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Trauma-focused cognitive behavioral therapy: Cultural adaptations for application in Jordanian culture

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The aims of this study were twofold: (1) to test the feasibility and acceptability of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as implemented by Jordanian counselors working in child protection organizations and schools, and (2) to examine the effect of TF-CBT on reducing the Post-Traumatic Stress Disorder (PTSD) and depression symptomatology of a sample of Children with Abuse Histories in Jordan. Methods: Ten experts and four children counselors were involved in the feasibility study. Eighteen abused children referred from Community Local Organizations associated with PTSD symptoms and depression, were randomly assigned to control and TF-CBT groups. The repeated measures design and thematic content analysis method were used for analyzing qualitative and quantitative results. Results: The results indicated the possibility of implementing TF-CBT in Jordanian culture. Most TF-CBT components were accepted and evaluated positively by children, parents, and children counselors. The descriptive statistics demonstrated significant post-treatment improvements for the TF-CBT group in all outcome measures and sustainability of the treatment gains for the TF-CBT group at 4 months follow-up. The study results support other reports on the rapid effects of TF-CBT intervention on abused children with PTSD and depression.

Keywords: Trauma-focused cognitive behavioral therapy (TF-CBT); adaptation and feasibility; PTSD; depression; children with abuse histories; Jordanian application

The problem of preventing and treating Children with Abuse Histories (CAH) is highly relevant. It involves many practical questions of an ethical, humanitarian, social, economic, legal, medical, and educational nature (Andronnikova, 2011). The term Child Abuse (CA) was first used in the United States for the notation of complex occurrences connected with negative influences on physical conditions of a child. Subsequently, the terms Physical CA, has been adopted as standard in the literature. The concept of CAH covers a wide spectrum of overt actions that seriously threaten a child’s health and safety resulting in considerable harm and reduction in physical and psychological well-being (Salter & Stallard, 2008; Weitzman, 2005). CAH or CA was defined in a recent text as: “… Acts of commission that involve either demonstrable harm to the child (observable injuries that last at least 48 h) or endangerment (deemed to be substantially at risk for injury) …” (Barnett, Miller-Perrin, & Perrin, 2011, p. 141). Physically, CAH
includes signs and symptoms as reflective of physical abuse (e.g. bruises, black eyes, welts, lacerations, or rope marks, open wounds, cuts, punctures, or untreated injuries in stages of healing, bone fractures, broken bones, and bleeding).

Experimental research showed that physical violence against children has long-term consequences for different parameters of mental health, depression, and other affective difficulties (Allen & Johnson, 2011; Cicchetti & Toth, 2005) and PTSD (Gover, 2004; Pelcovitz et al., 1994). These symptoms often result from children’s exposure to trauma, including physical abuse (Boney-McCoy & Finkelhor, 1995). Having these symptoms left without treatment may lead to chronic psychiatric difficulties and be associated with violent, criminal behavior in adolescence and adulthood (Lansford et al., 2007), as well as abusive or coercive behaviors in personal relationships (Gladstone et al., 2004). It is clear that PTSD and depression are among the most serious consequences in CAH (Adler-Tapia & Settle, 2009; Ahmad, Larsson, & Sundelin-Wahlsten, 2007; Cohen, 2008; Runyon, Deblinger, Ryan, & Thakkar-Kolar, 2004) which increases the need for some kind of initiative regarding treatment methods. Cohen (2005) argued that Childhood PTSD is highly comorbid with other serious psychiatric disorders, including depression, other anxiety disorders, attention-deficit hyperactivity disorder, conduct disorder, and substance use disorders. Yet, all of the heretofore published treatment studies for childhood PTSD have excluded children with some or any of these comorbid disorders (e.g. depression).

Like other countries, Jordan also suffers from a CAH problem. Based on the National Council for Family Affairs (NCFA, 2011) annual report for 2011, around 2301 cases were discovered and identified as a CAH cases (NCFA, 2011), but the same report highlighted that the problem goes beyond this number. Aqroosh and Al Farkh (2008) have claimed that around 7045 CAH cases were discovered during 2001–2007. The cases were distributed according to abuse type (82.14% physical, 50% psychological, and 28.57 sexual abuse) (Aqroosh & Al Farkh, 2008).

