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IN THIS ISSUE

Focus of the Month:
Sexual Abuse and Violence

Learning objectives for this issue:
1. Describe evidence-based treatment options for rape victims with posttraumatic stress disorder (PTSD). **2.** Summarize the latest research about sex offenders and the best way to treat them. **3.** Explain how trauma-focused cognitive behavioral therapy (TF-CBT) is used to treat child sexual abuse victims. **4.** Evaluate some of the current findings in the literature regarding psychological/psychiatric treatment.

Treatment Approaches for Rape Victims

Sherry A. Falsetti, PhD
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Dr. Falsetti has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Imagine hearing that a family responded this way after a sexual assault, "My father and mother said that the way I dressed and friends I chose provoked the incident. They blamed me for the first two months after the incident."

Or, as another young woman recounted, "[An acquaintance] mentioned that I should never have been talking to him and I should have fought harder—that I should have known what he wanted."

Just as these quotes from the

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In Summary

- Rape victims are at high risk for developing posttraumatic stress disorder (PTSD), depression, and substance abuse, and may also suffer from panic attacks, eating disorders, and sleep problems.
- A thorough trauma assessment is needed to provide effective treatment.
- Treatments with the strongest evidence base include cognitive processing therapy (CPT) and prolonged exposure (PE).

Q & A With the Expert

Treating Sexual Abusers

David S. Prescott, LICSW

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Becket Family of Services, Northern New England
Member and Former president
Association for the Treatment of Sexual Abusers (ATSA)

Mr. Prescott has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

TCRBH: What do we know about what leads someone to become a sex offender?

Mr. Prescott: The best way to answer this is to go back about 30 years when the problem of sexual abuse first started garnering widespread attention. Back then, it was believed that sexual abuse was perpetrated by a small number of individuals who had themselves been sexually abused. When researchers began to study the problem, however, they discovered that many of our assumptions proved to be incorrect.

TCRBH: What has the research shown?

Mr. Prescott: Only a minority of people who sexually abuse are ever caught, and those who are have usually abused a few times before they're caught. Once a person has been caught, the good news is that it is likely that they will not persist. However, it is still a crime that is serious enough that many of us feel that it is worthwhile to

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book *Talking about Sexual Assault* by professor Sarah E. Ullman, PhD, demonstrate, there is still much stigma and victim blaming for survivors of sexual assault.

It is of upmost importance that your clients do not perceive you as one of those people who does not understand, or worse, blames a rape victim for her perpetrator's behavior. Nor do you want to be a provider who thinks you don't have any rape survivors in your practice.

Whether you are aware of it or not, you almost certainly see rape survivors in your office. After all, estimates are that one in six women experiences rape or attempted rape in her lifetime (National Institute of Justice, *Extent, Nature, and Consequences of Rape Victimization: Findings from the National Violence Against Women Survey 2006*). While most rape victims are female (86% according to the report), sexual assaults are not a problem exclusive to women, and it is estimated that almost three million men in the US have been raped.

The keys to an informed practice are awareness and sensitivity, effective assessment, and the knowledge and skills to treat the mental health problems of sexual assault survivors.

Mental Health Sequelae Following Rape

Now that you know you likely have women in your practice who have experienced rape, you may be wondering how to best assess and treat clients who have experienced sexual assault.

Rape victims are at high risk for developing posttraumatic stress disorder (PTSD), depression, and substance abuse (Kessler RC et al, *Arch Gen Psychiatry* 1995;52(12):1048–1060).

They may also suffer from panic attacks (Falsetti SA & Resnick HS, *J Trauma Stress* 1997;10(4):683–689), eating disorders (Laws A & Golding JM, *Am J Public Health* 1996;86(4):579–582), and sleep problems (Clum GA et al, *J Nerv Ment Dis* 2001;189(9):618–622), among other disorders.

Assessment of Sexual Assault

A thorough trauma assessment is critical to provide effective treatment for rape victims. The assessment should include a detailed trauma history, such as information about the number and types of trauma experienced, whether the victim knew the perpetrator, and characteristics of the trauma, such as whether the victim's life was threatened and any injuries that occurred.

Trauma-screening questions need to be direct and behaviorally specific. Some women may not label their experience as rape, even if asked if they have ever been raped. So rather than using labels, use behaviorally specific terms, such as, "Has a man or boy ever made you have sex by using force or threat of force?"

It is also important to assess for PTSD and other common comorbid disorders, including major depression, panic disorder, and substance abuse. Finally, assessing for social support, coping skills, and available resources is helpful in planning treatment.

Treatment for PTSD Related to Sexual Assault

There are several evidence-based treatment options for patients suffering from PTSD. Two of the treatments with the strongest, evidence-based research behind them are prolonged exposure and cognitive processing therapy. Along with those, eye movement desensitization and reprocessing, stress inoculation training, and multiple-channel exposure therapy are treatments that show some effectiveness. Let's take a more detailed look at these treatments.

Prolonged exposure (PE) is one of the most well-studied treatments for PTSD, although sometimes therapists are uncomfortable with its use because it requires the client to repeatedly confront fearful images and memories of the trauma (Foa EB et al, *J Consult Clin Psychol* 1991;59(5):715–723).

During PE, a therapist helps a client recount the memory in the safe environment of the therapist's office. An oral narrative is repeated several times each session and recorded for the patient to listen to in between sessions. Clients are also asked to confront situations that are not dangerous, but that are associated in some way with the trauma and cause fear and anxiety. PE is conducted in 90 minute sessions for nine to 12 weeks.

