Thirteen of the 22 victims completed all of their therapy sessions, and 85% of these victims demonstrated a reduction in PTSD symptoms while 54% reported a decrease in depression symptoms. The reported effect on overall behavioral and emotional problems was less, which may have been due to the unstable care environments in which some of the victims lived, as well as the complex nature of their abuse cases. Research

³⁴ Jensen, *supra* note 29, at 363.

³⁵ *Child Maltreatment: Prevalence, Incidence and Consequences in the East Asia and Pacific Region*, UNICEF, at 54 (2012), http://www.unicef.org/eapro/Child_Maltreatment.pdf (last visited Feb. 21, 2014).

³⁶ Li-Jen Tan et al., *Trauma Focused CBT in Asia: A Pilot Study with High-Needs and Severely Traumatized Child Welfare Clientele (preliminary findings)*, ITSS Annual Meeting, Nov. 2012, Singapore Ministry of Social and Family Development.

³⁷ Tan, *supra* note 36.

has indicated that children, especially orphans, with increased social support have fewer symptoms of PTSD.³⁸

Success in this program included the proper training of clinicians to effectively assist victims in comprehending the TF-CBT components, participating in the session activities, and establishing trauma narratives. The six clinicians who administered the TF-CBT in the study attended a 3-day training to prepare. Some of the newer therapists struggled with the more complex abuse cases. Clinicians reported that minimal cross-cultural adjustments to the TF-CBT program were needed, even though the group was diverse. Reported challenges included inconsistent parent/caregiver involvement with the victims' therapies (82% of the sample were living in out-of-home placements and had parents who were resistant or uninvolved). It took participants an average of 19.92 sessions (versus the typical 12-15) to complete the program, and only 59% were able to do so, a fact that may have been influenced by the complex abuse cases and unstable living environments of many of the victims which was not supportive of TF-CBT.³⁹ The limitations of the study included the lack of a control group, small sample size, and the lack of a structured PTSD diagnostic assessment tool (the study relied on child self-report measures). Despite the limitations and challenges, this iteration of TF-CBT demonstrated that this method of treatment can be administered to children with different ethnicities and multiple traumas.

Tanzania

There are an estimated 143 million orphans in Africa (16.6 million of which have HIV/AIDS), many of whom have suffered sexual abuse.⁴⁰ In the East African country of Tanzania, researchers from Duke University performed a qualitative study on how orphans suffering from PTSD would respond to group TF-CBT, an iteration known to work well in more collectivistic cultures such as Tanzania.⁴¹ Recruitment techniques included leveraging relationships with local organizations and non-governmental groups. Potential victims were screened using the UCLA PTSD-Reaction Index (a similar measure as that used in the Singapore case) and the UCLA Traumatic Grief Screener and qualified children underwent additional

³⁸ Lucie Cluver et al., *Posttraumatic stress in AIDS-orphaned children exposed to high levels of trauma: the protective role of perceived social support*, 22 J. OF TRAUMATIC STRESS 106 (2009).

³⁹ Tan, *supra* note 36.

⁴⁰ Shannon Dorsey et al., *Group-based Trauma focused CBT for Orphaned Children in Tanzania*, Centers for Health Policy & Inequalities Research at Duke University, 2012.

⁴¹ Laura K. Murray et al., *Global Dissemination and Implementation of Child Evidence-Based Practices in Low Resources Countries, in Dissemination and Implementation of Evidence-Based Practices in Child and Adolescent Mental Health*, at 187 (Rinad S. Beidas and Philip C. Kendall eds. 2014).

screening questionnaires related to their mood and feelings.⁴² The victims selected were divided into eight single-sex focus groups by age (7-10 and 11-13). The study team finalized a sample of 64 orphans (32 from urban settings and 32 from rural settings) to undergo group TF-CBT with their guardians and a trained clinician in 12 sessions, which had both TF-CBT and grief-specific components. In addition, each orphan underwent individual imaginal exposure treatment – envisioning feared images or memories – at home or at school locations. Group-based TF-CBT sessions tend to function more like classes that build relationship skills and normalize the experiences of the patients, providing peer support as they learn to cope with their symptoms.⁴³ The researchers placed particular emphasis on establishing trust between the counselors, victims, and guardians – a critical aspect in the success of a TF-CBT intervention. The victims were evaluated at four different stages via interview: pre-treatment, post-treatment, a 3-month follow-up, and a 12-month follow-up. The research team discovered that many of the victims had experienced multiple traumas and were suffering from complex mental health issues (as reported by both the children and their guardians).⁴⁴ With good attendance and high levels of satisfaction from the orphans and their guardians, the study results indicated a steady decline in PTSD symptoms at the end of treatment and at the 3-month follow-up, which can be seen in *Figure 1*.