Most Jordanian studies have focused on treating the psychological symptoms of physically abused children by using variations of Cognitive Behavioral Therapy (CBT) (Abueita & Ahmad, 2005), Play Therapy (Al-Hweian, 2011), Assertive Training (Zeot, 2005), and Assertive Training and Play Therapy (Mqrdadi, 2003). We could find no previous studies that used Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as a treatment intervention. This can be supported by the fact that only 14.28% of research studies conducted between 2001 and 2007 focused on different evidence-based treatment interventions (not including TF-CBT; Aqroosh & Al Farkh, 2008). All previous Jordanian studies (Abueita & Ahmad, 2005; Al-Hweian, 2011; Mqrdadi, 2003; Zeot, 2005) have used a child-centered treatments, while the family’s involvement in all abused children treatment process is highly recommended (NCFA, 2011).

TF-CBT is one of the most researched and widely disseminated interventions for maltreated children in western cultures (Allen & Johnson, 2011). Recent reviews of literature (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011) have reported that TF-CBT has a positive role in reducing CAH’s PTSD. More than a dozen scientifically rigorous western studies have confirmed that TF-CBT helps children and families recover from the negative effects of traumatic experiences, including PTSD symptoms, depression, and related difficulties (National Child Traumatic Stress Network [NCTSN], 2008). Thus, this intervention has been used successfully and effectively with children who have experienced diverse and multi traumas including sexual abuses (Deblinger,
Mannarino, Cohen, & Steer, 2006), war traumas (Cox et al., 2007), domestic violence, and disaster (Cohen & Mannarino, 2008). Cohen and Mannarino (2011) highlighted that TF-CBT has family counseling component activities through parental involvement. This raised questions about the efficacy of the intervention in different cultures (e.g. Arabic and Islamic culture), where resistance to family counseling interventions may be encountered and a high dependency on traditional methods to deal with children psychological difficulties may be present. Introducing family focused interventions may challenge the patriarchal culture of Jordan, which allows the parents to use all possible methods to discipline the children behaviors without looking beyond their negative psychological consequences on children's mental health.

Provision of specialized interventions for abused Jordanian children and their families are relatively recent treatment options. Based on the NCFA (2011), most abused cases were not delivered to specialized services and the families have used traditional methods to deal with negative psychological abuse consequences (e.g. keeping problem inside family borders or ignoring it). Moreover, many Jordanian families resort to sorcery and witchcraft practiced by non-professionals, to treat children suffering from the psychological effects of exposure to trauma and physical abuse (NCFA, 2011). This study aims at assessing TF-CBT's acceptability, validity, and feasibility as important issues for its application in different cultures.

Implementing TF-CBT in the Jordanian population may present some challenges based on our experience with eastern Jordanian community. Parents from this region, for example, abusing fathers in particular, were less interested in participating in their child’s psychotherapy, which maybe to be the most challenging aspect of the treatment process. As Jordan is a country belonging to the middle-eastern culture, such parental involvement in psychological therapies process could transform the traditional CAH treatment from medico-legal and social interventions to psychological, family, and parenting ones. Implementing TF-CBT in Jordan is therefore considered to be unique for its comprehensive family counseling trend and it goes beyond the traditional treatment methods.

This study draws from the positive suggestions and recommendations of research (Deblinger et al., 2011; Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004) that emphasizes the importance and potential benefits of TF-CBT in different cultural settings. Our study highlights the fact that systematized support services for abused children in Jordan are deficient. This raises important questions about the need for developing, modifying, and implementing some valid treatments in other cultures (e.g. TF-CBT) in the absence of other supportive services in Jordan.