Cognitive processing therapy (CPT) is based on an information processing model and combines elements of exposure therapy and cognitive restructuring. CPT has been studied extensively and is an effective treatment for PTSD with comorbid depression (Resick PA et al, *J Consult Clin Psychol* 2002;70(4):867–879:, Resick PA et al, *J Consult Clin Psychol* 2008;76(2):243–258).

The goal of CPT is to integrate the rape by processing emotions and confronting cognitive distortions and maladaptive beliefs about the rape. Exposure happens through writing detailed accounts of the rape and reading these between sessions.

Writing about the meaning of the rape and cognitive restructuring in the areas of safety, trust, power, esteem, and

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Treatment Approaches for Rape Victims

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intimacy, are also part of the treatment.

These strategies assist with accommodating the rape in a healthy manner and help the victim develop and maintain a balanced and realistic view of the world. CPT can be done in groups or individually and can be completed in 12 weekly sessions.

Eye movement desensitization and reprocessing (EMDR) is a psychotherapy that involves exposure to the trauma by imagining the trauma and reciting words about the rape while the therapist moves his/her finger in front of the client, who follows this movement with her eyes (Shapiro F, *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures.* New York: Guilford Press;1995). After anxiety is reduced, the client practices new adaptive beliefs.

EMDR has some support for treating PTSD and depression in rape victims. However, it remains unclear whether the actual eye movements are a necessary component of treatment. Studies of EMDR have reported using five to 10 weekly sessions.

Stress inoculation training (SIT) was developed to treat the fear and anxiety symptoms often experienced by rape victims (Kilpatrick DG et al. Psychological Sequelae to Rape. In: Doleys DM et al eds. *Behavioral Medicine: Assessment and Treatment Strategies,* New York: Plenum Press;1982:473–497). Several studies have shown SIT to be effective for rape victims (see for example Foa EB et al, *J Consult Clin Psychol* 1999;67(2):194–200).

SIT consists of three phases: education, skill building, and application. The education phase involves learning how the fear response develops in response to trauma, learning to identify cues that trigger fear (eg, hearing certain noises at night or being alone), and learning progressive muscle relaxation. The skill building phase focuses on reducing fear reactions using thought stopping, mental rehearsal, guided self-talk, and role playing. In the application phase, clients apply the skills they have learned. SIT usually takes 10 to 14 sessions.

Multiple-channel exposure therapy (M-CET) is a treatment adapted from CPT, SIT, and the *Mastery of Your Anxiety and Panic* treatment manual (Barlow DH & Craske MG. Albany, NY: Graywind Publications Inc;1994).

M-CET targets both PTSD and panic attacks, conditions that often co-occur in rape victims. Because exposure therapy may cause initial high levels of physiological arousal, including panic attacks, clients with panic may avoid exposure-based therapies (Falsetti SA & Resnick HS, *J Cogn Psychother* 2000;14(3):261–285).

M-CET focuses on panic reduction before trauma exposure work begins. Clients are provided education about panic and trauma, taught diaphragmatic breathing, and learn methods to challenge and restructure negative and distorted thoughts. Clients also intentionally induce panic symptoms to learn that the sensations are not dangerous.

Following successful panic reduction, clients write about their rape, apply other cognitive strategies, and practice *in vivo* exposure to cues associated with the rape. M-CET is a 12 week treatment and has been shown to reduce PTSD, panic, and depression (Falsetti SA et al, *Cogn Behav Ther* 2008;37(2):117–130). As with CPT, M-CET can be done in groups or individually.

There are now several effective treatments available for rape victims who suffer from PTSD and other comorbid disorders. For mental health professionals who are unfamiliar with these treatments and who would like to receive further training, there are manuals and workshops available. They include webinars sponsored by the International Society for Traumatic Stress Studies (ISTSS), as well as presentations at the ISTSS annual conferences (www.istss.org). Books such as *Effective Treatments for PTSD* (Foa EB, et al. New York: The Guilford Press; 2009) and *Cognitive Processing Therapy for Rape Victims* (Resick PA & Schnicke M. Thousand Oaks, CA: Sage Publications; 1993), as well as treatment manuals for M-CET are also great resources.

Expert Interview

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provide some kind of treatment to known abusers.

TCRBH: How pervasive is sexual abuse? Is it likely that those of us who are in clinical practice may encounter individuals involved in sexual abuse who are seeking treatment for other reasons?

Mr. Prescott: Some studies have found that as many as 8% of college-age men engage in first-degree sexual assaults or rape (Abbey A et al, *J Interpers Violence* 2001;16(8):784–807). A recent study found that as many as 9% of teenagers do the same (Ybarra ML & Mitchell KJ, *JAMA Pediatr* 2013;167(12):1125–1134). Up to 30% of children experience sexual abuse (Ogloff JRP et al, *Trends and Issues in Crime and Criminal Justice* 2012;440:1–6). After 30 years of study in this area, I have come to the belief that no matter what your specific discipline—psychiatry, psychology, social work—if you are in a helping profession it is a wise idea to treat everybody who comes through your door as though they are suffering from something related to sexual abuse. Sexual abuse is really so pervasive that it is a public health problem that we need to devote resources to prevent.

TCRBH: You said past assumptions about what makes someone a sexual abuser were wrong. So what factors do lead someone to become a sexual abuser or rapist?