⁴² UCLA PTSD-Reaction Index is a self-report instrument to screen for trauma exposure and PTSD for children over the age of 6 (there is also a caregiver report version). The UCLA Traumatic Grief Screening Interview is a semistructured individual interview where the clinician asks questions and follow-up questions to determine the degree of trauma exposure and psychological distress. (Robert Pynoos et al., *UCLA PTSD Index for DSM-IV* Unpublished manuscripts, UCLA Trauma Psychiatry Service, 1998); Christopher M. Layne et al., *UCLA Trauma-Grief Screening Interview*, 1999. William R. Saltzman, Department of Educational Psychology, Administration, and Counseling, California State University at Long Beach, 1250 Bellflower Boulevard, Long Beach, CA 90840-2201).

⁴³ *Ibid.*

⁴⁴ Dorsey, *supra* note 40.

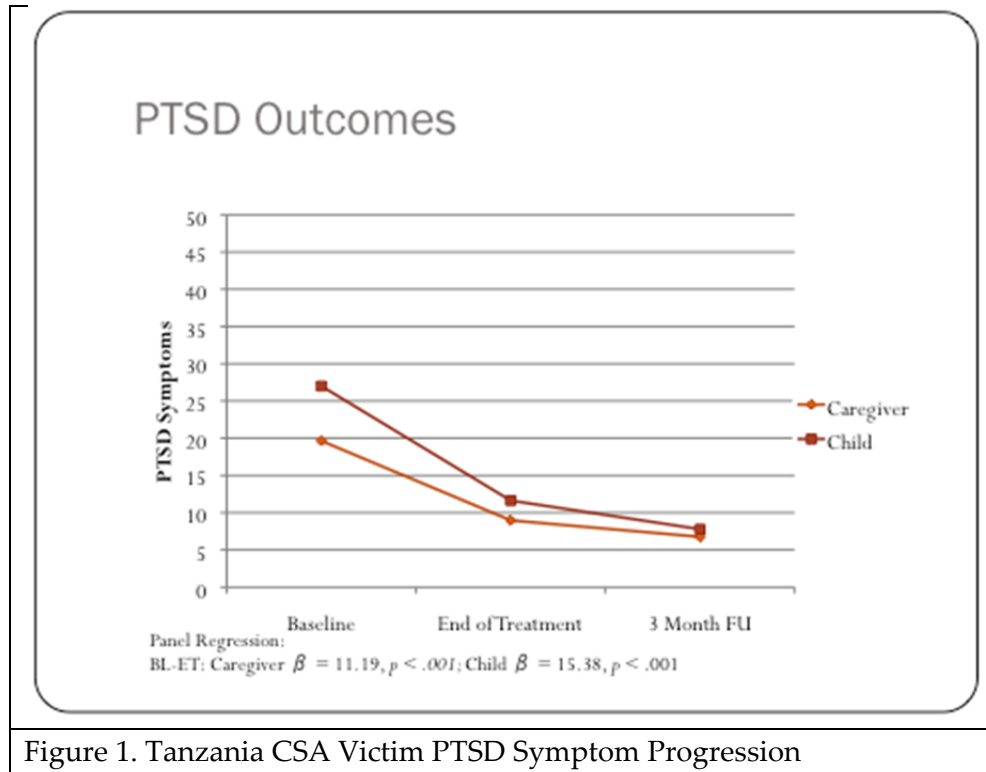


Figure 1. Tanzania CSA Victim PTSD Symptom Progression

Within this case study, the implementation was successful because the investigators worked within the local culture to recruit victims, which gave them credibility and leverage to ensure a more effective and culturally competent implementation. The investigators also partnered with other well-resourced organizations to train clinicians administering the TF-CBT and chose a form of TF-CBT (group therapy) that matched the cultural and psychological needs of the victims.

