Implementation of an Integrated Sanctuary and TF-CBT Model in Residential Treatment Centers with Children who Have Been Sexually Abused

Stewart Beazell

Dr. Heflin, PhD
Chair

Dr. Gadzichowski, PhD
Member

A dissertation submitted to the Faculty of the Chicago School of Professional Psychology at Washington DC in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Washington, DC
August 2019

Table of Contents

Acknowledgements

Thank you to my chairs, Dr. Heflin and Dr. Gadzichowski, for helping me complete my dissertation during a difficult final year.

The completion of my dissertation would not have been possible if I did not have the love and support of my mother. She believed in me when I did not believe in myself and reminded me of how my father would have been proud of my dedication and hard work.

Abstract

This dissertation will explore the development of an integrated Sanctuary and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) treatment model for children in residential treatment centers (RTCs) who have a history of child sexual abuse (CSA). Children who are survivors of CSA are often also diagnosed with co-occurring externalizing behavior disorders. These externalizing behaviors are most often the cause of children's out of home placement in RTCs. While the general RTC model focuses on behavior management within the milieu setting, research on the implementation of trauma-specific treatments for children who have experienced CSA, in RTCs has been limited. This dissertation will conduct a review of the emerging body of research on the use of the Sanctuary model and TF-CBT within RTC settings to propose recommendations for the effective implementation of an integrated Sanctuary and TF-CBT treatment model within RTCs.

Keywords: residential treatment centers, child sexual abuse, trauma-focused cognitive behavioral therapy, sanctuary model

Chapter 1: Introduction

This dissertation will review the treatment of children who have been sexually abused and reside in residential treatment centers (RTCs). Previous research has found that up to 80% of children in RTCs have experienced CSA (Baker, Curtis, & Papa-Lentini, 2006; Bettmann, Lundahl, Wright, Jasperson, & McRoberts, 2011; Collin-Vézina, Coleman, Milne, Sell, & Daigneault, 2011; Jaycox, Ebener, Damesek, & Becker, 2004; Warner & Pottick, 2003). Often the trauma resulting from CSA manifests itself in both internalizing and externalizing symptoms which are not addressed effectively in RTCs. The purpose of this dissertation is to identify the value and means of tailoring treatment in residential settings to the needs of children who have experienced traumas such as child sexual abuse.

The definition of child sexual abuse (CSA) varies within current research. However, child sexual abuse is defined by the federal Child Abuse, Domestic Violence, Adoption, and Family Services Act of 1992 as:

> …the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or…the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children. (S. 838, 1992)

It is important, for research purposes, that a comprehensive, inclusive working definition of CSA be utilized in the screening and evaluation of children and adolescents. For the purposes of this dissertation, the definition provided by the federal Child Abuse,

Domestic Violence, Adoption, and Family Services Act of 1992 (S. 838, 1992) will be used as the working definition for CSA.

Research has shown that children who have experienced CSA may be more difficult to treat than other children who reside in RTCs, as a positive trauma history has been found to be associated with deterioration and negative outcomes of treatment (Boyer, Hallion, Hammell, & Button, 2009). Unfortunately, children and adolescents who are treated in out-of-home treatment settings, such as RTCs, have been found to be more likely to report a history of CSA (Deblinger, Mannarino, & Cohen, 2015; Kumar, Steer, & Deblinger, 1996; Lanktree, Briere, & Zaidi, 1991; Rohsenow, Corbett, & Devine, 1988; Sansonnet-Hayden, Haley, Marriage, & Fine, 1987). Thus, it is important for clinicians who practice in residential settings to conduct trauma screenings, including a comprehensive clinical interview, to identify youth who have experienced CSA, and ultimately to treat these youth with evidence-based approaches proven to effectively address the sequelae of CSA.

Prevalence Rates of CSA

One meta-analysis found that among the approximately 10 million participants in studies related to CSA published around the world between 1982 and 2008, there was an overall CSA lifetime prevalence rate of 13% (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). Pérez-Fuentes et al. (2013) found that, amongst their surveyed sample of 34,000 adults residing in the United States, 10.4% of their sample had experienced CSA and within that group, 24.8% were men and 75.2% were women. After completing a thorough review of studies conducted in the US, Saunders and Adams (2014) estimated that approximately 8% to 10% of the surveyed sample of youth have

experienced at least one sexual assault in their lifetime. These experiences of CSA are highly concerning due to the increased risk of psychopathology and suicide attempts in this population (Bal, Crombez, De Bourdeaudhuij, & Van Oost, 2009; Banyard, Williams, & Siegel, 2001; Browne & Finkelhor, 1986; Deblinger et al., 2015; Pérez-Fuentes et al., 2013; Wilsnack, Vogeltanz, Klassen, & Harris, 1997).