Mr. Prescott: Some studies have found that being sexually abused, witnessing domestic violence, and being physically abused as a

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child, as well as being psychologically, physically, and emotionally neglected all might play a role in whether or not somebody becomes an abuser. Things such as the break-up of a family, low socioeconomic status, and various kinds of adverse childhood experiences all seem to play a role in whether or not somebody becomes abusive.

TCRBH: What are the different types of sexual abusers?

Mr. Prescott: Sex offenders come from all strata of society. We used to think in terms of child molesters versus rapists of adults. But within that there are subsections, and not everybody who abuses children is sexually attracted to children. There are some folks who are sexually attracted to children who never actually abuse children physically. So I think in a few broad categories: there are people who don't want to sexually abuse others, but seem not to have the skills to stop themselves; there are other people who would like to avoid offending; and then there is a smaller minority who are perfectly okay with offending and seek opportunities to do it.

The bottom line is one size does not fit all when it comes to the treatment of sexual aggression.

David S. Prescott, LICSW

TCRBH: How is it that people who are sexual offenders come to treatment?

Mr. Prescott: The vast majority of people who come into treatment, unfortunately, do so because the legal system told them they had to. The way that laws are set up in the United States makes it very difficult for somebody to come forward and say, "Help, I'm concerned I may offend." We have mandatory reporting laws that make it illegal not to file a report if somebody says things that indicate that sexual abuse may happen. They also create an unintended consequence that people who are afraid they might act on their impulses are very reluctant to enter treatment to begin with.

TCRBH: Is there a standard treatment for a broad spectrum of potential abusers or does it vary?

Mr. Prescott: The bottom line is one size does not fit all when it comes to the treatment of sexual aggression. There are basically three principles that I work on. The first is you have to have an excellent assessment that tells you a person's overall level of risk. Higher risk people require higher intensity treatment. The second principle is that we need to tailor everybody's treatment experience to their unique characteristics. There are some characteristics that seem to be common across the board. Pending research supports the idea that the majority of people who get in trouble tend to have problems with cognitive flexibility, meaning they are not able to change the way they think as much as other people (Morgan AB & Lilienfeld SO, *Clin Psychol Rev* 2000;20(1):113–136). The third principle is that whatever the person says they need to work on in treatment may or may not be the entire picture.

TCRBH: Are there other factors that are important to treatment?

Mr. Prescott: There are basically five common areas of treatment need that research shows are important to consider.

- First, there are people who need to work on the fact that they have sexual interests that are illegal and harmful if they act on them. Some call this sexual deviance; I tend to refer to it as abuse-related sexual interests.
- Second, very often clients have attitudes and beliefs that are supportive of sex crimes. For example, they might come into treatment believing that they are right, and society is wrong.
- The third of these treatment needs is what I would call interpersonal functioning. If I could have only one goal in treatment for the majority of my clients I would get them to develop a lifestyle in which they can feel competent in all of their interpersonal relationships and can relate to other people empathically.
- Fourth is overall self-regulation. Can they manage their impulses? Can they manage their stressors? Can they cope with things when things aren't going very well?
- Fifth is making sure that they are surrounded by positive influences.

I can summarize all of this by saying that the safest sex offender is somebody who is stable in their lifestyle, is occupied with activities such as a job or education, has supportive people to whom they are attached, and has some plan for their life such that they have everything to lose by repeating a sexual assault.

TCRBH: What is your goal in treatment?

Mr. Prescott: There has been a great deal of controversy over whether or not you can actually change somebody's sexual interests. My goal as a treatment provider is not to change what somebody is interested in, but to change how he behaves and how he lives his life. For instance, if a person has high cholesterol, he may love salt and fat, but he can't eat a lot of it. He has to live his life in a way that manages that cholesterol.

TCRBH: I am reminded of a young man who learned at a relatively late age that his interest in viewing images of naked children was illegal. He behaviorally managed his attention so that he did not look at illegal images; he looked at cartoon images.

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By the Numbers: Sexual Violence

Sexual violence and abuse is a pervasive problem, making it highly likely mental health professionals will encounter victims in their practice. Consider these statistics:

Adults

- 86% percent of rape victims are female
- Approximately one in six women experiences rape or attempted rape in her lifetime
- In a study of undergraduate women, 19% experienced attempted or completed sexual assault since entering college
- Nearly 1 in 71 men (1.4%) report experiencing rape at some time in their lives
- It is estimated that about 20 million women and almost three million men in the US have been raped
- Only about 16% of all rapes are reported to law enforcement
- Approximately 1 in 20 women and men (5.6% and 5.3%, respectively) have experienced sexual violence other than rape, such as being made to penetrate someone else, sexual coercion, unwanted sexual contact, or non-contact unwanted sexual experiences
- In one study, 4.8% of men reported they were made to penetrate someone else at some time in their lives
- 13% of women and 6% of men report experiencing sexual coercion at some time in their lives
- In 2010, 12% of rapes and sexual assaults involved a weapon
- In 2010, 25% of the female victims of rape/sexual assault were victimized by strangers

Children and Youth

- Up to 30% of children experience sexual abuse
- Approximately one out of five girls (20%) experience sexual victimization involving physical contact prior to age 18
- Approximately one out of 20 boys (5%) experience sexual victimization involving physical contact prior to age 18
- In as many as 93% of child sexual abuse cases, the child knows the person that commits the abuse
- Up to 47% of abusers are family or extended family
- Approximately 30% of cases of child sex abuse are reported to authorities
- 42.2% of female rape victims were first raped before age 18
- 29.9% of female rape victims were first raped between the ages of 11–17
- 12.3% of female rape victims and 27.8% of male rape victims were first raped when they were age 10 or younger
- A 2011 survey of high school students found that 11.8% of girls and 4.5% of boys from grades 9–12 reported that they were forced to have sexual intercourse at some time in their lives
- Approximately one in five (20%) female high school students report being physically and/or sexually abused by a dating partner
- Approximately 1 in 7 (13%) youth Internet users receive unwanted sexual solicitations

