Trauma-Focused Cognitive Behavioural Therapy for Abused Children with Posttraumatic Stress Disorder: Development and Evaluation of a Manualised Treatment Programme

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This thesis is dedicated to my parents, Reg and June Collins, who gave me a wonderful childhood full of fun and adventure, and a perfect base upon which to build this work.

ABSTRACT

A manualised trauma-focused cognitive behavioural therapy (TF-CBT) programme was developed for multiply-abused children diagnosed with posttraumatic stress disorder (PTSD; Feather & Ronan, 2004) referred to the specialist clinic of the statutory child protection agency in New Zealand. The TF-CBT protocol was based on: (1) a review of the history of child abuse (CA) and child protection in New Zealand and internationally, with particular reference to professional developments and the role of psychologists in ameliorating CA; (2) a conceptualisation of the clinical presentation of CA in children; (3) a review of the field of psychotraumatology and theoretical models, including locally developed, relevant to the development of a treatment programme for traumatised abused children in a child protection setting in New Zealand; and (4) a review of evidence-based practice, treatment outcome models, and current empirical research related to developing an effective treatment model in this area. The locally developed TF-CBT programme built on efficacious treatments for child anxiety and PTSD as a result of sexual abuse. It encompasses psychosocial strengthening, coping skills training, gradual exposure using expressive modalities, and special issues relevant to trauma and abuse.

A "scientist-practitioner" approach to local clinical research was used to evaluate the programme. A single-case multiple-baseline design demonstrated the controlling effects of the treatment across four studies; each comprising four typically-referred multiply-abused children aged 9-15 years who met diagnostic criteria for PTSD. Parent/caregivers were involved in treatment sessions. Study 1 was a pilot with four Pakeha/New Zealand European children; Study 2 trialled the protocol with two Maori and two Samoan children; Study 3 was an evaluation of the developed protocol with a multicultural group of typically-referred children; and Study 4 was an evaluation with other therapists delivering the manualised programme.

Despite some methodological difficulties related to conducting research in a setting of this nature, the overall results indicate a good deal of promise. Across the four studies, for the majority of children treated, PTSD symptoms decreased and child coping

increased. Where follow-up data was available, gains generally maintained or improved over 3-, 6-, and 12-month intervals.

Recommendations are made about further applications of this TF-CBT programme, including the interweaving of cultural models with TF-CBT, and development and evaluation of the protocol in other settings. Implications of the current research are discussed in terms of recognition of the crucial importance of evidence-based practice in CA/child protection settings, and the contribution psychologists and therapists can make to ensure quality outcomes for this most vulnerable population of children and families.

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Chapter 1: Introduction

Orientating Framework and Overview of the Thesis

This thesis documents a treatment development project, essentially designed to benefit the clients and clinicians of the agency involved. The local clinical setting (SSU; Specialist Services Unit) in which the research was carried out is part of the statutory child protection service in New Zealand (CYF; Child, Youth and Family, a Service of the Ministry of Social Development). SSU provides psychological and therapeutic services for children[1] and families referred by their CYF social workers. The children are all "open cases" with CYF, and invariably present with multiple-abuse histories and current trauma symptomatology. The main intention of the research was to develop and evaluate a manualised treatment programme that clinicians could readily use to help these children build skills to manage their symptoms and process the trauma of abuse, with the support of their parent/caregivers.

Recently, there has been emerging recognition of the need for evidence-based treatments in child abuse (CA) and child protection (Chaffin & Friedrich, 2004; G. Macdonald, 2001). This is a relatively new idea for this field, and is based on clinical science (Feather, 2004a) rather than on clinical lore or traditions. Having said that, evidence-based treatments inevitably arise from clinical wisdom and experience. However, practice traditions can be subjective and value-based and, while well-intentioned, there is no clear evidence that field services provided to abused children and families actually work (Chadwick Center for Children and Families, 2004; Saunders, Berliner, & Hanson, 2004). This thesis takes the view that in order to ensure safe and effective outcomes for traumatised abused children and their families in the local clinical setting, that local clinical practice is best interwoven with well-supported treatment models that have scientific evidence for proven outcomes.

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[1] Note; in this thesis, "children" and "child" refer to children *and* adolescents, unless otherwise specified.

In psychology, the prevailing paradigm of objectivism encourages us to seek objective verifiable facts through logical and empirical methods, based on the view that knowledge develops through an incremental process that leads to the discovery of universal laws (Neimeyer, 1995). This approach provides the rationale, structure, and means to evaluate the outcome of any project or pursuit. Conversely, the constructivist paradigm holds that the nature of truth is multiple, contextual, historical, and a created "act of meaning" (Neimeyer & Mahoney, 1995). The extreme view of constructivism is that, rather than there being a "real world" external to us, we in fact create our own reality (Mahoney, 1995). This view promotes a sense of agency and participation in one's life. While the paradigms of objectivism and constructivism seem to be mutually exclusive, the author has come to see each of these views as holding aspects of the truth, with both having something to offer this project.

Objectivism has informed, in particular, the research process. It has motivated the focus on a clear conceptualisation of the clinical concerns of CA[2] and trauma[3], a sound theoretical rationale, empirically supported treatments, the choice of a research design appropriate to the research question and setting, the selection of reliable, valid, and treatment sensitive measures, and ongoing data collection to enable the evaluation of treatment outcomes. As a clinician at heart, this focus has not always been easy to maintain; at times it would have been all too easy to abandon the research demands and just get on with the therapy. But an empirical approach was essential to answer the key question that precipitated this research: Is what we are doing in the therapy rooms at SSU really helpful for these children? Bringing the knowledge and attitudes of a scientist to the local setting in which the clinician works is the hallmark of a true "scientist-practitioner"[4] (Stricker & Trierweiler, 1995).

In terms of the development of the treatment programme itself, while an objectivist approach largely determined the choice of treatment elements and general structure,

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[2] For the purpose of this research, the definitions of child abuse developed by CYF (then Children, Young Persons and Their Families Service) in 1997 (and still in current use) are used (see Appendix A).

[3] For the purpose of this research, "trauma" is operationally defined by the DSM-IV-TR diagnostic criteria for Posttraumatic Stress Disorder; (PTSD; American Psychiatric Association, 2000) (see Appendix B).

[4] See Appendix C for an article describing how the scientist-practitioner approach can be applied in a child protection setting, written by the author, as cited on p.1 (Feather, 2004a).

constructivism provided the over-arching orientation. The essential premise here is that through therapy an abused child has the possibility of putting the "past in the past" and creating "a new way of being" in the present and the future. This has been encapsulated in a personal vision for the project: "empowering young people to live great lives". The treatment elements have been derived from a range of theories and models that have contributed to the field of CA trauma including: behaviourism, cognitive science, biological science, systems theory, developmental psychology, and cultural paradigms. The crucial model defining the building blocks of the treatment programme is trauma-focused cognitive behavioural therapy (TF-CBT). TF-CBT has been proven to date to be the most effective treatment for traumatised abused children (Cohen, Deblinger, Mannarino, & Steer, 2004; Saunders et al., 2004). In addition, through this project, it has become clear that a CBT approach is essentially compatible with a constructivist view, being a clinical style that is a co-operative venture with an emphasis on working with the client's own experiences in the context in which problems occur. Furthermore, CBT is imminently suited to working with children, being action-orientated, adaptable to developmental aspects, and aiming to build skills so that children can become "their own therapists" and have a better life in the present and the future (Graham, 2005).

A constructivist viewpoint has also focused attention on the local context of the research. Treatment does not occur in isolation and account must be taken of the divergent realities within which people live, as these impact greatly on their experiences. For example, the concepts of "empirical research" and "therapy" are historically foreign to local indigenous cultures such as Maori and Pacific Island people. In the context of research in Aotearoa[5]/New Zealand, these issues raise important questions, such as: Is therapy derived from Western psychology helpful for Maori and other local minority children and their families? Are empirically supported treatments developed overseas effective in our local context? What do we already know from our local knowledge that can be woven into our therapy to ensure it is appropriate and accessible for the children we see? How does a sense of connection relate to healing from CA trauma? These kinds of questions and attempts to address them thread through the research.

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[5] Aotearoa (land of the long white cloud), the Maori name for New Zealand; hereafter called the official name New Zealand for simplicity, but not intending to disregard the tangata whenua (people of the land).

In summary, a TF-CBT treatment manual has been developed as a tool for clinicians to use when working with traumatised abused 9-15 year old children and their families. It is based on an interweaving of a conceptual and theoretical rationale, empirically supported treatments, and local contextual knowledge, including local clinical practice and cultural models appropriate to the clientele of SSU. In the tradition of the scientist-practitioner, the effectiveness of the manualised programme has been evaluated via a single-case multiple-baseline design over a series of four studies. Each study involved four multiply-abused children who met DSM-IV-TR diagnostic criteria for posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000) and their available caregivers and family.

The thesis documents the historical, contextual, theoretical, and empirical background to the development of the treatment programme, and the research process and outcomes. Chapter 2 introduces the topic of CA; covering the history of CA from its conceptualisation to current issues, with particular reference to the New Zealand context. Chapter 3 presents the prevalence and sequelae of CA. Chapter 4 provides an overview of theoretical frameworks and models pertaining to CA trauma. Chapter 5 reviews the concepts of evidence-based practice in the field of CA/child protection, presents the research findings on empirically supported treatments related to traumatised abused children, and refers to local clinical practice models. Chapter 6 presents the current research, outlining the rationale and purpose. The overall methodology for the research is presented in Chapter 7. Chapter 8 presents Study 1, the piloting of the manualised TF-CBT programme with four children. Chapter 9 presents Study 2, a trial of the programme with two Maori and two Samoan children. Chapter 10 presents Study 3, the completed protocol tested with a group of four typically-referred children with the researcher as therapist. Chapter 11 presents Study 4, use of the completed protocol by other therapists. Chapter 12 presents a discussion of the overall findings and implications for clinical practice and further research.

Chapter 2: Child Abuse

Historical, Social, and Professional Context

Outline and Aims

Child abuse is an experience, not a pathology. As such, it cannot be considered without reference to the context in which it occurs. This context is at once historical, social, political, cultural, familial, and professional. To develop an effective treatment, one must firstly understand the clinical problem (Kazdin, 2000). In the case of CA, this is complex. There is no one theoretical conceptualisation about what factors lead to CA and how they operate. The etiology is multi-faceted, as are the sequelae.

In order to get clear about the nature of the problem to be treated, the concept of CA will be explored as it has developed over time to our understanding today. This will include a look at how Western society has responded to the growing awareness of CA, with a focus on the New Zealand context. This is important because in the case of CA, how society conceptualises the problem determines how individual children who experience abuse are treated by families and those in authority (e.g., police, health and welfare agencies, helping professions, funding providers).

This chapter begins with a brief scan back through history, as it is only in modern times that "child abuse" has been recognised as a "problem". Also, the focus in CA has changed over time; from early recognition of child neglect, to dawning awareness of child physical abuse (CPA), to the eventual acknowledgement of child sexual abuse (CSA), and a more recent focus on multiple-abuse, including the impact on children of witnessing violence and the subtle yet sometimes devastating effects of emotional abuse.

In this chapter, the history and current status of child care and protection in New Zealand is discussed to give a context to current CYF practice. This discussion includes the history and current status of the provision of psychological and therapeutic services to CYF by SSU psychologists and therapists.

History of Child Abuse

Sigmund Freud's early writings contain references to CA, specifically CSA. He realised that his hysterical patients often shared in common the experience of having been sexually abused in childhood, stating that: "Hysterics suffer mainly from reminiscences" (Breuer & Freud, 1895). Of course, later, Freud discarded his so-called "seduction theory" and emphasis on the causal effect of CSA. However, he did retain the view that traumatic events during childhood had a greater impact than trauma during adulthood due to the immature ego's lack of resources with which to process such experiences (Sugarman, 1994). It has been suggested that Freud retracted his earlier position due to pressure from colleagues who were unable or unwilling to accept his radical view about the impact of adult behaviour on children's wellbeing (Masson, 1985). Awareness of any form of CA subsequently lapsed among medical and psychological professionals until decades later.

Historically, CA did not exist as a concept, and maltreatment was not acknowledged as a social ill (R. S. Kempe & Kempe, 1978). For instance, in nineteenth century London, children were thought to be dispensable. Eighty percent of illegitimate children who were put out to wet nurse died after the nurse had collected her fee. Children were sold to slavery or used as a source of cheap labour. Children were considered to be their parent's property and responsibility; severe physical punishment was seen as necessary to maintain discipline, transmit education, and even to expel evil spirits. Thus, the prevailing values sanctioned many practices we now call abusive.

Historians have suggested that the contemporary notion of "childhood" did not come about until the period between the 1870s and 1930s. Religious, scientific, philanthropic, cultural and political influences combined to define and institutionalise the early years

of human development as a time of innocence and vulnerability which needed protection (Dalley, 1998).

A change in cultural views can be traced to the early days of the Child Welfare Movement in America. In New York, a scandal developed around a neglected and beaten child named Mary Ellen whose parents refused to change their treatment of her. The matter was brought before the court under laws designed to protect animals, as there were no such laws to protect children (Jones, 1987). This led to the founding of The Society for the Prevention of Cruelty to Children in 1875 in New York City, and subsequently to many other societies with similar objectives being formed throughout the United States (US).

The movement spread to Britain and led to the founding of the National Society for the Prevention of Cruelty to Children (NSPCC), which received its Royal Charter in 1895. The problem of CA was formally recognised by the British Parliament through the passing of the Prevention of Cruelty Act in 1889. Under this Act, power was given to police to arrest those suspected of ill-treatment, and to courts to remove children from maltreating parents. Various acts pertaining to the protection of children followed. By 1948, Children's Departments had been established in Britain staffed by child care officers who had responsibility for statutory supervision in the family home and looking after the interests of children in care.

Meanwhile, the medical profession was also slowly becoming aware of CA. The "battered-child syndrome" was first described in Paris in 1868 by Ambroise Tardieu, a professor of legal medicine. The same year Athol Johnson at the Hospital for Sick Children in London called attention to repeated fractures in children, although he put these down to "rickets". In 1946, radiologist Dr John Caffey in the US associated skeletal lesions in children with traumatic origins. However, it was not until 1955 that medical doctors suggested the possibility that parents or caregivers might deliberately cause injury (Woolley & Evans, 1955).

In 1961, Henry and Ruth Kempe, from the University of Colorado, organised an interdisciplinary presentation at the Annual Meeting of the American Academy of Paediatrics on the "Battered Child Syndrome", and subsequently published a description

of CA (C. H. Kempe, 1962). The Kempes ultimately defined four categories of CA: physical violence, physical and emotional neglect, emotional abuse, and sexual exploitation (R. S. Kempe & Kempe, 1978). These categories form the basis of the field of CA today, although each category has received varying amounts of attention by professionals over the decades.

History of Child Abuse and Child Welfare in New Zealand

New Zealand shared the international interest in child welfare from the late nineteenth century and adapted overseas models, developing local responses to meet local needs (Dalley, 1998). In 1890, the Children's Protection Act provided penalties for anyone who wilfully ill-treated, neglected or abandoned children (females under 16 years and males under 14 years). While punishments for neglectful parents were set out, there were no public mechanisms to protect children. Child care and protection was instead left to charitable organisations (Ehrhardt & Beaglehole, 1993).

In 1893 and 1896, the Infant Life Protection Acts were passed to stop baby-farming and provide for the registration of foster homes and greater powers of inspection by police. Concerns about a growing number of neglected, destitute and criminal children, associated with the 1860s gold rushes, led to the Neglected and Criminal Children's Act 1867. The Act provided for the establishment of "industrial schools" which provided training to enable the young people committed by the courts to become useful citizens, and keep them away from public view. The reality was often more grim. These environments were invariably punitive and lonely for the residents, who often lost contact with family and friends (Dalley, 1998).

As was seen with this Act, the motivation for change in child welfare policy and legislation was not always the wellbeing of children. In 1904, the Prime Minister, Richard Seddon, issued a "Memorandum on Child-Life Preservation". While aimed at improving maternity and health care facilities for mothers and infants, the real agenda was to counteract the perceived threat of "race suicide" of the white races in New Zealand (Mattheus, 1988). As Mattheus states, a hierarchy of concerns at government level was reflected in this document: "The mother must be saved for the sake of the

infant, who must be saved for the sake of the colony, which must be saved for the sake of the Empire" (1988, p. 47). The welfare of children was seen as a source of the nation's future and Seddon's Memorandum contained much rhetoric about the responsibility of the State to provide for its future citizens.

By the advent of the twentieth century, such developments illustrate the emergence of state intervention as a typically New Zealand method of dealing with situations of social concern. With the benefit of funding and legislative authority, the government over time became the most important child welfare agency (although at this point, not for Maori). Internationally, New Zealand was also beginning to develop a reputation as a "social laboratory" (Dalley, 1998). Alongside government initiatives, voluntary and church groups continued to be involved in child welfare as they had in the nineteenth century. For example, Truby King and the Plunket Society and groups such as the Women's Christian Temperance Union emphasised the importance of infant and maternal health and wellbeing. The Salvation Army and the Catholic Church provided institutional services for abandoned and neglected children.

In 1925, the Child Welfare Branch of the Department of Education was established as the first government department devoted exclusively to the welfare of children. The forerunner of the current CYF, the focus was on casework and investigation, inquiry and observation, and supervision and assistance predicated on the development of relationships with the young people and their families (Dalley, 1998). This model was based on practices in other Western countries. Child welfare policy moved away from institutionalisation for all but the most problematic children. Preventing children and young people and their families from requiring further contact with child welfare became a central philosophy of the Department by the late 1920s.

Child Welfare Embraces Psychology

The Child Welfare Branch encouraged new approaches and expected child welfare workers to be up to date with recent trends in policy, research and practice. Psychological precepts were increasingly used by child welfare officers to explain the "characters" of those under supervision. By the 1940s, coincident with increased psychological testing during World War I, psychological assessments and the use of psychological terms to describe social welfare problems had become a routine part of

the Branch's preventative work (Dalley, 1998). For example, reports exist of child welfare officers in Dunedin in 1948 meeting weekly with the local psychological clinic to discuss cases. While historians have argued whether the introduction of psychological assessments and terms actually made a difference to the practice of child welfare, Dalley states that their influence should not be minimised. Psychology provided a new model for describing problems and establishing links between a child's current circumstances, history and mental state which assisted practice plans. Furthermore, the growing influence of psychology marked the emergence of a new group of experts in the field of child welfare in New Zealand.

Child Welfare in the Post-War Period

The emphasis during the post-war years was on family welfare rather than on CA and neglect. The post-war baby boom saw the population of New Zealand grow from 1.7 million at the end of World War II to 2.9 million by 1972. The work of the re-named Child Welfare Division increased out of proportion to the increase in the juvenile population, which had doubled over this period. For example, the number of children under preventative supervision or supervision rose from less than 4,000 in 1948/9 to more than 10,000 in 1971/2.

One reason for the increase was that the 1950s saw a rise in juvenile delinquency, a phenomenon common to Western countries. At this time, problems such as delinquency were seen as evidence of moral neglect or inadequate family support (Dalley, 1998). Explanations focused on the complexities of modern life: excessive freedom, an emphasis on self-expression and individuality, a lack of parental interest, and a decline in family values in the aftermath of the war. All of these were thought to add stress and insecurity to adolescent life. The Division and its institutions relied increasingly on psychologists and therapists to discover the specific causes of problems, particularly delinquency, and plan treatment programmes.

Even with some improvements in child protection, there continued to be little awareness by professionals during this era that some "juvenile delinquents" may have been victims of physical, sexual, or emotional abuse. Child welfare officers apparently had neither the knowledge nor the awareness to pick up the warning signs. For example, young people who exhibited sexual behaviours were likely to be labelled as immoral. There

was little or no conception that this could indicate CSA. Psychologists too reportedly looked elsewhere for explanations for "disobedience" and overt sexual behaviour. Psychological interpretations of behaviour emphasised the emotional aspects of life and the importance of good family relationships (Dalley, 1998).

Maori and Child Welfare

Until the post-war period, Maori largely took responsibility for caring for their own health and welfare within traditional support structures. This was partly through choice, as Maori did not always agree with *Pakeha* (New Zealanders of European heritage) ways of dealing with problems. For example, Maori made it known that any separation of Maori children from the *whanau* (family) and locality was detrimental (Dalley, 1998). Maori also recognised that there was of a lack of resources from government, notwithstanding the existence of the Maori Affairs Department (previously The Native Department, founded in the 1860s) which held responsibility for Maori welfare (Ehrhardt & Beaglehole, 1993). Maori were aware of their disadvantaged position in the modern world, through lack of education, resources and money. In response to growing health and welfare needs, Maori women began to take responsibility for caring for their own communities (Ehrhardt & Beaglehole, 1993). In 1937 and 1951 respectively, the Women's Health League and the Dominion Maori Women's Welfare League were formed. The Maori Women's Welfare League branches often dealt with child welfare problems by placing children needing care with relatives.

Maori children and whanau had little contact with the government child welfare agency until the 1940s. Wartime conditions led to a drift of young Maori into the cities in search of work, and the network of child welfare officers expanded into the rural areas where most Maori lived. Post-war, Maori made up a disproportionate number of the Division's cases, predominantly in youth offending. This was thought to be associated with social and economic dislocation from whanau and traditional values and controls, and increased contact with Pakeha and the pressures of modern life (Dalley, 1998). In areas where *iwi* (tribal) committees were strong, there was little offending, but Maori groups had limited capacity to deal with young Maori delinquents in other areas.

The Rediscovery of Child Abuse

In the 1960s and 1970s, as was the case in other Western countries, attention increasingly focused on the diagnosis of CPA and use of medical intervention as a means of prevention (Dalley, 1998). Local medical professionals became aware of the "Battered Child Syndrome" and disseminated information about the syndrome to other practitioners. The Child Welfare Division began investigating the extent and causes of CPA. Figures were released that estimated that two or three per 10,000 children under sixteen experienced definite physical ill-treatment each year (Fergusson, Fleming, & O'Neill, 1972). There was some recognition that the incidence was probably higher due to lack of reporting and the disguising of abuse as childhood accidents (Ritchie & Ritchie, 1990).

By the early 1980s, increasing recognition in the US and Australia of the effects of CSA focused attention in New Zealand on the issue (Saphira, 1981). Also influencing local practitioners over this period were concerns over the effects of being exposed to interpersonal violence. Internationally, researchers and clinicians began to express concern that children who witnessed violence, particularly domestic violence in their own homes, suffered negative consequences, even when they were not targets of violence themselves (Fantuzzo et al., 1991).

In New Zealand, CPA and CSA, and exposure to domestic violence were increasingly recognised as resulting in "psychological scars" and long-term disturbances (Abbott, 1984; Dawson-Wheeler, 1984). There was more awareness of the indicators of a range of abuse types and openness to the fact that abuse could happen in family situations and was often an aspect of family violence (Le Feuvre, 1985; Ritchie & Ritchie, 1990).

Civil Rights Movements

During the 1970s and 1980s, the growing professional and public interest in CA in New Zealand was influenced not only by increased awareness of abuse, but also by the developing ethos on the rights of the child, the forces of the feminist movement, and the Maori cultural and political renaissance (Ehrhardt & Beaglehole, 1993).

Child rights advocates refocused attention on the wellbeing of the individual child. The feminist movement sought to challenge structural inequalities in society which were

seen to perpetuate disadvantages and the subjugation of both women and children. Meanwhile, Maori continued to be disproportionately represented in not only child welfare statistics, but also in crime and unemployment figures, and in poor health and housing. These issues led to a cultural resurgence and an assertion of *rangitiratanga* (Maori sovereignty), and a call to honour the Treaty of Waitangi's fundamental principle of partnership between Maori and Pakeha. Maori demanded management of Maori resources and issues, including child welfare (Dalley, 1998).

Child Abuse on the Social Agenda

By the mid 1980s, CA was no longer a taboo subject in New Zealand, and child maltreatment was placed on the social agenda as "a widely recognised and significant social problem requiring solution" (Abbott, September, 1984). While New Zealand followed international trends in CA policies and practices to some extent, the response in this country took on a distinctly New Zealand flavour by virtue of our unique population and social and political context.

Community and voluntary groups were recognised as important in dealing with abuse, both as gatekeepers and in direct servicing of client needs (Abbott, 1985). Community and government agencies alike developed initiatives to address CA, such as the joint Police and Ministry of Education "Keeping Ourselves Safe" Programme for primary school children (The New Zealand Police and the Ministry of Education, 1994). Departmental social workers in Auckland worked in a special sexual abuse team with combined staff from Police and the voluntary Sexual Abuse Help Foundation (HELP). The Accident Compensation Corporation (ACC) acknowledged they had an obligation with regard to CSA (Abbott, September, 1984), which culminated in claimants being entitled to treatment for mental injury arising from sexual abuse. The Office of the Commissioner for Children published guidelines for protecting children from abuse (Wood & Smith, 1993).

The need for Maori designed and managed delivery options to reduce the incidence of family violence and CA within their whanau was supported by government, reflecting a renewed commitment to the obligations of the Treaty of Waitangi (New Zealand Government, 1996). Overall, these initiatives were indicative of the beginning of a new multi-disciplinary, bicultural approach to CA in this country (Dalley, 1998).

Legislative and Child Welfare Service Developments

The Child Welfare Division became the Social Work Section of the Department of Social Welfare in 1972. The Children and Young Persons Act of 1974 superseded the 1925 Act. The next fifteen years saw a fundamental rethinking of child welfare services and legislation in New Zealand that reflected the prevailing ideologies, including a greater recognition of children's rights, women's and family rights, and cultural rights (Dalley, 1998).

The Department of Social Welfare was at the leading edge of bicultural development in the State Services. In 1986, *Puao-te-Atu-tu* (awakening to a new dawn), the Report of a Ministerial Advisory Committee, provided a Maori perspective on the most appropriate way for the Department to meet the needs of Maori in policy, planning and service delivery (Department of Social Welfare, 1986). This landmark document spawned a series of guidelines for bicultural and multicultural practice that were developed over the next decade, and underpin the current research (for further discussion, see Chapter 9).

Another turning point for the Department came from an inquiry following the death of a two year old South Auckland girl in 1987 as a result of injuries inflicted by her mother while under supervision of the Department and other agencies. The resultant criticism of the medical model of approaching CA and recognition of the need to use situational analysis and review the whole family situation led to the new philosophy of "make the child safe now". This case also highlighted the fact that the Department had not acted in a culturally sensitive manner in response to the extended family, despite its stated commitment to adopting a bicultural perspective. This led to greater consultation with Maori and Pacific Island groups.

By 1989, with The Children, Young Person's and Their Families Act, New Zealand had developed a truly indigenous model which put this country to the forefront of international policy and practice in dealing with CA and child welfare matters (Dalley, 1998). Cultural heritage and cultural practices were not only respected but formed the basis for the new model. Maori cultural views strongly influenced the legislation, centred on the concept of family/whanau having collective responsibility for children.

Families were given a central role in decision making to ensure their children's safety and wellbeing via family group conferences (FGC), which became the leading way of working with both care and protection and youth justice matters. The emphasis on empowering families and communities to take responsibility for their children was enshrined in the legislation through provisions for funding community and iwi-based schemes for assisting families to care for their children. The focus of CYF has remained essentially the same since the 1989 Act, despite having been through a number of name changes and a series of re-structuring, including being incorporated into the Ministry of Social Development in 2006.

Policy and legislation related to CA and child protection has continued to evolve. In 1993, the United Nations Convention on the Rights of the Child (UNCROC) was ratified, bringing New Zealand into line with international laws on the rights of children. The Domestic Violence Act (1995) made it illegal for children to witness their parents hitting each other. In 2004, the Care of Children Act was passed which legislates for a wide range of child welfare and guardianship issues. Currently, there is considerable social debate surrounding a bill before parliament proposing to repeal Section 59 of the Crimes Act (1961) which allows parent/caregivers to use "reasonable force" in disciplining children.

Professional Developments

Following the medical emphasis on CPA from the 1960s, internationally CSA had become established as professional speciality in the late 1970s. The new field was led by predominantly nonmedical disciplines that relied on interviewing rather than physical examinations, and focused on therapeutic interventions for adult survivors as well as the protection of young victims (Finkelhor, 1979). Treatment programmes, conferences, and research agendas diversified into subfields of CA.

By the 1980s, following international trends, New Zealand began to develop professional services to cater for the investigation, assessment and treatment of specialty areas of CA, particularly CSA. Local practitioners began to publish home-grown material designed to "break the silence" and dispel myths surrounding CSA for professionals, parents and the children themselves (L. Morgan, 1986, 1987, 1988; Saphira, 1981, 1985, 1987). Psychologists employed in health, welfare and education

recognised their role in assessment and treatment. They applied their specialised training in child development, attachment and relationship dynamics, behaviour analysis and management, and psychological assessment and testing to the specific problems of CSA (Ruthe, 1984; Swan, 1984) and to a lesser extent, emotional abuse (Dawson-Wheeler, 1984). Consultation on the psychological consequences of sexual assault and CSA was provided to government agencies, such as ACC (Pow, 1986). Psychologists began to develop local practice models, drawing on international literature to complement the developing local knowledge and experience (see Chapter 3).

Within the Department of Social Welfare, Regional Specialist Services teams of psychologists and therapists were set up in the 1980s. Referrals were received from social workers to carry out assessments and therapy, primarily with sexually abused children and their families. Literature reviews were carried out in specialty areas, such as the forensic interviewing of sexually abused children (Rugg, 1990), and applied to local practice development. The therapeutic models that developed were influenced by the local context, based on a systemic perspective with particular attention to the areas of gender and culture (McDowell et al., 1987). These teams were the fore-runners of the current SSU's.

Cultural perspectives contributed to the groundswell of developing professional knowledge and understanding of CA in New Zealand, particularly Maori (Tukukino, 1984) and Pacific Island perspectives (Foliaki & Hunuki, 1984). Interestingly, these cultural views on CA tended to be broader than that of mainstream Pakeha, or indeed that reflected in international literature, which tended to focus on one abuse type or another. For example, Maori expressed an understanding of CA in terms of adaptation and acculturation, referring to the impact on Maori families of a loss of traditional ways, and coping with adapting to a dominant culture life-style (Tukukino, 1984). So, while international trends were evident in the rise of specialty areas of CA in New Zealand, there were at the same time indigenous views influencing practice development in this country.

Current Status of Child Abuse and the Way Forward

By the 1990s, international research funding favoured CSA. For example, journal articles on CSA outnumbered all other subjects in major journals such as *Child Abuse & Neglect* (Behl, Conyngham, & May, 2003). This was despite the fact that CSA constituted a relatively small proportion of CA reports, compared with the incidence of child neglect and CPA that continue to dominate child welfare caseloads (Chaffin, 2006), and children who witnessed violence, who have been even less extensively researched, even though domestic violence is recognised to occur often in families with children (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997).

Psychologist, John Briere's work heralded a return in the US to a broader, more integrated view on CA (Briere, 1992). Briere's work has been influential in New Zealand due to his regular workshops in this country. He has been instrumental in synthesising and disseminating clinical knowledge and skills about abuse-focused psychotherapy, originally presented for adults sexually abused as children (Briere, 1989) and subsequently expanded to include the treatment of other forms of CA trauma (see Chapter 4). Briere's model strongly influenced the guidelines for sexual abuse counselling developed in New Zealand by Kim McGregor for ACC (McGregor, 2001).

Internationally, there has been a recent call to "de-Balkanize" the professionals in the field of CA. A growing body of research is emerging clearly demonstrating that many types of abuse and violence witnessed and experienced by children are not unique, singular experiences (Saunders, 2003). It has been recognised that it is not uncommon for children to have experienced a number of forms of abuse on multiple occasions (Finkelhor, Ormond, Turner, & Hamby, 2005; Green et al., 2000). The trend of limiting scientific inquiry to only one or two areas, while generating a plethora of information, may have restricted the ability of researchers to fully understand the complete picture of CA. Inferences and conclusions made may have been inaccurate because more complex relationships have not been investigated (Hamby & Finkelhor, 2000).

It has been mooted internationally that the way forward for the field of CA is collaboration across current professional boundaries, involving the development of

"meta" models that depend less on abuse type and can be applied to many situations in which children experience abuse or violence, along with comprehensive assessment and treatment protocols focused on identifying and ameliorating the effects of abuse (Daro, Edleson, & Pinderhughes, 2004; Saunders, 2003).

The potential contribution of psychologists to this changing landscape has been recognised, particularly with regard to having the skills to develop and evaluate interventions within child welfare settings (Chaffin, 2006). In a current commentary, Mark Chaffin proposes that psychological science has a distinct role to play in moving practice forward in the CA/child protection area:

> Using theory and evidence to craft effective behaviour change technologies is one of the strengths of psychology as a discipline…The roles in which psychologists' skills may be best utilised are less as direct clinical service providers and more as intervention developers, adaptors, or evaluators. (p. 677)

Moving Best Practice to Evidence-based Practice

The recent emphasis in the CA field on improving outcomes for abused and neglected children served by the child welfare system has been encapsulated by the notion of "best practice" (Kessler, Gira, & Poertner, 2005). However, the process has been hampered by a lack of consensus about what the term means. Various interpretations include "practice wisdom", "expert consultations", "professional guidelines", and "evidence-based practice" (Kessler et al., 2005).

Other difficulties associated with the development of evidence-based practice include a lack of existing efficacious models. A review of child maltreatment interventions in 2003 found only three interventions that were supported by randomised clinical trials (Thomlison, 2003). Additionally, the diversity of the child welfare population, and the fact that an intervention tested on one group may not fit the framework of another, is a complication that must be managed if this approach is to be helpful in the field of child protection (Kessler et al., 2005). Moreover, as Kessler observes "The field is complex, protective, and bureaucratic, with little research-based knowledge" (p. 250). These challenges will need to be addressed if research based best practice is to be implemented, with the goal of producing the most desired child and family outcomes.

As a starting point, there has been a call for creative research designs with purposeful sampling for heterogeneity, such as quasi-experimental designs in natural clinical settings (Cook & Campbell, 1979; Saunders, 2003). The current research has taken up this call.

Recognition of the Mental Health Needs of Abused Children

Related to recognition of the need to improve outcomes, there has been a recent emphasis on the mental health needs of children in the child protection system. Recent research in the US has shown that nearly half of children aged 2 to 14 years with completed child welfare investigations had clinically significant emotional or behavioural problems (Burns et al., 2004). Only one quarter of such youths had received any specialty mental health care during the previous 12 months. Notably, an earlier US study found that children who were in foster care due to sexual abuse were almost four and a half times more likely to receive mental health services than children who were not placed for this reason (Garland, Landsverk, Hough, & Ellis-Macleod, 1996). US researchers have called for the routine screening for mental health need, increased access to mental health professionals for further assessment and treatment for children in the child welfare system (Burns et al., 2004), and the development of specific treatment services based on specific emotional and behavioural problems (Landsverk, Garland, & Leslie, 2002).

In New Zealand these concerns appear to be equally relevant. An extensive review of CYF by former Principal Youth Court Judge Mick Brown highlighted the fact that a significant proportion of children involved with CYF due to care and protection concerns have serious mental health problems (Brown, 2000). He described this as an issue "of grave concern".

CYF responded to the concerns raised by the review by publishing guidelines to assist staff, primarily social workers, working with children and young people with mental health problems (Child Youth and Family, 2001b). The guidelines provide estimation that over 3,000 CYF child clients will have mental health problems at any one time. The following guiding principles are recommended:

- Children, young people and their family/whanau can live well in the presence of mental health problems.
- Children, young people and their family/whanau have a right to access mental health assessment, treatment and support services.
- The views of children and young people should be sought in a way that matches their developmental stage in order to incorporate their views in assessments and plans.

The guidelines, while comprehensive, were not designed to be a substitute for specialist mental health assessment and treatment for abuse-related concerns. Referral services, including CYF's own Specialist Services Units are recommended, as are internationally recognised evidence-based therapeutic interventions for abused children with mental health problems, such as multisystemic therapy (MST) and cognitive behavioural therapy (CBT). Despite these recommendations, it has largely fallen to the specialist practitioners themselves to adapt and develop evidence-based practice protocols for abuse related assessment and treatment of local clientele.

Current Status of Specialist Child Abuse Research and Practice in New Zealand

The New Zealand situation is somewhat unique in that we have a small population, the size of a large city overseas, with limited research funding and opportunities. Yet clearly, the work in the field of CA is no less complex than elsewhere. As a result, local clinicians have tended to assimilate international research and apply it to their own unique clinical settings, sometimes finding that they are at the cutting edge of their fields when they attend international conferences, for example, in the area of forensic interviewing of children (M. Libeau, personal communication, July 25, 2006). This perhaps reflects the "Kiwi ingenuity/ number 8 fencing wire" mentality of New Zealanders generally. Being a small country a long way from international research centres has perhaps given impetus to a need to "do it ourselves".

This is not to say that local clinicians have not sought help in striving to do the best work possible in the field. On the contrary, in addition to reading international journals and attending international conferences, international researchers and clinicians are regularly brought to New Zealand by organisations such as Doctors for Sexual Abuse

Care (DSAC) and the New Zealand Psychological Society (NZPsS). Furthermore, there has been government support for such initiatives. For example, in 1998 the Children, Young Persons and their Families Service (the forerunner of CYF) was the major sponsor of the Twelfth International Congress on Child Abuse and Neglect of the International Society for Prevention of Child Abuse and Neglect (ISPCAN) held in Auckland. Local clinicians have benefited from attending workshops by professionals at the forefront of the field[6].

In contrast to practice and training, there has been little treatment outcome research in the field of CA published in New Zealand. What goes on in clinical settings has tended to remain the preserve of those doing the work and other professionals within local teams or agencies. However, a trend towards documenting and disseminating locally developed clinical models is becoming evident. For example, in September 2004, a group of clinicians from Auckland SSU presented six papers at the Fifteenth ISPCAN conference in Brisbane (e.g., Feather, 2004b; Murupaenga, Feather, & Berking, 2004), compared to just three presentations from SSU clinicians nationwide when the conference was held in our own city seven years previously.

Puawaitahi Multi Agency Service

In 2002, as a result of local research that showed the needs of abused children and their families would be better served by a "one-stop-shop" including all relevant government agencies involved in the investigation, assessment and treatment of CA (Davies, 1999), a multi agency service was set up in Auckland City. This centre, located in Grafton opposite the Starship Children's Hospital, comprises *Te Puaruruhau* (sheltering the bud), the Auckland District Health Board's Child and Adolescent Abuse Assessment Service; the Police Child Abuse Team, Auckland City District Criminal Investigation Branch; the CYF Central Auckland SSU, *Te Kupenga Marumaru* (the safety net); and the Central Auckland Video Unit, a partnership between Police and CYF. *Puawaitahi* (blossoming into unity), while inspired by similar multi agency centres in the US, is unique in Australasia.

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[6] By way of illustration, from 1994-2007 the writer has attended workshops by international CA researchers and clinicians presented in New Zealand by John Briere, Cheryl Lanktree, Bruce Perry, Barbara Bonner, Lucy Berliner, William Friedrich, Daniel Siegel, and Thomas Achenbach, among others.

The work of Puawaitahi includes 24 hour medical and nursing assessments, forensic assessments and evidential interviewing, bringing about criminal proceedings when appropriate, coordinating court prosecutions, family liaison and parent and caregiver support, and psychological assessments and therapy for children who have experienced abuse and neglect. Puawaitahi also has a role in teaching and training, advocacy, and research in the area of CA. The current research, while beginning when the SSU was independently located, was primarily carried out within the setting of this multi agency service.

Summary

In summary, the history and professional development of the CA field in New Zealand has reflected international trends. Practice developments in this country have also developed a unique flavour, influenced by our own "Kiwi culture" and Maori perspectives. The reality for many children who come to the attention of care and protection services is complex. The need for comprehensive assessment and treatment protocols that can be applied to multiple forms of abuse and its outcomes, including serious child mental health problems, has been recognised. In order to ensure the best outcomes for abused children and their families, local clinical research is required to develop and test protocols based on overseas empirical research interwoven with clinically proven local practice and our own cultural models. This calls for creative research designs in natural clinical settings (Saunders, 2003), collaboration across cultural and professional boundaries (Davies, 1999), and a clinical context supportive of research (Kessler et al., 2005). Such a setting has become available at Puawaitahi. Attention is now turned to the clinical problem of CA, starting with prevalence and sequelae.

Chapter 3: Prevalence and Sequelae

Outline and Aims

Child abuse statistics in New Zealand are a major concern. For example, of 27 wealthy nations, New Zealand had the third highest CA death rate (1.2 per 100,000) during a five year period in the 1990s (UNICEF, 2003). Life time estimates of CA suggest that 4% to 10% of New Zealand children experience harsh or severe physical punishment and approximately 18% experience CSA (Ministry of Health, 2001). It is commonly agreed by service providers in New Zealand that one in seven families experience domestic violence (DV) (Snively, 1994). Family violence encompasses CPA, CSA, and psychological/emotional abuse including threats and witnessing violence (The Risk Management Project, 1997).

Chapter 3 presents international and New Zealand prevalence and sequelae data, including New Zealand official statistics, in order to establish the scope of the problem.

Prevalence

Prevalence is a measure of the number of individuals in a population that have experienced a particular problem in a given timeframe. Internationally and locally, the prevalence of CA has been assessed using a range of approaches, all yielding different information. For example, figures derived from retrospective accounts of adults vary widely depending on the sample selection, response rate, definition used, and the method of data collection (Putnam, 2003). Even surveys of adolescents may depend on retrospective data, and these figures may have only moderate correspondence with prospective measures of CA (Tajima, Herrenkohl, Huang, & Whitney, 2004). Surveys of children are more likely to reveal figures reflecting the current prevalence of CA

more accurately, but are rare, and more often rely on parent/caregiver reports (Putnam, 2003). Official statistics also do not give a complete picture of CA as they are reliant upon active reporting of incidents.

In addition, social and political factors can influence prevalence data. For instance, during the 1960s and 1970s, a growing awareness of CA among the public and professionals led to a dramatic increase in official statistics (Finkelhor, 1984; Kaplan, Pelcovitz, & Labruna, 1999). From the 1990s declines have been recorded in some forms of CA in the US, possibly related economic prosperity, increasing agents of social intervention among other explanations (Finkelhor & Jones, 2006). Moreover, as introduced in Chapter 2, figures collected for specific types of abuse may obscure the fact that many children have been multiply-abused (Saunders, 2003). Furthermore, comparison of CA statistics of different countries is extremely difficult as different recording systems are used.

Notwithstanding such difficulties, it is instructive to review the data available, particularly as there is some consistency across nations in the CA figures recorded in survey data.

Survey and Longitudinal Data

Prevalence studies based on surveys and longitudinal studies capture a sample of the general population and may detect abuse that has never been reported to an official agency. Therefore, the figures tend to be higher than official statistics, and are likely to be more accurate (Finkelhor & Dziuba-Leatherman, 1994).

Table 1.1 reports CA prevalence data gathered from children, young people and/or their caregivers over four community surveys and one longitudinal study across three nations. Three of these studies report United Kingdom (UK), US, and New Zealand lifetime prevalence and show remarkable consistency in the figures for familial CPA (7-9%) and CSA (10%; mostly girls). The UK and US studies were consistent in lifetime prevalence reports for non-family physical assault or bullying (approximately 20%).

Table 3.1: Studies Reporting Prevalence of Child Abuse in Children and Adolescents

Study	Cawson, Wattam, Brooker, & Kelly (2000)	Finkelhor & Dziuba-Leatherman, (1994)	Finkelhor et al. (2005)	Adolescent Health Research Group (2003)	Fergusson & Horwood (1998) Fergusson & Lynskey (1997) Lynskey & Fergusson (1997)
Design					
Location	UK	US	US	NZ	NZ
Source	Community	Community	Community	School	Birth cohort
Sample	3,000	2,000	2,030	9,699	1,265
Age	18-24 years	10-16 years	2-17 years	12-18 years	18 years
Informant	Young person	Child/caregiver	Child/caregiver	Young person	Young person
Data	Lifetime	Lifetime	Study year	Study year	Lifetime
Mode	Survey *CASI	Survey Telephone interview	Survey CASI	Survey CASI	Longitudinal study Interview
Results					
CPA (family)	7%	7.5%	-	-	8.6%
Physical assault or bullying (non-family)	20%	22%	-	-	-
Physical assault (total)	-	-	53%	52% males 41% females	-
CSA	10%	10.5%	8.2%	11% males 22% females (unwanted sexual behaviour)	10%
Emotional abuse/DV	6% (including witnessing DV)	-	35.7% (witness to violence or indirect victimisation)	-	6-10% (witness to parental physical violence)

*CASI = computer assisted interview

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The UK survey reported prevalence data for emotional abuse, including witnessing violence (6%), is comparable to NZ rates for witnessing parental physical violence (6-10%). More recently published New Zealand longitudinal data from approximately 1,000 Dunedin-born 26 year-olds found comparable rates of extreme parental physical punishment (6%) and frequent parental physical violence (10%) in childhood (Martin, Langley, & Millichamp, 2006; Millichamp, Martin, & Langley, 2006). Notably, a quarter (24%) of the Dunedin-born sample reported witnessing some form of physical or threatened violence between their parents or parent figures (Martin et al., 2006), and 40% of the Christchurch-born sample reported witnessing at least one violent act by one or more parent (Fergusson & Horwood, 1998), comparable to the recent US community sample rates for witnessing violence or indirect victimisation (35.7%), as shown on Table 1.1.

Two studies, representing a US community sample and a New Zealand secondary school student sample, respectively, reported prevalence data for the study year only. Around half the children and young people surveyed reported having experienced a physical assault in the previous year. Figures were not broken down into family versus non-family. This relatively high figure may reflect the age of the sample in the study year (i.e., school age and at more risk of physical assault). The prevalence of CSA in the study year in the US sample was comparable with the other studies, at 8%. The New Zealand figures were significantly higher, particularly for adolescent girls (22%). Whether this reflects a true difference or is due to a broader definition of CSA as "an experience of unwanted sexual behaviour" is not clear.

Some additional detail from these surveys is worth reporting. The UK study found that children were most at risk in their own family, and that overall they are much more at risk from CPA and emotional abuse than of CSA (Cawson et al., 2000). The emotional abuse figures included witnessing frequent violence between parents, being regularly humiliated, or told that their parents wished them dead or never born. Serious physical neglect at home was reported by 6%, including being left without food or having to fend for themselves because parents were absent or had drug or alcohol problems. Those from the worst off socioeconomic strata (SES) were more likely to have been abused. However, even in the professional and managerial class, 4% of respondents reported

being severely physically abused. Almost no children had reported the abuse to the police, social services, teachers, or other professionals.

The way questions are asked and how results of surveys are reported can mask the complexity and reality of children's abuse experiences. For example, the 1994 US survey found that many children in the study had been the victims of and/or witness to several types of violence on multiple occasions (Finkelhor & Dziuba-Leatherman, 1994). The researchers of the most recent US community survey concluded that for many of the children involved, their victimisation may be more accurately described as a chronic condition than a traumatic event. For example, a child with any victimisations had a mean number of victimisations of 3.0, and a 69% chance of experiencing another during a single year (Finkelhor et al., 2005).

Rates of abuse in other countries, where available, are reasonably comparable. For example, CSA prevalence rates ranging from 7% to 36% for females and 3% to 29% for males were found in a review of large sample population-based studies of CSA in 19 countries (Finkelhor, 1994). These figures included studies based on retrospective reports by adults. The ratio of female to male CSA was typically between 1.5:1 and 3:1. Across all of the studies, half or fewer of the victims had disclosed to anyone.

New Zealand Official Statistics

In New Zealand, there is as yet no co-ordinated collection of statistics on CA among the agencies involved. CYF is the government agency charged with the statutory responsibility for investigating notifications of suspected CA and neglect. The reported figures for CA in New Zealand began to climb dramatically from the 1970s. In the late 1980s, the number of investigations undertaken by the Department for CA and neglect soared from 2131 in 1987-88 to more than 6500 in the following year. By 1992, almost 11,000 notifications were recorded (Dalley, 1998). The number of care and protection notifications received by CYF has continued to rise steadily each year[7].

From 2000 to 2002, the time period during which the current research began, notification figures increased 2.9% to 28,509 children (0-17 years). CA requiring further action was established in about 85% of these cases each year (Melville, 2003).

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[7] Note that CYF does not report by calendar year, but by financial year, i.e. July 1 – June 30th.

Since then, notifications have continued to increase dramatically; 33,102 in 2003; 43,143 in 2004; 53,097 in 2005 (Child Youth and Family, 2004, July 15; Department of Child Youth and Family Services, 2005).

More specifically, 2000-2002 data from CYF investigation findings showed that the proportion of cases[8] in which abuse was substantiated was: CPA, 17%; CSA, 10%; emotional abuse, 18%; neglect, 25%; behavioural/ relationship difficulties, 29%; self harm/suicide, 1% (Melville, 2003). The number of children interviewed on videotape nationally by the CYF Diagnostic and Evidential Interviewers increased from 1675 in 2000 to 1953 in 2002. Of these, approximately three quarters (77% in 2000 and 76% in 2002) were interviewed for CSA concerns and a quarter for CPA, with some regional differences (Basher, 2003).

Over the same time period, during which the Starship Children's Hospital CA teams moved into Puawaitahi (see Chapter 2), their figures showed a rising trend in the number of cases of CSA, CPA and neglect. From 2000-2002 the total number of children seen by Starship's CA service increased from 384 to 442, with higher figures for CSA of 313 rising to 324, and CPA cases increasing from 67 to 113. Similarly, New Zealand Police national records showed an increase in selected CA offences over the same period from 2724 to 2954, primarily "assault on a child" (935 in 2002) and "sexual offences" (1552 in 2002). Rape Crisis had found, based on 12,432 contacts in 1999, that half of all sexual violence was committed against children under 17 years of age, and only 27% of these incidences were reported to police (Melville, 2003).

In addition to direct forms of abuse, children may be harmed through witnessing violence, particularly when it occurs in their own homes (M. James, 1994). The number of children in New Zealand witnessing DV is unknown (Melville, 2003). The statistics on these children are captured to some extent in the CYF emotional abuse figures (18% of substantiated abuse cases at the time the current research began), which includes by definition "witnessing violence". Also indicative is the number of children involved in women's refuges, numbering over 9,000 during this time (Women's Refuge, 2001)

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[8] The percentage figures quoted here are approximate, but are within 1-2% of actual annual figures, proportions of which changed very little over the financial reporting years of 2000-2002.

Age, Ethnicity, Gender, and Placement Statistics

CYF data showed that rates of abuse and neglect were fairly consistent across most age groups: in 2000, age 0-4, 29%; 5-9, 34%; 10-13, 26%; 14-16, 12% (Ministry of Social Policy, 2001). Nationally, Maori children were much more likely than non-Maori to be assessed as abused or neglected: in 2000, Maori, 44%; non-Maori, 56% (rate per 1,000: Maori, 12.0; non-Maori, 5.3). Pacific Island children accounted for 12% of children assessed as abused in 2000, about the same representation as in the general child population (Ministry of Health, 2001). CYF placement figures indicate many abused and neglected children require placement as a result of CA: in 2000, there were 12,391 such placements of children aged 0-16 years in agencies, family homes, family/whanau care or residencies (Ministry of Health, 2001).

Puawaitahi statistics from 29 November 2002 to 16 February 2007 across the three agencies showed gender of first visit clients (total = 3,151): female, 75%; male, 25%. Age bands: adult, 11%; youth (13-16), 35%; child (birth-12), 54%. Ethnicity: European, 43%; Maori, 28%; Polynesian, 19%; Asian, 3%; Indian, 3%; Other, 4% (Kirkham, 22 February, 2007).

Sequelae of Abuse

Unlike disorders of childhood such as anxiety and depression which are characterised by a distinct group of symptoms, CA is an experience that has a wide range of manifestations (Friedrich, 2002a). Reviews of CPA, CSA and child witnesses to DV have found that these traumas not only vary in severity, frequency and duration, but that they are modified by a range of variables; there is no symptom picture that characterises all abused children (English et al., 2005; Kaplan et al., 1999; Kendall-Tackett, Williams, & Finkelhor, 1993; Kitzmann, Gaylord, Holt, & Kenny, 2003; Putnam, 2003). For example, while child maltreatment may predict psychopathology, childhood family variables may be better predictors of adjustment (Higgins & McCabe, 2003). Moreover, symptoms and behaviour can vary according to the age at which the abuse occurred and may wax and wane with developmental progression (Dante Cicchetti & Rogosch, 2002).

Researchers have suggested that the heterogeneous responses of children to abuse may result from a complex set of interactions between preabuse factors, abuse factors, and postabuse factors (O'Donohue, Fanetti, & Elliott, 1998). The multiple risk factors frequently present in the environments of abused and neglected children limit conclusions about the specificity of effects. Children may be symptomatic if their family context is chaotic and distressing, or characterised by parental violence, even if they have not been directly physically or sexually abused (Allan, Kashani, & Reid, 1998; D. A. Wolfe & Mosk, 1983). Severity of abuse can be related to qualitative features of the parent-child relationship, such as interpersonal sensitivity and affective tone (Zielinski & Bradshaw, 2006). Child outcomes may vary depending on the relationship between the child and the perpetrator (Putnam, 2003). Abused children may fail to develop secure attachments with their parents or caregivers (Rogosch, Cicchetti, & Aber, 1995). The child's living circumstances postabuse for example, removal from home and multiple caregiving transitions may increase the risk for subsequent problems (E. C. Herrenkohl, Herrenkohl, & Egolf, 2003). Culture may influence a traumatised child's mode of symptom expression, and may shape the salience of the event and how it is responded to by other members of the culture (Dante Cicchetti & Rogosch, 2002). Therefore, contextual factors not only influence the incidence of maltreatment, but may also moderate its developmental effects (Zielinski & Bradshaw, 2006).

Developmental factors may also influence the impact of abuse. The child's age at the time of exposure to abuse may be important for a number of reasons. For example, due to the relative immaturity of their developing nervous system, younger children may be more vulnerable to PTSD and to the impact of abuse on brain development (Nemeroff, 2004). This is likely to be mediated by a second variable, the cognitive processes typical of younger children, which give them less capacity to fully anticipate or protect themselves, or to adopt nonegocentric causality (Famularo, Fenton, Kinscherff, Ayoub, & Barnum, 1994). Nor are younger children developmentally able to organise events into a system that can be managed emotionally, and they may re-enact their trauma repetitively through play (Terr, 1991). Exposure to violence has been linked to emotional dysregulation in young children (Osofsky, 1995). This inability to modulate the expression of affect in proportion to what a situation calls for can lead to subsequent difficulties, such as depression and behaviour problems (Gross, 1998). Further

exploration of the developmental stage at which abuse occurs and the pattern across developmental stages and relationship to child functioning is still required (English et al., 2005).

Related to developmental factors, child characteristics and contextual variables, other risk and protective/resilience factors may also influence CA sequelae. For example, the child's perception about living in unsafe circumstances may foster feelings of depression and anxiety, as well as behaviour problems (Buckner, Beardslee, & Bassuk, 2004), or alternatively, may contribute to the development of strengths and perceived benefits (McMillan, Zuravin, & Rideout, 1995). In adolescents, protective factors such as positive peer group characteristics, school climate, other adult support, and family support may ameliorate the negative effects of abuse, while risk taking behaviours may exacerbate problems (Perkins & Jones, 2004).

Analysis of the sequelae of abuse in children is further confounded by reporting factors intrinsic to this aspect of child psychopathology. For example, younger children often have cognitive features that limit their ability to report on symptoms and experiences (Hewitt, 1999). Younger and older children and adolescents may be reluctant to reveal their symptoms due to guilt, shame, a desire to maintain family intactness, and based on the avoidant aspects of anxiety and PTSD (Friedrich, 2002b).

Furthermore, many studies in the literature have serious methodological shortcomings. CA research often fails to identify the exact type(s) of abuse experienced by the subjects, reflecting the fact that the reality for abused children is variable and complex (Saunders, 2003). Other problems include inattention to sampling issues, lack of control groups, failure to assess moderator variables, and use of unvalidated measurement instruments (Myers et al., 2002). Notwithstanding these issues, the plethora of research which has been carried out in the area of CA has consistently identified a range of consequences that should be considered when assessing and treating abused children and young people.

Physical Abuse Sequelae

Sequelae in childhood associated with CPA include difficulties in interpersonal skills, such as insecure patterns of attachment (Dante Cicchetti & Barnett, 1992) and peer

difficulties (Okun, Parker, & Levendosky, 1994; D. A. Wolfe, Wekerle, Reitzel-Jaffe, & Lefbvre, 1998) including social problem-solving difficulties, a greater likelihood of interpreting interactions with peers as hostile, and greater levels of fear when exposed to anger between adults (Runyon, Deblinger, Ryan, & Thakkar-Kolar, 2004), aggression and behavioural difficulties (R. C. Herrenkohl, Egolf, & Herrenkohl, 1997; Kolko & Swenson, 2002), cognitive and academic impairment (Eckenrode, Laird, & Doris, 1993; McFayden & Kitson, 1996), suicidal and risk-taking behaviour (Kaplan, Pelcovitz, Salzinger, Mandel, & Weiner, 1997), and trauma-related emotional problems such as anger, guilt, shame, and sub-clinical PTSD, through to full-blown psychiatric disorders including depression, anxiety, PTSD, conduct disorder, attention deficit/hyperactivity disorder (ADHD), and substance abuse (Famularo, Kinscherff, & Fenton, 1992; Kaplan, Pelcovitz, Salzinger, & al, 1998; Kolko & Swenson, 2002; Pelcovitz et al., 1994; Runyon et al., 2004). Approximately 8% of physically abused children and adolescents have current diagnoses of major depressive disorder (MDD), approximately 40% have lifetime MDD, and at least 30% have lifetime disruptive disorder diagnoses (Kaplan et al., 1999). Studies have found between 6.9% and 42% of physically abused children meet criteria for PTSD (Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Dubner & Motta, 1999; McCloskey & Walker, 1999).

Longitudinal and retrospective studies indicate that the long-term effects of CPA include mental health problems in adulthood, antisocial behaviour problems such as dating violence and marital violence, higher rates of criminal offences, ongoing cognitive impairment, vocational problems, substance abuse, and suicidal attempts in adulthood (Kolko & Swenson, 2002). New Zealand research showed that at 18 years of age those exposed to CPA were at increased risk of violent behaviours, suicide attempts, alcohol abuse, and anxiety disorders (Fergusson & Lynskey, 1997).

Sexual Abuse Sequelae

The commonly reported sequelae of CSA in children include trauma and stress-related symptoms such as fear, sleep problems, and distractedness, other signs of anxiety, depression, anger, aggression, sexually inappropriate behaviour, and cognitive distortions such as guilt and shame (Browne & Finkelhor, 1986; Finkelhor, 1990; Kendall-Tackett et al., 1993). In a sample of non-clinically referred children who had been sexually abused, 62.8% met criteria for at least one psychiatric diagnosis and

29.5% met criteria for two or more, including 20.7% with PTSD (McLeer, Dixon, & Henry, 1998).

New Zealand research has found that exposure to increasingly severe forms of sexual abuse increased the rates of psychiatric disorders and adjustment difficulties at age 18 (Lynskey & Fergusson, 1997). For example, compared with nonabused children, young people with histories of CSA had an increased odds ratio of 4.6 for major depression. Those who reported intercourse had an increased odds ratio of 8:1 for major depression and 11.8:1 for a suicide attempt (Fergusson, Horwood, & Lynskey, 1996a; Fergusson, Horwood, & Lynskey, 1996b). However, a quarter of young people exposed to CSA did not meet any criteria for any adjustment difficulties. Protective factors were found to include parental care and prosocial peer affiliations (Lynskey & Fergusson, 1997).

Long-term outcomes of CSA have been extensively researched. International and New Zealand findings have linked CSA to a range of adverse effects and dysfunctional behaviours in adulthood. These include, low self-esteem, social relationship problems, self-destructive and suicidal behaviour, somatic complaints, health problems, sexual dysfunction, sex crimes and prostitution, and revictimisation (Briere & Elliott, 2003; Browne & Finkelhor, 1986; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Widom & Ames, 1996). Mental health outcomes include but are not limited to, the DSM disorders of MDD, PTSD, borderline personality (BPD), somatization, substance abuse, dissociative identity disorder (DID), bulimia nervosa (Putnam, 2003), and psychotic spectrum disorders (Read, Mosher, & Bentall, 2004).

Witnessing Domestic Violence Sequelae

A meta-analytic review of 118 studies of child witnesses to domestic violence found an average study-level ES of d=-0.34 (Kitzmann et al., 2003). This means 63% of child witnesses were showing outcomes poorer compared to the average child. Children's exposure to DV, even when they are not the target of the violence themselves, is associated with internalizing problems such as withdrawal, anxiety, and depression, and externalising problems including aggression and conduct disorders (Boney-McCoy & Finkelhor, 1995; Holden, 1998), which increase with the amount and severity of the violence (Johnson et al., 2002). Trauma symptoms through to diagnosable PTSD in children have been found to be associated with exposure to DV (McCloskey & Walker,

1999; Silvern et al., 1995). Younger children are more likely to exhibit somatic complaints and experience greater distress (Holden, 1998).

Children who witness DV are also at increased risk of CPA and neglect (Cox, Kotch, & Everson, 2003). A study of a nationally representative sample of 3,363 parents in the US found that a quarter (22.8% of husbands and 23.9% of wives) who behaved violently towards their spouse, also physically abused their children (Ross, 1996). Different types of family violence may contribute different outcomes to child behaviours. For example, witnessing violence and/or psychological abuse predicted anxious/depressed problems whereas child psychological and physical abuse together predicted aggressive behaviour (Litrownik, Newton, Hunter, English, & Everson, 2003).

Overall, while there is robust evidence that exposure to DV is associated with significant disruption in psychosocial functioning in children, the gaps and inadequacies in the research (e.g., which variables are associated with what outcomes) make it difficult to draw definitive conclusions (Kitzmann et al., 2003). However, recent New Zealand research showed that levels of distress in children at the time of the exposure to DV was more related to frequency of parental violence and not who carried it out, or whether it was physical or threatened (Martin et al., 2006).

Emotional Abuse Sequelae

Emotional abuse (also termed psychological abuse or maltreatment) occurs alongside CPA and CSA and witnessing DV, as well as occurring independently of other types of abuse. It is likely that emotional abuse and neglect is the form of abuse most frequently experienced by children (Kaplan et al., 1999). However, the actual extent of psychological maltreatment is not known (S. N. Hart, Brassard, Binggeli, & Davidson, 2002).

There has been little research on the sequelae of emotional abuse per se, probably because until recently it was not considered to be as damaging as physical forms of maltreatment, and it is more difficult to quantify. However, the research that has been carried out suggests that emotional abuse is a strong predictor of a wide range of problems, including emotional instability, social impairment, learning difficulties, physical health problems, internalising and externalising behaviours, suicidality and

psychiatric diagnoses (S. N. Hart et al., 2002; McGee, Wolfe, & Wilson, 1997; Mullen et al., 1996).

More specifically, verbal abuse and emotional neglect have been found to have negative effects on children's feelings and ideas about enjoyment of living, purpose in life, and prospects and expectations for the future (Ney, Fung, & Wickett, 1994). Longitudinal studies have found hostile verbal abuse to be similar to CPA in the negative impact on children, and psychologically unavailable caretaking to be the most devastating of all maltreatment forms studied (S. N. Hart et al., 2002). A recent study found emotional abuse (including that perpetrated by family *and* peers, including bullying) was the strongest predictor of the severity of PTSD symptoms in a sample of adolescent inpatients with a reported history of a range of abuse types (Sullivan, Lipschitz, & Grilo, 2006).

Children who are in situations where the cumulative effects of multiple risk factors outweigh protective resources are more susceptible to short and long-term social, cognitive, and psychological problems (Iwaniec, Larkin, & Higgins, 2006).

Neglect

Neglect is often part of the picture for children exposed to CPA, CSA and DV. Like emotional abuse, neglect is more prevalent, yet less studied than other forms of CA (De Bellis, 2005). Additionally, there is a lack of operational definitions and measures of neglect. However, as neglect is an act or omission that results in impaired physical functioning, injury, or development, it can have devastating effects on a child's subsequent development. For example, neglectful supervision or abandonment can impact on attachment security, and emotional, social and cognitive development. Likewise, failure to be given the necessities of life can cause not only physical growth delays, but also adverse brain development and other neuropsychological outcomes (De Bellis, 2005).

Biological and Neuropsychological Correlates of Abuse

Research relating to the biological correlates of abuse in children is receiving increasing attention, revealing the relationship between CA experiences, the stress response in the brain, and the subsequent effect on emotional, psychological and behavioural

difficulties observed in abused and neglected children (Glasser, 2000; Watts-English, Fortson, Gibler, Hooper, & De Bellis, 2006). Specifically, there is some evidence for decreased hippocampal size (Bremner, Randall, & Vermetten, 1997), altered brain development (Ito, Teicher, Glod, & Ackerman, 1998), hormonal changes including elevated cortisol levels (J. Hart, Gunnar, & Cicchetti, 1996) and reduced growth hormone levels (Jensen, Pease, Ten Bensel, & Garfinkel, 1991).

Abused children with PTSD have been found to have greater concentrations of urinary free cortisol than healthy controls and of urinary epinephrine than anxious nonabused children (De Bellis et al., 1999a), and smaller intracranial and cerebral volumes than control children (De Bellis et al., 1999b). In a recent pilot study, cognitive functioning of abused children with PTSD was found to be poorer than controls on neuropsychological measures of attention and abstract reasoning/executive function (Beers & De Bellis, 2002).

In summary, these findings suggest that the trauma of abuse is associated with biological effects including impaired brain development, cognitive functioning, and overall growth.

PTSD Sequelae in Abused Children

Investigations have shown that PTSD is common reaction to CA and exposure to interpersonal violence. Studies reviewed have documented the prevalence of PTSD in abused children between 6.9% and 67.3% depending on the nature of the abuse (e.g., Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Deblinger et al., 1989; Dubner & Motta, 1999; Famularo et al., 1994; Linning & Kearney, 2004; McCloskey & Walker, 1999). Overall prevalence of PTSD is generally reported for about a third of abused children.

Histories of any type of abuse can be associated with elevated symptoms, while multiple-abuse more likely portends the development of PTSD (Naar-King, Silvern, Ryan, & Sebring, 2002). Of children exposed to DV, tentative findings indicate that that those who are solely witnesses may be somewhat less at risk of developing symptoms (about 20%) than those who are targets of CPA (about 40%), but children who report being both a witness and a target are highly at risk of developing full-blown

PTSD (up to 100%) (McCloskey & Walker, 1999). There is some evidence that CSA results in higher levels of PTSD compared to CPA (Dubner & Motta, 1999; Runyon & Kenny, 2002). Children who have been jointly physically and sexually abused appear to be at greater risk for psychiatric disturbance (Ackerman et al., 1998).

Risk and Protective/ Resilience Factors for PTSD in Abused Children
In addition to multiple-abuse, risk factors that may increase the likelihood of a child developing PTSD as a result of abuse include severity and chronicity, coercion to maintain secrecy, younger age at onset, being female, and victimisation by more than one perpetrator and someone close to them (Browne & Finkelhor, 1986; Davis & Siegel, 2000; Linning & Kearney, 2004; D. A. Wolfe, Sas, & Wekerle, 1994).

Family factors that increase risk for PTSD in abused children include lower SES, higher stress, poorer maternal mental health, and more extensive family drug and alcohol use (Linning & Kearney, 2004; Shipman, Rossman, & West, 1999). Parents in at-risk families tend to be less interactive, supportive, and nurturing, and exhibit more aggression, negative affect, psychopathology, marital conflict, and poorer parenting (D. Cicchetti & Toth, 1995; Deblinger, Steer, & Lippmann, 1999; McFarlane & Yehuda, 2000).

Abused children who develop PTSD may also have more psychological risk factors. For example, a recent review found that chronic PTSD in children has been associated with maladaptive coping, helplessness, guilt, hyperaroused physical reactions, avoidance, and disturbances in memory and information processing (Linning & Kearney, 2004). Comorbid psychological disturbance, in particular other anxiety disorders and depression, as well as related problems are common for abused children with PTSD (Ackerman et al., 1998; Famularo et al., 1994; Linning & Kearney, 2004; McLeer et al., 1998). PTSD in abused children has been associated with negative abuse related attributions and a coping style that is more avoidant and less approach based (Cohen & Mannarino, 1996; Linning & Kearney, 2004).

Protective factors that may reduce the chance of a child developing PTSD as a result of abuse are important to note. These may include effective coping skills and a supportive

caregiving environment (Deblinger et al., 1999; Rutter, 1990). Protective factors are thought, for some, to be associated with posttraumatic growth (Christopher, 2004).

Social and Economic Sequelae

The cost of CA is enormous. A recent doctoral study estimated that the economic cost to New Zealand of CSA alone was $2.4 billion a year (Julich, 2001). Using a model for costing social problems developed in this country, Julich concluded that adult survivors pay $900 million in lost earnings, extra health bills and unmet potential; the balance is paid by the country. For example, ACC offers counselling, and in some cases regular weekly payments, to those people it accepts have been mentally injured from CSA. The economic costs of CPA and emotional abuse, neglect and witnessing violence are less quantifiable, but likely to be comparable.

Summary

CA has an effect on the lives of an alarming number of children, young people and families, and has far reaching effects for society. While New Zealand prevalence data for CA is comparable to that of the UK and the US, our official statistics as they stand are concerning. Notifications to CYF have soared in the last three decades. Whether this reflects an actual increase in CA in this country, or a growing awareness of the problem and willingness to report to official agencies is not clear. What is clear though is the extent and complexity of the problem, both in terms of types of abuse and sequelae. In most cases, the short and long-term effects are devastating. The reality for children is often one of multiple-abuse, with adverse effects on emotional well being, behaviour, cognitive processes, physiology, neurobiology, social relationships, and their future. Notably, abused children are at increased risk for child mental health problems, particularly PTSD.

Researchers who have examined the relationship between CA and PTSD recommend comprehensive assessment and treatment targeted to the specific sequelae of abuse and trauma (Linning & Kearney, 2004). An understanding of the sequelae of CA contributes to the development of treatment programmes designed to ameliorate the effects of this complex experience on children. Equally important is an understanding

of the mechanisms that operate between the event(s) of CA and the development of the effects. For this, we need to turn to theory related to CA trauma.

Chapter 4: Guiding Theories

Outline and Aims

By making a somewhat arbitrary distinction between theory, research and practice, an effort has been made in this chapter to discern the theoretical frameworks that have influenced and guided research and practice for those working in the field of CA trauma. This is bearing in mind that "child abuse" and "trauma" are concepts that have arisen as a way to understand and explain certain human experiences for which we had no words a mere 200 years ago. These concepts are at once theoretical constructs and guiding paradigms. They have enabled us to identify, describe, and speculate upon the genesis and path of these experiences (i.e. theories). These concepts have also given rise to vast endeavours of inquiry into the how and whys and wherefores of processes that both underpin and ameliorate their effects (i.e. research and practice).

Theoretical understandings, research, and clinical practice do not develop in a neat systematic pattern of one logically following the other. Instead, they develop side by side, one perhaps informing another, but not always. At present, there is no consensus as to how competing theories that contribute to the field of CA should be evaluated (G. Macdonald, 2001). Also, in child protection practice there is a tradition of a preoccupation with action rather than analysis, endemic at the "coal face" right through to the bureaucratic structures of management, including within treatment services for abused children and their families. A kind of a "can do" attitude that has at its heart a fervent desire to keep children safe and enhance their well being, but in doing so may fail to challenge what is chosen to be done and how problems are formulated. Geraldine Macdonald argues that theories should be evaluated for their relative merits on the extent and quality of underpinning empirical research (G. Macdonald, 2001). This thesis shares that view, and also considers clinical salience where empirical evidence is scant.

In this chapter, the overall aim has been to trace the development of theories that have influenced the field of CA trauma, and to evaluate their relative merits in contributing to an orientating framework for research and practice in working with children who have been traumatised by abuse. The emphasis is on trauma/PTSD models and behavioural and cognitive theories, as these are the focus of the current research. Also flagged are related theoretical constructs that pertain to working with abused children and their families, in particular, abuse-focused models, developmental perspectives, attachment theory, and contextual/systemic approaches.

