

Trauma-Focused Therapy for the Treatment of Posttraumatic Stress Disorder in Sexually Abused Children: A Summary and Evaluation of Research

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Abstract: Each year a great number of children are sexually abused and studies have suggested that more than 50% of sexually abused children meet either partial or full criteria for posttraumatic stress disorder (PTSD). Trauma-focused cognitive behavioral therapy (TF-CBT) has been developed to help these children and has the strongest support, showing decreases in depression, behavior problems, shame, and abuse-related attributions. TF-CBT contains four major components: exposure, cognitive processing and reframing, stress management, and parental treatment. Unfortunately, very few well-controlled studies have been completed on the use of TF-CBT for PTSD due to childhood sexual abuse and those that have contain problems with internal and external validity. These issues, along with measurement issues, are discussed, noting areas of future research that may be beneficial.

A great number of children are sexually abused each year, ranging from experiences of indecent exposure to rape at gunpoint. Often sexually abused children are at risk for developing psychiatric disorders and distress as adults, which also can vary from mild to debilitating distress (Saywitz, Mannarino, Berliner, & Cohen, 2000). With the large number of children who are sexually abused each year, finding a treatment that produces positive outcomes is very important. Saywitz et al. (2000) stated that studies have suggested more than 50% of sexually abused children meet either partial or full criteria for posttraumatic stress disorder (PTSD).

PTSD is an anxiety disorder in which a trauma is experienced to the person directly or is witnessed as it occurs to others and it is perceived to be life threatening. It is characterized by the following symptoms: reexperiencing, avoidance of trauma-related stimuli, and hyper-arousal (Feeny, Foa, Treadwell, & March, 2004). As explained in the text revision of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000), each of these three symptoms can occur in numerous ways. For example, reexperiencing includes the occurrence of recurrent images, thoughts,

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dreams, flashbacks, and illusions. Avoidance is characterized by avoiding thoughts, feelings, conversations associated with the traumatic event, activities, places, and people that may remind the individual of the trauma, and lack of interest or participation in activities. Finally, hyper-arousal involves sleep problems, irritability, poor concentration, hypervigilance, and exaggerated startle responses.

There is a struggle in diagnosing children with PTSD because some of the symptoms are not developmentally appropriate for children and younger people (Yule, 2001). In preschool aged children there have been some efforts to create more developmentally appropriate criteria, because very young children do not have abstract thought, emotional processing, or language of older children (Scheeringa, Zeanah, Myers, & Putnam, 2003). For example, young children may relive a trauma through repetitive play of what happened and they may not be able to explain or verbalize a loss of interest in an activity (American Psychiatric Association, *DSM-IV-TR*, 2000). Scheeringa et al. (2003) also state children may show a loss of developmental skills they previously had or have extreme temper tantrums.

Treating children with PTSD due to childhood sexual abuse (CSA) has proven to be a task with numerous obstacles. Many of the treatments that have been developed to treat trauma-related symptoms in children were modified from treatments for traumatized adults (Cohen, Mannarino, Berliner, & Deblinger, 2000). While therapy has been shown to be effective in treating PTSD, there is now a research focus on what forms of treatment work best for which groups of children (Saywitz, et al., 2000). The goal of this paper is to examine the effectiveness of trauma-focused cognitive-behavioral therapy (TF-CBT) for sexually abused children with PTSD. First, a description of TF-CBT will be presented followed by an examination of studies, the results they offer, and the implications for using this process in counseling.

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

Trauma-focused cognitive behavioral therapy for children and adolescents contains four major components: exposure, cognitive processing and reframing, stress management, and parental treatment (Cohen, et al., 2000). Exposure may be either intense and prolonged or gradual, and involves some type of an ongoing experiencing to stimuli that produce fear or anxiety. In gradual exposure the child would be

encouraged to first describe a part of the trauma that is less upsetting and then slowly progress to describing the events that are more traumatic (Cohen, et al., 2000). Cognitive processing therapy was developed specifically for adult sexual assault victims by Resick and Schnicke in 1992 and is now being adapted for use with traumatized children (Cohen, et al., 2000). This technique involves identifying the child's current cognitions, followed by the therapist and child evaluating the reasoning for any distorted cognitions, and finally replacing these distortions with an accurate cognition.

Stress management strategies have been found effective in decreasing symptoms in adult assault victims and non-traumatized children (Cohen, et al., 2000). This intervention may involve muscle relaxation and breathing techniques to help calm children who are anxious from a trauma and/or thought stopping and thought replacement to increase the child's sense of control over negative thoughts. Lastly, parental treatment is included for a variety of reasons. Information about the child's symptoms may be gathered from the parents. Cohen et al. (2000) stated the primary goals in including parents are to resolve their own emotional upset about their child's trauma, correct any cognitive distortions, and enhance effective parenting and appropriate parent support.

