Social Work/Maatskaplike Werk Vol 52 No 4; Issue 4
http://socialwork.journals.ac.za/pub doi:http://dx.doi.org/10.15270/52-4-528

WORKING ON TRAUMA – A SYSTEMATIC REVIEW OF TF-CBT WORK WITH CHILD SURVIVORS OF SEXUAL ABUSE

Leon Holtzhausen, Ashleigh Ross, Rian Perry

Although there is growing interest in evidence-based practice (EBP), the implementation of research into clinical practice is still underutilised (DiCenso, Guyatt & Ciliska, 2005; Rycroft-Malone & Bucknall 2010). One emerging method in clinical practice with child survivors of sexual abuse is trauma-focused cognitive behavioural therapy (TF-CBT). This study aimed to systematically review the literature on TF-CBT work with child survivors of sexual abuse in an attempt to provide social work educators and practitioners with sufficient information about these treatments, which they can pursue in ongoing education and training.

WORKING ON TRAUMA – A SYSTEMATIC REVIEW OF TF-CBT WORK WITH CHILD SURVIVORS OF SEXUAL ABUSE

Leon Holtzhausen, Ashleigh Ross, Rian Perry

INTRODUCTION

There is general consensus amongst clinicians and researchers about the negative effects of child sexual abuse (CSA) on children's psychological wellbeing and their development into adulthood. Over the past three decades researchers have evaluated the extent of psychological injuries to children who were sexually abused. Studies have documented a litany of short-term mental health and behavioural problems associated with CSA (Beitchman, Zucker, Hood, Dacosta & Akman, 1991; Beitchman *et al*., 1992; Browne & Finkelhor, 1986; Chapman *et al*., 2004; Jumper, 1995; Kendall Tackett, Williams & Finkelhor, 1993; Paolucci, Genuis & Violato, 2001; Romano & De Luca, 2001; Spatz, Widom, Czaja & Dutton, 2008; Widom, DuMont & Czaja, 2007). In meta-analyses on the prevalence of child sexual abuse around the world Stoltenborgh, Van Ijzendoorn, Euser & Bakermans-Kranenburg (2011) show that CSA is associated with a variety of problems in the short and the long term for both male and female victims. These can include, but are not limited to, depression, anxiety, behavioural problems, sexualised behaviours, posttraumatic stress disorder (PTSD), substance use, suicide attempts as well as being victims of adult rape (Cohen, Deblinger, Mannarino & Steer 2004; Padmanabhanunni & Edwards, 2016).

From the above it is reasonable to infer that without primary intervention, exposure to traumatic events during childhood and adolescence may have deleterious effects on wellbeing across the life span (Lenz & Hollenbaugh, 2015). Providing high-quality care and support services to survivors of sexual abuse is important for reducing trauma, helping survivors heal and preventing repeat victimisation and future risk-taking behaviour (WHO, 2014:40). Despite overwhelming evidence of the long-lasting consequences produced by childhood sexual abuse and the role trauma plays in causing this damage, the subsequent treatment of childhood trauma remains undeveloped in generalist social work practice.

Social workers are called on to help with the treatment of traumatised children and adolescents exposed to abuse (physical, sexual, psychological and emotional), crime, neglect, rape, domestic violence and community violence. They are often asked to advocate and be a voice for the needs of children and adolescents affected by childhood traumas. Because of the lasting effects of trauma, it is essential that social workers and other professionals provide these children and adolescents with the best and most effective treatment possible.

It must be acknowledged that, although social workers are in the "front line" when it comes to working with highly vulnerable and abused children, they frequently operate without the support, time, knowledge and training needed to ensure the identification of sexual abuse and the protection and wellbeing of extremely vulnerable children. Closer

to home, Fourie in her research shows the impact of CSA on direct victims, their families and communities, but also mentions that the high incidence of CSA in South Africa is compounded by inadequate service delivery by "front line" personnel (2013).

One reason for lack of knowledge on trauma work is that training does not always keep abreast of the increasing challenges of keeping children safe and preventing re-traumatisation after an abuse event in the life of the child. Training of social workers needs to be more focused on nonprocedural elements of the work, including more emphasis on direct trauma work with children, multi-agency work and supporting children and their families after disclosure.

As educators we need to collaborate to achieve greater consistency regarding the teaching of the nature of child sexual abuse and its treatment during qualifying training. Furthermore, there is a need to promote links between theoretical learning in areas of trauma work, evidence-based practice, social work methods and their application to the practice of child sexual abuse work.

A central task for social work practitioners is to ensure the selection and implementation of programmes and interventions that have proven to be effective or promising in child sexual abuse work. Youths who experience long-standing traumas such as sexual abuse that extend over several critical times in their development may demonstrate severe symptomatology without trauma intervention (English, Graham, Litrownik, Everson & Bandiwala, 2005). The challenge here is to find evidence-based practice and social work methods that work with multiple forms of abuse.

Researchers such as Murray and colleagues note that there is a growing evidence base of effective psychotherapeutic treatments for sexually abused children and their families (Murray *et al*., 2016). One such approach is trauma-focused cognitive behavioural therapy (TF-CBT).