Most of the published trials for TF-CBT efficacy were conducted in western cultures (Cohen & Mannarino, 2011; Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). Chemtob, Tolin, van der Kolk, and Pitman (2000) conducted a review that was intentionally inclusive, totaling 57 western studies of psychological treatment of acute
stress disorder, as well as PTSD published in 2008. The authors claimed that by looking at the literature undifferentiated by trauma type, there was evidence that TF-CBT is efficacious and specific for PTSD in Sexually Abused Children (SAC) in western cultures, but there was no evidence for its efficacy in other cultures. This resulted in the adaptation of TF-CBT to other cultures (Bass, Bearup, Bolton, Murray, & Skavenski, 2011; Murray, 2006; Tallant, 2010). The TF-CBT treatment manual was successfully adapted for use in Sri Lanka, Indonesia, and Thailand following the 2004 tsunami and was provided to therapists following the Beslan school terrorist attacks in Russia’s North Caucasus region in 2004, while TF-CBT was adapted to be used to reduce the trauma symptoms among formerly trafficked – sexually exploited and sexually abused girls in Cambodia (Bass et al., 2011). TF-CBT was used in Pakistan for children affected by the 2005 earthquakes and in order to facilitate the adaptation process in other countries. Moreover, the TF-CBT manual has been translated into Dutch, German, and other languages (Cohen & Mannarino, 2008). Tallant (2010) has indicated that there were several reasons why TF-CBT is adaptable to other cultures: (a) it is a strength-based approach, (b) it focuses on development of competency skills, (c) it uses cognitive behavioral treatment techniques which are relatively easy to adapt for people at different stages of development, and (d) it has already been structured for use across a wide range of developmental levels.

Objectives of this study

To test the acceptability, validity, and feasibility of TF-CBT as implemented by Jordanian counselors working in child protection organizations and schools. As a part of this feasibility and adaptation study, we evaluated the efficacy of group TF-CBT implementation in reducing the PTSD and depression symptomatology in a sample of physically abused children in group settings.

Method

Participants

Adaptation and feasibility study participants

Ten Jordanian experts in psychotherapy and counseling employed by two public Jordanian universities and child therapy centers; and four authorized, accredited children counselors: two employed in the Child Care Unit (CCU) at the Institute for Family Health and two working in the Child Protection Association (CPA).

Trial participants

Eighteen abused children (available participants) participated in this study, who were referred from Community Local Organizations (CLOs) and other local child protection institutes, for their previous experience with physical abuse in their homes by one of their parents. According to available medical, psychological, and psychiatric reports, all children were initially suffering from physical abuse and clinical symptoms of PTSD and depression for at least five weeks prior to treatment. A trained child specialist
interviewed all participated children individually and their parents and implemented the Post-Traumatic Stress Symptoms in Children (PTSS-C) and Children Depression Inventory (CDI). All participant children were distributed randomly to one of two groups (treatment and control) between July and August 2012 in CCU (nine children in each group). The children ages ranged from 10 to 12 years ($M = 11.3$). All of the children were boys, without any previous therapy experience. All children were requested verbally to provide their approval for participation and parents (non-perpetrating parents) who filled in the consent forms, agreed to participate at this study. The first assessment indicated that most of the children had been physically abused during the 4–6 months before the intervention.

**Measures**

*Post-traumatic stress symptoms in Children*

The PTSS-C yielded satisfactory internal consistency, high inter-rater agreement, and excellent validity on cross-validation with the Child Post-traumatic Stress Disorder Reaction Index and the Diagnostic Interview for Children and Adolescents according to the Diagnostic and Statistical Manual of Mental Disorders (Ahmad, Sundelin-Wahlsten, Sofi, Qahar, & Knorring, 2000). For this study, the PTSS-C was translated to Arabic by an accredited translator then re-translated to English to ensure translation accuracy. We then assessed psychometric proprieties for the new Arabic version through inter-rater validity (experts validity) and Cronbach’s Alpha reliability (.78) and test re-test reliability within 2 weeks between the first and second implementation ($Pearson \text{ correlation} = .87$).

The instrument comprised 30 items (Yes/No) located on 4 different dimensions with total scores ranging between 0 and 30 (0–10 low), (11–20 moderate) and (21–30 high–severe).

