

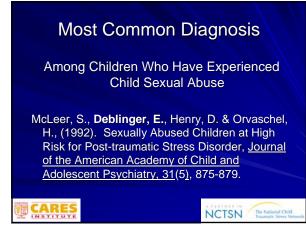
Esther Deblinger, Ph.D. Co-Director, CARES Institute Professor of Psychiatry

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Literature Review

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





PTSD symptoms specific to a history of child sexual abuse

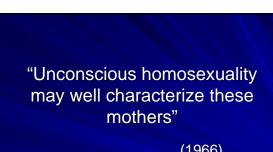
Deblinger, E., McLeer, S.V., Atkins, M., Ralph, D., & Foa, E. (1989). Post-traumatic stress in sexually abused children: physically abused and non-abused children. <u>International Journal</u> of Child Abuse and Neglect, 13, 403-408.

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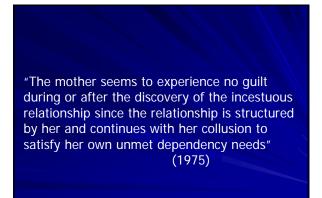
Literature Review – Nonoffending mothers

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



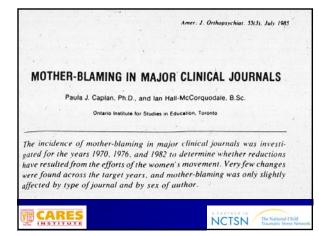


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"Whatever justification for physical absence, however, the effect is the same with respect to the incestuous relationship: mother manages to avoid setting limits for others and fails to fulfill her own role responsibilities by being elsewhere" (1982)



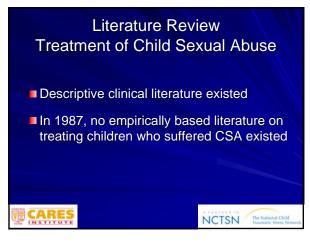


348	MOTHER-BLAM	
	Table 1	
PROBLEMS IDENTIFIED IN THE LITERATURE AS ATTRIBUTABLE TO MOTHERS		
Absence of genitality	Isolation ~	
Appressiveness	Koro (feeling of penile shrinkage	
Agitation	and fear of death)	
Agoraphobia	Loneliness	
Anal obsession	Loss of control	
Anorexia nervosa	Marijuana use	
Anxiety, lear	Minimal brain damage	
Arson	Moodiness	
Avoidance of peers	Narcissism	
Bed dreams	Need to be anally penetrated	
Behavior problems	Need to become pregnant/abort	
Bizarre behavior	Neonaticide	
Chronic vomiting	Pathological reaction to sexual stimuli	
Creation of rigidly sex-role	Phobias	
stereotypic daughters	Poor concentration	
Delinguency/criminality	Poor language development	
Delusions	Premature mourning	
Denial of pregnancy/childbirth	Problems in emotional well-being	
Dependency	Pseudoneurosis	
Depression	Pseudosociopathic neurosis	
Disturbance in Klinefelter's syndrome children	Psychiatric disorder	
Encooresis	Scapegoating	
Enuresis	Schizophrenia	
Failure to mourn	School dropout	
Fear of separation	School phobla	
Fetishism	Self-induced television epilepsy	
Frigidity	Severe mental handicap	
Gaslighting	Sexual dysfunction	
Homosexuality	Sibling jealoury	
Hyperactivity	Sleepwalking	
Hysterical character	Success conflict	
Inability to separate from mother	Suicidal behavior	
Inability to deal with color blindness	Tantruma	
inability to establish a transference	 Timidity/withdrawal 	
Incontinence	Transsexualism (regular and homicidal)	
incest	Truency	
Ineducability (intellectual)	Ulcerative colitis	

Understanding the Nonoffending Mothers

Deblinger, E., Hathaway, C.R., Lippmann, J., & Steer, R. (1993). Psychosocial Characteristics and Correlates of Symptom Distress in Nonoffending Mothers of Sexually Abused Children. <u>Journal of Interpersonal Violence</u>, <u>8</u>(2), 155-168.