Trauma-focused cognitive behavioural therapy (TF-CBT) (Cohen, Mannarino & Deblinger, 2006) was developed to address the multiple negative impacts of stressful or traumatic life events for children aged 3 to 17 years and for their parents or primary caregivers. As such, TF-CBT is widely accepted and documented as a best practice model when treating PTSD symptoms experienced by CSA as well as other types of trauma, domestic violence and grief (Johnson, 2012). In short, TF-CBT provides psycho-education and assists clients in developing coping mechanisms for when they are confronted with any abuse-related memories and feelings. Consequently this process aims to lessen the anxiety that underlies in PTSD as well as depression (Neubauer, Deblinger & Sieger, 2007). Included in trauma work is the need to address feelings of shame, emotional distress and depression (Neubauer *et al.*, 2007).

The literature shows consistently that utilising a trauma-focused approach that focuses on both behavioural as well as unhelpful cognitions is ideal for learning to cope with the effects of traumatic events (Heflin & Deblinger, 2003; Holstead & Dalton, 2013). As Kliethermes (2007) explains, "the client learns through operant and classical conditioning how to act and feel differently in a situation that usually causes distress". Trauma-focused cognitive behavioural therapy (TF-CBT) is widely considered to be one

of the most effective evidence-based practice (EBP) treatments utilised to address PTSD, depression or related symptoms caused by various traumatic experiences (Sigel, Benton, Lynch & Kramer, 2013; Vieth, Tchividjian, Walker & Knodel, 2012).

From the above it would seem that the evidence-based practice (EBP) movement has gained dominance in scientific discourse on the use of TF-CBT in trauma work and with that also its vision of what constitutes scientific evidence. However, the efficacy of some of these evidence-based practices with diverse populations, such as clients from underprivileged groups and non-Western cultures, has been a subject of controversy.

One of the primary criticisms of EBP that supports interventions such as TF-CBT has been that the research community has tended to ignore cultural variables and has consequently failed to recognise the distinctive clinical needs of underprivileged groups and diverse non-Western populations (Brown, 2006; Levant & Silverstein, 2006; Olkin & Taliaferro, 2006; Sue & Zane, 2006). Holstead and Dalton, two proponents of EBP, responded to this criticism by "proving" that TF-CBT is considered effective in different cultures and races (2013).

Whichever way "evidence" is constructed, it is clear what is needed here is interventions tested in real-world settings as opposed to controlled settings. A recent example is a qualitative study that examined Zambian counsellors', children's and caregivers' perceptions of an evidence-based treatment (EBT) for trauma (TF-CBT) utilised in Zambia to address mental health problems in children (see Murray *et al*., 2016).

TF-CBT THERAPEUTIC APPROACH TO WORKING WITH CHILD SURVIVORS OF SEXUAL ABUSE – SOME CONCERNS AND ALTERNATIVES

The treatment of a child and familial system after sexual abuse has occurred needs to be multifaceted for a number of reasons. Firstly, survivors of sexual abuse often experience maladaptive or unhelpful beliefs and attributions related to the abusive events, including a sense of guilt for their role in the abuse, anger at parents for not knowing about the abuse, feelings of powerlessness, a sense that they are in some way "damaged goods", and a fear that people will treat them differently because of the abuse.

Also, according to Berliner and Elliott (2002) and Briere and Elliott, (2003), other sequelae include acting out behaviours such as engaging in age-inappropriate sexual behaviours and mental health disorders, including major depression, posttraumatic stress disorder (PTSD) symptoms, characterised by:

- Intrusive and reoccurring thoughts of the traumatic experience;
- Avoidance of reminders of the trauma (often places, people, sounds, smells and other sensory triggers);
- Emotional numbing;
- Irritability;
- Trouble sleeping or concentrating;

- Physical and emotional hyperarousal (often characterised by emotional swings or rapidly accelerating anger or crying that is out of proportion to the apparent stimulus).

Likewise, as Murray *et al*. (2016) state that "it is common for sexually abused children to have other types of traumatic experiences; for example, being removed from their home, witnessing domestic violence, and experiencing multiple instances of sexual abuse, physical abuse, and neglect".

Bearing in mind the complex and multifaceted nature of CSA, it is interesting to note which treatment approaches are deemed the most effective by mental health practitioners. Sigel *et al*. (2013) report that in a 1999 study physiatrists were asked which of a list of six treatments they would consider the most effective for PTSD. At that time pharmacotherapy (a popular approach in the 1990s) was selected by 20.4% participants. As for the majority, 22.6% of them preferred cognitive behavioural therapy. This is over 15 years ago and still today TF-CBT for treating PTSD in children is the only treatment scoring a "highest rating" on academic reviews and evidence base (Sigel, *et al*., 2013:324; Scheeringa *et al*., 2011).