*Children depression inventory*

The CDI is a self-rating scale modeled on the Beck Depression Inventory and adapted for use with children (Kovacs, 1985). The depressive symptoms assessed include: cognitive, affective, somatic, and behavioral aspects. The CDI comprised 27 items scored from 0 to 2, where 0 means the symptom is not present, 1 the symptom is present and moderate, and 2 the symptom is present and marked. The CDI takes about 10–20 min to complete. The total scores ranged between 0 and 52. The CDI’s total cut points were (0–17.16, low depression symptoms), (17.17–34.32, moderate depression symptoms), and (34.33–52, severe and significant depression symptoms). In the present study, a 26-item questionnaire was used to represent the original 27-item CDI. The question concerning suicidal tendencies was excluded to avoid the possibility that consciousness about a previously unconscious suicidal idea could emerge in the child’s mind (Larsson & Melin, 2007). The CDI was translated from English to Arabic and back with high coincidence. The CDI had highly acceptable psychometric properties which encouraged some previous studies to use it (AL-Balhan, 2006). For this study, CDI attained high inter-rater validity (experts validity) and *Cronbach’s Alpha* reliability (.81) and test re-test reliability within 2 weeks between the first and second implementation ($Pearson \text{ correlation} = .80$).
Procedures

Adaptation and feasibility procedures observed following steps:

1. TF-CBT manuals (Camino, 2000; Deblinger & Heflin, 1996; NCTSN, 2008) were translated into Arabic by an accredited translator and then translated into English by a second translator.

2. Selection of the TF-CBT manual reviewers (ten experts) who were working in clinical and counseling departments at Jordanian universities and accredited child therapy centers.

3. Revisions sheet preparation. The following areas or themes were targeted: the length of treatment sessions, the number of sessions spent on each TF-CBT component, and the activities suitable for each component’s goals.

4. Meeting with the reviewers (one meeting) and explanation of the review aims, process, and procedures.

5. Children counselors training and supervision according to the adapted version took place over six days. Four children counselors volunteers working in CLOs received the following training activities:
   - Review the previous literature (Deblinger & Heflin, 1996; Tallant, 2010) to understand why TF-CBT was chosen as a treatment.
   - Introduce the basic cognitive behavioral conceptualization of child trauma.
   - Familiarize the counselors with the research that has made TF-CBT evidence-based treatment.
   - Introduce the TF-CBT components (PRACTICE) for the trainees.
   - Provide trainees with practical information and knowledge on implementing the core components of TF-CBT in a culturally flexible, yet adherent manner.
   - Discuss the recent adaptations of TF-CBT that have been implemented in Jordanian/Arabic cultural settings.
   - Obtain direct training and practice of the treatment components, through role-play techniques with colleagues.
   - Manage a discussion about the TF-CBT implementation in special populations; this includes the particular circumstances and limitations of children with physical abuse experiences in Jordan and how TF-CBT may or may not be appropriate.

6. Practice, monitoring, and supervision phase.

   All four trainees were divided into two teams (CCU and CPA) based on their working locations. Each team was asked to implement TF-CBT within its actual work settings. Two treatment groups consisted of physically abused children (nine children per group) and their parents. Ten TF-CBT sessions of two weeks duration were conducted and followed by separate supervised sessions (30 min per session) for CCU group counselors. The TF-CBT sessions were ceased in CPA for dropping out problem. One supervised session (2 h) was implemented at the end of the treatment.

7. Evaluation and assessment

   In addition to investigating the TF-CBT feasibility and usability by the Jordanian counselors, the study attempted to evaluate the impact of TF-CBT on some trauma symptomatology (PTSD and depression) for the physically abused children. The data
was purposely selected from only CCU groups as dropping out problem faced another treatment group. The CCU group counselors used PTSS-C and CDI to evaluate the PTSD and depression symptomatology. TF-CBT pre, post, and 4 months following PTSS-C and CDI were implemented, to learn how the children’s symptoms in treatment groups had changed over the course of treatment phases. In addition, all participating children, parents, and children counselors were interviewed by the supervisor and his assistant at the end of completing TF-CBT sessions. The interviews time duration ranged between 10 and 20 min. For ethical considerations, the control groups in (CCU and CPA) received TF-CBT sessions after finalizing all the procedures of the current study.