TF-CBT REPLICATION

TF-CBT has been used in urban, suburban, and rural settings within clinics, schools, and homes, demonstrating effective treatment of children and families from different cultural, socioeconomic backgrounds as well as diverse trauma experience.⁴⁵ Any intervention (mental health or otherwise) must consider racially, culturally, and economically diverse settings in its implementation.⁴⁶ In the case of the Norwegian Centre for Violence and Traumatic Stress, investigators did not make any major cultural adaptations to the therapy model as the treatment design was flexible to adapt. While their study indicated relative ease of use and implementation, as a highly developed and resourced European country, the investigators had fewer obstacles to overcome than countries with lesser resources. TF-CBT implementation efforts in low-resourced countries such as Cambodia, the Democratic Republic of Congo, and Zambia, have reported minor modifications to the TF-CBT model in consideration of cultural differences and limited availability of educated and experienced therapists.⁴⁷ Modifications may need to be made in countries with a broader range of traumatic events such as a history of migration, refugee status, and acculturation.⁴⁸ One of the most significant barriers to TF-CBT implementation is a lack of resources. Organizations or countries interested in implementing such treatment therapies as TF-CBT can overcome barriers through the following tactics:

- 1) **Establish partnerships with experienced organizations.** Countries interested in implementing TF-CBT programs should contact governments, universities, and organizations with a successful track record in TF-CBT treatment. None of the TF-CBT implementation cases mentioned in this report would have been possible without collaboration with successful partners. For example, the Norwegian Centre for Violence and Traumatic Stress partnered with the American authors of the web-based TF-CBT training to educate the therapists and monitor their progress throughout the study.⁴⁹ One can overcome cultural barriers by leveraging connections within the community to

⁴⁵ *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma*, CHILD WELFARE INFORMATION GATEWAY, at 4 (2012) <https://www.childwelfare.gov/pubs/trauma/trauma.pdf> (last visited Mar. 14, 2014).

⁴⁶ Misurell & Springer, *supra* note 21, at 137.

⁴⁷ Jensen, *supra* note 29, at 366.

⁴⁸ Michael A. de Arellano, *Culturally-Modified Trauma-Focused Cognitive Behavior Therapy and Other Applications of Evidence-Based Practices: Trying to Reach the Rest of the Iceberg*, MEDICAL UNIVERSITY OF SOUTH CAROLINA, 2012, http://psyc.uark.edu/de_Arellano_talk.pdf (last visited Mar. 12, 2014).

⁴⁹ Jensen, *supra* note 29, at 356.

support the implementation of a TF-CBT treatment program. For example, the Duke University TF-CBT project in Tanzania leveraged a relationship with a local community-based organization, the Tanzania Women’s Research Foundation, to connect the project leaders with valuable community leaders and resources.⁵⁰

- 2) **Tailor the intervention to the needs of the CSA population.** While TF-CBT has documented success with CSA victims, it may not be the sole treatment model and other iterations should be considered. For example, Game-Based Cognitive Behavioral Group Therapy (GB-CBT) combines the social and emotional skill building, psycho-education, and parental management training from TF-CBT with “structured, therapeutic, developmentally appropriate games in a group setting.”⁵¹ While developed in the United States, this form of therapy was originally targeted towards Latino and African-American CSA victims to meet certain cultural aspects, such as collectivism (i.e., emphasizing human interdependence, choosing group over self, shared responsibility), the centrality of the family unit, and the strength-based approach (emphasizing positive reinforcement for good behaviors over deficiencies). This approach was first implemented at Newark Beth Israel Medical Center’s (NBIMC’s) Metropolitan Regional Child Abuse Diagnostic and Treatment Center and has shown favorable results in terms of creating positive experiences for the CSA victims who underwent the treatment.⁵²
- 3) **Utilize the apprenticeship training model with local clinicians.** While importing TF-CBT-trained clinicians is one approach when designing a therapeutic intervention, providing basic training to lay counselors (i.e., counselors from the community of the CSA victims) is another possible method. Studies indicate that single training sessions are less effective than multiple training sessions that are supported by supervision, coaching, and feedback related to therapy administration.⁵³ Several randomized clinical trials examining mental health interventions showed success with “local lay counselors, with little or no previous mental health training experience” in such countries as Pakistan and Uganda.⁵⁴ The apprenticeship model is comprised of three groups: (1) trainers (expert mental health professionals in the intervention and often from outside

⁵⁰ Dorsey, *supra* note 40.