Murray *et al*. (2016) report on a more recent Cochrane Review that examined the effectiveness of psychological therapies in treating children and adolescents who have been diagnosed with PTSD (see Saunders, 2013). Saunders reviewed 14 randomised controlled trials (RCTs), totalling 758 participants who had experienced sexual abuse, civil violence, natural disaster, domestic violence and motor vehicle accidents (Saunders, 2013 in Murray *et al*., 2016). The therapies used in these 14 studies were: (1) cognitive-behavioural therapy (CBT); (2) exposure-based; (3) psychodynamic; (4) narrative; (5) supportive counselling; and (6) eye-movement desensitisation and reprocessing (EMDR) (Saunders, 2013, in Murray *et al*., 2016).

TF-CBT is a hybrid model that integrates elements of exposure-based, cognitive-behavioural, affective and humanistic, attachment, family and empowerment therapies into a treatment designed to address the unique needs of children with problems related to traumatic life experiences such as sexual abuse (Smith, Yule & Perrin, 2007, in Murray *et al*., 2016).

According to Murray *et al*. (2016), this treatment was developed to ideally include both the child (aged 3-18 years) and a supportive caregiver in weekly parallel sessions. Eight components are delivered and practised over a period of approximately 12 to 16 weeks (Murray *et al*., 2016). The components of TF-CBT include: (1) psychoeducation; (2) relaxation; (3) affective modulation; (4) cognitive processing; (5) trauma narrative (gradual exposure) and cognitive restructuring of the trauma; (6) in vivo desensitisation; (7) conjoint parent/child session; and (8) enhancing safety skills. Although the treatment is designed with specific components, each with a set of goals, TF-CBT is highly flexible in addressing the individual presentation of symptoms and the needs of different children and families (Smith *et al*., 2007, in Murray *et al*., 2016).

To help children and adolescents develop coping skills, treatment providers teach relaxation skills, affective modulation skills and cognitive coping skills. In addition, TF-

CBT uses exposure principles and cognitive-restructuring techniques that are specific to the traumatic experience. Exposure involves gradually introducing individuals to reminders of the trauma that may be tangible, such as places or people, or intangible, such as specific memories of traumatic events. The gradual exposure reduces distress associated with these reminders and decreases trauma-related reactions. Cognitive restructuring involves identifying inaccurate and unhelpful thoughts and beliefs (for example, self-blame) associated with traumatic events and developing more adaptive ways of understanding and drawing conclusions about the trauma and the victim's reactions to it.

Studies have examined the TF-CBT compared to treatments such as child-centred therapy (CCT), standard community treatment (SCT), nondirective supportive therapy and others. These studies have found that TF-CBT is particularly effective at reducing symptoms of PTSD and improving ways of coping with anxiety and other behaviours on a wide scale (Cohen, 2004; Deblinger *et al*., 2006; Cohen & Mannarino, 1996; Cohen *et al*., 2000).

From the above it would seem that TF-CBT is not only the most researched but also the most endorsed treatment for CSA; however, this is not necessarily the case. According to Cloitre (2009), there is strong evidence that other psychosocial interventions provide substantial relief of PTSD symptoms beyond the typical cognitive-behavioural treatments as usual. There is a growing debate amongst trauma specialists that some patients with histories of abuse and/or multiple forms of abuse require multimodal interventions, applied consistently over a longer period of time than the 12 to 16 weeks offered by TF-CBT (Feeny, Hembree & Zoellner, 2003).

Some have argued that findings from randomised clinical trials of manualised TF-CBT protocols cannot be generalised to community populations in which patients are more severely impaired and highly comorbid (for discussion, see Feeny *et al.*, 2003). These and other arguments have opened the treatment door to alternative treatment options.

One such alternative treatment option for CSA may be Shapiro's eye movement desensitisation and reprocessing (EMDR) (Shapiro, 2001). EMDR is a psychotherapeutic approach that was developed by Shapiro (1989, 2001) to resolve symptoms resulting from disturbing and unresolved life experiences. It is based on a theoretical information-processing model which posits that symptoms arise when events are inadequately processed and may be eradicated when the memories are fully processed and integrated. According to Diehle *et al*. (2015), EMDR has been put into practice for the treatment of children with PTSD during the past 10 years. In their recent study Diehle *et al*. (2015) conclude that TF-CBT and EMDR are both effective and efficient in treating children with PTSD in the outpatient setting.

A BRIEF SYSTEMATIC REVIEW OF TF-CBT WORK WITH CHILD SURVIVORS OF SEXUAL ABUSE

A systematic review is described by Higgins and Green (2011) as a literature review focused on a specific research question that aims to identify evidence relevant to that

question. It is an improvement on traditional literature reviews as reviews are prone to bias (Higgins & Green, 2011). This is avoided by using systematic methods to identify, select and analyse relevant research.

Conducting a review based on the Cochrane systematic review process should involve careful consideration, as the approach would be less profound than a full systematic review, while still maintaining the key aspects of the review process. These principles include retaining (Higgins & Green, 2006, 2011):

- A clear set of objectives with pre-defined eligibility criteria for studies;
- A reproducible methodology;
- A systematic search process;
- An assessment of the validity of the findings; and
- A systematic presentation of findings

The methods for conducting a systematic review are described in the Cochrane Handbook and have been adapted for the purpose of this review. Key aspects presented in this review were based on the systematic reviews conducted by Wethington *et al*. (2008) and MacDonald *et al*. (2012), as well as from the works of Higgins and Green (2006, 2011). The objective of this review was to assess the efficacy of TF-CBT approaches when working with CSA, and to find evidence to either support or discard the use of TF-CBT and to answer the following research question: "What is the evidence base for TF-CBT work with child survivors of sexual abuse?"