**Qualitative interviews with children, parents, and counselors**

The main goal of these interviews was to learn from each participating (child, parent, and counselor) about his/her experiences with TF-CBT, in his own words. The supervisor and his assistant interviewed each child, parent, and counselor and asked the following questions: What did you like about the TF-CBT treatment? What did you find challenging about the TF-CBT treatment? What did you dislike about the TF-CBT? How have you/ your child’s family changed since the beginning of the treatment? Do you attribute these changes to the TF-CBT or not. Do you have any suggestions or comments to improve TF-CBT?

**Trial procedures**

The children were admitted to day care activities at the CCU. In this setting, the first 5 weeks were designed for observation and assessment by the CCU child specialist. TF-CBT intervention was commenced in the first week and was concluded before completion of the observation. During this period, the researchers made sure not to have any other specific treatments for children. After obtaining written consent from the parents and verbal approval from their children, the 18 children were randomly assigned to the TF-CBT treatment group and the control group. The children in both groups completed a PTSS-C and CDI at pre-treatment during the first week of admission by the child specialist to avoid any possible inflated rating. Ten TF-CBT group treatment sessions of the recently adapted model were administered during a two-week period (two sessions per week) including the assessment session by child counselor. During the treatment, children practiced the skills they learned (e.g. cognitive restructuring, supportive social network, challenge thoughts, formulate helping thoughts, and practice behavior) within the sessions as group assignments, in addition to some homework for each session (checklists, self monitoring, drawings, and diaries of the exposure narrative). We estimated that the TF-CBT group children completed about 10–15 h of homework in total, but homework time was not systematically tracked. The TF-CBT interventions were implemented by two a qualified and accredited, registered child counselors who had prior clinical experience working with abused children and attended the TF-CBT training sessions. Formally supervised therapy sessions with an accredited supervisor (the first author), took place every session and week via meetings, phone calls, emails, and direct monitoring for the CCU treatment group counselors. No sessions were taped and no interventions were introduced for the control group between
the pre and follow-up assessments. After 2 weeks, the children in both groups were asked to complete the PTSS-C and CDI post-test and the follow-up assessment 4 months after the completion of therapy. There were no dropout cases in the treatment group. The duration of each session was limited to an average of 60 min. In line of the reviewers suggestions and recommendations, parents (seven mothers and two fathers) of the children in TF-CBT group also attended two Better Parenting Skills Education (BPSE), provided by the same group counselors, within the first treatment week (90 min each) and attended the ninth and tenth sessions of TF-CBT sessions (conjoint and close communication; and deep discussions) with their children.

Protocol and TF-CBT treatment condition

The treatment condition consisted of following steps:

Preparatory session

First session: The PTSD (PTSS-C) and depression (CDI) pre-test assessment was done by the child specialist, informed consent by parents and children, general discussions about the rules of participation, and confidentiality. The parents attended their first BPSE according to current Jordanian modification for TF-CBT after the first treatment session.

Active treatment

The second session: Cognition and feelings discussions regarding the children’s trauma and previous abuse, trauma-related cognitions, and feelings. The rationale for using TF-CBT was provided. Parents had their second BPSE training.

The third – eighth sessions: Provision of skills training (cognitive restructuring, creating supportive social networks, positive thinking, relaxation, and meditation). Homework assignments were given by the end of each session.

The ninth session: Parent–child session (conjoint and close communication). Each child and parent sits and runs deep discussion about their relations, security, and available parental support.

Termination

The tenth session: Discussions about the treatment program, its advantages and disadvantages, direct impact, feelings, and cognition and PTSS-C and CDI post-test assessment.

Data analysis

Descriptive statistics were calculated (means and standard deviations) for both groups (TF-CBT and the control) at different assessment phases. The repeated measures design (Greenhouse-Geisser test) one between – one within factor was used and One way ANOVA for repeated measures was conducted for examining whether participants’ scores on PTSS-C and CDI differ significantly according to study groups. More
specifically participants’ scores in each scale were considered as the within variable (pre, post, and follow-up), whereas the TF-CBT vs. control groups were used as the between variables comparisons. All the differences were tested at $p \leq .05$.