Perpetrators

- As many as 8% of college-age men engage in first-degree sexual assaults or rape
- Among female rape victims, perpetrators were reported to be intimate partners (51.1%), family members (12.5%), acquaintances (40.8%), and strangers (13.8%)
- Among male rape victims, perpetrators were reported to be acquaintances (52.4%) and strangers (15.1%)
- Among male victims who were made to penetrate someone else, perpetrators were reported to be intimate partners (44.8%), acquaintances (44.7%), and strangers (8.2%)

Non-Fatal Injuries and Medical Treatment

- In one report, 31.5% of women and 16.1% of men were physically injured as a result of rape; 36.2% of injured female victims received medical treatment
- For both women and men, links have been found between a history of nonconsensual sex and high cholesterol, stroke and heart disease; female victims of nonconsensual sex are more likely to report heart attack and heart disease compared to non-victims
- Rape results in about 32,000 pregnancies each year
- Among female victims of intimate partner violence who filed a protective order, 68% reported they were raped by their intimate partner and 20% reported a rape-related pregnancy

For a full list of references, see www.carlatbehavioralhealth.com

Trauma-Focused CBT for Child Sexual Abuse

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Dr. Pollio and Ms. McLean have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity. Dr. Deblinger receives grant funding, book royalties, and honorarium associated with her TF-CBT related research, training, and dissemination efforts. The editors have reviewed this article and found no evidence of bias in this educational activity.

Recent conservative estimates indicate that approximately one out of five girls and one out of 20 boys experience sexual victimization involving physical contact prior to the age of 18 (Saunders BE & Adams ZW, *Child Adolesc Psychiatr Clin N Am* 2014;23(2):167–184). However, these findings may underestimate the true rates of victimization because the stigma often associated with sexual abuse may keep some of those surveyed from reporting instances of abuse.

The effects of child sexual abuse vary. Some children have limited symptoms and other children experience mild to severe symptoms that can persist into adulthood (see for example, Kendall-Tackett KA et al, *Psychol Bull* 1993;113(1):164–180). The types of symptoms vary widely as well, and include poor self-esteem, depression, interpersonal difficulties, anxiety, dissociation, sexualized behaviors, substance use, suicide attempts, and an increased risk for revictimization (see for example, Maniglio R, *Clin Psychol Rev* 2009;29(7):647–657).

Psychiatric disorders associated with child sexual abuse include posttraumatic stress disorder (PTSD), major depressive disorder, panic disorder, alcohol/drug dependence, and bipolar disorder (Pérez-Fuentes G et al, *Compr Psychiatry* 2013;54(1):16–27). Sexual abuse also has been associated with neurobiological changes (Trickett PK et al, *Dev Psychopathol* 2011;23(2):453–476) as well as physical health difficulties that can persist into adulthood (Irish L et al, *J Pediatr Psychol* 2010;35(5):450–461).

A variety of unalterable factors, including increased frequency and invasiveness of the sexual abuse and the use of force, are associated with more severe abuse-related effects. However, one important factor that appears to positively impact youth outcomes is the degree of support received by these young people from non-offending caregivers (Elliot AN & Carnes CN, *Child Maltreat* 2001;6(4):314–331). In fact, research findings suggest that the participation of a non-offending caregiver in treatment positively influences children's behavioral adjustment in the aftermath of sexual abuse (Deblinger E et al, *Child Maltreat* 1996;1(4):310–321).

The Evidence for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

There are several promising treatments for child sexual abuse that involve youth with and without non-offending caregivers. However, with the exception of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), few of these treatments have been subjected to rigorous evaluations and replication studies (Cohen JA et al. *Treating Trauma and Traumatic Grief in Children and Adolescents.* New York: Guilford Press; 2006).

The efficacy of TF-CBT, a treatment model specifically designed for child sexual abuse, has been evaluated in over 25 scientific investigations, including more than a dozen randomized controlled trials (eg, Deblinger E et al. Introduction. In: Cohen JA et al, eds. *Trauma-Focused CBT for Children and Adolescents: Treatment Applications.* New York: Guilford Press; 2012;1–26).

TF-CBT research studies have documented significant improvements in anxiety, PTSD, depression, and behavioral problems among children and adolescents, as well as positive changes in parenting practices and abuse-related distress.

More specifically, the results of randomized controlled trials have demonstrated significantly greater improvements in youth and non-offending parents who participated in TF-CBT as compared to those on a waitlist and those who received community therapy services, nondirective supportive therapy, educational support group services, and/or child-centered therapy.

Several studies have documented the maintenance of these improvements over follow up periods ranging from six months to two years. Further, TF-CBT has received the highest ratings for efficacy and dissemination based on extensive reviews conducted by the US Department of Health and Human Services (www.nrepp.samhsa.gov) and the California Evidence-Based Clearinghouse for Child Welfare, a state-funded group whose goal is to advance the use of evidence-based practices for children and families in the child welfare system (www.cebc4cw.org).