A search was conducted to find articles that report the use of TF-CBT specifically for treating CSA. Electronic searches for literature were conducted on the EBSCOHOST engine and included the following databases: Academic Search Premier, ERIC, Humanities International, PsycArticle, PsycCritiques, PsycINFO and SocINDEX. The following search terms were used: "TF-CBT"; child sexual abuse"; "child survivors of sexual abuse"; "treating child sexual abuse"; "treating child survivors of sexual abuse"; as well as combinations of these search terms.

We also searched the Cochrane Central Register of Controlled Trials (CENTRAL) (5 March 2015); MEDLINE (1995 to October Week 43 2015); EMBASE (1995 to Week 47 2015); CINAHL (1995 to October Week 43 2015); PsycINFO (1995 to October Week 43 2015); LILACS (1995 to 2 October 2015) and OpenGrey, previously OpenSIGLE, (1995 to 2 October 2015). CENTRAL is a bibliographical database that provides a highly concentrated source of reports of randomised controlled trials. Records contain the list of authors, the title of the article, the source, volume, issue, page numbers and in many cases a summary of the article (Abstract). They do not contain the full text of the article.

Our review included the following types of articles: randomised controlled trials (RCTs), quasi-experimental studies, single-group time-series design studies, and review articles such as meta-analyses and systematic reviews. We also included review articles and meta-analyses that examined TF-CBT along with other cognitive-behavioural

approaches (for example, articles that reviewed all cognitive-behavioural approaches, including TF-CBT).

We excluded studies of other cognitive-behavioural-based interventions for traumatised children, such as cognitive behavioural intervention for trauma in schools, which involves school-based prevention and treatment groups with less caregiver involvement, and narrative exposure therapy, which does not include other core components of TF-CBT.

WHAT IS THE EVIDENCE BASE FOR TF-CBT WORK WITH CHILD SURVIVORS OF SEXUAL ABUSE?

During the literature review phase of research for this article we found numerous authors who commend the effectiveness of TF-CBT to treat PTSD and related symptoms in CSA (Black, Woodworth & Tremblay, 2012; Holstead & Dalton, 2013; Vieth *et al*., 2012; MacDonald *et al*., 2012; Sigel *et al*., 2013; Murray *et al*., 2016). Our review supports the general opinions found in the mentioned academic articles as it was found that most research reported high levels of effectiveness regarding the use of TF-CBT when working with CSA.

From the review it is clear that there is an impressive amount of empirical support for TF-CBT and a well-established track record for positive results. Jensen, Holt, Ormhaug, Egeland, Granly, Hoaas, Hukkelberg, Indregard, Stormyrem and Wentzel-Larsen (2014:365) state that the TF-CBT programme was developed and implemented in the United States of America (USA) and that this was the first study done in order to evaluate its effectiveness outside of the USA. The purpose of this study was to compare the use of TF-CBT to therapy usually provided in 8 community clinics in Norway. Jensen *et al*. (2013) found that all participants showed significant improvement from start of therapy to finish in terms of behavioural issues. To further substantiate the above, Mannarino, Cohen, Deblinger, Runyon and Steer (2012:231, 238-239) also found significant improvements that were sustained both 6 and 12 months after treatment, demonstrating TF-CBT's treatment successes.

Elsewhere Leenarts, Diehle, Doreleijers, Jansma and Lindauer (2012:269) conducted a systematic review on children exposed to childhood maltreatment, including sexual abuse, specifically where there is evidence of trauma-related psychopathology such as PTSD, anxiety, suicidal ideation and substance abuse. They found that TF-CBT is the best supported treatment for children following maltreatment (Leenarts *et al*., 2012:269, 280) as well as indicating that regardless of the length of treatment, this therapy is effective in overall improvement in both the children's and the parents' coping skills.

In their work Hébert and Daignault (2014:21,23,25) state that TF-CBT is clearly a best practice, with numerous studies indicating the reduction of symptoms associated with sexual abuse, and that the successes are maintained and positive outcomes are seen in both the child and parent. In an earlier study by Sheeringa *et al*. (2011:853) it was found that TF-CBT results in reduction of symptoms related to comorbid disorders and that the positive effects of this type of treatment are long lasting. Silverman, Ortiz, Viswesvaran,

Burns, Kolko and Putnam (2008, in Sheeringa *et al*., 2011) reported that TF-CBT has the largest controlled evidence base which consistently shows high efficacy.

According to Cohen and Mannarino (2008), TF-CBT for both children and parents is an evidence-based treatment model that is flexible and consists of individual and joint parent sessions (2008:158). The effectiveness of these sessions has been tested in a number of controlled treatment trials for child survivors of sexual abuse, all with outcomes that support the efficacy of this treatment being utilised to ameliorate PTSD, depression and other difficulties in children from ages 3 to 17.