Qualitative data analysis
The thematic content analysis method (Berg, 2004) was used for analyzing qualitative results, the interviews with the children, parents, and counselors were documented and recorded (video recording) by the supervisor and his assistant. The documented and recorded interviews were introduced to two experts for reviewing and analyzing separately according to credible checklists prepared for different interviews then they discussed the analyses results for each interview and agreed on the results.

Results

Trial results

PTSD results
Small means differences were demonstrated between TF-CBT group ($M = 23.66$, $SD = 1.658$) and control group ($M = 24.55$, $SD = 1.236$) in pre scores. However, there are clear differences between post mean ($M = 13$, $SD = 1.118$) and follow-up mean ($M = 11.88$, $SD = 1.964$) for the TF-CBT group, comparing with control group’s post means ($M = 24.2$, $SD = 1.544$) and follow-up ($M = 23.98$, $SD = 1.471$).

The Greenhouse-Geisser test (the within-subjects effects results) on PTSS-C revealed participants’ pre, post, and follow-up scores in both groups differ significantly ($F = 96.914$, $df = 1.480$, $p < .05$). Moreover, the Greenhouse-Geisser test results indicated that there was significant interaction ($F = 82.324$, $df = 1.480$, $p < .05$) between participants’ scores on PTSS-C and the groups. In other words, treatment group participants’ scores on the three measures of PTSD differ significantly compared to the control group.

For the purpose of examining whether treatment group participants’ scores on PTSS-C differ significantly compared to the control group, a one way ANOVA test for repeated measures was conducted. ANOVA results indicated that TF-CBT group participants’ averaged scores on the three repeated measures on the PTSS-C differ significantly ($F = 315.774$, $df = 1$, Partial Eta Squared .95, $p < .05$), compared to the control group. So as descriptive statistics results reveal TF-CBT group means on post and follow-up measures on PTSS-C have been reduced compared with its pre score mean.

Depression results
The results reveals no pre means differences between TF-CBT group ($M = 42.77$, $SD = 2.488$) and control group ($M = 44$, $SD = 1.87$) on CDI. However, the differences between the post and follow-up means on CDI between two groups are very obvious (TF-CBT post: $M = 26.44$, $SD = 3.844$, follow-up: $M = 27.44$, $SD = 1.943$), (control post: $M = 43.77$, $SD = 3.844$, follow-up: $M = 44$, $SD = 1.87$). The Greenhouse-Geisser test (the within-subjects effects results) on CDI revealed participants’ pre, post, and follow-up scores in both group differ significantly ($F = 99.617$, $df = 1.247$, $p < .05$). Moreover, the
Greenhouse-Geisser test results indicated that there was significant interaction ($F = 96.612$, $df = 1.247$, $p < .05$) between TF-CBT group participants’ scores on CDI and control group. ANOVA results revealed that TF-CBT group participants’ average scores on the three repeated measures on the CDI differed significantly ($F = 207.601$, $df = 1$, Partial Eta Squared .92, $p < .05$) compared to the control group. So as descriptive statistics results reveal TF-CBT group means on post and follow-up measures on CDI have been reduced compared with its pre score mean.

**Qualitative evaluation**

**Reviewers’ comments**

The main recommendations regarding the culturally adapted treatment manual by the reviewers were:

- Decrease the total number of sessions from 12 to 10.
- Treatment implementation can be individualized or group.
- There is added value in including non-perpetrating parents in the young children’s treatment, but not the perpetrating parents.
- Beside TF-CBT sessions, additional better parenting skills training sessions are highly recommended.
- It is recommended to commence adapted TF-CBT treatment with physically abused children.
- Consider the sessions duration from 50 to 60 min.
- The group parental involvement must be in accordance with parent’s gender. According to Jordanian culture, there are some limitations in having free involvement between the parents and children of differing gender. For that reason, the mothers should be with their daughters and fathers with their sons.