Additional research has shown that gender differences exist in terms of exposure to CSA among children who reside in the community. According to one metanalysis reporting on the prevalence of CSA worldwide, studies published between 2002 and 2009 reported that approximately 8 to 31% of girls and 3 to 17% of boys under the age of 18 residing in the community had experienced sexual abuse (Barth, Bermetz, Heim, Trelle, & Tonia, 2013). Dube et al. (2005) examined a sample of adults and found endorsement of CSA to be 16% for men and 25% for women. These findings indicate the importance of assessing for experiences of CSA among both boys and girls.

Deblinger et al. (2015) indicated that the estimates of prevalence of CSA provided by previous research likely underestimate the true prevalence rates as many victims of CSA are reluctant to disclose their experiences. The authors cited stigma, offender-imposed threats and self-blame as possible reasons that study participants may choose not to report experiences of CSA (Deblinger et al., 2015). As noted above, previous researchers have also cited gender differences in reported CSA prevalence (Barth et al., 2013; Dube et al., 2005; Pérez-Fuentes et al., 2013). It is unclear whether the gender difference in reporting reflects a true difference in experience of sexual abuse or a tendency for males to be less likely to report (Deblinger et al., 2015). Pérez-Fuentes et al. (2013) indicated that boys may be particularly reluctant to disclose because of "fear of

punishment, stigma against homosexuality, and loss of self-esteem" (p. 22). Both researchers and clinicians would benefit from an awareness of the differences in reporting between genders while conducting initial assessments and throughout each child's treatment.

Saunders and Adams (2014) reviewed the current epidemiological data on CSA and provided the recommendation for an improved data system to record incidences of CSA. The current methods of surveillance are noted by the authors as providing inadequate and unreliable data about the prevalence of CSA in the United States. Thus, it is difficult to pinpoint the specific number of children who have been sexually abused. There is a need for improved data collection and methodology in order to better screen for, and thus, provide clinicians with the opportunity to appropriately address the needs of children who have experienced sexual abuse.

Outcomes of CSA

Previous research has shown that the negative impact of experiencing sexual abuse in childhood can lead to an increased risk of developing mental health symptoms that may continue into adulthood. CSA has been found to be associated with approximately 47% of all childhood-onset psychiatric disorders (Green et al., 2010; Wilsnack et al., 1997). It is important to note that there is no "specific constellation of symptoms" (Deblinger et al., 2015, p. 4) that can be tied to an experience or experiences of CSA. Thus, each individual survivor of CSA may present with varying symptomatology as a result of not only their experience(s) of CSA, but also a combination of their own individual differences, other traumas and stressors and family dynamics.

As noted by Browne and Finkelhor (1986), the initial effects of CSA can be defined as the responses and reactions occurring within two years after the child's experience of sexual abuse. These initial effects are posited to be persistent by the authors, but this assertion has yet to be supported by research evidence.

Previous research (Deblinger, Behl, & Glickman, 2012) has noted the increased likelihood of the onset of symptoms such as fear, anger and hostility, and guilt and shame among youth who have experienced CSA, compared to children who have not experienced CSA. Deblinger et al. (2012) reported that adolescent survivors of CSA were more likely to develop avoidant coping strategies such as avoidant actions, wishful thinking, and repression when they made negative appraisals related to their experience(s) of CSA. The authors highlighted the significant impact of negative appraisals in the development of both internalizing and externalizing symptoms. In sum, previous research has shown that the initial emotional and behavioral reactions exhibited by survivors of CSA may vary significantly.

With regards to the long-term impact of CSA, previous research has focused on the similarities amongst survivors of CSA in terms of development of symptoms of psychological disorders. It has been found that approximately 26% to 32% of adult-onset disorders are correlated with a childhood experience of CSA (Green et al., 2010; Wilsnack et al., 1997). Banyard et al. (2001) found that childhood trauma, adult trauma, and adult sexual assault were significantly correlated with the following symptoms of trauma: anxious arousal, depression, anger, dissociation, sexual concerns, dysfunctional sexual behavior, intrusive thoughts, defensive avoidance, and impaired self-reference. These researchers found that CSA can have both direct and indirect effects, as mediated

by other types of trauma exposure (i.e., exposure to violence in childhood or adulthood), on the development of chronic mental health difficulties across the life span. However, a recent meta-analysis (Alisic et al., 2014) found that only 16% of trauma-exposed children and adolescents were diagnosed with PTSD. In a national study of adults, Pérez-Fuentes et al. (2013) found that participants who endorsed being survivors of CSA were more likely to experience substance use disorders, anxiety disorders, mood disorders, and to acknowledge a suicide attempt at some point during their lives. Given these potential, negative, long-term consequences of CSA, it is important to pursue effective treatment for children who have been sexually abused that may mitigate those negative outcomes.