Further evidence supporting the effectiveness of TF-CBT is documented by Cohen, Deblinger, Mannarino and Steer (2004:8). In this study TF-CBT and child-centred therapy (CCT) was used and from the results it is clear that TF-CBT demonstrated a higher level of improvement with regard to PTSD, depression and other behavioural problems. This study was the first trial done whereby alternative treatments such as standard community treatment (SCT), nondirective supportive therapy and others were compared using controlled groups with children suffering from PTSD as a result of sexual abuse. The systematic review indicated that TF-CBT, when compared to alternative treatment approaches, was the most successful approach to treating children who experienced trauma (Deblinger *et al*., 2004).

It is clear that TF-CBT is a highly adaptable therapeutic model that could be used for both children and families to provide them with skills in addressing behaviour problems where a traumatic event has been experienced (Cohen, Berliner & Mannarino, 2009:216, 224). Furthermore, because TF-CBT is structured around the child and parent having individual sessions as well as joint parent-child sessions, it offers a cost effective and timeous treatment approach given the scarcity of adequately trained trauma workers. TF-CBT is a flexible approach that can be adjusted and adapted to suit various possible treatment scenarios (Vieth *et al*., 2012). The client system is also unique and each case should be assessed and addressed according to individual needs (Heflin & Deblinger, 2003; MacDonald *et al*., 2012; Vieth *et al*., 2012).

CONCLUSION

In this article we have discussed the major, most fully researched evidence-based treatment practice for CSA, namely TF-CBT. Although there are certainly other, less well-researched approaches, such as EMDR, our review showed that TF-CBT still has the strongest evidence-base for treatment of children who have experienced sexual abuse, exposure to domestic violence and/or similar traumas.

An argument could be made that the research cited in this review is progressively positivistic in nature and only those verifiable (and refutable) scientific inferences were selected as "knowledge". We acknowledge that quantitative "verifiable" approaches, the foundation upon which the TF-CBT evidence base is constructed, is well funded and well endorsed in the scientific community, many times discounting the "evidence" offered by qualitative research. Post-modernists would argue that all knowledge has a social infrastructure and context because that knowledge is socially constructed, and by

its very observation not "impartial" or "objective". We would argue that effective practice necessitates an understanding of the evidence-based psychosocial treatments and how they fit within holistic work with a survivor of sexual abuse. Also important is the ability of "front-line" personnel such as social workers to work within and across under-resourced settings and systems as they select, advocate or deliver trauma-focused work.

"Gaining insight from comparative studies and measuring results are part of the Cochrane Review process", say Higgins and Green (2011). This systematic review and others like it could lay the groundwork for education of social workers in evidence-based psychosocial treatments such as TF-CBT for CSA.

Efforts to increase social work education in CSA treatment will ideally include coursework, practical work and continuing education initiatives. They may also require collaboration with professionals outside of social work, such as CSA treatment specialists and mental health workers to help generate a body of intervention research to support the enhancement of social work practice in this field.

REFERENCES

BLACK, P.J., WOODWORTH, M. & TREMBLAY, M. 2012. A review of trauma-informed treatment for adolescents. **Canadian Psychology**, 53(3):192-203. DOI: 10.1037/a0028441.

BROWN, L. 2006. The neglect of lesbian, gay, bisexual, and transgendered clients. **In**: NORCROSS, J., BEUTLER, L. & LEVANT, R. (eds), **Evidence-based practices in mental health: debates and dialogues on the fundamental questions**. Washington, DC: American Psychological Association, 161-189.

BROWNE, A. & FINKELHOR, D. 1986. Impact of child sexual abuse: a review of the research. **Psychological Bulletin**, 99(1):66-77. DOI: 10.1037/0033-2909.99.1.66.

BEITCHMAN, J.H., ZUCKER, K.J., HOOD, J.E., DACOSTA, G.A., AKMAN, D. & CASSAVIA, E. 1992. A review of the long-term effects of child sexual abuse. **Child Abuse and Neglect**, 16(1):101-118. DOI: 10.1016/0145-2134(92)90011-F.

CHAPMAN, D.P., WHITFIELD, C.L., FELITTI, V.J., DUBE, S.R., EDWARDS, V.J. & ANDA, R.F. 2004. Adverse childhood experiences and the risk of depressive disorders in adulthood. **Journal of Affective Disorders**, 82(2):217-225. DOI:10.1016/j.jad.2003.12.013.

CHILD WELFARE INFORMATION GATEWAY. 2012. **Trauma-Focused Cognitive Behavioural Therapy for Children Affected by Sexual Abuse or Trauma**. ISSUE BRIEF. [Online] Available: http://www.childwelfare.gov [Accessed: 26/08/2015].

CHILDREN'S HOSPITAL SAN DIEGO. 2004. **Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices. The findings of the Kauffman best practices project to help children heal from child abuse**. USA: Kauffman foundation.

COHEN, J.A. & MANNARINO, A.P. 2008. Trauma-focused cognitive behavioural therapy for children and parents. **Child and Adolescent Mental Health**, (13)4:158-162. DOI: 10.1111/j.1475-3588.2008.00502.x.