SUMMARY OF RESEARCH ON TF-CBT FOR PTSD DUE TO CSA

Very few well-controlled studies have been completed on the use of TF-CBT for PTSD due to CSA. For the articles that were reviewed, a discussion on the usefulness of the information provided and findings of these experiments will be presented. The strengths and weaknesses of the studies will help demonstrate what direction future research needs to go.

The studies being reviewed are efficacy studies and therefore were concerned about internal validity and showing causal relationships (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996; Deblinger, Lippmann, & Steer, 1996; Cohen & Mannarino, 1997; King, Tonge, Mullen, Myerson, et al., 2000; Deblinger, Mannarino, Cohen, & Steer, 2006). Randomized controlled studies (RCTs) are considered the gold standard, yet some may argue that we need more effectiveness studies to show generalizability to the population (Seligman, 1995). With RCTs being efficacy studies, the researchers need to address threats to internal validity.

One of the threats to internal validity that appears in many of the studies is that of attrition, or participants dropping out. Cohen, Deblinger, Mannarino, and Steer (2004) noted that 26 of 229 participants discontinued the study, although they included all of the original subjects in the intent-to-treat analyses to account for this. It was found that there was no significant difference between those who completed treatment and those who did not on any demographic or psychosocial background characteristics. In a study on preschool children, 86 participants were recruited with only 67 completing treatment (Cohen & Mannarino, 1996). The only difference found between completers and noncompleters was those who did not complete treatment had a lower socioeconomic status (SES). With such a great number of non-completers in many studies on CSA, future research needs to address attrition with more care and use intent-to-treat analyses.

Another threat to internal validity that should be considered here is maturation. There have been a number of longitudinal studies that have shown as a group, sexually abused children improve over time whether they receive treatment or not (Finkelhor & Berliner, 1995). To try to account for this difficult problem, researchers may want to include pretests and posttests over multiple times. Using multiple pretests over time may establish some type of baseline before treatment is implemented. Unfortunately, none of the studies reviewed included multiple pretests over time, but most included multiple measures used at both pretest and posttest assessment. Comparatively, many of the studies have included posttest information over time and/or have completed a follow-up study (Berliner & Saunders, 1996; Deblinger, Lippmann, & Steer, 1996; Cohen & Mannarino, 1997; King, et al., 2000; Deblinger, Mannarino, Cohen, & Steer, 2006).

The sample size can also greatly impact the results of a study. In a meta-analysis completed by Finkelhor and Berliner (1995), it was noted that in order to have enough power to detect a difference when comparing two treatment groups, rather than a treatment and no-treatment group, researchers need to include approximately 70 subjects per group. This sample size is desirable to detect differences in average effect sizes. Yet only one study reviewed has done this. Cohen et al. (2004) compared TF-CBT to child-centered therapy (CCT) which demonstrated that TF-CBT children improved significantly more on PTSD, depression, behavior problems, shame, and abuse-related attributions. For those participants who completed the study, 89 were in the TF-CBT group and 91 in the CCT

group. Other studies included approximately 70 subjects total (e.g., Cohen & Mannarino, 1996; Berliner & Saunders, 1996), while one had only 36 total participants who were then divided into three groups (e.g., King et al., 2000). Having so few participants is a great disadvantage that needs to be addressed because sample size greatly affects the power one has to detect differences between treatments.

For the studies that included how they obtained their participants many used convenience sampling and those who would volunteer after being referred from a variety of places. The type and number of places that children and their families were referred from may create a bias in the sample, therefore not representing the population in a variety of ways. While some studies included children who had been referred from many different places, such as parents, Child Protective Services, pediatricians, rape crisis centers, community mental health agencies, police departments, and the judicial system (Cohen & Mannarino, 1996), there were others with only a few places from where children were referred (Cohen, et al., 2004; Deblinger, Lippmann, & Steer, 1996). In order to allow for more generalizable results and to insure great numbers of subjects are not missed, researchers need to obtain their samples from a variety of sources.

Looking at the participants who have been included in the studies there are strengths as well as concerns that should be addressed. While having a homogenous sample can help account for some threats, such as maturation, this can be very hard to accomplish when examining CSA. With regards to gender, age, and ethnicity, many studies have been quite homogenous. The majority of the subjects are white females, with African-Americans being the next ethnicity most often studied (Cohen, et al., 2004; King, et al., 2000; Deblinger, Lippmann, & Steer, 1996). It has been shown that females are more likely than males to develop PTSD due to CSA (Cook-Cottone, 2004; Linning & Kearney, 2004). The lack of information on males and other ethnicities is reducing the generalizability of these studies.