History of Psychotraumatology

The genesis of theories pertaining to CA trauma lies in the broader study of psychological trauma. The recognition of trauma as a causal factor can be found in the oldest text in Western literature, the Iliad, in which Homer demonstrated the relationship between war crimes and psychic trauma (Weisaeth, 2002). Early theories of trauma, as indeed do those of today, tend to reflect the social and political context in which they were developed.

In the 19th century, psychiatry had its origin in England with the study of a new phenomenon resulting from new technology. Victims of horrific railway accidents demonstrated psychic changes that came to be known as "railway brain" (Weisaeth, 2002). In Germany, Oppenheim coined the term "traumatic neurosis" to describe the psychological effects of frightening experiences. At the Salpetrière in Paris, Charcot, Janet and Freud unravelled the nature of traumatic neurosis further. Freud was the first to conceptualise CSA as a psychological trauma. However, as introduced in Chapter 2, he moved away from an etiology of "unbearable situation" to one of "unacceptable impulse" by the end of his career (van der Kolk, Weisaeth, & van der Hart, 1996; Weisaeth, 2002).

In the 20th century, the invention of dynamite led to the advent of explosive artillery shelling in World War I. The psychological effects of this new style of warfare on soldiers refocused attention on psychotraumatology with the conceptualisation of the

notion of "shell shock". World War II had less influence on academic psychology and psychiatry, as combat stress reactions were treated generally using models developed in World War I. Later models of trauma owe more to studies of returning Vietnam veterans in America, the Feminist and Childrens' Rights movements, and the advances of behaviourism and cognitive theories (Weisaeth, 2002).

By the 1960s, a series of trauma-specific syndromes had been recognised that had common patterns of psychological distress derived from a diverse range of traumatic events. These clustered into trauma syndromes related to war experiences, such as "Vietnam veteran's syndrome", and those related to interpersonal violence, particularly against women and children, with terms including "battered women syndrome" , "rape trauma syndrome" and "abused child syndrome" (van der Kolk et al., 1996; Weaver & Clum, 1995).

In 1980, the wide range of signs, symptoms, and behaviours comprising the psychological effects of trauma exposure became subsumed under the new diagnosis of PTSD, with its own set of diagnostic criteria[9] (American Psychiatric Association, 1980). In contrast to nearly all other diagnoses in psychiatry, the main cause of the disorder was explicitly considered to be external. The PTSD diagnosis was intended to help victims of trauma gain understanding and acceptance and to promote appropriate treatment (Weisaeth, 2002).

Abuse-focused clinicians have argued that the trauma/PTSD conceptualisation does not specifically cover all manifestations of CA (e.g., social problems, biological sequelae, or other psychological disturbances) (Briere, 1992; Herman, 1992). Judith Herman contends that CA is often prolonged and repeated, occurring to a child victim who is a state of captivity, unable to flee, and under the control of the perpetrator. Hence, the sequelae of this trauma are more complex than that of the repetitive symptomatology of simple PTSD, and include disturbances in identity formation and relationships, and risk of repeated harm, either self-inflicted or at the hands of others. Herman proposes that a spectrum of disorders be delineated more closely, including Disorders of Extreme Stress

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[9] See Appendix B. Note also that the DSM-IV-TR diagnostic criteria for PTSD (American Psychiatric Association, 2000) was used in this research rather the alternative ICD-10 (World Health Organisation, 1992) classification system, which is not widely used in New Zealand.

Not Otherwise Specified (DESNOS). Lenore Terr proposes a similar distinction in children between Type I (single ordeal) and Type II (long standing or repeated ordeals), the former characterised by intrusive recollections, and the latter by denial, numbing and dissociation (Terr, 1991). While these are limitations, the conceptualisations of "trauma" and "PTSD" have provided useful frameworks for the development of theory, research and practice in the field of CA (Briere & Scott, 2006).

Psychoanalytic and Psychodynamic Theories of Trauma

Psychoanalytic and ensuing psychodynamic and expressive models have contributed much to the field of trauma. Freud's initial "seduction theory" was ahead of its time in identifying CSA as a traumatic event which could be profoundly distressing to the individual. As previously discussed, Freud rejected this idea, apparently in response to a society not ready to accept this notion. Nevertheless, Freud retained the idea that traumatic events were external stressors which were a threat to the ego (Pandit & Shah, 2000).

Psychoanalytic Models

In later years, Freud elaborated his understanding of trauma, emphasising that both the intensity of the traumatic stimulus as well as the degree of ego strength and availability of defences contributed to the experience of being traumatised. Freud laid the groundwork for a developmental perspective on trauma, proposing that traumatic events during childhood could be seen as having a greater impact than trauma during adulthood because of the immature ego's lack of resources with which to process such experiences (Sugarman, 1994). Notably, Freud's work with "Little Hans", a 5 year old boy with a phobia, was the first case that recorded that a child's difficulty may have emotional causes. This case was also the first to describe the therapeutic use of play, and was a forerunner of later child-focused expressive therapies (Landreth, 2002).

Subsequent analytic exploration of traumatised patients has given greater attention to the multifaceted variables contributing to the experience of trauma (Sugarman, 1994). For example, psychoanalysts may consider the meaning an individual attaches to the trauma that gives it its particular pathological significance. In addition, mechanisms

used to handle psychological trauma are studied, including repetition, repression, dissociation, isolation, regression, and somatisation. The developmental context of trauma has continued to be emphasised by psychoanalysts.

Psychodynamic Models

The psychodynamic treatment model focuses on gently confronting the client's feelings of helplessness, shame and vulnerability first by way of the therapeutic relationship. The aim is to modify the defensive and coping strategies (i.e. symptoms) used to manage the maladaptive representations of the trauma and facilitate processing of the meaning of the traumatic memories and accompanying emotional distress (Marmar, 1991). The therapeutic relationship is conceptualised in terms of (a) the working alliance, and (b) transference and counter-transference. In this model, the client may utilise the therapist as a functional equivalent of a lost parent, and this provides a framework for dealing with both past and present situations.

Expressive Therapy Models

Derived from psychoanalysis, three models of expressive therapy were developed simultaneously, and continue to be extensively used, particularly for working with children, including those with abuse and trauma histories (Gil, 2006). These are play therapy, art therapy, and sandplay therapy.

Play therapy was initially developed as a means of analysing young children (Landreth, 2002). Melanie Klein was one of the first psychoanalysts to document the use of play to encourage children to express fantasies, anxieties, and defences, which she then interpreted. Anna Freud used play as a means for facilitating a child's emotional attachment to the therapist and gain access to the child's inner world. Play therapy has continued to develop as a dynamic approach for working with children that allows the therapist to experience the child's world and enables the child to gain control in the environment (Landreth, 2002).

Art therapy has also been attributed to Freud, who recognised early on that patients used expressive techniques such as visual images to understand their experiences. Art was later used by Anna Freud to help young child patients bring unconscious material to the surface (Gil, 2006). Based on psychoanalytic concepts, expressive art therapy has

become a discipline in its own right (Rubin, 1999), and is used with abused and traumatised children (Malchiodi, 1997). Art techniques used therapeutically with children include drawings of self and family, life maps, and clay work (Kaduson & Schaefer, 2004).

Sandplay therapy was developed by child psychiatrist Margaret Lowenfeld and integrated into her analytic practice (Lowenfeld, 1979). This model involves the use of a sand tray and miniature objects with which children create a "world" in the presence of a therapist. While subsequently influenced by Jung, and adapted for use within this context with adults, many contemporary clinicians working with children have continued to use Lowenfeld's technique in largely unchanged form (Gil, 2006).

Contribution of Psychoanalytic/Psychodynamic Models

In summary, psychoanalytic and psychodynamic approaches have emphasised the importance of a developmental perspective in assessing trauma, and the therapeutic relationship as a vehicle for the processing of trauma memories and emotional distress.

In particular, expressive therapy models derived from psychoanalysis have been used clinically to address abuse and trauma in children (Kaduson & Schaefer, 2004; Labovitz-Boik & Goodwin, 2000). Play therapy models have been found to help abused children make sense of their experience of abuse and find ways of functioning that do not re-process the patterns of the abusive relationship (Cattanach, 1992). The usefulness of art therapy approaches for individuals with abuse histories has been documented (Gil, 2006). Clinical experience suggests that the sandplay therapy model engages an active imaginative and creative process, promotes a developmental and healing response, externalises the client's external world, and bridges conscious and unconscious processes (Gil, 2006). Empirical evidence shows that sandplay, in particular, can reduce presenting symptoms and increase insight and understanding in children who have been abused (Grubbs, 1994) and exposed to violence (Parson, 1997) by enabling children to play out traumatic situations in consecutive sand trays.

With regard to trauma theory, psychoanalytic and psychodynamic models have accounted for the recognition of symptoms of avoidance and re-experiencing of PTSD, and but do not directly address symptoms of physiological arousal. More importantly,

psychoanalytic theories have not been submitted to the kind of empirical testing required to verify their effectiveness in this area. Nevertheless, these models continue to strongly influence professional practice in the field of CA treatment (G. Macdonald, 2001).

Behavioural Theories of Anxiety and Trauma

Behavioural models, on the other hand, do account for symptoms of arousal, and have an inherent tradition of empirical rigour. Early behaviourists did not systematically apply their studies to traumatic stress, however, their theoretical ideas formed the basis for later developments that continue to contribute much to current treatment practices for trauma and abuse.

Russian physiologist, Ivan Pavlov developed a theory of traumatic shock as a result of his dogs becoming trapped in cages in a flooded laboratory, but the model was never tested. The central notion of this model was that very strong external stimuli causes overstrain of the excitatory processes (Weisaeth, 2002). Nonetheless, Pavlov's classical conditioning model did provide the idea that stimuli associated with external events can come to elicit responses similar to those shown during the exposure to the event itself, and that these associations can be undone through extinction.

B.F.Skinner's work on behaviourism postulated that all behaviour is learned and can be understood in terms of reinforcers (Skinner, 1953). This construct, known as operant or instrumental conditioning, also contributed to the development of theories related to anxiety and trauma.

Learning Theories of PTSD

Learning theories of PTSD based on Mowrer's Two Factor Theory (Mowrer, 1947, 1960) involve classical and operant learning and centre on the role of anxious arousal and avoidance and identifiable conditioning processes (Kilpatrick, Veronen, & Resick, 1982). In this model, trauma related anxiety is understood to be provoked through classical conditioning. The anxiety producing event acts as the unconditioned stimulus (UCS), leading to an unconditioned response of fear and feeling upset (UCR). Neutral

cues such as sights, sounds, thoughts, and situations are paired with the trauma and become conditioned stimuli (CS) which evoke conditioned anxiety, arousal and fear responses (CR) even in the absence of the event. Operant learning then maintains and strengthens the avoidance of feared stimuli, with the avoidance behaviours being reinforced by a resultant reduction in anxiety. Relatedly, the anxiety symptoms may be further maintained by an ongoing failure of extinction. For the learning to be undone, the CS must be repeatedly presented by itself without the UCS, and then the CR will gradually disappear. In Pavlov's terms, the CS-UCS link undergoes extinction. This is related to habituation, which is the decline in an organism's tendency to respond to a stimulus once the stimulus has become familiar. These ideas underpin the therapeutic technique of exposure.

Joseph Wolpe, a behaviourist in the Pavlovian tradition, was also influenced by learning theory. He extended earlier work on both extinction and the "principle of reciprocal inhibition" and developed the idea that a stimulus that normally produces fear or anxiety will cease to elicit a fear reaction if paired with a response that is incompatible with fear or anxiety (e.g., relaxation). Based on this theoretical construct, Wolpe developed systematic desensitisation, an exposure and relaxation based technique for treating neuroses (Wolpe & Lazarus, 1966).

Applied Behaviour Analysis

The operant orientation also led to approaches variously known as behaviour modification or applied behaviour analysis. The behaviour analytic framework examines external influences on behaviour, including social influences on symptoms and attempts at coping. Functional analysis methodology attempts to uncover the environmental causes of behaviour, rather than hypothetical inner causes, and challenges the concept of a posttraumatic stress "syndrome" or "disorder" (Naugle & Follette, 1998). This approach emphasises the influence of significant others and culture in shaping responses to trauma. It also highlights that the behavioural sequelae of traumatisation are many and varied, and may differ not only with context variables, but also across individuals. According to this model, problems defined under the category "PTSD" may be caused and maintained by very different variables.

Social Learning Theory

Albert Bandura was essentially a behaviourist who believed, in addition to the conditioning response theories, that people learn by observing and imitating others (Bandura, 1977). Social learning theory postulates how human beings acquire (or fail to acquire) skills, attitudes and patterns of behaviour. Conditioned emotional fears and anxieties are explained due to observation and vicarious learning of the conditioned fears and anxieties of others. Bandura holds that all individuals have a capacity to learn new, more effective behaviour. This can be achieved through conditioning, social modelling, and behaviour rehearsal.

Contribution of Behavioural Theories

In addition to a conceptual understanding, behavioural theories have contributed significantly to the treatment of trauma. The learning theory conceptualisation provides a rationale for the importance of exposure in treating trauma. Clinical applications show that if exposure is carried out in a safe therapeutic environment, entrenched and unhelpful stimulus-response patterns may be disconnected as the client recognises that the trauma-linked fear and anxiety is unrelated to current circumstances (e,g., Smith, Perrin, & Yule, 1998). Pavlovian-derived treatment approaches have formed the basis of anxiety management training using conditioned response techniques such as relaxation, visualisation, and assertion to treat symptoms of fear or anxiety (e.g., Meichenbaum, 1994). Operant approaches suggest the need for a close analysis of reinforcement variables maintaining symptoms (e.g., avoidance), and the encouragement of practice to enable new reinforcement patterns to become established and ameliorate against avoidance and other fearful behaviours. Social learning theory has contributed to the treatment of children in particular. On the basis of these ideas, a child may be encouraged to observe a live model, or imagine a fantasy hero coping with a fear, to practice the new-found coping skills in the therapy setting under conditions that approach reality, and then to generalise this coping behaviour to real life situations (e.g., Kendall et al., 1992).

However, behavioural models do not explain the re-experiencing aspect of PTSD, nor do they elucidate the cognitive and affective components of fear and anxiety.

Cognitive Theories of Trauma/PTSD

In the 1960s, cognitive science emerged and began to extend behavioural approaches. Cognitions such as "attitudes", "beliefs" and "memories" were identified as mediators between an organism and the environment (Beck, 1976). Consequently, theories were developed which acknowledged a more central role for cognitive process in the course of trauma reactions. These models are based on the proposal that traumatic events and subsequent symptomatology influence how an individual appraises their experience, themselves, others and the world. They also discuss reciprocal influence (e.g., how appraisal influences the nature of the trauma). They provide predictions about trauma-related behavioural and cognitive changes, including negative beliefs, "self-talk", assumptive bases or "schemas", and intrusive thoughts and memories (Follette & Ruzek, 2006).

Cognitive Content Approaches

Possibly the most universal is the cognitive content approach which emphasises the role of negative thoughts and beliefs in causing distress and helping to maintain symptoms. This was first conceptualised by Albert Ellis and is based on the premise that emotional problems often stem from "irrational" statements that people make to themselves (Ellis, 1984). Independently of Ellis, Aaron T. Beck developed cognitive therapy procedures also based on identifying and challenging dysfunctional thoughts and maladaptive assumptions (Beck, 1976). These approaches are particularly applicable to anxiety disorders and trauma, with symptoms considered to be maintained by debilitating thoughts and beliefs related to personal safety, low self-esteem, and negative future outcome expectancies.

Schema Based Models

Schema based models extend cognitive content approaches by highlighting that traumatic events can result in a permanent change to an individual's frame of reference or way of understanding life (McCann & Pearlman, 1990). Putting these ideas together, this perspective suggests that posttraumatic stress results from the shattering of basic assumptions that people hold about themselves and the world (Janoff-Bulman, 1992) and an inability to assimilate the experience (Horowitz, 1986). At the same time, the

oscillating phases of avoidance and intrusive symptoms are thought to facilitate the gradual assimilation of traumatic information into existing schemata (Horowitz, 1986).

While influential in the PTSD field, these theories have generally been superseded by cognitive models that propose more complex ideas about the relationship between pretrauma beliefs and posttrauma adjustment (e.g., Ali, Dunmore, Clark, & Ehlers, 2002; Meichenbaum, 1994) and address physiological arousal (e.g., Foa, Steketee, & Rothbaum, 1989).

Constructive Narrative Approach

Related to the concept of schemas, the constructive narrative approach is a tradition in the cognitive sciences based on the idea that people actively construct their own internal representations of themselves and the world (Mahoney, 1995). These personal "paradigms" are thought to determine how an individual perceives life. Donald Meichenbaum draws on this tradition to explain how individuals who have been exposed to trauma "construct" their accounts that can determine or influence how they cope. Those who do not cope well and who evidence continuing distress are thought to be stuck in "undoing" thoughts and stories (e.g., "why did it happen", "what might have been", or "if only I had…"), which are replayed over and over again (Meichenbaum, 1994). While similar to the cognitive restructuring approaches of Ellis and Beck, rather than focusing on single classes of negative thoughts, Meichenbaum's model is more integrative (Kendall et al., 1992). In order to resolve PTSD symptoms, including physiological arousal, this model proposes the need to construct a "new narrative" as well as changing behaviours. This is achieved through systematic desensitisation by way of repeated "tellings" and repeated practice, utilising "stress inoculation training" (SIT) to manage negative "self-talk" and emotions (Meichenbaum & Deffenbacher, 1988). Meichenbaum's model has been successfully applied to PSTD populations and has been found particularly helpful for children (Meichenbaum, 1994).

Information Processing Approach

The information processing perspective was developed to explain PTSD and provide a framework for treatment (Foa & Rothbaum, 1998; Foa et al., 1989). It is an exposure based model derived from Lang's concept of anxiety development in his emotional processing theory (Lang, 1977). PTSD is seen as primarily an anxiety disorder resulting

from inadequate processing of the trauma and the development of a fear memory or fear network. The model proposes that people who suffer from PTSD have developed "fear structures". These contain images and memories of threatening events along with information about emotions and plans for action, which are ready to be activated, especially in response to stimuli that are reminders of the original trauma. The treatment model requires exposure to corrective information. The purpose is to assist the client to identify the factors that disrupt emotional processing and incorporate new information to enable change and promote extinction. In prolonged exposure, the client is exposed to trauma related cues, either in imagination (imaginal flooding) or *in vivo* for extended periods without using relaxation until the anxiety response diminishes.

Cognitive processing therapy (CPT) designed by Patricia Resick and colleagues for rape survivors with PTSD has developed the information processing perspective to specifically emphasise cognitive components along with exposure (Resick & Schnicke, 1992). CPT involves the clients writing and talking about their trauma as well as identifying and challenging their faulty beliefs, and has been found to be effective in reducing PTSD symptoms and cognitive distortions in adults (Resick, Nishith, Weaver, Astin, & Feuer, 2002).

Information processing models provide an account of most PTSD symptoms and are consistent with the goals and procedures of empirically supported CBT treatments for PTSD, as are constructive narrative approaches (see Chapter 5). However, in terms of a theoretical explanation, research suggests that PTSD mechanisms may be more related to memory inhibition than memory modification (Taylor, 2006).

Dual Representation Model

Memory theorists propose that exposure-based and counter-conditioning approaches on their own may not abolish the conditioned fear, but rather inhibit its expression in a safe context (Bower & Sivers, 1998). They suggest that the inhibition account implies that the fear could be quickly reinstated should the individual who has been treated be exposed to a subsequent conditioning trial, for example another episode of abuse or even hearing about an abuse incident of someone else. Furthermore, the conditioning approach does not account for all the phenomena of PTSD, such as the fragmentary nature and sensory quality of trauma memories, or the paradox that some memories may

be intrusive at times and beyond voluntary retrieval at other times, in the same individual (Bower & Sivers, 1998).

The dual representation account of PTSD makes a distinction between implicit and explicit memory (Brewin, Dalgleish, & Joseph, 1996). This analysis is intended to provide an account of voluntary and flashback memories of trauma (Bower & Sivers, 1998). Implicit memories are considered to be cue-dependent and situationally accessible. Explicit memories are conscious and verbally accessible. The re-experiencing of sensory memories of the trauma triggered by external cues is thought to reflect the implicit/emotional system, while the coherent verbal narrative that is gradually constructed during therapy reflects the explicit/verbal system. These pathways are thought to be affected by the possibility that the trauma survivor's consciousness may be distorted, or attention narrowed at the time of the event. Thus, from these influences, the model proposes that traumatic memories may be more likely to be stored in implicit memory. That is, initial memories of the trauma stored in implicit memory are difficult to retrieve voluntarily with verbal probes whereas situational cues are more likely to trigger these particular sensory memories.

Criticisms of the dual representation model centre on the assumption that two distinct memory systems exist. This is based on the claim that there is a distinction between trauma images, such as flashbacks, which are experienced as vivid and undeniable, and verbal descriptions that are often confused or fragmented (Brewin, McNally, & Taylor, 2004). However, this is not necessarily evidence for two separate memory systems, and could be due to, for example, differences in encoding or retrieval (Taylor, 2006). It has been suggested that the model does not provide adequate explanation for the impact of pre-trauma risk factors or for how meaning may be transformed as a result of trauma (Dalgleish, 2004).

Ehlers and Clark's Cognitive Model
Recently, a comprehensive cognitive model of PTSD has been developed which provides a synthesis of a number of theories and is consistent with the clinical characteristics of PTSD (Ehlers & Clark, 2000). The model is designed to explain the persistence of PTSD and provide a framework for the CBT treatment of trauma. It is proposed that PTSD becomes persistent when trauma is processed in a way that leads an

individual to experience an ongoing sense of serious threat. This is thought to be caused by excessive negative appraisals of the trauma and/or its sequelae, along with trauma memory disturbances that are unchanging due to problematic behaviour and cognitive strategies (e.g., avoidance, thought suppression, rumination).

The cognitive model provides a compelling explanation, and research has indicated preliminary support (Ehlers & Clark, 2000; Halligan, Michael, Clark, & Ehlers, 2003). However, some of the mechanisms are speculative or implausible. For example, the claim that PTSD arises from excessive processing is questionable. Traumatic events can happen very quickly and children and adults alike report that they were well aware at the time of the terrible implications, even though they may not have known what to do. This is so common, that the cardinal feature required for a diagnosis of PTSD is that the person experienced an event(s) that involved serious threat with a co-existing response of intense fear, helplessness or horror (American Psychiatric Association, 2000). In addition, the model does not explain why some of the supposed causal factors may be present for some people but not others, and why only some people ruminate about the meaning of traumatic events they have experienced (Taylor, 2006).

Contribution of Cognitive Theories

Cognitive theories of trauma have highlighted the fact that all sorts of cognitive factors appear to play a role in the development and maintenance of PTSD. Notwithstanding the inability of any one model to comprehensively explain the phenomenon of PTSD, they all overlap in some ways, and are generally consistent with the effectiveness of CBT treatments, as reviewed in Chapter 5 (Taylor, 2006). Each model has something to offer to the development of a trauma-focused CBT programme for PTSD.

Cognitive restructuring methods have been applied to challenge negative or distorted interpretations of traumatic experiences, as well as to normalise thinking that PTSD is a "normal reaction to an abnormal event" (Bryant, Moulds, Guthrie, Dang, & Nixon, 2003). Information processing models that utilise prolonged exposure have been found to be effective for some populations, such as adult rape victims (Foa, Molnar, & Cashman, 1995). However, other populations, such as children, may find direct exposure too overwhelming and may require a more graduated approach with counter conditioning that uses a variety of anxiety management techniques, such as relaxation

and coping self-talk. The constructive narrative approach may be particularly helpful for children in incorporating these procedures as well as facilitating the creation of a new schema or "story" for their lives beyond the traumatic event(s) (Meichenbaum, 1994). The dual representation model has so far had more impact on theory, however has some implications for understanding of processes responsible for effective and ineffective treatment using CBT methods (Follette, Ruzek, & Abueg, 1998). For example, Brewin and colleagues have suggested that exposure therapy may be all that is needed in some cases (i.e., when emotions are driven by implicit memories). These ideas also provide a rationale for including non-verbal trauma-processing modalities in treatment packages for traumatised clients. This may be particularly pertinent for abused children, who may have no explicit memory of traumatic events that occurred pre-verbally, and instead have primarily implicit memories that may respond to expressive modalities (Stein & Kendall, 2004). However, when secondary emotions are present, related to explicit memory, such as self-blame, guilt or shame and consequent depression, cognitive therapy is likely to be necessary (Brewin et al., 1996). Treatment implications of Ehlers and Clark's cognitive model of PTSD are threefold: To modify problematic appraisals of the trauma and/or its sequelae that maintain the sense of current threat; to elaborate and integrate the trauma memory into a coherent whole that can be filed away as a past event and thereby reduce re-experiencing; and to target and change behavioural and cognitive strategies that are used as dysfunctional attempts to control the threat or the symptoms.

In summary, all the models reviewed have generally focused on precipitating and perpetuating factors, with less attention to predisposing and protective factors (Taylor, 2006). Overall, although there is significant development in this field, the current explanations are inadequate to account for the relative contribution of individual cognitive components to the development of trauma symptoms, particularly in children with abuse-related trauma (Cohen, Mannarino, Berliner, & Deblinger, 2000). In addition, because these models were primarily developed for adults, they fail to account for how developmental or contextual factors may influence the manifestation of PTSD in children. Notably, these models are not specifically abuse-focused. The following sections outline theoretical frameworks that provide a broader understanding of CA trauma in children, beginning with abuse-focused models.

Abuse-Focused Models

A number of models have been proposed that seek to explain the impact and trajectory of trauma processes specifically related to CA. It is an approach that is grounded in the perspective that abuse is a form of victimisation of the relatively powerless by the relatively powerful (Hecht, Chaffin, Bonner, Worley, & Lawson, 2002). Theoretical formulations have tended to focus on CSA.

PTSD Formulation of CSA

Wolfe and colleagues proposed the idea that the sequelae of CSA can be viewed within a PTSD formulation (V. V. Wolfe, Gentile, & Wolfe, 1989). This viewpoint was based on three premises: that CSA meets the definition for trauma as outlined in the DSM; clinical impressions and empirical evidence suggest many children demonstrate at least some of the characteristic symptoms of PTSD; and that the variables that mediate the responses of adult victims of CSA (i.e., severity of abuse, availability of social support, attributional styles) also mediate other types of trauma, such as rape and combat.

More recently, Wolfe and colleagues have elaborated their PTSD model further using a CBT framework (V. V. Wolfe & Birt, 1997). They suggest that the severity of abuse (e.g., use of coercion or force) is related to the development of symptoms of PTSD. The course of abuse (e.g., duration and frequency) is thought to be related to cognitive processes and coping mechanisms; specifically, attributional style, depression, dissociation, excessive emotionality, avoidant coping, and poor anger management. The PTSD conceptualisation of abuse-related symptomatology is an evolving model that is useful in understanding CA sequelae and processes (O'Donohue et al., 1998).

Traumagenic Theory of CSA

Finkelhor's traumagenic theory proposes that CSA has effects due to four processes: traumatic sexualisation, stigmatisation, powerlessness, and betrayal (Finkelhor, 1987). Each of these processes may result in different problems; sexual trauma may lead to sexual dysfunction or promiscuity; stigmatisation may lead to poor self-esteem, guilt, shame, suicidal ideation; powerlessness to anxiety and depression; and betrayal to anger and lack of trust. Although this model provides a theoretical conceptualisation of the

effects of CSA, its major limitation is that there is little empirical evidence evaluating its accuracy (O'Donohue et al., 1998).

Self-Trauma Model

John Briere's self-trauma model for resolving abuse trauma is based on the premise PTSD may be viewed as a self-healing mechanism (Briere, 2002). Derived from CBT, Briere proposes that painful event(s) are avoided through "blocking" (i.e., avoidance) through, for example, drugs, alcohol, or sex, preventing emotional processing and recovery. The self-trauma model involves addressing cognitive and behavioural avoidance by developing affect regulation skills prior to embarking on exposure therapy. These include relaxation, breath training, progressive relaxation, identifying and discriminating emotions, identifying and countering thoughts that antecede intrusive experiences (Briere & Scott, 2006). Like other models that utilise exposure, the theoretical rationale for trauma processing is to remove the conditional emotional response to the traumatic memories through exposure and activation of the feelings the client had at the time. Briere proposes that if this is carried out in a safe therapeutic environment with pacing and timing tailored to the client's individual characteristics and concerns, that the traumatic responses will be extinguished. Drawing on psychodynamic models, and given that abuse trauma disrupts relationships and normal development, Briere considers the therapeutic relationship critical as a process that can counter-condition relational trauma and facilitate the client's ability to create positive relationships.

While this model was developed for adults, like other abuse-focused models, it can be adapted for working with children (Briere, 2003). However, trauma and abuse may result in specific manifestations in children that differ from those in adults. There are a number of theoretical frameworks that seek to explain these processes in children, including the PTSD model, as presented in the following section.

Children and Trauma/PTSD

Recognition of the impact of traumatic events on children has lagged behind the recognition of the effects on adults (Davis & Siegel, 2000). Lenore Terr, a pioneer in

the field as a result of her studies of the children of Chowchilla[10], described prominent characteristics that distinguish the traumas of childhood: thought suppression, sleep problems, exaggerated startle responses, developmental regressions, fear of the mundane, deliberate avoidances, panic, irritability, and hypervigilance (Terr, 1979). Terr considered four characteristics were common to most cases of childhood trauma: 1) strongly visualised or otherwise repeatedly perceived memories, 2) repetitive behaviours, 3) trauma specific fears, and 4) changed attitudes about people, aspects of life, and the future. As described previously, Terr distinguishes between Type I trauma, resulting from one sudden blow, and Type II resulting from long-standing or repeated ordeals. Type I is thought to be characterised by intrusive recollections, and Type II by denial, numbing, and dissociation (Terr, 1991).

PTSD in Children

It has been only relatively recently that investigators in general have acknowledged that children may develop PTSD as a result of severe trauma in childhood (Shannon, Lonigan, Finch, & Taylor, 1994). PTSD as a diagnostic entity was not related to children and adolescents until the publication of DSM-III-R (American Psychiatric Association, 1987). Current criteria for PTSD in DSM-IV-TR (American Psychiatric Association, 2000) make some acknowledgement of the differential experience of trauma for children[11]. For example, instead of intense fear, helplessness, or horror, children may exhibit agitated or disorganised behaviour. Nightmares may be more general; for example, about monsters or threats to self and others, not just specifically about the traumatic event itself. Children may engage in traumatic play, involving repetitive acting out of the trauma. Also, sexually abusive traumatic events may include developmentally inappropriate experiences, without threatened or actual violence or injury. In other respects, PTSD in children and adolescents is similar to PTSD in adults, including the cardinal symptoms of re-experiencing, avoidance, and increased physiological arousal (Davis & Siegel, 2000). PTSD is now widely recognised in children, including abused children, with effects on neurobiological, psychological and social development, as indicated in Chapter 3.

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[10] A group of children who were kidnapped and buried in a school bus in Chowchilla, California
[11] See Appendix B.

However, there are limitations to the diagnostic category of PSTD for children and adolescents. The current DSM-IV-TR, like the earlier DSM-IV, does not have adequate descriptive categories for trauma-related syndromes observed in children, especially from deliberately inflicted trauma such as abuse (Perry, Pollard, Blakely, Baker, & Vigilante, 1995). Severely traumatised children with dramatic symptoms of physiological hyperarousal may not meet diagnostic criteria for PTSD, and may evidence symptoms of other diagnostic categories as well, such as affective, dissociative and borderline personality features. In addition, trauma appears to be a necessary, but insufficient, cause of PTSD in children, with many other factors modifying the response to trauma (McFarlane & Yehuda, 2000). In fact, as introduced in Chapter 3, a simplistic view of PTSD may underestimate its complexity and lead to simplistic or incomplete treatment plans (McFarlane & Yehuda, 2000). The aetiology and course of PTSD in childhood is likely to be a complex function of developmental stage, prior experiences and temperament, family functioning, subsequent coping, and reactions to secondary adversity (Pynoos, 1994).

So, while the concept of PTSD is useful in that it provides the field with an orientating framework for understanding, studying, and treating the trauma of abuse in children, it needs to be kept in mind that the diagnostic complications can also hinder research and clinical practice with traumatised children (Perry et al., 1995; Terr, 1991). The experience and understanding of trauma in children differs from that of adults, and care must be taken in applying theories which explain the symptoms and causes of PTSD in adults to children (Pandit & Shah, 2000).

The field of CA trauma has been strongly influenced by the PTSD model, however, this is not sufficient to understand the impact of CA or guide the broad based treatment that is needed, particularly for children and families (Friedrich, 2002a; Taylor, 2006). Recently, William Friedrich highlighted the need for treatment models in this area that are contextual and derived from theoretical formulations that are more unifying and empirically validated than those of the earlier trauma- and abuse-focused models. Friedrich suggested that theoretical frameworks particularly relevant to guide the assessment and treatment of abused children include developmental models, attachment theory, and systems-based approaches (Friedrich, 2002a).

Developmental Perspectives

When working with children who have suffered CA trauma, a developmental perspective provides an understanding of the child's ability to make sense of what has happened to them, and a rationale for what children need to participate effectively in the therapeutic process. Neurodevelopmental models have provided a significant contribution to understanding the impact of CA trauma on children's neurobiological development. Developmental psychopathology and developmental traumatology approaches relate development to family and social context and inter-generational effects.

Developmental Theories

With regards to understanding children's cognitive development, the ideas of Jean Piaget have been influential (Piaget, 1958). Piaget postulated that children go through a series of stages of growth in their thought processes, from egocentric illogical thinking to highly organised rational and logical thinking; namely, sensorimotor (0-2 years), preoperational (2-7 years), concrete operational (7-11 years) and formal operational (11-15 years). Another influential developmental model, developed by Vygotsky, is based on the notion that cognition and action are fundamentally social, and that language has a key role in the regulation of action (Vygotsky, 1981). Given that language and thought are connected, these ideas have implication for the age-appropriateness of a CBT approach.

A more recent proposal is that children's development of the cognitive self is linked to the emergence of autobiographical memory (M. L. Howe & Courage, 1997). While even young infants can display a memory for a specific event, the ability to remember information as "something that happened to me" does not occur until one has a "me" by which to organise it. Linking this idea to Piaget's theory, during the preoperational period children are thought to learn how to represent the world mentally, but are locked into their own perspective, and have not yet grasped that there are other "selves". While 7-11 year olds may be able to interrelate their own representations about concrete situations, Piaget's theory proposes it is not until 11 years that children begin to develop the cognitive abilities to think abstractly and self-reflect. Likewise, Vygotsky's theory

suggests that a child must be developmentally capable of using thought as a form of "inner speech" for the self-regulation of behaviour. In Piaget's formal operations stage, adolescents are thought to be able to think about other people's thinking, recognise general rules, and develop the capacity to hold more than one idea in mind at the same time. David Elkind extends Piaget's ideas regarding adolescence. He proposes that adolescent's create a "personal fable" about their own beliefs, attitudes, and uniqueness that is designed to manage intense emotion (Elkind, 1967). This is characterised by believing their thoughts and feelings are shared universally and yet at the same time feeling special, and therefore not governed by the rules that govern others.

More recently, it has been proposed that "meta-cognition" (the ability to reflect about cognition, or "think about one's thinking"; an inherent feature of CBT) may in fact comprise a range of aspects that may develop at different ages and stages (Bolton, 2005). For example, Derek Bolton refers to literature that suggests that recognition that thoughts are under a person's control and regulating behaviour may appear as early as 6 or 7 years, while concepts such as shame may appear between early and middle childhood, and recognition of the connection between beliefs (i.e., the capacity to theorise) may develop in later childhood or adolescence, although even preschoolers may have some aspects of this capacity, such as the ability to differentiate hypothetical beliefs from evidence (Bolton, 2005). Bolton suggests that in applying this theory to practice, clinicians should employ the principle that cognition in a particular context is best accessed in relation to that context through clinical methods appropriate to children, such as self-report, role-plays, story-telling, and asking parents/caregivers. Bolton concludes:

> On the positive side, there may be particular positive indications for CBT in children and adolescents. By the time of adulthood, people have had the time, capacity and need to build up styles and systems of belief around problematic behaviour, including entrenched secondary appraisals that unfortunately exacerbate and maintain the problem. Because they are still developing, by contrast, the child and adolescent have views of themselves and the world that are less fixed and so far more open to new possibilities. (p. 21)

The ideas of Erik Erikson are also relevant to a developmental perspective (Erikson, 1963). Erikson proposes that the developmental tasks of children from about 6 years to puberty is the development of social, physical, and school-related skills. In adolescence, the task is to make a transition from childhood to adulthood and develop a sense of identity. Development of self-identity involves an integration of not only cognitive factors, but also physical changes and social expectations. According to Erikson's views, identity is constructed rather than conferred by parents or society. This involves the young person actively exploring alternatives in a range of areas, including ideology, values, and relationships, and committing to options.

Neurodevelopmental Theories

There is considerable evidence to suggest that traumatic experiences as a child have a profound effect on the developing brain (Nemeroff, 2004). Biological and neuropsychological effects of the trauma of abuse on children have been documented in Chapter 3. The conceptual views in this field grew out of principles of neurodevelopment and ideas from the field of traumatology, along with extensive clinical experience with traumatised children (Perry et al., 1995). These models explain the problems of traumatised children as efforts to minimise objective threat and regulate emotional distress (van der Kolk, 2005).

A model by Bruce Perry describes how the trauma of abuse can affect the developing brain and shape children's physiology and related responses. He proposes that CA can result in the *deprivation* of sensory stimuli (e.g., via neglect, insecure attachment) and/or the *overactivation* of neural pathways (e.g., via the trauma of physical abuse, sexual abuse, and/or witnessing domestic violence), leading to a persistent pattern of hyperarousal or dissociation (Perry et al., 1995). The hyperarousal response is thought to be like an alarm reaction. This is characterised by physiological responses in the sympathetic nervous system resulting in increased heart rate, breathing, muscle tightness, a sense of hypervigilance and a tuning out of other information not critical to the response to fight, flight, or freeze. The neurobiology of the dissociative continuum is thought to be different. The complex set of interactions involving the nervous system, neuroendocrine system, and other neural systems in the brain comprising these processes have been well described elsewhere (Christopher, 2004; Perry et al., 1995).

Perry proposes that this so-called "use dependent" activation leads to the sensitisation of the stress-response brain systems and other critical physiological, cognitive, emotional and behavioural functions which are mediated by these systems. Eventually the fear response itself is thought to become sensitised, leading to the child being constantly "on edge", and very easily feeling threatened or, depending on the trauma and the reaction, even terrorised. As a result, traumatised abused children may begin to manifest a pattern of maladaptive emotional, behavioural and cognitive responses, mediated by a highly sensitised physiological system (Perry et al., 1995).

Daniel Siegal's integrated developmental approach examines the interface between biological processes and human relationships (Siegal, 1999). While not specifically abuse-focused, Siegal's work emphasises how experiences, especially within interpersonal relationships, shape the genetically programmed maturation of the nervous system and the structure and function of the developing brain.

Developmental Psychopathology

Like Siegal's model, developmental psychopathology appreciates both individual processes and contextual factors. This model highlights the fact that children's development is ongoing, and not fixated at the point of traumatic events. In addition, the developing child is viewed as a social organism. A key feature of developmental psychopathology is the concern with causal processes related to the normalcy and pathology in abused children. This includes how various factors interact over time, and suggest an interactive effect between individual differences in risk and resilience and environment (Gore & Eckenrode, 1997). Developmental psychopathology is a theoretical framework considered appropriate to guide the assessment and treatment of abused children (Rutter & Sroufe, 2000).

These ideas highlight a distinction between "risk indicators" and "risk mechanisms" (Rutter, 1990). While environments characterised by poverty and social disadvantage are thought to be likely to be accompanied by an increased risk of psychopathology, the model proposes that the mechanism does not lie in these factors per se. Rather, the evidence suggests the effect comes about as a function of the associated family disorganisation and conflict, leading to parental neglect and abuse, leading to attachment problems, probably in interaction with the child's own temperament.

Developmental Traumatology Model

De Bellis presents a developmental traumatology model to account for the intergenerational nature of CA (De Bellis, 2001). He proposes that PTSD symptoms may manifest differently through the developmental stages in a step-wise pattern of disorders including: attachment disorder, internalising disorders, externalising disorders and cognitive/learning disorders, then later, conduct disorder, alcohol and drug abuse, personality disorders, and an increased risk of abusing one's own children. While this might be a useful model for clinicians to keep in mind, it has not been empirically tested, and clinical observations suggest it may not apply to the majority of abuse victims.

Contribution of Developmental Perspectives

Developmental theories have implications for therapy with children of different ages. For example, therapy with younger children (7-11 years) is likely to be more helpful if it is skills-based with a focus on application to concrete situations. For adolescents, therapy may be more helpful if it provides opportunities for self-reflection and highlights and extends the range of options for their attitudes and behaviour.

Neurodevelopmental theories draw attention to the impact of CA on the developing brain, and suggest that targeting interventions to trauma-related symptoms and behaviours as they occur in current situations for the child may have the best chance of improving functioning (Perry et al., 1995). However, this needs to occur in a therapeutic environment that is characterised by safety, predictability, and fun, in order to allay trauma-related triggers and enable the initiation of physiological self-regulation (van der Kolk, 2005).

A number of these developmental models highlight the importance of considering individual developmental processes within the context of family and social systems, and the inter-relationship between these factors (De Bellis, 2001; Rutter & Sroufe, 2000; Siegal, 1999). Importantly, these models draw attention to the interaction between CA trauma and attachment relationships. Attachment theory provides a framework for understanding the importance of significant relationships in a child's life, particularly

when these may have been affected by CA trauma. Attachment theory is discussed below, with reference to implication for assessment and intervention with abused traumatised children. Related contextual/systematic approaches are presented in the following section.

Attachment Theory

As discussed in Chapter 3, abused children may form "insecure attachments" with their caregivers, and may have "disorganised attachment relationships". This conceptualisation is based on attachment theory, originally proposed by John Bowlby. Attachment is a biologically based reciprocal emotional and physical relationship between a child and a caregiver (Bowlby, 1969). It is proposed that infants and very young children develop a preferred or "primary" attachment person who is sought by the child when there is need for comfort and reassurance. Relationship-based models of children's psychosocial development are premised on the belief that the quality of children's close relationships, particularly in the early years, affects their behaviour and development (D. Howe, Brandon, Hinings, & Schofield, 1999; Sameroff & Emde, 1989).

Children's attachment behaviour has been categorised into four categories; secure, ambivalent, avoidant, and disorganised (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Soloman, 1986). Securely attached children are considered to have an "internal working model" of caregivers as consistent, supportive in times of stress, attuned to their needs, and demonstrating reciprocity. Insecurely attached children operate from the assumption that relationships are unpredictable, punitive and lacking reciprocity. Barriers to attachment are thought to include physical or emotional unavailability of the parent, loss or disruption of earlier primary attachment relationships, and parental maltreatment.

Attachment and Trauma

Trauma-related attachment problems are thought to derive from the fact that the source of danger and protection reside in one person, resulting in a "disorganised" attachment pattern. As early experiences with the attachment figure influence the child's

developing expectations about roles in relationships, children who have experienced abuse by their parent may have problems forming relationships with peers and subsequent caregivers. These problems may persist into the future, with partners and their own children (B. James, 1994).

Contribution of Attachment Theory

An attachment based model of intervention focuses on the role of the therapist in providing a secure base from which both children and caregivers can explore new ways of relating (Pearce & Pezzot-Pearce, 1994). According to this model, when working with children with co-existing attachment and trauma problems, the therapist provides a relationship in which a child can anchor himself and feel contained. Traumatised abused children may require a longer, more gradual process in order to develop a trusting relationship with their therapist. This is particularly so if their trauma and attachment histories are early and long-standing, as they may have a lack of words to convey thoughts and emotions and an inability to differentiate self from non-self (Perry et al., 1995). It is thought that some children may need to "re-do" an early stage of emotional development to safely release emotional trauma and move beyond a compulsive re-enactment of that trauma and build a foundation on which further development can grow (Witten-Hannah, 2002). It is proposed that this phase of therapy requires individual work with the child along with support for his caregivers.

Attachment theory highlights the importance of the child's relationships in contributing to and ameliorating the effects of CA trauma. Clearly, no child exists in isolation. Theoretical approaches that provide a framework for understanding traumatised abused children in the broader contexts in which they exist are relevant.

Contextual/Systemic Approaches

When working with children and adolescents who have been exposed to CA trauma, an ecological perspective draws attention to the many interconnected systems in which a young person exists (Bronfenbrenner, 1979). Contemporary CBT approaches generally incorporate a contextual or ecological approach to trauma and its consequences (Follette et al., 1998), particularly with children (Graham, 2005). Such an approach is likely to

enable a better understanding of the development and maintenance of symptoms, as well as guiding targets for intervention. In addition, modern psychological theories, including those of CA and trauma, are increasingly informed by the wider systems of dominant ideologies, political, and cultural perspectives (Abney, 1996; Cohen, Deblinger, Mannarino, & Arellano, 2001; DeVries, 1996).

Systems-Based Approaches

Many systems-based approaches in psychotherapy trace their ancestry to the work of Gregory Bateson (Bateson, 1972, 1979). Bateson was influenced by the work of the German biologist Ludwig von Bertalanffy who developed a model "General Systems Theory" based on extending the laws of biological organisms to other domains (Nichols & Schwartz, 1998). Through the study of cybernetics (i.e., the flow of information in closed systems), Bateson saw the importance of appreciating the context in which interactions occur.

Family therapy models arose from a systems approach. Rather than viewing emotional distress in linear terms, as solely a symptom of internal dysfunction with historical causes, family therapy is based on a recursive paradigm (Nichols & Schwartz, 1998). Recursive, or circular, explanations take into account the mutual interaction and influence of factors on individuals and relationships within the context of family. These models have had significant influence on New Zealand treatment practices in the area of CA, as described in a following section.

With regard to the etiology and treatment of abuse, there have been criticisms that "purist" allegiance to ideas such as circular causality led to family therapists blurring the responsibility of the abuser, and also of family therapists insensitively imposing ideas about always seeing entire families in therapy. Such allegiances may have resulted in abusive situations for the family members who had been abused (Durrant & White, 1990). However, the influence of the contribution of a systems-based focus to the treatment of abused children is important in that it emphasises that children are inherently part of their family system. Attention to the impact of abuse on the relationships between a child and his or her family members is considered to be intrinsic to any intervention (Deblinger & Heflin, 1996; Gil, 2006).

Dominant Ideologies, Political, and Cultural Perspectives

Feminism and the children's rights movements raised awareness about the psychological trauma that can result from interpersonal violence, including CA and rape. These views may continue to influence how a clinician, or even an agency or organisation, conceptualises CA and violence. Beliefs about what accounts for the development and maintenance of patterns of abuse are likely to strongly impact on assessment and treatment decisions (G. Macdonald, 2001).

Recently, enthnocultural aspects relating specifically to trauma and PTSD have been highlighted (Marsella, Friedman, Gerrity, & Scurfield, 1996). Cultural expectations can influence the conceptualisation and path of an individual and family's response to abuse and trauma, as well as have an effect on treatment (Elliott & Urquiza, 2006). Theoretical explanations relate to differences among ethnic groups in how issues such as intra-familial boundaries, sexuality, and discipline are viewed; differences in emotional responses, for example, shame about discussing negative feelings, and fear or reluctance to report CA, involve child protection, or seek help outside the family or cultural group (Cohen et al., 2001). Cultural world views and implications for the treatment of traumatised abused children are discussed further in Chapter 9.

New Zealand Models

As described in Chapter 2, New Zealand practitioners have a tradition of drawing on international theory and research in the fields of CA and trauma, and applying this in the local context in innovative ways. While there has been very little empirical investigation of New Zealand practice, there are a number of locally developed models that have received widespread regard by clinicians in this country. Two abuse-focused models for working with children and families are described. While neither was explicitly trauma-focused, the Leslie Centre model in particular included exposure techniques for resolving the trauma of abuse.

Early SSU Model

Early models that were developed at SSU focused on working with families with CSA, and drew on constructive narrative and systems approaches, influenced by dominant ideologies. Jane Waldegrave and colleagues at Auckland SSU of the then Department of Social Welfare, utilised the ideas of Bateson as applied by Michael White and David Epston in their narrative family therapy approach (White & Epston, 1989). Families were encouraged to see things from a different perspective by adopting a curious, yet respectful, "How come?" stance which was designed to challenge their assumptions about how things were. This established a threshold for the family to perceive "news of difference". The overall aim was to understand the various individual and family stories and "re-author" people's lives.

This version of narrative family therapy was strongly influenced by an analysis of the context of patriarchal ideology. Therapists viewed abusive situations as about one person having power over another, and held the view that society created an environment where men have power over women, and women and families were victims of that. This was important at the time within the paradigm of family therapy, as it led to an emphasis on individual work with the abuser, in order to assist the abuser to take responsibility for what he had done, to be able to acknowledge the harm he had caused, and to apologise. Meanwhile, work with individual family members, as well as different combinations of family members, was carried out to assist people to work through their emotional pain and resolve relationship issues. Empowerment of the family to prevent further abuse was an important part of the model.

This model continues to influence the process of assessment and therapy at SSU, although there are differences in emphasis. Offending parents tend to be referred to specialist treatment services which now exist. Interventions tend to focus on children, with support from non-offending parents and caregivers. However, legacies include an emphasis on bringing parties together at the outset to clarify expectations, roles, and desired outcomes; a curious yet respectful stance; tailoring of treatment to the specific needs of family members via both individual and family sessions; and the ongoing emphasis on a safe and empowering process for all involved.

The Leslie Centre Model

Alongside the SSU model, and similar in its theoretical orientation, Kathy Macdonald, Ian Lambie and Les Simmonds of the Presbyterian Church's family support service, The Leslie Centre in Auckland, developed a practical process-based model of therapy for sexual abuse (K. Macdonald, Lambie, & Simmonds, 1995). The model was based on systems approaches, family therapy, narrative therapy, expressive therapies, and was informed by cultural, feminist and empowerment perspectives (see Chapter 2). Assessment was both broad and abuse-focused and ongoing throughout therapy. The goals of the model included: Assigning responsibility for the sexual abuse to the perpetrator; putting the client in touch with their strengths; dealing with negative effects of abuse such as unhelpful behaviours, emotions, beliefs or physical symptoms; ensuring social support, and planning for future safety.

The Leslie Centre model was developed to work with abused children as well as adults. Being systems-based, involvement of parents and other family members was fundamental to the approach. Parent interventions, largely derived from behaviour therapy, addressed abuse-related symptoms and behavioural concerns. The focus of individual therapy sessions with children was to help them to construct a "new narrative". Like Meichenbaum's approach (Meichenbaum, 1994), this involved not only on therapeutic conversations, but also non-verbal behavioural interventions. Developmentally appropriate communication with the child, humour, and encouragement of the child's progress were emphasised. Drawing on cognitive and behavioural approaches, a four-stage exposure-based protocol was employed. This involved: describing the abuse; "catharsis" for helping the child experience the abuse scene(s) in a different (empowering) way; creation of a "rescue scene"; and checking for remaining trauma. To prepare for the future, changes made were highlighted and safety education for both children and parents carried out.

Both the SSU and the Leslie Centre models were influenced by expressive therapy approaches and relied on the availability of an attractively decorated playroom, well-stocked with equipment such as games, art materials, dolls, puppets, and dress-ups. These were used as vehicles for creating a relaxing format, expressing feelings, showing what happened, and recording progress. The Leslie Centre model described the use of action methods such as re-enactments, role plays, and video recordings for dealing with

the abuse and resultant symptoms and behaviours (K. Macdonald et al., 1995). Therapists used the therapy materials and action methods to facilitate awareness of "news of difference" in a concrete way.

Contribution of New Zealand Models

While these New Zealand models have not been subject to rigorous empirical investigation, they are included because they continue to influence local practice and have the benefit of clinical validation. The writer received training in these models in 1990s and has continued to be strongly influenced by family therapy and empowerment approaches, clarity around the importance of safety and ongoing assessment, stage-wise protocols, and child-focused techniques. While developed primarily for addressing CSA, clinical experience has shown that these elements can equally be applied to working with multiply-abused children.

Summary

Theoretical frameworks provide an understanding of the processes involved in the interaction between the experience of CA and the wide-ranging effects. Prominent among these is the trauma/PTSD model. This has its roots in psychoanalysis and psychodynamic theories, emphasising the developmental context of trauma and the importance of the therapeutic relationship and expressive techniques for healing. Behavioural theories provide a rationale for the use of anxiety management techniques, analysis of reinforcement variables maintaining symptoms, social modelling, encouragement of practice to establish new patterns, and the use of exposure in treating trauma. Cognitive models underpin restructuring methods such as "coping self-talk", exposure techniques that enable cognitive integration of trauma memories as a coherent whole that can be filed away as a past event, and constructive-narrative approaches that encourage the client to create new, more helpful schemas. Memory-related theories provide a rationale for non-verbal as well as verbal trauma processing modalities, in order to address what may be different memory processes. Neurobiological theories remind us to assess and treat physiological responses to trauma such as hyperarousal and dissociation, as well as emotional, cognitive, and behavioural reactions. Recognition of the differential experience of CA trauma on children highlights the need

to keep in mind developmental perspectives, attachment relationships, and family and wider systems, including cultural world views and children's rights, and not forgetting to ensure that with children, that the therapy should be child-focused and fun.

Chapter 5 builds on this theoretical basis by presenting an overview of empirical research related to CA trauma treatment.

Chapter 5: Treatment Outcome Research

Outline and Aims

The development and evaluation of a treatment protocol should involve an interplay between science and practice. In the broadest sense, evidence-based practice[12] is an attempt to ensure that what we do will result in the best possible outcomes for those we seek to help. This depends not only on a sound theoretical basis, but also good quality outcome research, application and evaluation in local settings, and careful monitoring and review of the progress of change for everyday clients (Proctor & Rosen, 2004).

Chapter 5 begins with an analysis of what kinds of research are required in the field of CA/child protection to give local practitioners the information they need to increase the chances of a good outcome for the children and families they are treating. Reference is made to the challenges of research in this area. A brief history of treatment outcome research is presented, along with a distinction between efficacy and effectiveness research models. Variables that influence treatment outcome are also flagged. A model for child and adolescent psychotherapy research is presented. Relevant practice guidelines are summarised. "State of the art" empirically supported treatments (EST's) relevant to the treatment of CA trauma are reviewed. Limitations are discussed. Finally, a summary and rationale for the current research is presented.

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[12] Different terminology is used to identify treatments that have evidence on their behalf. The term "evidence-based practice" has been used here in a broad sense to cover the three levels of intervention (primary, secondary, and tertiary prevention) identified in the CA/child protection field (G. Macdonald, 2001). "Treatment outcome research" is used to refer to "tertiary level" interventions (i.e., interventions at the level of children and families). "Empirically supported treatments" (ESTs) is a general term to describe treatments which have empirical evidence, whether that be from "efficacy" or "effectiveness" studies, although a distinction is usually made between these latter two categories.

Evidence-based Practice in Child Protection

In the field of CA/child protection, there has been extensive research, but paradoxically, a dearth of rigorous research that can assist in making informed decisions about *what* sorts of problems are amenable to *what* sorts of interventions, in *what* circumstances, and with *what* degrees of certainty (G. Macdonald, 2001). The best sources of evidence come from research strategies that have high internal and external validity. That is, we can be sure that the outcomes are attributable to the interventions studied, and able to be generalised to other populations and settings of interest. Of course, outcome research normally emphasises one of these two features, given that there is often an inverse relationship between the two (e.g., Cook & Campbell, 1979). In addition to delineation between efficacy-emphasis (internal validity) and effectiveness-based (external validity) strategies, interventions themselves are also delineated or based on a prevention continuum.

Three Levels of Intervention

In the CA/child protection field three levels of intervention have been identified (G. Macdonald, 2001). These are:

Primary prevention: Interventions aimed at communities or populations, targeting professionals, parents and/or children, whether or not there is any known risk. These are typically educational; for example, raising awareness of issues such as CA, or community parent education programmes.

Secondary prevention: Interventions aimed at those identified to be at high risk of abuse; for example, keep safe programmes for preschool children.

Tertiary prevention: Interventions aimed at those who have already abused or been abused; for example, "living without violence" programmes, individual therapy for abused children. These interventions are designed to prevent further abuse and ameliorate the effects of abuse that has already occurred.

Compared to other levels of intervention in child protection, "tertiary prevention" is primarily concerned with intervention at the individual and family level. As such, there is a great deal of overlap with the field of psychology. Given the scientific basis for research in psychology, one would expect that psychological research on the treatment

of abused children and their families would have been subject to much rigour. It is somewhat surprising, therefore, to discover that by and large this has not been so. Then again, the complexities of the field accentuate many of the methodological and practice challenges faced by researchers who engage in treatment evaluation in this area.

Challenges to Research in CA/Child Protection

A particular challenge to research in this field relates to definition and construct validity to do with the nature of CA. As noted in Chapter 2, CA is an experience, not a pathology. It can occur to children in vast range of contexts and circumstances, resulting in an equally vast array of possible sequelae. There is often interplay between factors operating at different levels; for example, personal, interpersonal, and cultural. The context and nature of the abuse, as well as the relationship between the abuser and abused, will clearly impact on the child's response and the course of recovery. Abuse can be a single experience, through to multiple experiences over many years. It may be perpetrated by parents, family members or strangers. Additionally, the child's subsequent living situation and relationships will affect recovery, as will his or her history prior to the abuse, and degree of personal resilience, as noted in Chapter 3. Researchers in the field need to take all these factors into account when designing their studies, and reporting the results.

A second set of challenges that face a researcher in the CA/child protection field also apply to all researchers who engage in the evaluation of treatments. These are generally subsumed under the category "threats to internal validity" (Cook & Campbell, 1979; Kazdin, 2003). For example, the child's symptoms and behaviour may have improved merely because of the passage of time (e.g., history, maturation), not due to the therapy intervention. Likewise, external stressors may have lessened, perhaps due to improvements in the family's circumstances through support from social services, or an even a more global reason, such as a general recovery in the economic climate. The research design chosen should control as far as possible for these threats to the validity of the outcome, as discussed further in Chapter 7.

In terms of threats to external validity, all researchers must consider the representativeness of the sample selected, multiple-treatment effects, and experimental reactivity (Kazdin, 2003). As Kazdin notes, the most persuasive demonstration of

external validity is replication of findings across several studies in which some conditions are varied (e.g., cultural groups of subjects, different therapists). In the field of CA/child protection, given the vast array of CA experiences and contexts, the ability to generalise from a particular piece of CA treatment outcome research needs to be balanced against its usefulness in the local clinical setting. Ultimately, any research carried out in this area must be benefit the children and families treated. This is particularly so when one considers the vulnerability of this population. Prior to considering other issues in more depth, it behoves the current research to address the general matter of research with children and the contexts and circumstances within which they live.

Research with Children

The United Nations Convention on the Rights of the Child (UNCROC) 1989 led to a debate in professional psychology regarding children's perspectives (Christensen & James, 2000). It could be argued that psychologists, especially those engaged in clinical and therapeutic work might be expected to be experienced and skilled in listening to children and eliciting their views. However, more often children's behaviour, thoughts, and actions are interpreted against models of psychological processes first constructed for adults. This includes CBT models (e.g., Beck, 1976). Additionally, the research product is invariably "data" interpreted by adults about children, albeit framed in terms of their welfare and intended to promote quality interventions (Woodhead & Faulkner, 2000).

As in other areas of research, this method of conducting research with children reflects the prevailing paradigm that currently defines psychology. As discussed in Chapter 1, this is primarily derived from the scientific principle of objectivism and the concern with the development of logical and empirical methods for discovering objective, verifiable facts. This paradigm has its genesis in the physical and biological sciences and has had profound implications for the way researchers relate to children as subjects. Within this way of thinking, it makes perfect sense for a psychologist to take a child into a laboratory for closer inspection and testing (Greene, 1998, as cited in Woodhead & Faulkner, 2000). Even the renaming of children as "subjects" or even "participants" may not occur as odd or dehumanising within this paradigm. In recent years, however, there has been greater sensitivity to the rights and welfare of children in research.

It is important to bear these ideas in mind when carrying out research with children, young people and their families. The social and cultural context in which the research is being carried out should inform the research focus and design and ways of collecting data and measuring change. Even when empirical scientific principles are employed, at very least, children should at some point be given free reign to open-endedly give feedback on not only the research process, but also the topic under investigation. Unquestionably, children's consent to involvement in the research must be gained, with clear explanations about their role and the use of the data. These research practices not only respect children, but also give researchers an opportunity to hear their voices.

State of the Art of Treatment Outcome Research in CA/Child Protection

Notwithstanding the aforementioned issues, perhaps the greatest challenge to researchers in this field is to actually <u>do</u> good quality research on the effects of interventions on these most vulnerable of children in the settings in which they are normally treated. In 2001, Macdonald pointed out that there was no shortage of descriptive accounts of work with children who have been physically, sexually, or emotionally abused or neglected, but that there was a "near scandalous" lack of research on the effects of particular interventions in the lives of abused children (G. Macdonald, 2001). Macdonald further stated that this absence of good quality evaluation should be "a source of serious professional disquiet" (p. 193). In a search for research studies in the area, Macdonald found a dearth of studies using baseline, control, or comparison groups. Few had a good theoretical and/or empirical rationale or provided some evidence of potential efficacy.

Compared to Geraldine Macdonald in Britain, North American researchers reputable in the field seemed more upbeat about the state of the literature on the clinical treatment of problems associated with CA, including the treatment of children. In the same year, in the *Draft Guidelines for the Psychosocial Treatment Interfamilial Child Physical and Sexual Abuse* (Saunders, Berliner, & Hanson, 2001) the statement was made that this literature had reached a "critical mass", and was "extensive, sophisticated, and mature". These researchers presented the view that mental health practitioners have a large, scientifically sound, and field tested body of knowledge on which to base treatment plans for abused children and their families. They put forward that the literature was

robust enough to distinguish between treatments that worked well with these clients, and those that were of questionable value.

Why would there be this difference of opinion published in the same year about the same area of clinical treatment? It is possible that this reflects the fact that most of the research on interventions with abused children has been carried out in the US, and relatively less in the UK and elsewhere. In fact, at this time Australian and New Zealand research in child protection utilising an evidence-based approach with experimental rigour was found to be virtually non-existent (Tomison, November, 2000). Researchers and practitioners in geographic areas other than where research has been carried out, with different contextual issues and ethnic populations, have reason to be wary of treatment outcome research unless it has been tested in their own "backyard". That is, the issue here is a question of the external validity, or generalisability of existing research findings to local context.

It may also be that the difference in opinion relates to the perspective from which the appraisal is being made. To explain, the American researchers explicitly state that they based their view that it was time to establish guidelines for the treatment of abused children on the large body of "clinical and empirical knowledge and experience" that was available. In other words, they were going beyond pure empirical research and included clinically supported treatments in their consideration. Macdonald on the other hand appeared to be making her appraisal from a more purely empirical stance. This difference in perspective is likely to relate to the distinction between "efficacy" and "effectiveness" research, as introduced earlier and discussed more fully later in this chapter.

While a review of treatment outcome literature with sexually abused children in 1992 found only 11 published studies (O'Donohue & Elliott, 1992), it is a fact that over the last decade or so there has been increase in empirical studies evaluating treatment outcomes for abused children, primarily in North America (Cohen et al., 2004; N. J. King, Tonge, & Mullen, 2000; Saywitz, Mannarino, Berliner, & Cohen, 2000; Skowron & Reinemann, 2005). However, when viewed in relation to the scale of the existing, untested interventions in the arena of CA/child protection, not only in the US, UK or New Zealand, but worldwide, this is still a very small amount of research. In addition,

the existing research, as with psychotherapy outcome research generally, may have had little impact on the day-to-day practice of clinicians working in child protection and community settings (Chaffin & Friedrich, 2004). So while researchers may have reason to celebrate the progress, grounds remain for the disquiet that Macdonald expresses.

Some of the disparities between different researchers, and between researchers and clinicians might be further understood against the wider backdrop of the history and current state of treatment outcome research. Reference to the broader field provides a means to clarify some of the relevant issues apparent in the specific field of outcome research on interventions for abused children.

History and Models of Treatment Outcome Research

The history of outcome research in the realm of psychotherapy began relatively recently with the first published outcome study in 1930. This was an attempt to evaluate the effectiveness of psychoanalysis by means of analyst rated outcomes (Ogles, Lambert, & Masters, 1996). Early evaluations centred on the basic question: "Is psychotherapy effective?" By 1952, based on his own findings, Hans Eysenck maintained that psychotherapy had not yet been supported as effective. This probably reflected the fact that treatments in vogue at the time were lengthy, and the design of the studies did not enable treatment effects to be distinguished from the passage of time. Subsequently, researchers began using both pre- and post-tests as well as treatment versus no treatment designs. Studies utilising placebo control groups showed that placebo treatments were more effective than no treatment, but specific treatments were more effective than both. In the 1970s, investigators began to turn their attention to comparative outcome studies to determine which treatments were more effective. By 1980, reviewers concluded that psychotherapy was generally effective, achieving outcomes better than natural healing processes or spontaneous remission (M. L. Smith, Glass, & Miller, 1980). The "Dodo Bird" analogy became prevalent: "All have won and all must have prizes" (paraphrased from Lewis Carroll's *Alice in Wonderland*) (Luborsky, Singer, & Luborsky, 1975).

More recently, the focus of investigation has expanded to include identifying more specific factors responsible for client improvement (Ogles et al., 1996). Since the

1980s, there has been increasing interest in the processes responsible for change. For example, once a treatment package has been established as effective, "dismantling" research may be carried out to determine the effective ingredients of that therapy package. As described in the following sections, any outcome evaluation, general or specific, can be carried out as an efficacy or effectiveness study.

Efficacy and Effectiveness Research

In the 1990s, psychotherapy outcome research moved towards developing a distinction between efficacy and effectiveness research (Nathan & Gorman, 2002). Efficacy studies are based on the experimental method, involve a systematic evaluation of an intervention in a controlled clinical research context, and are concerned with internal validity and replication. Effectiveness studies on the other hand are concerned with feasible and beneficial effects in real-life settings, and emphasise external validity and generalisability.

Efficacy Model

Based on an efficacy model, Nathan and Gorman outline six levels by which to judge the methodological adequacy of treatment outcome studies (Nathan & Gorman, 2002). *Type 1 studies* are considered to provide the most rigorous scientifically-based evidence for efficacy. These involve a randomised prospective controlled clinical trial (RCT) with "state of the science" diagnostic and statistical methods, clear exclusion and inclusion criteria, and an adequate sample size to afford statistical power. *Type 2 studies* are clinical trials in which an intervention is made, but lack rigorous adherence to all the criteria of Type 1 studies. *Type 3 studies* are methodologically limited due to uncontrolled data collection and/or retrospective recall error; for example, open treatment pilot studies, or retrospective surveys. *Type 4 studies* comprise reviews with secondary data analysis; for example, meta-analyses. *Type 5 studies* are reviews without secondary data analysis that may be subject to the writer's opinion and biases. *Type 6 studies* encompass reports that, according to Nathan and Gorman, have marginal value, including case studies, essays, and opinion papers (Nathan & Gorman, 2002).

Challenges to the Efficacy Model

It is of note that many studies of high research calibre within the behavioural tradition are excluded from this framework as they utilise small group or single-case designs

(Paul, 2004). Single-case designs have proved their worth over a thirty year time period. For example, multiple-baseline designs provided the research underpinning for many of the behavioural strategies at the core of the behavioural management of children (Hersen & Barlow, 1976; Kazdin, 2003; Sulzer-Azaroff & Mayer, 1977). Yet studies utilising single-case multiple base designs would not reach the level of proof needed for recognition as an EST in Nathan and Gorman's model (Paul, 2004).

Moreover, while efficacy researchers focus on RCT's as the gold standard for drawing causal inferences about whether psychotherapy actually works, for local clinical practitioners this literature may not be particularly helpful (Jacobson & Christensen, 1996). The more complex or profound the pathology of the individual client who might typically present to a real-world clinical setting, the less likelihood there is of finding a treatment that has been validated by a Type 1 study (Paul, 2004). Most efficacy research has highly restrictive inclusion criteria, tending to be focused on participants with homogeneous characteristics that fit a DSM-IV diagnosis. The overall clinical usefulness of a treatment that has been trialled with such participants is a subject of considerable debate, as many clinic-based clients, including children and adolescents, have a complex diagnostic profile and multiple behavioural and social problems (McClellan & Werry, 2003; Weisz, Donenberg, Han, & Kauneckis, 1995). In addition, the RCT approach pays little heed to other factors that are known to be prime ingredients in therapy and are likely to impact on therapeutic outcome, such as the therapeutic relationship (Norcross, 2002).

Effectiveness Models

Effectiveness approaches are intended to offer proven technology for behavioural change in clinical settings (Barlow, 2001). Clinical considerations, rather than the demands of the research design are the primary determinant underpinning the choice of treatment method and outcome assessment targets and processes. Therapist and client variables that are considered important in relation to the particular problem are considered. Overall the emphasis is on "clinical utility" and "transportability" of treatment programmes in "real world" settings, including with children (Okamoto & LeCroy, 2004).

However, effectiveness studies typically have insufficient control over methodological inadequacies, involve sampling biases, and may lack rigorous diagnosis, control or comparison groups and adherence to treatment protocols that would enable replication (Nathan & Gorman, 2002). Additionally, investigations of real-life interventions have been shown to produce outcomes of negligible value in the child therapy domain (Weisz, Weiss, Han, Granger, & Morton, 1995).

Lack of Interaction between Researchers and Clinicians

Researchers have expressed concerns about the apparent discomfort and lack of mutual interaction between psychotherapy researchers and clinicians (Nathan, 2004). This concern has in fact spanned over fifty years, with David Barlow stating in 1981 (Barlow, 1981) :

> At present, clinical research has little or no influence on clinical practice. This state of affairs should be particularly distressing to a discipline whose goal over the last 30 years has been to produce professionals who would integrate the methods of science with clinical practice to produce new knowledge. (p. 147)

Have we made progress in the quarter century since Barlow's comments?

State of the Art of Treatment Outcome Research

There is general agreement that most of the theories and therapeutic approaches used by clinicians today remain unsupported empirically (Nathan, 2004). Some commentators paint a particularly gloomy picture, referring to the "scientist-practitioner gap" and the proliferation of unsubstantiated, untested, and otherwise questionable treatment and assessment methods. There are concerns that the lack of empirical support may increase the risk of harmful techniques (Lilienfield, Lynn, & Lohr, 2003). However, a number of researchers have made proposals to remedy this situation.

Alternating between Efficacy and Effectiveness Approaches

Nathan argues the need to solve the efficacy/effectiveness paradox so as to achieve a consensus on how best to identify evidence-based treatments (Nathan, 2004). He puts

forward that while a number of solutions have been proposed to the paradox posed by the need to satisfy both internal and external validity criteria, none has yet proven ideal. He suggests that the solution might be found in taking the findings from the best efficacy studies and using them to design robust effectiveness studies; that is, alternating "in bootstrap fashion" between the two approaches may well result in the most clinically relevant findings.

Combined Efficacy/Effectiveness Models

Other schemes for evaluating the benefits of a given treatment have taken a more pragmatic approach, proposing models that combine the benefits of both efficacy and effectiveness research (Chambless & Hollon, 1998) (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). These models accept the requirement of replication and the need to demonstrate the efficacy of a treatment, but also recognise that sound methodology is reflected in methodologies other than the RCT. For example, an accumulation of well designed single-case evaluations are considered adequately sound to justify reasonable confidence, particularly during the initial development and testing stage (e.g., Kane & Kendall, 1989).