How it Works

TF-CBT helps families heal from child sexual abuse and/or other childhood trauma(s) by engaging youth and their caregivers in parallel individual sessions as well as conjoint parent-child sessions. Though structured and time limited, mental health professionals can flexibly implement TF-CBT to address the therapeutic needs of youth who have experienced a single-incident trauma or repeated, complex trauma(s) that have impacted their functioning in multiple domains.

Prior to starting the TF-CBT journey, it is important to therapeutically engage the child and caregiver by taking into consideration their general needs. It is also important to attend to potential obstacles that can impede or hinder the therapeutic engagement, including negative prior experiences with therapy. It is often useful to highlight how TF-CBT

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Trauma-Focused CBT for Child Sexual Abuse
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may differ from prior therapy experiences. If there are other high-priority issues following the trauma, providing the family with appropriate referrals may help to engage them in therapy once their basic needs have been met. The treatment components of TF-CBT, described briefly below, are captured by the acronym PRACTICE (Cohen JA et al, *op.cit*).

***P*sychoeducation** begins the journey and continues throughout the treatment process. It includes educating the caregiver and child by providing general information about the prevalence, dynamics, characteristics, and impact of child sexual abuse. The educational information often helps clients to understand the link between the specific symptoms experienced by the child and the proposed treatment plan.

***P*arent skills training** is provided to all parents to assist them in optimally responding to children's abuse-related behavioral and emotional difficulties. The implementation of positive praise, selective attention, time-out, and contingency reinforcement schedules often have a positive impact on the child's behavioral adjustment as well as the caregiver-child relationship.

***R*elaxation training** is an effective way to help the child and caregiver manage their emotions and to reduce tension that may result from reminders of the sexual abuse. It includes relaxation skills that may be practiced by the child and caregiver as well as mindfulness and meditation practices.

***A*ffective expression** and modulation skill building helps youth and their caregivers to express and manage distressing emotions. The child and caregiver learn to express basic feelings, along with feelings that may be associated with the sexual abuse. Other affective regulation skills that may be introduced during individual, as well as conjoint, sessions include the sharing of feelings, the use of positive imagery, and participation in positive activities, such as exercise, music, art, and other creative outlets for managing emotions.

***C*ognitive coping** is introduced with the goal of assisting the caregiver and child in understanding the relationships between thoughts, feelings, and behavior, while learning to catch and challenge problematic thinking patterns. The cognitive triangle is presented, which visually demonstrates the relationship between thoughts, feelings, and behaviors, and clients learn to track, catch, and correct dysfunctional thoughts that may interfere with their daily functioning.

***T*rauma narrative and processing** helps children gradually and repeatedly face traumatic memories in the context of a safe therapeutic environment. The narrative is typically created in written form, but art or play activities may also provide the mediums for describing the trauma(s) endured.

The narrative often reveals dysfunctional thoughts and beliefs such as "the sexual abuse was my fault," or "he abused me because I am worthless," that may underlie children's emotional difficulties. When the narrative is complete, therapists can then assist youths in identifying and challenging unhelpful and inaccurate thoughts, while replacing them with healthier views of themselves, their relationships, and their expectations for the future (eg, "I am worthy of respectful treatment; I have a great deal to look forward to in the future").

***I*n vivo mastery** of trauma reminders occurs when narrative and other exposure activities are not sufficient in helping youth overcome problematic avoidant behaviors. In such instances, a systematic *in vivo* plan may be developed to diminish or extinguish unnecessary anxiety and avoidance related to trauma cues in the environment.

During *in vivo* exposure, the child faces real-world reminders of the trauma. For example, a clinician should develop a plan for a child who fears being in a room alone. The exposures may involve having the parent at gradually greater distances from the room the child is in (eg, right outside the door, in the next room, down the hall, on another floor, etc). The parent is then coached to praise the child's courage while minimizing attention to fearful behavior.

***C*onjoint parent-child trauma-focused sessions** are designed to strengthen general communication between caregivers and children, help them practice the skills they have learned, review educational information, share the trauma narrative (when clinically appropriate), and increase children's comfort in discussing the sexual abuse they have experienced with their caregiver.

***E*nhancing future safety and development** is accomplished with youth who have endured sexual abuse through the provision of sex education and training in safety skills. These activities, which often include role plays, are designed to enhance children's feelings of mastery, while simultaneously reducing their feelings of vulnerability and their risk of re-victimization.

TF-CBT typically ends with a celebration that acknowledges the accomplishments and progress made by the youth and caregiver. Celebratory activities, such as handing out certificates of completion and eating cake, are designed to acknowledge the hard work of therapy, while also encouraging optimism and confidence about the family's continued success in using the skills learned in treatment.

Recent large-scale training efforts designed to assist therapists using this model have expanded the dissemination of TF-CBT, thereby greatly enhancing its accessibility for youth impacted by child sexual abuse as well as other trauma(s). Therapists interested in learning more about TF-CBT can complete a free training online at http://tfcbt.musc.edu as a first step toward developing the skills needed to implement TF-CBT with youth and their families.

TCRBH'S TAKE: Rigorous randomized trials examining TF-CBT have repeatedly documented its efficacy in supporting the recovery of children, adolescents, and non-offending caregivers in the aftermath of child sexual abuse. This is the go-to, most supported treatment for sexual abuse. Any practitioner who sees patients who are victims of childhood sexual abuse should consider adding this therapy to their toolbag.