Saywitz et al. (2000) made note of the difficulty with the heterogeneity of samples saying, "The heterogeneity of this population complicates research design, requiring a great many replication studies on children of different ages, genders, symptom patterns, and family contexts," (pg. 1042). It is rather difficult to produce studies with enough participants and have some homogeneity between groups in regards to the type of sexual abuse experienced, the perpetrator involved, and the

symptoms the child is now showing. Heterogeneity in these aspects is found in many studies involving CSA, but this can allow researchers to analyze different factors as potential moderators of treatment (Cohen, et al., 2004). Unfortunately, many of the studies today probably do not include a large enough sample size with regards to this diversity to detect differences in the possible moderators.

Resick, Monson, and Rizvi (2008) made a very important point involving the gender of the therapist, saying since sexual assault is usually perpetrated by a male, victims of sexual assault often do not trust men. It is important to note that male therapists may be very effective if properly trained, although this is a concern that has not been well addressed in the reviewed research. Having proper training may include being knowledgeable about rape and PTSD and seeing rape as not just a sexual crime, which is a tendency for men, but also a crime of violence (Resick, Monson, & Rizvi, 2008). King et al. (2000) was the only study to include the gender of the therapists, having one male and three females, but the difference between genders was not examined in the study. Research needs to consider the sex of the therapist and discover if there are any differences in the results that depend on the gender of the therapist.

Since these studies are efficacy studies, there is another concern that arises: the generalizability of what is found. In an attempt to create somewhat of a homogenous sample with less diversity, the studies describe inclusion and exclusion criteria. Deblinger, Lippmann, and Steer (1996) and King et al. (2000) excluded subjects who were taking antidepressant or antianxiety medication, without giving reasons to do so. Children who demonstrated an active substance use disorder, and in some cases if their parents did, were also excluded from studies (Cohen, et al., 2004; Cohen & Mannarino, 1996).

Using some of the exclusion criteria, such as depression, anxiety, and substance use disorders may create samples which are not representative of the population. The *DSM-IV-TR* acknowledged PTSD is associated with increased rates of many other disorders including but not limited to: Major Depressive Disorder, Substance-Related Disorder, Panic Disorder, Agoraphobia, Social Phobia, Bipolar Disorder, and Obsessive-Compulsive Disorder (American Psychiatric Association, 2000). In a meta-analysis on the effects of CSA, Paolucci, Genuis, and Violato (2001) showed a 21% increase in both depression and suicide outcome for CSA. Comorbidity is yet another factor that is important to consider, as CSA victims may present other disorders along with PTSD.

Finkelhor and Berliner (1995) discussed two issues that may also threaten the generalizability of research, asymptomatic children and the sleeper effect. There have been initial assessments that have suggested up to 40% of CSA children show few symptoms on standard instruments. Asymptomatic children create many dilemmas, both for researchers and therapists. Being included in research will make it difficult to find positive results, yet including these children may be effective in preventing symptoms of PTSD in their future (Finkelhor & Berliner, 1995). The articles reviewed for this paper did not address this issue.

The sleeper effect, where symptoms may not appear until months or many years later, is also a serious concern (Finkelhor & Berliner, 1995). Some studies tried to account for this through including children who met or fell short of the diagnosis for PTSD, although there was variability in how many symptoms must be present. Deblinger et al. (1996) and King et al. (2000) set inclusion criteria so that children had to show three PTSD symptoms, with one in either avoidance or reexperiencing. More strict inclusion criteria were included in Cohen et al. (2004) in which children needed to exhibit five criteria for PTSD with one symptom in each of the three clusters. The sleeper effect may be diminished with early treatment, and therefore should be examined.

With all of the above concerns in mind involving internal and external validity, it is necessary to examine how researchers measure what they are looking for such as symptoms and distress. The studies all used multiple measures, which was a good decision because it may allow for a more accurate description of a participant and reduce bias from using only one measure. However, making comparisons between studies may prove to be difficult because there were numerous different measurements used and each may measure different aspects of PTSD. Some of the measurements used for the children include but not are limited to: structured background interviews, Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime (K-SADS-PL), K-SADS-E, and the Children's Attributions and Perceptions Scale (CAPS). Some of the measures used for the parents include: Child Sexual Behavior Inventory (CSBI), Beck Depression Inventory (BDI), Parent's Emotional Reaction Questionnaire (PERQ), and Parental Support Questionnaire (PSQ).

A few measures for the children were used in more than one study. The State/Trait Anxiety Inventory for Children (STAIC) is a self-report that consists of two 20-item scales which assess situationally specific

anxiety and anxiety as a stable characteristic of the person. This is said to demonstrate high internal consistency and validity (Deblinger, Lippmann, & Steer, 1996; Cohen, et al., 2004). The most common used measurement for children was the Child Depression Inventory (CDI), which is another self-report, but measures affective, cognitive, and behavioral symptoms of depression in children. The CDI was stated to be a well-established self-report with moderate test-retest reliability (Berliner & Saunders, 1996; Deblinger, Lippmann, & Steer, 1996; Cohen, et al., 2004).