Chambless and Hollon's model recommends that for a treatment to be efficacious it should have been found superior in at least two independent research settings, with a sample size of three or more in the case of single-case experiments. For a designation of "possibly efficacious", one study is considered sufficient in the absence of conflicting evidence. Studies must have been conducted with: (a) a treatment manual; (b) a population treated for specified problems, delineated in a reliable and valid manner; (c) reliable and valid outcome assessment methods; and (d) appropriate data analysis (Chambless & Hollon, 1998). As discussed in the next section, this thesis takes the view that, in the first instance, the carrying out of this research in the actual day-to-day setting for which it is intended is vital.

A New Model for Child and Adolescent Psychotherapy Research

Alan Kazdin proposes a new model for developing effective treatments in child and adolescent psychotherapy that looks at what the field requires, rather than emphasising the pros and cons of existing treatment models (Kazdin, 2000). This model arises out of a concern that, although there have been many studies of child therapy, there has been

limited progress in transporting them to everyday settings. It is considered to be user-friendly for clinicians and forward-thinking, providing an overall vision and plan for developing effective treatments that will actually be used.

Kazdin's model is intended to integrate theory, research and practice in a series of steps towards building a foundation of knowledge and transportability in a systematic unified way:

Theoretical development: How does theory (a) conceptualise the clinical problem of interest; and (b) explain the processes or mechanisms through which the treatment ameliorates this problem. Kazdin proposes that, with a wide range of possible moderating influences, mediators, and treatment approaches, theory is an obvious starting point to begin to unravel these possibilities. Likewise, while there is an abundance of available treatments, there may only be a few common mechanisms of therapeutic change. A theoretical approach can provide a means to focus on mechanisms of change.

Manualised treatment protocol: Once the clinical problem and treatment processes have been conceptualised and tested, Kazdin recommends that the procedures should be operationalised, preferably in manualised form. This should include a theoretical rationale for including treatment elements. The manual should be specific enough to enable procedures to be evaluated for treatment integrity and replicated in research and practice. This development should include information from clinicians that speak to real life intervention and implementation (e.g., Kazdin, Siegal, & Bass, 1992).

Outcome testing: Tests of outcome should be carried out drawing on diverse designs, including single-case studies and clinical trials, and dismantling and comparative outcome studies. Tests of child, parent, family and contextual factors with which the treatment and therapist interact should be undertaken, including ascertaining any limits around application. Finally, tests of generalisability should be carried out with different samples, settings, problems and variations of the treatment (Kazdin, 2000).

Implications for the Current Clinical Research

Kazdin's model provides a clear blueprint for treatment outcome research that can be applied at local clinical level right through to multi-site randomised control trials. Applying this model to developing effective treatments requires a conceptual view of the factors involved in treatment, starting with an understanding of the population of interest as a basis for the operationalisation of a treatment package. Overall, it appears applicable and user-friendly in providing a guide to developing a treatment protocol for children and adolescents and an associated programme of research. In addition, it is consistent with more recent recommendations of evaluation standards for psychosocial interventions and evidence-based practice in clinical psychology (N. J. King & Ollendick, 2006) and evidence-based treatments in the area of CA and neglect (Chaffin & Friedrich, 2004).

The balance of this chapter examines treatment related research that provides additional foundation for the development of an effective treatment package for traumatised abused children. This begins with a more detailed consideration of some of the factors that Kazdin refers to that influence treatment outcome.

Factors that may influence Treatment Outcome

Factors related to treatment outcome that may be common to all psychotherapies are often termed "moderating" and "mediating" variables. Moderators influence the relationship between two or more variables (e.g., therapist factors, age/developmental level of the child, family dysfunction); mediators are the process or mechanisms through which variables operate (e.g., therapy may be effective because physiological arousal to traumatic cues reduced, attributions changed, and/or beliefs changed). These types of factors are reviewed here.

Treatment Characteristics

The extent a treatment is effective may depend on how it is implemented, not simply on the content. For example, there are indications from adult outcome research that the treatment protocol itself (e.g., CBT) may account for only about 15% of the therapeutic outcome variance, while common factors, such as therapeutic alliance and agency and

client factors, may account for about 70% of the outcome variance (Okamoto & LeCroy, 2004). Other treatment elements that contribute to adult outcomes include rapid and early assessment, precise problem identification, agreement on goals for therapy, and active participation (Bergin & Garfield, 1994). Some treatment variables have interactive effects. For example, outcome research on brief therapy (less than 25 sessions) suggests that this may be most appropriate for clients with acute onset, good pre-morbid state, good ability to relate, higher levels of motivation and less severe problems (Koss & Shiang, 1994).

Compared with the research on adult outcomes, the effect of treatment characteristics on child outcomes has been less carefully studied (Kazdin, 2000). Most existing studies of child treatment do not assess clinical significance of outcomes or conduct follow-up assessments, including in the CA area (Skowron & Reinemann, 2005). In addition, most treatment packages that have been studied with children tend to brief and time limited (e.g., 1 hour per week for 8-10 weeks) with scant regard for the fact that many childhood clinical problems are complex and are likely require longer-term interventions.

CA researchers have found that in clinical settings, treatment may extend to as many as 40 or more sessions depending on the needs of the child and the complexity of the case (Deblinger & Heflin, 1996). A group of mainly sexually abused children were found to have averaged 36 sessions, with a medium of 23, and 3% were involved in long-term therapy (>100 sessions). The optimal length of treatment has not been established, although guidelines suggest that in most cases abuse-focused treatment for children can be in the 12-24 sessions range (Saunders et al., 2004).

Therapist Factors

Therapist factors that predict outcome, at least in adult therapy, include a positive focus, likeability and warmth, and high therapist activity using a range of techniques; for example, the flexible use of treatment manuals and structuring of sessions, such as agenda setting, pacing, and homework assignments (Beutler, Machado, & Neufeldt, 1994). Less attention has been given to the role of the therapist in child treatment (Kazdin, 2000). However, a recent meta-analysis found that the therapeutic relationship was only modestly associated with child treatment outcome (i.e., a small effect size

(ES)[13]; r = .24).   This result was consistent across diverse types and modes of child treatment, and consistent with adult treatment ESs (r = .22) (Shirk & Karver, 2003). Notably, though, children treated for anxiety using the manualised "Coping Cat" programme, on which the current research is based, rated their relationship with the therapist as the most important aspect of treatment (Kendall & Southam-Gerow, 1996).

Match of ethnicity or culture and other differences between the therapist and the child and family also needs to be considered. Adult research shows that if a client decides to stay in therapy with a culturally different therapist, culture does not predict outcome (but does predict dropout).   The important variable predicting outcome is that the therapist gets to know something about the client's background and values (Beutler et al., 1994).

Child Characteristics

In child and adolescent psychotherapy research, child characteristics likely to influence treatment outcome have been found to include severity, chronicity, and nature of the dysfunction, as well as gender, ethnicity and age (Kazdin, 2000).   As described in Chapter 3, significant differences in adjustment patterns among abused children have been found depending on a complex set of interactions between pre-abuse, abuse factors, and post-abuse factors, including the type of abuse experienced and the developmental period during which the abuse occurred.   For example, compared to other child clinical problems, sexual abuse has been found to predict longer treatment (Cohen, Berliner, & Mannarino, 2003).   Younger children are referred more often and receive more treatment than adolescents (Cohen, Berliner, & March, 2000).   In addition, children's abuse-related attributions and perceptions have been found to influence treatment progress and outcomes (Cohen et al., 2000).

Context Variables

Contextual influences are often associated with clinical problems of children and adolescents, such as culture, SES, parental mental health, family functioning, and caregiving arrangements.   Because children are dependent on adults, they are

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[13] ES refers to the magnitude of the difference between two (or more) conditions or groups and is expressed in standard deviation units. ES is assumed to reflect the magnitude of the difference, but is dependent on a well-designed and executed study (Kazdin, 2003).

particularly vulnerable to these influences impacting on the nature and severity of their impairments, the degree of therapeutic change, and the extent to which changes are maintained at follow-up (Kazdin & Weisz, 1998).

In the CA domain, various context factors may moderate the effects of abuse and impact on therapy. Continued contact with the abuser, an offender denying the abuse, multiple placements, and protracted legal proceedings are all associated with poorer long-term outcomes (Edgeworth & Carr, 2000). Factors that may help or hinder outcomes include family cohesion and adaptability, parental support of the child, and parental emotional reaction to the child's abuse (Cohen et al., 2000). Child-focused CBT interventions place considerable emphasis on supporting and strengthening the relationship between the child and caregivers (Deblinger & Heflin, 1996; Mendlowitz et al., 1999). Research shows that positive parental/caregiver involvement enhances treatment results for children (Spence, Donovan, & Brechman-Toussaint, 2000).

Culture may influence treatment-seeking behaviour and responses. Ethnic minority groups may be less likely to seek or receive treatment following CA victimisation (Cohen et al., 2001). Reviewers have suggested that culturally sensitive treatment makes it more likely that clients of ethnic minorities will become engaged in the therapeutic process and be less likely to drop out (Cohen et al., 2003). However, race has been found to have no significant impact on treatment outcome for sexually abused children (Cohen & Mannarino, 2000; Lanktree & Briere, 1995), families whose children had been physically abused (Kolko, 1996), and limited effects with younger sexually abused children (Cohen & Mannarino, 1996). Research evidence continues to be lacking in this area (Cohen et al., 2001; Elliott & Urquiza, 2006). Cultural factors related to treating traumatised abused children in the New Zealand context are reviewed in depth in Chapter 9.

Implications for Treatment Outcome Research with Children and Families
Clearly, a full understanding of a treatment and its delivery will require consideration of therapist, child, parent, family, and other contextual influences. Whatever treatment outcome research design chosen must provide the ability to at least begin to detect the impact of these variables (Kazdin & Nock, 2003). For example, does the design allow an evaluation of a "dose-response" relationship between a hypothesised mechanism for

change and outcome? Does the design provide a time line that allows an evaluation of the relationship between the mechanism and outcomes on a number of occasions pre-, during, and post-treatment?

With the issue of variables that may influence treatment in mind, we turn to a review of child and adolescent psychotherapy research in general. This is followed by a more specific focus on outcome research pertaining to ameliorating the impact of abuse and trauma effects on children.

Child and Adolescent Psychotherapy Outcome Research

Meta-Analyses of Child Psychotherapy

A number of broad based meta-analyses have reviewed the child and adolescent psychotherapy literature. These are useful to report, notwithstanding limitations including confounding among independent variables, omitting studies utilising single-case experimental designs, and many variations in meta-analytic method (Kazdin & Weisz, 1998). In short, meta-analysis has indicated that therapy with children and adolescents has been shown to be effective, and more effective than the passage of time (Casey & Berman, 1985; Durlak, Fuhrman, & Lampman, 1991; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss et al., 1995). The overall pattern indicates medium to large ESs, ranging from 0.71 to 0.88. This is quite comparable to treatment effects found in adult psychotherapy meta-analyses (M. L. Smith et al., 1980).

Empirically Supported Treatments in Child Psychotherapy

CBT in particular has been found to be efficacious over a range of child problems (Durlak et al., 1991). This is partly because CBT is amenable to EST research with a tradition of utilising treatment manuals, relatively standardised assessment processes, and stepwise intervention procedures. It is also reflects the popularity of CBT in contemporary work (Kazdin, 2000), including in New Zealand (Merrick & Dattilio, 2006). Psychotherapy approaches other than CBT have been less well researched, including a dearth of evidence for the effectiveness of the widely used traditional child psychotherapies (Weiss, Catron, Harris, & Phung, 1999), although recently support has been published for the effectiveness of play therapy (e.g., Le Blanc & Ritchie, 2001).

There is some empirical support for the use of interpersonal therapy with adolescents (e.g., Rossello & Bernal, 1999). Family and parent interventions have been found efficacious in reducing non-compliance and problem behaviours (e.g., Patterson, Dishon, & Chamberlain, 1993); ameliorating childhood anxiety (e.g., Barrett, Dadds, & Rapee, 1996), and eating disorders (e.g., Robin et al., 1999). Multisystemic therapy (MST) has been found efficacious for conduct disorder (e.g., Borduin, Mann, & Cone, 1995; Curtis, Ronan, & Borduin, 2004); including in New Zealand (Curtis, 2004).

Unsupported Treatments

It is important to note that treatments that are not empirically supported are not necessarily ineffective. They may not have been investigated yet, or have had some investigation, but not rigorous enough to provide certainty. It has been argued that continuing to use treatments with little or no empirical support is unprofessional and potentially dangerous (Musson, 2004). This is even more the case when there are well established and probably efficacious treatments that can be tried (Kazdin, 2000). However, if clinicians consider certain untested treatments worthy of use, they should endeavour to carry out their own case studies or single-case research utilising the scientist-practitioner model to verify that the treatments they are employing are helpful for children (Feather, 2004a). Louise Woolf advocates this approach with regards to play therapy with traumatised abused young children, a treatment with limited research backing but that is widely used by clinicians with this population in New Zealand (Woolf, 2002).

Psychopharmacology

Child treatment outcome research in the field of psychopharmacology finds empirical evidence supporting medications for some childhood disorders, such as ADHD and obsessive-compulsive disorder, but little research has examined medication for comorbid conditions or more complex problems (McClellan & Werry, 2003). There is recognition in the child psychiatry literature that psychotherapy remains the mainstay of treatment for children, and that more research is needed to establish how it may be best combined with other treatments, such as medication, where this may be indicated (Harrington, 2005).

Practice Guidelines

Practice guidelines have arisen out of similar concerns to those that have driven efforts to identify EST's; that is, to inform clinical practitioners, funding agencies and training providers. Practice guidelines are based on reviews of the evidence and consensus opinions from panels of experts about the status of treatments and their use in clinical work. While intended to draw on treatment evidence, these guidelines are aimed more directly at practice and may reflect the conceptual views and clinical experience of panel members in recommending clinically useful treatments (Kazdin, 2000).

Guidelines are available for the treatment of PTSD in children and adolescents (American Academy of Child and Adolescent Psychiatry, 1998; Cohen et al., 2000). More recently, guidelines for the treatment of abuse in children have been published (Chadwick Center for Children and Families, 2004; Saunders et al., 2004). While created in the US, these guidelines are nonetheless helpful for New Zealand clinicians as a basis for developing best practice protocols to be tested in the local context.

Guidelines for the Treatment of Childhood PTSD

Guidelines for the treatment of PTSD in children and adolescents indicate that empirical evidence favours CBT over other forms of psychotherapy, and suggest that CBT be considered the first-line approach (American Academy of Child and Adolescent Psychiatry, 1998; Cohen et al., 2000). Practice guidelines indicate that, while there has been little empirical research on other psychosocial treatments for PTSD in children, such as psychodynamic psychotherapy and art therapy, there is some anecdotal support for these approaches. Recommended treatment approaches for PTSD generally include psychoeducation for both children and parents, stress management techniques, and some discussion of the trauma, although children should not be coerced to participate in exposure exercises (American Academy of Child and Adolescent Psychiatry, 1998). For abused children with PTSD, it is suggested that interventions are initially delivered in an individual mode, with subsequent rehearsal and practice, including with parents/caregivers (Cohen et al., 2000).

Guidelines for the Treatment of CA in children

Saunders and colleagues describe 16 treatment protocols for abused children and their families that have at least some empirical support (Saunders et al., 2004). Overall, TF-CBT has been recommended by at least two sets of guidelines in the most rigorous category as a "well supported, efficacious treatment" for treating the specific problems of sexually abused children with PTSD (Chadwick Center for Children and Families, 2004; Saunders et al., 2001; Saunders et al., 2004), as described further below.

For working with physically abusive families, the most recent guidelines recommend abuse-focused CBT (AF-CBT) and Parent Child Interaction Therapy (PCIT) (Chadwick Center for Children and Families, 2004). The AF-CBT model was published subsequent to the initiation of the current research, and both AF-CBT and PCIT are primarily focused on working with parents. Hence, although efficacious, neither protocol has informed the current research protocol, which focuses on individual child therapy with parent/caregiver support.

Child Abuse Treatment Outcome Research

Although until recently there has been little emphasis on studying the effectiveness of treatments for abused children (Skowron & Reinemann, 2005), the development practice guidelines has highlighted the fact that there is an increasing body of evidence in the field on which local practitioners can base development projects. This includes narrative reviews, meta-analyses, encompassing ESTs and, more recently, RCTs.

Narrative Reviews of CA Interventions

Narrative reviews have variously concluded that psychological interventions for CA have generally been ineffective (Emery, 1989; Melton & Flood, 1994; O'Donohue & Elliott, 1992) or conversely, that some appear promising (Finkelhor & Berliner, 1995; Oates & Bross, 1995; Saywitz et al., 2000). These conflicting reports reflect not only the particular samples of studies reviewed and treatments used, but also some of the interacting and confounding effects which are inevitably present when working in real life settings with children with a history of abuse and violence. One of the issues

underpinning a number of studies is a lack of rigour in the research designs used. Many researchers in the field have been reluctant to use experimental designs entailing no-treatment or placebo control groups because of the ethical issues related to withholding treatment with this population (Skowron & Reinemann, 2005). Additionally, as previously discussed, the broad field of CA and its treatment has been characterised by specialised fields of interest and practice and a lack of a co-ordinated, planned approach to treatment outcome research (Saunders, 2003).

Meta-Analyses of CA Treatment Outcomes

A recent meta-analysis has made a significant contribution by being the first to review quantitatively the effectiveness of psychological interventions for CA across a range of types of abuse, treatment modalities and types of comparison group (Skowron & Reinemann, 2005). The 21 treatment studies published between 1974 and 2000 included in the review had participants who had been referred for CA, CPA, CSA, and/or physical neglect. One of the main inclusionary criteria was that the treatment had been compared with a control group from the same population, and results reported in sufficient detail to calculate or estimate ES. The results showed that, following intervention, the treated clients appeared to be functioning better than 71% of control group participants. The average weighted ES was $d = .54$, a medium ES. This is a similar ES to those found by other meta-analyses of psychological treatments for child-identified problems (Casey & Berman, 1985; Durlak et al., 1991; Weisz et al., 1987; Weisz, Weiss et al., 1995).

Overall, treatments for sexual abuse were found to be associated with higher ESs (average ES, $d = .69$) compared to those for general forms of child maltreatment (CM) (average ES, $d = .40$). The authors also noted in particular a dearth of treatments developed and evaluated for CPA (physical abuse, $n = 1$ study found and included in the meta-analysis). Notably, studies of child witnesses to violence were not specifically accounted for in the study, even though this is a widely recognised form of CA (as discussed in Chapters 2 and 3).

Importantly, it was noted that only a small number of studies included follow-up assessment, making generalisations not yet possible. Consequently, Skowron and Reinemann rendered the following conclusion and recommendation:

> In response, we encourage CM treatment researchers to ... obtain follow-up data on all clients completing treatments, because professionals who work with this group have long asserted that "sleeper effects," defined as the development of serious psychological symptoms at some point in time after termination of abuse, are likely present among victims of CM[14] (Finkelhor & Berliner, 1995) (p. 66).

A more recent meta-analysis has investigated therapy modality outcomes for sexually abused children and adolescents (Hetzel-Riggin, Brausch, & Montgomery, 2007). Twenty-eight studies were included and treatment modalities and secondary problems were investigated. The results showed that the mean weighted ES was $d = 0.72$, indicating that CSA treatment tended to result in better outcomes than no treatment. The effectiveness of each treatment modality differed based on the secondary problem examined. Consistent with narrative reviews (Cohen et al., 2000; Saywitz et al., 2000). CBT seemed to be the most effective treatment for CSA related psychological distress, along with family and individual therapy; behaviour problems, along with abuse-specific and supportive therapy in either group or individual formats; and low self-concept, along with abuse-specific and group therapy. Play therapy appeared to be the most effective treatment for social functioning (based on four studies).

Longer duration of treatment and non-Caucasian ethnicity were found to be associated with better outcomes for sexually abused children with secondary problems. Intrafamial CSA was associated with poorer outcomes. Family therapy was associated with relatively low outcomes, which was not consistent with previous findings (Berliner & Elliott, 2002), although the researchers suggest that including family therapy with other treatment elements may be helpful (Hetzel-Riggin et al., 2007).

Child Trauma Treatment Outcome Research

Child-focused PTSD outcome research, other than the TF-CBT research for CSA, has lagged behind treatment outcome research in the area for adults and is generally limited

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[14] CM = child maltreatment

to case illustrations and open trials (Ruggiero, Morris, & Scotti, 2001), although gold standard treatment approaches based on CBT have been described for adults (Foa & Rothbaum, 1998; Foa, Rothbaum, Riggs, & Murdock, 1991). There is some support for anxiety management and exposure techniques for treating children with trauma/PTSD.

Anxiety Management Training

Anxiety management training (AMT), in particular stress inoculation training (SIT), originally developed by Meichenbaum, as discussed in Chapter 4 (Meichenbaum, 1994), has received some support for its efficacy with PTSD in adults (Foa & Rothbaum, 1998; Foa et al., 1991). Preliminary support for the usefulness of SIT in treating PTSD in sexually abused children has been found (Farrell, Haines, & Davies, 1998).

Exposure Techniques

Published treatment outcome studies specifically designed to evaluate the effectiveness of exposure-based techniques for children with PTSD are virtually non-existent (Ruggiero et al., 2001). With adults, several RCT's have demonstrated the efficacy of prolonged exposure for the treatment of PTSD (e.g., Foa et al., 1991). Case illustrations have indicated preliminary support for the use of this technique for children with war and disaster-related trauma (e.g., Saigh, 1987). While only preliminary evidence is available for the usefulness of systematic desensitisation and gradual exposure for PTSD in children, researchers have suggested that these less intrusive approaches may be more suitable for children (Ruggiero et al., 2001).

Combined Anxiety Management and Exposure

A number of group design treatment outcome studies have indicated the usefulness of a combined anxiety management and exposure-based approach (e.g., Bisson et al., 2007), including with children. These include the TF-CBT studies for PTSD from CSA (e.g., Deblinger, Lippmann, & Steer, 1996), and similar approaches for a variety of personal and community-based traumas (e.g., March, Amaya-Jackson, Murray, & Schulte, 1998), and natural disasters (e.g., Goenjian et al., 1997), including an experimental study in New Zealand following the 1995 Mount Ruapehu eruptions (Ronan & Johnston, 1999).

Clinical Adaptations for Complex PTSD

The disparity between existing treatment research samples and clinical populations means that, of necessity, clinicians have quite often carried out interventions for clients with more complex presentations based on accumulated clinical experience (van der Kolk & Courtois, 2005). Additional considerations include a focus on client safety, affect regulation, coping and self-management skills, and the therapeutic relationship itself. The treatment of complex trauma has been primarily applied to adults and is thought to require three phases: (a) symptom reduction and stabilisation; (b) processing of traumatic memories and emotions; and (c) life integration and rehabilitation after trauma processing (Ford, Courtois, Steele, Van der Hart, & Nijenhuis, 2005).

Developmental and Ethical Considerations

Researchers and clinicians have highlighted the importance of developmental considerations in the treatment of childhood PTSD. For example, flexibility in the treatment protocol permits children to choose from a range of forms of exposure to suit their age and stage; for example, doll play or puppets, drawing, writing or talking about what happened (Deblinger & Heflin, 1996). It is recommended that treatment should be phased and paced; for example, coping skills should be introduced and practiced prior to exposure. Given that PTSD can be fluctuating and long-lasting, treatment may need to be pulsed, with booster sessions made available for when the child reaches a new developmental stage, or symptoms are re-triggered due to new circumstances or events (Cohen et al., 2000).

Ethical factors are relevant to child trauma treatment outcome. For example, researchers recommend that children and their caregiving adults be thoroughly educated about treatment protocols, particularly regarding exposure-based procedures, including the potential for symptom exacerbation during treatment. Caregiving adults may need psychoeducation in order to understand and respond appropriately to trauma-related symptoms such as avoidance, attachment disruptions, and behaviour problems (Ruggiero et al., 2001).

Limitations of Current Child Trauma Research

While the problem area of PTSD has been well-conceptualised and the components for child trauma treatment have been formulated, there has been a relative lack of child-focused research targeting treatment of PTSD. Some of the reasons suggested include a tendency for parents/caregivers to over-emphasise behaviour problems and under-assess internalising problems such as PTSD; an apparent hesitancy to diagnose PTSD, particularly in CA; and a bias of therapists towards educational components and play therapy, rather than on coping strategies and exposure-based procedures (Ruggiero et al., 2001).

Ruggiero and colleagues note child-focused trauma treatment research has made only preliminary progress compared to developments in the adult literature, and conclude:

> Thus, a breadth of opportunities for empirical investigation awaits researchers seeking to extend the literature on the childhood treatment of PTSD-related responding. (p. 222)

Empirically Supported Treatments for Child Abuse Trauma

Over the last decade, a growing body of empirical research has begun to emerge supporting the efficacy of certain treatment protocols with traumatised abused children and their families, although much remains unknown (Cohen, 2005).

TF-CBT for Sexual Abuse Trauma

Prominent among EST's for CA, as noted by reviewers and practice guidelines, is the intensively researched TF-CBT for PTSD from CSA (Saunders et al., 2004; Skowron & Reinemann, 2005). This protocol is child-focused with parent involvement, and is designed to target thoughts and feelings about the abusive experience and the perpetrator, to address specific psychological symptomatology related to the traumatic effects of the abuse, teach coping skills, and provide education on sexual abuse, safety, and healthy sexuality.

Evidence from initial RCT's found TF-CBT useful in reducing symptoms of PTSD in sexually abused children, with improvements holding over 1 and 2-year follow-ups (Cohen & Mannarino, 1996, 1997; Deblinger et al., 1996; Deblinger et al., 1999; N. J. King et al., 2000). These studies had relatively small sample sizes and were not carried out in community settings, limiting the generalisability of the findings.

TF-CBT for Multiple-Abuse and Trauma

A recent multi-site RCT utilised a manualised child and parent TF-CBT programme in clinic-based settings. The results suggest the efficacy of TF-CBT with regard to PTSD, depression, behaviour problems, shame and abuse-related attributions for 7 to 17 year old olds who have experienced sexual abuse as well as other types of trauma, and multiple traumas, including CPA and exposure to domestic violence (Cohen et al., 2004). Sustained improvements were recorded in anxiety, depression, dissociation, and sexual concerns at 6-months, and significantly greater improvements in PTSD and dissociation at 1-year follow-up compared with a non-directive supportive therapy (NST) comparison group (Cohen, Mannarino, & Knudsen, 2005).

Overall, TF-CBT has been found to be superior to play therapy, supportive counselling, and standard community treatment in decreasing PTSD and other trauma-related symptoms in children from 3-18 years (Cohen et al., 2000; Cohen et al., 2004; Cohen et al., 2005; N. J. King et al., 2000). Parental involvement has been found to variously improve outcomes relating to parenting and child behaviour (Deblinger et al., 1996), or to have no significant impact on outcome (N. J. King et al., 2000).

ESTs for Physical Abuse

ESTs for CPA have been predominantly parent and/or family focused and tend to consist of parent training in child behaviour management techniques, changing beliefs that may lead to physical abuse, and training in anger control and stress management (Azar & Wolfe, 1998), parent-child interaction training and abuse-focused family interventions (Kolko, 2002). There is a paucity of research evaluating treatment outcome for protocols aimed at ameliorating abuse and trauma-related symptoms for children who have suffered CPA (Runyon et al., 2004). A review a decade ago reported only 13 studies that have addressed the needs of children at risk for CPA and neglect (Oates & Bross, 1995). A more recent pilot study demonstrated reductions in PTSD,

anxiety, dissociation, and anger in school-age children participating in a 16-week CBT group programme for CPA, (Swenson & Brown, 1999). There were no reductions in externalising problems or depression. The treatment components included relaxation, exposure, anger management, and social skills building. No follow-up data was reported.

To date, only one treatment outcome study for CPA has involved random assignment and a controlled comparison (Runyon et al., 2004). This RCT compared the treatment outcomes of an individual child and parent treatment model similar to TF-CBT, family therapy (FT), and a routine community service (RCS) (Kolko, 1996). Compared with RCS, CBT and FT were associated with improvements in child-to-parent violence and child externalising behaviour, with efficacy of treatment maintained through 1-year follow-up. This study supports the usefulness of a TF-CBT approach with children traumatised by CPA.

Emotional and Psychological Abuse

Identification of effective intervention approaches for emotional and psychological abuse lags behind that of other areas. Few have been shown to effectively treat these effects of CA and neglect, and this type of abuse seems to be particularly resistant to intervention efforts (S. N. Hart et al., 2002). Those models that have been found to improve client outcomes in this area require intensive resources including highly trained well-supervised therapists, reduced client load, and many client contact hours (MacLeod & Nelson, 2000).

Limitations to Current CA Trauma Treatment Outcome Research

Limitations to current knowledge include the fact that most treatment studies for traumatised children have focused on sexually abused cohorts, and individual studies seldom distinguish other types of abuse represented (James & Mennen, 2001). Additionally, while sexually abused children are often highly symptomatic and difficult to treat, it is not clear that effective treatments for this group would be optimal for other types of abuse, or multiple-abuse, or for children who have PTSD comorbid with other disorders (Cohen, 2005). Published treatment studies for childhood PTSD to date, with the exception noted, have excluded children with comorbid disorders, and have not specifically addressed the needs of children with "complex PTSD". Cohen notes that

traumatised children suffering the greatest functional impairments have received the least attention from treatment researchers.

In addition, it is not clear whether the same treatment components are necessary for all children. For example, there may be some children for whom gradual exposure is not necessary, or even detrimental. There is no information about optimal treatment dosage, or what proportion of children recover to the point of optimal functioning. Similarly, the need for active parental treatment component is not known as there is some evidence that traumatised children respond well to CBT interventions without parental involvement (Cohen, 2005). It is impossible to isolate abuse experiences from contextual factors. Existing research has not measured the impact of contextual factors on treatment outcome; for example, social support, family functioning, and/or exposure to further abuse (James & Mennen, 2001).

Need for Further Research
Overall, it is clear that there is a need for more study, particularly of children who have been multiply-abused and present to clinic settings with other complicating vulnerabilities or risk factors. Notwithstanding the limitations, there is a growing body of research in the US showing ample evidence that TF-CBT is a first-line treatment for PTSD, anxiety and depression in sexually abused children, and possibly for children exposed to other traumas as well (Berliner, 2005). However, virtually no such research is being carried out, or at least being published, in other countries.

O'Donohue and colleagues propose building on existing models using a theory-based approach as a basis for the development and testing of manualised treatments for other child trauma populations (O'Donohue et al., 1998). Their recommendations in 1998 continue to hold true today, particularly in New Zealand, where CA trauma research is in its infancy:

> …a lack of empirical research (for children who have experienced trauma) does not mean that there is a lack of seemingly sound *theoretical* examinations of possible treatments. We recommend that practitioners faced with sexually abused children follow Deblinger and Heflin's (1996) treatment manual… For other childhood traumas we recommend that researchers follow the lead of

Deblinger and her colleagues and develop and test other manualised treatments. (p. 376)

Child Anxiety Treatment Outcome Research

Treatments for CA trauma reflect the fact that PTSD is an anxiety disorder. At the time the current research was initiated, there was less empirical support than now available for CBT models specifically for CA trauma. In contrast, CBT treatment for child anxiety was the most thoroughly researched child psychotherapy and was considered to be a "gold standard". The tradition of research in this area spans nearly two decades and began with Phillip Kendall and associates at Temple University, Philadelphia (Howard & Kendall, 1996; Kane & Kendall, 1989; Kendall, 1994; Kendall et al., 1992; Kendall et al., 1997; Kendall & Southam-Gerow, 1996). This group of clinical researchers developed a treatment protocol for 9-13 year old children with anxiety disorders, based on the theoretical principles of CBT (Kendall et al., 1992; Kendall, Kane, Howard, & Siqueland, 1990).

The treatment research of CBT for children with anxiety disorders is exemplary in a number of ways (Kazdin, 2000). The studies have been with children who have met DSM criteria for an anxiety disorder, rather than having unknown diagnoses. Strong and consistent impact has been demonstrated across a number of settings and countries, including Australia and New Zealand (Barrett, 1998; Barrett, Duffy, Dadds, & Rapee, 2001; Girling-Butcher, 2000; Huzziff, 2004). There has been an investigation of some of the moderators of treatment such as comorbidity, gender, and ethnicity. Treatment processes have also been studied, such as individual versus group formats. Homework (STIC; "Show-that-I-can") tasks are an integral part of the treatment approach, which have empirical support, particularly in the adult literature, for contribution to treatment outcome (Kazantzis & L'Abate, 2007). Importantly, treatment manuals are available for use in clinical work and as a basis for further research (e.g., Girling-Butcher & Ronan, 2002; Kendall et al., 1990).

The treatment was initially evaluated with single-case designs, and subsequently with group studies (Howard & Kendall, 1996; Kane & Kendall, 1989; Kendall, 1994;

Kendall et al., 1997). In the two initial RCT's, the treatment was compared to a waiting list control condition. The results indicated that treated children improved on child-, parent-, and teacher-report measures of anxiety as well as in other symptom domains, such as aggression, social problems and depression (Kendall, 1994; Kendall et al., 1997). Treatment effects have been shown to maintain over 1-year and 3-year follow-ups (Kendall & Southam-Gerow, 1996).

A second team of investigators in Australia has replicated and extended the treatment (Barrett, Dadds, & Rapee, 1991; Barrett et al., 1996). In a RCT, CBT was found to be effective in reducing anxiety in children to below clinical levels. Long-term (6 year) follow-up indicated that effects for treatment of anxiety were largely maintained (Barrett et al., 2001). Overall, studies are somewhat equivocal about the extent of parental involvement required to enhance treatment effectiveness for children. However, it is thought that having both children and parents/caregivers directly involved in the treatment process may be helpful for monitoring progress and performing the role of co-therapist for the child outside of treatment sessions (Mendlowitz et al., 1999; Nauta, Scholing, Emmelkamp, & Minderaa, 2003), and for producing more immediate effects, as demonstrated in Australia (Barrett et al., 1996) and in New Zealand (Girling-Butcher, 2000).

In summary, efficacy and effectiveness studies support the usefulness of CBT for anxiety disordered children. It has proven to be a treatment that is transportable to real-world cases across a range of settings and countries, and demonstrates long-term maintenance of treatment gains. The treatment protocol itself has proved to be durable for over a decade, with many children responding to the child-focused approach, including in New Zealand. Based on this evidence platform combined with its theoretical basis, it appears to be a sound protocol from which to develop a treatment programme for abused children with PTSD.

Implications for Child Abuse Trauma Clinicians

Limitations intrinsic to the process mean that evidence-based practice is necessary but not sufficient to drive clinical decision making for specific clients (Rosenthal, 2004).

Furthermore, there is a need to know how evidence-based practices vary according to client characteristics such as abuse-type, severity of disorder, ethnicity or culture, and other contextual factors. So far there has been minimal research examining such differences (Okamoto & LeCroy, 2004). In general, child treatment outcome research has produced extensive information on treatments that are not very much like those used in practice. Many studies have been conducted with non-referred children and adolescents whose impairment and level of dysfunction do not represent those seen in clinical settings. To be clinically useful, outcome studies need to be relevant to what is done, who is seen, and what is needed in clinical practice.

It is clear that there is a need for more rigorous evaluation of effectiveness of CA treatments with clinic-based populations of children who present with abuse-types that are less well researched, in particular CPA, witnessing DV, and multiple-abuse with multiple problems (Runyon et al., 2004; Saunders, 2003). Within the bounds of ethical and legal standards of care, this can be achieved by using control groups assigned to alternative psychological treatments whose effectiveness has been empirically established and that appear to be clinically useful (Skowron & Reinemann, 2005). However, clinic settings in New Zealand rarely have the resources or the client numbers for large samples to get sufficient cell sizes.

Given such problems in real life settings, there has been the call for theoretically based manualised protocols to be developed and initially tested using single-case experimental designs in these situations (Kazdin, 2000; Saunders, 2003). In this way, local clinicians can draw on evidence-based research carried out in related areas elsewhere to develop and trial the effectiveness of treatment protocols for particular populations and problems. Ultimately, research can most scientifically inform clinical practice if research participants adequately reflect the population for whom the treatment is desired (Behl et al., 2003).

Summary

Until recently there has been a dearth of treatment outcome research that can be readily applied in clinical settings. This has partly been due to the models of outcome research

employed. In an attempt to rigorously control for internal validity, efficacy researchers may have sacrificed clinical utility. Effectiveness researchers have been criticised for compromising methodological rigour. Recently a new model has been proposed that integrates theory, research, and practice, and takes account of other factors that may influence treatment response, providing a blueprint for treatment outcome research with children and adolescents (Kazdin, 2000).

The field of CA has been replete with research but there has been a lack of a planned approach, and treatment outcomes have been conflicting. Likewise, child trauma treatment outcome research has lagged behind that of adults and has generally been limited to case illustrations and open trials. However, two related arenas of treatment outcome research offer promising models for CA trauma researchers. The treatment approach of CBT has been found to be efficacious over a range of child problems. In particular, efficacy studies support the usefulness of CBT for anxiety disordered children, including in New Zealand. It has proved to be transportable to real-world cases across a range of settings and countries, and demonstrates long-term maintenance of treatment gains. As well, a growing body of empirical research has begun to emerge supporting the efficacy of TF-CBT for treating PTSD from CSA, with gains holding over 1 and 2-year follow-ups. More recently this approach has been extended to community settings and multiple-abuse, with promising results.

Taken together, Kazdin's model for treatment outcome research, combined with the two well-supported child CBT approaches, provide the structure and empirical basis for the development and testing of a new manualised TF-CBT programme for the particular population of abused children that is the focus of the current research. Chapter 6 presents the rationale and purpose of this development project.

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Chapter 6: The Current Research

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Outline and Aims

Chapter 6 presents the research rationale and purpose. The current research is essentially a treatment development project, designed for application within a statutory child protection agency (SSU; the Specialist Services Unit of CYF, the statutory child protection agency in New Zealand, as described in Chapter 2). In order to be helpful for the agency, the practitioners who work there, and of course, for the clients served, it was necessary to choose one aspect of the field that would be clinically useful to research. This chapter summarises the background rationale for that choice. It also briefly describes the development of the manualised treatment programme, a rationale for the research design and overall methodology, and, finally, the aim of the current research.

Rationale for Clinical Problem of Interest

The literature review presented in Chapter 3 revealed that CA statistics in New Zealand are alarmingly high, with referral rates to CYF growing dramatically each year. As many as a tenth of New Zealand children experience harsh or severe physical punishment and approximately a fifth experience sexual abuse. At least a quarter of children are exposed to some form of family violence. It almost goes without saying that that it makes essential the need for interventions with the most likelihood of ameliorating the short and long term effects.

The review of the literature pertaining to CA revealed that at least some New Zealand practitioners (e.g., clinical psychologists) have a tradition of drawing on international research and practice, and applying this in ways designed to meet the particular needs of New Zealand children and families. As described in Chapter 2, the field in New

Zealand is now at a point where we have highly developed systems and processes for dealing with CA (Davies, 1999). This is reflected in the establishing in 2002 of Australasia's first multi-agency service, Puawaitahi, a "one-stop-shop" of all government agencies involved in the investigation, assessment, and treatment of CA. Puawaitahi has been set up explicitly as a "centre of excellence". Related to this idea of excellency, one of the aims of the multi-agency service is to provide a setting for research on aspects of service delivery.

A glaring gap in New Zealand CA practice has been the lack of treatment outcome research. For example, since the opening of Puawaitahi there has been only one study focused on treatment outcome (Woolf, 2002), and no research to date has been published in peer reviewed journals[15]. It could be argued that clinicians in New Zealand have been too busy simply managing the work, reflected the large increase in referral rates, documented in Chapter 3. However, it is proposed here that that the field may be coming of age in this country with regard to an increased willingness to evaluate our practices. This thesis was designed to be part of that vanguard.

Drawing on the model proposed by Kazdin for developing effective treatments in child and adolescent psychotherapy (Kazdin, 2000), the current research began with looking at what the field, and CYF/SSU required. There were many areas in which this research might have focused. However, the research on the effects of CA that was coming out at the time the current research was being planned highlighted the needs of the group of children who were experiencing trauma as a result of abuse (see Chapter 3). Combined with specific SSU needs, this appeared to be important to investigate, as the effects of PTSD can be long-lasting and fluctuating, and particularly insidious for many children.

Theoretical Rationale

The second step in Kazdin's model is to explore how theories (a) conceptualise the clinical problem of interest; and (b) explain the processes or mechanisms through which the treatment is thought to ameliorate this problem.

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[15] The exception is Study 1 of this thesis (Feather & Ronan, 2006) (see Appendix D.)

The theoretical literature presented in Chapter 4 provides insight into the mechanisms that explain the impact of traumatic experiences on physical, cognitive, emotional, and behavioural features. It is evident from theory and research that contextual factors play a significant role in how traumatic effects play out in a person's life. For example, in the case of children, account must be taken of developmental age and stage, family relationships, support systems, and other factors (see Chapter 4). At a wider level, world views including cultural paradigms (see Chapter 9) may mediate the experience of trauma for some. Clearly, therapy should be planned and conducted within the context of an ecological approach, consistent with respect for different world views.

When considering essential elements for the treatment of trauma, the theoretical frameworks of behavioural and cognitive models of trauma have much to offer. Behavioural theories provide a clearly delineated rationale for the analysis of variables maintaining symptoms, and for treatment elements including anxiety management, social modelling, practice, and use of exposure to treat trauma. Cognitive models provide a rationale for cognitive restructuring methods such as "coping self-talk", and gradual imaginal and *in vivo* exposure techniques that enable integration of trauma memories as a coherent whole that can be assimilated. More recent cognitive approaches, such as cognitive science and memory theories, provide a rationale for verbal as well as non-verbal trauma processing modalities, in order to address both explicit and implicit memories. Neurobiological theories reinforce the need to address physiological responses to trauma, such as hyperarousal and dissociation, as well as emotional, cognitive, and behavioural reactions. Constructivist narrative approaches seem particularly applicable to children, with an emphasis not only on resolving past trauma, but also on creating a new narrative for life.

The trauma model that has its roots in psychoanalysis and psychodynamic theories emphasises the importance of the therapeutic relationship for healing, and the use of expressive therapies for facilitating trauma processing. Likewise, CBT approaches highlight the importance of a collaborative therapeutic relationship, as well as use of creative applications of the model, particularly when working with children (Kendall et al., 1992). These ideas underpin the ultimate aim of the therapist and child (and parent/caregivers) working together with a range of modalities to alleviate symptoms

and enhance coping such that the child will think, feel and behave differently in the present and the future, beyond the experience and effects of abuse (Kendall, 2000).

Local models of clinical practice in this area have a tradition of integrating a number of theoretical approaches and perspectives (e.g., K. Macdonald et al., 1995). These practical process-based models of therapy are derived from various frameworks including systems theory, family therapy, narrative therapy, and informed by developmental, feminist, and empowerment perspectives. Drawing on constructive narrative approaches, change is created by providing clients with "news of difference". CBT techniques are utilised to deal with negative effects of abuse such as unhelpful behaviours, emotions, beliefs or physical symptoms. The social and cultural context of the abuse is taken into account; for example, with regard to ensuring social support and planning for safety.

A main aim of this research was to develop an intervention with a coherent theoretical rationale based on elements from the theoretical approaches described here. A second aim was to ensure that the intervention was empirically sound.

Treatment Rationale

As described in Chapter 5, existent child and adolescent treatment outcome research has found CBT in particular to be efficacious over a range of child problems. Notably, efficacy and effectiveness studies support the usefulness of CBT for anxiety disordered children (Barrett, 1998; Barrett et al., 2001; Howard & Kendall, 1996; Kane & Kendall, 1989; Kendall, 1994; Kendall & Southam-Gerow, 1996), and TF-CBT for children with PTSD from CSA, (Cohen & Mannarino, 1996, 1997; Deblinger et al., 1996; Deblinger et al., 1999) in particular. TF-CBT treatment outcome research has extended this protocol to community clinic settings and multiple-abuse since the current research began (Cohen et al., 2004). However, at that time, the CBT treatment protocol developed by Kendall and colleagues for anxiety disordered children (Kendall et al., 1990) was already well-researched, with demonstrated long-term maintenance of treatment gains across a range of settings and countries, including in New Zealand. It appeared to be a sound protocol and basis from which to develop a treatment

programme for abused children with PTSD that incorporated additional elements thought necessary to treat both PTSD and CA.

Other than the notable progress made in the area of TF-CBT for sexually abused children, the literature review highlighted the fact that treatment outcome research on CA trauma has lagged behind that of adults. Adult outcome literature provides a rationale for focused assessment, agreement on therapy goals, and tailoring therapy to the problems identified, and these ideas are echoed in recommendations for child treatment (Cohen et al., 2003). For abuse-related trauma, phase-based approaches are generally recommended, with a focus on symptom reduction and stabilisation, trauma-processing, and life integration (Briere & Scott, 2006; Cloitre, Cohen, & Koenen, 2006), including with children (Deblinger & Heflin, 1996). For child trauma, initial support has been found for the usefulness of anxiety management techniques, systematic desensitisation and gradual exposure approaches (e.g., Farrell et al., 1998; Saigh, 1987).

Treatment outcome researchers have also recognised the need to attend to wider issues, including therapist factors. While research on the impact of treatment variables is limited with children, adult literature emphasises the importance of a positive therapist focus, and high therapist activity including flexible use of treatment manuals, structuring of sessions, and use of homework (Beutler et al., 1994). Significantly, cultural sensitivity and getting to know something about the client's background and values has been found, at least indirectly, to contribute to treatment outcome (Sue, Zane, & Young, 1994).

For children, CA researchers have found that in clinical settings, treatment may extend to as many as 40 or more sessions depending on the needs of the child and the complexity of the case (Deblinger & Heflin, 1996). However, research on brief therapy and CA therapy indicate that in many cases far fewer sessions can produce clinically significant change (Cohen et al., 2004; Koss & Shiang, 1994). Abuse-specific factors affecting treatment outcome include the severity, chronicity, and type of abuse experienced, as well as age of onset, current age and stage of development, and parent/caregiver involvement (Cohen et al., 2003; Cohen & Mannarino, 2000). Importantly, the literature suggests that treatment protocols need to be developmentally appropriate to the child, encompass parent/caregiver psychoeducation, and facilitate

caregiver support of the child's therapy (Cohen, Mannarino, & Deblinger, 2006; Deblinger & Heflin, 1996).

Manualised Treatment Protocol

Kazdin recommends that once the clinical problem and treatment processes have been conceptualised and tested, the procedures should be operationalised, preferably in manualised form (Kazdin, 2000). This should include a theoretical rationale for inclusion of treatment elements and delivery mechanisms. The manual should be specific enough to enable procedures to be evaluated for treatment integrity and replicated in research and practice.

In the current research, a TF-CBT treatment programme based on theoretical models, local clinical approaches and empirical research was operationalised into a manualised format: *Te Ara Whetu*[16]: *TF-CBT for Abused Children* (Feather & Ronan, 2004). It was developed in the local clinical setting for multiply-abused 9-15 year old children with PTSD, typical of the population referred for assessment and therapy to the agency. The programme is set out in a 16-session format, with regular scheduled parent/caregiver sessions. The manual is designed to be flexible to cater for the range of issues which may present, and to be adaptable to different developmental stages. A more detailed description of the programme is presented in Chapter 7. The reader is also referred to the introduction of the manual for a full rationale of the specific treatment elements (Feather & Ronan, 2004).

To summarise the approach here, the treatment is phased, with each phase emphasising important elements identified in the literature, complemented with aspects from local clinical practice: *Phase 1* focuses on relationship and contextual factors, in particular, psychosocial strengthening and social support. *Phase 2* is derived from the CBT programme for anxiety disordered children developed by Kendall and colleagues (Kendall et al., 1990), and helps the child develop coping skills based on a 4-step coping template, "*The STAR Plan*". *Phase 3* is based on a gradual exposure procedure for processing and resolving trauma, derived from behavioural, cognitive and expressive

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[16] *Te Ara Whetu* – the way guided by stars

therapy models. *Phase 4* provides a transition to life beyond therapy; any issues that are so far unresolved are addressed, the narrative emphasis is incorporated to help the child to create a new future to step into, and relapse prevention is covered. Booster sessions are offered if required.

The manual is designed to be used flexibly. For example, some children may not need all sessions, or may cover therapy elements more quickly, whereas others may take longer to work through the sessions, and/or require booster sessions, depending on their characteristics and context. The consistent therapy session structure enables the process of therapy to be more predictable, and allows for frequent summaries and opportunities for feedback from the child. The emphasis on collaborative empiricism enables the therapist and child to form hypotheses or ideas about what might help him manage his symptoms and feel better. The child tests these in and out of the sessions, reviewing progress week by week. In this way, the therapy is designed to facilitate the generalisation of in-session therapeutic change to everyday situations that the child encounters, to ensure better outcomes and reduce relapse.

The entire programme has the classic hallmarks of an overarching CBT framework, including a collaborative therapeutic relationship, an ever-evolving formulation of the child and his problems in cognitive-behavioural terms, working with the child's idiosyncratic view of himself, others and the world, active involvement of the child, and helping the child discover data for himself with the aim of teaching him to become "his own therapist".

Adapting a treatment for abused children involves special considerations. CA invariably affects the relationships children have with their family members and means the involvement of helping professionals in the child's life. Many children who come to the attention of child protection services are placed in care to ensure their safety, including a number of children in the current study. Removal from parents adds another layer of trauma for these children and necessitates forming new relationships with caregivers. The early part of the treatment programme is devoted to exploring and strengthening the child's psychosocial context as a basis for the later treatment interventions. Abuse-informed issues are incorporated in the treatment, as recommended in practice guidelines, such as psychoeducation about abuse and personal

safety, and emotional processing of guilt, blame, anger, separation, grief and loss (Saunders et al., 2001).

A key consideration in adapting the anxiety-based programme of Kendall and colleagues to the treatment of PTSD is that anxiety is about current and future threat whereas PTSD, while an anxiety disorder, also has much to do with a past event(s). Children who have PTSD are processing trauma and/or its sequelae in a way that often involves not only ongoing distress but also ongoing reminders (Ehlers & Clark, 2000). Hence, the aim of a treatment programme for PTSD needs to be to help children develop skills to manage their symptoms, and to process trauma so that it is seen as a time-limited past event(s) that can be managed effectively by the child and his family/caregivers, coupled with a focus on current and future concerns.

A CBT approach holds that gradual exposure is an optimal strategy for reducing PTSD symptoms (Kendall et al., 1992). This can be achieved in a number of ways, including using creative media to create a trauma narrative and desensitisation to trauma triggers in a safe therapeutic environment (Yule, Smith, & Perrin, 2005). In particular, sand-play therapy has been found clinically useful for children as a medium for processing abuse and violence trauma in children (Grubbs, 1994; Parson, 1997). This approach, drawing on both verbal and non-verbal modalities, is consistent with the theory as well as local clinical practice (Woolf, 2002). In this way, the therapist helps the child to learn that he can approach his fears and not experience the feared consequences, leading to an overall reduction in anxiety and trauma symptoms in everyday life.

As has been clearly delineated throughout the literature, a contextual framework is particularly important when working with children, adolescents, and families, particularly where abuse has occurred. The CBT model considers a child's thoughts, feelings and behaviours not only in relation to specific situations but also in relation to his broader context (Graham, 2005; Reinecke, Dattilio, & Freeman, 2003). The programme is designed to assist the therapist to take into account the finer nuances of antecedents and consequences of the child's presenting problems, as well as the interactive effects of his history and development, family relationships and attachments, and social and cultural context on his symptom expression and response to therapy.

Outcome Testing

The final step in Kazdin's model for developing effective treatments is outcome testing. Kazdin proposes that tests of outcome should be carried out drawing on diverse designs, including single-case studies and clinical trials, and dismantling and comparative outcome studies. Tests of parental, family and contextual factors with which the treatment interacts should be undertaken, including ascertaining any limits of application. Finally, tests of generalisability should be carried out with different samples, settings, problems and variations of the treatment (Kazdin, 2000).

Being a development project, the current research utilised a single-case design, as recommended by Kazdin and employed by others (e.g., Kane & Kendall, 1989) for the initial testing of a new manualised treatment protocol. Chapter 7 describes the research design in more detail. Based on a scientist-practitioner model of local clinical research, a multiple-baseline across participants involving between-person replications (Hersen & Barlow, 1976) was used to demonstrate the controlling effects of treatment on PTSD symptoms and child coping. Repeated measures were used to assess child co-morbid symptoms and parent/caregiver and teacher views on child functioning. The research used four studies, designed in a way to build on each other.

Purpose of the Current Research

The overall purpose of the research was to develop and evaluate the TF-CBT treatment programme by comparing treatment to no treatment (i.e., the baseline phase) over a series of studies.

Study 1

The purpose here was to pilot the effectiveness of the manualised TF-CBT programme with a group of four multiply-abused children who had been diagnosed with PTSD. These children all identified as New Zealand European/Pakeha, the most commonly referred cultural group to the agency.

It was expected that Study One participants would show a reduction in PTSD symptoms and an increase in coping behaviours related to specific abuse and trauma related concerns, compared to pre-treatment levels. It was also expected that these gains would maintain over follow-up intervals (3-month, 6-month and 12-month).

Study 2

The purpose here was to carry out a trial of the manualised TF-CBT programme with a sample of abused Maori and Pacific Island children, representing the two cultural groups most often referred to the agency after Pakeha. An important part of the purpose of Study 2 was to ascertain how the programme needed to be adapted in order to be culturally appropriate and meet the needs of these children and families.

It was expected that, provided the programme was adapted to their world view and tailored to their needs, that Study Two participants would similarly show a reduction in PTSD symptoms and an increase in coping that maintained over follow-up intervals.

Study 3

The purpose here was to conduct a study evaluating the completed TF-CBT protocol with the researcher as therapist, with a group of four typically referred children, regardless of culture.

It was expected that Study Three participants would show a reduction in PTSD symptoms and an increase in coping that maintained over follow-up intervals.

Study 4

The purpose here was to carry out a replication study, evaluating use of the completed TF-CBT protocol by two other therapists, each with two typically-referred abused children who had PTSD.

It was expected that Study Four participants would show a reduction in PTSD symptoms and an increase in coping that maintained over follow-up intervals.

Summary

Chapter 6 has reviewed the need for clinic-based treatment outcome research in the field of CA trauma in New Zealand. The overall aim of this research is to evaluate the usefulness of a manualised TF-CBT treatment programme for traumatised abused children and young people typically referred to SSU, CYF. This includes an evaluation of the programme for cultural groups including Maori and Samoan, as well as when used by therapists other than the researcher. Chapter 7 details the methodology.

Chapter 7: Method

Outline and Aims

Chapter 7 outlines the participants involved in the research, the measures used, the research design, the procedure used, including a summary of the assessment and treatment protocol, and ethical considerations.

Participants

Sixteen children (9 girls, 7 boys) aged 9 to 15 years who had experienced CA resulting in PTSD participated in the research, along with their available parent/caregiver(s). The sample was drawn from children referred by their Department of Child, Youth and Family (CYF) social worker to the CYF Specialist Services Unit (SSU) at Puawaitahi for psychological assessment and treatment. These children were "open cases" with CYF who were typical of those who presented to SSU with multiple-abuse histories and current mental health concerns. The research was conducted over the period 2001-2004. The sample was primarily recruited in 2002-2003.

There were no exclusion criteria specified explicitly for the research, as all referrals to SSU are subject to the agency's criteria. Children who may not be accepted include those who present primarily with child mental health concerns (CMH), rather than a mixed picture of abuse, trauma, child protection and CMH concerns, who may be more appropriately referred to a CMHS; or children with primarily a sexual abuse history who may, according to statute, be referred for counselling funded by ACC.

The majority of children and parents/caregivers invited to participate in the research agreed. That is, of the 24 approached, 22 agreed to take part and 16 finished the programme. Details on those who did not finish are now provided. Two children, a girl and a boy (both Maori), moved out of the area during the treatment phase. Two siblings, a girl and a boy (Tokelauan), decided to end therapy after 8 sessions, coinciding with their return home. These four children comprised the original cultural sample (Study 2), and were replaced by a second sample of Maori and Pacific Island children. A 10 year old Pakeha girl (Study 3) was withdrawn from the sample early in the treatment phase, as clinical judgement indicated that she required another treatment approach, due to aspects of developmental delay. A 10 year old Maori girl (Study 4) did not complete the programme due to lack of caregiver support for therapy.

The characteristics of the 16 participants are outlined in detail on Tables 8.1, 9.1, 10.1, and 11.1 (see respective Chapters 8-11). The specific abuse-types represented in the overall sample, as recorded on CYF files or during the SSU assessment, were: 100% (n=16) of the children had experienced emotional abuse; 75% (n=12), CPA; 75% (n=12), witnessing domestic violence; 37% (n=6), CSA/witnessing sexual assault; 31% (n=5), neglect.

Thirty-one percent (n=5) of children identified as New Zealand European ("Pakeha"); 31% (n=5), New Zealand born Samoan; 19% (n=3), Maori; 12% (n=2), South American; and 6% (n=1), Eastern European/North African. Thirty-three percent (n=6) of children experienced multiple placements during the research period, including in two cases, moves between foster care and parental care; 31% (n=5) were in a parent's care throughout, although two moved with their mother from a women's refuge, to a family residential programme, to a rented home; 19% (n=3) experienced one change of placement, moving from extended family, or in one case a foster home, back to a parent's care; 12% (n=2) were in a stable placements with extended family or non-kin caregivers. Seventy-five percent (n=12) of participants experienced at least one change of school over the research period.

Child mental health diagnoses and related problems were assessed on a structured diagnostic interview on the basis of child interview alone, or in combination with the parent/caregiver interview (see measures), compatible with DSM-IV criteria (American

Psychiatric Association, 1994). All participants (n=16) met diagnostic criteria for PTSD; 81% (n=13) had anxiety symptoms, and of these, 44% (n=7) met criteria for at least one anxiety disorder; 31% (n=5) depression symptoms, including two with suicidal ideation and 6% (n=1) who met criteria for Dysthymia; 38% (n=6) symptoms of disruptive behaviour problems, 6% (n=1) met criteria for Oppositional Defiant Disorder (ODD). Other related problems noted in parent/caregiver interviews were learning difficulties, 11% (n=3), anger problems, 19% (n=3); sexual behaviour problems, 13% (n=2); and grief and loss from the death of a parent/family member 13% (n=2).

Measures

The protocol for the research comprised a multi-modal, multi-informant battery of instruments, as recommended by the CA and child trauma literature (American Academy of Child and Adolescent Psychiatry, 1998; Myers et al., 2002). A structured clinical interview was used for diagnostic purposes. A full battery of child self-report measures, parent/caregiver, and teacher measures was designed to assess the impact and symptomatology of CA trauma pre-treatment, post-treatment, and at 3-month, 6-month, and 12-month follow-up assessment points. A short battery of child self-report measures additionally tracked ongoing progress across baseline and treatment, according to a single-case design procedure. All the measures selected have known reliability and validity and have been shown to be sensitive to the effects of treatment. Assessments were conducted by a trained and independent research assessor (i.e., a postgraduate student training in clinical psychology), with some exceptions, as will be explained.

The current research was primarily interested in answering questions related to selected instruments from the test battery: In particular, the self-report measures that were completed by the children weekly during the baseline and treatment phases, and at follow-up points, that tracked changes in PTSD symptoms and self-identified coping factors. Other measures were included to provide data on common comorbid anxiety and depression symptoms, and additional parent/caregiver and teacher perspectives concerning broadband behavioural and emotional functioning.

Structured Diagnostic Interview

Anxiety Disorders Interview Schedule for Children (ADIS) (Silverman, 1987). The ADIS is a structured clinical interview administered to children (ADIS-C), with a parallel version for parents (ADIS-P). Revisions have ensured it is compatible with the DSM-IV and can be used for diagnostic purposes (Silverman, 1994).

The interview schedules enable diagnoses of each of the DSM-IV anxiety disorders, including PTSD. In addition, the ADIS-C has diagnostic sections that provide assessment of affective and externalising disorders commonly comorbid with anxiety (e.g. major depressive disorder; MDD, oppositional defiant disorder; ODD, attention deficit hyperactivity disorder; ADHD) and related childhood problems (e.g. school refusal, substance abuse, psychosis) (Albano & Silverman, 1996). The ADIS-P screens for additional childhood disorders (e.g., conduct disorder, learning disorders, pervasive developmental disorder). The formulation of a diagnosis usually requires both the parent and child versions to be administered. The interviewer uses the information obtained from both sets of interviews, along with clinical judgement to determine the child's diagnoses. In cases where there is no parent or other adult available who knows the child well enough to complete the parent version, as can happen when children have recently come into care as the result of parental abuse, the child version alone can form the basis of the clinician's diagnosis (Linning & Kearney, 2004).

The ADIS is appropriate for use in both clinical and research settings, providing reliable and valid diagnoses (Albano & Silverman, 1996). It has good test-retest (.61 to .78) and interrater (.59 to .82) reliability (Rapee, Barrett, Dadds, & Evans, 1994; Silverman, Saavedra, & Pina, 2001). An Australian study also supports the diagnostic reliability cross-culturally (Rapee et al., 1994). Concurrent validity has been demonstrated with youths diagnosed with anxiety disorders using the ADIS-C displaying significantly higher scores compared with normative values on the Child Behavior Checklist (CBCL) Internalising scale (Silverman, 1994).

The ADIS has been used extensively by childhood anxiety researchers due to its psychometric properties and user-friendly structure which enhances rapport and enables in-depth gathering of information on the child's historical and current functioning (Ronan, 1996). The ADIS has been recommended and used for screening for PTSD and

comorbidity in children who have been exposed to trauma (Yule et al., 2005), including abuse-related trauma (Linning & Kearney, 2004).

Child Self-Report Measures

Children's Post-traumatic Stress Reaction Index (CPTS-RI) (Frederick, Pynoos, & Nader, 1992). The CPTS-RI is a 20-item measure rated on a 5-point Likert scale (scored 0-4) that assesses the features and symptoms of PTSD in children, based on DSM-III criteria for PTSD (American Psychiatric Association, 1980). Most items, however, do correspond to DSM-IV PTSD criteria; for example, all three symptom clusters − reexperiencing, avoidance/numbing, and increased arousal − are well represented on the CPTS-RI. It can be administered in a self-report or interview format. Scores can range from 0 to 80. Empirical comparisons of CPTS-RI scores with independent clinical assessments for severity levels of PTSD resulted in these guidelines: A score of 12 to 24 indicates a *mild* level of PTSD; 25 to 39, a *moderate* level; 40 − 59 *severe*; and >60 *very severe* (Frederick, 1985).

The CPTS-RI has been widely used in research, including with abused children (e.g., Haviland, Sonne, & Woods, 1995; Runyon & Kenny, 2002). Reliability and validity have been documented in previous studies (Frederick et al., 1992). Alpha reliability was found to be .88 in a New Zealand study with children who had been exposed to a natural disaster (Ronan, 1997). The CPTS-RI has good construct validity, with one study demonstrating that 44% of children scoring in the moderate range, and 92% scoring in the very severe range met DSM-III criteria for PTSD (Nader, 1997). It has been shown to be treatment sensitive with children with disaster trauma (e.g., Ronan & Johnston, 1999) and CA trauma (e.g., Dubner & Motta, 1999).

State Trait Anxiety Inventory for Children (STAIC) (Spielberger, 1973). The STAIC measures both acute (state) and chronic (trait) anxiety in children aged 9 to 12 years. Each scale has 20 items rated on a 3-point Likert scale (scored 1, 2, or 3). The Trait scale is treatment sensitive and can be used to measure the effectiveness of clinical procedures designed to reduce anxiety in children. Scores can range from 20 to 60, with higher scores indicating greater anxiety.

Alpha reliability data presented in the STAIC Manual is acceptable (State = .82 to .87; Trait = .78 to .81). Test-retest correlations are low for the State (.31 to .47), and higher for the Trait (.65 to .71), as would be expected. Moderate to strong concurrent validity has been found for the Trait scale with the Children's Manifest Anxiety Scale (CMAS, r=.75), and the Revised CMAS (RCMAS, r=.85) (Spielberger, 1973). Normative data is presented in the STAIC Manual for children aged 9 to 12 years, based on a sample from Florida of varying SES and ethnic backgrounds. Comparative normative data has been found with New Zealand samples (Ronan, 1997). Moreover, the STAIC-T has been found to be sensitive to treatment effects, both overseas and in New Zealand (Huzziff, 2004; Kendall, 1994).

Children's Depression Inventory (CDI) (Kovacs, 1981). The CDI is a 27 item scale that assesses affective, behavioural and cognitive signs of depression in children and adolescents aged 8 to 17 years. Modelled after the Beck Depression Inventory (Beck, Steer, & Brown, 1996), it is designed to measure the severity of depressive symptoms. Each item has 3 choices (scored 0, 1, or 2) each of which characterises the child over the previous two weeks. Scores can range from 0 to 54, with higher scores indicating greater severity.

The reliability of the CDI has been reported across various population samples, with internal consistency ranging from .71 to .89 (Kovacs, 1981). Internal stability has also been found to be adequate in New Zealand research (Ronan, 1997). Stability over time is moderate to high, with test-retest reliability ranging between .56 to .87 over 2 to 4 week periods; .41 to .69 over 6 weeks to 1 year (Kovacs, 1981). Criterion validity has been demonstrated with correlations of .67 for boys and .72 for girls reported with self-esteem scores as measured on the Coppersmith Inventory; .66 with the short version of the Piers-Harris Self-Concept scale; construct validity has been demonstrated in multiple studies indicating that the CDI can discriminate between children with general emotional distress and normal school children (Kovacs, 1981).

Normative data is extensive for the CDI, with both normal and clinical child populations. New Zealand research has found that local "normal" children were similar to the relevant manual-based normative samples (Ronan, 1997). The CDI Manual provides normalised *T*-scores for two age groups (7 to 12 and 13 to 17 years). In a

clinical setting *T*-scores above 65 are generally considered clinically significant (Kovacs, 1981). The CDI has been found to be treatment sensitive in treatment outcome studies with child anxiety (e.g., Kendall et al., 1997) and CA trauma (e.g., Lanktree & Briere, 1995).

Coping Questionnaire (CQ-C) (Kendall et al., 1992). The CQ-C was devised to address the situational specificity of childhood anxiety disorders and is designed to capture the fears and anxieties specific to the child (Kendall et al., 1992). The CQ-C measures the self-perceived coping ability of a child in specific anxiety-provoking situations. The three situations most distressing for the child are identified during the assessment interviews are listed on the CQ-C and rated each week by the child on a 7-point Likert scale ranging from *not at all able to help myself* (1) to *completely able to help myself feel comfortable* (7).

The internal stability of the CQ-C has been found to be acceptable at .70 (Ronan & Kendall, 1997). Test-retest reliability across a 2-month waitlist period for a small sample of 20 children was .46 (Kendall, 1994). The CQ-C provides a baseline for the target behaviours addressed during treatment (Kendall et al., 1992). It has proved to be treatment sensitive across a range of settings in child anxiety research, including in New Zealand (Huzziff, 2004; Kendall, 1994; Kendall et al., 1997).

Following the example of a recent local treatment outcome study of child anxiety (Huzziff, 2004), a fourth question was added to the CQ-C to assess treatment expectations. The question asked children to rate on a 7-point Likert Scale how much they thought the treatment programme would help them cope generally, and subsequent to the programme, how much they thought it had helped them.

Trauma Symptom Checklist for Children (TSCC) (Briere, 1996). The TSCC evaluates self-reported trauma symptoms in children aged 8-16 years. It is a 54-item instrument with two validity scales (Under-response; UND, and Hyper-response; HYP) and six clinical scales: Anxiety (ANX), Depression (DEP) , Anger (ANG) , Posttraumatic Stress (PTS), Sexual Concerns (SC), and Dissociation (DIS). The test-booklet presents a list of thoughts, feelings, and behaviours, related to unspecified traumatic responses in a number of different symptom domains. The child is asked to rate how often these

things happen to him or her. Each item is rated on a 4-point scale from 0 (*never*) to 3 (*almost all of the time*). For all but the SC scale, *T*-scores at or above 65 are considered clinically significant (SC, *T*>70). *T*-scores of 60 to 65 are suggestive of difficulty.

The TSCC demonstrates good reliability and validity (Briere, 1996). The TSCC has been normed in the U.S. with a sample of 3,008 children. Reliability analysis in the normative sample demonstrated high internal consistency for five clinical scales (.82 to .89), and moderate for the SC scale (.77). The two validity scales had reliability coefficients of .85 (UND) and .66 (HYP). The TSCC Manual reports acceptable validity data. For example, with regard to convergent and discriminant validity, the CDI was most correlated with the DEP scale of the TSCC and least with the SC scale. As might be expected of a self-report measure, the TSCC correlates best with CBCL Youth-report scores, and less well with CBCL Parent-report scores. CBCL Youth-report Internalisation correlated most with ANX, DEP, and PTS, whereas Youth-report CBCL Externalisation correlated most with SC, DIS, and ANG. These data suggest the TSCC has good convergent validity. Construct validity has been demonstrated, with significant amounts of variance in TSCC scores being related to children's exposure to violence, experience of stressful life events, and CA histories. The TSCC Manual reports that CSA has been found to be related to all TSCC scales except ANG; CPA to all scales but SC; and neglect specifically related to DEP and DIS.

The TSCC has been found to be sensitive in assessing treatment effects of therapy for abused children, in particular, sexually abused children (Cohen & Mannarino, 1996; Lanktree & Briere, 1995). As the TSCC examines both trauma symptoms and common comorbidities, it is useful for evaluating complex posttraumatic outcomes and has been recommended for use with abused, traumatised children (Briere & Spinazzola, 2005; O'Donohue et al., 1998).

Parent/Caregiver and Teacher Measures

Child Behaviour Checklist/4-18 – Parent Form (CBCL/4-18) (Achenbach, 1991a). The CBCL/4-18 is presented in a standardised format for parent/caregivers to report on a range of child competencies, emotional functioning and behaviour problems in children aged 4 to 18 years. The CBCL/4-18 is a revised version of the original CBCL (Achenbach & Edelbroek, 1983, cited in Achenbach, 1991a). Since the current research

began there has been a new version published, the CBCL/6-18 and associated Teacher Report Form (TRF) and Youth Self Report (YSR) which appears to be an improvement over the previous one, with new norms, more items and scales, and specific reference to the disorders in the DSM-IV (Briere & Spinazzola, 2005). More recently, a comprehensive system has been produced that includes cross-informant comparisons and multicultural norms (Achenbach & Rescorla, 2007).

On the CBCL/4-18, two sections measure (a) social competencies, assessing the child's participation in areas such as sports, hobbies, and social interactions; and (b) problematic behaviours, comprising 118 problem items rated on a 3-point scale (scored 0, 1, or 2). The problem item raw scores are recorded on a scoring profile, which provides percentile and *T*-scores based on norms for each sex in each age range, presented in a series of problem scales. There are nine specific behaviour syndrome scales (Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviour, Aggressive Behaviour, and Sex Problems), and two broad domains of behaviour (Internalising and Externalising). The Internalising scale represents behaviours such as anxiety, depression, and withdrawal. The Externalising scale represents aggressive and delinquent behaviours.

Interrater reliabilities have been reported in the .93 to .96 range for interviewers, and somewhat lower for inter-parent correlations, in the .65 to .76 range across both scales (Achenbach, 1991a). Achenbach found mean test-retest reliabilities across a 1-week period were high (.87 to .89), and reports studies that show stability has been found over a longer period of time. The manual provides extensive information regarding the validity of the CBCL/4-18. A study of 172 abused children reported greater behaviour problems on the CBCL than a matched sample of 155 nonabused children (Kinard, 1995). Normative data has been based on large samples of children including multiple ethnic, SES, and urban/rural groups. Normalised *T*-scores and clinical cut-offs are provided; *T*-scores of less than 65 are within normal range and scores of 67 or higher are in the clinical range.

The CBCL is one of the most widely used measures for the assessment of general psychological problems in children, and is often used to evaluate children who have experienced CA (Friedrich, 2002b). Although it does not provide information

concerning abuse-specific difficulties (O'Donohue et al., 1998), the CBCL is still currently recommended for use with traumatised abused children (Briere & Spinazzola, 2005). In child anxiety research, CBCL scales have been found sensitive to treatment effects (Barrett et al., 1996; Kendall et al., 1997), including in New Zealand (Huzziff, 2004).