News of Note

One in Thirteen Children Take Psych Medications

Analysts at the US Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics have found that 7.5% of children between the ages of six and 17 years old were prescribed a psychotropic medication during the last six months, according to a study released by the federal agency in April.

Many parents perceive the medication as beneficial, with parents of more than half of the children on prescribed medication reporting that the drug helped the child "a lot." Another 26% of parents said the medication helped "some" and 18.9% said the medications did not help their child. (It's not clear from the study how many children prescribed medication actually took it.)

You can find the study, which was based on data from the National Health Interview Survey 2011–2012, at http://1.usa.gov/1mgZ6sB.

Here are some other key findings:

- Use of prescribed medication for emotional or behavioral problems varied by sex, age, and race, as well as Hispanic origin. More males (9.7%) used medications than females (5.2%). Older girls had a higher percentage (6.3%) of use than younger girls (4%). The rate was highest for non-Hispanic white children (9.2%), followed by non-Hispanic black children (7.4%) and Hispanic children (4.5%).
- Children insured by Medicaid or the Children's Health Insurance Program were more likely to use prescribed medication than privately insured or uninsured children.
- Use of prescribed medication varied by income level, with more children in families with an income below 100% of the poverty level using medications.

Brain Activity Tied to Ability to Resist Temptations

Is it our own brains that are leading us into temptation? A new study suggests that brain activity is responsible for whether people can resist or give in to various temptations in their daily lives.

The study suggests that activity in areas of the brain related to reward and self-control may offer neural markers that predict whether people are likely to succumb to temptations, such as food. The research in the journal *Psychological Science* was aimed at answering the question of why some people are more likely to resist temptations, while others fail (Lopez RB et al, *Psychological Science* 2014;online ahead of print).

While researchers focused on food temptations, the same may be true for other desires such as sex or drugs. Researchers showed 31 female participants pictures that included appetizing food and also had them undergo self-control tasks—using functional MRI to monitor brain activity. The research findings reveal that activity in reward areas of the brain predicts whether people tend to give in to their food cravings and desires. On the other hand, activity in prefrontal areas during taxing self-control tasks predicts their ability to resist that tempting food.

The researchers suggested future studies should explore the extent to which brain systems associated with reward and self-control can serve as neural markers of other appetite and addictive behaviors, from binge drinking, to compulsive gambling, to risky sexual behaviors.

More Long-Term Physical Effects of Bullying Found

Being the victim of childhood bullying can lead to long-term, low-level inflammation, according to new research published online in May in the *Proceedings of the National Academy of Sciences of the United States (PNAS)*. The study found that, when compared to non-bullied peers, young adults who had been bullied as kids had higher levels of C-reactive protein (CRP), a standard measure of inflammation. CRP has been tied to a number of adult health risks, including cardiovascular disease.

Researchers looked at blood samples of participants at various times from age nine up through age 21, and found that while CRP increased for nearly everyone in that timeframe, children who were bullied had greater increases. This trend was maintained when controlled for things like obesity and other psychosocial adversity. There were no significant differences in CRP levels among any of the children at the start of the study (baseline).

During childhood, there was a dose-dependent relationship between the number of times a child had been bullied and CRP levels. In other words, the more a kid was bullied, the higher the CRP got.

In contrast, bullies themselves had ever lower levels of inflammation than kids uninvolved in bullying at all. The researchers note that adults with higher social status tend to have lower markers of inflammation. Since bullies often aim to increase their social status, the protective role of social status in inflammation is a possible explanation for this.

The study can be found on the PNAS website at http://bit.ly/1lK1p5p.

Depression: There's an App for That

In the last several years, a number of tools using modern technology have become available for mental health care, including online telepsychiatry appointments and text messaging to support smoking cessation. A recent article in the *Wall Street Journal* explores what may be the next frontier in "connected" mental health care: evidence-based game apps for depression and anxiety (http://on.wsj.com/1p3VxKG).

The *Journal* article focuses on SuperBetter, a game app that guides users through simple tasks aimed at alleviating depression and anxiety symptoms. People are given a task—"call a friend," for example—that they gain points for completing. SuperBetter was shown to decrease scores on the Center for Epidemiologic Studies depression

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scale, and is currently the subject of a National Institute of Health (NIH)-funded study.

There are many other apps aimed at improving mental health, from those that simply encourage positive thinking (eg, the Moody Me app) to those that offer CBT self-help tools (eg, the Depression CBT Self-Help Guide). Most can be found on iPhone or Android app stores.

The US Veterans Affairs (VA) currently has two mobile tools for PTSD. The first, PTSD coach, helps users monitor PTSD symptoms and teaches easy-to-use skills to help users handle stress symptoms, such as relaxation and breathing exercises.

In addition, the PE Coach app is an adjunct for those who are participating in exposure therapy. (For more in these tools, see the interview with Matthew Friedman in the October 2013 issue of *TCRBH*).

For Many, Home is More Stressful Than Work

Work is a huge source of stress and home is where we go to relax and decompress, right? New research says maybe not. A team at Penn State recently studied levels of cortisol (the "stress" hormone) in adults at work and at home and found that people were actually *less* stressed in the office than they were in their homes.

Participants provided saliva samples three times a day and were asked to rate their moods. It turned out men and women had significantly lower salivary cortisol levels at work than at home. And women were found, in fact, to be in better moods at work than at home. This was true of women with and without children. Men rated their moods as higher at home than at work. These findings spanned socio-economic classes.

The researchers say these results may explain a long-known fact that people who work are in better health than those who don't. The results may relate to the task-oriented culture of work, where people are recognized for a job well-done, versus the tedious day-to-day nature of home life, especially in homes with children.