**Parents’ and children comments**

The parents demonstrated positive feedback toward using TF-CBT with their abused children (e.g. *I like the relaxation, being with my child again, being with other parents with the same problem, I have learned positive parenting skills, it is new, and I feel that I’m a real parent*). Furthermore, the interviews with children indicated some positive feedback (e.g. *being with my parent again would be great, I can depend again on my mother to deal with my distresses, I have learned some positive ways to deal with my loneliness problem, being in a group, playing with others and speaking about my physical abuse in a secure place was strange experience and I’m not alone any more*).

**Counselor’s comments**

Counselors, in general, adopted positive attitudes and were open to learning more about TF-CBT techniques. The main problem facing counselors was the need to move away from traditional counseling techniques, such as giving suggestions towards achieving certain treatment goals of the different TF-CBT components. For example, in the relaxation component, the counselors proposed some thoughts, movements, and exercises to the children in the groups instead of having the group members come up with it
themselves. One counselor proposed a trauma symptoms triangle (feelings, thoughts, and physiological reactions) during her efforts to explain the trauma reactions to the children and parents. We noticed that counselors performed better when treatment instructions were broken down into discrete steps by the supervisor. These were subsequently practiced and performed in each session. For example, some of the training methods and techniques (e.g. role play) were initially not preferred by one particular counselor, who felt shy practicing new skills in front of her colleagues. Limited training time was considered a major challenge: limiting deeper discussion, further analysis, and additional training in some TF-CBT components (e.g. trauma narrative, enhancing skills, and cognitive reprocessing).

Here are some other comments and suggestions:

- More training on assessment and evaluation tools which can be used to assign cases suitable for TF-CBT.
- Counselors and psychotherapists should pick up at least 1–2 actual cases before the feasibility study commences.
- Supervision must be provided for all participating counselors. The main supervisory comments were:
  - Consider extending the session duration from 50 to 60 min (as recommended by the reviewers) to not less than 60 min.
  - Counselors should be provided with practical methods to connect with the children in initial sessions.
  - Group counseling techniques are vital for the modified and adapted TF-CBT model.

Discussion

This is the first clinic-based study of TF-CBT for abused children in Jordan using TF-CBT techniques specifically adapted for the Jordanian culture. In this investigation, we have tried to examine the efficacy of TF-CBT on reducing depression and PTSD levels for abused children in Jordan. We also wanted to gather perspectives on TF-CBT that could allow furthering adapting the intervention in Jordan. The overall results suggest that TF-CBT has immediate effects on reducing symptoms of PTSD and depression. The pre- to post-treatment changes in the TF-CBT group based on Partial Eta Squared values were large, (.95 for PTSD and .92 for depression), suggesting that the TF-CBT treatment was efficacious.

Our study provided very useful information and feedback about the impact of non-perpetrating parents’ involvement in a culturally adapted intervention. We concluded that not all TF-CBT components had the same acceptance or required the same counselor training time. For example, trauma narrative and cognitive reprocessing were the TF-CBT components which needed the most counselor training and practice, whilst working directly with parents and providing them with BPSE was considered the most challenging aspect of TF-CBT. In order to facilitate working with physically abused children in groups, there was a need for more advanced group counseling techniques.

The adaptation process has indicated the importance of continued supervision and monitoring during implementation of all TF-CBT components. Clinical supervision in
counseling and psychotherapy for working with CAH is not yet practiced in Jordan, for
that we think this supervision may be considered a step towards enhancing chances of
positive treatment results. Counselors should undertake continuous and ongoing supervi-
sion. This will ensure they acquire all the necessary skills to implement TF-CBT in a
way that adheres to the treatment model. Group counseling skills, the documentation of
case notes and treatment progress and certain cultural limitations, all played an impor-
tant role in treatment delivery. These factors were discussed in-depth during the sessions
with the supervisor and as a result, counselors, parents, and children all approved of
TF-CBT as an intervention and found it helpful in addressing problems as they arose.

The TF-CBT treatment involves BPSE sessions which include the “abuse clarifica-
tion process” components where the counselor and the parent who engaged in punitive
or abusive behaviors are responsive to the child and attempt to dispel negative abuse-
related beliefs. This aspect of treatment may have been critical in helping the children
overcome their PTSD and depression. Despite the lack of quantitative data in our pres-
ent study of the effects of parental participation in BPSE sessions, we think the parents’
involve may enhance the delivery of TF-CBT. During the parent–child conjunction
session, the therapist encouraged direct discussions of the abuse initially with each par-
ent and child individually, which subsequently led to a more open parent–child commu-
nication.