Child Behaviour Checklist – Teacher Report Form (TRF) (Achenbach, 1991b). The TRF is used to assess child problems and competencies in the realm of social/emotional functioning at school. It mirrors the parent version of the CBCL and provides teacher ratings of the child's academic performance, adaptive functioning, and behavioural/emotional problems. In a standardised format, the teacher reports on the child's academic performance, how hard the child is working, appropriateness of behaviour, and happiness. The 118 behaviour problems provide the same scales as the CBCL, divided into the two main domains of Internalising and Externalising, which were used for the purposes of the current research.

The CBCL-TRF Manual reports moderate interrater reliability with a sample of 19 boys (aged 7 to 11 years) with behavioural/emotional problems. For teachers seeing the boys under different conditions interrater correlations were .55 for adaptive functioning and .45 for problem scores (Achenbach, 1991b). Score stability coefficients over a two to four month period for the same sample were .75 and .66 respectively. Validity data reported in the Manual is adequate. A study of matched samples of two groups of 1275 children revealed significant differences between referred and non-referred children on most of the problem items and all the adaptive functioning items (Achenbach, 1991b). Normative data is drawn from a subset of 4 to 18 year old children from the CBCL national normative sample in the U.S., including multiple ethnic, SES, and urban/rural groups. Normalised T-scores and cut-offs are provided for each of the scales. T-scores of less than 65 are within the normal range, and 67 or higher in the clinical range.

As with the CBCL, the TRF is not specifically designed to measure CA related difficulties that may manifest in the school environment. However, it is a widely used teacher report measure on general psychological functioning in the school setting and is recommended for supplementing informal reports of child behaviour when assessing abused children (Pearce & Pezzot-Pearce, 2007). In child anxiety research, the TRF has

been found to be sensitive to treatment effects where TRF pre-treatment scores have been elevated (Howard & Kendall, 1996). In a New Zealand child anxiety study, teachers generally did not report clinically concerning levels of internalising or externalising levels of behaviour pre- or post-treatment (Huzziff, 2004). This mirrors overseas research that has found that teachers' reporting of anxious children within normal limits is the norm (Flannery-Schroeder & Kendall, 2000). Like Huzziff's study, a small-scale New Zealand treatment outcome study of four young abused children carried out in the same setting as the current research found relative consistency in teacher report scores pre- and post-treatment, with significant discrepancies often noted between caregiver and teacher reports (Woolf, 2002). Notwithstanding these issues, the wide acceptance of the CBCL and TRF in child clinical research warranted their use in the current research.

Research Design

The current study was based on a scientist-practitioner model of local clinical research and utilised a single-case design. A multiple-baseline across participants involving between-person replications (Hersen & Barlow, 1976) was used to demonstrate the controlling effects of treatment on PTSD symptoms (CPTS-RI) and coping (CQ-C). The participants were randomly assigned to a baseline of 3, 5, 7, or 9 weeks following the initial assessment. Continuous measures were completed throughout the baseline, treatment, and follow-up phases. This strategy is justified, as numerous measures of a participants' behaviour increases confidence that the sample of behaviour being measured is representative under experimental conditions (D. L. Morgan & Morgan, 2003). Secondly, it represents a conceptualisation of behaviour as ever-evolving, and captures treatment outcome as an unfolding phenomenon, rather than a single discrete observation which may be logistically convenient, but lacks a natural and full context. A non-concurrent procedure was employed (Hayes, 1981; Watson & Workman, 1981). This relaxes the requirement that the participants enter assessment at the same time and makes it possible to use the data from several clients seen at different times, exploiting the fact that their baselines were of different durations.

Multiple-baseline designs provide experimental evidence that the treatment effects are probably not due to other processes, nor to the placebo effect of the experience of assessment and treatment itself (Blampied, 1999; Kazdin, 2003). Participants act as their own controls, with comparisons being made across experimental conditions. Successive replications across participants that show change in symptoms and coping when treatment is introduced support the hypothesis that the treatment is producing the changes. Graphed results enable visual assessment of the effects of phased treatment elements, as well as the impact on treatment of any documented external events (Kazdin, 2003). Bar graphs may be used to provide a simple and relatively clear way of comparing the data across phases, whereby each bar or column represents the mean or average level of all data points for each phase (i.e., baseline, treatment, and follow-up) (Kazdin, 1982b). Simple line graphs are used to plot continuous data representing the level of response for the participant at each assessment point. Assessment points are plotted in noncumulative fashion, enabling response patterns to over time to be easily discerned from the graphs. Changes in mean, level, slope, and trend are easily examined, and how a participant is performing can be interpreted at a glance (Kazdin, 1982b).

The fit between single-case research designs and conventional inferential statistics remains quite contentious. There has been little consensus on statistical methods for analysing sequential response data from single-cases (D. L. Morgan & Morgan, 2003). Single-case researchers continue to justify the graphic display and visual analysis of such data, maintaining that the evidence of an independent variable's effect on a dependent variable should be visible to the naked eye. For example, a smooth curve showing a change in probability of response as a function of a controlled variable would be considered indisputable.

In reality, human behaviour in response to therapeutic interventions rarely shows up as a smooth curve, but more like a jagged trend. In fact, variability is captured with increased specificity in single-case research. Unlike Fisherian designs, in which variability is considered "noise" to be controlled for, single-participant research begins with the assumption that variability represents a core theme of science (D. L. Morgan & Morgan, 2003). Not only is pivotal information available about the impact of the independent variable on the dependent variables over time, but the single-case protocol

may reveal the unintentional effects of extraneous variables. This can provide valuable data for the continuing development and application of a treatment programme.

Single-case multiple-baseline designs are intended to be user-friendly in clinical settings. Initial assessments can occur promptly, and the baseline phase can occur while the client is on the wait list for treatment. Once treatment begins, it is not necessary to withdraw or alter the intervention to demonstrate the treatment effects. Moreover, all clients receive a treatment that is designed to work best for their presenting problems, as there is no need for a comparison group. The single-case design meets the basic criterion of clinical (external) validity in that it can be used to evaluate a treatment programme that can be flexibly tailored to individual clinical cases (Goldfried & Wolfe, 1998). For example, in the current research, the manualised treatment programme is designed to be adapted to the age of the child, abuse type, particular sequelae, or need for shorter or longer interventions and/or booster sessions. Clearly, in clinical research, if there are any concerns that the research constraints may impact on therapeutic outcomes, clinical concerns must be prioritised.

The most frequently noted limitation of single-case research designs is their presumably minimal external validity in terms of generality. However, this view has been contested (Kazdin, 1982b). As described, these designs rely on both intra- and inter-participant replications. The latter, in particular, serve as a reliability check on the functional relationships being studied, as well as providing an assessment of individual differences in responses. Hence, generality is not an exercise in statistical inference in single-case research, but an experimental practice that extends replications across a range of independent variable parameters, stimulus conditions, and participant variables (D. L. Morgan & Morgan, 2003). Systematic replication consists of repetition of the experiment in step-wise fashion that is particularly applicable to treatment outcome research in clinical settings (Kazdin, 1982b).

In the current research, the manualised treatment programme was replicated across four different conditions, comprising four studies of four children each, as described below. Continuous assessment data was intended to be collected weekly for target concerns ("short battery"; CPTS-RI, CQ) across baseline and treatment, and at follow-up intervals. The research design also included pre-, post-, and 3-month, 6-month and 12-

month follow-up assessments of target and co-morbid concerns. This involved repeated measures of the "full battery" of child self-report measures, parent/caregiver and teacher measures.

The Four Studies

Study 1: Pilot Study

Study 1 was a pilot, trialling the treatment programme with the first group of four children who met research criteria and consented to be involved. By chance, these children all identified as "Pakeha" New Zealanders. As with the subsequent three groups of participants, these children presented with multiple-abuse histories and current mental health concerns.

Study 2: Cultural Study

Study 2 comprised an opportunity sample of two Maori and two Samoan children. With significant cultural consultation with Maori and Samoan SSU colleagues, this enabled the treatment programme to be tested with children of our local indigenous population, and children of the largest Pacific Island cultural group in Auckland.

Study 3: Developed Protocol

Study 3 involved the next group of four children who met research criteria. This was a multi-cultural sample, reflecting the diverse range of cultural backgrounds of children typically referred to SSU. The developed treatment programme was tested with this group of children.

Study 4: Other Therapists

Study 4 was not planned at the outset of the research, but arose as an opportunity when there were more children meeting research criteria than were required for Study 3. It was decided to formally test the manualised treatment programme with other therapists from the agency delivering it, under supervision of the researcher. Again, these children represented a multi-cultural population with multiple-abuse histories.

Procedure

Recruitment

Participants were accessed as part of the usual referral process of children to the agency. The referrals of young people identified during triage as potentially suitable for the study were allocated to an independent research assessor, who carried out the initial assessment. The assessment findings were presented by the assessor to the parent/caregiver(s) and child. Following the agency protocol, recommendations for treatment were discussed, and agreement for the continuation of treatment within the agency was gained. If the child met research criteria, the research therapist was introduced and the parent/caregiver(s) and child were given the opportunity to participate in the research. Consent to research participation was gained from both child and caregiver(s).

Setting

The Specialist Services Unit (SSU) of the Child, Youth and Family (CYF) receives referrals from care and protection social workers for specialist assessment and treatment of child clients and parents/caregivers/family. The children are all "open cases" with CYF, generally at the "intervention" phase of the agency's involvement. The particular SSU clinic where the research was conducted services four site offices of CYF. Referrals are made for forensic assessments, parenting assessments, parent/caregiver support, as well as individual psychological and therapeutic needs assessments, and therapy. Cases referred generally involve complex care and protection concerns and often multiple-abuse and trauma.

This particular SSU clinic is located in the multi-agency CA assessment and treatment service, Puawaitahi, as described in Chapter 2. The setting is purpose-built and child focused. A range of therapy rooms are set up age appropriately for younger children through to adolescents. A range of media is also available, including sand trays and miniatures, paints, coloured pens, scrapbooks, stickers, puppets, games, and books.

Children are transported to assessment and therapy sessions by parents, caregivers, social workers or CYF transporters. Parents and caregivers are expected to attend

specified sessions at Puawaitahi. Circumstances can necessitate some caregiver consultation being carried out over the telephone. Teachers and other professionals are usually liaised with by telephone and/or in writing.

Assessors and Therapists

The main assessor ("LW") for the current research was a post-graduate student in clinical psychology, who was employed as a part-time assistant psychologist at SSU. LW completed the independent assessments for Studies 1 and 3. Study 4 also included independent assessment, as documented later in this section. Study 2 did not use independent assessment.

Therapy was provided to the participants of Studies 1 and 3 at the SSU clinic by the researcher, a doctoral candidate, clinical psychology trainee, and an experienced child and family clinician.

With regard to Study 2, the opportunity sample, these children had been allocated to clinical caseloads, without having being identified as potentially meeting the research criteria. When the ADIS was administered during routine clinical assessment, all four children were diagnosed with PTSD. The researcher had assessed the two Maori children and one of the Samoan children, and an agency therapist ("TB"), who is Samoan, had assessed the sibling of this child. These children and their caregivers were given the opportunity to participate in the research, and agreed. Cultural consultation with Maori and Samoan colleagues indicated that it would not be in the children's best interests to change to a different therapist for research purposes at this stage, as a therapeutic relationship had already been established on the basis that they would continue to see the same clinician for therapy. In addition, as demonstrated in the literature, treatment-seeking can be difficult enough for abused children and families of minority cultures (Cohen et al., 2001; Elliott & Urquiza, 2006), without adding to their stress and discomfort with unforeseen changes in personnel. Therapy proceeded with the researcher seeing the two Maori children, under cultural supervision of a Maori colleague. The two Samoan children were seen concurrently by the researcher and TB, with significant supervision each way (cultural and clinical) related to use of the manualised programme with these children and their mother.

For Study 4, two children were initially assessed by LW, and a further two were assessed by the researcher, who then took over the subsequent assessments for all the children in Study 4, as LW left the agency. The treatment for Study 4 participants was carried out by two agency therapists trained in the use of the manualised programme (TB and "JT").

On occasions when the independent assessors were not available to administer the assessment measures, and out of practical necessity, the therapists conducted these. In an attempt to minimise demand characteristics, in those cases where relevant, the children were told that this data was being gathered for the assessor.

Initial Assessment

Following referral and according to agency protocol, the assessor made contact with the child's social worker to set up a case plan and arrange an appointment with the child and his parent and/or current caregiver(s). Once formalities had been addressed, the initial assessment took the form of semistructured interviews with the child (ADIS-C) and the parent/caregiver (ADIS-P). Many of the children referred to SSU have been removed from their parents and recently placed in care. It was not uncommon for there to be no adult who knew the child well enough to be able to provide the detailed information required by the ADIS-P. In these cases, the assessor made the child diagnoses based on the ADIS-C and clinical judgement, using supervision and cultural consultants as appropriate. The initial assessment included the child completing the full battery of self-report measures (CPTS-RI, TSCC, CDI, STAIC and CQ-C). The parent/caregivers and teacher were asked to complete the CBCL and TRF respectively. Pre-paid self-addressed envelopes were provided when it was necessary to post these out, to enable the completed forms to be posted back.

Informed Consent

If the child met diagnostic criteria for PTSD on the ADIS, informed consent from the child and legally responsible adult(s) was sought for participation in the study. The research therapist was introduced and the information sheets were provided that outlined the aims and procedures of the research, and what would be expected if they took part. Potential participants were informed, both verbally and in writing that participation was voluntary, and that the child would still receive treatment if they

declined to take part. Informed consent was obtained from the child and legally responsible adult(s) in writing. (See Appendix E for information sheets and consent forms).

Random Allocation

Once consent was obtained, the children were randomly assigned by the assessor (in groups of 4) to a baseline duration of 3, 5, 7 or 9 weeks. It is to be noted that when required, clinical judgement overrode research requirements when it was considered important for client safety and wellbeing that treatment begin promptly. The number of cases where clinical judgement overrode random assignment was n=3. In these cases, the immediate clinical concerns were suicidal ideation (S1.1), placement breakdown and emotional safety (S3.1), running away and physical safety (S4.1).

Baseline Phase

The participants completed the weekly measures of the short assessment battery (CPTS-RI, CQ-C, STAIC, and CDI) during the baseline period. In all situations, the assessor attempted to collect the requisite number of weekly baseline assessment measures as planned and to hold to the randomly assigned baseline lengths across participants. However, adherence to the assigned baseline period was not possible in every case. For example, over the Christmas period, not only was the agency closed for a period of time, but children were away and/or reluctant to begin therapy while on holiday, resulting in an extended baseline period. In some cases, social workers were busy or left the agency, and children waited longer for treatment to begin. In addition, children did not always complete and forward the weekly measures. As per the informed consent agreement, if a child did not wish to complete measures at any time, this of course was respected.

In a single-case design the baseline data must be examined for stability (Kazdin, 2003). Notwithstanding the fluctuating nature of PTSD symptoms (a dependent variable of particular interest to the current research, along with self-reported coping), a stable baseline is characterised by relatively little variability and the absence of a slope (or trend). At least three baseline points are required to establish stability (Barlow & Herson, 1984). For single-case methodology in applied clinical research, it is recommended that the variability in the baseline scores should not exceed a 50 per cent

level in any case (Barlow & Herson, 1984). The baseline data should be stable enough to make a prediction that, without intervention, participants would be likely to continue to record dependent variable scores at a similar level.

In terms of the current research, of primary interest are the variability and trend of the data points during baseline, and whether it is the treatment that makes a difference when it is introduced. These factors are likely to be more important than the length of the baseline period per se, although the differential length of baselines across participants is important in order to ascertain that it is the treatment that is causing the changes in the dependent variables, rather than time alone. Thus, while planned baseline intervals were not possible in every case, baseline variability across all four studies was able to be established, as documented in Chapters 8-11.

Treatment Phase

On completion of the baseline phase, participants began treatment. All participants were offered the same treatment condition. Although the manual was in draft at the outset of the pilot, and was not completed in its final form until after the cultural study, the treatment elements remained essentially the same. Adaptations tended to be to be in the realm of suggestions regarding order of delivery for different cultural groups, or additional techniques presented as alternatives for different age groups.

Given that the manualised treatment was designed to be delivered flexibility, number of treatment sessions required to complete the programme varied, as described in the results (Chapters 8-11).

Treatment Manual and Materials

Children received the TF-CBT programme and parents/caregivers were offered 3 structured sessions, as described in a 16-session format in the 65-page manual (Feather & Ronan, 2004). In addition, booster sessions and additional parent/caregiver sessions and social worker support were provided as required. The manual describes the purpose and goals for each session, materials required, session format and activities, and associated out-of-session activities (homework). Worksheets for the child are provided to accompany each session. The TF-CBT programme comprises four phases as follows:

Phase 1: Psychosocial Strengthening. Rapport building and orientation to therapy, relationships and support networks, exploration of the child's history and introduction of the 4-step coping template; the "STAR Plan"[17], and a session with parents/caregivers to give additional information about the treatment to caregivers and encourage their support.

Phase 2: Coping Skills. Introduction and practice of the coping skills template, the STAR Plan, comprising: Recognition and expression of feelings, recognition of body reactions to trauma and anxiety and introduction of relaxation techniques, introduction to the role of thoughts in perpetuating symptoms and teaching the modification of unhelpful self-talk into coping self-talk, teaching the use of problem solving skills for symptom management, introduction of self-evaluation and self-reward for success in managing symptoms; followed by a review of the coping plan and preparation of the child for the trauma processing phase of the programme, including a session with parents/caregivers to review the coping skills the child has learnt, and to prepare the caregivers for the trauma-processing phase of the programme. (See Appendix F for examples of worksheets from the manual; the STAR Plan and the 5-Part Model for children; Appendix G for examples of participants' own versions of the STAR Plan).

Phase 3: Trauma processing. Introduction of the child to the trauma processing phase of the programme and practice telling a story using expressive modalities, followed by a series of sessions of imaginal exposure to create a trauma narrative and allow emotional processing of traumatic memories using media chosen by the child, with gradual exposure from least to most traumatic memories. Subjective Units of Distress (SUDS) scales are used to titrate the intervention to maximise exposure, minimise over-whelming symptoms, and enable habituation as indicated via the child's report and from observation. The 4-step STAR Plan is used to manage trauma symptoms. A session with parents/caregivers during this phase enables review of the trauma processing phase of the programme and identification of any special issues or problems to be addressed before therapy ends. (See Appendix H for an example of imaginal exposure using expressive modalities).

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[17] The STAR Plan coping template: S= Scared, sad or mad feelings? T=Thinking bad thoughts?
A=Attitudes and actions that will help? R=Results and rewards (see Appendix F). Note: Children may
make up their own version using the STAR Plan initials and concepts (see Appendix G).

Phase 4: Special issues and completion of therapy. This phase addresses any special issues that have been identified by the child and/or caregivers, and relapse prevention, and includes celebration of the child's progress in therapy, and saying goodbye.

Assessment and Treatment Integrity

Overall supervision of the assessment and treatment was provided by an on-site registered senior psychologist with extensive experience in assessment, treatment and clinical research with traumatised abused children and their families. Off-site university-based supervision was provided by a registered senior clinical psychologist skilled in the assessment procedures, CBT with children, and the development and implementation of treatment packages (e.g., Kendall et al., 1992; Ronan & Deane, 1998). Cultural consultation was sought with on-site Maori and Samoan colleagues, as well as clinicians of other cultures as required (e.g., South American).

Use of a treatment manual was designed to increase internal validity and treatment integrity by ensuring adherence with intervention procedures. The manual allows for individualised case formulations to address specific problems within a standardised protocol for treatment implementation. Manualised treatment enables a comparison across type and sequelae of abuse, participant characteristics, and different therapists. To ensure the treatment programme was being adhered to, random screening of audio-taped therapy sessions of Studies 3 and 4, in which the completed protocol was used, were undertaken by a senior clinical psychologist and experienced CBT therapist ("BH") who was independent of the research.

To guard against experimenter bias, the assessment measures were scored by a graduate student in psychology ("SM") who was trained in the task and independent of the research.

Ethical Considerations

The research was carried out according to the Code of Ethics for Psychologists working in Aotearoa/New Zealand prepared by the Code of Ethics Review Group, formally adopted by the Psychologists Board, 2002. Ethical approval to conduct the research was gained from the Massey University, Albany Campus Human Ethics Committee

(MUAHEC 00/095) and the CYF Research Access Committee (RAC). Ethical issues pertinent to the current research are outlined.

All potential participants in the research were provided with information sheets that delineated the nature and purpose of the study. The names and roles of all involved in the research were clearly described. It was highlighted that, whether or not they participated in the research, the child would still receive assessment and therapy at SSU appropriate to his or her needs. The requirements of their research involvement, should they wish to participate, were delineated. Importantly, their rights were explained, including their right to have questions answered, to decline to answer questions related to the research at any time (e.g., measures), or to withdraw from the research and continue to receive therapy services. Written consent for participation in the research was gained from the children and their parents/caregivers. The child information sheets and consent forms were worded in age-appropriate language.

The research was considered to be of low risk of harm to participants. Given the nature of the research and the setting, children's safety and wellbeing was of paramount importance. Safety and clinical concerns were of priority over research considerations. Regular clinical supervision ensured this focus was maintained at all times. This included the researcher being prepared to modify or discontinue treatment if any participant was at risk, or not able to benefit from this particular programme.

Confidentiality limitations with regard to any safety issues or further disclosures that apply to all CYF/SSU clients were explained to participants. Confidentiality of client information has been maintained for all participants (children, parents, caregivers, and teachers). Assessment data, treatment information and follow-up data is kept in a locked, secure environment. Case material and assessment and therapy reports are stored on the child's individual SSU file in order to facilitate care and protection matters. For research purposes, participants are coded by numbers and are not identifiable in any research reports or publications.

Chapter 8: Study 1

Pilot Study[18]

Outline and Aims

The major research goal of Study 1 was to pilot the effectiveness of the manualised TF-CBT programme in reducing posttraumatic stress symptoms and increasing coping in multiply-abused children. Target and comorbid symptoms were monitored at pre- and post-treatment, and 3, 6-, and 12-month follow-ups. Collateral data was collected. Study 1 was carried out as a development project, encompassing an initial trial of the treatment elements and overall structure of the programme. As such, qualitative data is reported to illustrate programme phases and outcomes.

Study 1 Participants

Four multiply-abused children aged 9 to 13 years (2 boys and 2 girls) who met DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for PTSD participated in the treatment programme. All four children identified as New Zealand European or "Pakeha". Participant characteristics are summarised in Table 1.

Method Pertinent to Study 1 and Results

Variations to Research Design

As described in Chapter 7, the multiple-baseline single-case design relies on random assignment of participants to differential baseline lengths, in order to determine whether introduction of treatment causes expected changes in dependent variables.

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[18] This study has been published (Feather & Ronan, 2006), see Appendix D.

Table 8.1. Study 1: Participant Characteristics, History and Current Circumstances

Partic-ipant	Sex	Age	Cultural Heritage	Abuse History	Diagnosis	*Severity of PTSD	Safety Issues	Placement issues
S1.1	F	9	New Zealand European	Witnessing domestic violence, physical abuse, emotional abuse	PTSD, Separation Anxiety Disorder, Generalised Anxiety Disorder, depression symptoms, suicidal ideation	Severe	Intermittent contact with itinerant, alcoholic, suicidal mother; alleged physical abuse by father	Foster care broke down, subsequent placement with father broke down, placed in second foster home
S1.2	M	13	New Zealand European	Physical abuse, emotional abuse	PTSD, Oppositional Defiant Disorder, sexual behaviour problems	Moderate	Was unable to return home as his safety could not be ensured; physically abusive step-father, and non-protective mother	Removed from home, first foster placement broke down, completed a residential programme, placed in second foster home
S1.3	M	12	New Zealand European	Witnessing domestic violence, emotional abuse, sexual abuse	PTSD, Generalised Anxiety Disorder, obsessive compulsive symptoms	Severe	Some contact with emotionally abusive mother	Removed from mother's care to foster home, to father's care at end of therapy
S1.4	F	9	New Zealand European	Physical abuse, witnessing domestic violence, emotional abuse	PTSD, Social Phobia, generalised and separation anxiety symptoms	Moderate	Ongoing contact with emotionally abusive mother and violent step father	Informal placement with grandmother – formalised during follow-up

*As measured on the CPTS-RI pre-treatment

While it was planned that the baseline lengths would be 3, 5, 7, and 9 weeks respectively, practical circumstances dictated extra weeks on baseline for all four Study 1 participants (total weeks on baseline: S1.1, 4; S1.2, 10; S1.3, 8; S1.4, 14)[19].   The baseline points on the graphs (see Figs. 8.3 and.8.4) represent the baseline data returned, in order of dates recorded on the coversheets. Generally these represent the first weeks of the baseline period for the requisite number of weeks assigned, as this is what the assessor explained to the child was required (and dated the coversheets accordingly). Notwithstanding these difficulties, visual inspection of the baseline data returned suggests that it is stable enough to make a prediction that, without intervention, all four participants would be likely to continue to suffer PTSD symptoms and cope at a similar level, as discussed in more detail in subsequent sections.

In addition, treatment sessions were intended to be weekly, but on occasion, weekly sessions were missed for practical reasons. Thus, the treatment phase points on the continuous measures graphs represent *sessions* rather than *weeks*. For Study 1, there is a close correlation between these figures over the period of the delivery of the initial programme: S1.1, 16 sessions, 18 weeks; S1.2, 16 sessions, 18 weeks; S1.3, 16 sessions, 20 weeks; S1.4, 16 sessions, 20 weeks (weeks include post-treatment). Two children required booster sessions beyond the initial programme, as will be described.

Child Report: Continuous Measures

Overall Mean Results

CPTS-RI

Figure 8.1 shows that the level of posttraumatic stress symptoms of Study 1 participants decreased with treatment, and decreased further over a 12-month follow-up period. The overall average self-reported CPTS-RI score for the four children was in the *severe* range during baseline (mean = 45.3; SD = 12.3), in the *moderate* range over the treatment phase (mean = 37.3; SD = 12.7), and in the *mild* range over the follow-up phase (mean = 23.2; SD = 10.3), on a scale of 0-80.

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[19] Please note that an error was made in the reporting of this data in the published pilot study (Feather & Ronan, 2006). In fact, an extra *point* on baseline was recorded for each of S1.1 and S1.2 rather than an extra *week* (p.137). A review of the original scoring records revealed a mismatch between the number of weeks on baseline and the number of measures collected. Here, it is clarified that the baseline data on the graphs records baseline *points* (generally recorded weekly), and the details are spelt out.
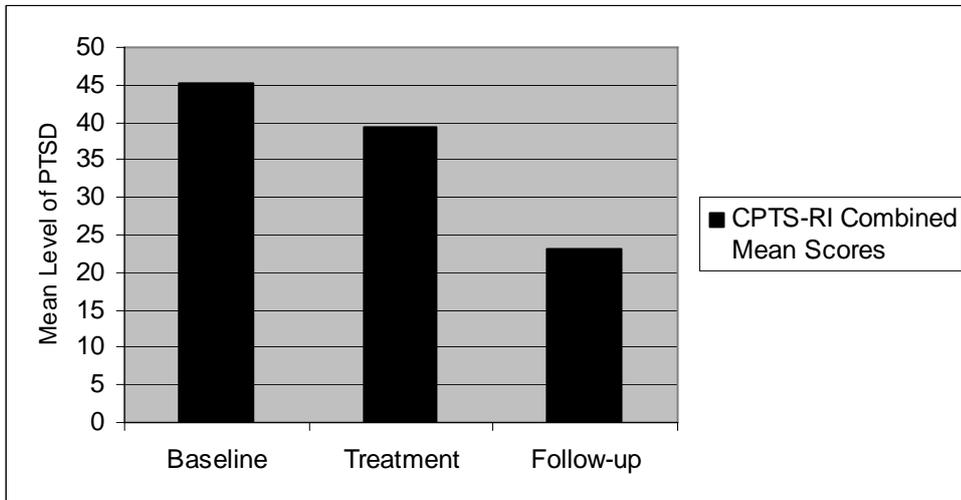
Figure 8.1. Changes in mean level of posttraumatic stress symptoms (average of CPTS-RI scores for all four participants) across baseline, treatment, and follow-up phases.
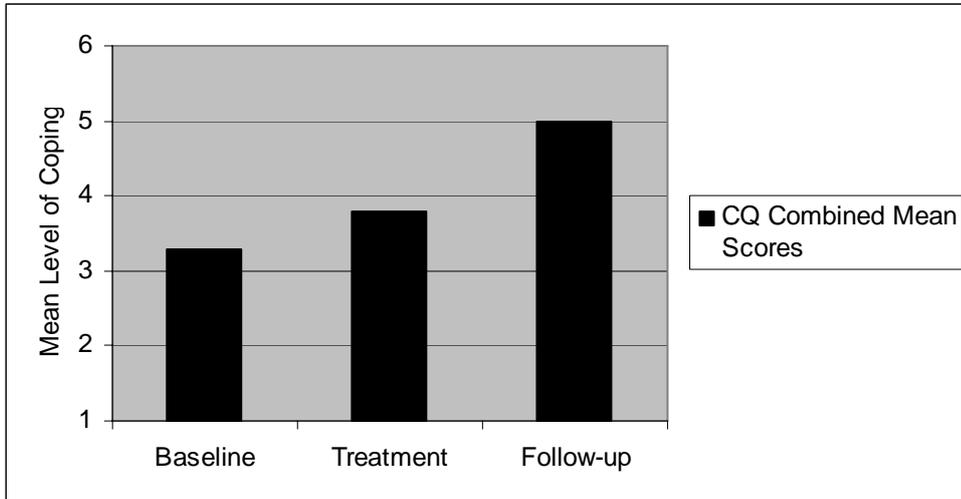
Figure 8.2. Changes in mean level of child reported coping (average of CQ scores for all four participants) across baseline, treatment, and follow-up phases.

CQ[20]

Figure 8.2 shows that the level of self-perceived coping ability of participants increased with treatment, and increased further over the following 12 months. The children's mean coping scores (averaged across the four participant's three self-identified target concerns[21]; CQ1, CQ2, CQ3) increased from 3.3 (SD = 1.9) during the baseline phase, to 3.8 (SD = 2.1) over treatment, and 5.0 (SD = 1.8) over follow-up (on a scale of 1 = *not at all able to help myself to* 7 = *completely able to help myself*).

While the variability for the overall sample data is relatively high, this masks the individual results; that is, there was less variability within each child's scores on both the CPTS-RI and the CQ. For example, on the CQ, the range of scores for each child's individual target concerns within each phase was 3 or less, except in two instances.

Individual Results
CPTS-RI

Figure 8.3 presents the graphed weekly level of posttraumatic stress symptoms for each of the four participants across the baseline, treatment and follow-up phases. As can be seen, each participant reported a unique pattern of baseline PTSD symptoms, an idiosyncratic response to treatment, and variation in symptom manifestations over the 12-month follow-up. This is likely to reflect the fact that PTSD is a fluctuating experience that can be triggered by not only internal, but also external factors and subsequent trauma. The CPTS-RI results are presented for each phase. See also, Table 8.2 for pre-, post-, and follow-up CPTS-RI scores for each participant.

Baseline
In a single-case design the baseline data must be examined for stability (Kazdin, 2003). As described in Chapter 7, notwithstanding the fluctuating nature of PTSD symptoms, a stable baseline is characterised by relatively little variability and the absence of a slope (or trend). At least three baseline points are required to establish stability (Barlow & Herson, 1984). For Study 1, the variability in the CPTS-RI baseline scores for the four participants did not exceed a 50 per cent level in any case (baseline ranges = 47-61, 30-35, 44-50, and 26-55 on a 0-80 scale; variability = 17.5%, 6.2%, 7.5% and 36.3% for

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[20] Note, CQ4 results on perceived helpfulness of the TF-CBT programme are presented in Appendix J.
[21] See Appendix I for Study 1 participants' self-identified target concerns.
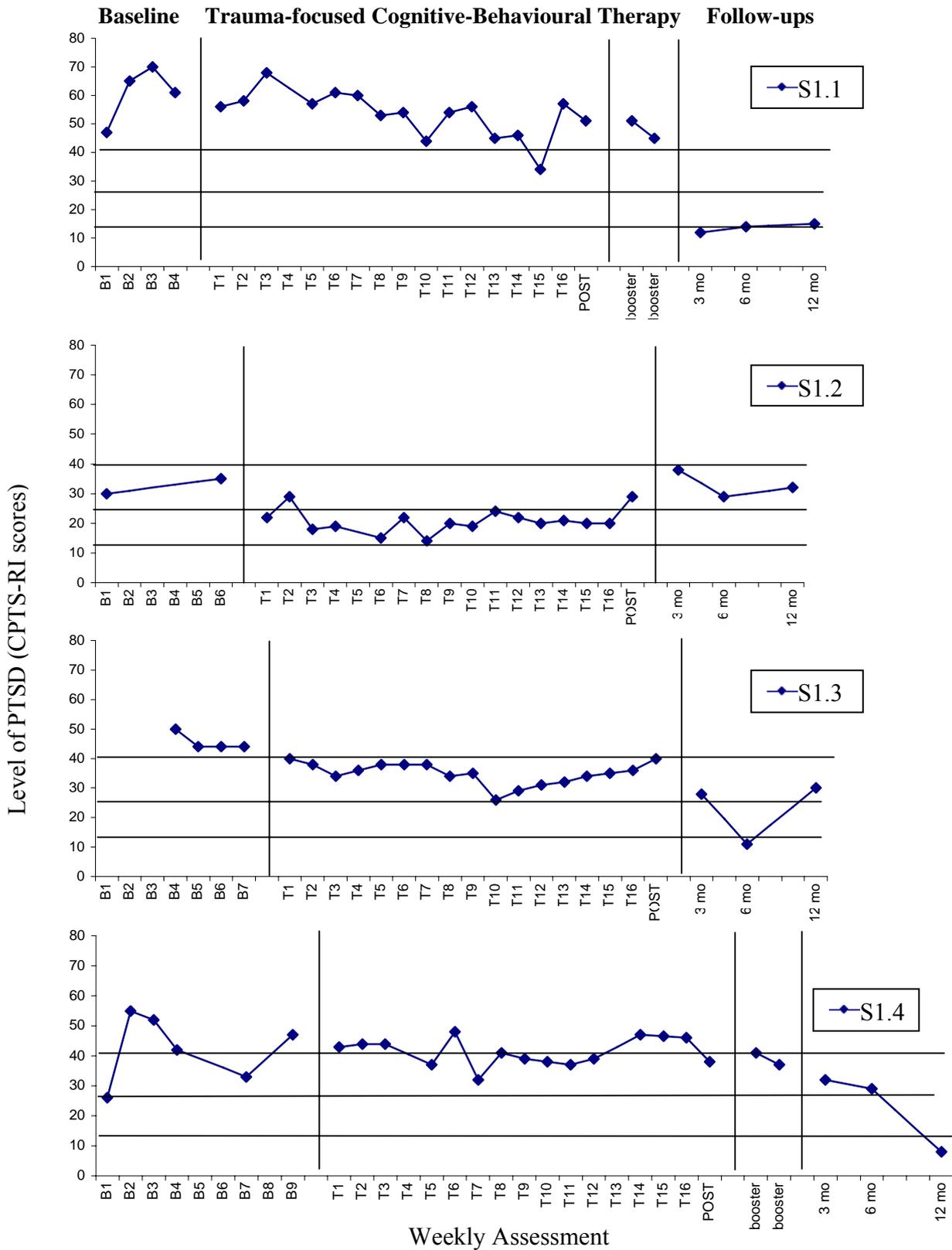
Figure 8.3. Study 1: Changes in posttraumatic stress symptoms (CPTS-RI scores) across assessment, treatment and follow-up sessions.

S1.1, S1.2, S1.3, and S1.4 respectively), as recommended for single-case methodology in applied clinical research (Barlow & Herson, 1984). Additional visual inspection indicates a relatively horizontal trend in their baseline data. One participant (S1.2) completed only two of the CPTS-RI baseline measures; however, the slope over the two points shows a slight acceleration, so the lack of a third point is of less concern.

Treatment

Visual inspection of the CPTS-RI scores over the treatment phase for all four participants shows an initial brief upward trend over 2-3 sessions for two participants (S1.1 and S1.2). This may reflect the fact that Sessions 2 and 3 covered family relationships and the child's history, precipitating a brief exacerbation of the child's PTSD symptoms. However, over the coping skills phase of the TF-CBT programme all four participants showed a moderate downward trend in PTSD symptoms. As the exposure phase was introduced, all four children then demonstrated a brief upward trend in PTSD symptoms. The spikes in CPTS-RI scores noted at the end of the treatment phase can perhaps be explained by individual circumstances: S1.1 disclosed that her father, with whom she had been placed during the treatment phase, had recently physically abused her; S1.2 found out he was not returning to the care of his mother as he had been led to believe (as she was still living with his physically abusive stepfather); S1.3 disclosed a further incident of historical sexual abuse that required an evidential process; and S1.4 was experiencing episodes of emotional abuse from her mother and placement uncertainty with her grandmother. These issues are discussed further below, with regard to the impact on each child's coping.

Booster Sessions

Following the completion of the 16 week intervention, two participants (S1.1 and S1.4) required booster sessions as their symptoms remained elevated. This is likely to have related to their younger age as well as their individual circumstances, including, in each case, intermittent contact with emotionally abusive parents, and ongoing placement uncertainty. There were no additional contacts with S1.2 and S1.3 following the completion of the 16 session programme, other than at the prescribed follow-up assessment points. S1.2 was referred for brief specialist treatment for sexual acting out problems, which was carried out elsewhere during the follow-up phase.

The complete intervention for each of S1.1 and S1.4 involved individual and booster sessions, parent sessions, joint parent and child sessions, and caregiver and social worker support throughout the follow-up phase, as perceived necessary by clinical judgement. This amounted to an overall total of 45 face-to-face contacts with each of S1.1 and S1.4 and/or their caregiving adults. Assessment data was collected at two scheduled booster sessions prior to the 3-month follow-up, and subsequently at the 6-month and 12-month points. Collection of data at each individual booster session was discontinued as the children each made it clear they no longer wished to complete the measures every session.

Follow-up

Across follow-up, none of the children reported PTSD symptoms in the severe range at any assessment point. Three participants (S1.1, S1.3, and S1.4) experienced an overall drop in level of PTSD symptoms compared to baseline and treatment levels. S1.1 and S1.4's scores tracked down from severe to non-clinical/mild by 12-month follow-up. S1.3 spiked back from non-clinical to a moderate level at 12-month follow-up, apparently due to self-reported concerns about contact with his mother. S1.2's PTSD symptoms remained in the moderate range throughout the 12-month follow-up phase. The fact that he remained in care due to his stepfather's refusal to undertake treatment for physically abusing him, and that he was receiving treatment for sexual acting out problems, may have contributed to the continued elevation of S1.2's PTSD symptoms. As reported below, it is notable that for those children who experienced ongoing trauma triggers during the follow-up interval, coping remained high relative to baseline levels (S1.2, S1.3), or bounced back after a setback (S1.1).

CQ

Figure 8.4 presents each child's self-reported coping over the baseline, treatment and follow-up phases. The baseline data is relatively stable in terms of variability and trend. Overall, child coping tended to increase slowly over the treatment phase and generally showed higher levels across the 3-month, 6-month and 12-month points. The CQ results are reported for each child individually, as this provides a clearer picture of the interacting effects of the treatment programme and external circumstances on child
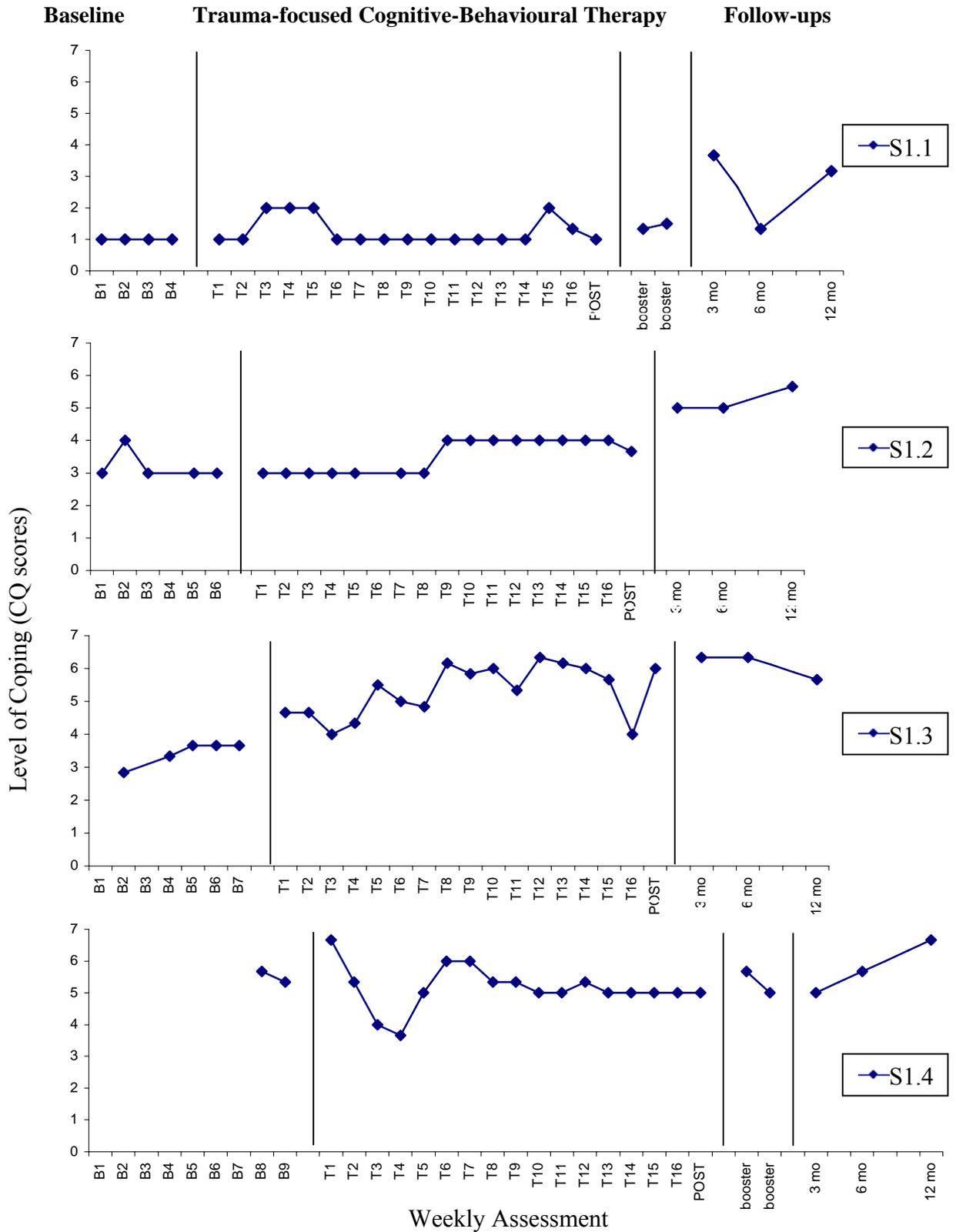
Figure 8.4. Study 1: Changes in child reported coping skills (average of scores for three target concerns) across assessment, treatment and follow-up sessions.

coping. See also, Table 8.2 for pre-, post-, and follow-up CQ scores for each participant.

S1.1 reported extremely low levels of coping throughout the treatment phase. She was worried about her mother's whereabouts and risk from suicide. While her coping increased slightly during the coping skills training, it dropped again during the exposure phase, during which S1.1 worked through the trauma of witnessing her mother's serious suicide attempt that had led to her removal from her care. Her coping rose slightly during the special issues phase, when her identity and self-esteem was addressed with an intervention to take photos of people, places and things that mattered to her, and mount them on a photo board. It dropped at the end of treatment, coincident to her disclosure of physical abuse by her father.

Subsequently, S1.1 was placed with caregivers, but continued to report worries about her mother. Booster sessions were arranged in which S1.1's mother was able to tell her that she did not want or need her daughter to worry about her as she was getting help for her problems from other adults. The relieving of safety concerns appeared to enable S1.1 to utilise her coping skills, as evidenced by the marked increase in her self-reported coping scores at 3-month follow-up. At the 6-month follow-up, S1.1 had not had contact from her mother and did not know where she was, and, not surprisingly, her coping had decreased. By the 12-month follow-up, S1.1 had been placed in a stable foster home. While she was still anxious about her mother's wellbeing, she reported that she was more frequently utilising helpful coping strategies to control her anxiety.

S1.2 demonstrated a stable pattern of moderate coping throughout the coping skills training phase of the treatment, with a slight increase in coping coinciding with the exposure and special issues phases. During the exposure phase, the impact of the physical abuse from S1.2's step father was fully explored with a trauma narrative. The special issues sessions (i.e., Phase 4) focused on psycho-education around the effects of abuse on young people, strategies for keeping safe, and anger management. Despite the fact that S1.2 reported experiencing ongoing child mental health symptomatology throughout the follow-up phase, notably both his self-reported and collateral-reported coping was high. For example, his caregiver commented at 6-month follow-up: "S1.2 is

infinitely better…CBT has been good for him; he has strategies for dealing with situations".

S1.3 showed an overall trend of increased coping throughout the treatment and follow-up phases. A drop in coping coincided with the end of the exposure phase, when he disclosed a further incident of historical sexual abuse. S1.3 was referred to the CYF Evidential Video Unit (EVU) to formally report the abuse immediately prior to the post-treatment assessment. Following the EVU interview, his self-reported coping increased to a high level, where it remained at 3-month, 6-month and 12-month follow-ups.

S1.4 demonstrated a decrease in coping over the first four sessions. This is likely to reflect the fact that she entered the programme initially denying her problems, even though she appeared well aware of her symptoms in sessions. These early sessions focused on strengths and support networks, but also elicited the problem areas. S1.4's self-reported coping increased during the coping skills phase and was maintained during the exposure phase. These were new-found skills for S1.4, and while she could not always use them in real-life situations that evoked strong feelings, she clearly demonstrated that she could use them in the therapy environment. S1.4's self-reported coping continued to increase throughout the follow-up phase. This coincided with a decision that she would be placed permanently in her grandmother's care. This was a safe option for S1.4, and she reported being happy about the decision.

Child Report: Repeated Measures

Child report repeated measures scores related to target concerns and co-morbid problems are presented on Table 8.2. These data fill out the symptomatology picture for the participants at pre- and post-treatment and follow-up.

STAIC-S

Scores on the STAIC-S presented on Table 8.2 indicate that for all participants, state anxiety was generally within the normal range and remained fairly stable across each assessment point.

Table 8.2. Study 1: Child Report Scores on Repeated Measures of Target and Comorbid Symptoms

Measure	Participant	Pre treatment	Post-treatment	3-month follow-up	6-month follow-up	12-month follow up
				Assessment points		
CQ	S1.1	1.0	1.0	3.7	1.3	3.2
(Mean)	S1.2	3.0	4.0	3.7	5.0	5.7
	S1.3	2.8	6.0	6.3	6.3	6
	S1.4	-	5.0	5.0	5.7	6.7
	Mean	**2.3**	**4.0**	**4.8**	**4.6**	**5.4**
CPTS-RI	S1.1	47**	51**	12	14	15
(Total)	S1.2	30*	29*	38*	29*	32*
	S1.3	48**	40**	28*	11	30*
	S1.4	26*	38*	32*	29*	8
	Mean	**37.8**	**39.5**	**27.5**	**20.8**	**21.3**
STAIC-S	S1.1	65	52	44	32	50
(*T* score)	S1.2	35	39	59	24	30
	S1.3	59	61	-	-	48
	S1.4	44	50	34	41	50
	Mean	**50.8**	**50.5**	**45.7**	**32.3**	**44.5**
STAIC-T	S1.1	45	60*	21	21	21
(*T* score)	S1.2	40	42	42	42	42
	S1.3	51	39	30	40	34
	S1.4	46	53	47	55	49
	Mean	**45.5**	**48.5**	**35.0**	**39.5**	**36.5**
CDI	S1.1	85*	88*	52	63	61
(*T* score)	S1.2	40	39	68*	68*	68*
	S1.3	53	36	41	41	44
	S1.4	56	49	46	50	50
	Mean	**58.5**	**53.0**	**51.8**	**55.5**	**55.8**

* Clinically elevated scores compared with age and gender norms (CDI, $T > 65$; STAIC, $T \geq 60$)

* Clinical cut-off for moderate PTSD, CPTS-RI ≥ 25; **Severe PTSD, CPTS-RI ≥ 40

- Data incomplete or not obtained

Note: CQ = Coping Questionnaire; CPTS-RI = Child Posttraumatic Stress Reaction Index; STAIC-S = State Trait Anxiety Inventory for Children – State; STAIC-T = State Trait Anxiety Inventory for Children – Trait; CDI = Child Depression Inventory

STAIC-T

The mean STAIC-T scores were similar at pre- and post-treatment, and decreased during follow-up, mainly due to reduced anxiety scores reported by two participants (S1.1 and S1.3). Of note, was the remarkable consistency in responses on one of the items on the STAIC-T by all these children: "I worry about my parents" was commonly scored "often", reflecting the fact that for duration of the study most of these children were placed away from their parents. This separation was clearly a source of anxiety for each of the children.

CDI

The mean scores on the CDI suggest little variability in childhood depression symptoms across pre- and post-treatment and follow-up, hovering around the cut-off for moderate levels of symptoms (CDI $T > 55$). However, closer inspection of the individual scores indicates considerable within-participant and across-participant variability. S1.1 reported symptoms above the cut-off for the severe range (CDI $T > 65$) at pre- and post-treatment dropping to moderate at follow-up. Conversely, S1.2 reported virtually no depressive symptoms at pre- and post-treatment, and severe levels at follow-up. S1.3 reported close to a moderate level of depressive symptoms at pre-treatment, and very few symptoms following treatment and at follow-up. S1.4 reported moderate to low depressive symptoms throughout. Of note is that the two participants who experienced the most variability in depressive symptoms (S1.1 and S1.2) also had the most tenuous relationship with caregiving adults. The period of most severe depression in each case correlated with losing contact and/or connection with their most significant parent, albeit an unprotective, emotionally abusive relationship.

TSCC

The TSCC results are presented on Table 8.3. These are discussed in terms of response validity and symptom categories at pre-, post-treatment, and follow-up for each child. The TSCC results provide further information on the interaction between the treatment programme, situational factors, and trauma symptomatology. Each participant's results on the TSCC are presented in turn.

Table 8.3. Study 1: Child Report Scores on Repeated Measure of Child Trauma

Symptom category (T score)	Participant	Pre-treatment	Post-treatment	3-month follow-up	6-month follow-up	12-month follow up
TSCC-UND/HYP	S1.1	57/65	[52/102]	[91/47]	[86/47]	[72/47]
	S1.2	39/47	39/67	39/87	46/47	54/47
	S1.3	39/87	46/47	39/47	39/47	42/47
	S1.4	52/47	[42/111]	52/83	42/47	52/47
TSCC-ANX	S1.1	69**	[57]	[35]	[35]	[35]
	S1.2	62*	74**	77**	62*	46
	S1.3	64*	51	51	49	46
	S1.4	43	[61]	74*	44	35
TSCC-DEP	S1.1	60*	[84]	[35]	[36]	[39]
	S1.2	59	61*	86**	64*	46
	S1.3	59	49	49	49	51
	S1.4	46	[69]	65**	46	43
TSCC-ANG	S1.1	63*	[55]	[35]	[35]	[36]
	S1.2	51	58	63*	56	46
	S1.3	43	45	50	50	48
	S1.4	44	[72]	61*	48	46
TSCC-PTS	S1.1	62*	[65]	[35]	[35]	[35]
	S1.2	53	60	74**	47	41
	S1.3	62*	54	56	53	58
	S1.4	53	64]	65**	49	38
TSCC-DIS	S1.1	36	[47]	[35]	[35]	[35]
	S1.2	55	64*	84*	58	41
	S1.3	74*	64*	58	54	50
	S1.4	53	[83]	83*	55	45
TSCC-SC	S1.1	57	[41]	[41]	[41]	[41]
	S1.2	51	69	100**	60	48
	S1.3	57	63	51	44	44
	S1.4	51	[46]	41	41	46

**Clinically significant compared with age and gender norms ($T \geq 65$; SC $T \geq 70$)
* Sub-clinical (but significant) symptomatology (T=60-64)
[ ] Invalid due to Under-response ($T \geq 70$) or Hyper-response ($T \geq 90$)

Note: TSCC = Trauma Symptom Checklist for Children; UND/HYP = Under-response/Hyper-response; ANX = Anxiety; DEP=Depression; ANG=Anger; PTS=Posttraumatic stress; DIS=Dissociation; SC=Sexual Concerns

S1.1's scores on the TSCC were valid only at pre-treatment. At this time her score on the anxiety scale (ANX) was in the clinical range (T=69); and her scores on the depression scale (DEP; T=60), anger (ANG; T=63), and posttraumatic stress (PTS; T=62), represented sub-clinical, (but significant) symptomatology. At post-treatment S1.1's profile was invalid due to hyper-responding. This can represent a desire to appear especially distressed, or a "cry for help". It may have reflected S1.1's recent disclosure of physical abuse from her father and imminent removal from home and placement in a foster home. At follow-up, her profiles were invalid due to under-responding. This can indicate defensive or avoidant responding, opposition to test-taking, or some other reason. In S1.1's case, it may have reflected her strong desire to return to her mother's care; under- reporting symptoms could have been an attempt to send a signal that she could cope with this situation. S1.1's scores are presented on Table 8.3, but are not interpreted due to invalidity.

S1.2's scores on the TSCC were valid. At pre-treatment, he scored in the sub-clinical range for ANX (T=62), and below clinical cut-offs for all other symptom categories. At post-treatment, he scored in the clinical range for ANX (T=74) and dissociation (DIS; T=64), and in the sub-clinical range for DEP (T=61) and PTS (T=60). This is likely to reflect S1.2's response to the news that he was not to be returning home as he had expected, re-triggering the trauma of his first removal following an episode of serious physical abuse from his stepfather. At 3-month follow-up, S1.2 continued to show clinically elevated scores on ANX (T=77), DEP (T=86), PTS (T=74), and DIS (T=84), and his scores were also clinically elevated on the anger scale (ANG; T=63), and the sexual concern scale (SC; T=100). Verbal reports from S1.2 suggested that these scores reflected his response to his stepfather's continued refusal to take responsibility for getting treatment so S1.2 could return home, exacerbated by his mother's support for her partner over him. In addition, S1.2 was having specialist treatment for sexual acting out at this time, which is likely to have intensified his sexual concerns. By the 6-month follow-up, S1.2's symptomatology was decreasing, with only sub clinical anxiety (ANX; T=62) and depression (DEP; T=64) evident. By the 12-month follow-up, S1.2 was in a stable placement with new caregivers, and he reported no symptoms in the clinical or sub-clinical range. Of note, as described earlier, is the fact that following

treatment, S1.2 reported an ongoing ability to cope with his problems, even when his symptomatology was elevated.

S1.3's scores on the TSCC were valid. At pre-treatment, he scored in the clinical range for DIS (T=74), and in the sub-clinical range for ANX (T=64) and PTS (T=62). At post-treatment he scored in the sub-clinical range for DIS (T=64), representing a drop from pre-treatment levels, and below clinical cut-offs for all other symptom categories. Throughout the follow-up phase S1.3 scored below clinical cut-offs on all symptom categories.

S1.4's scores were valid, except at post-treatment, when they were invalid due to hyper-responding. This is likely to reflect her distress at this time due to episodes of emotionally abusive contact with her mother and placement uncertainty with her grandmother. It was also possibly a "cry for help", as both S1.4 and her grandmother expressed the wish for therapy to continue beyond the scheduled 16 sessions. At pre-treatment, S1.4 scored below clinical cut-offs for all symptom categories. As discussed previously, clinical observations suggested that she was denying her problems at the assessment stage. S1.4 and her grandmother participated in a series of booster sessions during the follow-up phase, largely reinforcing the coping skills. At the 3-month follow-up point she scored in the clinical range for ANX (T=74), DEP (T=65), PTS (T=65) and DIS (T=83), and in the sub clinical range for ANG (T=61). However, by the 6-month and 12-month follow-up points, S1.4 scored below clinical cut-offs in all symptom categories.

Child Subjective Data

The collection of subjective data was not explicitly part of the original research design, although its usefulness had been noted in supporting the quantitative data derived from single-case designs. On occasion when Study 1 participants offered feedback, this was noted, and is reported here. As discussed in Chapter 5, this is consistent with the view that children in participating in research have the right to have their voices heard.

Subjective data was not recorded for S1.1 or S1.4.

S1.2 reported at the 3-month follow-up point that he was using the coping skills, for example: "The breathing thing worked...last time had a fight I walked away. When I'm feeling upset and angry, I use the same thing – the breathing". At 6-month follow-up, S1.2 reported that he was continuing to use these skills: "When I'm upset, I talk with someone, do that breathing, sometimes muscle relaxation". In addition, while his PTSD symptomatology was elevated on the quantitative measures at this time, he noted some symptoms had abated, "I'm not getting bad dreams". However, S1.2 reported he wanted his step-father to "get over the last few years so I can go home". This was clearly an ongoing source of anxiety for him. At 12-month follow-up, S1.2 reported that he continued to use the coping skills, particularly muscle relaxation, to help himself calm down. He was still tempted to steal at times, but could distract himself by talking to someone, or moving away from the desired object. He recalled the "feelings faces" and "5-part model" exercises as being particularly helpful during therapy, but had not found it helpful having to complete the assessment measures so often.

S1.3 reported at the 12-month follow-up assessment point that his sleeping had improved and he was less worried, "I can go to sleep on my own account, not scared anymore that I'm going to get into trouble". He reported that the therapy, "gave me techniques that helped, such as clenching my fists and the deep breathing". In addition, S1.3 reported that he had found two new techniques to help himself calm down, "painting and riding". When asked whether he still had any worries, S1.3 stated, "I can't really be worry free, but I have no worries I need help with". However, on occasion when his symptoms were re-triggered, he had ways of dealing with them.

Parent/Caregiver and Teacher Results

Results from the parent/caregiver CBCL and teacher CBCL-TRF reports of internalising, externalising and total problems for each participant are presented in Table 8.4. Of primary note is the low rate of return. Every endeavour was made to ensure the completion and retrieval of these forms. However, all four participants experienced multiple placements and/or several teacher and school changes throughout

Table 8.4. Study 1: Parent/Caregiver and Teacher Scores on Child Behaviour Measures

Behaviour scales (*T* scores)	Participant	Assessment points				
		Pre-treatment	Post-treatment	3 month follow-up	6-month follow-up	12-month follow up
CBCL Internal	S1.1	-	-	-	-	-
	S1.2	61 Mo	-	-	-	83* Ca3
	S1.3	-	-	-	81*Mo&Fa	75*Mo/65*Fa
	S1.4	79*Gm/51Mo	77* Gm	79* Gm	65 *Gm	78* Gm
CBCL External	S1.1	-	-	-	-	-
	S1.2	59 Mo	-	-	-	79* Ca3
	S1.3	-	-	-	69*Mo&Fa	63*Mo/58Fa
	S1.4	71*Gm/56Mo	70* Gm	70 *Gm	75 *Gm	77 *Gm
CBCL Total	S1.1	-	-	-	-	-
	S1.2	66* Mo	-	-	-	86* Ca3
	S1.3	-	-	-	79*Mo&Fa	73*Mo/66*Fa
	S1.4	80*Gm/52Mo	77* Gm	77* Gm	73* Gm	80* Gm
CBCL-TRF Internal	S1.1	-	44 Te1	-	-	60 Te2
	S1.2	-	-	-	-	65* Te4
	S1.3	-	-	-	63 Te2	62 Te2
	S1.4	68* Te1	64* Te2	-	69* Te3	-
CBCL-TRF External	S1.1	-	43Te1	-	-	62 Te2
	S1.2	-	-	-	-	66* Te4
	S1.3	-	-	-	59 Te2	64* Te2
	S1.4	58 Te1	70* Te2	-	60 Te3	-
CBCL-TRF Total	S1.1	-	42 Te1	-	-	61 Te2
	S1.2	-	-	-	-	65* Te4
	S1.3	-	-	-	65* Te2	68* Te2
	S1.4	63 Te1	66* Te2	-	63 Te3	-

* Clinically elevated compared with age and gender norms (≥ 64)
- Not returned, stated did not know child well enough, did not consent to completing, and/or gave verbal report
Note: CBCL = Child Behavior Checklist completed by parents/caregivers; CBCL-TRF = Child Behavior Checklist Teacher Report Form completed by the child's teacher; Mo=Mother; Fa=Father; Gm=Grandmother; Ca=Caregiver (Ca3=third caregiver since research began); Te=Teacher (Te1=first teacher; Te2=second teacher; Te3=third teacher; Te4=fourth teacher)

the period of the study. For example, two children experienced multiple caregivers during the treatment phase alone. As a result, some caregivers and teachers expressed the view that they did not know the child well enough to be able to comment to the level of detail required on the measures. Others were well-meaning in agreeing to complete forms, but failed to return them within the time-frame required for the research, even when followed up. Some gave verbal reports. One parent (S1.1's father) did not consent to completing the CBCL, although he continued to consent to participate in the research. In addition, in situations where there were more than one parent or caregiving family member completing forms at the same assessment point, the results could differ markedly. Overall the parent/caregiver and teacher data were considered to be too inconsistent to provide meaningful results. However, the results for each participant are useful to present and discuss as they highlight issues to do with measuring change with a population of multiply-abused traumatised young people receiving treatment in a real-life clinic setting with ongoing care and protection involvement.

S1.1

Due to the problems highlighted, no parent/caregiver CBCL forms were returned for S1.1. However, throughout her changes in placement she had remained at the same school. S1.1's teacher returned the TRF at post-treatment, and the following year, at 12-month follow-up, her second teacher returned the TRF. Neither identified clinically significant concerns compared with age and gender norms.

S1.2

S1.2's mother completed the CBCL at pre-treatment. She did not report clinically elevated concerns for her son, in contrast with his own self-report of problems. She appeared to have limited insight and/or willingness to accept the impact of her partner's physical abuse on her son. Subsequently, S1.2 did not return to his mother's care, and experienced three placements. His third caregiver, with whom he had recently been placed, agreed to complete a CBCL at the 12-month follow-up. She had been well briefed about S1.2's problems and identified clinically elevated concerns on the internalising, externalising and total scales. Likewise, S1.2 had a number of school changes throughout the study. At 12-month follow-up he had recently started at a new school, coinciding with his new placement. Again, the new school had been well briefed about his history and the current concerns, as reflected on the TRF, which

identified clinically elevated concerns in all areas. Clinical observations suggested that these scores are likely to have reflected S1.2's observable anxiety, sadness, and anger, probably related to his feelings about not being able to return home and experiencing another change in placement.

S1.3

S1.3's caregivers and teachers did not return forms during the assessment and treatment phase. This may reflect the fact that he was in a temporary placement while social workers were finalising plans for his future. Subsequent to completing the treatment, S1.3 was placed with his father, with whom he had recently been reunited. His mother continued contact through visits. Both parents participated in the 6- and 12-month follow-up assessments. At 6-month follow-up, both parents completed the CBCL together, and reported clinically elevated concerns in both internalising and externalising behaviours. This could possibly have reflected some difficulties related to S1.3 settling into a new caregiving arrangement, with the father taking on a new primary caregiving role, and some issues related to the mother's role and contact. TRF's were obtained from S1.3's teacher at his new school. He expressed no concerns in the clinical range. By the 12-month follow-up, S1.3's father reported no concerns at clinical levels, while his mother remained concerned about perceived internalising problems. S1.3's teacher reported some elevation in total concerns, but this was not reflected in the internal and external scales, which were scored at levels below clinical concerns.

S1.4

S1.4 was placed with her grandmother throughout the duration of the study, although she experienced two house moves, a change of schools, and four changes of teachers. S1.4's mother participated in the pre-treatment assessment, but due to ongoing care and protection concerns, was not involved in the treatment and follow-up phases. The results on Table 8.4 show a significant discrepancy between the mother's and grandmother's CBCL scores. Whereas S1.4's mother reported no clinically elevated scores with regard to her daughter, her grandmother reported clinically elevated scores on all scales. S1.4's grandmother continued to report clinically elevated concerns across treatment and follow-up. A possible explanation of the incongruity between the mother's and the grandmother's reports is that the mother was a perpetrator of abuse

and apparently not able or willing to take responsibility for this, whereas the grandmother was a safe caregiver and aware of S1.4's needs, but was worried about her own capability to meet these and required a lot of support.

In contrast, three different teachers in two different schools recorded remarkably similar TRF scores at three assessment points (pre-, post-, and 6-month follow-up), hovering around the clinical cut-off for internal, external, and total scales. The teacher reports seem to reflect the child's own self-reports more accurately at these assessment points, compared to either her mother's or her grandmother's reports.

Study 1 Discussion

The results of the pilot study were promising in suggesting the usefulness of the TF-CBT protocol for the treatment of PTSD in multiply-abused children. Use of a single-case multiple-baseline design across four participants indicated that the treatment could be helpful in reducing PTSD symptoms and increasing coping related to specific abuse and trauma related concerns. The follow-up findings showed that the treatment effects were generally durable over a 12-month period.

The four participants had PTSD diagnosed at initial assessment. Symptoms remained at clinically significant levels throughout the baseline phase. These young people were having trouble coping with a range of problems related to a history of multiple CA, such as flashbacks and bad dreams, having trouble sleeping, getting angry, and anxiety related to being separated from their parent(s). The results across treatment represent clinically significant changes in their functioning, indicating that TF-CBT can be effective in resolving past CA trauma. In addition, all four children and/or their caregivers anecdotally reported they had learned skills to cope with current situations. The young people consistently recorded high levels of coping at follow-up, even when their PTSD symptoms had been re-triggered by subsequent traumas (with the exception of one assessment point for one child, at which time she was experiencing an extremely anxiety provoking situation).

The use of a single-case experimental design means that preliminary conclusions can be made about the overall effectiveness of the programme, as well as an initial investigation of the specificity of treatment elements, and comparisons about individual responses to treatment. Visual inspection of the data suggests that the psychosocial phase of the treatment had mixed effects on the children, whereas the coping skills phase was generally associated with a reduction in PTSD symptoms and an increase in self-identified coping, as would be hoped. The exposure sessions seemed to be often associated with a slight increase in symptoms and decrease in coping. However, the 12-months following treatment were generally characterised by a reduction in PTSD symptoms and a marked improvement in coping, whether or not the child was having ongoing booster sessions, suggesting the long-term helpfulness of the treatment approach.

The pattern of individual responses to treatment highlighted a number of potentially confounding variables embedded within the pilot study, as exemplified by the variation in number of sessions required to resolve problems. By chance, the sample comprised two 9 year old girls and 12 and 13 year old boys. At initial assessment, there appeared little disparity in the nature and severity of problems between all four young people. However, the older boys were not re-referred to the clinic after the 16-session programme was completed, whereas the social workers and caregivers of the younger girls requested booster sessions on and off over the next 12-months. One explanation is that both boys were in safe placements following treatment, although they had ongoing family issues, and one had residual behaviour problems for which he was receiving treatment elsewhere. Both girls had ongoing contact with an emotionally abusive parent, which appeared to re-trigger their trauma symptoms and compromise their treatment gains. These relationships appeared to be characterised by trauma-related attachment problems, related to early and long-standing abuse. This can also require a longer intervention to enable the therapeutic relationship to develop and treatment elements to be integrated (Perry et al., 1995; Witten-Hannah, 2002). Linked to this, clinical observation suggested that the younger children were less able to assimilate the coping skills and apply them in their everyday lives than the adolescents, suggesting there was perhaps an additional developmental difference in response to this treatment approach. These findings are similar to those of other researchers who have found that treatment response may vary with developmental/age level for children with anxiety

(Kane & Kendall, 1989) and abuse-related concerns (Cohen et al., 2000), and that in clinical settings, treatment may extend to as many as 40 or more sessions depending on the needs of the child and the complexity of the case (Deblinger & Heflin, 1996). Overall, these factors highlight the need to keep in mind safety issues, contextual factors, attachment relationships, and a developmental focus when working with traumatised abused young people.

With regard to parent/caregiver involvement in the programme, it was found that adhering to the three prescribed sessions was not possible given the caregiving arrangements of these children. The typical scenario was unavailable or abusive parents who had restricted, generally supervised, contact, and busy caregivers who had limited time to attend sessions and focus on the individual child's psychological progress at home. However, every endeavour was made to involve parents and caregivers in the programme and this aspect of the intervention was administered flexibly, for example, before and after child sessions, and by telephone.

In terms of the collateral data as a measure of outcome, while multi-modal multi-source evaluations are recommended in the CA and child trauma literature in order to obtain corroborating information, the results of the pilot study highlighted some of the problems inherent in this approach. It was found that scores on parent/caregiver and teacher measures may vary with:

- How well the adult knows the child
- Even an adult who knows a child well may underestimate internalising problems
- How well a caregiver has been briefed about a child's problems
- The child's behaviour in different settings
- The agenda of the adult; for example, a parent lacking in insight, or not willing to take responsibility for the impact of their abuse or neglect of a child may under-respond or minimise the child's problems. Conversely, a caregiver seeking to gain ongoing or additional support may hyper-respond or maximise the child's problems.

Similar problems with the incongruity between adult reports of children's distress have been noted by other researchers. For example, following a traumatic event, parents tend to report lower levels of symptomatology and fewer symptoms of anxiety, depression and fear (Davis & Siegel, 2000). In the context of family problems like abuse, parents might be "biased reporters", as they can experience strong feelings of guilt or ambivalence about a child's disclosure (Kendall-Tackett et al., 1993). This may lead to either over-emphasising or under-reporting child symptoms. In addition, children and adolescents may pick and choose who they share their thoughts and feelings with, particularly if the perpetrator is a family member. As internalising problems are not readily observable, unless symptoms are manifested behaviourally, adults may rely on what the young person tells them, contributing to discrepancies in reporting (Davis & Siegel, 2000). The results of the pilot study emphasise the need for researchers and clinicians to be aware of potential biases in collateral data when evaluating a young person for trauma and abuse.

In terms of the external validity of the pilot study, the use of a single-case design, while having advantages also confers limitations. With a small sample size, it cannot be assumed that the results can be generalised to other cases. All four children identified as "Pakeha"/European New Zealanders. It is evident that the extent to which this manualised approach is appropriate, and what adaptations may need to be made, needs to be investigated for working with other cultures, including Maori and Pacific Island children and families, and other migrant and refugee populations.

Variations to the research design arose due to the nature of this clinical population, and provided additional limitations to the outcome data. Notably, it was found to be impossible to adhere to the specified number of weeks each child was assigned to the baseline phase, due to a range of reasons. These included, as described in Chapter 7, changes in social worker (SSU has a policy of not treating children if there is no allocated social worker, although this is sometimes waved due to clinical priorities), transport difficulties, school holidays, unavailability of parent/caregivers, and child placement changes. These factors also affected the total number of weeks a child spent in treatment, regardless of number of sessions required to treat their particular presenting problems. Nevertheless, the continuous data afforded by the single-case design revealed trends, despite these design variations.

A positive therapeutic relationship is considered essential for CBT with young people, including for those with anxiety disorders (Kendall & Southam-Gerow, 1996). While the use of a manualised treatment may potentially reduce the contribution of the therapeutic relationship to treatment outcome (Shirk & Karver, 2003), it is a limitation of the pilot study that the treatment was carried out by a single therapist. Use of the manual by other therapists will enable the specificity of this approach to be determined. In addition, a full assessment of treatment integrity was not carried out as this was a development project and the manual was being finalised as the study progressed.

In summary, the pilot study contributed to the development of the manual by enabling an initial testing of the treatment elements and overall structure of the TF-CBT programme with real-life children and their parent/caregivers. In fact, no significant changes were made to the draft programme that had been initially designed on the basis of theory, empirical research, and local clinical practice.