COHEN, J.A., MANNARINO, A.P. & KNUDSEN, K. 2005. Treating sexually abused children: 1 year follow-up of a randomized controlled trial. **Child Abuse and Neglect**, 29:135-145. DOI: 10.1016/j.chiabu.2004.12.005.

COHEN, J.A., MANNARINO, A.P. & DEBLINGER, E. 2006. **Treating trauma and traumatic grief in children and adolescents**. New York: Guilford Press.

COHEN, J.A., DEBLINGER, E. & MANNARINO, A. 2004. Trauma-focused cognitive-behavioural therapy for sexually abused children. **Psychiatric Times**, 11:10-25.

CORNELL, W. & OLIO, K. 1991. Integrating affect with adult survivors of physical and sexual abuse. **American Journal of Orthopsychiatry**, 61(1):1-10.

CORNELL, W. & OLIO, K. 1993. The therapeutic relationship as the foundation for treatment with adult survivors of sexual abuse. **Psychotherapy: Theory, Research, Practice, Training**, 30(3):512-523.

DEBLINGER, E., MANNARINO, A.P., COHEN, J.A. & RUNYON, M.K. & STEER, R.A. 2011. Trauma-focused cognitive behavioural therapy for children: impact of the trauma narrative and treatment length. **Depression and Anxiety**, 28:67-75. DOI 10.1002/da.20744.

DEBLINGER, E., STAUFFER, L.B. & STEER, R.A. 2001. Comparative efficacies of supportive and cognitive behavioural group therapies for young children who have been sexually abused and their non-offending mothers. **Child Maltreatment**, 6(4):332-343. DOI: 10.1177/1077559501006004001.

DICENSO, A., GUYATT, G. & CILISKA D. 2005. **Evidence-based nursing. A guide to clinical practice**. St. Louis, MO: Elsevier Mosby.

DIEHLE, J., DE ROOS, C., BOER, F. & LINDAUER, R.J.L. 2015. A cross-cultural validation of the clinician administered PTSD scale for children and adolescents in a Dutch population. **European Journal of Psycho-traumatology**, 4.

DUMONT, K.A., WIDOM, C.S. & CZAJA, S.J. 2007. Predictors of resilience in abused and neglected children grown-up: The role of individual and neighbourhood characteristics. **Child Abuse and Neglect**, 31(3):255-274. DOI: 10.1016/j. chiabu.2005.11.015.

ENGLISH, D.J., GRAHAM, S.C., LITROWNIK, L.K., EVERSON, R.B. & BANDIWALA, D.B. 2005. The dimensions of maltreatment: introduction. **Child Abuse & Neglect**, 29(5):441-460.

NCCTS. n.d. **Questions and answers about child sexual abuse**. An interview with Esther Deblinger, PhD. [Online] Available: www.nctsn.org. [Accessed: 18/08/2015].

FEENY, N.C., HEMBREE, E.A. & ZOELLNER, L.A. 2003. Myths regarding exposure therapy for PTSD. **Cognitive and Behavioral Practice**. 10:85-90.

FEENY, N.C., ZOELLNER, L.A. & FOA, E.B. 2002. Treatment outcome for chronic PTSD among female assault victims with borderline personality disorder characteristics: a preliminary examination. **Journal of Personality Disorders**, 16(1):30-40.

FINKELHOR, D., ORMROD, R.K. & TURNER, H.A. 2007. Poly-victimization: a neglected component in child victimization. **Child Abuse Neglect,** 31:7-26.

FOURIE, A. 2013. **Family play therapy in the context of child sexual abuse: an ecological and Gestalt field approach model**. Potchefstroom: North-West University. (Doctoral dissertation)

FOSTER, J.M. 2014. Supporting child victims of sexual abuse: implementation of a trauma narrative family intervention. **The Family Journal: Counseling and Therapy for Couples and Families**, 22(3):332-338. DOI: 10.1177/1066480714529746.

HEFLIN, A.H. & DEBLINGER, E. 2003. Treatment of a sexually abused adolescent with posttraumatic stress disorder. **In**: REINECKE, M.A., DATTILIO, F.M. & FREEMAN, A. (eds), **Cognitive therapy with children and adolescents. a casebook for clinical practice**. New York: Guilford Press.

HEBERT, M., & DAIGNEAULT, I. 2014. Effectiveness of a sexual assault awareness and prevention workshop for youth: a 3-month follow-up pragmatic cluster randomization study. **The Canadian Journal of Human Sexuality**, 24(1):19-30.

HERNANDEZ, D. 2014. **The use of trauma focused cognitive behavioural therapy with children who have experienced trauma to improve social functioning**. Minnesota: St. Catherine University. (MA Social Work Thesis)

HIGGINS, J.P.T. & GREEN S. EDS. 2006. **Cochrane Handbook for Systematic Reviews of Interventions Version 4.2.6** [updated September 2006]. The Cochrane Collaboration. [Online] Available: http://www.cochrane.org/resources/handbook/hbook.htm [Accessed: 18/08/2015].