For the parent measurements, two instruments were used frequently. One was a self-report to assess parenting skills, the Parenting Practices Questionnaire (PPQ). Deblinger, Lippmann, and Steer (1996) reported that the PPQ has good internal consistency and test-retest reliability. The measure used most overall, when including child and parent measures, was the Child Behavior Checklist (CBCL) which measures behavior problems and social competence in children. Again, studies simply state that the psychometric properties are well established for the CBCL, and that it is a reliable measure which provides normal scores by age and sex groups (Berliner & Saunders, 1996; Cohen & Mannarino, 1996; Deblinger, Lippmann, & Steer, 1996; Cohen, et al., 2004).

From solely examining these studies, one can not be certain how reliable and valid all of these measurements are. Many times there is only a statement saying the measure is reliable and valid. Cohen and Mannarino (1996) did state that the test-retest reliability of the CBCL over a one week period is .88. Since the measurements that are used in a study are extremely important, a little more information on what each is suppose to be measuring and how reliable and valid the measure is would be useful.

When the measures and statistics have been completed, there are somewhat mixed results, and many times a lack of practical and clinical significance that is given. Saywitz et al. (2000) noted that effect sizes varied by presenting problems. There has been greater success found with phobic, somatic, and anxiety symptoms than there has been found for global adjustment symptoms and personality characteristics. Berliner and Saunders (1996) found that using group therapy to reduce fear and anxiety, in which one group had elements common to sexual abuse treatment and the other group included stress inoculation training and gradual exposure, there were no differences between the groups on improvement of symptoms. The main argument as to why this occurred is that the majority of the children in this study did not have clinically

significant levels of anxiety and fear during the pretreatment assessments that were given.

Only one article presented effect sizes, along with its follow-up article, although the significance of the effect size was not discussed. Cohen et al. (2004) simply put the effect sizes in a table that included each measurement scale but did not use these effect sizes to discuss clinical significance. In their follow-up study examining more long-standing effects of TF-CBT as compared to CCT, it is written that the majority of the effect sizes showed small effects, but again this is not explained (Deblinger, et al., 2006). It is interesting that in the discussion and clinical implications sections Deblinger et al. (2006) do not discuss the significance of the effect sizes, but simply say the results were statistically significant, and TF-CBT led to faster and greater improvements with regards to PTSD symptoms.

While the studies examined in this paper revealed, for the most part, a greater improvement in PTSD symptoms after receiving TF-CBT treatment, there is still not a clear answer about how clinically significant these results are (e.g., Cohen, et al., 2004; Deblinger, et al., 2006; King, et al., 2000; Deblinger, Lippmann, & Steer, 1996). Many studies do not discuss or report effect sizes, which makes it very difficult to know how much the difference between treatments really is. Simply because they are showing statistical significance does not mean that TF-CBT is the end all answer to helping sexually abused children with PTSD.

CONCLUSIONS

Trauma-focused cognitive behavioral therapy aims to decrease symptoms of PTSD in sexually abused children through a combination of different techniques. Childhood sexual abuse is a very serious and sometimes complicated problem that needs to be addressed because it can affect a child throughout his or her adulthood. Developing PTSD due to CSA is quite common and can be devastating for both the child and family. Therefore, we need treatments that are going to help alleviate these concerns quickly, effectively, and preferably over-time.

After reviewing TF-CBT studies, it is difficult to come to any firm conclusions. While the studies reviewed shed a positive light on TF-CBT as compared to other methods, more research should be completed to demonstrate its clinical significance. The evidence for cognitive-behavioral treatments is the strongest, although unfortunately there is

relatively little research that has been studied using other types of treatment for PTSD in youth (Cohen, et al., 2000; Feeny, et al., 2004).

Understanding some of the concerns with the present research will hopefully help future research become much stronger. Examining diversity may lead to more promising treatments for different types sexual abuse, various ethnicities, and other diverse areas in CSA. Many of the studies to date have contained quite small sample sizes, and may be biased due to a small number of referral sites. Measurements used are another concern because there is lack of a clear demonstration of the reliability and validity for these measures. However, a strength that seemed to be consistently found when looking at the measurements used in each study was the utilization of multiple measures.

Keeping all of this in mind, TF-CBT used for sexually abused children with PTSD seems to be an effective treatment when considering the evidence that is currently available. There surely needs to be more research conducted, specifically dismantling studies, to determine what parts of TF-CBT are most effective in the treatment. Research needs to be completed to see what aspects of treatments work for which symptoms, types of CSA, and what influence various demographics have. Also, research needs to determine which children do not respond well to TF-CBT and find alternatives to help them. Until further research is completed, it appears that TF-CBT is generally beneficial in improving symptoms of PTSD in sexually abused children.

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