Three further studies, reported in the following three chapters seek to address the limitations of the pilot study with replications across different conditions. Study 2 involved trialling the manualised TF-CBT programme with two Maori and two Samoan children and their respective caregivers and families.

Chapter 9: Study 2

Cultural Study

Outline and Aims

The major research goal of Study 2 was to evaluate the effectiveness of the manualised TF-CBT treatment programme in reducing child posttraumatic stress symptoms and increasing coping in multiply-abused children of Maori and Pacific Island[22] heritage. Target and comorbid symptoms were monitored at pre- and post-treatment, and 3-, and 6-month follow-ups. Families/whanau and caregivers were involved and collateral data was collected.

Significantly, Study 2 was carried out as a development project. Cultural consultation and supervision were integral to ensuring that the structure and elements of the programme were culturally appropriate, and that the clients' cultural and treatment needs were being met. A view shared by the author, CYF promotes the view that it is only by understanding the cultural context of a child and family that the information about their mental health, behaviours, fears, and thoughts can be correctly interpreted (Child Youth and Family, 2001b). Cultural factors may influence symptom patterns and treatment responses among abused and neglected children (Cohen et al., 2001). There has been increasing recognition of the need for culturally competent practice with traumatised children and families in the child welfare system (Hendricks & Fong, 2006). This chapter includes a review of cultural factors related to treatment and research with clients of indigenous and migrant cultures, in particular, with regard to Maori and Samoan people in New Zealand.

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[22] It is recognised that there is tremendous diversity among Pacific peoples in New Zealand. For the purpose of this research, only the Samoan culture has been explored in any depth, as the Pacific Island children in the research study were all of Samoan descent, reflecting the population of the catchment area.

The current study aims to begin to address gaps in the existing literature. Research to date has failed to show consistent findings on the role culture plays in CA outcomes. Recent reviewers note that this is partly to do with studies being based on broadly defined cultural or ethnic categories, ignoring the variability within groups (Elliott & Urquiza, 2006). They advocate utilising finer-grained concepts such as acculturation (the degree to which the values, norms and behaviours of the majority culture are adopted) and cultural identity. In addition, some authors criticise the use of quantitative methods to capture cultural variables (Sue, 1999), and recommend qualitative methods to enable increased participation and empowerment of research participants of minority cultures (Ponterotto, 2003). Limitations associated with the cross-cultural use of psychometric instruments have also been highlighted (Cohen et al., 2001). Multiple methods of information gathering in order to assess the constructs of interest have been recommended (Elliott & Urquiza, 2006). Initial findings have indicated that cultural characteristics may be less salient than other factors in predicting response to treatment among abused children, including type of treatment, abuse-related cognitions, and parental support, but more research is needed, particularly in real-life settings (Cohen et al., 2001).

Study 2 Participants

Four multiply-abused children aged 9 to 14 years (4 girls) who met DSM IV (American Psychiatric Association, 1994) diagnostic criteria for PTSD participated in the treatment programme. Participant characteristics are summarised on Table 9.1. Two participants identified as Maori. As typical of many Maori referred to the Central Auckland SSU, these children were of urban Maori families with little connection to traditional marae-based Maori culture. English was their first and only language. Two participants (siblings) identified as New Zealand born Samoan. Their parents were Samoan born, but had drifted from traditional Samoan culture, although the church was still prominent in their lives. The parents' first language was Samoan. The children were encouraged by their family to speak English, although they also understood and spoke some Samoan.

Table 9.1. Study 2: Participant Characteristics, History, and Current Circumstances

Partic-ipant	Sex	Age	Cultural Heritage	Abuse History	Diagnosis	*Severity of PTSD	Safety Issues	Placement issues
S2.1	F	11	New Zealand Maori	Sexual abuse, physical abuse, emotional abuse, neglect, witnessing violence	PTSD, anxiety symptoms, behaviour problems	Severe	Intermittent contact with itinerant mother who did not prioritise child's safety and needs	First foster placement broke down, second placement during therapy with supportive caregivers
S2.2	F	10	New Zealand born Samoan	Physical abuse, emotional abuse, witnessing domestic violence	PTSD, behaviour problems	Severe	Father in prison for physical abuse of this child. Mother now separated and learning new skills	Family moved three times during therapy
S2.3	F	9	New Zealand born Samoan (sister of S2.2)	Witnessing domestic violence, physical abuse, emotional abuse	PTSD, Separation Anxiety Disorder, depression symptoms, behaviour problems	Severe	As above; father in prison for physical abuse of sister	As above
S2.4	F	14	New Zealand Maori	Sexual abuse, emotional abuse, neglect	PTSD, GAD**, separation anxiety social anxiety & OCD** symptoms, depression symptoms	Moderate	Concurrent investigation of siblings in unsafe, neglectful environment with mother	Living with supportive extended family throughout therapy

*As measured on the CPTS-RI pre-treatment
**Generalised Anxiety Disorder, Obsessive Compulsive Disorder

Cultural Context

New Zealand is first and foremost a bicultural nation. The founding document, The Treaty of Waitangi, was signed in 1840 between the indigenous Maori and the Crown of England, on behalf of the European settlers from Britain. Today the Treaty is interpreted by most New Zealanders to signify a partnership between Maori and Pakeha. There are many arguments about what this means exactly and how it should be enacted, and even by some as to whether it is relevant today. CYF policy, however, is clear in upholding the Treaty commitment to partnership, as embodied in the guiding documents *Puao-te-Ata-tu*, *Te Punga* (our anchor) and *Te Pounamu*[23] (greenstone) (Child Youth and Family, 2001a; Department of Social Welfare, 1986, 1994). A bicultural approach includes understanding and sharing cultural values, sharing responsibility for decision making, and accountability of the agency for meeting the particular needs of clients according to their cultural background, especially Maori. Biculturalism is considered the essential prerequisite in New Zealand to the development of a multicultural society (Department of Social Welfare, 1986).

Maori are over-represented in CA statistics. While one in seven of the population identify as Maori (Statistics New Zealand, 2006), approximately 45% of the children and young people CYF deal with are Maori (Brown, 2000). As was highlighted in Chapter 2, Maori have been subject to enormous social change in their recent history, which has impacted on their social, economic and health status. Today nearly 90 percent of all Maori youth live in urban areas (Child Youth and Family, 2001b). This has changed the traditional relationship of individual Maori to *whanau* (family), *hapu* (related families), *iwi* (tribe), and the land.

It has been put forward that adaptation and acculturation and the wide differences to be found over three to four generations are key to understanding CA in Maori families (Tukukino, 1984). The cornerstone of this view, as espoused by Hana Tukukino, is that violence being perpetrated against the young in many Maori whanau reflects the hopelessness, anger, powerlessness, and resentment of a colonised people attempting to

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[23] *Te Pounamu* (greenstone) was traditionally acknowledged as a medium for reconciling relations between iwi in times of dispute and indifference.

adapt their culture in the face of a dominant Pakeha culture. Mason Durie also discusses CA as one of the impacts on health and safety that can occur when a whanau is dysfunctional (Durie, 2001).

However, Maori live in diverse cultural worlds. While the gaps between Maori and non-Maori in health, education and the economy continue to be serious and may be growing, a Maori renaissance has created new vitality. Approximately 14,000 children are learning *te reo* (Maori language) in *Te Kohanga Reo* (Maori language preschools), and there is an increase in Maori attending university (Durie, 2004). Maori perspectives on health and well being are making a significant impact on mainstream health and welfare services. An interweaving of ideas, values, aspirations, policies and practices is beginning to emerge that is unique to Aotearoa/New Zealand.

New Zealand is also a Pacific Islands nation. Almost 7 percent of the population define themselves as Pacific Islander (Statistics New Zealand, 2006). Auckland reputedly has the largest population of Pacific Island people of any city in the world. Samoans make up the biggest group, comprising approximately 50 percent of this country's total Pacific Island population (Department of Social Welfare, 1996). As the Government Department with the most contact with Pacific Island peoples, and employing the most Pacific Islands staff, the former Department of Social Welfare took the lead in developing a strategy for Pacific Island staff and clients (Department of Social Welfare, 1996). The resulting document *'Lali[24]'* (drum) includes strategies for staff to become culturally aware and sensitive to Pacific Island needs, customs and issues, so that Pacific Island clients can feel supported and understood.

Today New Zealand is truly a multicultural society. Clients of CYF represent migrants and refugees from regions as diverse as Asia, Africa, Europe, the Middle East, and Central and South America, including those from New Zealand born first and second generations. In response, the Department produced a third guideline to raise awareness and provide strategies for working with the diversity of peoples that form ethnic minorities in the New Zealand context (Department of Social Welfare, 1997).

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[24] For many Pacific Island nations, the *lali, pate* or *nafa* is a tool of communication used to unite, entertain and inform their people.

Working with Indigenous Cultures

As has been referred to elsewhere in this thesis, the view of life as a series of problems for which we must find solutions arises out of the scientific paradigm, which focuses on the detail of cause and effect in order to gain a sense of mastery over human nature and the environment (Axelson, 1993). Axelson proposes that "prescientific" or "nonscientific" views tend to accept and flow with human nature and the cultural and physical environment and take life as it comes. The forces may be feared or respected, but in general life is lived as creatively as possible under the existent conditions. Traditional societies are built on the bonds and mutual understandings found in family, kinship, friends, religion and custom. People often work together on the same activity. In this way they feel a sense of belonging, purpose, and meaning. By contrast, modern societies are often characterised by a faster pace of life and rapid change. Individuals have specialised jobs and channel their interests. The bonds of family and community become weakened. It is more difficult to establish relationships with others and to understand the lives of others. People lose the sense that problems may affect all, and problems become individualised. Overall, the identity and focus of people moves from collective to individual.

In Western thinking, we do not often consider the notion that therapy is a cultural construct. It arose to address the problems created and exacerbated by modern life, including those related to CA and neglect (McFarlane & van der Kolk, 1996). In traditional societies, people designated to provide help to others generally have a role based on a spiritual, religious or philosophical view of reality shared by the community. In collectivist-based societies, group norms serve as functional principles for personal conduct and life paths. Where there is general agreement about what is a "healthy" and "good" life, there tend to be many mutual or informal sources of help. "Formal" helpers in modern society, that is, trained specialists, may not differ in terms of their function, or basic incentive to help others, but formal systems of helping are vastly different in terms of: (1) the philosophical and psychological views of human nature and social nature; (2) the therapy relationship and goals stemming from those views; and (3) the system of techniques and action to carry out these goals (Axelson, 1993). The theories and practices of psychologists and therapists are undeniably based in Western world thought. As such, they may well be foreign to people who are still living within, or strongly connected to a traditional collective society (Murupaenga et al., 2004).

In New Zealand, an understanding of this idea is particularly relevant, as people of the indigenous cultures of the Pacific are generally not fully acculturated into the individualistic framework of Western society. While locating themselves variously on the continuum of traditional to contemporary, Maori and Pacific Island people often identify with a collective way of thinking (Eruera & Sefo-Godinet, 2004, November 17 November 17). People from different ethnic backgrounds and at different points on this continuum may have very different expectations about therapy and healing.

Maori World View

The majority culture of Pakeha in New Zealand has increasingly had the opportunity to reflect on the fact that Maori have a very different world view (M. King, 1999). Two decades ago, Mason Durie, a Maori Psychiatrist, highlighted that while Western models seek to help people by going into detail about what is wrong with them in order to gain insight about their circumstances, traditional Maori thinking is opposite. Rather than dissecting, uncovering, or going deeper, Maori focus "outwards". Knowledge is gained from the relationship Maori people have with the wider system, including their families, the land, and constructs thought to be much bigger than the individual (Durie, 1985 1985), rather than through a relationship with their own feelings, thinking, or intelligence.

As a result, some ideas about mental health and therapy can be foreign to Maori people. For example, to talk about your own feelings can be a strange way of looking at things for Maori. For example, Durie describes the Maori word for anger is *puku* (stomach) or *riri* (battle). Emotions are not separated from the whole body or wider context. This can be observed at a *tangi* (funeral). There is no need for people to put their feelings into words; the tears say it all. So in therapy, Maori may have a problem with having to talk about feelings, when in their world the feelings speak for themselves.

As Western models of therapy are based on an individualistic rather than a collective paradigm, self actualisation is upheld as an ultimate goal. For Maori, a person who is self-sufficient, autonomous, and governed by what is best for themselves may be seen

as unhealthy (Durie, 1985). On the other hand, *whanaungatanga* (connection to family) is fundamental to Maori mental health. Similarly, *whakamanawa* (to encourage someone) and *manaakitanga* (caring for someone) are very important. In the context of therapy with Maori people, Durie explains that this can include offering a hot drink before getting underway, or asking a person if they want to lie down for a while if they are really distressed. Likewise, *awhi* (to touch or embrace) is a customary way of addressing distress within a Maori cultural context. For example, rubbing someone on the back rather than asking them to talk about their feelings. These concepts are particularly applicable to working with Maori children and young people who are likely to have been raised with at least some of these customary ways, even among Maori whanau who are urbanised and would describe their way of life as contemporary (P. Murupaenga, personal communication, 2004).

Importantly, the concepts of *mauri* (the essence or heart of something) and *wairua* (spirituality) represent vital elements of Maori culture that tend to be left out of Western therapy models. In the Maori world, these ideas are inseparable from how a person feels about themselves and whether or not they are able to fulfil their potential. Mauri can depend on many things, including knowledge of whanau and *whakapapa* (where they come from). Durie suggests that helping professionals have a duty to put Maori people in touch with their whanau and iwi origins (Durie, 1985). Wairua is generally felt by Maori to be the most essential element of health. It is related to a capacity to have faith and to understand the links between the human situation and the environment. A belief in God may be one reflection of wairua, but it is also evident in connection to the land, as the natural environment is considered integral to identity and fundamental to a sense of well-being (Durie, 2004).

Durie reminds us that other world views are important to keep in mind in the context of developing and testing a treatment programme for abused young people and their whanau:

> You could say that what the Maori perspective brings is a reminder to us all that there are some very basic humanistic principles that western thinking has gradually devalued. Spirituality and human values have taken second place to scientific thinking. Maori thinking isn't so different from many other cultures,

but it hasn't yet given way to the overwhelming importance of the scientific approach. It holds that science is of value, but it is just a small part of life with the human experience being much greater (Durie, 1985), p.14)

Maori Models of Health

Maori perspectives on health began to emerge in the mainstream in the early 1980s, challenging the more narrow focus of Western medical practice (Durie, 2004). These wholistic models and frameworks based on Maori values and principles are now considered to offer a legitimate alternative to the Western biomedical model, and are recommended in CYF documentation as appropriate for working with children and whanau with mental health problems in the context of abuse (Child Youth and Family, 2001b).

"Te Whare Tapa Wha" (a four-sided house) is the model that has gained the widest acceptance, by both Maori and non-Maori practitioners. Part of its appeal is that it is simple and readily understandable. It has provided a framework for Maori to define health in their own terms. Developed by Durie in 1982, he noted the model presented a wholistic view not dissimilar to the 1947 World Health Organisation definition of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmary". However, it was distinct in firmly anchoring health on a spiritual rather than solely on a somatic base (Durie, 2004).

The Te Whare Tapa Wha model compares health to the four walls of a house, with all four required to ensure strength and symmetry: *taha wairua* (the spiritual side), *taha hinengaro* (thoughts and feelings), *taha tinana* (the physical side), and *taha whanau* (family). The model reflects the Maori view that health and well-being is dependent on the essential element of wairua. Expression of thoughts and emotion is considered vital, as is bodily health. The relevance of whanau to health and well-being is acknowledged. Whanau is recognised as the primary support system, not only in terms of care and nurturance, but also culturally and emotionally. Even in modern times, personal identity for Maori invariably derives as much if not more from whanau connections and credibility than from occupation or place of residence (Durie, 2004). The Te Whare Tapa Wha model provides a fundamental guide for working with Maori children and whanau, applicable to the current study.

"Te Wheke" (the octopus) was put forward by Ruth Pere in 1984 to illustrate the main features of health from a Maori whanau perspective (Durie, 2004). Each of the eight tentacles symbolise a particular aspect of health, while the body and head represent the whole family unit. The intertwining tentacles represent: *wairuatangata* (spirituality), taha tinana, hinengaro, whanaungatanga, mauri, *mana ake* (positive identity based on the uniqueness of each individual and family), *ha a Koro ma* (the breath of life that comes from forebears), and *whatumanawa* (healthy expression of emotion). *Waiora* (total wellbeing for the individual and the family) is represented by the eyes of the octopus. This model is useful to keep in mind when working with Maori, as it highlights a broader range of interactive features that may influence the response of a child and whanau in a therapeutic context.

"Nga Pou Mana" (the four supports) was a model proposed by the Royal Health Commission on Social Policy in 1988 to examine the foundations for social policies and social well-being. It comprises a set of values and beliefs considered prerequisites for health and well-being: whanaungatanga, *taonga tuku iho* (cultural heritage), *te aro turoa* (the physical environment), and *turangawaewae* (an indisputable land base). The model brought together and demonstrated the links between social, cultural, and economic dimensions in a way that could be readily appreciated by Maori (Durie, 2004). In the therapy context, Nga Pou Mana highlights the importance of connection to Maori identity and well-being. This includes connection to whanau, to *Maoritanga* (Maori culture), as well as level of access to a *marae* (meeting area of whanau or iwi), and land rights.

Maori World View and CBT

Te Whare Tapa Wha appears on the face of it to be well-matched with a CBT model. Like Te Whare Tapa Wha, CBT emphasises thoughts and feelings, physical aspects, and recognises the influence of context on functioning. This is graphically displayed in the CBT "5-part model diagram" (e.g., see Feather & Ronan, 2004), whereby the four interacting components of thoughts, feelings, physiology, and behaviours are depicted as four smaller circles with the context of a large circle, representing environment, culture, history and situations. While not necessarily specifically referred to in CBT, spirituality and family are clearly wider context variables that have interactive effects

with internal processes. For example, case formulation approaches to CBT with children invariably include familial cultural context and environment (Friedberg & McClure, 2002).

However, it is important to note the distinctions between Te Whare Tapa Wha and CBT. Durie makes it clear that for Maori, wairua is the cornerstone of health and well-being, and whanau is the source of personal identity. CBT reflects Western thinking in placing the inner world of an individual at the centre of the model. For example, while CBT models for working with children recommend the inclusion of family in treatment in order to understand and resolve issues to do with the origins or maintenance of a child's problems (O'Connor & Cresswell, 2005); Maori are more likely to encourage whanau involvement in order to enable connections, promote mauri, and enhance wairua.

Moreover, for Maori an event or situation is experienced holistically and inseparably from the wider system, rather than in terms of apparently discrete effects within the individual, impacted by equally discrete aspects of the outside world. For example, while expression of thoughts and feelings are considered vital, Maori do not draw a sharp distinction between the spoken word (which in Western thinking, including CBT, we tend to consider interchangeable with thoughts) and feelings. For Maori, emotional expression and thoughts do not depend on words to be conveyed, but may be communicated through subtle gestures, eye movements or facial expressions (Durie, 1985). Similarly, bodily responses may not be separated from emotional expression (e.g., puku = stomach <u>and</u> anger).

Maori psychologists have cautioned the use of CBT with Maori, while highlighting some of the strengths of the approach. Garry McFarlane-Nathan notes: "If wielded by an unaware therapist, cognitive behavioural therapy probably has as much potential for misuse and misdiagnosis as any other therapy…(however)…using this therapy with Maori I find no difficulty in explaining its practical and common sense theory" (McFarlane-Nathan, 1994, p.36) In particular, McFarlane-Nathan sees the CBT insistence on developing a collaborative relationship and its practical approach to finding out "what went wrong" and "how we can fix it up" as lending itself well to working with Maori. He has found in his own clinical experience that the functional analysis approach inherent to CBT can provide the opportunity to define problems and

work out how they might be solved in a way can respect both the Maori client and the therapist.

Paul Hirini warns of cross-cultural limitations inherent in a CBT approach. He asserts that CBT does not provide a protocol for situations where a client's issues are not internal or person-bound, such as racism and discrimination (Hirini, 1997). In addition, in adhering to a CBT paradigm, a Pakeha therapist may have the best intentions, but inadvertently cause embarrassment. For example, in an attempt to develop a collaborative relationship, a therapist may ask about whakapapa as a way of beginning to get to know Maori clients, as advocated by Durie (Durie, 1985). However, Hirini suggests that it is preferable not to immediately ask clients to reveal personal information without first taking time to develop rapport and gaining an appreciation of their level of awareness regarding their Maori identity. Today many young urban Maori may not be aware of their whakapapa, and to be asked about it could engender a feeling of *whakama* (shame, embarrassment), due to a sense of disadvantage or loss of standing. This caution serves to remind us that Maori are a dynamically changing population representing many varied experiences. Hirini emphasises the need to maintain flexibility in providing therapeutic services to Maori.

What Can a Pakeha Clinician Do?

There are a number of assumptions against which one can check one's own clinical practice when working with Maori, or indeed with any other culture. For example, Terry Huriwai puts forward four principles (Huriwai, 2004):

1. *Cultural competence* – awareness of your own *kawa* (cultural framework) on the therapeutic relationship, and taking this into account when planning and delivering programmes, activities and interventions.

2. *Cultural safety* – is similar, but different, and asks you to look at your practice and service from a client perspective to ensure that people feel fully able to use a health service provided by people of another culture without risk to their own culture.

3. *Framework of health and wellbeing* – with Maori clients, operate from a framework of health and wellbeing that is articulated in a Maori paradigm or way of thinking, such as Te Whare Tapa Wha or Te Wheke.

4. *Process model of practice* – utilise a process-orientated framework that supports your relationship with your client and their significant others. Rather than exploring causation, look to *rau menamena* (amendment), restoration and balance. Allow for and take consideration of the variables that contribute to the process of engagement and attaining wellbeing (e.g., whanaunatanga).

Keriata Paterson, Maori psychologist and current President of the New Zealand Psychological Society, recently highlighted the need to make clinical practice more relevant and helpful for Maori (Paterson, 2006). Paterson recommended that this can be furthered by Pakeha (and clinicians of other cultures) seeking exposure to the people of the land, supporting indigenous colleagues, carrying out research, and maintaining an awareness of biculturalism. In particular, she called for clinicians to work together towards the establishment of a new science; one that utilises analysis and hypothesis testing, experimental trials, replication, and contributes to a developing literature. Based on the idea that to date CBT and Tikanga Maori interwoven together has been most effective for Maori, Paterson suggested that Pakeha work with Maori colleagues to develop models using CBT with Tikanga Maori. However, she cautioned that CBT has to be applied in a different way for Maori; that the clinical viewpoint needs to be worked in and around the cultural viewpoint, not the other way round.

In summary, provided the therapist is aware of his or her own assumptions and the potential pitfalls in using a CBT approach with Maori *tamariki* (children) and whanau, there appears to be a potential compatibility. Maori instinctively work as collective unit, and understand the power of the collective and its ability to strengthen nurture and heal (Pakura, 2004). If the therapist respects the rights and dignity of the whanau and child, and is prepared to step into their world and collaboratively work together, an interweaving of Maori Tikanga with CBT principles and practices provides a potential for healing (Murupaenga et al., 2004).

Samoan World View

While there are some similarities, the world view and cultural experiences of Samoan people are quite distinct from those of Maori. Prior to the arrival of the missionaries in the late 18th and early 19th centuries, Polynesian societies had a polytheistic religion, particularly in Samoa (Pereira, 2004). There were non-human (Atua) and human (Aitu) gods. As the Samoan god, Nafanua, had predicted the coming of a religion that would be more powerful and stronger than the old gods, the arrival of Christianity led to rapid and wide-scale conversion of the population. The church, with its hierarchical structure and God as the ultimate authority, remains central to Samoan culture today. This mirrors Samoa's own culture, with its hierarchical structure, including father at the head of the family, and the ultimate authority of the *Matai* (chief) in the family unit.

In Samoa, the ideal social organisation is the *Faamatai*, which is based on three points of reference pertaining to identity (*Faasinomaga*). Every Samoan is heir to a matai title, the land owned by the matai title, and the Samoan language. This is so whether or not they live in Samoa, are born overseas, or are a child of mixed parentage (Tagaloa, 1999). The three basic values of Samoan culture are: *alofa* (love), *fa'aaloalo* (respect), and *fa'amagalo* (forgiveness) (Lui, 2003). Alofa is the concept of giving, receiving and sharing of gifts and service, and qualifies most Samoan ideals. Fa'aaloalo is the foundation of good relationships, and is maintained through *va fealoaloai* (protocols and etiquettes). Fa'amagalo is what is required if a person breaches a *tapu* (something sacred). *Fa'amagaloga* (protocols or etiquettes by which a person seeks forgiveness) may be sought through a process of *fa'atoesega* (formal apology) in order to rebuild relational bonds. This process instigates healing of the soul, rebuilding of relationships, and enables all parties to deal with the past and move forward to the future.

Samoan Perspective of Health and Healing

Pacific people have a holistic view of health that encompasses positive balanced relationships between *Atua* (God), *Tagata* (people) and *Laufanua* (land/environment) (Lui, 2003). Health is achieved when a person's physical, mental and spiritual needs are in balance, and the person is able to meet their obligations to self, family, village

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and community. The relationships between these three elements are bound by tapu. Breaching tapu may pose a health risk.

Traditional Samoan healers (*Taulasea*) have the skill or *mana* (authority, power) of healing handed to them from another possessing the gift, and may in turn hand over this gift of healing, through the ritual of shared hand washing in a bowl of water. Alofa underpins the giving and receiving of healing. Taulasea provide their healing out of alofa for people and their desire to be of service. Healing is usually transferred to the person who is unwell through gentle rhetoric and massage (Lui, 2003). Those who are helped show their alofa through offering gifts such as food, mats and money.

Faasamoa, Aiga (family) and Child Rearing

Samoan people generally have a strong sense of identity and belonging (Lui, 2003). This involves a strong connection to aiga, as well as to God, spirituality, ancestors, the land, and homeland. The culture is collective and the unit of society is the aiga not the individual. Traditional values as well as theological beliefs underpin child rearing practices. Children are viewed as treasures, the carriers of heritage, and the essence of a culture rooted in principles of human interaction (Pereira, 2004). This is reflected in the linguistic principle that has been handed down from time immemorial:

> "*Fafaga Tama a manu i fuga o laau ma ia, ae fafuga tama a tagata I upu ma tala*" (feed the young of animals with fruit of trees and fish, but feed the young of man with words and speech) (Pereira, 2004, p. 100).

In terms of human development, in traditional Samoan culture there is no notion of stages of development; one is either a child or an adult (T. Berking, personal communication 13 August, 2004). Children are taught to honour and obey parental authority. "Well-reared" children are expected to be obedient.

With regards to disciplining children, is a matter of debate, but it has been suggested that literal interpretation of biblical teachings that sparing the rod spoils the child may have legitimized physical punishment by Samoan parents (Pereira, 2004). Older generation Samoans report having been beaten for disobedience and defiance in childhood, and accepting that a certain amount of physical punishment is necessary to

teach children how to behave (Wurtzburg, 2000). The use of physical punishment has also been ascribed to lacking the proper words, loss of face, or being put on the spot for negligence of traditional teachings; and the pressures of modern life and generational differences relating to language, formal schooling and migration (Tagaloa, 1999). However, there is no evidence to suggest the sanctioning of physical punishment in pre-missionary Samoan history (Pereira, 2004).

Working Therapeutically with Samoan Children and Families

Western therapy is foreign in a traditional Samoan context (Murupaenga et al., 2004). Samoan children and families referred for therapy in the New Zealand context may or may not have an understanding of assessment and therapy (T. Berking, personal communication, 13 August 2004). The traditional Samoan way to resolve problems is *soalaupule*, involving face-to-face discussions (Lui, 2003). This depends on the development of personal relationships, and may take time, depending on the issue. The emphasis is on a collective process and interdependence, not on the individual and being independent. Traditionally in Samoa, family and extended family, or even the whole village looks after those with problems. Many Samoans find it challenging to ask outsiders for assistance with problems. There may be resistance to dealing with social service agencies due to cultural barriers such as language and feelings of shame (Wurtzburg, 2000).

Many New Zealand born Samoans who live within a contemporary Samoan paradigm are moving towards a more individualistic way of life, although traditional values are likely to be influential (T. Berking, personal communication 14 May 2004). For example, parents may be more relaxed, but would still like their children to be obedient, and may strive to bring their children up in the Samoan way. Along with adequate resourcing in terms of housing, employment and education, the strength of connection to family, aiga, church, culture and homeland continue remain important in enabling a sense of belonging and identity that is considered vital to wellbeing.

The implication for *Palagi* (people of European heritage) clinicians working with Samoan children and families, or indeed those of other Pacific Islands, is to consider these issues in advance of meeting with the clients. This may include taking opportunities to learn about Samoan and Polynesian cultural concepts, and consulting

with Pacific colleagues. Pacific practitioners highlight that effective intervention requires openness to understanding differences, while not allowing practices to be used that excuse unsafe behaviour or abuse (Wurtzburg, 2000).

Engaging in Any Cross-Cultural Situation

Practitioners participating in a Clinical Round Table at the 2006 New Zealand College of Clinical Psychologists Conference agreed that an important part of engaging cross-culturally was to be flexible (Banks et al., 2006). This group of six practitioners, of Maori, Pakeha, Pacific and Asian descent, suggested asking early on how clients choose to define themselves, rather than making assumptions on the basis of cultural group. In addition, they emphasized the importance of taking extra care in discussing the referral question and goals, and how these are perceived from the person or family's perspective. The suggestion was made to ask the family directly what needs to be kept in mind from a cultural perspective to assist the person and family on their recovery. Psychologist's awareness of their own cultural issues was also highlighted. It was concluded:

> This respectful, empathetic inquisitiveness and the psychologist's awareness of their own cultural issues, processes, expectations, and assumptions is immensely important in helping to strengthen the therapeutic relationship and engagement (p. 21)

Method Pertinent to Study 2 and Results

Variations from Research Design

As recorded in Chapter 7, Study 2 comprised an opportunity sample. Three children were assessed by the researcher (S2.1, S2.2, S2.4), and one by her Samoan colleague (S2.3). For each participant, the treatment was provided by the assessor (see also, this chapter discussion). The four participants were randomly assigned to baseline periods following assessment. It was planned that baseline data would be collected weekly for 3, 5, 7, and 9 weeks respectively prior to the commencement of therapy, however, this was not able to be adhered to for any Study 2 case. Two children in particular (S2.2, S2.3) experienced significant delays between assessment and commencement of therapy

due to changes in social worker and family circumstances, and one adolescent (S2.4) began treatment earlier than planned due to clinical concerns related to depression and safety (total weeks on baseline: S2.1, 5; S2.2, 25; S2.3, 22; S2.4, 7). For all children, the baseline measures were administered in the weeks following the assessment as planned, and discontinued once the assigned number of weeks had been reached. In addition, three participants failed to return some measures (S2.2, 1; S2.3, 2; S2.4, 2). Hence, for Study 2, as for Study 1, the baseline data reported on the graphs is that of returned measures (reported on Figures 9.3 and 9.4 in order of the dates on the coversheets, and not necessarily representing consecutive weeks). In addition, during treatment, on occasion children requested not to complete the measures. This was of course respected, consistent with the consent forms the children signed which prescribed this leeway.

Length of Treatment, Booster Sessions, and Follow-up Data

The 16-session programme was delivered flexibly, as described in the manual. Order of content and number of sessions required to complete the programme was adapted to meet the needs of the individual participants and their families and caregivers. Number of treatment sessions for Study 2 participants varied from 15 to 28 (S2.1, 20; S2.2, 15; S2.3, 28; S2.4, 16). S2.1 completed the basic programme in 20 sessions, however, she and her caregivers were provided with an additional nine booster sessions over the 6-month follow-up period to address ongoing placement and behavioural concerns (29 sessions in total). S2.3 took considerably longer (28 sessions) than the other participants to complete the basic programme (see discussion). Length of the treatment phase varied due to a range of disruptions including multiple placements and transport difficulties (total weeks: S2.1, 35; S2.2, 39; S2.3, 64; S2.4, 44). For Study 2, follow-up data is available for two children at 3- and 6-months (S2.1, S2.2). Two children were not able to be located or did not return follow-up measures following discharge from CYF involvement, despite every endeavour being made (S2.3, S2.4). Due to time restrictions on the data collection phase, planned 12-month follow-ups were not able to be carried out.

Child Report: Continuous Measures

Overall Mean Results

CPTS-RI

Figure 9.1 shows that the level of posttraumatic stress symptoms of Study 2 participants decreased with treatment, and for two participants with data available, decreased further over a 6-month follow-up period. The overall average self-reported CPTS-RI score for the four children was in the *moderate* range during baseline (Mean = 30.4; SD = 13.6), in the *mild* range over the treatment phase (Mean = 18.6; SD = 12.3), and below clinical levels for the two participants at follow-up (Mean = 8.5, SD = 0.6), on a scale of 0-80.

CQ[25]

Figure 9.2 shows that the four participants' level of self-perceived coping ability increased with treatment, and increased further over the following 6-months for two participants. The children's mean coping scores (averaged across the four participant's three self-identified target concerns; CQ1, CQ2, CQ3) increased from 3.9 (SD = 0.9) during the baseline phase, to 5.2 (SD = 1.8) over treatment, and 6.6 (SD = 0) over follow-up for two participants (on a scale of 1 = *not at all able to help myself* to 7 = *completely able to help myself*).

Individual Results

CPTS-RI

Figure 9.3 presents the graphed weekly level of posttraumatic stress symptoms for each of the four participants across the baseline, treatment and follow-up phases. Unlike Study 1 participants, Study 2 participants showed remarkable consistency in a reported drop in PTSD symptoms following assessment, prior to treatment (see discussion). As with Study 1 participants, Study 2 children showed an idiosyncratic response to treatment. The limited follow-up data available showed relative stability in reported PTSD symptoms at follow-up.

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[25] Note, CQ4 results on perceived helpfulness of the TF-CBT programme are presented in Appendix J.
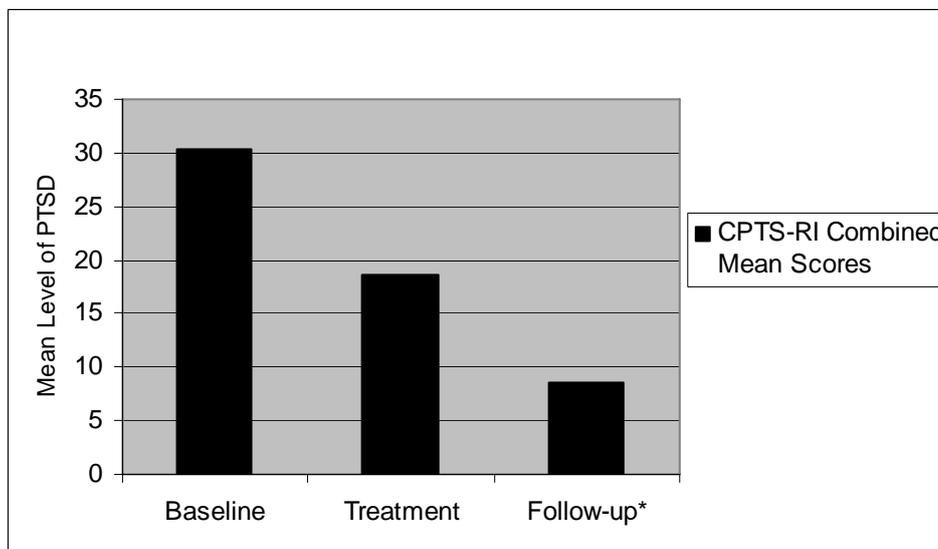
*2 children only, with 2 data points each

Figure 9.1. Study 2: Changes in mean level of PTSD symptoms (average of CPTS-RI scores for all four participants) across baseline, treatment, and follow-up phases.
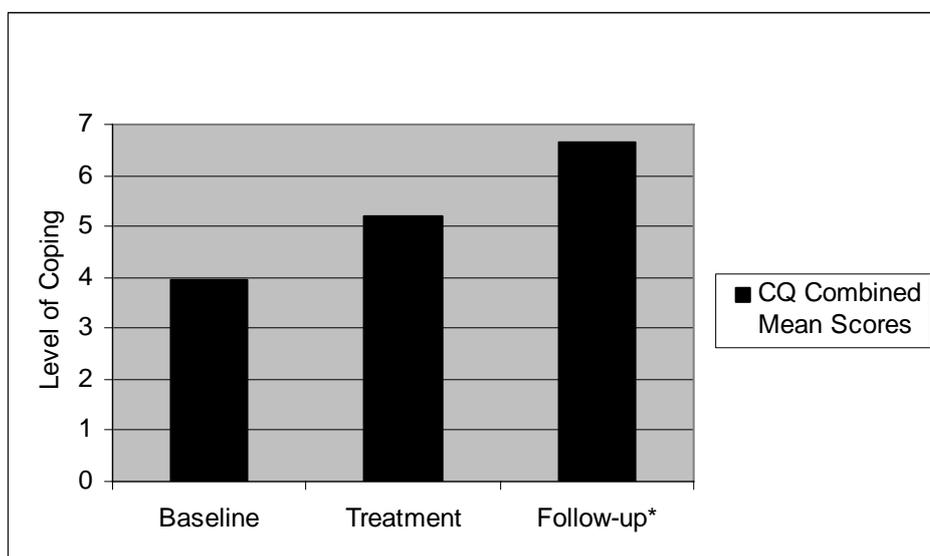
*2 children only, with 2 data points each

Figure 9.2. Study 2: Changes in mean level of child reported coping (average of CQ scores for all four participants) across baseline, treatment, and follow-up phases.

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Baseline

A stable baseline demonstrates relatively little variability and an absence of slope. In the case of Study 2 this criteria was not met. For the CPTS-RI results, the baseline ranges and variability were 31-43 (25%), 25-40 (18.8%), 4-52 (60%), and 13-35 (27.5%) on a scale of 0-80, for S2.1, S2.2, S2.3, and S2.4 respectively. While only one participant (S2.3) exceeded the 50% level recommended for single-case methodology in applied clinical research (Barlow & Herson, 1984), in each case the baseline data showed a downward trend following assessment. The baseline data for the CPTS-RI called into question the need for treatment for PTSD for some participants. At T1, S2.1 reported symptoms in the *moderate* range, S2.2 and S2.4 in the *mild* range, and S2.3 below clinical levels. A clinical decision was made to commence with Phase 1 (Psychosocial Strengthening) and Phase 2 (Coping Skills) of the TF-CBT programme, as caregivers, social workers, and the children themselves continued to report concerns warranting therapeutic intervention, and re-assess for the need for the exposure phase for treating PTSD (Phase 3). Additionally, these children all qualified for PTSD diagnosis at assessment and it is not uncommon for anxiety-disordered children to under-report symptoms (e.g., Kendall, 1994; Ronan & Deane, 1998).

Treatment

Visual inspection of the CPTS-RI scores over the treatment phase shows a different pattern of response for each participant (see Fig. 9.3). These are now discussed.

S2.1's CPTS-RI scores dropped from the *moderate* range to the *mild* range during the psychosocial strengthening phase of the programme (sessions 1-3), and remained around this level throughout the coping skills phase (sessions 4-8). At the outset of the exposure phase (sessions 9-13), S2.1 reported experiencing bad dreams and her CPTS-RI score had risen to *moderate* range. It was collaboratively agreed to complete a series of sand trays to process these dreams and related trauma. Her CPTS-RI scores subsequently dropped to below clinical levels, and remained so over the special issues phase.
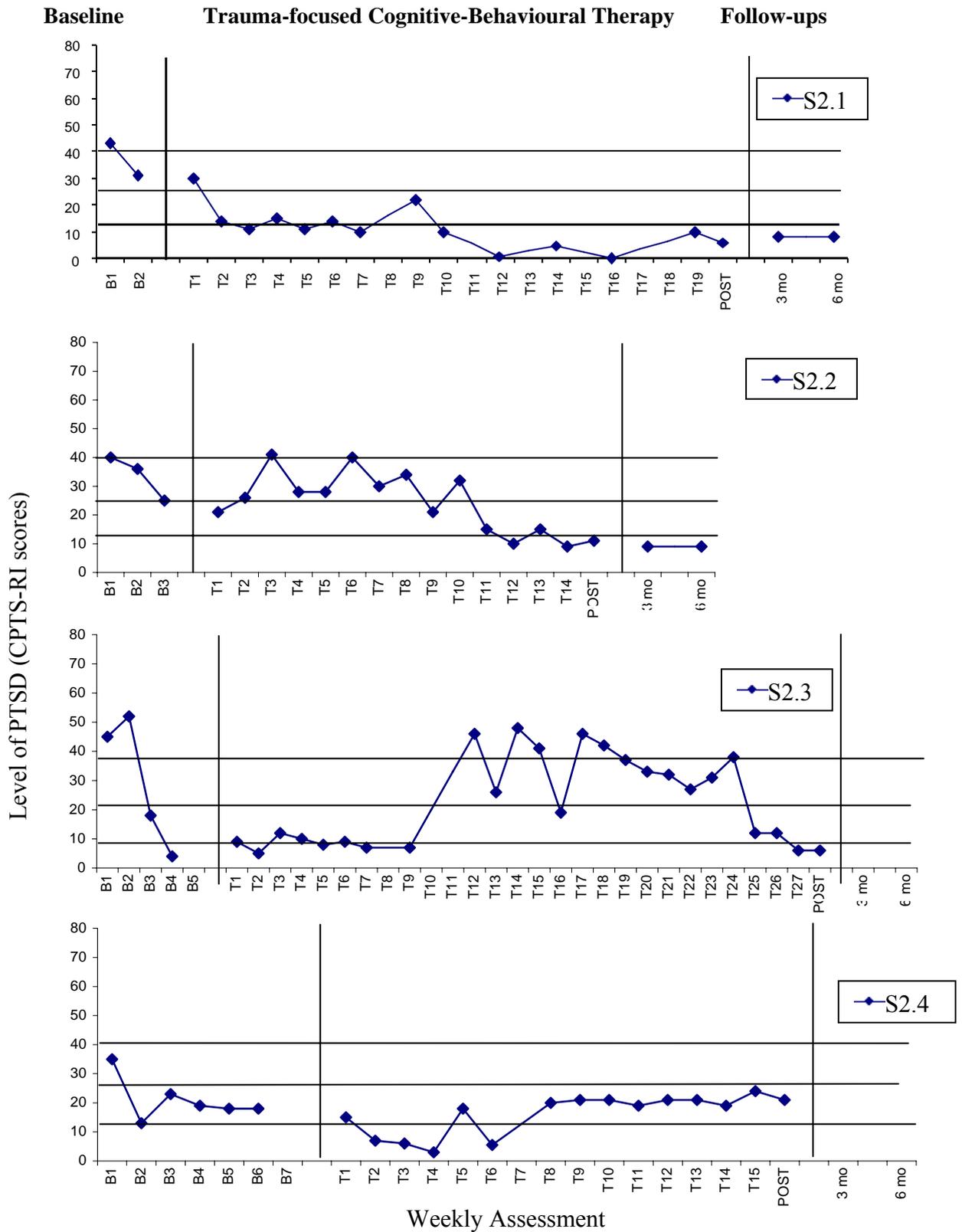
Figure 9.3. Study 2: Changes in posttraumatic stress symptoms (CPTS-RI scores) across assessment, treatment, and follow-up sessions.

S2.2's CPTS-RI scores rose from *mild* to *moderate* range during the psychosocial strengthening phase of the programme, and generally fluctuated in the *moderate* range during the coping skills phase. Over the exposure phase, as S2.2 processed trauma associated with CPA and witnessing violence, her CPTS-RI scores decreased and stabilised around the borderline of the *mild* range.

S2.3 had reported clinically significant PTSD symptoms related to witnessing a serious incident of physical assault by her father against her sister (S2.2) at assessment. Over the baseline phase her CPTS-RI scores had shown a drop from *severe* to *non-clinical*. Throughout the psychosocial strengthening and coping skills phases of the treatment, S2.3 continued to report CPTS-RI scores in the *mild/non-clinical* range. S2.3's father had been imprisoned for the assault; however, prior to the commencement of the treatment phase, she had begun to deny that he was responsible, apparently out of a desire to have him return to the family. While S2.3 reported low levels of PTSD symptoms over these phases, her behavioural problems had escalated. With the mother's support, it was agreed that the exposure phase would be carried out in order to help S2.3 understand and integrate what had happened. The results show that throughout the exposure phase, S2.3's CPTS-RI symptoms fluctuated between *mild* and *severe,* but ultimately began to track down. The special issues phase focused on helping her to manage her anger, to accept her father was responsible for the assault and the consequences, and to come to terms with her new family configuration, without her father. Joint sessions were carried out with her mother and siblings addressing these issues. Towards the end of the special issues phase, S2.3's CPTS-RI scores dropped to *mild*, then to *non-clinical* by the final two sessions of treatment.

S2.4's CPTS-RI scores tracked down from *mild* to *non-clinical* during the psychosocial strengthening phase of the treatment, and fluctuated between *mild* and *non-clinical* during the coping skills phase. S2.4 processed historical sexual abuse during the exposure phase. However, her CPTS-RI scores remained in the *mild* range throughout the remainder of treatment. Clinical observation suggested that the ongoing elevation of her scores was related the fact that S2.4 had become concerned about the safety and well-being of her younger siblings, who she believed were at risk of neglect and abuse

(e.g., elevated scores on items related to feeling scared and upset, feeling bad or guilty, and having bad dreams about being away from her siblings). These issues were addressed by helping S2.4 to convey her concerns to her CYF social worker, who carried out an investigation. By the end of the treatment phase S2.4 (by now aged 15 years) made the decision to leave the care of safe extended family where she had been voluntarily staying, and return to her immediate family so she could reconnect with her siblings and take steps to protect them if necessary.

Follow-up

The results show that for the two children who participated in follow-up (S2.1 and S2.2), both reported CPTS-RI scores below clinical levels at 3- and 6-month assessment points.

<u>CQ</u>

Figure 9.4 presents each child's self-reported coping over baseline, treatment and follow-up phases. For the CQ data, the baseline is relatively stable in terms of trend and variability. During treatment, coping generally tracked upwards for each participant, although there were variations in the patterns of coping response. Follow-up data for two participants showed that coping remained at high levels at 3- and 6-month follow-up.

Baseline

Unlike the CPTS-RI results, there were no overall similarites in trend in baseline CQ scores across the four participants in Study 2. The CQ scores for all four particpants hovered around the mid-range at baseline. In addition, the baseline variability was within the recommended 50% level for each participant. Baseline ranges and variability were 4.0-4.0 (0%), 4.0-5.6 (23.7%), 3.0-4.0 (14.3%), and 2.6-4.3 (23.9%) on a scale of 1-7, for S2.1, S2.2, S2.3, and S2.4 respectively.
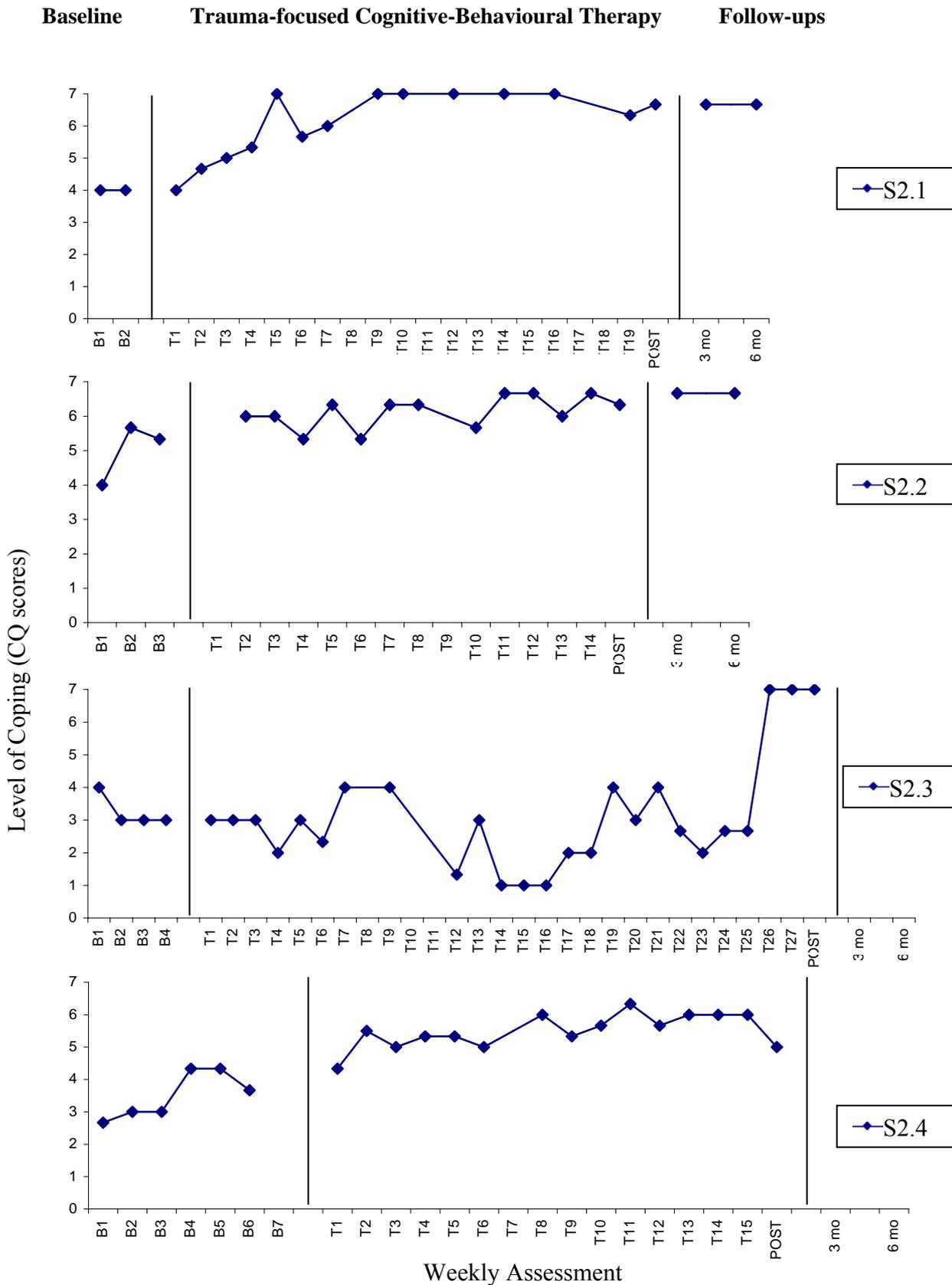
Figure 9.4. Study 2: Changes in child reported coping skills (average of scores for three target concerns) across assessment, treatment, and follow-up sessions.

Treatment

S2.1 demonstrated an coping response to self-identified difficulties that increased from the mid-range at the outset of treatment (4 = *somewhat able to help myself feel less upset*) to to top of the scale (7 = *completely able to help myself feel less upset*) by the end of the coping skills phase of the programme (as reported at the beginning of session 9), where it essentially remained over the exposure and special issues phases of treatment.

S2.2's coping increased from mid-range at assessment (4/7), to almost completely able to help herself (6/7) by the beginning of treatment (T1). Her coping remained at high levels throughout the treatment.

During treatment, S2.3 reported below mid-range to mid-range scores on the CQ over the psychosocial strengthening and coping skills phases of the programme. Her self-reported coping dropped further as the exposure phase was introduced, but showed a trend of rising towards the end of this phase. Over the special issues sessions, S2.3's coping scores fluctuated, but showed an increase to reach the top of the scale by the last three sessions, apparently coinciding with her acceptance of parental responsibility for the physical abuse and coming to terms with her new family situation (see discussion).

From mid-range at the outset of treatment, S2.4's results showed a steady rise in self-reported coping scores over treatment to close to the top of the scale. A slight drop at the final treatment (post) session (from 6/7 to 5/7) may have reflected some trepidation around her recent decision to return to her mother's home, where she anticipated some problems.

Follow-up

The available follow-up CQ data demonstrates high levels of coping in both S2.1 and S2.2 at 3 and 6-month follow-up assessment points (see details in following section).

Child Report: Repeated Measures

Child self-report repeated measures scores related to target concerns and co-morbid problems are presented on Table 9.2. These data fill out the symptomatology picture for the Study 2 participants at pre-, and post-treatment, and follow-up assessment points.

CPTS-RI

At pre-treatment, the mean CPTS-RI score for the four participants was above clinical cut-off (mean = 40.8), with three participants above clinical cut-off for severe PTSD (S2.1, 43; S2.2, 40; S2.3, 45), and one for moderate PTSD (S2.4, 35). At post-treatment the overall mean CPTS-RI score for Study 2 participants was in the non-clinical range (mean = 11.0). Three children reported CPTS-RI scores in the non-clinical range (S2.1, 6; S2.2, 11; S2.3, 6), and one reported a score in the mild range (S2.4, 21). At follow-up, the two participants for whom data is available reported further decrease in their non-clinical CPTS-RI scores (mean = 8.5 at 3-months; 8.5 at 6-months).

CQ

As shown on Table 9.2, the mean CQ score for all four participants increased from pre-treatment (mean = 3.3) to post-treatment (mean = 6.3), and for the two participants for whom data is available, increased further at 3-month (mean = 6.7) and 6-month follow-up (mean = 6.7).

STAIC-S

Scores on the STAIC-S presented on Table 9.2 indicate that overall state anxiety was generally within the normal range for these children. Mean scores indicate state anxiety was generally higher at pre-treatment ($T = 57.5$) compared with post-treatment ($T = 47.0$), as would be expected. Scores above clinical cut-off were reported by two participants: S2.3 at pre-treatment ($T = 73$), suggesting anxiety about the assessment process, although her responses to the ADIS-C also indicated high levels of state anxiety at this time about her father being in prison; and S2.4 ($T = 72$) at post-treatment, possibly reflecting state anxiety about her recent decision to return to live with her mother and siblings.

Table 9.2. Study 2: Child Report Scores on Repeated Measures of Target and Comorbid Symptoms

Measure	Participant	Assessment Points			
		Pre-treatment	Post-treatment	3-month follow-up	6-month follow-up
CQ	S2.1	4.0	6.7	6.7	6.7
(Mean)	S2.2	4.0	6.3	6.7	6.7
	S2.3	2.5	7.0	-	-
	S2.4	2.7	5.0	-	-
	Mean	**3.3**	**6.3**	**6.7**	**6.7**
CPTS-RI	S2.1	43**	6	8	8
(Total)	S2.2	40**	11	9	9
	S2.3	45**	6	-	-
	S2.4	35*	21	-	-
	Mean	**40.8**	**11.0**	**8.5**	**8.5**
STAIC-S	S2.1	53	48	23	41
(*T* score)	S2.2	53	43	62	35
	S2.3	73	25	-	-
	S2.4	51	72	-	-
	Mean	**57.5**	**47.0**	**42.5**	**38.0**
STAIC-T	S2.1	52	36	21	34
(*T* score)	S2.2	47	51	38	36
	S2.3	63*	25	-	-
	S2.4	63*	51	-	-
	Mean	**56.3**	**40.8**	**29.5**	**35.0**
CDI	S2.1	57	53	50	46
(*T* score)	S2.2	53	42	37	37
	S2.3	71*	37	-	-
	S2.4	65*	66*	-	-
	Mean	**61.5**	**49.5**	**43.5**	**41.5**

* Clinically elevated scores compared with age and gender norms (CDI, $T > 65$; STAIC, $T \geq 60$)
* Clinical cut-off for moderate PTSD, CPTS-RI ≥ 25; **Severe PTSD, CPTS-RI ≥ 40
- Data not returned or incomplete

Note: CQ = Coping Questionnaire; CPTS-RI = Child Posttraumatic Stress Reaction Index; STAIC-S = State Trait Anxiety Inventory for Children – State; STAIC-T = State Trait Anxiety Inventory for Children – Trait; CDI = Child Depression Inventory

STAIC-T

The mean STAIC-T scores show a similar pattern to the mean STAIC-S scores, indicating an overall drop in trait anxiety from initial assessment ($T = 56.3$) to post-treatment ($T = 47.8$). Mean STAIC-T scores at follow-up for two participants show a further drop in trait anxiety ($T = 29.5$ at 3-months; $T = 35.0$ at 6-months).

Two participants reported STAIC-T scores above clinical cut-offs at pre-treatment (S2.3, $T = 63$; S2.4, $T = 63$). At this time S2.3 reported significant anxiety in a number of areas, particularly as noted, separation anxiety related to her father being in jail and being away from her mother, general worries about her family, health, and things going on in the world, such as war and crime and people dying in Iraq. S2.4 also reported feeling scared and worried about being away from her family, including her mother and siblings as well as her aunty and uncle, social anxiety at school and in public, a range of physiological symptoms, and OCD traits related to sexual abuse, including feeling dirty and having to have a shower twice a day, and having thoughts about the abuse over and over again. By post-treatment the STAIC-T scores of S2.3 and S2.4 had decreased to below clinical levels (S2.3, $T = 25$; S2.4, $T = 51$).

CDI

The overall mean scores on the CDI show a decrease in self-reported depression symptoms from pre-treatment ($T = 55.0$) to post-treatment ($T = 44.0$). Two participants reported relative stability in CDI scores at 3-month (43.5) and 6-month (41.5) follow-up. At pre-treatment, two children reported CDI scores above clinical cut-off (S2.3, $T = 71$; S2.4, $T = 65$). Neither met criteria on the ADIS-C for Major Depression or Dysthymia, but both reported a range of symptoms related to feeling sad about their family circumstances, with effects on their eating, sleeping, energy levels, and a feeling that things would never work out. At post-treatment S2.3's CDI score ($T = 37$) indicated that her depression symptoms had alleviated. S2.4 continued to report clinical levels of depression on the CDI ($T = 66$). While she reported gains in self-esteem and assertion (see child subjective data), clinical observations suggested she continued to have issues related to a sense of belonging and feeling cared about.

TSCC

For Study 2, as a result of these children being part of an opportunity sample, the TSCC was not administered as part of their routine initial assessment and was therefore not included in the assessment battery.

Child Subjective Data

At post-treatment and follow-up, child participants were offered the opportunity to openly give feedback about the treatment, the research process, and any other related topic. As discussed in Chapter 5, this is consistent with the view that children participating in research have the right to have their voices heard.

S2.1

At post-treatment, S2.1 used a "Feelings faces" chart to document and report on changes, but also ongoing frustrations:

> I am frustrated not knowing why I'm in the home, and because I've had so many social workers. I'm happy – just happy – I've been improving at school and at home. I'm proud – X and Y (extended family of her caregivers) helped me do the dishes because I wasn't complaining. I'm scared – I've been told my room is haunted (by another foster child in the home). I'm spaced out – between friends, between the popular kids and my actual friends. I've started the new term as though I'm new at Ca 2's. (S2.1, post-treatment)

S2.1 and her caregivers participated in 9 booster sessions during the follow-up phase to address identified issues that were outstanding. These included, being assisted to ask her social worker why she was in care. At 6-month follow-up, S2.1 reported she had asked her social worker why she was not with her mother, and had been satisfied with the answer. This information had been corroborated by an extended family member, with whom she had contact. S2.1 reported she was happy to be having regular contact with her siblings and extended family, and with the plans to stay with her current caregivers and complete Year 8 at her current school. She stated she did not need further therapy at this time.

S2.2

At post-treatment, when given the opportunity to give feedback, S2.2 reviewed her workbook and identified activities that she had enjoyed and that had particularly helped:

> All about me, What I'd like help with, Paper people, Timeline, Feelings faces, Feelings chart, Body picture, "Show that I can tasks", Calm down ideas, and especially the "5-part model"…Mostly what really helped was the relaxation. STAR Plan – helped me with ideas and to use good techniques if something happens. You have to think really clever about how to solve your problems and what actions to do, like how to protect yourself and keep safe. Most important – 4 steps. Sand trays – they helped me if something happens you can get ready, prepare. Nothing I didn't like or wasn't helpful. (S2.2, post-treatment)

In a discussion initiated by the therapist about coming to see a Palagi, and whether she might rather have seen a Samoan therapist, S2.2 made it clear she had been comfortable, commenting, "I'm German too…I can't speak Samoan, I do at home, but (not well)".

At 6-month follow-up, S2.3 reported that by coming to therapy she had learnt:

> …to calm myself, calming other people down when they fight or argue – I did that two times in the holidays with my sisters. I learnt not to fight, not to be scared of other people. How I got calmed down was by coming here. And my friend helps me to calm down, and my Mum. (S2.3, 6-month follow-up)

S2.3

In response to the opportunity to give feedback at post-treatment, S2.3 made a card for her therapist, stating:

> To TB, You are the best thrapy (sic) and thank you for helping me with my problems and may God bless you and your families. I love you TB. (S2.4, post-treatment)

S2.4

At post-treatment S2.4 was given the opportunity to give feedback, including regarding seeing a Pakeha therapist. S2.4 responded:

> It has been helpful to realise I am worth something; to realise that even in a bad situation there's always something good will happen out of it if you think of it the right way. The STAR Plan was good – to make me think about what happened and how I felt about it – to give me other ways of thinking about it. Sand trays were helpful – made me see the things I was thinking about – when I set it up and then changed it, it could be another way that I wanted it to be. Timeline – to see what I've been through - all this, even the bad stuff, has made me who I am today and I reckon I'm pretty alright. Everything I've done since I've been here has been helpful in some way. It would help regardless of culture – the person just has to understand or listen. It's applicable to anyone. If something bad happens the thoughts used to stay and now they stay for a little while, but now I think I just have to let it go and move on – can't let that scar my life. (S2.4, post-treatment)

Parent/Caregiver and Teacher Results

Table 9.4 presents the results from the parent/caregiver CBCL and the teacher CBCL-TRF reports of internalising, externalising and total problems for each participant, compared with age and gender norms. Of note is the low rate of return. Every endeavour was made to ensure the completion and retrieval of these forms. As with Study 1, overall the parent/caregiver CBCL and teacher CBCL-TRF data for Study 2 were considered too inconsistent to provide meaningful results.

However, these results are useful to present and discuss with regards to each participant, as they highlight issues pertaining to measuring change with young people and parent/caregivers who have ongoing care and protection involvement and whose families are culturally different to that of test designers. Subjective evaluations by

Table 9.3. Study 2: Parent/Caregiver and Teacher Scores on Child Behaviour Measures

Scales (*T* scores)	Participant	Assessment points			
		Pre-treatment	Post-treatment	3 -follow-up	6-month follow-up
CBCL Internal	S2.1	57 Ca1	59 Ca2	-	-
	S2.2	48 Mo	-	-	-
	S2.3	55 Mo	65 Mo	-	-
	S2.4	-	68*Ca	-	-
CBCL External	S2.1	79*Ca1	74*Ca2	-	-
	S2.2	48 Mo	-	-	-
	S2.3	56 Mo	63 Mo	-	-
	S2.4	-	58 Ca	-	-
CBCL Total	S2.1	68*Ca1	71*Ca2	-	-
	S2.2	44 Mo	-	-	-
	S2.3	52 Mo	65 Mo	-	-
	S2.4	-	65 Ca	-	-
CBCL-TRF Internal	S2.1	57 Te1	-	-	-
	S2.2	62 Te1	-	-	64 Te2
	S2.3	64 Te1	-	90*Te2	
	S2.4	-	-	-	-
CBCL-TRF External	S2.1	69*Te1	-	-	-
	S2.2	52 Te1	-	-	62 Te2
	S2.3	83*Te1	-	77*Te2	-
	S2.4	-	-	-	-
CBCL-TRF Total	S2.1	68*Te1	-	-	-
	S2.2	55 Te1	-	-	64 Te2
	S2.3	77*Te1	-	90*Te2	-
	S2.4	-	-	-	-

* Clinically elevated compared with age and gender norms ($T \geq 67$)

- Not returned, stated did not know child well enough, did not consent to completing, and/or gave verbal report

Note: CBCL = Child Behavior Checklist completed by parents/caregivers; CBCL-TRF = Child Behavior Checklist Teacher Report Form completed by the child's teacher. (Mo=Mother; Ca=Caregiver (Ca1=first caregiver; Ca2=second caregiver); Te=Teacher (Te1=first teacher; Te2=second teacher).

parent/caregivers and teachers are included to provide further information on the clinical significance of the treatment, as suggested in the single-case (Kazdin, 1982a) and cross-cultural literature (Elliott & Urquiza, 2006).

S2.1

S2.1 experienced a change of caregiver during the treatment phase. At pre-treatment, S2.1's caregiver (Ca1) reported clinically elevated scores on the CBCL for externalising ($T = 79$) and total concerns ($T = 68$). At post-treatment, S2.1's subsequent caregiver (Ca2) also reported clinically elevated scores for externalizing ($T = 74$) and total concerns ($T = 74$). While these scores are remarkably consistent, to compare measures pre- and post-treatment completed by two different people is not valid. However, the results indicate that both caregivers noted concerns about S2.1's behaviour, even following completion of the TF-CBT programme. This was addressed in booster sessions, as described previously. Subsequently, Ca2 gave verbal feedback in lieu of completing follow-up CBCL measures:

> We have appreciated knowing more about (S2.1's) history and why she is like she is... she has settled down and is able to calm herself down and reacts less often now. (Ca2, 6-month follow-up)

S2.1 changed school when she changed placement. Her teacher at pre-treatment (Te 1) reported clinically elevated scores for CBCL-TRF external ($T = 69$) and total concerns ($T = 68$). Concerns included S2.1 finding it difficult to maintain a steady relationship with friends. S2.1's subsequent teacher declined to complete the CBCL-TRF. At 6-month follow-up, she gave a verbal report in lieu of completing measures:

> (S2.1) has matured a lot more towards the end of the year. For a while she was distant, distracted and emotional. She settled down at the end of the year. At the moment she seems very happy at home and school...she is well liked by a number of other students. (Te2, 6-month follow-up)

S2.2

S2.2's mother (Mo) reported scores in the non-clinical range on the CBCL at pre-treatment. Her first language was Samoan, and she required translation assistance to

complete the measure. Even though encouraged to complete the CBCL at subsequent assessment points, she declined, preferring to give verbal feedback. At pre-assessment she was concerned that S2.2 did not eat well, and was not happy. At post-treatment, when asked whether she had noticed any change in her daughter as a result of participation in the programme, S2.2's mother reported:

> Her attitude – before she's not happy. She couldn't sleep well or eat well. She was mad and angry. She didn't like anyone to touch her stuff – she banged the door and swear. She didn't want to help me do any work. I thought she can't hear me. She was always asking me to see the father. She doesn't want to play with other kids. She didn't share with other kids, especially food. And she fight with her sisters. At night time she always have bad dreams. She didn't care I didn't have any money – she wants to buy more. But now it's all changed, a big change. She's always blamed everything on me, she said it's all my fault. Now she eats well, sleeps well, no more bad dreams. She helps me to do the work at home, do her stuff without any voices or sound. Now there is a peace, doing her homework, cleaning her room every morning. She's keeping her things nicely. Never asking me stupid questions, like do I have a boyfriend. She doesn't blame everything on me. She helps her sisters. When her sisters are doing stupid things or talking stupid she tells them off – she stops them and says Mummy doesn't like that. When she's angry with her sister or a friend she comes to me and tells me and I give her a hug and she feels better. Things that make me proud of her – she loves the young kids and looks after them (before she played rough with the young kids – punched them – she hated babies and young children). She brings food and water for them – she always plays with them. Her teacher said there's a big change in Tina. She's working hard at school and she's very good. She shares her lunch with other kids bringing no lunch. (S2.2) has a peaceful look. Now she walks away until she can tell someone. Now she sings in church (she didn't sing before). Now she's the one in front singing. All the mothers and children like her because of her attitude. She looks alright, she's healthy. (Mo, post-treatment)

At pre-assessment, S2.2's teacher (Te 1) reported no concerns in the clinical range on the CBCL-TRF, although she did comment that, "she will under-achieve with the low

self-esteem she seems to have". S2.2 changed school prior to the post-treatment assessment. This teacher (Te 2) did not return the CBCL-TRF at the next two assessment points. At 6-month follow-up, Te 2 reported internal and total scores just reaching clinical cut-off on the internal ($T = 64$) and total scales ($T = 64$). Te 2 recorded a concern that S2.2 had a tendency to become angry quickly, but noted that, "(S2.2) has become a lot more cheerful and carefree over the last 6-months".

S2.3

At pre-treatment S2.3's mother reported no concerns in the clinical range on the CBCL, although subjectively she reported concerns about her fighting with her siblings. At post-treatment, S2.3's mother again reported no clinically elevated concerns on the CBCL. Subjectively, she reported that she was happy with the changes in her daughter, and that she did not have a lot of concerns about her now. She noted that S2.3 was, "a clever girl, helpful, respectful, and polite". As a result of involvement in the therapy, S.3's mother reported she had gained an understanding of the TF-CBT programme, and in particular, the rationale, process and outcome of the trauma-processing phase, which she had had difficulty understanding at the outset.

At pre-treatment, S2.3's teacher (Te 1) reported CBCL-TRF scores in the clinical range on the internalising ($T = 64$), externalising ($T = 83$), and total scales ($T = 77$). This teacher's concerns about S2.3 included, "mood swings drastically; output of work depends on mood; inappropriate behaviour, and attention seeking". The best thing this teacher had observed was that S2.3 was "well-coordinated". S2.3 changed schools between pre- and post-treatment. Her subsequent teacher did not return the CBCL-TRF, but gave a verbal report. This teacher had some concerns about S2.3's behaviour in the classroom which tended to get her in trouble with peers and staff, for example, teasing others and loud shouting, but noted that S2.3 had a gentle loving side.

S2.4

The CBCL was not returned at pre-treatment. However, S2.4's caregiving aunty (Ca) verbally expressed the following concerns:

> (S2.4) keeps to herself and mopes around, isolates herself so can go on a bit of a low…she is anxious about what people might think of her, speaking to adults, meeting new people…she is afraid of the dark. (Ca, pre-treatment)

Ca completed the post-treatment CBCL, reporting clinically elevated scores on the internalising ($T = 68$) and total scales ($T = 65$), reflecting some ongoing concerns about S2.4's emotional state, apparently related to her decision to return to her mother's care. However, Ca's subjective evaluation indicated positive changes in S2.4's behaviour:

> (S2.4) has been good…she's more receptive to talk to, has come out of her shell a lot…she's opened up a lot more. (Ca, post-treatment)

The CBCL-TRF for S2.4 was not returned at either assessment point, despite best endeavours.

Study 2 Discussion

The results of the trial of the manualised TF-CBT programme with two Maori and two Samoan children indicate that this treatment approach can be helpful for children of indigenous and migrant Pacific heritage. Overall, the single-case multiple-baseline design showed that with treatment PTSD symptoms reduced and coping related to specific trauma and abuse concerns increased. Repeated measures results indicated that target and co-morbid concerns generally ameliorated. The follow-up results, while limited to two children, one Maori and one Samoan, showed that treatment gains improved further over a 6-month period. Subjective data from parent/caregivers and teachers provided additional support for treatment helpfulness.

The four participants had PTSD diagnosed at assessment. Of note, is that all four participants recorded a decrease in symptoms across the baseline phase. It is not entirely clear, but the adaptation to the research protocol whereby the assessor also saw the child for therapy may explain the baseline data trend for all four children in Study 2, compared with those in Study 1. That is, the awareness on the part of both the therapist and the child that this was to be an ongoing relationship, and the child's connection to a therapist who instilled hope, may have contributed to an immediate impact on

symptoms. There could also be cultural aspect to these results. The therapeutic connection itself may be particularly salient for children of Maori and Pacific heritage, given the collective world view of both cultures. As noted previously, Maori instinctively work as a collective unit, and understand the power of collaboration and its ability to strengthen, nurture, and heal (Pakura, 2004). Similarly, for Samoan people, healing and relationships go hand in hand, based on the fundamental value of alofa (love). The cultural value of fa'aaloala (respect) may also have contributed. Samoan children are taught to respect adults, and out of respect may have taken on board the therapists' supportive and hopeful stance. It is also possible that time alone caused symptoms to exacerbate, especially given that two children waited a considerable length of time for treatment to commence. However, the other two children who waited the requisite, and fewer, number of weeks also showed a decrease in symptoms. In addition, subsequent assessment data and clinical observations indicated that posttraumatic stress symptomatology, while having abated following the initial assessment, had not actually resolved for these children. Also of note, is that baseline child coping did not show a parallel increase in trend. Self-identified coping regarding target concerns varied for each of the four participants over the baseline phase. This suggests that while therapeutic connection and hope alone may temporarily ameliorate symptoms, coping is less likely to increase without targeted intervention (see also, Ronan & Johnston, 1999).