Research on gender differences in outcomes of CSA has provided evidence indicating that both genders experience similar negative outcomes. Dube et al. (2005) found that male and female participants who experienced CSA in childhood were more likely to develop substance abuse problems, attempt suicide, marry an alcoholic, and have higher incidences of marital and family difficulties than participants who had not experienced CSA. The authors highlighted the importance of using prevention and treatment programs that are inclusive of the needs of both genders and are appropriate for use with child and adult survivors of CSA.

Given the inherent vulnerabilities of children who have been sexually abused, it is important that the treatment of child survivors of CSA, who present in RTCs with severe behavioral and emotional issues, be tailored to the specific needs of this population (Cohen, Mannarino, & Navarro, 2012). A subset of the population of child survivors of CSA display severe externalizing behavior problems, which are often inadequately addressed by treatment in other settings. Thus, these children may be placed into the

more restrictive setting of residential treatment in the hopes that this highly structured and intensive treatment environment will better address their maladaptive and disruptive behaviors (Deblinger et al., 2012). For some children, their experience(s) of CSA may be one of the precipitating factors that contributed to their development of severe behavioral and emotional difficulties. Thus, this dissertation will attempt to address how to best implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) within the RTC model in order to provide the most efficacious treatment for children who reside in RTCs and have experienced CSA.

Research Objectives

The first research objective of this dissertation is to identify the characteristics of children who have experienced CSA and are referred to RTCs. The second research objective is to identify the current level of empirical support for TF-CBT. The third research objective is to discuss the treatment models most commonly used in RTCs. The fourth research objective is to delineate how TF-CBT has been implemented in RTCs to date. The final research objective is to offer recommendations for how to effectively integrate the Sanctuary model and the TF-CBT treatment model within RTC settings.

Major Areas of Literature to be Reviewed

In this dissertation, Chapter 2 will explore how CSA is operationalized in the literature and provide an overview of the prevalence and outcomes of CSA among children who reside in RTCs. In Chapter 3, the research addressing the efficacy of TF-CBT for CSA will be reviewed. In Chapter 4, the definition of residential treatment will be provided, models of residential treatment centers will be discussed, and the empirical evidence regarding the outcomes of the most effective models of residential treatment

will be presented. Research findings regarding the efficacy of the trauma-informed care models, such as the Sanctuary model, and TF-CBT in RTCs will be discussed in Chapter 5. In Chapter 6, recommendations will be offered for ways to best integrate the Sanctuary model and the TF-CBT treatment model for use in RTC treatment. Through this integration of the Sanctuary and TF-CBT treatment models, an attempt will be made to enhance treatment and more effectively address the trauma of CSA, as well as the severe, maladaptive behaviors often displayed by child survivors of CSA who reside in RTCs.

Chapter 2: Prevalence and Outcomes of CSA Among Youth in Residential Treatment Centers

This chapter will review the prevalence and outcomes of CSA among youth in RTCs. The discussion of prevalence is important to provide the reader with an understanding of the number of children who have experienced CSA and who reside in RTCs. The experience of youth who have been victims of CSA is varied and their treatment in RTCs must take into consideration their unique needs. Outcomes of youth who have experienced CSA and receive treatment in RTCs will be examined in order to learn more about what works in treatment with this vulnerable population.

Reported prevalence rates of trauma, in general, amongst youth residing in RTCs or similar out-of-home settings, such as foster care, have been varied. Researchers have found that children who have experienced some type of trauma or abuse have been estimated to represent 50 to 80% of those children who reside in RTCs (Bettmann et al., 2011; Collin-Vézina et al., 2011; Jaycox et al., 2004; Warner & Pottick, 2003). More recently, Knoverek, Briggs, Underwood, and Hartman (2013) posited that the population of children residing in RTCs is more likely than the population of youth residing in their respective communities to have experienced traumatic events that contributed to their subsequent removal from their family homes.

