

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



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Most Common Diagnosis

Among Children Who Have Experienced  
Child Sexual Abuse

McLeer, S., **Deblinger, E.**, Henry, D. & Orvaschel,  
H., (1992). Sexually Abused Children at High  
Risk for Post-traumatic Stress Disorder, Journal  
of the American Academy of Child and  
Adolescent Psychiatry, 31(5), 875-879.



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## 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. International Journal 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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“Unconscious homosexuality may well characterize these mothers”

(1966)



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“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)



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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)



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*Amer. J. Orthopsychiat. 53(1), July 1983*

### MOTHER-BLAMING IN MAJOR CLINICAL JOURNALS

Paula J. Caplan, Ph.D., and Ian Hall-McCorquodale, 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.*



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348 MOTHER-BLAMING

Table 1  
PROBLEMS IDENTIFIED IN THE LITERATURE AS ATTRIBUTABLE TO MOTHERS

Absence of genitality	Isolation
Aggressiveness	Koro (feeling of penis shrinkage and fear of death)
Agitation	Loneliness
Agoraphobia	Loss of control
Anal obsession	Marijuana use
Anorexia nervosa	Minimal brain damage
Anxiety, fear	Moodiness
Arsen	Narcissism
Avoidance of peers	Need to be anally penetrated
Bad dreams	Need to become pregnant/abort
Behavior problems	Neonaticide
Bizarre behavior	Pathological reaction to sexual stimuli
Chronic vomiting	Phobias
Creation of rigidly sex-role stereotypic daughters	Poor concentration
Delinquency/criminality	Poor language development
Delusions	Premature mourning
Denial of pregnancy/childbirth	Problems in emotional well-being
Dependency	Pseudoneurosis
Depression	Pseudoneurotic neurosis
Disturbance in Klinefelter's syndrome children	Psychiatric disorder
Enoprosia	Scapegoating
Enuresis	Schizophrenia
Failure to mourn	School dropout
Fear of separation	School phobia
Fetishism	Self-induced television epilepsy
Frigidity	Severe mental handicap
Gaslighting	Sexual dysfunction
Homosexuality	Sibling jealousy
Hyperactivity	Sleepwalking
Hysterical character	Success conflict
Inability to separate from mother	Suicidal behavior
Inability to deal with color blindness	Tantrums
Incontinence	Timidity/withdrawal
Incest	Transsexualism (regular and homicidal)
Ineducability (intellectual)	Truancy
	Ulcerative colitis

The listing in this table is of items considered to be problems by the authors of the various articles reviewed.

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## 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. *Journal of Interpersonal Violence*, 8(2), 155-168.




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## Literature Review Treatment of Child Sexual Abuse

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




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## 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). *Child Maltreatment*, 1(1), 65-76.



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## Empirical Support: Randomized Controlled Trials

3. Deblinger, E., Lippmann, J., & Steer, R. (1996). *Child Maltreatment*, 1(4), 310-321.
4. Cohen, JA & Mannarino, AP (1996). *JAACAP*, 35(1), 42-50.
5. Cohen, JA, & Mannarino, AP (1998). *Child Maltreatment*, 3(1), 17-26.
6. Deblinger, E., Stauffer, L. & Steer, R. (2001). *Child Maltreatment*, 6(4), 332-343.



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## 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)



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## Follow-up and replication studies

7. Cohen JA, Mannarino AP (1997). *JAACAP*, 36(9), 1228-1235.
8. Cohen JA, Mannarino AP (1998). *JAACAP*, 37(1),44-51.
9. Deblinger, E., Steer, R., & Lippmann, J. (1999). *Child Abuse and Neglect*, 23(12), 1371-1378.
10. King, N, Tonge, BJ, Mullen, P, Myerson, et al. (2000). *JAACP*, 59(1),1347-1355.



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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.<sup>1</sup>  
Esther Deblinger, Ph.D.<sup>2</sup>,  
Anthony P. Mannarino, Ph.D.<sup>1</sup>  
Robert A. Steer, Ed.D.<sup>2</sup>

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



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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  $\geq 5$  PTSD sx.,  $\geq 1$  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



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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.



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## Treatment (Cont'd)

### TRAUMA-FOCUSED COGNITIVE 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



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## Subjects

- 229 sexually abused 8-14 yo children and parents (203 completed  $\geq 3$  sessions)
- 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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### 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




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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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### National Registry of Effective Programs & Practices (NREPP)

U. S. Department of Health and Human Services - SAMHSA




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## A Learning Resource for TF-CBT



- Web-based learning
- Learn at own pace
- Concise explanations
- Video demonstrations
- Clinical scripts
- Cultural considerations
- Clinical Challenges
- Resources
- Links
- 10 hours of CE
- Free of charge

Access at:  
[www.musc.edu/tfcbt](http://www.musc.edu/tfcbt)

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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.

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## TF-CBT is based on art and science

- **A**daptable and flexible  
(to address developmental, gender, initial presentation)
- **R**espectful of cultural, family values
- **T**herapeutic relationship is central

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## 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)



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## 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



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## 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



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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




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## TF-CBT Sessions Flow

..... Entire process is gradual exposure .....

	1/3	1/3	1/3
Baseline Assessment: Neutral + Baseline Trauma Narrative	Sessions 1 - 4	Sessions 5 - 8	Sessions 9 - 12
	<ul style="list-style-type: none"> <li>✓ Psychoeducation /Parenting Skills</li> <li>✓ Relaxation</li> <li>✓ Affective Expression and Regulation</li> <li>✓ Cognitive Coping</li> </ul>	<ul style="list-style-type: none"> <li>✓ Trauma Narrative Development and Processing</li> <li>✓ In vivo Gradual Exposure</li> </ul>	<ul style="list-style-type: none"> <li>✓ Conjoint Parent Child Sessions</li> <li>✓ Enhancing Safety and Future Development</li> </ul>

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## 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**

© 1996 Deblinger & Heflin

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## 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



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