Visual inspection of the continuous measures data showed that, as with Study 1 participants, Study 2 participants had idiosyncratic responses to treatment. In general PTSD symptoms fluctuated around a similar level for each child over the coping skills phase of the programme. Two children (one Maori and one Samoan) reported a further decrease in symptoms over the exposure phase, during which they resolved past abuse-related trauma. The other two children reported an increase in symptoms over this phase, reflecting ongoing current triggers. Interestingly, clinical observations suggested that this appeared to be related neither to culture, nor necessarily to family circumstances per se, but rather to the child's cognitions and age-related factors. For example, PTSD symptoms showed opposite trends during this phase for each of the Samoan siblings. This seemed to be determined by each child's attributions and perceptions to do with the historical abuse and the perceived effect on their current situation. Linked with this, were differences in willingness to talk about what had

happened and process the abuse-related trauma. One sibling was more ready to attribute responsibility for the abuse to the offending parent and accept being part of a single-parent family, while the other was resistant to seeing her father as at fault, even though he was in prison for the offence, and to the new family configuration. Possible explanations include the fact that the former child had been the direct victim of physical abuse, while the later had primarily been a witness and partly blamed her sister for the family break-up. In addition, the former was the older sibling (10, turning 11 years), and the latter the younger (9 years). Consistent with the results of Study 1, and that of other researchers (Cohen et al., 2000; Kane & Kendall, 1989), treatment response may vary with developmental level/age, with younger children apparently taking longer to grasp the concepts presented and apply these to resolving problems.

Conversely, the other participant who recorded an increase in PTSD symptoms over the exposure phase was the oldest in Study 2 (Maori, 15 years). Her elevation in symptoms was only to a mild level, and coincided with processing historical sexual abuse trauma. From her own report, it seemed likely that this was triggered in part by becoming aware of safety issues for her younger siblings, who remained in a neglectful environment. By the end of treatment she reported that while she felt resolved about her own past abuse-related trauma, she was constantly thinking about her siblings' current lack of safety and wellbeing. Her ongoing symptomatology appeared to be maintained by her cognitions (worrying about her siblings), linked to an age-related ability to self-reflect and take the perspective of others (see Chapter 4), manifested here by a developing sense of responsibility for younger whanau.

As found in Study 1, Study 2 participants generally showed a gradual increase in self-perceived coping over the treatment phase, regardless of fluctuations in PTSD symptoms, with the exception of the younger Samoan child, who reported a brief decrease in coping at the beginning of the exposure phase.

Overall, the results support the findings of other researchers, that cultural characteristics may be less salient in predicting response to treatment than other factors (Cohen et al., 2001). Notably, this study supports previous findings that the child's current cognitions and age may predict treatment response more strongly than culture, or even abuse-related factors such as identity of the perpetrator, abuse-type or number of abusive

episodes (Cohen & Mannarino, 2000). For example, on the basis of the Samoan children's data, it seemed that the salient factors in influencing treatment response were not their culture per se (e.g., each had a different pattern of response to treatment), or the identity of the perpetrator (he was father to both), but each child's current cognitions and related affect, about the abuse and its aftermath and age-related responses to treatment. With regards to abuse-type and number of episodes, the two children who presented with the more complex or serious abuse history[26] (one Maori and one Samoan) responded more rapidly to treatment, did not report a subsequent rise in symptoms at the exposure phase, and reported treatment gains were sustained over the 6-month follow-up period.

Parental support for the child has been found in previous research to predict treatment outcome for abused children, regardless of culture (Cohen & Mannarino, 2000). The results of Study 2 are consistent with this finding. On the basis of this small sample and clinical obervations, it seems that an important factor is a supportive caregiver who is willing to be involved in the treatment, whether or not a parent. Neither of the two Maori children had parental support, but both had supportive caregivers (not of their own culture) who were involved in the treatment, and demonstrated favourable responses. The Samoan siblings had a supportive mother who was involved in the treatment. Each of her children showed a differential response, but ultimately both demonstrated a positive outcome with regard to targeted concerns.

In Study 2, the fact that in each case the abuse had been intrafamilial had clearly impacted on these children's lives. All these children had limited or no contact with at least one parent due to care and protection concerns. Research to date suggests that the challenges intrafamilial abuse presents to children and non-offending family members may outweigh the effect of cultural issues (Cohen et al., 2001). The results of the current study bear this out to some extent, although cultural consultation with Maori and Samoan colleagues (P. Murupaenga, & T. Berking, personal communication, September 1, 2004) and clinical observations suggest that family and culture are not distinct factors in this respect, rather, they are intertwined. While targeted symptoms and coping improved through participation in the TF-CBT programme regardless of current family

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[26] Based on social work files and clinical records

circumstances or cultural background, issues related to loss of connection and identity as a result of abuse-related separation from family/whanau and culture were more difficult to address.

The impact of abuse-related separation was particularly notable for the Maori children. Both had experienced not only separation from parents, but also loss of connection to Maori whanau, iwi, marae, and the land. It was not possible to involve Maori whanau in the therapeutic process, because there were no safe whanau available. In the case of the younger Maori child, her caregivers were Pakeha, and she was the only Maori child at the small local school. While she identified as Maori, she had no knowledge of te reo or tikanga, and no access to making connection with her Maori heritage in her every day life. As part of the therapeutic intervention, an endeavour was made to encourage her participation in *Kapa Haka* (Maori performance group). She was keen to become involved in Maori cultural activities, but this did not happen due to logistic factors. Notably, regardless of her history of intrafamilial abuse and current supportive placement, clinical observation indicated that this child remained distressed about her lack of connection with whanau and culture. The older Maori child's situation was somewhat different. Her caregivers were extended family members related by marriage, who were Pakeha and Samoan. At the outset of therapy, she identified strongly with her Samoan peer group at school. However, as she resolved her historical abuse, which had been perpetrated by Maori family members, she became more open to exploring Maoritanga, and more willing to integrate herself back into her Maori whanau. The situation for both these children highlights the dilemma faced by young Maori whose whanau have become disconnected and characterised by abuse and a lack of safety. Yet, it was apparent from clinical observation that, notwithstanding their abuse history and current circumstances, both these young people appeared to have a basic desire to seek their identity from whanau connections and their cultural heritage.

The ideas of Huriwai (Huriwai, 2004) and cultural consultation guided the intervention in order to ensure its relevance and helpfulness for these young Maori people. This included referencing a framework of health and wellbeing based on a Maori way of thinking. In terms of Te Whare Tapa Wha, the TF-CBT programme was able to directly address taha hinengaro (thoughts and feelings) and taha tinana (the physical side), but without access to whanau, the taha whanau (family) aspect could only be addressed by

metaphorically bringing the whanau into the therapy room, for example, through the "Paper People" exercise or sand play work, as described in the TF-CBT manual (Feather & Ronan, 2004). With regard to taha wairua (spirituality), in the Maori world, as discussed previously, this is related to a capacity to have faith and to understand the connection between the human situation and the environment, and is integral to identity and fundamental to a sense of well-being (Durie, 2004). Cultural consultation suggested that for Maori children without connection to whanau, iwi, marae, and the land it is difficult for this issue to be addressed in the context of therapy in a mainstream Pakeha-based agency (P. Murupaenga, personal communication, October 21, 2004). Wairua, and the related concept, mauri (the essence or heart of something), in the Maori world are inseparable from how a person feels about themselves, and this may depend on knowledge of whanau and whakapapa (where they come from). Ultimately both Maori children in this study, while safe and relatively symptom-free with a *kete* (kit) of coping skills, continued to struggle with issues of connection and identity that could not be remedied by participation in the TF-CBT programme without the involvement of safe whanau.

The contextual and cultural situation for the Samoan children was quite distinct from that of the Maori children. The parents were Samoan born and Samoan was their first language. The mother had disconnected herself and her children from her own and her husband's family, for a range of reasons. However, she remained closely connected to the church and maintained many Samoan cultural traditions, including speaking Samoan at home. The children were New Zealand born and bilingual. However, they were having difficulty establishing their cultural identity, as they straddled two worlds between home and school. In contrast to the situation for the Maori children, with the Samoan children it was possible to address both interfamilial abuse-related issues and wider cultural issues within the framework of the TF-CBT programme. This was enabled through engagement, mutual respect, learning, and appreciation of each other's cultural world view, consistent with the three basic values of Samoan culture; alofa (love), fa'aalola (respect), and fa'amagalo (forgiveness). Two factors that were seen to be key in this respect were the participation of their mother in the programme and the significant contribution of the Samoan therapist. The latter made possible communication with the family in Samoan, an inherent understanding of their world view, and on-the-spot cultural consultation for the Palagi therapist.

At the outset, the concept of therapy was foreign to the mother of the Samoan siblings. While she welcomed our involvement and help, there was a conflict between some of her values and beliefs and those underpinning the programme. For example, she wished her children to be obedient, as the more obedient a Samoan child is, the more well-reared they are seen to be (Murupaenga et al., 2004). This led to her encouragement of the children to be quiet in the presence of adults, which conflicted with the therapists' encouragement of the children to openly express their opinions. These issues were discussed and agreement reached. A similar collaborative process is illustrated by the interaction between the family's Christian beliefs and CBT. One child came up with the idea of "saying a prayer" to help her challenge and change her unhelpful thoughts. This strategy was shared and became part of the "coping skills tool kit" for all family members. In addition, the therapists actively supported and reinforced the children's cultural identity. For example, at one stage of therapy the children expressed the view, "Samoans are dumb". This was addressed by the therapists telling a story about how throughout history Samoans had journeyed from island to island in canoes, navigating by the stars, and that they had to be very intelligent to do this. From then on the girls regularly recounted the "canoe story", and observed, "Samoans are very intelligent".

There were a number of aspects of the TF-CBT programme that appeared to not work so well for the Samoan children and their mother. The most immediately evident difficulties related to the measures used for assessment and monitoring. The mother found the English used on the parent/caregiver measures foreign and complex. In addition, the Samoan therapist found the concepts difficult to translate into the Samoan language. Similarly, the children found the child-report measures difficult to comprehend, and frequently asked for clarification of meaning of items, even after having completed the forms many times previously. There are likely to be a number of reasons for this. The measures are based on a Western world view and ethnocentric assumptions about mental health, assuming an individualistic sense of self and a view that psychopathology resides within the individual rather than in interaction between the individual, other people, physical, historical, and spiritual realities. While the therapy process and content could be interwoven with a cultural world view, as described above, the measures could not be adapted or discarded due to the need for empirical rigor. However, it was evident that these measures based on a Western paradigm could not be

readily translated into the Samoan world view or language without loss or distortion of meaning. The results of Study 2 support findings of previous research psychologists who have questioned assumptions that psychological measures describe and order experience for people of other cultures (Andary, Stolk, & Klimidid, 2003), and highlight the need for further research and development in this area.

A further identified problem related to therapist adherence to the Palagi-based manualised programme, without consideration for the cultural world view of the child. This was illustrated in the first session with an activity that involved sharing personal facts as a way of getting to know each other. The older Samoan child, working with the Palagi therapist, was asked about her favourite things, and clearly found the task difficult, even when prompted to identify her favourite toys. Subsequently, cultural consultation clarified the matter. Samoan children raised traditionally hold a collective view with regard to possessions, and share toys as a group rather than identifying individual ownership of things, as would be the case in a Palagi family. As a result of further cultural consultation, it was recognised that when working with children of cultures with a collective world view, it would be more appropriate to begin the TF-CBT programme with activities that focus on the child's relationship with family/whanau and others in their world, and introduce the more self-focused activities in the second session, rather than the other way round. This cultural adaptation has been incorporated in the manual.

In summary, Study 2 results and clinical observation suggest that cognitions, age-related factors, and caregiver support may have more salience in determining treatment outcome with regard to symptom reduction and coping than culture or family circumstances per se. Intrafamilial abuse and culture appear to be intertwined in their impact on treatment outcome, in particular with regard to connection and identity. These factors are difficult to address in a TF-CBT programme without the availability of family/whanau with whom to work therapeutically. However, the TF-CBT model can be expanded to include cultural aspects, including spiritual dimensions as appropriate.

Study 2 has a number of limitations. There were variations to the research protocol. As described, and based on cultural consultation, the assessment and therapy was carried by

the same therapist for each child. Hence, the results may be skewed in a positive direction due to demand characteristics. Children in Study 2 may have completed measures in such a way as to please the therapists. There may have been a particular risk of this with the Samoan children, who were raised to be obedient to adults. The prescribed baseline lengths were not able to be adhered to, and the possible effects of this have been discussed. The treatment phase was extended up to periods of over a year for a range of reasons related to conducting therapy in a care and protection clinic setting, exacerbated by particular difficulties for indigenous and migrant populations (e.g., language barriers, limited resources, lack of own transport). This increases the likelihood of the effect of maturation, history, multiple treatment interference or other extraneous variables on the outcome results (Kazdin, 2003). Two children were not available for follow-up data, limiting the generalisability of the follow-up results, which was already limited due the small sample size. There were gaps in the data, particularly with regard to the adult measures. In addition, the validity of the quantitative data may be limited due to the measures not representing the world view of the participants.

However, Study 2 also has a number of strengths. It was carried out with cultural consultation and a willingness to be flexible and adapt the manualised programme to the world view and circumstances of the participants. The use of subjective data enabled the participants to have a voice and provide open ended feedback on their experience.

Overall, the findings of Study 2 have implication for clinicians using manualised intervention programmes with children and families of indigenous and migrant cultures. The salience of a collaborative therapeutic relationship was highlighted, as was the critical importance of interweaving models based on Western psychology with culturally different world views in order to facilitate best outcomes for clients. Keriata Paterson suggests with regard to Maori psychology, that Tikanga has been under-emphasised and CBT over emphasised (Paterson, 2006). With cultural supervision, the writer experienced a transition in thinking from a view that culture should be considered as part of a CBT approach, to a view that each should receive equal weighting, to a realisation that CBT is a tool for change that exists within cultural paradigms (P. Murupaenga, personal communication, August 19 2004). Figure 9.5 depicts this transition in thinking. Accordingly, the therapeutic process ideally involves the therapist stepping into the child and family's cultural world and taking CBT in the kete.

This requires developing an awareness of the cultural frameworks of both therapist and clients, taking the clients' perspective, adapting the CBT framework of health and wellbeing to that of the clients', and attempting to articulate the process in terms of their cultural world view (Huriwai, 2004).
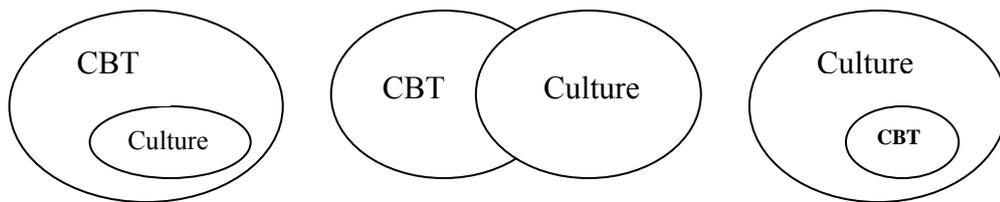
Figure 9.5. Transition in thinking regarding CBT and Culture

With these ideas in mind, Study 2 indicates that the TF-CBT programme is a useful tool in the context of a culturally sensitive collaborative therapeutic relationship to facilitate healing from abuse-related symptoms and concerns, and enable all parties involved in the therapy to deal with the past and move forward to the future. When working with Maori and Samoan children and families, the TF-CBT programme can be adapted to their respective cultural world views, but is not a panacea to address wider issues of connection and identity.

Study 2 trialled the manualised TF-CBT programme with two Maori and two Samoan children, building on Study 1, a pilot study of the programme with four Pakeha children. The manual was updated to provide guidance for working with indigenous and migrant children and families. Study 3 describes the results of use of the completed protocol with a sample of typically referred children and their caregivers and families, regardless of cultural identity.

Chapter 10: Study 3

Developed Protocol

Outline and Aims

The major research goal of Study 3 was to evaluate the effectiveness of the developed manualised TF-CBT treatment protocol in reducing child posttraumatic stress symptoms and increasing coping in multiply-abused children typically referred to SSU. The researcher was therapist, every endeavour was made to adhere to the research procedure, and treatment integrity was assessed and verified. Target and comorbid symptoms were monitored at pre- and post-treatment, and 3-, and 6-month follow-ups. Families and caregivers were involved and collateral data was collected.

Study 3 Participants

Four multiply-abused children aged 11 to 13 years (2 boys and 2 girls) who met DSM IV (American Psychiatric Association, 1994) diagnostic criteria for PTSD[27] participated in Study 3. The sample comprised the next group of four children referred to SSU who met research criteria. This was a multi-cultural sample, reflecting the diverse range of cultural backgrounds of children typically referred to SSU. Participant characteristics are summarised on Table 10.1.

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[27] The two 13 year old boys (S3.2, S3.4) were each one symptom short of meeting PTSD criteria on the ADIS-C and did not meet self-reported clinical interference ratings, but parent and collateral reports noted additional symptoms and indicated clinical interference sufficient to warrant a PTSD diagnosis.

Table 10.1. Study 3: Participant Characteristics, History, and Current Circumstances

Partic-ipant	Sex	Age	Cultural Heritage	Abuse History	Diagnosis	*Severity of PTSD	Safety Issues	Placement issues
S3.1	F	11	New Zealand European	Witnessing mother's death, domestic violence, physical abuse, sexual abuse, emotional abuse, neglect	PTSD, anxiety, depression, anger and dissociation symptoms, grief and loss related to death of mother, behavioural problems	Severe	Little contact with family; lack of consistent caregiving and emotional safety	Three placements during assessment and therapy – first two broke down, the third stabilised with a supportive caregiver
S3.2	M	13	Other**	Witnessing domestic violence, including sexual assault, physical abuse, emotional abuse	PTSD, anxiety symptoms, anger problems	Mild	Father in prison. Mother protective	Parents separated. Stable living situation with mother and siblings
S3.3	F	12	Other**	Witnessing domestic violence, physical abuse, emotional abuse	PTSD, anxiety symptoms, learning difficulties	Moderate	Supervised contact with mother. No contact with abusive ex-stepfather	Stable placement with caregivers
S3.4	M	13	New Zealand born Samoan	Physical abuse, sexual abuse, emotional abuse	PTSD, sexual behaviour and anger problems	Moderate	Ongoing monitoring by social worker to ensure safety from abuse in the home	Living with parents and siblings throughout involvement

*As measured on the CPTS-RI child self-report measure

**Includes Eastern European, North African and South American heritage

Method Pertinent to Study 3 and Results

Treatment Fidelity

A senior clinical psychologist (and experienced cognitive behavioural therapist) independent from the current research reviewed 13% of randomly selected audiotapes of treatment sessions with the two children who consented to this procedure. Adherence to treatment content and session goals was rated 100% for delivery, and no alternate treatment strategies were identified.

Variations from Research Design

As described in Chapter 7, the assessments for Study 3 participants were conducted by a trained evaluator not involved in the treatment. However, owing to the assessor leaving the agency, while not optimal, the researcher carried out the follow-up assessments.

It was planned that the baseline data would be collected weekly for 3, 5, 7, and 9 weeks. As found in the previous two studies, participants experienced unforeseen delays between the initial assessment and planned treatment commencement for a range of reasons, including, in the case of Study 3 participants, placement changes, caregiver unavailability, and transport difficulties (total weeks on baseline: S3.1, 7; S3.2, 9; S3.3, 14; S3.4, 17). In addition, three children failed to return some baseline measures (S3.2, 2; S3.2, 2; S3.4, 4). The baseline data reported on the graphs are those of the measures returned over the prescribed weeks of the baseline period (reported on Figs 10.3 and 10.4 in order of the dates recorded on the coversheets, and not necessarily representing consecutive weeks).

Length of Treatment, Booster Sessions, and Follow-up Data

The 16-session TF-CBT programme was delivered flexibly, as described in the manual. Number of treatment sessions varied from 11 to 17, and length of treatment ranged from 15 to 33 weeks (S3.1, 17 sessions, 33 weeks; S3.2, 11 sessions, 15 weeks; S3.3, 15 sessions, 25 weeks; S3.4, 16 sessions, 18 weeks). The differential treatment requirements of participants are explained in following sections. Duration of treatment was primarily affected by placement changes and caregiver availability.

Booster sessions were requested for one child by her social worker periodically over the 9 months following the completion of the 16-session programme (S3.1; 16 additional sessions, 33 in total). Coping skills were reviewed and reinforced to address issues related to changes in placement and contact with family.

Follow-up data is available for two participants at 3- and 6-months (S3.1, S3.3), and one participant at 3-months only (S3.4). Following discharge from CYF involvement, S3.4 was not able to be located at 6-months despite many endeavours made, and S3.2 did not consent to complete follow-up measures. This was of course respected. Due to time restrictions on the data collection phase, planned 12-month follow-ups were not achieved.

Caregiver Involvement

S3.1 experienced three changes of caregiver over the assessment and treatment. As a result, it was not possible to have continuity of caregiver involvement in the programme. In addition, the latter two placements were in foster homes with busy caregivers who were not available to attend sessions. Caregivers were contacted by telephone and every endeavour was made to cover relevant treatment elements in this way.

In the case of the two adolescent boys (S3.2, S3.4), their respective non-offending parents had issues of their own related to the abuse. This was resolved by referring each parent to an SSU therapist to enable them to address their own issues concurrently. In both cases, the parent's therapist was of a similar cultural background to the parent and spoke the same first language. The parent/caregiver elements of the TF-CBT programme were covered flexibly by the child therapist and the parent therapist, as appropriate.

S3.3's caregiver brought her to each session, and participated fully in the programme as prescribed.

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Child Report: Continuous Measures

Overall Mean Results

CPTS-RI

Figure 10.1 shows that the level of posttraumatic stress symptoms of Study 3 participants decreased with treatment, and for three participants with data available, decreased further over a 6-month follow-up period. The overall average self-reported CPTS-RI score for the four children was in the upper *mild* range during baseline (Mean = 22.6, SD = 12.0), just below clinical levels over the treatment phase (Mean = 9.4, SD = 9.5), and well below clinical levels at follow-up (Mean = 3.5, SD = 3.3), on a scale of 0-80.

CQ[28]

Figure 10.2 shows that Study 3 participants' overall level of coping increased with treatment, and increased further over the following 6-months for three participants. The children's mean coping scores (averaged across the four participants' three self-identified target concerns; CQ1, CQ2, CQ3) increased from 4.5 (SD = 1.3) during the baseline phase, to 5.7 (SD = 0.8) over treatment; and 6.33 (SD = 0.8) over follow-up for three participants (on a scale of 1 = *not at all able to help myself* to 7 = *completely able to help myself*).

Individual Results

CPTS-RI

Figure 10.3 presents the graphed weekly level of posttraumatic stress symptoms for each of the four participants across the baseline, treatment and follow-up phases. Study 3 participants generally showed a downward trend in PTSD symptoms over the three phases, with gains maintained at follow-up. The results of each phase are analysed more specifically using visual inspection, quantitative, and qualitative data, as recommended in the single-case literature (Kazdin, 1982a).

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[28] Note, CQ4 results on perceived helpfulness of the TF-CBT programme are presented in Appendix J.
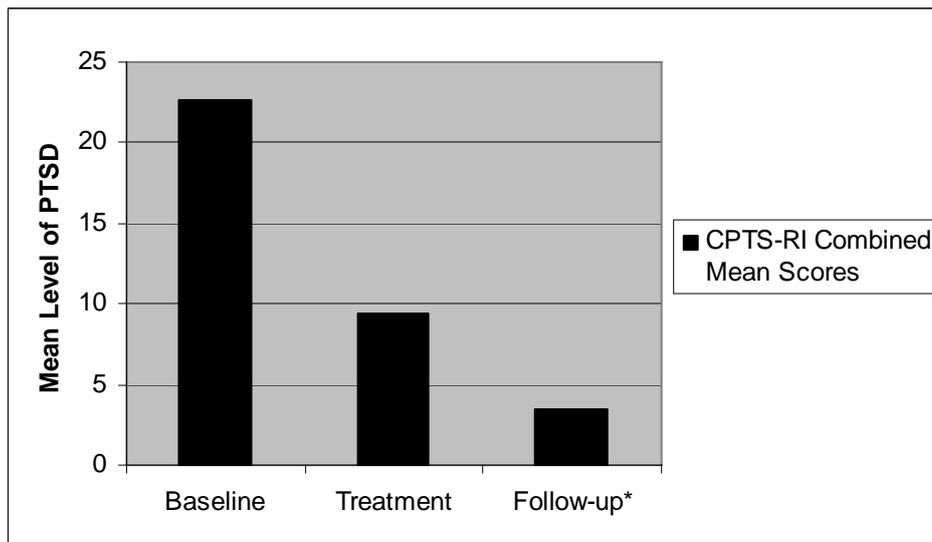
*3 children, 5 data points

Figure 10.1. Study 3: Changes in mean level of PTSD symptoms (average of CPTS-RI scores for all four participants) across baseline, treatment, and follow-up phases.
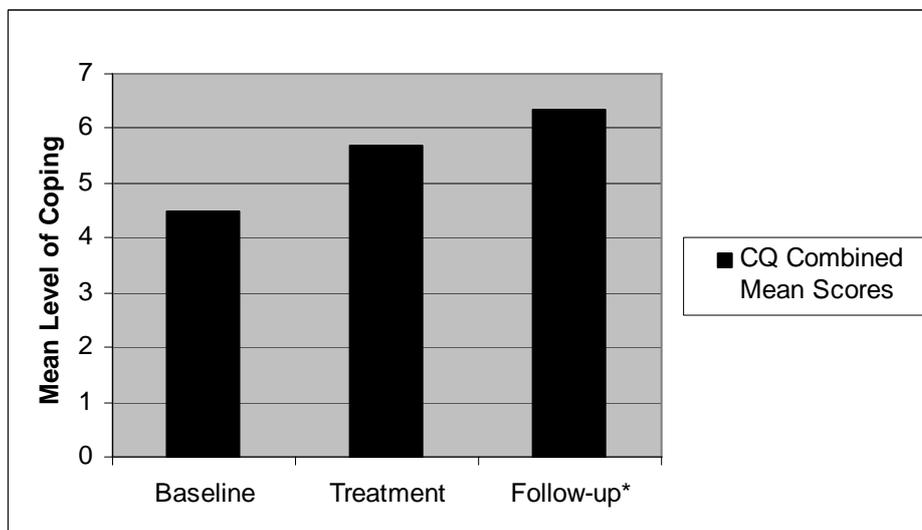
*3 children, 5 data points

Figure 10.2. Study 3: Changes in mean level of child self-reported coping (average of CQ scores for all four participants) across baseline, treatment, and follow-up phases.

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Baseline

As discussed previously, a stable baseline demonstrates little variability and an absence of slope. For the CPTS-RI, the individual baseline ranges and variability were 33-53 (25%), 8-13 (6.3%), 11-27 (20%), and 2-26 (30%) on a scale of 0-80, for S3.1, S3.2, S3.3, and S3.4 respectively. While no participant exceeded the 50% level recommended for single-case methodology in applied clinical research (Barlow & Herson, 1984), three participants (S3.1, S3.2, S3.4) showed a downward trend in CPTS-RI scores following the initial assessment. While S3.1 recorded a reduction in PTSD symptoms following the initial assessment, her S3.1 baseline scores stabilised at moderate levels, warranting TF-CBT intervention. Conversely, the baseline data for S3.2 and S3.4 dropped below clinical levels, and called into question the need for trauma-focused treatment. These results are discussed with reference to qualitative data.

The baseline results for S3.2 show CPTS-RI scores in the *mild* range, notwithstanding the fact that he had reported significant re-experiencing, avoidance, and hyper-arousal symptoms at initial assessment, and collateral data confirmed sufficient symptoms at levels warranting a PTSD diagnosis. Notably, as part of the forensic interviewing process, S3.2 had already given an account of the serious domestic violence he had witnessed. This process can be therapeutic, functioning as exposure. In addition, S3.4 underwent preparation for court during the baseline phase. Due to his involvement in these activities, S3.2 expressed an initial reluctance to attend therapy, possibly contributing to under-responding (see also, S3.2's TSCC results). However, his mother continued to be very concerned about the ongoing impact of physical abuse and witnessing violence on S3.2's well being and behaviour. She noted anger problems and fighting with siblings. She wanted her son to have the opportunity to process his feelings and learn coping skills to manage his own strong feelings in the future. Given overall clinical concerns, a decision was made to commence treatment with Phase 1 and 2 of the TF-CBT programme, and reassess the need for the exposure phase for treating PTSD.
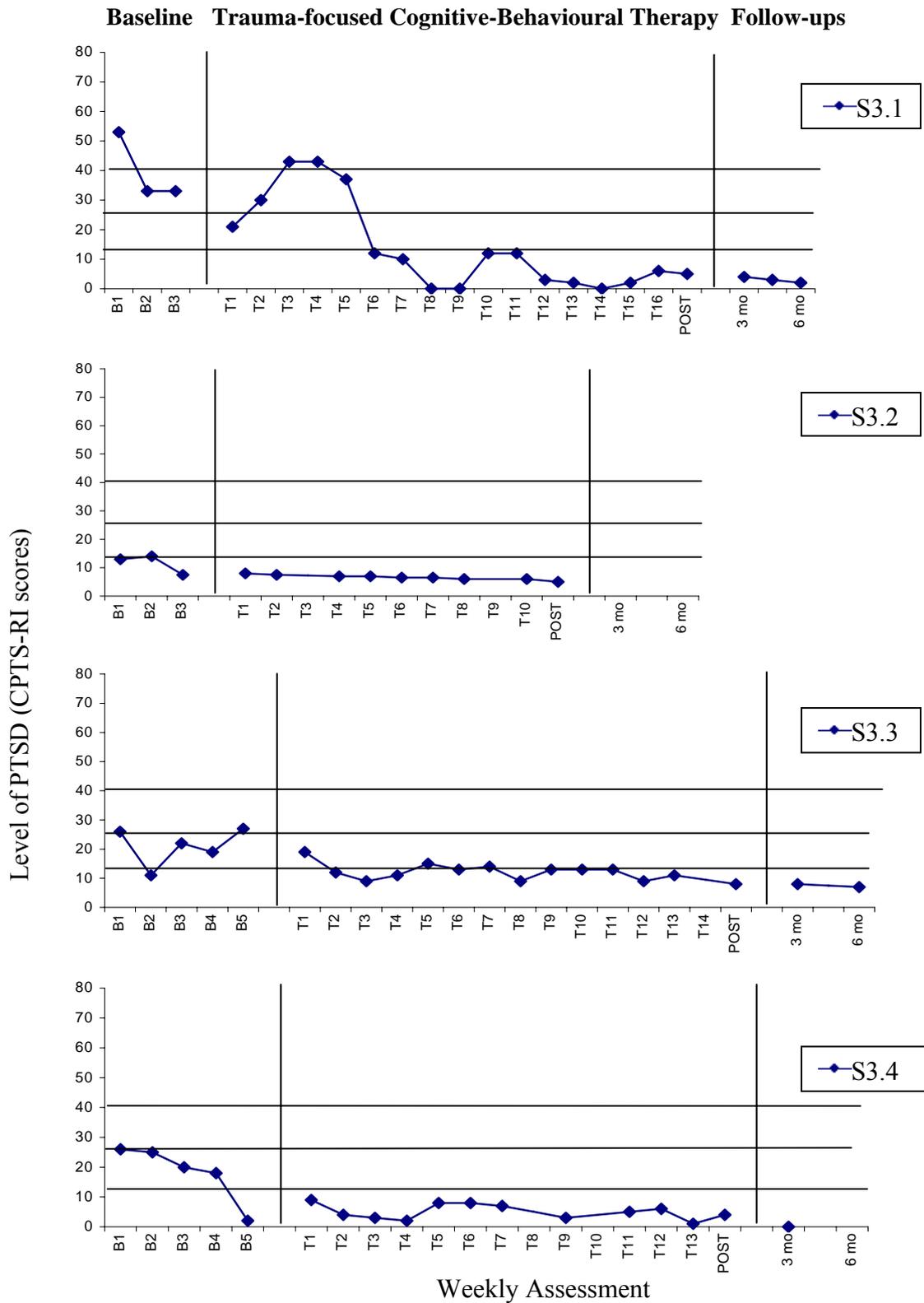
Figure 10.3. Study 3: Changes in posttraumatic stress symptoms (CPTS-RI scores) across assessment, treatment and follow-up sessions.

S3.4 recorded a *moderate* CPTS-RI score at initial assessment. During the ADIS-C interview, he made significant new disclosures to the assessor about past sexual abuse. A number of factors are likely to have contributed to a subsequent drop in PTSD symptoms during the baseline phase. As noted, the process of disclosure can be therapeutic, functioning as exposure. The disclosures necessitated the assessor developing a relationship with S3.4 to ensure his safety, according to agency protocol. Notably, S3.4 was Samoan. The salience of the therapeutic relationship for Samoan children and ensuing symptom reduction was noted in Chapter 9. In addition, clinical observation suggested the assessor took extra care to instil hope and reassure this young person that therapy would be helpful. Consultation with caregiving adults and overall clinical concerns led to a decision to commence treatment with Phase 1 and 2 of the TF-CBT programme, and reassess the need for the exposure phase for treating PTSD.

Treatment

Visual inspection of the CPTS-RI scores over the treatment phase indicates a similar pattern of a gradual reduction and maintenance of symptoms to below clinical levels for all but one participant, who showed an initial rise in symptoms, followed by a reduction (S3.1).

S3.1's CPTS-RI scores tracked up over Phase 1 of the TF-CBT programme (psychosocial strengthening). This is likely to reflect the fact that her placement with extended family had recently broken down and she had been placed with caregivers. The content of Phase 1 includes exploration of family relationships and support networks, and a brief review of the child's history of trauma. It is likely that these topics and S3.1's current circumstances exacerbated her PTSD symptoms. Conversely, over the coping skills phase (Sessions 4-8), S3.1's PTSD symptoms reduced to below clinical levels. A particularly sharp drop was noted after Session 5, which covers bodily reactions to trauma and introduces relaxation techniques. Notably, once the coping skills phase had been completed, although there was a slight rise in symptoms at the beginning of the trauma processing phase, S3.1's PTSD symptoms remained below clinical levels throughout the remainder of the treatment.

S3.2's CPTS-RI scores remained below clinical levels throughout the psychosocial strengthening and coping skills phases of the programme. Given that he was no longer reporting PTSD symptoms, and collateral reports indicated the other clinical concerns had abated, a decision was made to exclude the exposure phase and complete treatment after Phase 2 with relapse prevention.

S3.3's CPTS-RI scores show a reduction in PTSD symptoms to below clinical levels over the psychosocial strengthening phase of treatment. This was likely to have been helped by her stable placement and close involvement of her caregiver in the treatment. While her scores approached mild levels of PTSD while she was learning coping skills (Sessions 5-7), and again while she was processing past trauma via exposure based activities (Sessions 9-11), ultimately her scores dropped to below clinical levels and remained so over the final phase of treatment (Sessions 12-15; special issues and relapse prevention).

S3.4's CPTS-RI scores remained below clinical levels throughout the treatment phase, showing only minor fluctuations associated with the coping skills and exposure phases. It was agreed that S3.4 would work through salient incidents of physical abuse and sexual abuse he had experienced using the trauma processing modalities available, even though his PTSD symptoms had abated. It was identified by the therapist and S3.4 himself that there was a link between his memories of abuse and current behaviour problems. S3.4's mother supported S3.4 completing the entire treatment programme.

Follow-up

The CPTS-RI results show that PTSD symptoms remained below clinical levels for the three participants for whom data is available at 3-month (S3.1, S3.3, S3.4) and 6-month (S3.1, S3.3) follow-up assessment points.

CQ

Figure 10.4 presents each child's self-reported coping over the baseline, treatment and follow-up phases. The baseline data for the CQ scores is relatively stable in terms of
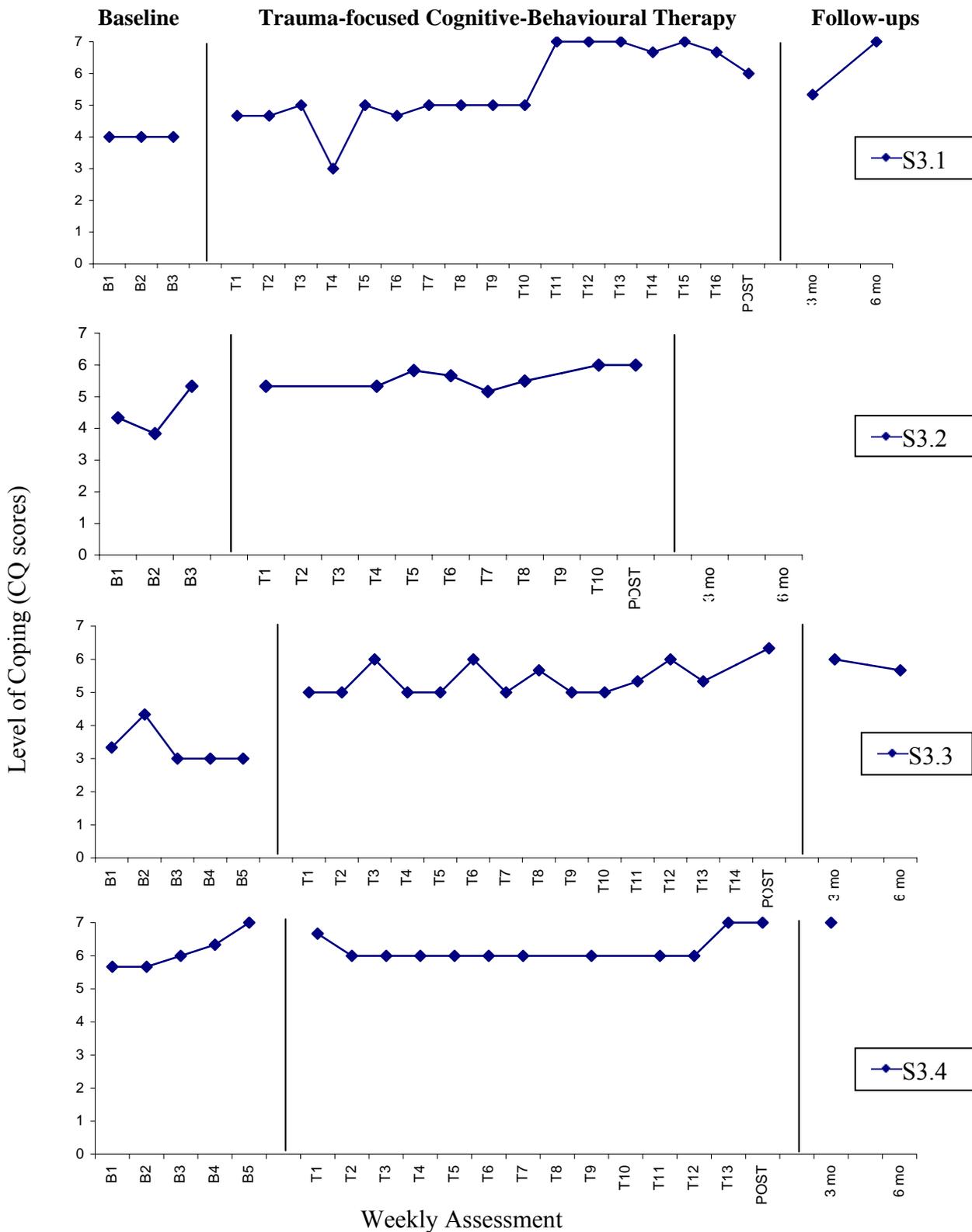
Figure 10.4. Study 3: Changes in child reported coping skills (average of scores for three target concerns) across assessment, treatment and follow-up sessions.

variability and trend. Overall, child coping showed a gradual upward trend over the treatment phase and maintained at overall higher levels at 3- and 6-month follow-up for the participants for whom data is available. The results for each phase are presented, with particular reference to individual responses.

Baseline

For the CQ, the individual baseline ranges and variability were 4.0-4 0 (0%), 3.8-5.3 (21%), 3.0-4.3 (19%), 5.7-7.0 (19%) for S3.1, S3.2, S3.3, S3.4 respectively, all within acceptable limits for single-case research. Two participants showed a stable or slightly downward trend (S3.1, S3.3), while S3.2 showed an initial downward trend, spiking upwards prior to treatment commencing, and S3.4 showed a gradual upward trend over the baseline phase, indicating an increase in coping. These results correspond to those presented for the CPTS-RI. That is, those participants who recorded a decrease in PTSD symptoms over baseline, showed a related increase in coping. The qualitative data presented in the previous section is likely to apply here as well.

Treatment

The individual results for S3.1 show an increase in coping linked with the beginning therapy and a slight increase over the psychosocial phase of treatment. She recorded a marked drop just prior to the coping skills phase, related to an incident of stealing. Her coping resumed throughout the coping skills training, and increased markedly during the gradual exposure phase, correlated directly with a session in which she worked through trauma associated with her mother's death. Her coping maintained at high levels, with a slight drop associated with ending therapy, as can sometimes happen for children as they anticipate coping without the support of therapy.

For S3.2, the beginning of treatment coincided with being called to court as a witness. This was, of course, the focus of therapy at the outset, flexibly utilising TF-CBT programme elements as required to assist him to cope with this process. Ultimately, all elements of the psychosocial strengthening and coping skills phases were covered over the first eight sessions, as for all children. As described, with PTSD symptoms abated and coping increased, treatment was concluded with relapse prevention. The results

show that S3.2's coping gradually increased and maintained at high levels by the end of therapy.

S3.3's coping increased at the outset of treatment compared with baseline levels, reflecting clinical observations that she welcomed the opportunity to attend therapy and readily developed a therapeutic relationship. Her coping maintained at high levels with minor fluctuations over the first two phases of treatment, and continued to gradually increase over the exposure phase as she processed serious historical abuse, to a maximum level by the end of treatment.

S3.4's coping showed a slight drop at the outset of treatment, but maintained stability at a high level throughout Phases 1-3, with an increase in coping to maximum levels by the end of treatment.

Follow-up

The follow-up CQ results for three participants indicate that self-reported coping maintained (S3.4), or dropped slightly (S3.1, S3.3), at 3-months; and for two participants, either continued to increase (S3.1) or maintained at a similar level (S3.3).

Child Report: Repeated Measures

Child report repeated measures scores related to target concerns and co-morbid problems are presented on Table 10.2. These data fill out the symptomatology picture for the participants at pre- and post-treatment and follow-up assessment points.

<u>CPTS-RI</u>

At pre-treatment the mean CPTS-RI score was in the *moderate* range (mean = 29.5). One participant recorded a score above clinical cut-off for severe PTSD (S3.1), two for *moderate* PTSD (S3.3, S3.4), and one for *mild* PTSD (S3.2). At post-treatment all participants scored below clinical cut-off (range = 4-8; mean = 5.5, on a scale of 0-80), with treatment gains maintained at 3-month follow-up for three participants (S3.1, S3.3, S3.4; range = 0-8, mean = 6.0), and 6-months for two participants (S3.1, S3.3; range = 2-7, mean = 4.5).

Table 10.2. Study 3: Child Report Scores on Repeated Measures of Target and Comorbid Symptoms

Measure	Participant	Assessment Points			
		Pre-treatment	Post-treatment	3-month follow-up	6-month follow-up
CQ	S3.1	4.0	6.0	5.3	7.0
(Mean)	S3.2	4.3	6.0	-	-
	S3.3	3.3	6.3	6.0	5.3
	S3.4	5.7	7.0	7.0	-
	Mean	**4.3**	**6.3**	**6.1**	**6.2**
CPTS-RI	S3.1	53**	5	4	2
(Total)	S3.2	13	5	-	-
	S3.3	26*	8	8	7
	S3.4	26*	4	0	-
	Mean	**29.5**	**5.5**	**6.0**	**4.5**
STAIC-S	S3.1	39	35	23	23
(*T* score)	S3.2	53	27	-	-
	S3.3	53	48	48	48
	S3.4	38	27	27	-
	Mean	**47.8**	**34.3**	**32.7**	**35.5**
STAIC-T	S3.1	58	48	46	41
(*T* score)	S3.2	35	21	-	-
	S3.3	38	25	25	27
	S3.4	44	24	27	-
	Mean	**43.8**	**29.8**	**32.7**	**34.0**
CDI	S3.1	57	44	47	44
(*T* score)	S3.2	44	37	-	-
	S3.3	36	38	36	36
	S3.4	48	44	46	-
	Mean	**46.3**	**40.1**	**43.0**	**40.0**

* Clinically elevated scores compared with age and gender norms (CDI, $T > 65$; STAIC, $T \geq 60$)
* Clinical cut-off for moderate PTSD, CPTS-RI ≥ 25; **Severe PTSD, CPTS-RI ≥ 40
- Data not returned or incomplete

Note: CQ = Coping Questionnaire; CPTS-RI = Child Posttraumatic Stress Reaction Index; STAIC-S = State Trait Anxiety Inventory for Children – State; STAIC-T = State Trait Anxiety Inventory for Children – Trait; CDI = Child Depression Inventory

CQ

The mean CQ score for all four participants increased from pre-treatment (mean = 4.3, on a scale of 1-7) to post-treatment (mean = 6.3), and for participants for whom data is available, and maintained at 3-month (mean = 6.1), and 6-month (mean = 6.2) follow-up assessment points.

STAIC-S

Scores on the STAIC-S presented on Table 10.2 indicate that for all four participants state anxiety was within the normal range at initial assessment, and reduced further at post-treatment. State anxiety maintained at low post-treatment levels for the three participants for whom follow-up data is available (S3.1, S3.3, S3.4).

STAIC-T

Scores on the STAIC-T show that trait anxiety was within the normal range for all four participants at initial assessment, reduced further at post-treatment, and maintained at similar levels at follow-up for each of the three participants for whom data is available.

CDI

CDI scores were below clinical cut-offs for depression for all participants at all assessment points. Three participants showed a reduction in scores at post-treatment compared to pre-treatment (S3.1, S3.2, S3.4), and one participant maintained scores at a similar low level (S3.3). Available follow-up data indicates that CDI scores maintained at similar levels to post-treatment at 3-months (S3.1, S3.3. S3.4) and 6-months (S3.1, S3.3).

TSCC

The TSCC results are presented in Appendix K. Given the extent of missing data and invalid responses, these were considered to be insufficiently meaningful to report here. However, where valid scores were reported, a reduction in symptoms was generally noted to below clinical levels by follow-up assessment.

Child Subjective Data

S3.1

At the outset of treatment, S3.1 noted that she would like help with, "Being less upset, coping with school, coping at home".

At 3-month follow-up, S3.1 took the opportunity to give feedback about her participation in the TF-CBT programme. She reported:

> I'm more calm, less fidgety. I'm more easier to talk with. I lie and steal less. I am able to stop myself from lying and stealing and I think of the consequences.

S3.1 reported that the following had been particularly helpful:

> The relaxation thingies – the breathing. I use it whenever I'm angry. The fact that there's help. Sand trays – being able to express my feelings so I don't have to keep it in me any more, so someone else knows. The STAR Plan[29] – helped when it was needed – would probably still use it if I really needed to.

The only aspect S3.1 identified that had not been helpful was the timing of therapy, which meant she had missed out on school. When asked what she thought had helped the most, S3.1 stated, "All of it. My attitude has changed – I'm more calm."

S3.2

At post-treatment S3.2 reported that he felt proud about gaining control over his anger. He reported using the STAR Plan (see Appendix G) to deal with situations.

S3.3

At post-treatment S3.3 gave the feedback, "I'm more confident, not as scared as I was". She reported as most helpful, "Talking over the stuff, sand trays, normal talking about it". She noted nothing that had not been helpful.

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[29] See Appendix G for Study 3 participants' STAR Plans, presented as an example of children' personal versions of the coping skills template, and to give a flavour of the TF-CBT protocol in practice.

S3.4

At post-treatment S3.4 reported that his anger problem had reduced, he no longer had a "pornography" problem and he had more control of his "mouth" and his "fight picking attitude". At 3-month follow-up S3.4 continued to report that he remained free of trauma symptoms and had more control over his behaviour.

Parent/Caregiver and Teacher Results

As with Studies 1 and 2, the parent/caregiver CBCL and teacher CBCL-TRF data were considered too inconsistent to provide meaningful results. Factors that contributed to inconsistency included: Changes in caregivers (S3.1), changes in teachers (S3.1, S3.3, S3.4), parent(s) with cultural world view different from test developers and English as a second language (S3.2, S3.4), request to not involve school (S3.2, S3.4), and, linked to these issues, measures not completed, despite every endeavour made (CBCL; S3.2, S3.4; TRF, S3.3). Due to these difficulties, a decision was made not to pursue follow-up parent/caregiver quantitative measures for Study 3, but to gather qualitative data when possible. The quantitative data available is presented on Table 10.4, and considered along with collateral subjective data for each participant.

S3.1

Table 10.4 shows that CBCL scores at pre-treatment reported by S3.1's aunty (Ca1), with whom she was placed at the time, were clinically elevated for all symptom categories ($T \geq 64$). Concerns included "blanking out", "tuning out" when spoken to, over-eating, and a repetitive "butterfly dance". Profiles highlighted on the CBCL were social problems, attention problems, delinquent behaviour, and withdrawn behaviour. Best things were, "Despite problems in life she keeps trying; very positive and plucky".

At post-treatment S3.1's current (and third) caregiver reported scores within the normal range for internalising concerns. Clinically elevated scores for externalising and total behaviours were reported, although somewhat lower than at pre-treatment. Behavioural issues related to some difficulties with honesty and peer relationships within the foster home; however these were of less concern than at pre-treatment and the caregiver reported that she and S3.1 had been able to work through these issues together. Overall, the caregiver reported that S3.1 had "been good, she's very settled".

Table 10.3. Study 3: Parent/Caregiver and Teacher Scores on Child Behaviour Measures

Scales (*T* scores)	Participant	Assessment points	
		Pre-treatment	Post-treatment
CBCL Internal	S3.1	70*Ca1	47 Ca3
	S3.2	60 Mo	-
	S3.3	73*Ca	60 Ca
	S3.4	-	69*Mo
CBCL External	S3.1	75*Ca1	71*Ca3
	S3.2	52 Mo	-
	S3.3	54 Ca	57 Ca
	S3.4	-	74*Mo
CBCL Total	S3.1	78*Ca1	65*Ca3
	S3.2	53 Mo	-
	S3.3	68 Ca	61 Ca
	S3.4	-	75*Mo
CBCL-TRF Internal	S3.1	44 Te1	60 Te
	S3.2	-	-
	S3.3	-	-
	S3.4	-	-
CBCL-TRF External	S3.1	54 Te1	60 Te2
	S3.2	-	-
	S3.3	-	-
	S3.4	-	-
CBCL-TRF Total	S3.1	49 Te1	63 Te2
	S3.2	-	-
	S3.3	-	-
	S3.4	-	-

* Clinically elevated compared with age and gender norms ($T \geq 67$)
- Consent not given, not completed, or gave verbal report

Note: CBCL = Child Behavior Checklist completed by parents/caregivers; CBCL-TRF = Child Behavior Checklist Teacher Report Form completed by the child's teacher. (Mo=Mother; Ca=Caregiver (Ca1=first caregiver; Ca3=third caregiver); Te=Teacher (Te1=first teacher; Te2=second teacher).

At pre-treatment S3.1's teacher recorded scores in the normal range on all symptom categories on the CBCL-TRF. The teacher noted that S31's school work was somewhat below grade level. Some behavioural difficulties were noted, including not getting along with other pupils, poorly co-ordinated or clumsy, messy work, stealing, and unhappy/sad or depressed. Best things were her focus and diligence in the classroom. Overall, the teacher stated that S3.1 was working hard and generally behaving appropriately, but her learning and happiness were less than expected. At post-treatment S3.1's teacher reported no concerns on the CBCL-TRF.

S3.2

The CBCL for S3.2 was completed by his mother. She had some difficulty with this measure as English was her second language. She required assistance from the assessor to interpret the meaning of some items. Overall, the scores indicated S3.2 was functioning within a normal range in all areas. However, his mother noted withdrawn behaviour in the borderline clinical range. Such behaviours included: rather be alone, won't talk, secretive, sulks, sad, and withdrawn. She also noted anger problems and fighting with siblings.

At post-treatment S3.2's mother requested to give verbal feedback rather than complete a CBCL. She stated:

> (S3.2) is a lot more happy; not showing much anger any more – much less fighting between him and his brother since he has been having therapy. (He is) a little bit more close with me (his mother) and more friendly with his brother.

While teacher CBCL-TRF scores are not available, anecdotal collateral feedback was received from two sources. The police officer involved with the court case noted, "(S3.2) has come out of his shell since he has been seeing you…I feel the therapy is helpful". S3.2's CYF social worker reported that as a result of therapy, "(S3.2) has opened up; he is talkative, confident, positive".

S3.3

S3.3's caregiver completed the CBCL. At pre-treatment she reported clinically elevated internalising and total scores. Problem areas in the clinical range were withdrawn behaviour, somatic complaints, thought problems, attention problems, and anxious/depressed behaviour. Concerns expressed included S3.3 having many fears; such as of conflict, doing wrong, men she did not know, being hugged or shown affection, the dark, being left alone in the house, and fear of death/dying. She had nightmares and bad dreams. She had learning difficulties at school, which were improving with remedial help. Best things noted by S3.3's caregiver were that she was "a pleasant child who was very obedient and willing to please, has a sense of humour, takes care of chores and personal hygiene very well".

At post-treatment S3.3's CBCL scores were in the normal range for all areas. Her caregiver reported that since participating in the TF-CBT programme, S3.3 was:

> A lot more relaxed at home, more confident with other people and with having friends over to stay. (She is) feeling safe and secure at home. Doesn't need her glasses anymore; reading recipes better. More interested in doing other things – netball at school, dancing. No nightmares anymore – sleeping much better. Much easier to look after, a pleasure to be around the house; good company. Learning to look after pets – has a kitten.

At 6-month follow-up S3.3's caregiver gave mixed feedback. She reported that S3.3 (now 14) was much more confident about looking after herself, going to friends, and was very happy. However, in the last 3-months she had been "more anti" doing homework and chores, and had not been going to remedial help at school, wanting to be like others her age who did not need to go. S3.3 had been having contact with safe extended family and there were plans for her to spend more time with them, with a view to a permanent placement in their care.

S3.4

The initial parent interview was conducted in Samoan without the use of measures. S3.4's mother reported that she had noticed problems developing in the last two years of primary school, including S3.4 complaining of being teased and picked on by other

children. He had started to hit other children at school, and his father had been embarrassed about his behaviour and had hit him on a number of occasions. She reported that at home he "pushed his rights", including "backchatting" his parents, fighting with his brothers and picking on his sister. He had been in trouble at school for playing with matches and calling teachers names. His appetite was good, he slept through the night, did well at school academically, and was always helpful. S3.4's parents were aware of his disclosures of historic sexual abuse and had taken steps to ensure his safety, but did not consent to forensic processes proceeding. They consented to S3.4 having therapy to address his issues.

At post-treatment, S3.4's mother completed a CBCL with the help of the Samoan SSU therapist. While she reported clinically elevated scores in all areas, anecdotally she reported S3.4's behaviour was a lot better, and that he just needed to keep putting into practice what he had learned now. At 3-month follow-up she reported that S3.4 still had some behaviour problems, such as picking fights with his brothers, but overall he had maintained gains.

Study 3 Discussion

The results of Study 3 indicate that the developed manualised TF-CBT programme can be helpful in reducing PTSD symptoms and increasing coping for children typically referred to the agency. Notably, these four participants presented with serious multiple-abuse and trauma histories and represented diverse cultural backgrounds.

Study 3 was essentially an extension and replication of Studies 2 and 3, and sought to provide evidence for external validity in terms of generality of the developed TF-CBT protocol. In single-case research, the design relies upon intra- and inter-participant participant replications (D. L. Morgan & Morgan, 2003). While there were limitations to the intra-participant reliability of Study 3, particularly in terms of the trend of some of the baseline data and restricted follow-up data, as discussed below, overall the results support those of the previous two studies. Inter-participant replications showed that levels of PTSD symptoms consistently reduced and child coping consistently increased across the three phases of baseline, treatment, and follow-up. The repeated measures

results showed that co-morbid concerns showed a similar trend of reduction in symptoms. Parent/caregiver and collateral quantitative and subjective data generally supported the child data in indicating participation in the programme was associated with amelioration of concerns.

Study 3 provided a serendipitous result. By chance, two participants (both 13 year old boys) had provided detailed accounts of their abuse histories prior to treatment commencing; one as part of an ongoing forensic process during the baseline phase, and the other during the initial assessment interview. Notably, their PTSD symptoms reduced and coping increased correspondingly. The forensic interviewing and disclosure processes seem to have functioned as exposure. This appears to support the salience of exposure (i.e., telling the details of traumatic events in a safe environment with appropriate support available) in reducing trauma symptoms, and increasing coping. While the treatment phase was associated with further reduction and maintenance of symptoms and coping at clinically improved levels, the significant impact had occurred analogous with the telling of their trauma histories. Nonetheless, subjective data suggests that the treatment was helpful in reinforcing coping skills, particularly with regard to anger control and behaviour management, and increasing positive social connections, confidence, happiness, and general wellbeing. This is significant, as previous research has found that adolescent boys who have been exposed to sexual assault report, as had been the case for both these boys, constricted affect and a restricted range of emotions, intensified anger, and inhibition in interpersonal attachment (e.g., Pynoos & Nader, 1988). It has been suggested that these effects may be related to a feeling that no-one has ever experienced what they have, and gives weight to the usefulness of the TF-CBT approach, which enables such ideas to be challenged and laid to rest.

With respect to the influence of cultural factors, the results of Study 3 provide additional support for the findings of Study 2. With participants of Pakeha, Samoan, South American, and Eastern European/North African heritage, Study 3 provided an opportunity to test the TF-CBT programme with a wide diversity of cultural backgrounds/world views. Like Study 2, the results with this group of participants suggest that culture may be less salient in predicting treatment response for abused children than other factors (Cohen et al., 2001). For example, this study highlighted the

particular relevance of prior exposure opportunities and gender-related factors, as described above. Cultural differences may still have had an influence on results however. For example, the particularly dramatic impact on symptoms and coping observed for the Samoan boy may be explained by the therapeutic relationship he developed with the assessor as a result of his disclosures in the initial assessment and the ongoing connection with her due to safety monitoring over the baseline period. As noted in Study 2, for Samoan people, relationships and healing go hand in hand (Lui, 2003). In addition, Study 3 also highlighted difficulties in using Western-based measures with clients who have English as a second language and different cultural world views, similar to those noted in the Study 2 discussion.

With regard to parent/caregiver involvement, three participants had continuity of support throughout the assessment and treatment; two from parents and one from a stable caregiver. Notably, their response to treatment was rapid and lasting. The participant who experienced three changes in caregivers demonstrated an initial increase in symptoms, and a longer time-frame before symptoms reduced and coping increased. Ultimately, she appeared better able to respond to treatment once she had settled into a stable placement with a caregiver who was supportive of the therapeutic process.

There are a number of limitations inherent in Study 3. Variations to the design included unforeseen changes to baseline lengths, and missing baseline and follow-up data. As with Study 2, treatment length was extended for some participants, which increases the likelihood of the effect of maturation, history, multiple treatment interference or other extraneous variables on the outcome results (Kazdin, 2003). In addition, the original plan to collect 12-month follow-up data had to be abandoned due to restrictions on the data collection period. A notable limitation of Study 3, as with Study 2 and some of the follow-up assessments for Study 1, was that the therapist was also the assessor at follow-up intervals, as the independent assessor had left the agency. This may have influenced results in a direction more favourable to the research hypotheses, due to demand characteristics and reactivity of experimental arrangements (Kazdin, 2003). In addition, it is a limitation of the three studies to date that the treatment of all participants, with the exception of one child in Study 2, has been carried out by the researcher. While the use of a manualised treatment may potentially reduce the contribution of the therapeutic relationship to treatment outcome (Shirk & Karver,

2003), use of the manual by other therapists will allow the specificity of the programme to be better determined.

In summary, Study 3 provides further evidence for the usefulness of the TF-CBT programme in ameliorating concerns for multiply-abused children of diverse cultures, and indicated support for some of the other factors that may influence treatment response and outcomes. Study 4 attempts to address the limitations of the previous studies by utilising other therapists to deliver the manualised protocol, with independent assessors.

Chapter 11: Study 4

Other Therapists

Outline and Aims

The major research goal of Study 4 was to evaluate the effectiveness of the developed manualised TF-CBT treatment programme in reducing child posttraumatic stress symptoms and increasing coping in multiply-abused children when delivered by other therapists. The two therapists involved in Study 4 were both trainees in the agency, with qualifications in social work, counselling and/or psychology, and experience in child protection. They were of Samoan (TB) and Pakeha/Fijian (JT) heritage respectively. The pre-treatment assessments were carried out by either the independent assessor (LW; S4.2, S4.4), or the researcher (JF; S4.1, S4.3), and the subsequent assessments by the researcher. The research protocol was adhered to, although clinical and cultural matters were of course prioritised when clinical judgement and cultural consultation deemed it necessary for client safety, respect, or treatment outcomes. Treatment integrity was evaluated. Target and comorbid symptoms were monitored at pre- and post-treatment, and 3-, and 6-month follow-ups. Families and caregivers were involved and collateral data was collected.

Study 4 Participants

Four multiply-abused children aged 9-12 (2 boys and 2 girls) who met DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for PTSD participated in Study 4. In all cases, the abuse had been intrafamilial. This was a multi-cultural sample, reflecting the diverse range of cultural backgrounds of children typically referred to SSU. Participant characteristics are summarised on Table 11.1.

Table 11.1. Study 4: Participant Characteristics, History, and Current Circumstances

Partic-ipant	Sex	Age	Cultural Heritage	Abuse History	Diagnosis	*Severity of PTSD	Safety Issues	Placement issues
S4.1	F	12	New Zealand born Samoan	Physical abuse, emotional abuse, neglect	PTSD, anxiety symptoms, grief and loss from traumatic deaths of mother and brother, learning difficulties	Moderate	Lack of safe consistent caregiving; conflicted family dynamics, physical and supervisory neglect	Placed with CYF, ran away, placed with extended family, broke down, informal placement with school counsellor
S4.2	M	12	New Zealand Maori	Physical abuse, witnessing domestic violence, emotional abuse, neglect	PTSD, Social Phobia, Dysthymia, generalised anxiety symptoms, behaviour problems, learning difficulties	Mild	Intermittent contact with itinerant non-protective mother. Disclosed physical abuse from caregivers	Placed with extended family. One caregiver died during therapy. Subsequently placed out of Auckland
S4.3	M	11	Other (brother of S3.2)	Witnessing domestic violence, emotional abuse	PTSD, anxiety symptoms	Mild	Father in prison. Mother protective	Parents separated. Stable living situation with mother and siblings
S4.4	M	9	New Zealand born Samoan	Physical abuse, witnessing domestic violence, emotional abuse	PTSD, Generalised Anxiety Disorder (GAD)	Moderate	Mother not consistently protective; incident of contact with abusive ex-step-father/ inappropriate boundaries in sharing information with child	Initially placed with grand-parents, returned to mother's care during therapy

*As measured on the CPTS-RI

Method Pertaining to Study 4 and Results

Treatment Fidelity

A senior clinical psychologist (and experienced cognitive behavioural therapist) independent from the current research reviewed 30% of the audiotapes of treatment sessions with the one child in Study 4 who consented to this procedure[30]. Adherence to treatment content and session goals was rated 100% for delivery, and no alternate treatment strategies were identified.

Variations to Research Design

The participants were randomly assigned to weekly baseline lengths of 3, 5, 7, and 9 weeks. Three participants experienced delays between the initial assessment and planned treatment commencement (total weeks on baseline: S4.1, 13; S4.2, 15; S4.3, 23; S4.4, 9). The reasons here were similar to those of participants in previous studies: for example, placement changes, social worker and/or caregiver unavailability, and transport difficulties. In addition, two children failed to return two sets of baseline measures each (S4.2, S4.3). Like the previous studies, the baseline data on the graphs represents the measures collected over the requisite weeks of the baseline phase for each participant (data points on Figures 11.3 and 11.4 are in order of dates on the coversheets, and do not necessarily represent consecutive weeks).

Length of Treatment and Assessment Data

The 16-session TF-CBT programme was delivered flexibly, as described in the manual. Number of treatment sessions varied from 9-25, delivered over time periods ranging from 18-68 weeks (S4.1, 17 weeks, 41 weeks; S4.2, 17 sessions, 34 weeks; S3.3, 9 sessions, 18 weeks; S4.4, 25 sessions, 68 weeks). Extended treatment phases were related to a range of reasons, including parent/caregiver factors, placement difficulties, and care and protection and safety concerns, which at times needed to be addressed as a priority over continuity of treatment for the child.

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[30] S4.2 with JT. Note, that it was of course respected when children were reluctant to have therapy sessions audiotaped.

In terms of assessment data, one participant requested not to complete measures at six assessment points during treatment (S4.4; T13, T14, T17, T18, T19, T20), and at 3-month follow-up. This was of course respected. Follow-up data is available for one participant at 3-months (S4.3) and two participants at 6-months (S4.2, S4.4). While every endeavour was made, follow-up measures were not returned by three participants who were placed out of area at the time (S4.1, S4.2) or had been discharged from CYF involvement (S4.3). As for Studies 2 and 3, due to time restrictions on the data collection phase, the planned 12-month follow-ups were not carried out.

Caregiver Involvement

The parents/caregivers of all participants were involved in the assessment and treatment. However, there were variations and limitations to involvement due to a range of factors. S4.1 had a series of placements during the study and continuity of caregiver involvement was not possible. The involvement of S4.2's caregivers was limited due to foster care commitments and ill health, culminating in the death of his caregiving uncle and his subsequent placement out of Auckland. S4.3's mother was involved, with the support of her own SSU therapist, a registered psychologist with relevant training and experience who spoke her first language (the mother of S4.3 had already been involved in the TF-CBT programme with her older son, S3.2). S4.4 was placed with her grandparents at the outset of treatment, and subsequently returned to her mother's care; all were involved in the assessment and treatment.

Cultural Factors

It is of note that all children and their parent/caregivers involved in Study 4 were of cultural minorities (including Maori, Samoan and a recent migrant family). All strongly identified with their culture and, with the exception of the Maori caregivers, English was their second language. These cultural factors were addressed in a number of ways. The two Samoan children and their families were allocated to the Samoan therapist. The therapist of the other two families (JT) consulted liberally and as required with his Maori supervisor with regard to S4.2, and with a colleague of relevant cultural heritage (FM) with regard to S4.3.

On the basis of Study 2, the researcher guided the therapists to prioritise the world view of their clients and, within this framework, to use the TF-CBT as a tool-kit flexibly, as

intended, taking care to include all treatment elements. With regard to the use of Western based measures, given that the children were acculturated into the New Zealand Western-based education system and English was their first language, it was considered appropriate to use the child measures. However, the parent/caregivers were less acculturated, and English was generally not their first language. While endeavours were made to administer the parent/caregiver measures at the outset, if the preference was to give verbal feedback, this was respected.

Child Report: Continuous Measures

Overall Mean Results
CPTS-RI

Figure 11.1 shows that the level of posttraumatic stress symptoms of Study 4 participants decreased with treatment, and for three participants with data available, decreased further over a 6-month follow-up period. The overall average self-reported CPTS-RI score for the four children was in the upper *mild* range during baseline (Mean = 23.2, SD = 6.8), in the mid *mild* range over the treatment phase (Mean = 19.7, SD = 8.8), and below clinical levels for the participants for whom data is available at follow-up (Mean = 9, SD = 4.6), on a scale of 0-80.

CQ[31]

Figure 11.2 shows that Study 4 participants' overall level of coping increased with treatment and increased further over the following 6-months for three participants. The children's mean coping scores (averaged across the four participants' three self-identified target concerns) increased from 4.8 (SD = 1.3) during the baseline phase, to 5.8 (SD = 1.2) over treatment; and 7.0 (SD = 0.0) over follow-up for three participants (on a scale of 1 = *not at all able to help myself* to 7 = *completely able to help myself*).

Individual Results
CPTS-RI

Figure 11.3 presents the graphed weekly level of posttraumatic stress symptoms for each of the four participants across the baseline, treatment and follow-up phases. Study

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[31] Note, CQ4 results on perceived helpfulness of the TF-CBT programme are presented in Appendix J.
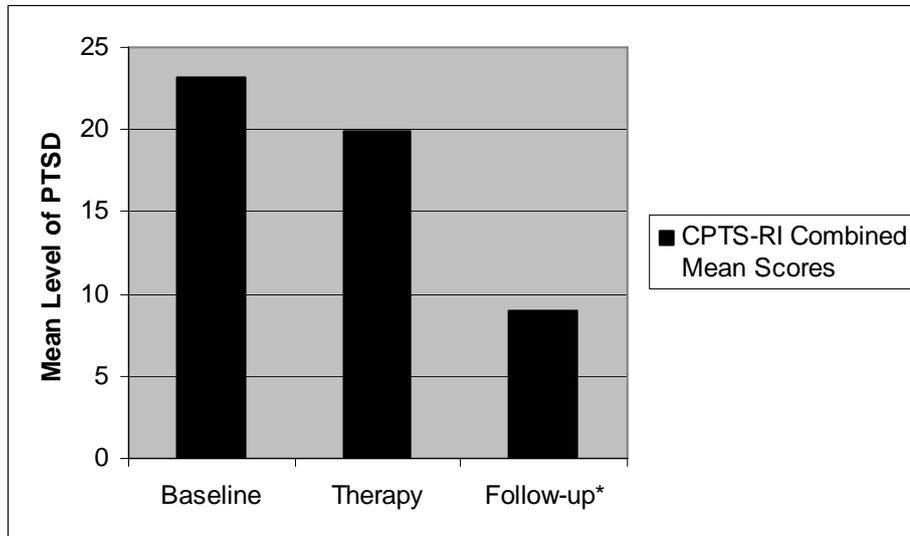
* 3 children, 3 data points

Figure 11.1. Study 4: Changes in mean level of PTSD symptoms (average of CPTS-RI scores for all four participants) across baseline, treatment, and follow-up phases.
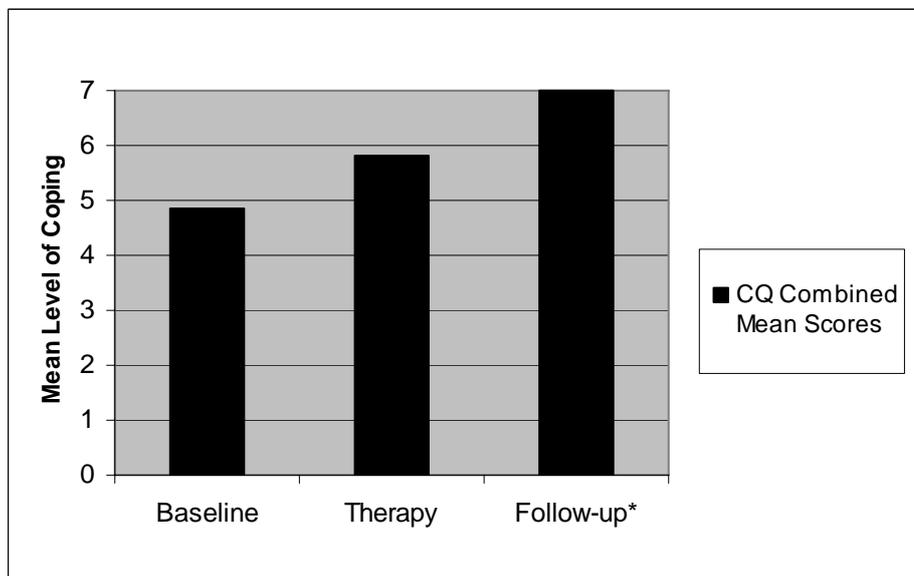
* 3 children, 3 data points

Figure 11.2. Study 4: Changes in mean level of child self-reported coping (average of CQ scores for all four participants) across baseline, treatment, and follow-up phases.