Other researchers have specifically examined the prevalence of CSA among children placed in RTCs with varying results. Some researchers have reported that the majority of the children who are placed in RTCs have experienced CSA (Collin-Vézina et al., 2011; Zelechoski et al., 2013). In contrast, Bettmann et al. (2011) conducted a study examining the characteristics and presenting problems of children residing in

residential and wilderness treatment programs and reported that approximately 9.5% of children in their sample of 473 adolescents had experienced sexual abuse. More recently, Fischer, Dölitzsch, Schmeck, Fegert, and Schmid (2016) found that 17.3% of their sample of 370 at-risk youth residing in 64 RTCs across Switzerland disclosed alleged sexual abuse. Collin-Vézina et al. (2011) found that among their convenience sample of 53 youth residing in one RTC, 38% reported experiencing sexual abuse, which is a higher prevalence rate than has previously been reported. Considering the small convenience sample used, this finding cannot be generalized to the larger overall sample of children residing in RTCs.

In a larger study, Baker et al. (2006) sought to further examine the prevalence of CSA across RTC settings and used data entry systems to ensure accurate data coding which likely decreased the potential for missing data. This study was the largest conducted at that time and served as a landmark study for the investigation of the prevalence of children who have experienced child sexual abuse and who reside in RTCs. They found that 30% of the 399 youth in their sample derived from 22 RTCs from 13 states across the United States had experienced sexual abuse. Their results indicated that approximately 20% of these youth experienced sexual abuse only, 36% experienced both sexual and physical abuse, 9% experienced sexual abuse and neglect, and 36% experienced all three types of abuse (Baker et al., 2006). The authors posited the total percentage found was a potential *underestimation* of the true prevalence due to a potential lack of disclosure, inconsistent definitions of child sexual abuse, and missing information in youth records. However, subsequent research by Milne and Collin-Vezina

(2014) provided evidence to the contrary that indicated youth who had experienced sexual abused were, in fact, able to reliably self-disclose.

Briggs et al. (2012) conducted a study using the National Child Traumatic Stress Network (NCTSN) *Core Data Set*, which was constructed to allow NCTSN members to assess children and families from 56 NCTSN-affiliated sites providing trauma-informed care across the US. The *Core Data Set* sample consisted of 9,942 community-based youth and 525 youth residing in an RTC setting. The trauma history of participants was assessed using the UCLA Post Traumatic Stress Disorder (PTSD) Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004), which screened for 20 different types of traumatic events. The authors found a clinically significant difference in the mean percentage of youth who reported CSA: 25% in community-based treatment versus 40.4% in residential treatment. In addition, children residing in RTCs had experienced a higher average number of trauma exposures than youth not residing in an RTC (3.6 vs. 5.8, respectively). The data also indicated that 92% of youth in RTC settings experienced multiple traumatic events versus 77% of youth who did not reside in RTC settings. Briggs et al. (2012) found evidence of a dose-response relationship between the number of traumatic events experienced and increases in overall behavioral and emotional difficulties. Thus, these results highlight the importance of trauma screenings in order to better address the troubling symptoms of youth who have experienced any CSA through a trauma-informed lens.

Gender differences in reported experiences of CSA in RTCs have been noted in the research. Previous researchers have noted that rates of 63-64% of girls residing in RTCs reported a history of CSA, compared to 17-27% of boys (Connor, Doerfler,

Toscano, Volungis, & Steingard, 2004; Milne & Collin-Vezina, 2014). The prevalence of psychiatric disorders among youth residing in RTCs will be discussed in the following section. Gender differences in the prevalence of different psychiatric disorders after experiences of CSA will also be addressed.

Prevalence of Psychiatric Disorders

The prevalence of psychiatric disorders among survivors of CSA residing in RTCs has been well-established in the research literature; however, exact prevalence rates tend to be highly varied (Zelechoski et al., 2013). Grasso et al. (2009) cited increased clinical impairment amongst their sample of foster care youth who reported experiences of trauma. Fischer et al. (2016) found that the majority of their sample of adolescents (73.1%) who had experienced any interpersonal trauma, including CSA, qualified for a mental health diagnosis.

Multiple experiences of trauma. Many authors have reported evidence that supports the hypothesis that experiencing two or more types of trauma increases risk for a formal diagnosis of PTSD and overall mental health difficulties (Alisic et al., 2014; Boyer et al. 2009; Cloitre et al., 2009; Fischer et al., 2016; Ford, Elhai, Connor, & Frueh, 2010; Greeson et al., 2013; Teicher & Samson, 2014). Fischer et al. (2016) found that 85 out of 370 adolescents in their sample reported experiences of multiple interpersonal traumas. These youth were more likely to receive elevated scores on caregiver reports of thought problems and self-reports of somatic complaints, anxious-depressed symptoms, thought problems, rule-breaking, and aggressive behavior than adolescents who did not report those multiple experiences of trauma.