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

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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 Foa, EB, et al., (1991) *JCCP*, *59*, 715-723.
- Significant treatment modifications to address developmental differences and parent involvement

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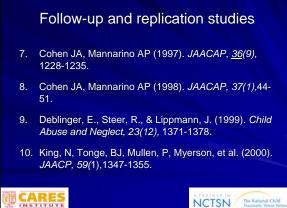
Empirical Support for TF-CBT: Pre-post findings

- 1. Deblinger, E., McLeer, S.V. & Henry, D.E. (1990) Journal of the American Academy of Child and Adolescent Psychiatry, 29(5), 747-752.
- 2. Stauffer, L. & Deblinger, E. (1996). <u>Child Maltreatment,</u> <u>1</u>(1), 65-76.

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Empirical Support: Randomized Controlled Trials		
 Deblinger, E., Lippmann, J., & Steer, R. (1996). Child Maltreatment, 1(4), 310-321. 		
4. Cohen, JA & Mannarino, AP (1996). <i>JAACAP, 35</i> (1), 42-50.		
 Cohen, JA, & Mannarino, AP (1998). Child Maltreatment, 3(1), 17-26. 		
 Deblinger, E., Stauffer, L. & Steer, R. (2001). <i>Child</i> <i>Maltreatment</i>, 6(4), 332-343. 		
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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)

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A Multisite Randomized Controlled Trial For Sexually Abused Children With PTSD Symptoms (2004). Judith A. Cohen, M.D.¹ Esther Deblinger, Ph.D.², Anthony P. Mannarino, Ph.D.¹ Robert A. Steer, Ed.D.²

¹Center for Traumatic Stress in Children and Adolescents, Allegheny General Hospital ²CARES Institute, UMDNJ-School of Osteopathic Medicine

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

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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 COGNTIVE BEHAVIORAL THERAPY (TF-CBT)

- 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 <u>> 3 sessions)</u> 79% female, 21% male, mean age 10.76 years

60% Caucasian, 28% African American, 4% Hispanic American, 7% Biracial, 1% Other

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Multip	ole Traumas (Mean = 3.6 <i>Types)</i>
■ 100%	sexually abused
■ 70%	received traumatic news (e.g., den death of family member)
■ 58%	domestic violence
37%	serious accident
26%	physical abuse
17%	community violence
1 3%	fire/natural disaster
2 5%	other PTSD-level traumas
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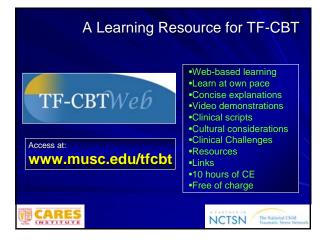
Lessons learned.....

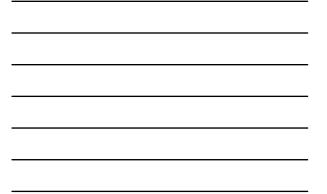
- Both TF-CBT and CCT produce significant improvements
- TF-CBT more effective than CCT in helping parents overcome depression and abuse specific distress (Cohen, et al., 2004)
- TF-CBT more effective than CCT in helping children overcome feelings of PTSD, depression, behavior problems, shame and dysfunctional 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)

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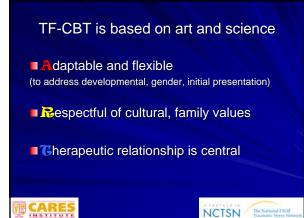




TF-CBT Web Learners

- 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.





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)
REALES NCTSN Revaluation Child

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

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- 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

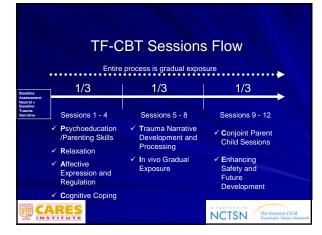
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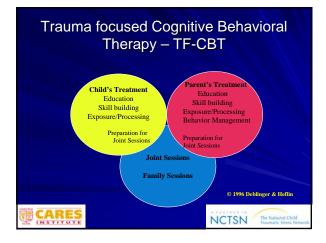
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PRACTICE components

- P sychoeducation and parenting skills
 R elaxation
- A ffective 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









Specifics 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

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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





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