4 participants showed relatively little individual variability in baseline CPTS-RI scores, but some evidence of downward slope following initial assessment. As with previous studies, unique responses to treatment were demonstrated, generally with a reduction in symptoms. Available follow-up data indicated gains maintained below pre-treatment levels. The results are discussed using visual inspection and relevant qualitative data, as recommended in the single-case literature (Kazdin, 1982a).

Baseline

A stable baseline demonstrates little variability and an absence of slope. The CPTS-RI baselines of all four participants demonstrate variability well within the acceptable limits for single-case methodology in applied clinical research (50%; Kazdin, 2000). The individual baseline ranges and variability were 24-33 (11%), 23-25 (3%), 6-21 19%), and 23-35 (15%) on a scale of 0-80, for S4.1, S4.2, S4.3, and S4.4 respectively. However, three participants showed a downward trend immediately following initial assessment (S4.1, S4.3, S4.4), although only one had scores that continued to trend downwards (S4.3).

S4.1's and S4.4's CPTS-RI scores dropped from *moderate* to *mild* following the initial assessment. Both these girls were Samoan, and showed a similar pattern to other Samoan children in the research, further indicating the potential salience of engagement in setting in motion their healing. Notably, without further intervention, their baseline scores subsequently stabilised, although below the level of their scores at initial assessment.

Conversely, S4.3's CPTS-RI scores dropped and continued to track down over baseline, from *mild* to below treatment levels. Over this period, S4.3's father came before court and was sentenced to imprisonment for domestic violence. His mother reported that while S4.3 was sorry for his father, he was relieved that he was in prison and the family were safe. This is likely to have impacted on his PTSD symptomology, as triggering circumstances had abated. As with his brother, whose scores had also reduced to below clinical levels over baseline, S4.3's mother wanted him to have the opportunity to process his feelings, and was concerned about his ongoing well being and behaviour, particularly fighting with his siblings. Given overall clinical concerns, a decision was
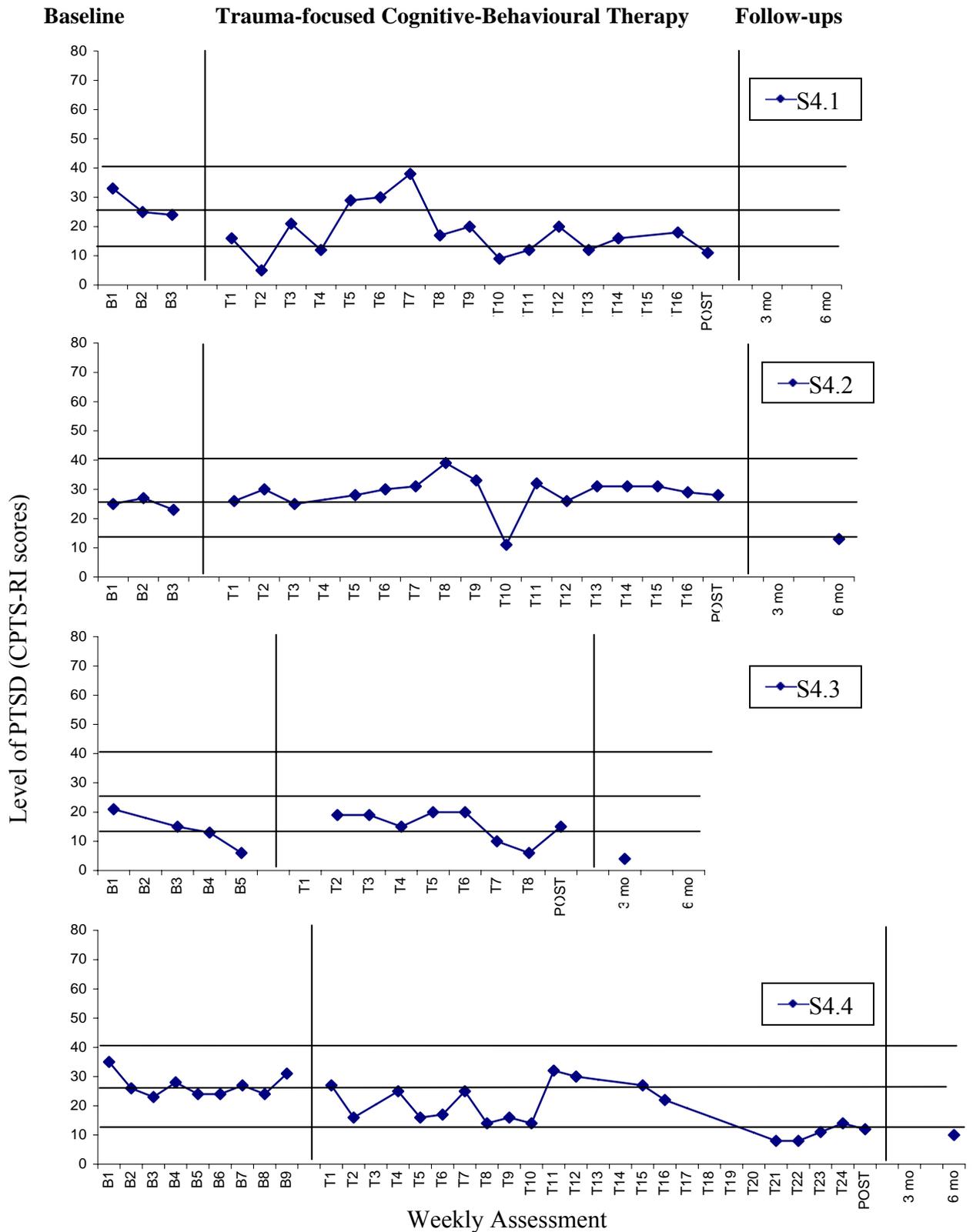
Figure 11.3. Study 4: Changes in posttraumatic stress symptoms (CPTS-RI scores) across assessment, treatment and follow-up sessions.

made to commence treatment with Phase 1 and 2 of the TF-CBT programme, and reassess the need for the exposure phase for treating PTSD.

S4.2 showed a stable baseline with respect to both variability and trend.

Treatment

Visual inspection of the CPTS-RI scores over the treatment phase indicates idiosyncratic patterns of response for Study 4 participants. These are reported with reference to qualitative data.

S4.1 showed a drop in PTSD symptoms associated with beginning therapy, apparently linked with developing a therapeutic relationship with her Samoan therapist. However, her symptoms increased over the coping skills phase. While she engaged well with the therapist, she found it difficult to apply these skills as she felt conflicted by family loyalties and her need to feel love and belonging. This was reflected when she ran away from the CYF foster home and back to her grandparents, where the abuse had occurred. Subsequently she was placed in an Aunt's care. While there were some concerns about this placement, S4.1 appeared to feel more emotionally supported, and better able to process past abuse and grief issues during the exposure and special issues phases. This placement subsequently broke down, primarily due to neglect issues, and S4.1 was temporarily placed with her school counsellor, where she continued to make treatment gains. Her treatment was concluded prior to all traumatic events having been processed, as she was placed in a residential school out of Auckland. Notwithstanding this, by post-treatment S4.1's CPTS-RI score had reduced to below clinical levels.

S4.2's CPTS-RI scores were in the *moderate* range during the early phases of treatment, with the exception of a reported reduction in PTSD symptoms to below clinical levels coinciding with the end of the coping skills phase. However, his scores subsequently rose and remained elevated in the *moderate* range throughout the remainder of treatment. S4.2 later disclosed that he had been getting physical abused in his placement. This is likely to explain the rise and ongoing elevation of his PTSD symptoms.

At the beginning of treatment, S4.3's reported CPTS-RI scores in the *mild* range, reducing to below clinical levels by the end of the coping skills phase. At this point clinical concerns had abated and it was decided to discontinue treatment. A slight spike in PTSD symptoms, back into the *mild* range, was noted at post-treatment, as can occur for children as they contemplate coping on their own without the support of therapy.

S4.4's CPTS-RI scores showed an initial drop coinciding with engagement with her Samoan therapist, demonstrating a similar pattern to S4.1. Her scores fluctuated in the *mild* range over the remainder of the psychosocial strengthening and coping skills phases of treatment. Over this time, S4.4 was living with her grandparents. An increase in scores to the *moderate* range during the exposure phase (T11) was associated with the outcome of a family meeting, in which she had been told by her mother that her therapist (TB) had not supported her return home. She was angry with TB, and did not want to continue with the trauma processing as this would involve talking about what had happened in the past. She thought TB would tell her mother and social worker, and this would jeopardise her return home. However, this was not the case, and S4.4 was returned to mother's care. A clinical decision was made to suspend the planned exposure sessions and address boundary and safety issues with individual parent and family sessions. Over this period, S4.4's scores remained in the *moderate* range. Once the family sessions were completed, it was agreed she would resume the TF-CBT programme (T15). She was now able to process her past abuse trauma via a series of sand trays and her CPTS-RI scores dropped to below clinical/borderline *mild*.

Follow-up

Available follow-up data shows that for three participants, PTSD symptoms decreased further, to below clinical levels (S4.3, 3-month follow-up; S4.4, 6-month follow-up) or borderline *mild* (S4.2, 6-month follow-up).

CQ

Figure 11.4 presents each child's self-reported coping over the baseline, treatment, and follow-up phases. For three participants, the baseline CQ data is stable in terms of
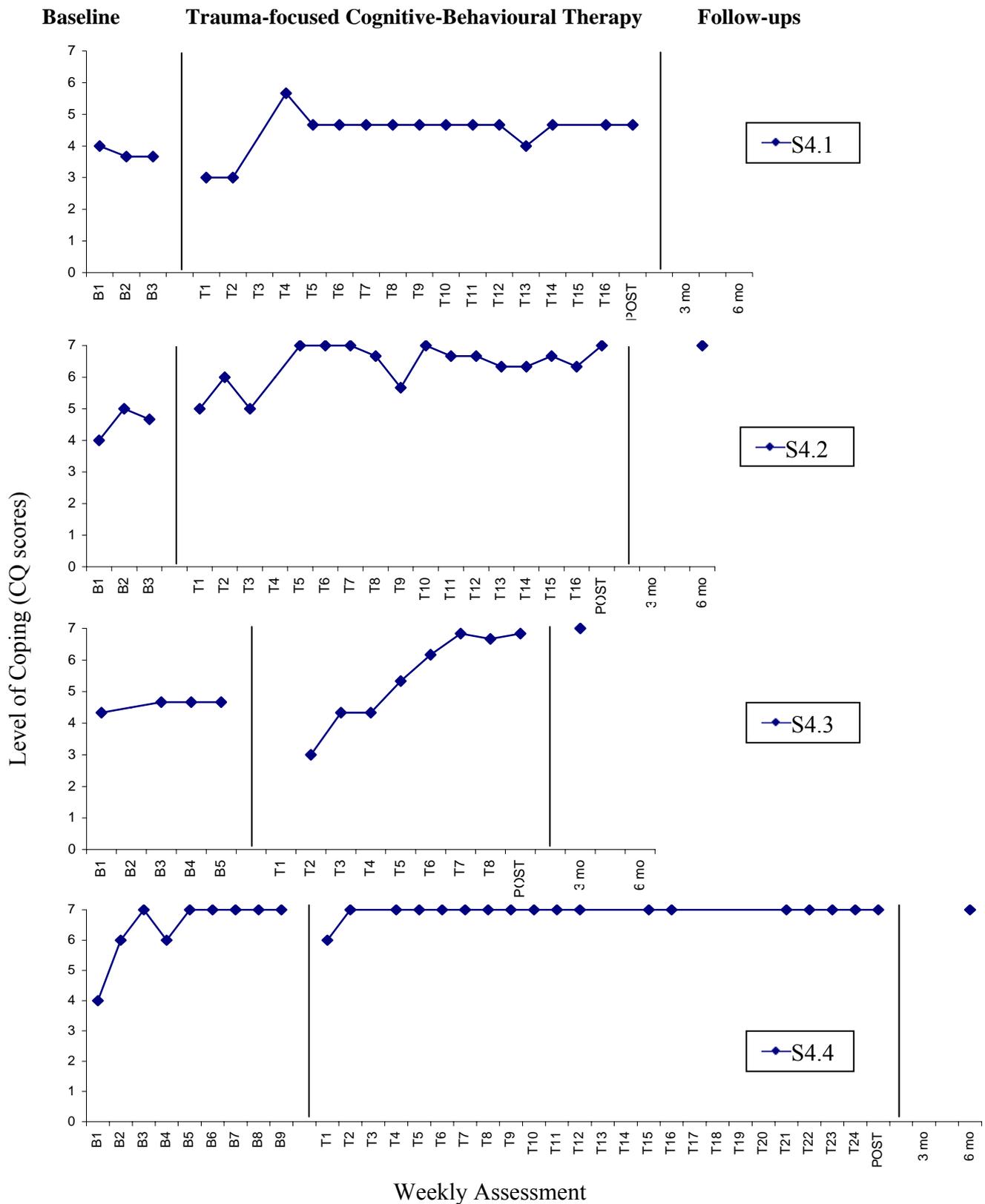
Figure 11.4. Study 4: Changes in child reported coping skills (average of scores for three target concerns) across assessment, treatment and follow-up sessions.

variability and trend. One participant (S4.4) reported an increase in coping after the initial assessment, and subsequent stability at a high level. Over the treatment phase, child coping showed an upward trend, or stability at a high level. Available follow-up data indicates maintenance of treatment gains at high levels of coping.

Baseline
For the CQ, the individual baseline ranges and variability were within acceptable limits: 3.7-4.0 (4%), 4.6-5.0 (6%), 4.3-4.7 (1%), 4.0-7.0 (43%), on a scale of 1-7, for S4.1, S4.2, S4.3, S4.4 respectively. Three participants demonstrated a stable baseline with regards trend, while one participant demonstrated an increase in coping following the initial assessment (S4.4). This was the youngest Samoan child, and as discussed, this may reflect the salience of engagement and instilled hope on her self-perceived ability to cope.

Treatment
Notably, all four participants in Study 4 demonstrated an increase in coping with treatment. For S4.1, this was marked during the psychosocial strengthening phase, and maintained at high levels throughout the remainder of treatment, despite the difficulties she was experiencing, as described.

Likewise, S4.2 showed an increase in coping, particularly after the last session of the psychosocial strengthening phase. His coping generally maintained at high levels over the coping skills phase, to the highest level (7/7) at post-treatment. Like S4.1, this was regardless of the difficulties he was experiencing, including, in his case, ongoing incidents of physical abuse and related elevation of PTSD symptoms.

S4.3's coping increased in a smooth curve over the first two phases of treatment, to very high levels by the end of the coping skills phase.

S4.4's self-reported coping increased at the outset of treatment to the highest level, and maintained at this level for the remainder of treatment. Like S4.1 and S4.2, S4.4 appeared to maintain her new-found coping in the face of ongoing trauma triggers, trust issues, and placement difficulties.

Follow-up

For the three participants for whom follow-up CQ data is available, self-reported coping maintained at highest levels at 3-months (S4.3), and 6-months (S4.2, S4.4).

Child Report: Repeated Measures

Child report repeated measures scores related to target concerns and co-morbid problems are presented on Table 11.2. These data fill out the symptomatology picture for participants at pre- and post-treatment, and follow-up assessment points.

CPTS-RI

At pre-treatment, the mean CPTS-RI score for Study 4 participants was in the *moderate* range (mean = 28.5).   Three participants reported scores above clinical cut-off for *moderate* PTSD (S4.1, S4.2, S4.4), and one for *mild* PTSD (S4.3). At post-treatment S4.2 reported PTSD in the low *moderate* range and the other three participants reported scores in the low *mild* range (S4.3, S4.4), or below clinical cut-off (S4.1). At follow-up, the three participants for who data is available reported a further reduction in PTSD symptoms to below clinical cut-off (S4.3, 3-month follow-up; S4.4, 6-month follow-up) or low *mild* (S4.2, 6-month follow-up).

CQ

The mean CQ score for all participants increased from pre-treatment (mean = 4.1) to post-treatment (mean = 6.4), and for participants for whom data is available, increased further at follow-up assessment points (mean = 7.0) on a scale of 1-7.

STAIC-S

STAIC-S scores indicate that two participants had elevated state anxiety at pre-treatment (S4.2, S4.3). Missing data at post-treatment due to the STAIC-S form being mistakenly omitted from the assessment package does not allow pre- and post-treatment comparisons to be made. However, available follow-up data indicates state anxiety in the normal range for these two participants, as well as for S4.4, as would be hoped.

Table 11.2. Study 4: Child Report Scores on Repeated Measures of Target and Comorbid Symptoms

Measure	Participant	Assessment Points			
		Pre-treatment	Post-treatment	3-month follow-up	6-month follow-up
CQ	S4.1	4.0	4.7	-	-
(Mean)	S4.2	4.0	7.0	-	7.0
	S4.3	4.3	6.8	7.0	-
	S4.4	4.0	7.0	-	7.0
	Mean	**4.1**	**6.4**	**7.0**	**7.0**
CPTS-RI	S4.1	33*	11	-	-
(Total)	S4.2	25*	28*	-	13
	S4.3	21	15	4	-
	S4.4	35*	12	-	10
	Mean	**28.5**	**16.5**	**4.0**	**11.5**
STAIC-S	S4.1	-	-	-	-
(*T* score)	S4.2	61*	-	-	27
	S4.3	66*	-	42	-
	S4.4	25	-	-	28
	Mean	**50.7**	**-**	**42**	**27.5**
STAIC-T	S4.1	53	21	-	-
(*T* score)	S4.2	48	49	-	48
	S4.3	40	24	21	-
	S4.4	45	21	-	25
	Mean	**46.5**	**28.7**	**21**	**36.5**
CDI	S4.1	49	36	-	-
(*T* score)	S4.2	60	38	-	46
	S4.3	42	-	37	-
	S4.4	40	37	-	39
	Mean	**47.7**	**37.0**	**37.0**	**42.5**

* Clinically elevated scores compared with age and gender norms (CDI, $T > 65$; STAIC, $T \geq 60$)

* Clinical cut-off for moderate PTSD, CPTS-RI ≥ 25

- Data not returned or incomplete

Note: CQ = Coping Questionnaire; CPTS-RI = Child Posttraumatic Stress Reaction Index; STAIC-S = State Trait Anxiety Inventory for Children – State; STAIC-T = State Trait Anxiety Inventory for Children – Trait; CDI = Child Depression Inventory

STAIC-T

Scores on the STAIC-T show that trait anxiety was in the normal range for all participants at pre- and post-treatment, and maintained at similar levels at follow-up for each of the three participants for whom data is available.

CDI

CDI scores were below clinical cut-offs compared to age and gender norms for all participants at all assessment points. A reduction of scores from pre-treatment levels is noted.

TSCC

The TSCC results are presented in Appendix K. Due to the extent of missing data (partly due to the measure being mistakenly omitted from the follow-up assessment package) and invalid responses, these results were considered to be insufficiently meaningful to report here.

Child Subjective Data

S4.1

At post-treatment, S4.1 reported that the therapy had been helpful, especially being able to talk about her experiences and feelings.

S4.2

At post-treatment, S4.2 reported using "calm down tricks"; for example, "freeze-framing", whereby he was able to stop and think of an alternative, and then do that, such "walk away". He reported finding the measures really hard to do, and found it difficult to understand some of the questions on the measures.

S4.3

At post-treatment, S4.3 reported that the sessions had helped him, in that he didn't think so much about the bad moments in the past (i.e., domestic violence). Instead, he thought more about the good times. He said he was still worried about his Mum sometimes, but "not as much lately because she was doing alright". If he did worry

about her, he reported he would talk to someone about it (e.g., an adult family member). He stated he did not worry about his Dad, as his Dad had said he was comfortable where he was and that was a good place for him now (in prison). S4.3 said he had fewer anxious or nervous moments; instead he reported he felt "confident". For example, during the previous week he had felt OK about speaking in front of assembly at school, and not nervous like he had a previous time. He was able to identify actions and attitudes that had helped and coping thoughts he had used.

S4.4

At post-treatment, S4.4 reported the therapy had been helpful, although she had been reluctant to complete the regular measures and do the trauma processing because she had not wanted to be reminded about what had happened. She reported that the "STAR Plan" had helped her to know what to do when she was upset or angry. She reported having no more bad dreams or going to a different place in her mind because she did not have thoughts about the domestic violence and physical abuse any more.

Parent/Caregiver and Teacher Results

For Study 4, for reasons discussed (see also, Chapter 9), parent/caregiver results are based on qualitative rather than quantitative data. Due to incomplete or unreturned measures and/or changes in school (S4.1, S4.2, S4.4), or lack of consent to contact school (S4.3), CBCL-TRF reports were considered too inconsistent to be valid. Available subjective teacher reports are presented.

S4.1

At pre-treatment parent/caregiver data is not available for S4.1 as she was in temporary care, and disconnected from family members. At post-treatment, S4.1 had been re-united with her father and stepmother, although she remained in foster care. At this time, her father and stepmother reported that she was well and they had no concerns about her.

At pre-treatment, S4.1's school reported concerns about her academic progress, health and well being, and behavioural problems, including stealing and absenteeism.

At post-treatment, S4.1's school reported no behavioural concerns or social problems, although she was still academically behind her peers. She had been referred for a Special Education assessment and had been accepted for a place at a school for young people with special needs.

S4.2

At pre-treatment, S4.2's caregivers reported some behavioural difficulties at home, including anger and running away, but not the extent of the problems reported at school.

At pre-treatment, S4.2's teacher completed a CBCL-TRF. This indicated below average academic performance and behaviour problems.   His externalising score and total problem score were in the clinical range (EXT, $T = 74$; TOT, $T = 69$).   Individual scales indicated most concern for aggressive behaviour, withdrawn/depressed behaviour, attention problems, and rule-breaking. He was described as artistic and likeable when co-operative, but persistently off-task, with periods of non-compliance at school.

Post- and follow-up parent/caregiver data was not available for S4.2 due to placement break-downs and caregiver safety concerns.

At post-treatment S4.2 was attending an alternative 'Kaupapa Maori' Education Unit, where he had been referred due to behaviour problems at his previous school.   The Kaupapa reported that S4.2's behaviour had improved and he was not as reactive. The changes noted by the school appeared to coincide with a point in therapy where his therapist (JT) noticed "things seemed to click" and S4.2 began to use the coping skills to deal with situations as they occurred.

S4.3

At pre-treatment, S4.3's mother reported that her son had a lot of worries. She thought he was confused about the domestic violence that had occurred between his parents. She was also concerned about him fighting with his siblings.

While teacher reports are not available, as the family did not consent to the school being involved in the research, S4.3's mother reported that his teachers said he was so sad and

worried at school that he could not do his school work. However, his behaviour was good, and he was very helpful at school.

At post-treatment S4.3's mother reported no concerns about her son's emotional wellbeing or behaviour.

S4.4

At pre-treatment, S4.4's caregiving grandmother reported that S4.4 was scared and worried due to past traumatic events she had experienced, including a family death, domestic violence, and physical abuse. Her grandmother noted concerns including bad dreams and nightmares, getting upset, avoiding reminders, not sleeping well, irritability, attention problems, and being on the lookout. Behaviour problems included restlessness, not listening, butting in, lying, rule-breaking, losing her temper, and being physically cruel or annoying to people.

At post-treatment, S4.4 had returned to her mother's care. Her mother stated she believed the therapy had been helpful for S4.4, who had enjoyed coming to sessions. She reported S4.4 was no longer having bad dreams and did not get as angry with her younger sister.

At pre-treatment, S4.4's teacher completed a CBCL-TRF, and reported no concerns in the clinical range. S4.4 was helpful in class and open and honest. The teacher noted that S4.4 appeared confused about what was going on at home, and did not know where she was going to be living. She sometimes complained of loneliness and cried.

At post-treatment, S4.4's teacher at her new school reported that there were no concerns about her at school, although she had cried quite easily at the start of term, but had since then had become more happy and outgoing.

Study 4 Discussion

The results of Study 4 show that the TF-CBT programme can be helpful in reducing PTSD symptoms and increasing coping in abused traumatised children when delivered

by other therapists. In this case, the two therapists involved were trainees in this speciality area of psychotherapy, notwithstanding their considerable experience in child protection. The four participants in Study 4 presented with serious multiple-abuse and trauma histories and represented diverse backgrounds.

This single-case multiple-baseline replication provides support for the overall effectiveness of the programme, regardless of therapist. Notably, the pattern of results was similar to that of the previous three studies. Inter-participant replications demonstrated that levels of PTSD symptoms generally decreased and coping increased over the three phases of baseline, treatment, and follow-up. The repeated measures of co-morbid concerns showed a similar tendency of reduction in symptoms. Though qualitative in general, parent/caregiver and teacher reports provided support for the helpfulness of the TF-CBT programme in ameliorating child problems and increasing well being.

As with the previous three studies, Study 4 participants demonstrated an idiosyncratic pattern of response to assessment and treatment. The continuous data highlighted the likely effect of a range of variables on treatment outcomes. Importantly, improved outcomes appeared to be associated with positive therapeutic engagement, the involvement of supportive parent/caregivers, and resolution of external trauma triggers and safety concerns.

A lack of treatment response appeared to be linked with factors such as conflicted family dynamics, disruption in therapeutic engagement, and current safety concerns. As would be expected, the TF-CBT programme may not be effective in ameliorating symptoms when children are experiencing current conflict, abuse or neglect, as noted in previous studies (e.g., Study 1; S1.1, S1.4). For example, in this study, for one participant, despite an increase in coping scores and subjective reports that he was using the coping skills to deal with situations, his PTSD symptoms did not reduce until follow-up, when he was in a safe placement.

Cultural and age-related factors may also have influenced outcomes in Study 4. For example, the salience of the therapeutic relationship in supporting healing for Samoan children was noted, supporting a similar finding in Study 2. In addition, while there

may have been other factors at play, the youngest child in Study 4 required more sessions to integrate the treatment elements, comparable to the results for other younger children in the research (e.g., S1.1, S1.4, S2.3).

Study 4 has a number of strengths.   The effectiveness of the manualised TF-CBT approach was demonstrated with other therapists delivering the programme to children and their families representing a range of multiple-abuse histories and cultural backgrounds. Cultural issues were carefully addressed, drawing on the learning from Studies 2 and 3. In addition, treatment integrity was established. However, there are a number of limitations. The sample was small, with only two therapists having seen two children each. Three children waited for treatment to commence much longer than the planned baseline period, although visual inspection of the continuous data suggests that this did not appear to result in reduction in symptoms or increase in coping. As with Study 3, treatment length was extended to over six months in two cases, and up to a year in one case, increasing the likelihood of the effect of time or other extraneous variables on their outcome results. A further limitation was that, on occasion, when the assessor was not available, treatment and follow-up measures were administered by the therapist. In these cases, the child was told that he or she was completing them for the independent assessor to reduce the reactivity of the experimental arrangements. This may have increased the risk of participant's responding favourably due to demand characteristics with respect to pleasing their therapist.   In addition, the fact the researcher was an assessor in this study may have created a potential bias in the results due to experimenter expectancy.

Perhaps of greater concern with regard to the validity of the results derived from the quantitative measures in Study 4 was the fact that all participants were of cultural backgrounds and world views different to that of the test developers. This led to expressed difficulties in understanding questions on the measures, reluctance to complete measures, and unknown effects on the results. Furthermore, there was considerable missing quantitative data for Study 4, for a range of reasons. Problems with the use of outcome measures noted for Study 4 are similar to those for the previous studies. This will be considered as part of a discussion on the overall limitations of the research presented in the following chapter.

Chapter 12 presents a general discussion summarising and integrating the results of all four studies, with overall implications of findings and future directions.

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Chapter 12: Discussion

Summary and Conclusions

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Outline and Aims

This chapter presents the overall findings of the four studies with reference to the research purpose, as delineated in Chapter 6. The results are interpreted in terms of past literature, and implications are discussed. Limitations of the current research and suggestions for future research are outlined. A final conclusion is presented.

Summary of Major Findings

The primary purpose of the current research was to develop an effective treatment programme for children with PTSD from CA. A manualised 16-session TF-CBT programme was developed based on relevant theory, empirical research, local practice and contextual factors. It was evaluated over a series of four single-case multiple-baseline studies with four groups of four multiply-abused children diagnosed with PTSD at referral to the specialist clinic of the statutory child protection agency in New Zealand (see Chapter 7 for details of abuse-types and co-morbid problems). Overall, the results indicated that, compared to pre-treatment levels, the majority of participants demonstrated (a) a reduction in PTSD symptoms to below clinically significant levels, (b) an increase in coping behaviours related to specific abuse and trauma related concerns, (c) amelioration of co-morbid concerns, and (c), for those participants for whom data was available, treatment gains that maintained or improved over 3-, 6-, 12-month follow-up intervals. Specific objectives met with respect to each study are as follows.

The results of Study 1 were promising in suggesting the usefulness of the manualised TF-CBT programme with four Pakeha/New Zealand European children, the most

commonly referred cultural group to the agency. Overall, PTSD symptoms reduced, coping increased, and co-morbid concerns improved with treatment. Treatment effects were generally durable over 12-month follow-up intervals.

Study 2 results indicated the approach can be helpful for children of Maori and migrant Pacific heritage (i.e., Samoan), when flexibly adapted to meet the needs of these children and families and delivered in the context of a culturally sensitive collaborative therapeutic relationship. Overall, PTSD symptoms decreased, coping increased, and comorbid concerns ameliorated with treatment. The follow-up results, while limited to two children (one Maori and one Samoan), showed treatment gains improved over a further 6-month period. The manual was updated to provide guidance for working with indigenous and migrant cultural groups.

Study 3 was an extension and replication of Studies 1 and 2, with the researcher as therapist using the fully developed TF-CBT protocol. The results showed an overall reduction of PTSD symptoms and an increase in coping with treatment in a sample of typically referred children with serious multiple-abuse histories, representing diverse cultural backgrounds. Available follow-up data indicated that treatment gains maintained at 3- and 6-month intervals.

A senior clinical psychologist (and experienced CBT therapist) independent from the research assessed therapist adherence to the treatment protocol and found 100% integrity.

Study 4 was a replication of Study 3 with therapists other than the researcher delivering the developed TF-CBT programme with a group of typically referred children. The overall pattern of results was similar to that of the other three studies, and provided support for the overall effectiveness of the programme, regardless of therapist.

The independent assessor found 100% integrity for the therapist for whom treatment adherence monitoring was able to be carried out.

As the findings of each study have already been discussed in detail in previous chapters, the following discussion considers common themes and integrated study outcomes.

Interpretation and Implications

Bearing in mind the methodological limitations discussed in Chapters 8-11 and summarised in a later section here, a number of common themes emerged in the data. These are related to theory and previous research, and integrated outcomes are presented. Implications for clinical practice are noted.

Treatment Fidelity

The manualised TF-CBT programme is designed to be adaptable for children with different needs, using the flexible treatment elements provided. Fidelity to the treatment protocol was found to be very high across two studies. While this result is based on limited treatment integrity data, and also may reflect the inherent flexibility, nevertheless, it suggests that the results reflect the TF-CBT approach as described in the manual with respect to these two therapists. As recent commentators on evidence-based treatments in CA have noted, when using manualised treatments, an understanding of the underlying theory-base and good general clinical practices are necessary to deliver these competently, and adapt to case-by-case variations (Chaffin & Friedrich, 2004).

Treatment Response Patterns

While the overall results for all four studies showed remarkably similar patterns (see Figures 8.1, 8.2, 9.1, 9.2, 10.1, 10.2, 11.1, 11.2), the single-case design enabled the idiosyncratic responses to treatment of individual participants to be discerned. Patterns of response to the treatment phases are described here.

While participants demonstrated a range of responses to the psychosocial strengthening phase, the coping skills phase was often associated with an improvement in PTSD symptoms and an increase in coping. For many children, the exposure phase appeared to bring about a temporary increase in symptoms while past trauma was processed (e.g., S1.1, S1.2, S1.3, S1.4, S2.3, S2.4, S3.3, S4.1, S4.2, S4.4). For participants for whom follow-up data is available, treatment gains generally maintained or continued to improve (e.g., S1.1, S1.3, S.4, S2.1, S2.2, S3.1, S3.3, S3.4, S4.2, S4.4). Overall, the results suggest that the children continued to experience relief from symptoms and an increase in coping as a result of the treatment elements.

This is consistent with previous treatment outcome research, which has shown the long term effectiveness of CBT coping skills on anxiety-related problems in children (Kendall & Southam-Gerow, 1996), and the usefulness of systematic desensitisation and exposure in resolving trauma-related symptomalogy in children (Farrell et al., 1998; Saigh, 1987) and adults (Foa & Rothbaum, 1998; Foa et al., 1991). These findings also make sense in terms of research on sequelae, as well as theory. PTSD in abused children has been associated with negative abuse-related attributions and a coping style that is more avoidant and less approach based (Cohen & Mannarino, 1996; Linning & Kearney, 2004). Theory-based behavioural and cognitive approaches, that is, exposure-based processes, while for a therapist can seem counter-intuitive to implement, actually work to desensitise physiological and associated behavioural responses. Likewise, targeting cognitive coping means the child has a template to use to manage not only current, but also future difficulties. This was borne out in the subjective reports at post-treatment and follow-up intervals, when children often reported that they used cognitive coping techniques they had learnt in therapy (e.g., S1.2, S1.3, S2.2, S2.4, S3.1, S3.2, S4.2, S4.3, S4.4).

Developmental/Age Responses

Consistent with other studies on CBT for anxiety and abuse and trauma-related problems, treatment response appeared to vary with developmental/age level (Cohen et al., 2000; Kane & Kendall, 1989). In the case of the current research, the results suggested that younger children may take longer to integrate the coping skills into their every day lives than adolescents (e.g, S1.1, S1.4, S2.3, S4.4). This may be partly explained by the level of cognitive development required to assimilate the cognitive elements of the TF-CBT programme (other factors may also have contributed, as discussed below, e.g., safety and relationship issues). A theoretical rationale for this finding is provided by the developmental theories of Piaget (Piaget, 1958) and Vygotsky (Vygotsky, 1981) (see Chapter 4), tempered by more recent perspectives which suggest that cognitive development may comprise a range of aspects that may develop at different ages and stages (Bolton, 2005). In this study, children as young as 10 and 11 appeared able to grasp the concept that thoughts were under their control and that they could use thoughts to regulate their behaviour (e.g., S2.2, S3.1), consistent with more recent research in this area (Bolton, 2005).

Duration of Treatment

Linked to this finding, children varied in the number of treatment sessions required to complete the programme (9-28 individual child sessions), and, relatedly, to demonstrate treatment responses to below clinically significant levels (up to 45 face-to-face contacts, including child and parent/caregiver booster sessions and social worker support related to implementation of the TF-CBT programme). A quarter of the participants required booster sessions. Broadly, this finding is convergent with that of other researchers in the area of CA trauma, who have similarly found that some children require as many as 40 or more sessions depending on the needs of the child and the complexity of the case (e.g., Deblinger & Heflin, 1996). In the current research, longer length of treatment appeared to relate to not just the developmental/age level of the child, but also to contextual factors. Not surprisingly, when children were exposed to situations in which their safety was at risk (and/or they were aware of safety concerns for significant others) whether physical or emotional, trauma symptoms were frequently re-triggered and/or remained elevated, and treatment gains were compromised (e.g., S1.1, S1.4, S2.3, S2.4, S4.2, S4.4). Theoretical explanations for these findings are to be found in neuro-developmental theories that describe the effects of trauma on the brain, and related physiological responses (e.g., Perry et al., 1995). Behavioural and cognitive models provide a rationale for children's avoidance reactions and cognitive processes that may require extended treatment (recognising, of course, that when safety is compromised avoidance may be an appropriate coping response). Related to these theories about individual functioning, attachment theory suggests that trauma-related relationship issues may require a more gradual process of intervention (e.g., Witten-Hannah, 2002). Notably, once these children were placed in a safe environment and/or safety concerns were resolved, they appeared able to implement the coping skills they had learnt in therapy, and their symptoms generally abated.

Attributions and Perceptions

The treatment response of a number of participants suggested that, regardless of the complexity and severity of the abuse history, if the child was able to process and resolve unhelpful abuse-related attributions and perceptions (e.g., inaccurately attributing blame to someone other than the perpetrator), treatment gains were made. Once again, this appeared to be age-related, as clinical observations suggested that adolescents seemed to be able to process unhelpful attributions more readily than younger children. These

findings suggest that age, current cognitions and related affect are particularly salient, and support those of other CA researchers, who have found that abuse-related attributions may predict treatment response more strongly than abuse-related factors such as identity of the perpetrator, abuse-type, or number of abusive episodes (Cohen & Mannarino, 2000). Mindful of the single-case design used, more research would be worthwhile to get a more differentiated picture and to assess whether the other factors suggested here do in fact reliably predict treatment response in this population.

Cultural Minorities

Previous research has found that culture appears to be less significant in predicting response to treatment than other factors, such as those described above (Cohen et al., 2001). The current research bears this out. Preliminary findings indicated that the TF-CBT programme was helpful for children and families of minority indigenous and migrant cultures in New Zealand, provided it was delivered in the context of a culturally sensitive collaborative therapeutic relationship and flexibly adapted to the clients' world view. This is consistent with current understanding that the important factors in engaging cross-culturally are flexibility of approach and respect of cultural perspectives (Banks et al., 2006). Interestingly, the positive treatment response of the minority children in the current research is consistent with findings of a recent meta-analysis that found greater treatment effect sizes for non-Caucasian sexually abused children (Hetzel-Riggin et al., 2007), which the reviewers suggest may be due to either having more problems to begin with, or that participants from minority cultures were given more attention by the therapist. Notably, the results of this study suggested another possible reason here; that for children of Maori and Samoan heritage, related to cultural views on healing, the therapeutic relationship may be particularly relevant in contributing to treatment outcome (see Chapter 9). Overall, the TF-CBT programme was found to be adaptable to delivery within a range of cultural world views (see Chapters 9, 10, 11).

Intrafamilial Abuse

Like other studies, the current research revealed the significant impact of intrafamilial abuse on children's lives and child outcomes (E. C. Herrenkohl et al., 2003; Zielinski & Bradshaw, 2006). Children in this research study invariably had limited or no contact with at least one parent due to care and protection concerns. In almost all cases, this resulted in the children worrying about their parent(s), and related elevated anxiety. As

discussed previously, attachment theory suggests that these symptoms may be related to an insecure attachment caused by CA trauma, attachment disruption, and physical or emotional unavailability of a parent (see Chapter 4). Significantly, abuse-related separation was found to be often associated with loss of connection not only to parent(s), but also wider family/whanau, and in the case of the Maori children in particular, loss of cultural identity. Research to date has suggested that the challenges intrafamilial abuse presents to children and nonoffending family members may outweigh the effect of other factors, such as cultural issues (Cohen et al., 2001). However, the results of this study suggest that intrafamilial abuse and culture appear to be intertwined in their impact on treatment outcome (see Chapter 9). While the TF-CBT programme could go some way towards addressing these concerns, loss of connection and loss of cultural identity were difficult to address unless family/whanau were available with whom to work therapeutically. Abuse-related separation issues and cultural factors require further treatment outcome research in order to establish effective interventions.

Parent/Caregiver Involvement

Parent/caregiver involvement in the TF-CBT programme varied considerably, as would be expected in a care and protection clinic setting. In this research, every endeavour was made to involve non-offending parents and/or caregivers in the treatment. This was achieved by administering this aspect of the intervention flexibly when necessary, for example, before and after child sessions and by telephone. In previous research, parent support has been found to predict treatment outcome in the area of children's PTSD as the result of sexual abuse (Cohen & Mannarino, 2000). Additionally, in the area of conduct disorder in youth, recent New Zealand research has highlighted the central role of family in facilitating and supporting positive treatment outcomes in youth (Curtis, 2004; see also, Ronan & Curtis, 2007). In the present research, it seemed that the salient factor was a supportive caregiver who was willing to be involved in the treatment, whether or not a parent. However, again, this more anecdotal finding requires more systematic data support.

Assessment Measures

In terms of the assessment measures used in the research, while multi-modal multi-source evaluations are recommended in the CA and child trauma literature in order to

obtain corroborating information, response-rate and consistency were problematic in this study due to the nature of the clinical population. For example, over half of the children experienced at least one change of caregivers and three quarters had at least one change of school during the research period. For two fifths of parent/caregivers, English was their second language. As has been found by other researchers in the CA area, parent and caregiver feedback seemed to vary with how well the adult knew the child and/or their own agenda, which at times seemed to lead to either under-reporting or over-emphasising child symptoms (Kendall-Tackett et al., 1993). In addition, as has been noted by child trauma researchers, internalising problems are not readily observable, and adults may rely on what a child tells them, contributing to discrepancies in reporting (Davis & Siegel, 2000). Importantly, significant difficulties were found with using measures based on a Western world view with children and families of indigenous and minority cultures, particularly when English was their second language. This supports the findings of previous research psychologists who have questioned the applicability of such measures with people of other cultures (Andary et al., 2003). As a consequence of these factors, the results of the current research highlight the need for researchers and clinicians to be aware of multiple factors, including potential biases, in pursuing multi-modal, multi-source assessment when evaluating a young person for abuse and trauma and measuring treatment progress and outcome. More recently developed assessment measures, such as the new Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescorla, 2007) which includes cross-informant comparisons and multicultural norms, may address these problems. However, New Zealand norms for the ASEBA CBCL/6-18 are not currently available, and development of local measures may ultimately be more beneficial. In addition, it is acknowledged that some practice settings may not have the resource capacity to pursue extensive data collection.

Treatment Acceptability

Importantly, the TF-CBT treatment package was generally perceived as acceptable and helpful by the children and families involved, as indicated by the subjective reports of children and parents/caregivers. In addition, quantitative child reports showed that the majority of children found the TF-CBT approach helped them to feel less upset while they were engaged in treatment, and these gains typically maintained at follow-up for the children for whom data is available (see Appendix J). Clearly, acceptability and

perceived helpfulness are linked with effectiveness in terms of treatment adherence and cooperation, as well as being a fundamental obligation for clinicians and treatment providers (N. J. King & Ollendick, 2006).

Research Design

While there are limitations to the current research, which are covered in the following section, as recent commentaries emphasising "local clinical science" have attested to (Chaffin & Friedrich, 2004; N. J. King & Ollendick, 2006), with the use of a single-case design methodology support, evaluation of treatment models such as the current TF-CBT programme is nevertheless imminently feasible in a day-to-day setting such as SSU, or indeed, in a range of child and family community mental health settings.

Limitations of the Current Research

The current research is limited by a range of methodological problems related to carrying out research in a day-to-day clinic setting within a child protection statutory agency, including the need to prioritise care and protection concerns over research protocol, resource capacity, and children and families who were involved with a service that, in most cases, they would rather not have in their lives. In addition, treatment at SSU is concurrent with the social work intervention, with unknown multiple-treatment interference. Other limitations relate to the study being small-scale and exploratory. Limitations have previously been discussed with respect to each study, and are reiterated and summarised here.

In terms of the external validity, the use of a single-case design, while having advantages also confers limitations. With small sample sizes, it cannot be assumed that the results can be generalised to other cases and other settings. While the replications carried out in current study provide initial findings regarding effectiveness across a number of conditions within a single setting, it is evident that the extent to which this manualised approach is appropriate, and what adaptations may need to be made, needs to be investigated for working with other populations in other settings.

A positive therapeutic relationship is considered essential for CBT with young people, including for those with anxiety disorders (Kendall & Southam-Gerow, 1996). While the use of a manualised treatment may potentially reduce the contribution of the therapeutic relationship to treatment outcome (Shirk & Karver, 2003), it is a limitation of this research study that a full assessment of treatment integrity was not carried out with all cases and all three therapists involved, partly due to this being a development project and the manual being finalised as the studies progressed, and partly due to the reluctance of children in this clinic setting to be audiotaped. This reluctance appeared to be particularly relevant for children of cultural minorities for whom English was a second language. Given the particular difficulties these groups were considered to face in participating in therapy, lack of consent to this further research procedure was of course respected.

Other threats to external validity related to the participants' awareness they were involved in a research study. A notable limitation of the research, largely related to resource capacity in the agency, was that, on occasion, when the assessor was not available, treatment and follow-up measures were administered by the therapist. In these cases, the child was told that he or she was completing them for the independent assessor to reduce the reactivity of the experimental arrangements. However, this procedure may have increased the risk of participant's responding due to demand characteristics with respect to pleasing their therapist, potentially influencing the results in a direction more favourable to the research hypotheses (Kazdin, 2003). In addition, the researcher was in the role of both therapist and assessor at times, which may have created a further bias in the results due to experimenter expectancy.

External validity can also be influenced by reactivity of assessment, test sensitisation, and timing of measurement (Kazdin, 2003). These threats are inherent to single-case designs that depend on continuous assessment. The main problem noted in this respect in the current research was that children tired of completing measures at every session, and at times appeared to "go on automatic" as they filled out their forms, and at other times, requested to not complete measures. Both these factors may have influenced the outcome results, although notwithstanding these observations, trends in the data do appear to be congruent with treatment effects noted clinically. In addition, generality of findings is limited due to considerable missing data, not only from children, but also

from parent/caregivers and teachers. Furthermore, the follow-up period for three studies is limited to 6-months, as the original plan to collect 12-month follow-up data had to be abandoned due to restrictions on the data collection period. Finally, the current study did not involve a re-administration of a diagnostic interview. Thus, while target and co-morbid concerns were tracked on self-report measures, it cannot be stated definitively that the children did not meet diagnostic criteria for PTSD at post-treatment following participation in the TF-CBT programme.

In terms of internal validity, attrition or loss of participants can be a threat. Two thirds of those approached ultimately completed the TF-CBT programme and remained in the research, although, as described, not all participants completed follow-up measures. This is considerably higher retention than most child, adolescent and adult psychotherapy treatment outcome studies, which indicate a drop-out rate of 40-60% (Kazdin, 2003). Selection effects were also limited, as a complete sample of all children who at referral were considered likely to meet diagnostic criteria for PTSD were included.

Variations to the research design arose due to the nature of this clinical population, and provided additional limitations to the outcome data and threats to internal validity. Notably, it was found to be impossible to adhere to the specified number of weeks each child was assigned to the baseline phase, due to a range of reasons. These included, as described in Chapter 7, changes in social worker, transport difficulties, school holidays, unavailability of parent/caregivers, and multiple changes in placements and schools. These factors also affected the total number of weeks a child spent in treatment, regardless of number of sessions required to treat their particular presenting problems. This may have resulted in increased effects of maturation and history on the outcome data. The multiple baseline design controls for these factors to some extent, in showing how change occurs in the dependent variables with introduction of the treatment. For example, a longer baseline may be of less concern in terms of the research if symptoms have remained elevated. Likewise, duration of treatment may be of less import given the ability to track patterns in the data related to treatment phases and known impacts outside of treatment.

Study 2 has a number of additional limitations, with further variations to the research protocol. As described, and based on cultural consultation, the assessment and therapy was carried by the same therapist for each child. Hence, the results may be skewed in a positive direction due to demand characteristics and reactivity of experimental arrangements (Kazdin, 2003). Children in Study 2 may have completed measures in such a way as to please the therapists. There may have been a particular risk of this with the Samoan children, who were raised to be obedient to adults. In terms of threats to internal validity the treatment phase was extended up to periods of over a year, for a range of reasons exacerbated by particular difficulties for indigenous and migrant populations (e.g., language barriers, limited resources). This increases the likelihood of the effect of other extraneous variables on the outcome results, as discussed above. The validity of the quantitative data may be limited not only due to gaps in the data, but also due to the measures not representing the world view of the participants.

Likewise, the majority of participants in Studies 3 and 4 were of cultural backgrounds and world views different to that of the test developers. This led to expressed difficulties in understanding questions on the measures, reluctance to complete measures, and unknown effects on the results. However, the use of subjective data enabled the participants to have a voice and provide open ended feedback on their experience.

Recommendations for Future Research

There are a number of suggestions for future research that arise from the initial findings of the current study:

1. Replication of the manualised TF-CBT programme in other SSU clinics. This is already underway on a case-by-case basis, but needs to occur using controlled single-case designs to ensure empirical validation.

2. Replication of the TF-CBT programme using single-case designs in other local clinic settings in New Zealand where abused traumatised children and families

may be referred. For example, child mental health services, non-governmental agencies and private clinics, particularly those that receive referrals from CYF.

3. Development and evaluation of the TF-CBT protocol using single-case designs for treating related populations of children who may present with trauma primarily from sources other than abuse, but where abuse may also have occurred. For example, refugee children and families.

4. Replication, development and evaluation of the TF-CBT programme in local child and family agencies in Australia and the Pacific, where populations may be similar to that studied here.

5. Dismantling studies to evaluate the effectiveness of particular treatment elements, for example; the role of parent/caregivers and wider family/whanau in facilitating treatment outcomes; the use of expressive therapies (i.e., sand-play therapy, art therapy, play therapy) for trauma processing.

6. Further development and evaluation of TF-CBT treatment elements targeting particular developmental/age groups, including children younger than in the current study (see also, Woolf, 2002).

7. Development and evaluation of treatment models/modules for treating trauma-related attachment and relationship problems related to intrafamial abuse.

8. Drawing on the latest developments in neurobiological and cognitive science, research linking mechanisms responsible for abuse-related outcomes in children (e.g., abuse-related attributions and perceptions, dissociation and hyperarousal) to refine and evaluate targeted treatment elements.

9. Further development on the interweaving of cultural models and TF-CBT, and evaluation with particular populations (see also, Feather, Ronan, Murupaenga, Berking, & Crellin, 2007).

10. For children of cultural minorities, further research into interventions for ameliorating loss of connection and cultural identity, particularly for those

children who have no available family/whanau available to participate in treatment.

11. Further research on development and evaluation of culturally sensitive outcome measures for this population. Evaluation of the new measurement system with cross-informant comparison and multicultural norms, and development of local norms (i.e., ASEBA; Achenbach & Rescorla, 2007).

12. Eventually, in order to determine whether the TF-CBT protocol is "efficacious", randomised controlled trials in at least two settings would be required.

Finally, in the light of these recommendations, continued updating and evaluation of the manualised TF-CBT protocol, drawing on theoretical, empirical, and practice developments in New Zealand and internationally, will ensure best-available treatment for traumatised abused children and their families.

Conclusion

The current research involved the development of a TF-CBT protocol for abused children with PTSD and their parent/caregivers in a day-to-day clinic setting, within the broader context of a statutory child and protection agency. The programme was evaluated using a single-case multiple-baseline design across four studies involving a pilot, a cultural trial, the completed protocol, and other therapists. Bearing in mind the limitations discussed, the results suggest that this is a promising treatment that can be effective in reducing PTSD symptoms and increasing coping in multiply-abused children. These results are encouraging, given the complexity of the presenting problems and current situations for these children, and the demands of the particular clinic environment.

Considering the CA experiences that lead to child protection involvement, the stresses involved with these processes, and, for those in care, the added impact of removal from home, it is evident that many children in CYF care warrant referral for mental health assessment and treatment (Brown, 2000). Although studies document the urgent need

for treatment, only recently have researchers begun to study mental health service use by children who have experienced CA (Landsverk et al., 2002). Studies of specific treatments for abused children are still relatively uncommon, despite compelling reasons to treat children, such as the international imperative provided by the United Nations Convention on the Rights of the Child (see in particular, article 39; United Nations (UN) General Assembly, 1989, November 17) and recent reviews that clearly indicate abused children function better with treatment (e.g., Skowron & Reinemann, 2005). Psychologists have begun to recognise the potential contribution we can make beyond our traditional role as clinical service providers. In particular, our skills may be best utilised as developers, adaptors, and evaluators of treatment programmes (Chaffin, 2006). The current research is at the vanguard of recognition of the crucial importance of evidence-based practice in CA/child protection settings, and an example of the contribution psychologists and therapists can make to ensure quality outcomes for this most vulnerable population of children and families.

In conclusion, despite the difficulties associated with carrying out clinical research with multiply-abused and traumatised children and their families and caregivers in a care and protection setting, and notwithstanding the limitations, this study has provided a unique contribution to treatment outcome research in CA/child protection in New Zealand. In addition to providing a valuable foundation for future evidence-based practice and research in this area, involvement in this project alleviated distressing symptoms and enabled ongoing coping skills to be integrated into the lives of the majority of children who participated.

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Appendix A

Definitions of Child Abuse[32]

The current practice of child abuse work in New Zealand has been informed by the recognition that it is not helpful to isolate types of abuse. In a current CYF publication, social workers are advised to consider that multiple types of abuse may be present. In fact, narrowing an investigation towards one type of abuse is thought to potentially endanger a child further. Moreover, failure to identify the full details of abuse may prevent the most appropriate intervention from being implemented. Social workers are trained to look for signs of abuse; including disclosures, and physical, behavioural, developmental, and parent/caregiver or family signs. They are also trained to consider other possible explanations, and to seek specialist assessment if required.

Legal Definition

Child abuse means the harming (whether physically, emotionally or sexually), ill-treatment, abuse, neglect or deprivation of any child or young person. (Section 2, Children and Young Persons Amendment Act, 1994)

Family Violence

For the purposes of CYF guidelines, family violence is defined in accordance with Section 3 of the Domestic Violence Act 1995 and the New Zealand Government Statement of Policy on Family Violence.

The New Zealand Government Statement of Policy on Family Violence defines family violence as: *a range of behaviours perpetrated by partners and former partners, family members, household members and within other close personal relationships.*

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[32] (The Risk Management Project, 1997)

Family violence encompasses:

- Physical abuse

- Sexual abuse

- Psychological abuse

Psychological abuse is defined as including intimidation, harassment, damage to property, threats of physical, sexual or psychological abuse, and (in relation to a child or young person) causing the child to witness the physical, sexual or psychological abuse of another person.

"Victims" refer to all victims of family violence, including children and young people who witness family violence.

Physical Abuse

Physical abuse is any act or acts that result in inflicted injury to a child or young person. It may include, but is not restricted to:

- bruises and welts

- cuts and abrasions

- fractures or sprains

- abdominal injuries

- head injuries

- injuries to internal organs

- strangulation or suffocation

- poisoning

- burns of scalds

Such injury or injuries may be deliberately inflicted or unintentional result of rage. Regardless of motivation, the result for the child, young person or person is abuse.

Sexual Abuse

Sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not. It may include, but is not restricted to:

- non-contact abuse
    - exhibitionism
    - voyeurism
    - suggestive behaviours or comments
    - exposure to pornographic material

- contact abuse
    - touching breasts
    - genital/anal fondling
    - masturbation
    - oral sex
    - object or finger penetration of the anus or vagina
    - penile penetration of the anus or vagina
    - encouraging the child or young person to perform such acts on the perpetrator

- involvement of the child or young person in activities for the purposes of pornography or prostitution.

Emotional/Psychological Abuse

Emotional abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person. It may include, but is not restricted to:

- rejection, isolation or oppression
- deprivation of affection or cognitive stimulation

- inappropriate and continued criticism, threats, humiliation, accusations, expectations of, or towards, the chid or young person
- exposure to family violence
- corruption of the child or young person through exposure to, or involvement in, illegal or anti-social activities
- the negative impact of the mental or emotional condition of the parent or caregiver
- the negative impact of substance abuse by anyone living in the same residence as the child or young person

Neglect

Neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or young person. It may include, but is not restricted to:

- physical neglect – failure to provide the necessities to sustain the life or health of the child or young person
- neglectful supervision – failure to provide developmentally appropriate and/or legally required supervision of the child or young person, leading to an increased risk of harm
- medical neglect – failure to seek. Obtain or follow through with medical care for the child or young person resulting in their impaired functioning and/or development
- abandonment – leaving the child in any situation without arranging necessary care for them and with no intention of returning
- refusal to assume parental responsibility – unwillingness or inability to provide appropriate care or control for a child or young person

Appendix B

DSM-IV-TR criteria for Posttraumatic Stress Disorder[33]

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror. **Note:** in children, this may be expressed instead by disorganised or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. **Note:** in children, there may be frightening dreams without recognizable content

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucination, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). **Note:** in young children, trauma-specific re-enactment may occur

(4) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

(5) physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

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[33] (American Psychiatric Association, 2000)

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of disturbance (symptoms in criteria B, C, and D) is more than 1 month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Specify if:

   Acute: if duration of symptoms is less than 3 months
   Chronic: if duration of symptoms is 3 months or more

Specify if:

   With delayed onset: if onset of symptoms at least 6 months after the stressor

Appendix C

Becoming a Local Scientist Practitioner

Article published in Social Work Now, 2004

Becoming a local scientist-practitioner

Jackie Feather reports on a model of clinical research all practitioners can use to examine their practice and enhance outcomes

As a psychologist I love to dwell on the art and science of my role. I have the privilege of working with children, young people and their families, along with their social workers, parents and caregivers, and other professionals. The dedication and passion of the practitioners involved, as well as the courage and willingness of the majority of our clients to participate in assessment and therapy, never fails to stir my heart. The art of my work is an interweaving of my training and experience, along with a good dollop of creativity, a sense of fun, and a belief that all people have the possibility of living a great life regardless of what may have happened to them. The science of my role is, of necessity, a little more deliberate. As practitioners we all use a scientific approach whether we are aware of it or not. There is enormous strength and potential in becoming cognisant of the scientific aspect of our work and using this to enhance not only the outcomes for our clients, but also our own job satisfaction.

> This approach brings the knowledge and attitudes of a scientist to the local setting

The 'scientist-practitioner model' is one of the models that provides the foundation for training and practice in clinical psychology but there is no reason why this model cannot be applied equally to social work or any other form of professional practice. Basically this approach brings the knowledge and attitudes of a scientist to the local setting in which the practitioner works, recognising the value of local observations and local solutions to problems (Stricker and Trierweilar, 1995). If you remember those science experiments at school, it's a similar process. We begin with a problem to solve (in this situation, a new case) and amass our tools (such as training, experience, resources, and those 'arty' things described already – passion, creativity, sense of possibility and so on). We assess the situation and come up with a plan (a 'hypothesis'). It is here that the application of science to practice can become a vibrant and interactive process. Ever asked a colleague for ideas? Remembered something you learned in training? Drew on something that worked

before? We all use these applications and supervision to help us formulate ideas and reflect on our casework. The distinction in becoming a scientist-practitioner is that this is developed into an intentional process. As with any scientific experiment, once the hypothesis has been formulated, it is tested. How do we know whether a case plan is effective? We gather evidence in a number of ways – talk to parents, caregivers and teachers, observe children, request reports from other professionals, consult with our supervisors and so on. If we are not satisfied with the results we create a new hypothesis and test it out. To express our work very simply, if we believe we have achieved the aim of safety and wellbeing for the child, we close the case.

The value in becoming an intentional scientist-practitioner is manifold. To begin with, the way we approach our work in the first instance can be grounded in science. What is the justification for the way we assess a situation and plan our intervention? For example, the Risk Estimation System (RES) is a social work tool which gives a picture of the strengths and risks and provides a clear rationale for targets for intervention. Similarly, it may only take a few minutes to email the Information Centre for a literature search on a particular issue where a key article may offer an approach that is effective and saves time. A familiarity with the scientific literature in the field and use of the tools available is the first step.

A second and more indirect benefit of science to the practitioner is the use of scientific thinking. In any situation there are many observations that can be made and avenues that can be followed. Your own 'theory of practice' provides

the lens through which you look and determines the choices you make. It is important to be aware of your own lens. A good way to do this is to sit down with your supervisor and brainstorm all the influences on your practice. For example, what is your cultural world view? What theoretical models of practice do you draw on? Are there any other beliefs that influence your practice? To what extent is there scientific evidence to support your beliefs?
In this way it is possible to evaluate the theoretical basis for your casework plans.

> Are there any other beliefs that influence your practice?

Thirdly, a scientific approach will pay attention to documenting change in order to evaluate interventions. For example, an initial assessment using tools such as the RES or Wellbeing Assessment will provide quantifiable data that can be reassessed for change following an intervention – 'pre' and 'post' testing being a very simple scientific method we can all engage in. Qualitative data can also be used. It is not uncommon for a practitioner to be presented with a lot of verbal information, but the trick for the scientist-practitioner is to ask the right questions at crucial times so that targeted data can be obtained. For example, a caregiver may be asked at the outset of a child's therapeutic intervention: what are the key issues for this child? The same question can be asked during and at the completion of therapy. Further detail around these issues can be obtained and documented.

Finally, a scientist-practitioner gains ample data from his or her work, which can be used to discover trends, identify useful interventions, develop resources and provide the basis for local research.

As an example, I would like to share with you a research project I have been carrying out at the Specialist Services Unit (SSU), Puawaitahi, based on the scientist-practitioner model. To begin with I wish to acknowledge and thank my manager, Dr Mary Dawson, and my PhD supervisor at Massey University, Dr Kevin Ronan, for their support and encouragement, my colleagues who have worked collaboratively with me, and the children, parents and caregivers who have participated in the research.

I was interested in learning more about how to maximise and measure the effectiveness of therapy conducted with children and young people at SSU. Through my training I was aware of evidence-based therapy, and I was also familiar with the therapeutic approaches that we use at SSU. A literature review established that there has been a major lack of research in New Zealand and overseas on effective psychotherapeutic interventions for children traumatised by abuse (James and Mennen, 2001; McFarlane, 2000). This was in spite of evidence that the trauma of abuse strongly influences children's affective, cognitive and neurobiological development, and that early comprehensive intervention may effectively reverse some of these changes (Streeck-Fischer and van der Kolk, 2000). Recent research has documented the prevalence of post-traumatic stress disorder (PTSD) in abused children as 21 per cent to 64 per cent depending on the nature of the abuse (Ackerman, Newton, McPherson, Jones and Dykman, 1998; Dubner and Motta, 1999; McClosky and Walker, 2000). Initial studies suggest that trauma-focused cognitive

behavioural therapy (TFCBT) may be effective and long-lasting in the treatment of PTSD in abused children (Cohen, Deblinger, Mannarino and Steer, 2003; Deblinger, Steer and Lippman, 1999; Kolko, 1996).

> **The programme has been tested with sixteen 9 to 15-year-olds presenting with PTSD as the result of multiple abuse**

Drawing on the literature about evidence-based approaches and our own existing clinical practice, I developed a 65-page manualised TRCBT programme designed to be used flexibly over 16-20 weeks. There are four phases to the therapy: psychosocial support and education, coping skills training, trauma-processing and special issues. Social work support and parent/caregiver sessions are an important part of the therapy.

The programme has been tested with sixteen 9 to 15-year-olds presenting with PTSD as the result of multiple abuse and referred to SSU for therapy by their social workers. All children and their parents/guardians consented to being involved in the research, which has been carried out with the ethical approval of Child, Youth and Family and Massey University.

There were four children in the pilot study, which involved initial testing of the draft treatment manual. The results were positive and showed that the therapy was effective, as indicated by the quantifiable and qualitative data collected throughout the assessment and therapy. The second study was carried out with two Māori and two Samoan children. This has been an exciting process of collaboration with my colleagues Paora Murupaenga and Tina Berking, and has entailed an interweaving of cultural and Western psychology models. The third study has involved the use of the

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developed manual by me as the therapist with four children from a range of cultural backgrounds, and the fourth study has entailed the use of the developed manual by other therapists. Final sessions, follow-ups and data analyses are currently being carried out. Overall results look promising, with some children resolving their trauma symptoms in 8-16 weeks, while others require a longer time period, particularly if there are ongoing issues, such as placement uncertainty.

So how was change documented and the programme evaluated? As with all children and families referred to SSU, there was an initial consultation with the social worker and a case plan was jointly formulated and signed off. A therapeutic needs assessment included a structured clinical interview with the child and the caregiver separately to gain a clear picture of the child's problems. This was augmented by a full battery of self-report checklists (which were all reliable and valid psychometric measures) that were completed by the caregiver, teacher and child pre-therapy. During therapy, three of the self-report measures targeting the child's specific difficulties were completed by the child every week. The full battery was again completed by the child, caregiver and teacher following therapy, and later at 3 month, 6 month and 12 month follow-ups. These checklists have provided ample quantitative data to enable the child's progress throughout therapy to be monitored and changes to be documented. Qualitative data has also been gathered by seeking feedback from the child, caregivers, and social worker throughout therapy as well as at the conclusion of therapy and at follow-ups.

> This is an appeal for all practitioners to consider becoming scientist-practitioners

Verbal reports by the children and their caregivers and their scores on the checklists all indicate that the children's coping skills have increased and their PTSD symptoms decreased by the end of the therapy programme. These results have been maintained over the follow-up period.

The thrilling part of being a scientist-practitioner is the ability to document the effects of your intervention in very specific ways. Scientific thinking reminds us to ask questions which give us information we may never have gained otherwise. Participants in this research have reported outcomes such as: "fewer or no bad dreams", "less upset when thinking about the abuse", "less jumpy or nervous". Young people report that they continue to use the coping skills that they have learnt. For example, at a 6 month follow-up S (aged 14) reported: "[When feeling upset] I talk to someone, do that breathing". Caregivers report positive results from the programme: "S is infinitely better. Cognitive behavioural therapy has been good for him – he has strategies for dealing with situations. It's made a big difference." It has also made a big difference to me to know that my work is helpful to my clients.

In conclusion, this is an appeal for all practitioners to consider becoming scientist-practitioners. Not only is this likely to benefit your own practice and outcomes for clients, but it also provides a basis for local research that can be used as evidence for the good work that we know we do in Child, Youth and Family. This can be shared with colleagues at site and at community level, as well as providing a springboard for developing models that can be presented nationally and internationally.

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Appendix D

Trauma-Focused Cognitive Behavioural Therapy for Abused Children with Posttraumatic Stress Disorder: A Pilot Study

Article published in New Zealand Journal of Psychology, 2006

Trauma-Focused Cognitive Behavioural Therapy for Abused Children with Posttraumatic Stress Disorder: A Pilot Study

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A manualised trauma-focused cognitive behavioural therapy (TF-CBT) programme was developed for multiply-abused children diagnosed with posttraumatic stress disorder (PTSD; Feather & Ronan, 2004). It was piloted with 4 children (aged 9-14 years) referred to a specialist clinic of the statutory child protection agency. The locally developed programme built on efficacious treatments for childhood anxiety and PTSD as a result of sexual abuse. It comprises psychosocial strengthening, coping skills training, gradual exposure using creative media, and special issues relevant to trauma and abuse. A multiple baseline design was used to demonstrate the controlling effects of the treatment. The results indicate a good deal of promise. PTSD symptoms generally decreased and child coping increased. Gains improved over 3, 6, and 12 month follow-ups. Results are discussed in terms of the value of clinicians engaging in local research aimed at increasing outcomes for their clients.

Child abuse (CA) statistics in New Zealand are alarmingly high. Violence against children leading to death is an indicator for non-fatal forms of CA. Of 27 wealthy nations, New Zealand had the third highest CA death rate (1.2 per 100,000) in the 1990's (UNICEF, 2003). Life time estimates of CA suggest that 4% to 10% of New Zealand children experience harsh or severe physical punishment and approximately 18% experience sexual abuse (Ministry of Health, 2001). It is commonly agreed by service providers in New Zealand that one in seven families experience family violence (Snively, 1994). Family violence encompasses child physical, sexual, and psychological/emotional abuse including threats and witnessing violence (The Risk Management Project, 1997). Notifications of suspected CA reported to the Child, Youth and Family Service of the Ministry of Social

Development (CYF) continue to rise. CYF statistics show that intakes to the end of June 2005 stood at 53,097, up from 43,314 the year before (to end of June 2004) and 31,781 the year before that (year to end of June 2003). CA requiring further action was established in approximately 85% of these cases each year (Department of Child Youth and Family Services, 2005).

Clinical and population studies have found that CA is responsible for long-term psychiatric disabilities, medical problems, substance abuse, learning problems, interpersonal violence and other serious social and health problems (Mullen, Martin, Anderson, Romans, & Herbison, 1996; Streeck-Fischer & van der Kolk, 2000). While recent researchers have emphasised the potential for growth rather than pathology (Christopher, 2004), reviewers have identified that many children who have been abused demonstrate adverse reactions in their

affective, cognitive, behavioural, and neurobiological development both in the short- and long- term (Berliner & Elliott, 2002; Glasser, 2000; Kaplan, Pelcovitz, & Labruna, 1999; Kendall-Tackett, Williams, & Finkelhor, 1993; Kitzmann, Gaylord, Holt, & Kenny, 2003; Kolko, 2002; Putnam, 2003). There is growing evidence that early comprehensive intervention may effectively reverse some of these changes and considerably lessen the long-term risk abused children pose to themselves and to society at large (Streeck-Fischer & van der Kolk, 2000).

It has been recognised that CA can lead to a pattern of psychological distress similar to that derived from other traumatic events (van der Kolk, Weisaeth, & van der Hart, 1996; Weaver & Clum, 1995). In 1980, the psychological effects of trauma exposure became subsumed under the diagnosis of Posttraumatic Stress Disorder (PTSD) (American Psychiatric Association, 1980). In 1987, it was acknowledged that PTSD can also occur in children (American Psychiatric Association, 1987). In fact, children appear to be the demographic group at highest risk for PTSD (e.g., Norris et al., 2002). Like adults, children show the cardinal tripartite grouping of symptoms: re-experiencing, avoidance and increased arousal (American Psychiatric Association, 1994). However, symptoms of PTSD in children may manifest differently at different ages, and other reactions can also occur (Terr, 1991; Yule & Williams, 1990). Interpersonal and separation

difficulties are common. Children may become irritable and angry with parents and peers. Some blame themselves for events (Yule, Smith, & Perrin, 2005). Co-morbid conditions may include depression, anxiety, oppositional behaviour and grief reactions (Ronan & Johnston, 2005).

Abuse-focused clinicians have argued that the trauma/PTSD conceptualisation does not specifically cover all manifestations of CA (Briere, 1992; Herman, 1992; Terr, 1991). Nevertheless, a PTSD diagnosis can help victims of CA gain understanding, acceptance and appropriate treatment. Recent research has documented diagnostic rates of PTSD in abused children of between 19% and 64%, with higher figures reflecting multiple traumatisation, younger age, lack of parental support, and other risk factors (Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Dubner & Motta, 1999; Lehmann, 2000; Pelcovitz, Kaplan, DeRosa, Mandel, & Salzinger, 2000; McCloskey & Walker, 1999; Norris et al, 2002).

Despite the fact that CA is so prevalent and an array of psychological treatment approaches have been developed and are in use clinically, until recently there has been little emphasis on studying the effectiveness of treatments (Skowron & Reinemann, 2005). Narrative reviews have variously concluded that psychological interventions for CA have generally been ineffective (Emery, 1989; Melton, 1994; O'Donohue & Elliott, 1992) or conversely, that some appear promising (Finkelhor & Berliner, 1995; Oates & Bross, 1995; Saywitz, Mannarino, Berliner, & Cohen, 2000). These conflicting reports reflect not only the particular samples of studies reviewed, and treatments used, but also some of the interacting and confounding effects which are inevitably present when working in real life settings with children with a history of abuse and violence. One of the issues underpinning a number of studies is a lack of rigour in the research designs used. Many researchers in the field have been reluctant to use experimental designs entailing no-treatment or placebo control groups because of the ethical issues related to withholding treatment

with this population (Skowron & Reinemann, 2005). Additionally, to date, the broad field of CA and its treatment has been characterised by specialised fields of interest and practice and a lack of a co-ordinated, planned approach to treatment outcome research (Saunders, 2003).

A recent meta-analysis has made a significant contribution by being the first to review quantitatively the effectiveness of psychological interventions for CA across a range of types of abuse, treatment modalities and types of comparison group (Skowron & Reinemann, 2005). The 21 treatment studies published between 1974 and 2000 included in the review had participants who had been referred for CA, child physical abuse (CPA), child sexual abuse (CSA), and/or physical neglect. One of the main inclusionary criteria was that the treatment had been compared with a control group from the same population, and results reported in sufficient detail to calculate or estimate effect sizes. The results showed that following intervention the treated clients appeared to be functioning better than 71% of control group participants. The average weighted effect was $d = .54$, a medium effect size (J. Cohen, 1988). This is a similar effect size to those found by other meta-analyses of psychological treatments for child-identified problems, and somewhat lower than others (Casey & Berman, 1985; Durlak, Fuhrman, & Lampman, 1991; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995).