⁵¹ Misurell & Springer, *supra* note 21, at 139.

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ Laura K. Murray et al., *Building Capacity in Mental Health Interventions in Low Resource Countries: An apprenticeship model for training local providers*, 5 INT’L J. OF MENTAL HEALTH SYSTEMS 30 (2011).

the project area); (2) supervisors (local individuals to oversee the clinical staff on the ground); and (3) counselors (local individuals who will provide the mental health therapy).⁵⁵ The counselors and supervisors ideally come from the same community as the patients, have at least a high school-equivalent education, and have the time to conduct the therapy, as well as an interest in mental health. Counselor training will be basic, but should be interactive and experiential and accommodate different learning styles. With an understanding of local customs and cultural considerations, counselors and supervisors can play a critical role in tailoring the TF-CBT treatment to fit the needs of the community.⁵⁶

4) **Cultural considerations.** It is important to consider cultural influencers when introducing a community to a new form of treatment such as TF-CBT, which is a Westernized concept that might not coincide with the methods and beliefs in non-Western countries.⁵⁷ In fact, the American Psychological Association requested an expansion of evidenced-based therapies to include culturally sensitive interventions.⁵⁸ An examination of 76 culturally adapted mental health interventions (not trauma-related) found that these therapies had a greater positive impact on patient health than those not adapted to the cultures of their patients.⁵⁹ With TF-CBT, minor considerations by therapy interventions can make a difference in how the therapy is received. For example, in cultures with strict gender roles such as in many Middle Eastern countries, therapists introducing TF-CBT should ensure that female counselors work with female patients and male counselors work with male patients. In addition, therapists should consider cultural aspects such as spirituality, folk beliefs, sexual beliefs, family focus, views of mental health and language – all of which may or may not clash with the principals of TF-CBT treatment.⁶⁰

5) **Sustain support.** Establishing a mental health intervention program should include planning for sustainability in the long-term to ensure successful implementation and

⁵⁵ Murray, *supra* note 54.

⁵⁶ *Id.* at 36.

⁵⁷ See generally Ethan Watters, *The Wave that Brought PTSD to Sri Lanka, Crazy Like Us: The Globalization of the American Psyche*, 65-125 (2010).

⁵⁸ Misurell & Springer, *supra* note 21, at 137.

⁵⁹ Derek Griner & Timothy B. Smith, *Culturally adapted mental health intervention: a meta-analytic review*, 43 PSYCHOTHERAPY THEORY RESEARCH AND PRACTICE 531 (2006).

⁶⁰ De Arellano, *supra* note 48.

farther-reaching impact on CSA victims in the community. Research has shown that mental health intervention (or any intervention) cannot be sustained without continual support and attention.⁶¹

⁶¹ Murray, *supra* note 41.

CONCLUSION

The high prevalence of CSA around the world is unacceptable and the resulting post-traumatic stress that is suffered by the child victims will only worsen if left untreated. TF-CBT is a mental health treatment with proven success in helping victims of trauma including CSA. However, the majority of empirical evidence indicating this success comes from American studies with little consideration for cultural diversity. This is beginning to change with countries like Norway and Singapore conducting their own research into the effectiveness of TF-CBT in treating CSA victims within their borders. More successful implementations of TF-CBT are being developed around the world with the help of community partnerships, apprenticeship training, and tailored, sustainable interventions.

As seen in the examples provided, cultural competence and evidence-based treatment are both equally important in providing successful treatment to CSA victims.⁶² Cultural considerations regarding trauma and therapy must be considered and local mores must be respected with the implementation of any treatment. In situations where culture dictates that CSA victims are not afforded rights or provided proper treatment, cultural brokers within the community must work to advocate for those children and over time help to change those societal values that diminish the value of children, especially in the case of child sexual abuse.

⁶² Arthur L. Whaley & Keith E. Davis, *Cultural competence and evidence-based practice in mental health services: A complementary perspective*, 62 AMERICAN PSYCHOLOGIST 563, 572 (2007).