HIGGINS J.P.T. & GREEN, S. (eds). 2011. **Cochrane Handbook for Systematic Reviews of Interventions Version 5.1.0** [updated March 2011]. The Cochrane Collaboration, 2011. [Online] Available: www.cochrane-handbook.org. [Accessed: 15/08/2015].

HOLSTEAD, J. & DALTON, J. 2013. Utilization of trauma-focused cognitive behavioural therapy (TF-CBT) for children with cognitive disabilities. **Journal of Public Child Welfare**, 7:536-548. DOI: 10.1080/15548732.2013.843495.

HOLTZHAUSEN, L. 2015. **Introduction to cognitive behaviour therapy**. [SWK4002S Lecture slides]. [Online] Available: https://vula.uct.ac.za/access/content/group/660f409a-62d6-477c-9c48-9784225e0a18/CBT%20Intro.pdf [Accessed: 25/06/2015].

HOUSE, R. & LOEWENTHAL, D. (eds). 2008. **Against and For CBT. Towards a constructive dialogue?** UK: Athenaeum Press.

JABERGHADERI, N., GREENWALD, R., RUBIN, A., ZAND, S.O. & DOLATABADI, S. 2004. A comparison of CBT and EMDR for sexually-abused Iranian girls. **Clinical Psychology and Psychotherapy**, 11:358-368.

JENSEN, T.K., HOLT, T. & ORMHAUG, S.M. 2013. A randomized effectiveness study comparing trauma-focused cognitive behavioural therapy with therapy as usual for youth. **Journal of Clinical Child and Adolescent Psychology**, 22(3):332-338.

JOHNSON, B.C. 2012. Aftercare for survivors of human trafficking. **Social Work and Christianity**, 39(4):370-389.

JONES, D. 2004. **Working with dangerous people**. The psychotherapy of violence. UK: Radcliffe Medical Press.

JUMPER, S.A. 1995. A meta-analysis of the relationship of child sexual abuse to adult psychological adjustment. **Child Abuse and Neglect**, 19(6):715-728. DOI: 10.1016/0145-2134(95)00029-8.

KENDALL TACKETT, K.A., WILLIAMS, L.M. & FINKELHOR, D. 1993. Impact of sexual abuse on children: A review and synthesis of recent empirical studies. **Psychological bulletin,** 113(1):164. DOI: 10.1037/0033-2909.113.1.164.

KLIETHERMES, M. 2007. **Trauma focused cognitive behavioural therapy for children/ado** [2015, August 18]. [video file]. [Online] Available: https://www.youtube.com/ watch?v=FQlfc-cz5yk [Accessed: 04/04/2015].

LEENARTS, L.E.W., DIEHLE, J. DORELEIJERS, T.A.H., JANSMA, E.P. & LINDAUER, R.J.L. 2013. Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: a systematic review. **European Child Adolescent Psychiatry**, 22:269-283. DOI 10.1007/s00787-012-0367-5.

LENZ, A.S. & HOLLENBAUGH, M.H. 2015. Meta-analysis of trauma-focused cognitive behavioral therapy for treating PTSD and co-occurring depression among children andadolescents. **Counseling Outcome Research and Evaluation**, 5(1):18-32.

LEVANT, R.F. & SILVERSTEIN, L.B. 2005. How well do empirically supported therapies and "treatment as usual" address gender as a dimension of diversity? **In**: NORCROSS, J.C., BEUTLER, L.E. & LEVANT, R.F. (eds), **Evidence-Based practices in Mental Health: debate and dialogue on the fundamental questions** Washington, D. C: American Psychological Association Books, 338-345.

MANNARINO, A.P., COHEN, J.A., DEBLINGER, E., RUNYON, M.K. & STEER, R.A. 2012. Trauma-focused cognitive-behavioural therapy for children sustained impact of treatment 6 and 12 months later. **Child Maltreatment**, 17(3):231-241. DOI: 10.1177/1077559512451787.

MacDONALD, G., HIGGINS, J.P.T., RAMCHANDANI, P., VALENTINE J.C., BRONGER, L.P., KLEIN, P., O'DANIEL, R., PICKERING, M., RADEMAKER, B.,

RICHARDSON, G. & TAYLOR M. 2012. **Cognitive-behavioural interventions for children who have been sexually abused** (Review). The Cochrane Collaboration. UK: JohnWiley and Sons, Ltd.

MURRAY, L.K., SKAVENSKI, S., MICHALOPOULOS, L.M., BOLTON, P.A., BASS, J.K., FAMILIAR, I. & COHEN, J. 2014. Counsellor and participant perspectives of trauma-focused cognitive behavioural therapy for children in Zambia: a qualitative study. **Journal of Clinical Child and Adolescent Psychology: The Official Journal for the Society of Clinical Child and Adolescent Psychology**, 43(6):902-914. [Online] Available: http://doi.org/10.1080/ 15374416.2013.859079.

NEUBAUER, F., DEBLINGER, E. & SIEGER, K. 2007. Trauma focused cognitive-behavioural therapy for child sexual abuse and exposure to domestic violence. **In**: WEBB, N.B. (ed), **Play therapy with children in crisis. Individual, group and family treatment** (3rd ed). New York: Guilford Publications.