The suggested Jordanian modification for TF-CBT includes BPSE, which does not
exist in the western version of TF-CBT. As mentioned previously, the proposed treat-
ment includes BPSE sessions conducted separately for parents and children. Parent’s
participation in the BPSE sessions was considered an excellent opportunity to help them
gain new parenting skills, which helped to change their attitudes towards the use of
physical discipline. This may give parents the opportunity to understand and empathize
with their children’s feelings, thereby changing negative perceptions of their children’s
behavior and leading to more positive approaches to parenting. Parents also had an
opportunity to practice these newly acquired parenting skills with other parents in the
session, while being coached and provided with positive and corrective feedback.
Parental involvement in BPSE would raise their awareness of professional services that
help them deal with their children’s psychological problems, without resorting to unor-
thodox, traditional methods such as sorcery or witchcraft.

The results of this study are consistent with previous attempts which had shown
some effectiveness of TF-CBT in decreasing PTSD levels for children with abuses and
those suffering other kinds of trauma (Cohen & Mannarino, 1996; Scheeringa et al.,
2011). The participants in both groups had PTSD diagnosed at referral and symptoms
remained at clinically significant levels throughout the baseline phase. These children
were having trouble coping with a range of problems related to a history of abuse, such
as flashbacks, nightmares, difficulty sleeping, anger, and anxiety, which stresses the
importance of service sustainability. The results represent significant changes in their
functioning. This suggests that TF-CBT can be effective in resolving past CA trauma.
Furthermore, the results demonstrate positive gains for at least 4 months after the inter-
vention ceased. Our findings are consistent with some previous studies (Deblinger
et al., 2011; Feather & Ronan, 2006; Kornør et al., 2008; Scheeringa et al., 2011)
regarding to TF-CBT sustainability. Additionally, all children and/or their caregivers
anecdotally reported they had learned skills to cope with current situations.
Several methodological limitations and obstacles in the present study provide grounds for caution in interpreting the findings. In this study, we were only able to obtain 18 clients for the different study stages. This sample size may restrict the power of the implemented statistics, which could limit our ability to generalize the findings. Despite this, the study design and methodology indicated that the improved PTSD and depression symptoms for participants in the treatment group were attributable to the implemented treatment, and not to other factors. As in most randomized studies, the study sample was not randomly selected with respect to abuse factor, but included only those children with CAH and not SAC. Consequently, participants in the present study may not have been representative of the population (i.e. children who suffered from multi-abuses and younger children). The generalizability of the results may therefore be limited. In the qualitative part, the findings should be considered in the light of certain limitations (e.g. the parent’s and children’s abilities to read, write, and communicate with researchers and their levels of understanding and awareness. Despite these limitations, the present study was able to provide preliminary evidence for the therapeutic benefits of TF-CBT for children with a history of CAH, as well as for the ability of these benefits to be maintained over a 4-month follow-up period.

As mentioned before, working with the fathers was the main expected trial limitation, most participant parents were mothers, the fathers refused to involve in the treatment process. This was highlighted as a challenge by the TF-CBT Jordanian reviewers. The parents’ connections, interactions, and involvements in group sessions were minimal and limited to the parents of the same sex.

Furthermore, the present study is uniquely based on the Arabic culture, traditions, and customs and is the first study in Jordan to test the ability of TF-CBT to deal with symptoms of PTSD and depression for a sample of physically abused children. We think the parents’ involvement in this study through their participation in two BPSE sessions, might be considered the most challenging factor for this study, given the fact that some of the parents were involved in the abuse of their children. Additional controlled experiments are needed for more conclusive evidence of the immediate and long-term benefits of TF-CBT. Future investigations should have larger sample sizes, other type of traumas, and should perhaps provide longer term treatment (more than 10 sessions of TF-CBT before post-testing) and multi-assessment for all treatment clients (children and parents) including assessment of the improvements in parenting skills for the parents.

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References