An overview of the research from the Council on Contemporary Families can be found at http://bit.ly/1jYXbW8.

Expert Interview
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Mr. Prescott: Herein lies the interesting dilemma: do we want to stop clients from doing anything that even looks remotely inappropriate, or do we want to engage in some sort of harm reduction? These are areas of great controversy. The only thing I care about is stopping sexual abuse. Many people would say it is not acceptable to have even the slightest impulse toward children. Unfortunately, that is not going to happen. So I am only interested in building healthy lives and safe communities for all human beings, and sometimes that means that we are not going to have clients that are perfectly solid citizens, but instead they are going to do the best they can with what they have. My clients beat themselves up a lot, and it is very common in treatment programs to encounter clients who really hate themselves, their lives, their bodies, as a result of what they have done. I never excuse behavior, but I do believe there is a role for compassion in the treatment of people who have sexually abused.

TCRBH: How well does treatment work and who does it work best for?

Mr. Prescott: Whether or not treatment works is a source of controversy because it is so difficult to measure. However, we do know that people who complete treatment programs re-offend at a 40 percent lower rate than people who don't (Hanson RK et al, *Sex Abuse* 2002;14(2):169–194). The people who seem to benefit the most are the people who are the highest risk and most dangerous of the sex offenders, and yet these are the very people who are the most likely to drop out or get themselves kicked out of treatment programs. But it is actually the least dangerous of the sex offenders who seem to be the most amenable to treatment. Very often the treatment providers are most attracted to clients who are bright and have good verbal skills. The fact of the matter is the people who could benefit the most tend to be the most antisocial.

TCRBH: An issue with all kinds of treatment is maintenance and relapse prevention. Are those issues relevant in the treatment of sexual abusers?

Mr. Prescott: I emphasize that treatment should begin as soon as possible, including for people in prison, and it should continue into the community. Treatment should always be viewed as an opportunity for rehabilitation and should never be viewed as part of a system of punishment. That is where treatment immediately starts to go bad and possibly to cause harm. When people get out of prison, those first few months are easily the most vulnerable time that they will have for many years. Everybody that comes out of prison needs support and access to services, and we are pretty foolish if we only provide treatment in prison and then let them go. The best system seems to be a supportive supervising agent and treatment provider.

TCRBH: What other information do we need to know about sexual abusers?

Mr. Prescott: We need to remember that sexual abuse exists in our communities, our neighborhoods, and very often even in our families. Any amount of sexual abuse is unacceptable and—in my view—much of the sexual abuse that occurs is ultimately preventable. What we need to do is to be able to identify our most dangerous citizens and provide them the greatest amount of treatment. We need to do a better job of helping them before they offend.

TCRBH: Thanks very much for sharing your thoughts on treating sexual abusers, Mr. Prescott.

Research Updates

Section Editor, Glen Spielmans, PhD

Glen Spielmans, PhD, has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

DEPRESSION

What's the Benefit of Antidepressants for Young People?

A recent meta-analysis suggests that antidepressants offer little to no benefit in improving the overall functioning and quality of life in children and adolescents suffering from depression.

The analysis, though limited by a small number of trials, looked at studies to determine the efficacy of antidepressants on overall well-being and the self-reported severity of depression symptoms among young people.

Other recent meta-analyses looked at the efficacy of antidepressants for young people and concluded that the medications had a statistically significant advantage over placebo when it came to clinician-rated depressive symptoms. But those studies did not include measures indicating well-being such as quality of life, global mental health, self-esteem, or autonomous functioning. They also did not include self-reported symptoms of depression.

In this study, which examined nine trials with 2,130 participants reported in 12 journal articles, researchers found the difference was not statistically significant between selective serotonin reuptake inhibitors (SSRIs) and placebo when it came to self-reported depressive symptoms. There was also no significant advantage to the medications over placebo when it came to those measures of well-being. All the studies included in the meta-analysis were acute-phase, placebo-controlled trials in which participants were randomly assigned to groups.

The authors said their findings suggest the overall benefit of antidepressants in youth have been overstated. They concluded that a broader examination of the risk-benefits of antidepressants in youth is needed, and researchers need to look beyond just considering the risk of suicidality and consider other risks to young people from antidepressants, such as excessive arousal/agitation or hostility (Spielmans GI & Gerwig K, *Psychother Psychosom* 2014;83(3)158–164).

TCRBH's Take: The small benefit on clinician-rated depressive symptoms does not carry over to other important outcomes. Improvement on antidepressants in youth is largely due to the passage of time and a placebo effect. Paradoxically, this reflects positively on depressed youth, who often demonstrate substantial improvements during antidepressant treatment despite the drugs' pharmacological properties apparently contributing little to the positive outcome.

Editor's note: Glen Spielmans, section editor for Research Updates, was coauthor on the reviewed study and edited this research update. He has published several meta-analyses regarding mental health treatment efficacy.

SEXUAL VIOLENCE

Prolonged Exposure Therapy Successful in Treating Teen Rape Victims

The same therapy used to treat military veterans and other adults with posttraumatic stress disorder (PTSD) has been shown to be successful in treating teen rape victims.

A study by University of Pennsylvania researchers found prolonged exposure (PE) therapy, where victims are exposed to reminders of their trauma, helped eliminate symptoms in sexually abused teens with PTSD. The results are the first to show that the same kind of therapy used to help trauma-exposed adults (combat veterans and survivors of violence and man-made and natural disasters) who suffer symptoms such as flashbacks and nightmares, also can work for teen rape victims who have PTSD.