OLKIN, R., & TALIAFERRO, G. 2006. Evidence-based practices in mental health: debate and dialogue on fundamental questions. **In**: NORCROSS, J.C., BEUTLER, L.E. & LEVANT, R.F. (eds), **Evidence-Based practices in Mental Health: debate and dialogue on the fundamental questions**. Washington DC: American Psychological Association.

PADMANABHANUNNI, A. & EDWARDS, D. 2016. Rape survivors' experiences of the silent protest: implications for promoting healing and resilience. **Qualitative Health Research**, 26(6):818-29.

PAOLUCCI, E.O., GENIUS, M.L. & VIOLATO, C. 2001. A meta-analysis of the published research on the effects of child sexual abuse. **The Journal of Psychology**, 135(1):17-36. DOI: 10.1080/00223980109603677.

ROMANO, E. & DE LUCA, R.V. 2001. Male sexual abuse: a review off effects, abuse characteristics, and links with later psychological functioning. **Aggression and Violent Behaviour,** 6(1): 55-78.

RYCROFT-MALONE, J. & BUCKNALL, T. 2010. Using theory and frameworks to facilitate the implementation of evidence into practice. **Worldviews on Evidence-Based Nursing**, 7:57-58.

RUNYON, M.K., DEBLINGER, E. & STEER, R.A. 2014. PTSD symptom cluster profiles of youth who have experienced sexual or physical abuse. **Child Abuse and Neglect**, 38:84-90. DOI: 10.1016/j.chiabu.2013.08.015.

SAUNDERS, B.E. 2003. Understanding children exposed to violence: toward an integration of overlapping fields. **Journal of Interpersonal Violence**; 18(4):356-76.

SCHEERINGA, M.S., WEEMS, C.F., COHEN, J.A., JACKSON, L.A. & GUTHRIE, D. 2011. Trauma-focused cognitive-behavioural therapy for posttraumatic stress disorder in three through six year-old children: a randomized clinical trial. **Journal of Child Psychology and Psychiatry**, 52(8):853-860. DOI: 10.1111/j.1469-7610.2010.02354.x

SHAPIRO, F. 2001. **Eye movement desensitization and reprocessing: basic principles protocols and procedures**. New York: Guildford Press.

SIGEL, B.A., BENTON, A.H., LYNCH, C.E. & KRAMER, T.L. 2013. Characteristics of 17 state-wide initiatives to disseminate trauma-focused cognitive-behavioural therapy (TF-CBT). **Psychological Trauma: Theory, Research, Practice, and Policy**, 5(4):323-333. DOI: 10.1037/a0029095

SMITH, P., YULE, W. & PERRIN, S. 2007. Cognitive-behavioural therapy for PTSD in children and adolescents: a preliminary randomized controlled trial. **Journal of the American Academy of Child and Adolescent Psychiatry**, 46:1051-1061.

SPATZ, S.J., WIDOM, C.S., CZAJA, S.J. & DUTTON, M.A. 2008. Childhood victimization and lifetime revictimization. **Child Abuse and Neglect**, 32(8):785-796.

STALLARD, P. 2006. Psychological interventions for post-traumatic reactions in children and young people: a review of randomised controlled trials. **Clinical Psychology Review**, 26:895-911.

STOLTENBORGH, M., VAN IJZENDOORN, M.H., EUSER, E.M. & BAKERMANS-KRANENBURG, M.J. 2011. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. **Child Maltreatment**, 16:79-101.

SUE, S. & ZANE, N. 2006. **Ethnic minority populations have been neglected by evidence-based practices. In**: NORCROSS, J.C., BEUTLER, L.E. & LEVANT, R.F. (eds), **Evidence-Based practices in Mental Health: debate and dialogue on the fundamental questions** Washington, DC: Am. Psychol. Assoc, 338-345; 359-361.

VIETH, V.I., TCHIVIDJIAN, B.J., WALKER, D.F. & KNODEL, K.R. 2012. Child abuse and the church: a call for prevention, treatment, and training. **Journal of Psychology and Theology**, 40(4):323-335.

WEBB, C., HAYES, A.M., GRASSO, D. & LAURENCEAU, J. 2014. Trauma-focused cognitive behavioural therapy for youth: effectiveness in a community setting. **Psychological trauma: Theory, Research, Practice, and Policy**, 6(5):555-562. DOI: 10.1037/a0037364.

WETHINGTON, H.R., HAHN, R.A., FUQUA-WHITLEY, D.S., SIPE, T.A., CROSBY, A.E., JOHNSON, R.L., LIBERMAN, A.M., MOSCICKI, E., PRICE, L.N., TUMA, F.K., KALRA, G. & CHATTOPADHYAY, S.K. 2008. The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents. A systematic review. **American Journal of Preventive Medicine**, 35(3):287-313. DOI: 10.1016/j.amepre.2008.06.024.

Dr Leon Holtzhausen, Department of Social Development; Ms Ashleigh Ross, Mr Rian Perry (MSocSc Probation and Correctional Practice Students), Department of Social Development, University of Cape Town, Cape Town, South Africa.