Fischer et al. (2016) also found that among female adolescents, multiple reports of interpersonal trauma were associated with a higher number of somatic complaints. The authors further reported that male adolescents who had experienced interpersonal trauma were more likely to report higher ratings of somatic complaints and rule-breaking behaviors compared to males without reported experiences of interpersonal trauma. Males who reported more than one experience of interpersonal trauma self-reported higher incidences of thought problems than males without reported interpersonal trauma. Fischer et al. (2016) also found that males who experienced interpersonal trauma were at greater risk for the development of substance use and affective disorders than girls who reported experiences of interpersonal trauma.

Collin-Vézina et al. (2011) noted that youth who experienced multiple occurrences of abuse have been found to be more likely to have low resilience. This finding, among others, points to the importance of trauma screening in high-risk settings, such as RTCs in order to best address PTSD symptoms and potentially increase resilience of these youth during treatment (Milne & Collin-Vezina, 2014). As stated by the authors in their conclusion, "a systematic method of screening for trauma would facilitate the identification of not only the youth's maltreatment experiences, but the corresponding treatment programs to address the trauma-related symptoms" (Collin-Vézina et al., 2011, p. 586).

Prevalence of externalizing and internalizing disorders. Previous research has shown that approximately 34-49% of youth residing in RTCs who have experienced CSA have been diagnosed with externalizing disorders, such as conduct disorder and attention-deficit hyperactivity disorder (Boyer et al., 2009; Connor et al., 2004). The high

prevalence rate of externalizing disorders is not surprising, given that most children who are referred to RTCs display severe acting out behaviors that contributed to their subsequent out-of-home placement. Additionally, Boyer et al. (2009) and Connor et al. (2004) found that 31-32% of their sample of youth residing in RTC settings were diagnosed with internalizing disorders, such as anxiety and depression. Considering that most of the youth residing in RTCs tend to be referred for treatment due to their externalizing behaviors, this finding demonstrates the importance of the assessment for co-morbid internalizing disorders during initial intake assessment.

Prevalence of PTSD. Reported rates of PTSD are varied in research with youth who have experienced CSA and receive treatment in RTCs. Boyer et al. (2009) reported a 39% prevalence rate of PTSD among their sample of youth in RTCs. In contrast, Greger, Myhre, Lydersen, and Jozefiak (2015) found that only 0.6% of their sample of maltreated adolescents qualified for a diagnosis of PTSD. This low prevalence rate is hypothesized to be a result of the researchers' focus on sensitivity to symptoms associated with other psychiatric diagnoses, such as autism spectrum disorder, conduct disorder, and dysthymia, rather than symptoms associated with PTSD. In addition, the Child and Adolescent Psychiatric Assessment Interview (CAPA; Angold et al., 1995) used may have been more sensitive to identification of psychiatric disorders other than PTSD.

Kolko et al. (2010) collected data regarding the prevalence of post-traumatic stress (PTS) symptoms in a sample of children involved in the Child Welfare System (CWS) who were placed in out-of-home care compared to the prevalence of those symptoms among children who maintained their placement in their respective homes. The authors found that approximately 12% of their overall sample reported elevated

levels of PTS symptoms in both out-of-home and in-home settings. There was a significant difference in PTS symptoms among youth in out-of-home (19.5%) versus in-home care (10.7%; Kolko et al., 2010). It was also noted that elevated PTS symptoms were associated with "younger age, alleged abuse by a non-biological parent perpetrator, violence victimization in the home, and child depression" (Kolko et al., 2010, p. 58).

Gender differences in symptoms. Previous research has shown that older girls, especially, who reside in RTCs are more likely to exhibit trauma symptoms, internalizing symptoms, and problematic sexual behaviors than are boys (Collin-Vézina et al., 2011; Fischer et al., 2016; Greeson et al., 2013). Girls have also been found to be more likely to report multiple experiences of victimization and to receive more psychiatric diagnoses than boys (Greger et al., 2015). Findings reported by Fischer et al. (2016) suggest that the treatment of girls who are survivors of CSA may be more effective if these gender differences in experiences of CSA and overall trauma are taken into account. For example, educating girls about body safety might help female survivors of CSA avoid the negative physical and emotional consequences associated with re-victimization in future intimate relationships (Deblinger et al., 2015). It is likely that the incorporation of gender specific psychoeducation within treatment could be beneficial. However, it still remains unclear whether gender is a potential moderator of interpersonal trauma and psychopathology (Fischer et al., 2016). Future research may be able to clarify whether gender differences are an important factor that should be considered in the treatment of youth who have experienced CSA and who reside in RTCs.

The Assessment of Trauma Symptoms in RTCs

Miele and O'Brien (2010) examined the assessment and diagnosis of PTSD in