Sixty-one patients, all girls aged 13–18, were recruited from a rape trauma center in Philadelphia. All had a history of sexual assault and had five or more current symptoms of PTSD. After undergoing an average of 1.5 initial sessions dealing with safety issues, parental involvement in treatment, and interest in treatment, the girls were randomly selected to receive 14 weeks of PE therapy, which was modified for adolescents, or supportive counseling. The girls who received supportive counseling were given the opportunity to speak about their trauma, but none of them chose to do so.

Counselors, who had no prior experience with PE therapy, were trained in a four-day workshop and received group supervision every two weeks. The counselors also received two, two-day training sessions in supportive counseling. All treatment was provided in a community mental health clinic. Thirty-one girls received 14, 60- to 90-minute sessions of PE and 30 girls received supportive counseling.

At the end of the treatment, girls in both groups experienced significant reductions in PTSD and depression and significant improvements in global functioning. However, significantly more girls in the PE group improved: 83% of participants who received PE no longer met criteria for PTSD diagnosis, compared with only 54% who received supportive counseling. Also, participants receiving PE therapy were two to three times more likely to be a "good responder," in a measure of PTSD symptom change from baseline, than those receiving supportive counseling (73% versus 27%). At 12-month follow-up, researchers found both groups maintained treatment gains and the superiority of PE over supportive counseling remained evident (Foa EB et al, *JAMA* 2013;310(24):2650–2657).

TCRBH's Take: The study's results align with other studies conducted among adults. PE is a very effective inter-

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CE/CME Post-Test

To earn CE or CME credit, you must read the articles and log on to www.CarlatBehavioralHealth.com to take the post-test. You must answer at least six questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by June 30, 2015. As a subscriber to *TCRBH,* you already have a username and password to log on www.CarlatBehavioralHealth.com. To obtain your username and password or if you cannot take the test online, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlatbehavioralhealth.com. Note: Learning objectives are listed on page 1.

1. Which of the following treatments focuses on processing emotions and confronting cognitive distortions and maladaptive beliefs about a rape (Learning Objective #1)?

   [ ] a) Prolonged exposure (PE)
   [ ] b) Eye movement desensitization and reprocessing (EMDR)
   [ ] c) Cognitive processing therapy (CPT)
   [ ] d) Multiple channel exposure therapy (M-CET)

2. A National Institute of Justice report estimates that how many women experience rape or attempted rape in their lifetime (LO #1)?

   [ ] a) One in three
   [ ] b) One in six
   [ ] c) One in 10
   [ ] d) One in 20

3. How do most people who are sexual offenders come into treatment (LO #2)?

   [ ] a) They are mandated by the legal system
   [ ] b) They are afraid they may offend and seek help on their own
   [ ] c) They are in treatment for a separate problem
   [ ] d) A family member recommends they seek help

4. People who complete sex offender treatment programs re-offend at how much of a lower rate than people who don't complete treatment (LO #2)?

   [ ] a) 20%
   [ ] b) 30%
   [ ] c) 40%
   [ ] d) 50%

5. Conservative estimates indicate that approximately how many girls will experience sexual victimization involving physical contact prior to the age of 18 (LO #3)?

   [ ] a) One out of three
   [ ] b) One out of five
   [ ] c) One out of 10
   [ ] d) One out of 12

6. One important factor that appears to positively impact outcomes for youth who are victims of sexual abuse is the degree of support these young people receive from non-offending caregivers (LO #3).

   [ ] a) True
   [ ] b) False

7. A study by University of Pennsylvania researchers, found which of the following was true about treating teenage girls who were victims of sexual assault (LO #4)?

   [ ] a) Prolonged exposure (PE) therapy, where victims are exposed to reminders of their trauma, helped eliminate symptoms of posttraumatic stress disorder (PTSD)
   [ ] b) Supportive counseling, where girls had the choice of whether to talk about their trauma, was most effective in eliminating PTSD symptoms
   [ ] c) At 12-month follow-up, neither the teens receiving PE or supportive counseling maintained the gains achieved in treatment
   [ ] d) PE is dangerous in treating teen victims of rape because it further traumatizes them and should be reserved for trauma-exposed adults

8. A recent meta-analysis found which of the following was true about the use of antidepressants in children and adolescents suffering from depression (LO #4)?

   [ ] a) The medications offer a great benefit in improving the overall functioning and quality of life
   [ ] b) The medications offer little to no benefit in improving the overall functioning and quality of life
   [ ] c) The medications increase the likelihood of suicide
   [ ] d)Parents report the medications decrease depression

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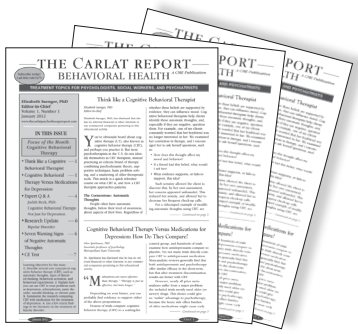

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Research Updates

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vention for people suffering PTSD secondary to sexual abuse/assault. The main limitation was the comparison to supportive therapy, in which adolescents were responsible for directing sessions. PE has clearly demonstrated superiority to nondirective client-centered treatment but more studies are needed comparing PE to other active therapies (eg, interpersonal, other cognitive behavioral therapy (CBT) interventions, present-centered treatment).