However, treatments for sexual abuse were found to be associated with higher effect sizes (average ES, $d = .69$) compared to those for general forms of child maltreatment (CM) (average ES, $d = .40$). The authors also noted in particular a dearth of treatments developed and evaluated for CPA (physical abuse, $n = 1$ study found and included in the meta-analysis). In addition, it was noted that only a small number of studies included follow-up of immediate effects making generalisations not yet possible. Consequently, Skowron and Reinemann rendered the following conclusion and recommendation:

"In response, we encourage CM[1] treatment researchers to ...

obtain follow-up data on all clients completing treatments, because professionals who work with this group have long asserted that "sleeper effects," defined as the development of serious psychological symptoms at some point in time after termination of abuse, are likely present among victims of CM (Finkelhor & Berliner, 1995)" (p. 66).

Treatments for CA trauma reflect the fact that PTSD is an anxiety disorder. CBT treatment for child anxiety is currently considered to be the gold standard (Howard & Kendall, 1996; Kane & Kendall, 1989; Kendall, 1994; Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Sessa, & Siqueland, 1992; Kendall & Southam-Gerow, 1996; Kendall, Schroeder, Panichelli-Mindel, Southam-Gerow, Henin & Warman, 1997). CBT treatment has been established as "probably efficacious" for child anxiety (Kendall, Hudson, Choudhury, Webb, & Pimental, 2005). Strong and consistent impact has been demonstrated across a number of settings and countries, including Australia and New Zealand (Barrett, 1998; Barrett, Duffy, Dadds, & Rapee, 2001; Huzziff & Ronan, 2004). Importantly, treatment manuals are available for use in clinical work and as a basis for further research (e.g., in New Zealand, Girling-Butcher & Ronan, 2002; Kendall et al., 1992).

Given findings to date, practice guidelines recommend a variation of CBT, trauma-focused CBT (TF-CBT), for treating the specific problems of traumatised abused children (Saunders, Berliner, & Hanson, 2001). Treatment outcome studies on TF-CBT for abused children with PTSD have been published (J. A. Cohen, Berliner, & March, 2000; Deblinger, Lippmann, & Steer, 1996). While focused on CSA, the results of a recent multi-site, randomised controlled trial suggests the efficacy of this treatment for children who have experienced multiple traumas (J. A. Cohen, Deblinger, Mannarino, & Steer, 2004). The hallmark of CBT for anxiety and of the trauma processing approach for CSA is gradual exposure, linked in this area to the idea of creating a trauma narrative.

There is a need for more rigorous evaluation of the effectiveness of CA

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treatments with clinic-based populations of children who are typically multiply-abused with multiple problems (Saunders, 2003). Within the bounds of ethical and legal standards of care, this can be achieved by using control groups assigned to alternative psychological treatment whose effectiveness has been empirically established, or a community case management condition that is thoroughly documented (Skowron & Reinemann, 2005). However, clinic settings in New Zealand rarely have the resources or the client numbers for large samples to get sufficient cell sizes. Given such problems in real life settings, there has been the additional call for the use of single-case experimental designs in these situations (Saunders, 2003). In this way, local clinicians can draw on evidence-based research carried out in related areas elsewhere to develop and trial the effectiveness of treatment protocols for particular populations and problems. Ultimately, research can most scientifically inform clinical practice if research participants adequately reflect the population for whom the treatment is desired (Behl, Conyngham, & May, 2003).

A manualised treatment programme was developed in the local clinical setting for multiply-abused children with PTSD, typical of the population referred for assessment and therapy to the specialist unit of the statutory child protection agency in New Zealand. The manual presents a TF-CBT programme for abused 9-14 year old children with PTSD in a 16-session format with sessions for parents and/or caregivers (Feather & Ronan, 2004). The manual is designed to be flexible to cater for the range of issues which may present, and designed to be adapted to different developmental stages within this age range. It is based on a manualised CBT programme for children in this age range with anxiety disorders (Kendell, Kane, Howard, & Siqueland, 1990; Ronan & Deane, 1998). A key consideration in adapting an anxiety-based programme to the treatment of PTSD is that anxiety is about current and future threat whereas PTSD, while an anxiety disorder, also has much to do with a past event(s). Children who have PTSD are processing trauma and/or its sequelae in a way that often involves not only ongoing distress but also ongoing reminders (Ehlers & Clark, 2000). Hence, the aim of a treatment programme for PTSD needs to be to help children develop skills to manage their symptoms, and

to process trauma so that it is seen as a time-limited past event(s) that can be managed effectively by the child and his family/caregivers. A CBT approach holds that gradual exposure is necessary to reduce PTSD symptoms. This can be achieved using creative media to create a trauma narrative and desensitisation to trauma triggers in a safe therapeutic environment (Yule, Smith & Perrin, 2005).

Adapting a treatment for abused children involves special considerations. CA invariably affects the relationships children have with their family members and means the involvement of helping professionals in the child's life. Many children who come to the attention of child protection services are placed in care to ensure their safety. Removal from parents adds another layer of trauma for these children and necessitates forming new relationships with caregivers. The early part of the treatment programme is devoted to exploring and strengthening the child's psychosocial context as a basis for the later treatment interventions. Abuse-informed issues are incorporated in the treatment, as recommended in practice guidelines, such as psychoeducation about abuse and personal safety, and emotional processing of guilt,

Table 1. Participant characteristics, history and current circumstances

Participant	Sex	Age	Cultural Heritage	Abuse History	Diagnosis	Severity of PTSD	Safety Issues	Placement issues
S1	F	9	New Zealand European	Witnessing domestic violence, physical abuse, emotional abuse	PTSD, Separation Anxiety Disorder, Generalised Anxiety Disorder, depression symptoms, suicidal ideation	Severe	Intermittent contact with itinerant, alcoholic, suicidal mother; alleged father hit her	Foster care broke down, subsequent placement with father broke down, placed in second foster home
S2	M	13	New Zealand European	Physical abuse, emotional abuse	PTSD, Oppositional Defiant Disorder, sexual behaviour problems	Moderate	Was unable to return home as his safety could not be ensured; physically abusive step-father, & non-protective mother	Removed from home, first foster placement broke down, completed a residential programme, placed in second foster home
S3	M	12	New Zealand European	Witnessing domestic violence, emotional abuse, sexual abuse	PTSD, Generalised Anxiety Disorder, obsessive compulsive symptoms	Severe	Some contact with emotionally abusive mother	Removed from mother's care to foster home, to father's care at end of therapy
S4	F	9	New Zealand European	Physical abuse, witnessing domestic violence, emotional abuse	PTSD, Social Phobia, generalised and separation anxiety symptoms	Severe	Ongoing contact with emotionally abusive mother & violent step father	Informal placement with grandmother – formalised during follow-up

blame, anger, separation, grief and loss (Saunders et al., 2001).

The purpose of the present study was to pilot the effectiveness the manualised TF-CBT programme with a group of four multiply-abused children who had been diagnosed with PTSD. It was expected that the participants would show a reduction in PTSD symptoms and an increase in coping behaviours related to specific abuse and trauma related concerns, compared to pre-treatment levels. It was also expected that these gains would maintain over follow-up intervals.

Method

Participants

Four abused children who met DSM IV (American Psychiatric Association, 1994) diagnostic criteria for PTSD participated in treatment. The children ranged in age from 9 to 13 years at the outset of treatment. The sample was drawn from children referred by their Child, Youth and Family (CYF) social worker to the CYF Specialist Services Unit (SSU) in Central Auckland for psychological assessment and treatment. These children were 'open cases' with CYF who were typical of those who presented to SSU with multiple abuse histories and current mental health concerns. The research was carried out with approval from the ethics committees of CYF and Massey University. Informed consent from the child and adults legally responsible for their care (parent/caregiver(s) and/or social worker) was necessary for participation in the research. Participant characteristics are summarised in Table 1.

Measures

The protocol for the research comprised a multi-modal, multi-informant battery of instruments, as recommended by the child abuse and child trauma literature (American Academy of Child and Adolescent Psychiatry, 1998; Myers et al., 2002). A full battery of self-report measures, and parent/caregiver and teacher measures was designed to assess the impact and symptomatology of child abuse trauma pre, post and at 3 month, 6 month and 12 month follow-up. A subset of measures additionally tracked

ongoing progress across baseline and treatment. All the measures selected have known reliability and validity and have been shown to be sensitive to the effects of treatment. Assessments were administered by a tracked and independent assessor (i.e., a postgraduate student training in clinical psychology). The current study was primarily interested in answering questions related to selected instruments from this battery: In particular, the weekly self-report measures completed by the children that tracked changes in PTSD symptoms (CPTS-RI) and self-identified coping factors (CQ) (see below).

Anxiety Disorders Interview Schedule for Children (ADIS) (Silverman, 1987). The ADIS is a structured clinical interview administered to children, with a parallel version for parents. Revisions have ensured it is compatible with the DSM IV and can be used for diagnostic purposes (Silverman, 1994). The ADIS has been used extensively by childhood anxiety researchers due to its high reliability, and user-friendly structure which enhances rapport and enables in-depth gathering of information on the child's historical and current functioning (Ronan, 1996).

Children's Post-traumatic Stress Reaction Index (CPTS-RI) (Frederick, Pynoos, & Nader, 1992). The CPTS-RI is a 20-item measure rated on a 5-point Likert scale (scored 0-4) that assesses the features and symptoms of PTSD in children. Widely used in research, it can be administered in a self-report or interview format. Scores can range from 0 to 80, with a cut-off of 12+ indicating a mild PTSD reaction; 25+ a moderate PTSD reaction; and 40+ a severe PTSD reaction.

State Trait Anxiety Inventory for Children (STAIC) (Speilberger, 1973). The STAIC measures both acute (state) and chronic (trait) anxiety in children aged 9 to 12 years. Each scale has 20 items rated on a 3-point Likert scale (scored 1, 2, or 3). The Trait scale is treatment sensitive and can be used to measure the effectiveness of clinical procedures designed to reduce anxiety in children. Scores can range from 20 to 60, with higher scores indicating greater anxiety.

Children's Depression Inventory (CDI) (Kovacs, 1981). The CDI assesses affective, behavioural and cognitive signs of depression. It has 27 items. Each item has 3 choices (scored 0, 1, or 2) each of which characterises the child over the previous two weeks. It is designed to measure the severity of depressive symptoms in children and adolescents aged 8 to 17 years. Scores can range from 0 to 54, with higher scores indicating greater severity.

The Coping Questionnaire (CQ) (Kendall et al., 1992). The CQ-C measures the self-perceived coping ability of a child in specific anxiety-provoking situations. The three situations most distressing for the child are identified during the assessment interviews are listed on the CQ-C and rated each week by the child on a 7-point Likert scale ranging from *not at all able to help myself* (1) to *completely able to help myself feel comfortable* (7).

Child Behaviour Checklist/4-18 – Parent Form (CBCL/4-18) (Achenbach, 1991a). The CBCL measures parent/caregiver reports of child competencies, emotional functioning and behaviour problems in a standardised format. Two sections measure (a) social competencies, assessing the child's participation in areas such as sports, hobbies, and social interactions; and (b) problematic behaviours, comprising 118 problem items rated on a 3-point scale (scored 0, 1, or 2). The problem item raw scores are recorded on a scoring profile, which provides percentile and T scores based on norms for each sex in each age range, presented in a series of problem scales.

Child Behaviour Checklist – Teacher Report Form (TRF) (Achenbach, 1991b). The TRF is used to assess child problems and competencies in the realm of social/emotional functioning at school. It mirrors the parent version of the CBCL and provides teacher ratings of the child's academic performance, adaptive functioning, and behavioural/emotional problems.

Design

The current study was based a scientist-practitioner model of local research and utilised a single-case design. A multiple

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baseline across subjects involving between-person replications (Hersen & Barlow, 1976) was used to demonstrate the controlling effects of treatment on PTSD symptoms and coping. The four participants were randomly assigned to a baseline of 3, 5, 7, or 9 weeks at intake. Weekly measures were completed throughout the baseline and treatment phases. A non-concurrent procedure was employed (Hayes, 1981; Watson & Workman, 1981). This relaxes the requirement that the participants enter assessment at the same time and makes it possible to use the data from several clients seen at different times, exploiting the fact that their baselines were of different durations. Multiple baseline designs are user-friendly in clinical settings and provide experimental evidence that the treatment effects are probably not due to other processes, nor to the placebo effect of the experience of assessment and treatment itself (Blampied, 1999; Kazdin, 2003). Successive replications across participants that show change in symptoms and coping when treatment is introduced support the hypothesis that the treatment is producing the changes. Furthermore, the graphed results enable visual assessment of the effects of phased treatment elements, as well as the impact on treatment of any documented external events (Kazdin, 2003).

Procedure

Following referral, an assessment interview with the independent assessor was scheduled for the child and parent/caregiver. If the child met diagnostic criteria for PTSD on the ADIS, informed consent from the child and legally responsible adult(s) was sought. The full battery of assessment measures was completed with the child, parent/caregiver and teacher. The child was randomly assigned to a baseline duration of 3, 5, 7 or 9 weeks. The child completed the weekly measures of the short assessment battery (CPTS-RI, STAIC, CDI, and CQ) during the baseline period and during treatment. The full battery was administered again post-treatment and at 3 month, 6 month and 12 month follow-up points. As per the informed consent agreement, if the child did not wish to complete

measures at any time, this of course was respected. If there had been concerns that the research constraints would impact on safety, clinical concerns would have been prioritised. Therapy was provided at the SSU clinic by the senior author, a doctoral candidate, postgraduate clinical psychology trainee, and an experienced child and family clinician.

Treatment Manual and Materials

Children received the initial 16-session programme and parents/caregivers were offered 3 structured sessions, as described in a 65-page manual (Feather & Ronan, 2004). In addition, booster sessions and additional parent/caregiver sessions and social worker support were provided as required. The manual describes the purpose and goals for each session, materials required, session format and activities, and associated out-of-session activities (homework). Worksheets for the child are provided to accompany each session. The TF-CBT programme comprises 4 phases as follows:

Phase 1: Psychosocial strengthening. Rapport building and orientation to therapy, relationships and support networks, exploration of the child's history and introduction of the 4-step coping template, the STAR Plan, and a session with parents/caregivers to give additional information about the treatment to caregivers and encourage their support.

Phase 2: Coping skills. Recognition and expression of feelings, recognition of body reactions to trauma and anxiety and introduction of relaxation techniques, introduction to the role of thoughts in perpetuating symptoms and teaching the modification of unhelpful self-talk into coping self-talk, teaching the use of problem solving skills for symptom management, introduction of self-evaluation and self-reward for success in managing symptoms, a review of the STAR Plan and preparation of the child for the trauma processing phase of the programme, and a session with parents/caregivers to review the coping skills the child has learnt, and to prepare the caregivers for the trauma-processing phase of the programme.

Phase 3: Trauma processing. Introduction of the child to the trauma processing phase of the programme and practice telling a story using creative media followed by a series of sessions of imaginal exposure to create a trauma narrative and allow emotional processing of traumatic memories using media chosen by the child, with gradual exposure from least to most traumatic memories. Subjective Units of Distress (SUDS) scales are used to titrate the intervention to maximise exposure, minimise over-whelming symptoms, and enable habituation as indicated via the child's report and from observation. The 4-step STAR Plan is used to manage trauma symptoms. A session with parents/caregivers enables review of the trauma processing phase of the programme and identification of any special issues or problems to be addressed before therapy ends.

Phase 4: Special issues and completion of therapy. Addressing of any special issues that have been identified by the child and/or caregivers, and relapse prevention, celebration of the child's progress in therapy and saying goodbye.

Results

The major research goal of this study was to pilot the effectiveness of a TF-CBT programme in reducing posttraumatic stress symptoms and increasing coping in multiply abused children. As can be seen in Figure 1, the level of posttraumatic stress symptoms of participants decreased with treatment, and decreased further over a 12 month follow-up period. The overall average self-reported CPTS-RI score for the four children was in the *severe* range during baseline (mean = 45.3; *SD* = 12.3), in the *moderate* range over the treatment phase (mean = 37.3; *SD* = 12.7), and in the *mild* range over the follow-up phase (mean = 23.2; *SD* = 10.3) on a scale of 0-80. Likewise, the participants' level of self-perceived coping ability increased with treatment, and increased further over the following 12 months. Figure 2 shows that children's mean coping scores (averaged across the four participant's three self-identified target concerns) increased from 3.3 (*SD* = 1.9) during the baseline phase, to 3.8

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(*SD* = 2.1) over treatment, and 5.0 (*SD* = 1.8) over follow-up (on a scale of 1 = "not at all able to help myself" to 7 = "completely able to help myself"). While the variability for the overall sample data is relatively high, this masks the individual results; that is, there was less variability within each child's scores on both the CPTS-RI and the CQ. For example, on the CQ the range of scores for each child's individual target concerns within each phase was 3 or less, except in two instances.

Figure 3 presents the graphed weekly level of posttraumatic stress symptoms for each of the four participants across the baseline, treatment and follow-up phases. As can be seen, each participant reported a unique pattern of baseline PTSD symptoms, an idiosyncratic response to treatment, and variation in symptom manifestations over the 12 month follow-up. This is likely to

reflect the fact that PTSD is a fluctuating experience that can be triggered by not only internal, but also external factors and subsequent trauma.

In a single-case design the baseline data must be examined for stability (Kazdin, 2003). Notwithstanding the fluctuating nature of PTSD symptoms, a stable baseline is characterised by relatively little variability and the absence of a slope (or trend). At least three baseline points are required to establish stability (Barlow & Herson, 1984). The variability in the CPTS-RI baseline scores for the four participants did not exceed a 50 per cent level in any case (baseline ranges = 47-61, 30-35, 44-50, and 26-55 on a 0-80 scale; variability = 17.5%, 6.2%, 7.5% and 36.3% for S1, S2, S3, and S4 respectively), as recommended for single-case methodology in applied clinical research (Barlow & Herson,

1984). Visual inspection of the baselines of all four participants indicates a relatively horizontal trend in their baseline data. One participant (S2) completed only two of the CPTS-RI baseline measures; however, the slope over the two points shows a slight acceleration, so the lack of a third point is of less concern. Also, while it was planned that the baselines would be 3, 5, 7, and 9 weeks long respectively, practical circumstances dictated an extra week on baseline for each of S1 and S2. In summary, the baseline data is stable enough to make a prediction that without intervention, all four participants would be likely to continue to suffer PTSD symptoms at a similar level.

Visual inspection of the CPTS-RI scores over the treatment phase shows an initial brief upward trend over 2-3 sessions for two participants (S1 and S2). This may reflect the fact that Sessions 2 and 3 covered family relationships and the child's history, precipitating a brief exacerbation of the child's PTSD symptoms. However, over the coping skills phase of the TF-CBT programme all four participants showed a moderate downward trend in PTSD symptoms. As the exposure phase was introduced, all four children then demonstrated a brief upward trend in PTSD symptoms. The spikes in CPTS-RI scores noted at the end of the treatment phase can be explained by individual circumstances: S1 disclosed that her father, with whom she had been placed, had recently physically abused her; S2 found out he was not returning to the care of his mother as he had been led to believe; S3 disclosed a further incident of sexual abuse; and S4 was experiencing emotional abuse from her mother and placement uncertainty with her grandmother. These issues are discussed further below, with regard to the impact on each child's coping.

Following the completion of the 16 week intervention, two participants (S1 and S4) required booster sessions as their symptoms remained elevated. This is likely to have related to their younger age as well as their individual circumstances, including, in each case, intermittent contact with emotionally abusive parents, and ongoing placement uncertainty. There were no additional contacts with S2 and S3 following

Figure 1. Changes in level of posttraumatic stress symptoms (average of CPTS-RI scores for all four participants) across baseline, treatment, and follow-up phases.
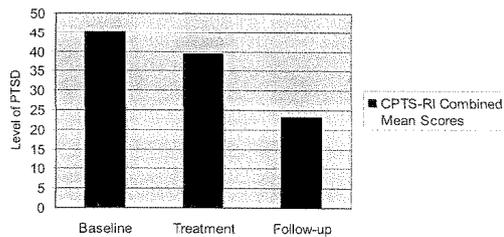

Figure 2. Changes in level of child reported coping (average of CQ scores for all four participants) across baseline, treatment, and follow-up phases.

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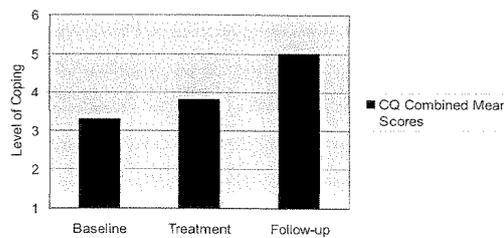
Figure 3. Changes in posttraumatic stress symptoms (CPTS-RI scores) across
assessment, treatment and follow-up sessions.
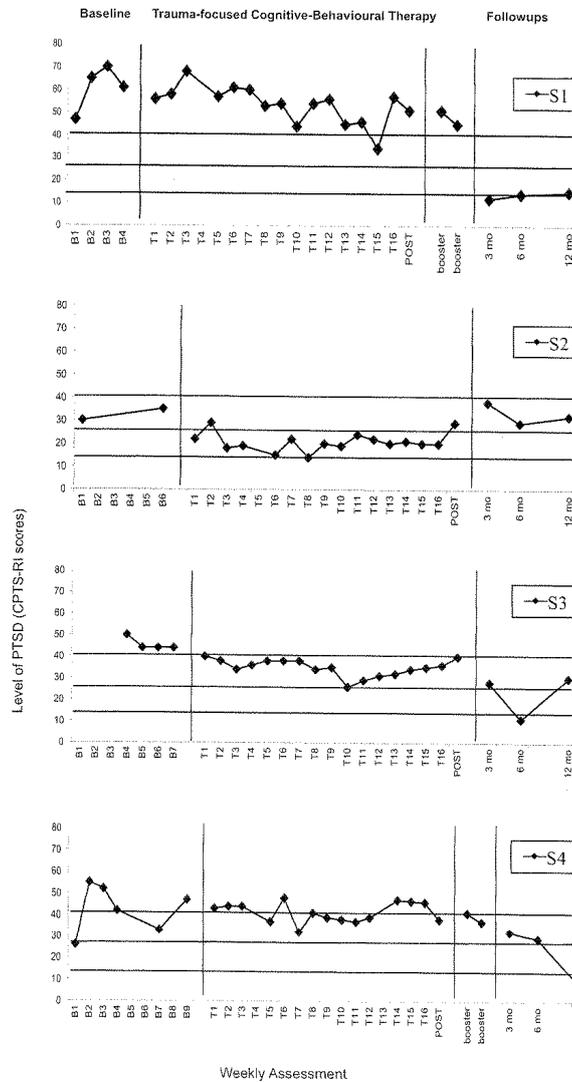
the completion of the 16
week programme, other than
at the prescribed follow-up
assessment points. S2 was
referred for brief specialist
treatment for sexual acting
out problems, which occurred
during the follow-up phase.

The complete intervention
for each of S1 and S4 involved
individual booster sessions,
parent sessions, joint parent and
child sessions, and caregiver
and social worker support
throughout the follow-up
phase, as perceived necessary
by clinical judgement. This
amounted to 45 face-to-face
contacts with each of S1 and
S4 and/or their caregiving
adults. Assessment data was
collected at two scheduled
booster sessions prior to
the 3 month follow-up, and
subsequently at the 6 month
and 12 month points. It
was decided to discontinue
collection of data at each
individual booster session
as the children each made it
clear they no longer wished to
complete the measures every
session. Booster sessions
essentially built on the skills
that had been covered in the
initial programme.

Across follow-up, none
of the children reported PTSD
symptoms in the severe range
at any assessment point. Three
participants (S1, S3, and S4)
experienced an overall drop
in level of PTSD symptoms
compared to baseline and
treatment levels. S1 and S4's
scores tracked down from
severe to non-clinical/mild
by 12 month follow-up. S3
spiked back from non-clinical
to a moderate level at 12 month
follow-up, apparently due to
self-reported concerns about
contact with his mother. S2's
PTSD symptoms remained in
the moderate range throughout
the 12 month follow-up phase.
The fact that he remained in
care due to his stepfather's
refusal to undertake treatment

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Figure 4. Changes in child reported coping skills (average of scores for three target concerns) across assessment, treatment and follow-up sessions.
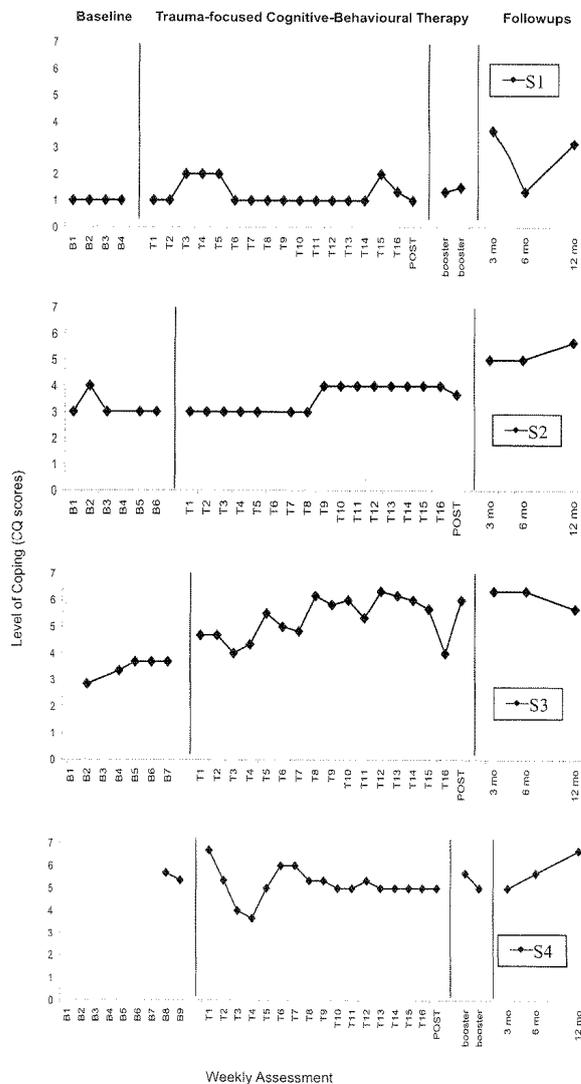
for physically abusing him, and that he was receiving further treatment for sexual acting out problems, may have contributed to the continued elevation of S2's PTSD symptoms. As reported below, it is notable that for those children who experienced ongoing trauma triggers during the follow-up interval, coping remained high relative to baseline levels (S2, S3), or bounced back after a setback (S1).

Figure 4 presents each child's self-reported coping over the baseline, treatment and follow-up phases. The baseline data is stable in terms of variability and trend. Coping tended to increase slowly over the treatment phase and generally showed much higher levels across the 3 month, 6 month and 12 month points.

S1 reported extremely low levels of coping throughout the treatment phase. She was worried about her mother's whereabouts and risk from suicide. While her coping increased slightly during the coping skills training, it dropped again during the exposure phase, during which S1 worked through the trauma of witnessing her mother's serious suicide attempt. Her coping rose slightly during the special issues phase, when her identity and self-esteem were addressed. It dropped at the end of treatment, coincident to her disclosure of physical abuse by her father. Subsequently, S1 was placed with caregivers, but continued to report worries about her mother. Booster sessions were arranged in which S1's mother was able to reassure her that she was getting help for her problems. The relieving of safety concerns appeared to enable S1 to utilise her coping skills,

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as evidenced by the marked increase in her self-reported coping scores at 3 month follow-up. At the 6 month follow-up, S1 had not had contact from her mother and did not know where she was, and, not surprisingly, her coping had decreased. By the 12 month follow-up, S1 had been placed in a stable foster home. While she was still anxious about her mother's wellbeing, she reported that she was more frequently utilising helpful coping strategies to control her anxiety.

S2 demonstrated a stable pattern of moderate coping throughout the coping skills training phase of the treatment, with a slight increase in coping coinciding with the exposure and special issues phases. During the exposure phase, the impact of the physical abuse from S2's step father was fully explored with a trauma narrative. The special issues sessions focused on psycho-education around the effects of abuse on young people, strategies for keeping safe, and anger management. Despite the fact that S2 reported experiencing ongoing child mental health symptomatology throughout the follow-up phase, notably both his self-reported and collateral-reported coping was high. His caregiver commented at 6 month follow-up: "S2 is infinitely better...CBT has been good for him; he has strategies for dealing with situations."

S3 showed an overall trend of increased coping throughout the treatment and follow-up phases. A drop in coping coincided with the end of the exposure phase, when he disclosed further sexual abuse. S2 was referred to the CYF Evidential Video Unit (EVU) to formally report the abuse immediately prior to the post-treatment assessment. Following the EVU interview, his self-reported coping increased to a high level, where it remained at 3 month, 6 month and 12 month follow-ups.

S4 demonstrated a decrease in coping over the first four sessions. This is likely to be because she entered the programme initially denying her problems, even though she was well aware of her symptoms in sessions. These early sessions focused on strengths and support networks, but also elicited the problem areas. S4's self-reported coping increased during the coping skills phase and maintained

during the exposure phase. These were new-found skills for S4, and while she could not always utilise them in real-life situations evoking strong feelings, she clearly demonstrated that she could use them in the therapy environment. S4's self-reported coping continued to increase throughout the follow-up phase. This coincided with a decision that she would be placed permanently in her grandmother's care.

Child report scores for target concerns and co-morbid problems are presented in Table 2. The co-morbid data fills out the picture of what was happening for each participant at pre- and post-treatment and follow-up.

Scores on the STAIC-S indicate that for all participants, state anxiety was generally within the normal range and remained fairly stable across each assessment point. The mean STAIC-T scores were similar at pre- and post-treatment but decreased during follow-up. Of note was the remarkable consistency in responses on one of the items on the STAIC-T by all these children: "I worry about my parents" was invariably scored 'often', reflecting the fact that for duration of the study most of these children were placed away from their parents. This separation was clearly a source of anxiety for each of the children.

The mean scores on the CDI suggest little variability in childhood depression symptoms across pre- and post-treatment and follow-up, hovering around the cut-off for moderate levels of symptoms (CDI ≥ 13). However, closer inspection of the individual scores indicates considerable within-participant and across-participant variability. S1 reported symptoms above the cut-off for the severe range (CDI ≥ 30) at pre- and post-treatment, dropping to moderate at follow-up. Conversely, S2 reported virtually no depressive symptoms at pre- and post-treatment, and moderate levels at follow-up. S3 reported a moderate level of depressive symptoms at pre-treatment, and very few symptoms following treatment and at follow-up. S4 reported moderate to low depressive symptoms throughout. Of note is that the two participants who experienced the most variability in depressive symptoms (S1 and S2) also had the most tenuous relationship with

caregiving adults. The period of most severe depression in each case correlated with losing contact and/or connection with their most significant parent, albeit an unprotective, emotionally abusive relationship.

With regard to parent/caregiver involvement in the programme, it was found that adhering to the three prescribed sessions was not possible given the caregiving arrangements of these children. The typical scenario was unavailable and/or abusive parents who had limited, generally supervised, contact, and busy caregivers who had limited time to attend sessions and focus on the individual child's psychological progress at home. In addition, two children experienced multiple caregivers during the therapy phase alone. However, every endeavour was made to involve parents and caregivers in the programme and this aspect of the intervention was administered flexibly, for example, before and after child sessions, and by telephone.

Parent/caregiver and teacher measures (CBCL and TRF) were gathered where possible, but as the majority of these children experienced multiple placements and/or several teacher and school changes throughout the period of the study, these data were considered to be too inconsistent to provide meaningful results. Thus, particularly given the overall low return rate, these data are not reported (but are available upon request from the first author).

Discussion

This is the first clinic-based study of TF-CBT with children in New Zealand. The results are promising in suggesting the usefulness of this approach for the treatment of PTSD in multiply-abused children. Use of a single case multiple baseline design across four participants indicated that the treatment can be helpful in reducing PTSD symptoms and increasing coping related to specific abuse and trauma-related concerns. The follow-up findings show that the treatment effects were generally durable over a 12 month period. The results of the present study are consistent with the results of single case studies and randomised controlled trials demonstrating the effectiveness of CBT with anxiety disordered children

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(Howard & Kendall, 1996; Kendall, 1994; Kendall & Southam-Gerow, 1996), and TF-CBT with sexually abused children (J. A. Cohen et al., 2004; Deblinger et al., 1996; Deblinger, Steer, & Lippmann, 1999). It is also complementary to a pilot study carried out in the same setting trialling a manualised play therapy programme with CBT elements for younger children with abuse trauma (Woolf, 2002).

The four participants had PTSD diagnosed at referral. Symptoms remained at clinically significant levels throughout the baseline phase. These young people were having trouble coping with a range of problems related to a history of multiple CA, such as flashbacks and bad dreams, having trouble sleeping, getting angry, and anxiety related to being separated from their parent(s). The results across

treatment represent clinically significant changes in their functioning, indicating that TF-CBT can be effective in resolving past child abuse trauma. In addition, all four children and/or their caregivers anecdotally reported they had learned skills to cope with current situations. The young people consistently recorded high levels of coping at follow-up, even when their PTSD symptoms had been re-triggered by subsequent traumas (with the exception of one assessment point for one child, at which time she was experiencing an extremely anxiety provoking situation).

A strength of this study is that it was carried out in a real-life clinical setting with typically-referred children. The fact these children all presented with multiple-abuse histories supports calls for researchers to move away from speciality areas and re-focus on studying the complexity and the reality of exposure to violence and abuse for young people (Saunders, 2003). A further strength is that the study is based on a locally developed manual derived from empirically supported treatments and local clinical practice, supported by local experience and knowledge about what works in the context.

The use of a single-case experimental design means that preliminary conclusions can be made about the overall effectiveness of the programme, as well as an initial investigation of the specificity of treatment elements, and comparisons about individual responses to treatment. Visual inspection of the data suggests that the psychosocial phase of the treatment had mixed effects on the children, whereas the coping skills phase was generally associated with a reduction in PTSD symptoms and an increase in self-identified coping, as would be hoped. The exposure sessions seemed to be associated with a slight increase in symptoms and decrease in coping. However, the 12 months following treatment were generally characterised by a reduction in PTSD symptoms and a marked improvement in coping, whether or not the child was having ongoing booster sessions, suggesting the long-term helpfulness of the treatment approach. The pattern of findings here, combined with a limited number of previous studies reporting follow-up data, point to the critical need

Table 2. Child Self-Report Scores on Repeated Measures

| Measures | Participants | Assessment Points | | | | |
		Pre-treatment	Post-treatment	3 month follow-up	6 month follow-up	12 month follow up
CQ	S1	1.0	1.0	3.7	1.3	3.2
(Mean)	S2	3.0	4.0	3.7	5.0	5.7
	S3	2.8	6.0	6.3	6.3	6
	S4	-	5.0	5.0	5.7	6.7
	Mean	**2.3**	**4.0**	**4.8**	**4.6**	**5.4**
CPTS-RI	S1	47*	51*	12	14	15
(Total)	S2	30	29	38	29	32
	S3	48*	40*	28	11	30
	S4	26	38	32	29	8
	Mean	**37.8**	**39.5**	**27.5**	**20.5**	**21.3**
STAIC-S	S1	42	31	27	23	30
(Total)	S2	23	25	35	20	21
	S3	35	37	-	-	29
	S4	27	30	23	26	30
	Mean	**31.7**	**30.7**	**28.3**	**23.0**	**27.5**
STAIC-T	S1	35	46*	22	22	22
(Total)	S2	31	32	32	32	38
	S3	39	30	25	31	27
	S4	36	41	37	42	38
	Mean	**35.3**	**37.3**	**29.0**	**31.8**	**31.3**
CDI	S1	34*	39*	12	20	19
(Total)	S2	3	2	26*	26*	26*
	S3	14	0	4	4	6
	S4	13	8	6	11	11
	Mean	**16.0**	**12.3**	**12.0**	**15.3**	**15.5**

*Clinical cut offs indicating severity of concerns are reported where available from test developers.

Note: CQ = Coping Questionnaire; CPTS-RI = Child Post Traumatic Stress Reaction Index; STAIC-S = State Trait Anxiety Inventory for Children – State; STAIC-T = State Trait Anxiety Inventory for Children – Trait; CDI = Child Depression Inventory.

for examining treatment effectiveness over longer intervals (see also, Skowron & Reinemann, 2005)

The pattern of individual responses to treatment highlighted a number of potentially confounding variables embedded within the study, as exemplified by the variation in number of sessions required to resolve problems. By chance, the sample comprised two 9 year old girls and 12 and 13 year old boys At initial assessment, there appeared little disparity in the nature and severity of problems between all four young people. However, the older boys were not re-referred to the clinic after the 16 session programme was completed, whereas the social workers and caregivers of the younger girls requested booster sessions on and off over the next 12 months. One explanation is that both boys were in safe placements following treatment, although they had ongoing family issues, and one had residual behaviour problems for which he was receiving treatment elsewhere. Both girls had ongoing contact with an emotionally abusive parent, which appeared to re-trigger their trauma symptoms and compromise their treatment gains. Additionally, clinical observation suggested that younger children did not integrate the coping skills into their everyday lives as quickly as the adolescents, suggesting there was perhaps an additional developmental difference in response to this treatment approach. These findings are similar to those of other researchers who have found that treatment response may vary with developmental/age level (Kane & Kendall, 1989), and that in clinical settings, treatment may extend to as many as 40 or more sessions depending on the needs of the child and the complexity of the case (Deblinger & Heflin, 1996). Overall, these factors highlight the need for therapists who work with traumatised abused young people to keep in mind safety issues, contextual factors, and a developmental focus. Researchers should also take account of these potentially confounding variables when designing future studies.

The use of a single-case design, while having advantages, also confers limitations. With a small sample size, it cannot be assumed that the results

can be generalised to other cases. All four children identified as "Pakeha" (European) New Zealanders. It will need to be investigated the extent to which this manualised approach is appropriate, and what adaptations may need to be made, for working with other cultures, including Maori and Pacific Island children and families, and other migrant and refugee populations. Furthermore, while a multiple baseline design can allow for visual inspection of the data, only broad generalisations can be made about the effects of treatment or its components, particularly in light of so many complexities associated with each case. Related, given the infrequency of data collected across multiple informants, findings are also restricted here to self-report data. However, with that said, the self-report data themselves are a valuable source of information regarding these children's circumstances (Ronan, 1996; Ronan & Deane, 1998).

A positive therapeutic relationship is considered essential for CBT with young people, including for those with anxiety disorders (Kendall & Southam-Gerow, 1996). While the use of a manualised treatment may potentially reduce the contribution of the therapeutic relationship to treatment outcome (Shirk & Karver, 2003), it is a limitation of this study that the treatment was carried out by a single therapist. Use of the manual by other therapists will enable the specificity of this approach to be determined. In addition, a full assessment of treatment integrity was not carried out as this was a development project and the manual was being written as the study progressed.

Another limitation of this study is that fact that the psychological treatment was not the only intervention occurring in the lives of these children. They were also receiving social work input, caregiver support, and in some cases, the support of extended family members. While the single-case design can capture changes in target outcome measures associated with the term of the treatment, the specific contribution of the various aspects of the overall intervention for these children cannot be definitively distinguished. Having said that, the clinical goal of all involved of course is a good outcome for the child, and may best

occur with a multi-element approach, of which the psychological therapy is a part (e.g., Curtis, Ronan, & Borduin, 2004) .

Overall, this study makes a contribution to treatment outcome research in this area. Child abuse is a major problem in New Zealand and worldwide. There is limited research on the effectiveness of psychological treatments for multiply-abused children who typically present to child protection services and are referred for therapy not only to specialist clinics, but also community agencies. Real-world tests of empirically based locally-informed treatments are vital, and the field can only move forward on the basis of increased use of related strategies (Kazdin & Nock, 2003). It is hoped that this study will encourage other local practitioners to carry out their own clinic-based research, whether based on further applications of this manualised TF-CBT programme, or development and testing of their own treatment approach (see also, Feather, 2004b). Ultimately, children and families who receive treatment under these circumstances will benefit from an increased commitment to quality delivery and evaluation.

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Notes
1. CM; child maltreatment, an alternative term to CA.

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Appendix E

Information Sheets and Consent Forms

(Massey University Letterhead)

RESEARCH STUDY ON THERAPY FOR CHILDREN WHO COME TO
SPECIALIST SERVICES FOR HELP

**INFORMATION SHEET FOR
PARENTS/GUARDIANS/CAREGIVERS**

Jackie Feather, Registered Psychologist and Clinical Team Leader at Central Auckland Specialist Services, Child, Youth and Family, is carrying out a research study in part fulfilment for a Doctorate degree in Psychology at Massey University. Jackie is supervised at Specialist Services by Dr Mary Dawson, Managing Psychologist, and at Massey by Dr Kevin Ronan, Associate Professor and Coordinator of the Clinical Psychology Programme, Massy University School of Psychology.

Many of the children we see at Specialist Services need special help to help them to cope with stress and anxiety as a result of things that have happened to them. This study is about researching a particular 16-week therapy programme that has already been shown to work in other studies with children who have anxiety problems. What we want to find out is whether this programme is equally as effective with children who have anxiety as the result of the trauma of abuse (i.e., 'posttraumatic stress').

Jackie is carrying out the therapy programme, and her co-worker, Louise Woolf, is carrying out the initial and follow-up assessments.

Whether or not you choose to be involved in the research study, your child will still receive assessment and therapy at Specialist Services, appropriate to his or her needs.

If you agree to take part in this study, you and your child would be involved in five assessment sessions, each expected to take approximately 1 ½ hours. These would be carried out before the therapy programme began, directly after therapy is completed, and again 3-, 6-, and 12-months later.

After the completion of the initial assessment there would be a delay of 3-9 weeks before therapy began. The therapy part of the programme would involve your child coming to one (1-1 ½ hour) session once a week for about 16 weeks.

Assessment and therapy would also be audio taped if your prior consent is given. This is required for research purposes; to allow the researcher and her supervisors to check that the therapy programme guidelines are being followed.

If you decide to participate in the research study, you have the right to:

- Withdraw from the research study at any stage and continue to receive therapy services.

- Ask any questions about the research study at any time and have them answered.

- Refuse to answer questions at any time and continue to receive therapy services.

- Decline to have assessment or therapy sessions audio taped at any time, regardless of prior consent.

- Have access to a summary of the findings of the study when it is concluded.

All information and records collected for the purposes of the research study will be:

- Completely confidential to the researcher, her co-worker and supervisors.

- Identified only by a code number, and seen only be the researcher, her co-worker and supervisors, and only used for the purposes of the research. It will not be possible to identify individuals in any reports of the research results.

- If you withdraw from the study at any time but wish to continue with therapy, all information collected for the purposes of the assessment and therapy will be excluded from the research.

Please note that any information collected for the purposes of the assessment and therapy per se will be subject to the usual confidentiality limitations that apply to all Child, Youth and Family clients with regards to any further disclosures or safety issues.

If you are interested in taking part and/or would like to ask any questions, please talk to **Jackie Feather** at Specialist Services, or phone her on **917 5394**.

(Massey University letterhead)

RESEARCH STUDY ON THERAPY FOR CHILDREN WHO COME TO SPECIALIST
SERVICES FOR HELP

PARENT/GUARDIAN/CAREGIVER CONSENT FORM

I have read the Information Sheet and have had the details of the research study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw my child from the research at any time and to decline to answer any particular questions, and my child will continue to receive assessment and therapy.

Parental/guardian consent is required for children to participate in this research. In agreeing to participate, I also provide consent for my child's participation.

I agree to provide information to the researcher on the understanding that my name or my child's name will not be used without my permission.
(*The information will be used only for this research and publications arising from this research study*).

I agree/do not agree to the therapy sessions being audio taped.
(*I understand that I have the right to ask for the audio tape to be turned off at any time during the sessions*).

I agree for myself ....**(your name)**

and my child...**(child's name)**

to participate in this study under the conditions set out in the Information Sheet.

Signed: ....

Date: ....

(Massey University letterhead)

RESEARCH PROJECT ON THERAPY FOR CHILDREN WHO COME TO SPECIALIST SERVICES FOR HELP

INFORMATION SHEET FOR CHILDREN

Here at Specialist Services we are always interested in finding out the best ways of helping children. One way is to ask children and young people who are coming here if they would like to take part in a research project.

Jackie Feather is doing a research project with Specialist Services and Massey University that you might want to take part in.

What is the research project about?

This research is about a special therapy programme that helps children with their feelings and worries. Other children have found this therapy programme has helped them. We want to know how helpful this therapy programme is for children who come to Specialist Services.

What happens if you don't want to take part in the research project?

If you don't want to take part in the research project you will still come for therapy at Specialist Services. You will have your own therapist.

What happens if you do want to take part in the research project?

Your therapist will be Jackie. You will come to see Jackie for therapy for about an hour a week for 16 weeks. You will be doing a workbook and lots of different activities.

Jackie has two supervisors (sort of like her teachers) called Mary Dawson and Kevin Ronan, and a helper called Louise Woolf.

Louise helps with the research part. Her job is to ask you, and your parent or caregiver, some questions before you start your therapy, during your therapy, and when you have finished it. Your answers to these questions will tell us how helpful the therapy is for you.

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We will ask you if it's OK if we tape some of the therapy sessions. The tapes will be used to make sure Jackie is doing her therapy job well.

If you want to take part in this research project you can:

- Choose to stop taking part in the research at any time, and still come for your therapy sessions.

- Ask any questions about the research at any time.

- Say you don't want to answer questions or fill out forms, and still come for therapy.

- Say you don't want us to tape things, even if you said yes at first.

- Find out how helpful the therapy programme has been for you and other children, once the research project is finished.

No one will know you have been part of the research project because the names of all the children taking part will be changed.

Jackie and Louise will keep what you tell them private. If they are worried about something you tell them, they will talk to you first, before talking to your parent or caregiver or your social worker.
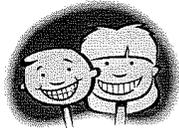
If you would like to take part in the research project or you would like to ask any questions you can talk to Jackie now, or tell your parent or caregiver who can talk to her at Specialist Services, or ring her on 917 5394.

Thank you for taking the time to read this and think about it.

(Massey University letterhead)

RESEARCH PROJECT ON THERAPY FOR CHILDREN WHO COME TO
SPECIALIST SERVICES FOR HELP

CHILD CONSENT FORM

- I have read the information sheet for children and have had the research project explained to me.

- My questions have been answered, and I know that I can ask more questions at any time.

- I know that I can stop taking part in the research project at any time and can say I don't want to answer any questions, and still come for my therapy sessions.

- I know that what I tell the researchers is confidential, meaning private.

- I also understand that there might be some things that might need to be talked about with my parent or caregiver or my social worker, but the researchers will talk about this with me before saying anything to anyone else.

PLEASE TICK ONE:

................I *want* to take part in this research project

................I *don't want* to take part in this research project

I agree to the therapy sessions being audio taped (circle one)   Yes   No

If I said yes, I know that I can ask to have the tape turned off at any time.

YOUR NAME..

TODAY'S DATE:...

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Appendix F

The Star Plan and 5-Part Model
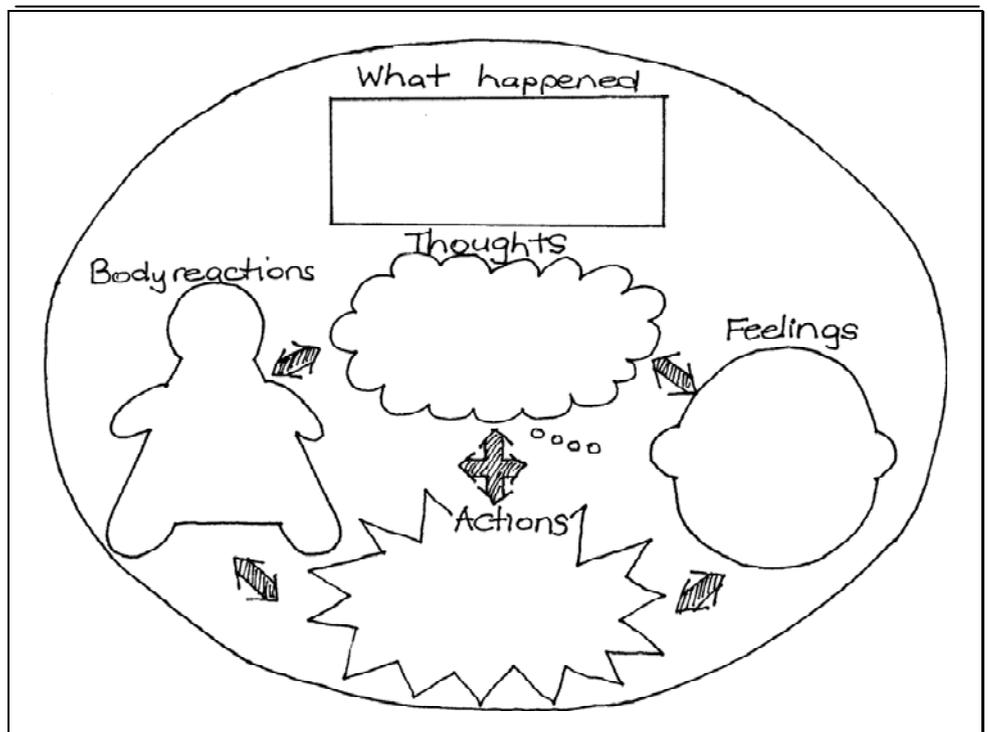
Figure 1.1. Examples of worksheets from the TF-CBT manual (Feather & Ronan, 2004)

Appendix G

Study 3 Participants' Star Plan's[34]

S3.1

1. Scared or mad feelings?

    a) Breathe

    b) Put water on face

    c) Imagining a calm scene- Antarctica

2. Thinking bad thoughts?

    Stop and notice thoughts

    Why am I thinking this?

    Is it really worth it?

    Should I leave it?

    Yes I will (helpful thought)

3. Actions and ideas that will help

    Call for help

    Go get help

    Keep calm

    Walk away

4. Results and rewards

    Say nice things to encourage yourself

    Don't put yourself down

    Treat yourself

    Relax while listening to your favourite music

    Party – friends

---

[34] In their own words

S3.2

1. *Stink feelings?*
   Think of a calm scene
   Deep breathing
   Listening to music

2. *Thinking bad stuff?*
   Think about what the other persons feeling
   Think differently about the situation
   I gonna stay calm about this
   Think of a good outcome

3. *Actions and attitudes that can help*
   Don't do something you might regret later
   Walk away
   Change your attitude towards the situation
   Talk to someone
   Go outside and kick a ball/go to my room

4. *Results and rewards*
   Don't get in trouble
   You have better friends
   Feel good

S3.3

1. *Stink feelings*

    Go lye down

    Take deep breaths

    Have some water

    Have a shower/bath

    Listen too some slow music

    If your hot then get changed into your cooler clothes

2. *Thinking bad stuff:*

    Stop and notice them

    You could think of more helpful thoughts

    You could test the thought out (is it worth worrying about)

3. *Actions and attitudes that can help!!!!*

    Take big breaths

    Try to think positive (i'll find them)

    Brainstorm a list of ideas and then choose the best one to do

4. *Results and rewards* ☺

    At least I tryed

    It's not the end of the world and lots of people make mistakes

    Oh well, I'm not perfect, but at least I gave it ago

    You could go and treat yourself with your favourite food, or do something fun

    You could tell other people what you want

S3.4

1. *Stink feelings?*

   Calm down

   Think about what would Nana[35] do

   It works

2. *Thinking bad stuff?*

   Remember the good stuff

   Thinking positive

   Remembering there will always be someone there

   God's on my side

3. *Actions and attitudes that can help*

   Walk away

   Talking to someone sometimes helps

4. *Results and rewards*

   Self-rewards – the way you rate yourself – telling yourself you did well

   Sharing successes with others, including family and friends

   Others give rewards

   Others see me as a more responsible, mature person – family, girls, mates see me as a more serious, mature, fun-loving, kind-hearted person

---

[35] S3.4 valued his Nana as a role model for dealing with life.

Appendix H

Trauma Processing with Expressive Modalities

Trauma processing with sandtray

Trauma processing with clay
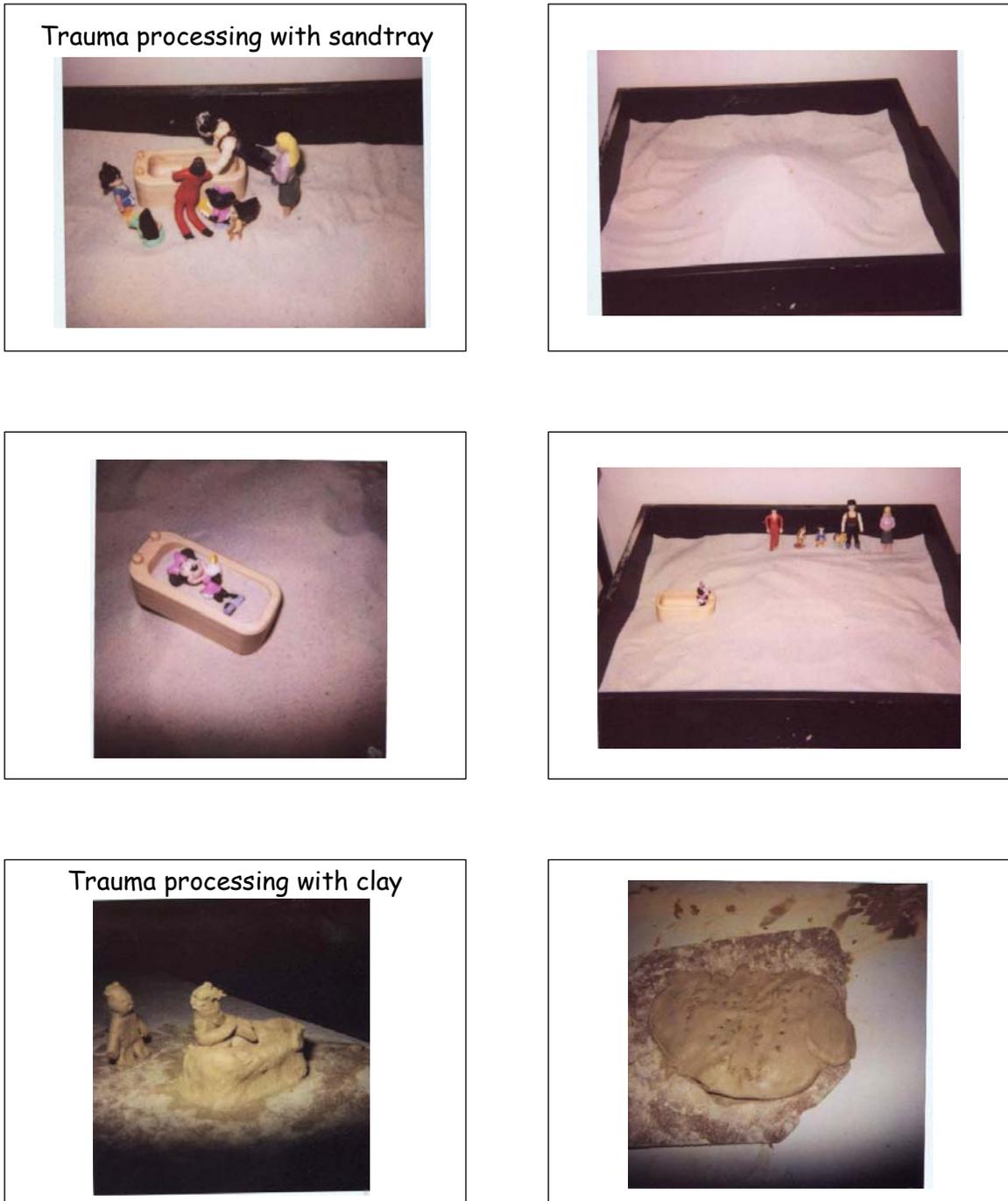
Figure 1.2. Examples of trauma processing with expressive modalities

Appendix I

Examples of Target Concerns

Table 1.1. Child Self-Identified Target Concerns on the Coping Questionnaire (CQ)

Participant		Target Concerns
S1.1	CQ1	Thinking that I might not go back home
	CQ2	Thinking that I might not be with (my siblings)
	CQ3	Remembering what happened (witnessing mother's suicide attempt)
S1.2	CQ1	Thinking about being away from Mum
	CQ2	Thinking about the times my stepfather hit me
	CQ3	Having trouble sleeping
S1.3	CQ1	Thinking about where I am going to live
	CQ2	Thinking about what happened with X (CSA)
	CQ3	Thinking about Y threatening me and my Mum (DV)
S1.4	CQ1	Thinking about being away from my Mum
	CQ2	Thinking about the hitting that happened (DV, CPA)
	CQ3	Having trouble sleeping

Appendix J

Additional Results: CQ4

The following graphs present the results of participants' reported scores on the Coping Questionnaire CQ4: *How much do you think this programme will help you feel less upset?* (On a scale of 1-7; 1=*not at all able to help myself*; 7=*completely able to help myself*).
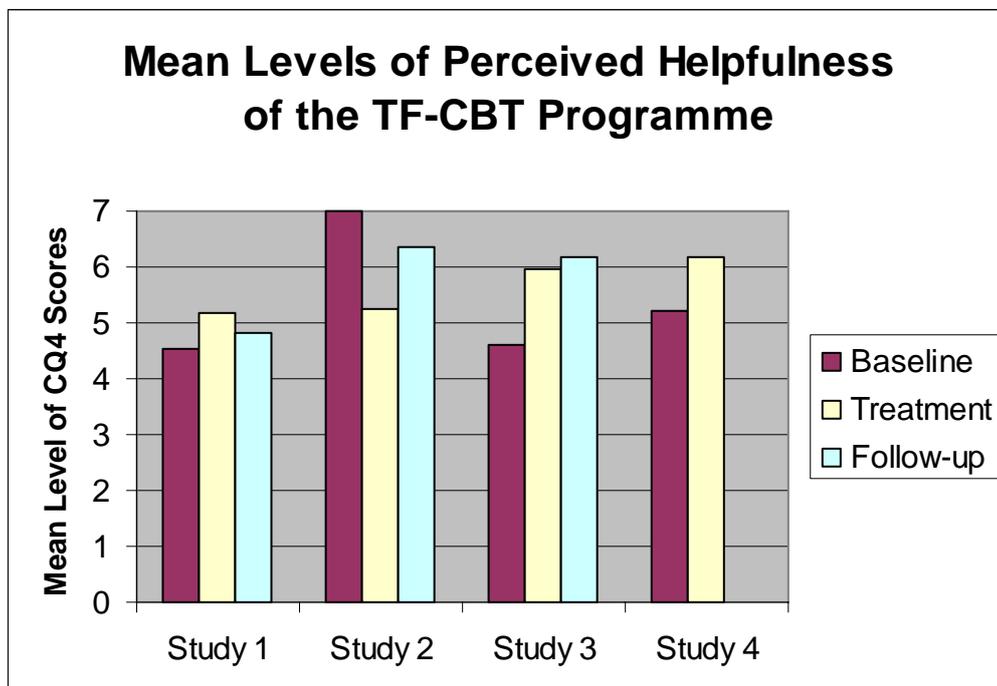
NB: Follow-up CQ4 results for Study 4 was limited to one participant so is not recorded on the graph (S4.4; follow-up CQ4 = 7). Other phases also have some missing data (see Figures 1.4-1.7).

Figure 1.3. Mean level of participants' perceived helpfulness of the programme across baseline, assessment and treatment for each of the four studies.
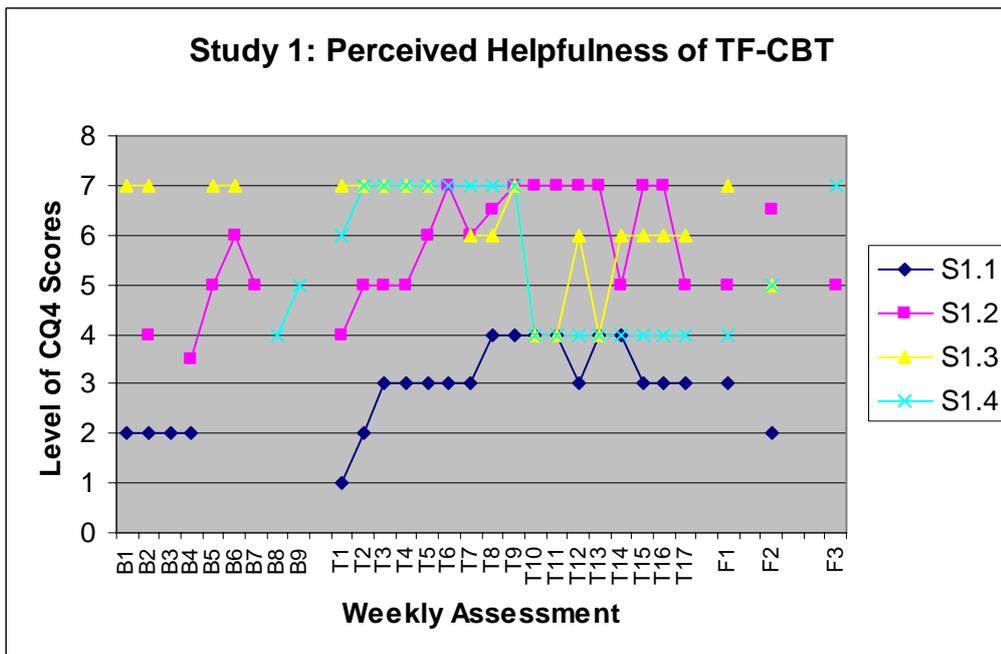
Figure 1.4. Study 1 participants' perceived helpfulness of the programme across baseline, assessment and treatment.
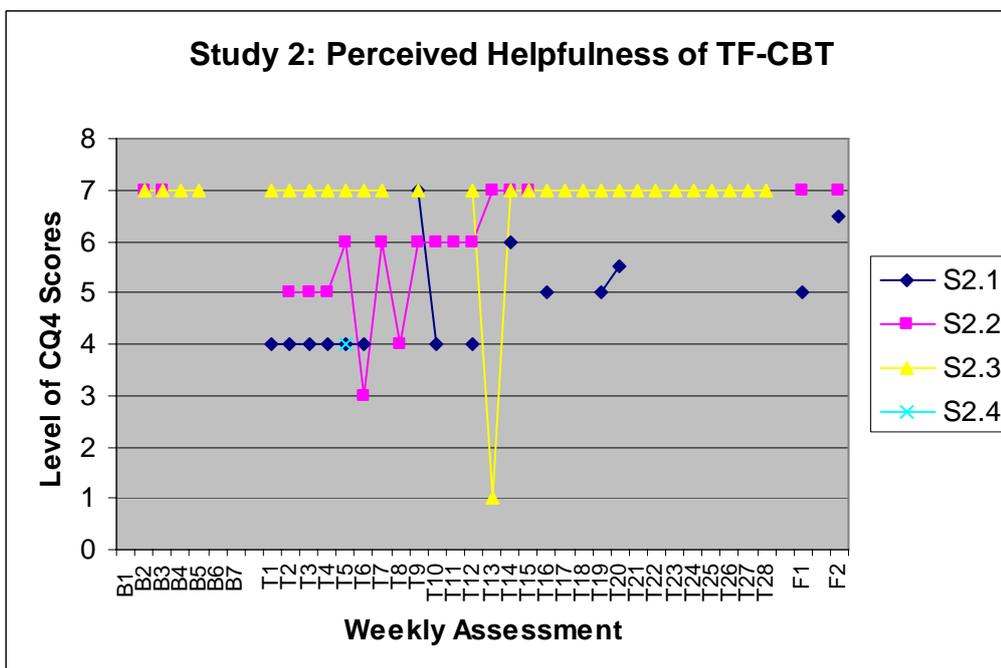

Figure 1.5. Study 2 participants' perceived helpfulness of the programme across baseline, assessment and treatment.
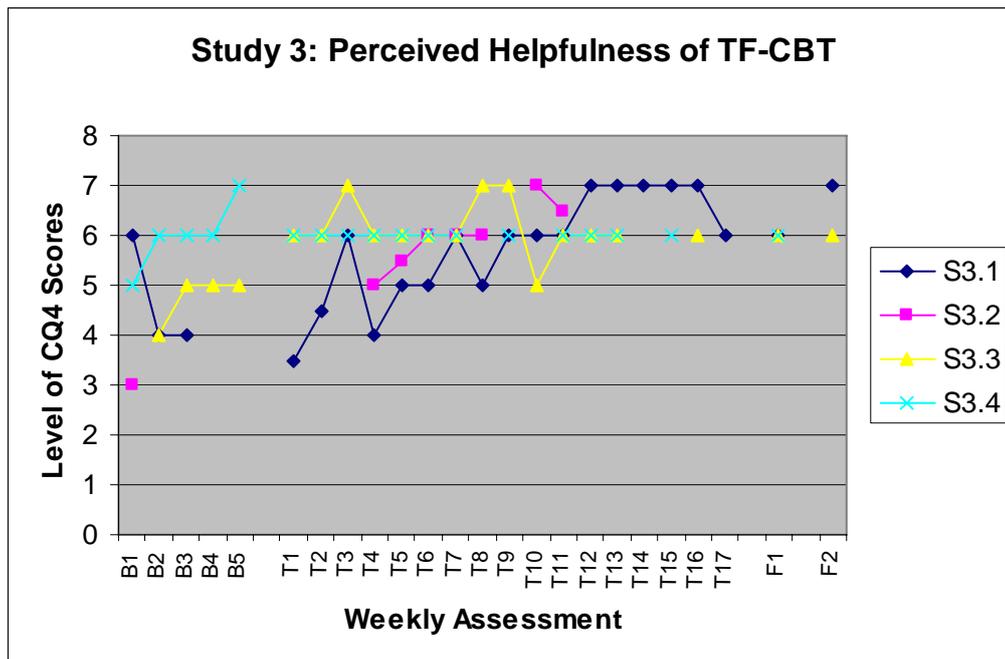
Figure 1.6. Study 3 participants' perceived helpfulness of the programme across baseline, assessment and treatment.
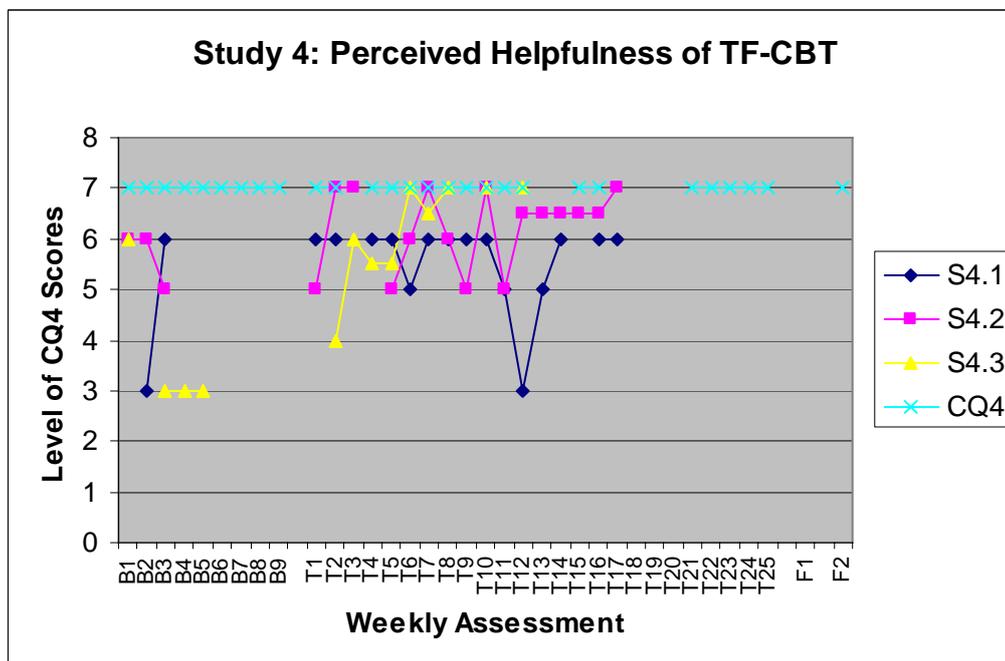

Figure 1.7. Study 4 participants' perceived helpfulness of the programme across baseline, assessment and treatment.

Appendix K

Additional Results: TSCC

Table 1.2. Study 3: Child Report Scores on Repeated Measure of Child Trauma

Symptom categories (T scores)	Participant	Assessment points			
		Pre-treatment	Post-treatment	3 month follow-up	6 month follow-up
TSCC-UND/HYP	S3.1	47/83	57/65	57/47	[81/46]
	S3.2	58/47	[74/47]	-	-
	S3.3	42/65	[86/46]	[81/46]	67/46
	S3.4	39/47	39/47	62/47	-
TSCC-ANX	S3.1	75**	42	39	[35]
	S3.2	46	[39]	-	-
	S3.3	52	[37]	[35]	35
	S3.4	41	62	41	-
TSCC-DEP	S3.1	73**	43	36	[43]
	S3.2	41	[39]	-	-
	S3.3	43	[37]	[39]	39
	S3.4	57	61	44	-
TSCC-ANG	S3.1	68**	44	48	[37]
	S3.2	45	[38]	-	-
	S3.3	39	[35]	[37]	38
	S3.4	57	53	43	-
TSCC-PTS	S3.1	72**	49	42	[35]
	S3.2	45	[41]	-	-
	S3.3	59	[36]	[38]	41
	S3.4	49	56	41	-
TSCC-DIS	S3.1	69**	63	49	[43]
	S3.2	43	[42]	-	-
	S3.3	44	[37]	[38]	37
	S3.4	62*	58	41	-
TSCC-SC	S3.1	57	67**	46	[41]
	S3.2	41	[38]	-	-
	S3.3	41	[36]	[36]	36
	S3.4	97*	78*	44	-

**Clinically significant compared with age and gender norms ($T \geq 65$; SC $T \geq 70$)
* Sub-clinical (but significant) symptomatology (T=60-64)
[ ] Invalid due to Under-response ($T \geq 70$) or Hyper-response ($T \geq 90$)
Note: TSCC = Trauma Symptom Checklist for Children; UND/HYP = Under-response/Hyper-response; ANX = Anxiety; DEP=Depression; ANG=Anger; PTS=Posttraumatic stress; DIS=Dissociation; SC=Sexual Concerns.

Table 1.3. Study 4: Child Report Scores on Repeated Measure of Child Trauma

Symptom categories (*T* scores)	Participant	Assessment points			
		Pre-treatment	Post-treatment	3 month follow-up	6 month follow-up
			-	-	-
TSCC-UND/HYP	S4.1	62/70			
	S4.2	46/47	-	-	41/47
	S4.3	41/47	-	[86/47]	-
	S4.4	67/65	-	-	[86/47]
TSCC-ANX	S4.1	63			
	S4.2	50	-	-	39
	S4.3	50	-	[35]	-
	S4.4	44			[35]
TSCC-DEP	S4.1	50			
	S4.2	50			40
	S4.3	48		[35]	-
	S4.4	43			[35]
TSCC-ANG	S4.1	42			
	S4.2	50			45
	S4.3	45		[37]	-
	S4.4	40			[36]
TSCC-PTS	S4.1	63			
	S4.2	53			39
	S4.3	45		[36]	-
	S4.4	56			[35]
TSCC-DIS	S4.1	61			
	S4.2	50			47
	S4.3	45		[37]	-
	S4.4	49			[37]
TSCC-SC	S4.1	50			
	S4.2	75*			51
	S4.3	42		[42]	-
	S4.4	46			[43]

**Clinically significant compared with age and gender norms ($T \geq 65$; SC $T \geq 70$)
* Sub-clinical (but significant) symptomatology (T=60-64)
[ ] Invalid due to Under-response ($T \geq 70$) or Hyper-response ($T \geq 90$)

Note: TSCC = Trauma Symptom Checklist for Children; UND/HYP = Under-response/Hyper-response; ANX = Anxiety; DEP=Depression; ANG=Anger; PTS=Posttraumatic stress; DIS=Dissociation; SC=Sexual Concerns.