Sexual Abuse Treatment from a Child’s Perspective: An exploration of TF-CBT and EMDR

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Abstract

Currently within the United States, there are roughly 39 million survivors of child sexual abuse (Administration for Children and Families [ACF], 2008). Out of the 1.1 billion people residing within the United States, one in every four girls and one in every six boys will be sexually abused before they are eighteen (ACF, 2008). Some of these children will disclose their abuse as children, some will not disclose their abuse until they are adults, and some may never disclose their abuse. For those children that divulge abuse or in which abuse is suspected and substantiated by persons outside the family, like school officials and subsequently Child Protective Services (CPS), treatment is necessary in order to mitigate the negative effects of this traumatic experience. Child survivors of abuse are treated by social workers, psychologists, and other mental health professionals. They are treated through many modalities in hopes of alleviating their stress. However, it has been found that the two most prevalent treatment options for this population are Eye Movement Desensitization Reprocessing (EMDR) and Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) (Seidler & Wagner, 2006). The following study examines the similarities and differences between these two modalities and the research that both supports and argues against them. Very little research has been done comparing these two modalities in children (Seidler & Wagner, 2006). A case presentation is presented in order to further explore what these treatment methods look like on a personal basis. Goals for future research will be discussed. EMDR and TF-CBT are currently the two most recently proclaimed treatment methods for trauma (Greenwald, 1998; Cohen, Mannarino, & Deblinger, 2006). The hope of this paper is to better understand the positive and negative aspects of EMDR and TF-CBT in treating survivors of child sexual abuse in order to contribute to a more efficacious treatment modality.
Case Presentation

In studying the efficacious nature of treatment modalities, it could be considered adequate to only review the current research on the individual therapies and synthesize this information. However, statistics and research information often do not translate literally to the client population in which they are focused. The children receiving treatment do not care whether their therapist is using the most cutting-edge treatment methods; they only care if it works. In attempting to unite the research on these treatments with the actual events of client lives, these modalities will be looked at both from a research lens and by exploring their progression and potential positive and negative effects on a hypothetical client. The case presentation is loosely based on a case study included in a work by Naubauer, Deblinger, and Seiger (2007). The hope is that this client’s story will help the research knowledge about EMDR and TF-CBT take on a multidimensional context within this paper.

Julia is a 9 year old Euro-American female. She lived with both of her parents until roughly 6 months ago. At that time the father was arrested for assault and battery against her mother, of which this was not the first account. The mother was hospitalized due to her injuries and Julia went to stay with her grandmother. While Julia was with her grandmother she revealed that her father often tucked her into bed and that this included him touching her “chest and private areas.” She also later revealed that her father would watch her while she bathed and eventually began to “clean” her instead of allowing Julia to do it herself. Julia was told that she “smelled” and that the father was the only one who “could keep her from stinking.” However, Julia said that he only cleaned her private area. Upon moving in with her grandmother, Julia asked her grandmother if she would help her take a bath and explained how her father “helped” her. The grandmother immediately reported the abuse to CPS, and would not allow Julia to
return home with her mother. Child Protective Services granted temporary guardianship to the grandmother until the investigation could be completed. During that time, Julia was enrolled by her grandmother in treatment due to the disclosure of sexual abuse.

**Efficacy of Treatment Modalities**

**TF-CBT**

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) was designed by Dr. Judith Cohen and Dr. Anthony Mannarino (Cohen J., n.d.). The theory has been studied by at least seven in-depth projects that included at least five hundred children each (Cohen J., n.d.). The theory, however, has changed names during these studies as it is at times referred to as Sexual Abuse Cognitive Behavioral Therapy (SA-CBT) (Cohen & Mannarino, 1998). It is however currently known as TF-CBT. The treatment theory and the research that has been done to support TF-CBT mainly focused on interventions with sexual abuse survivors, as this is the population that Dr. Cohen and Dr. Mannarino had in mind while creating this modality. Some research has been done relating this treatment to other traumatic events, but none to the extent of sexual abuse (Deblinger, Mannarino, Cohen, & Steer, 2006). TF-CBT is built on the foundation of cognitive and learning theories (Cohen et al., 2006). It aims to understand and change negative cognitions while providing a safe haven for processing the abuse (Child Welfare Information Gateway, 2007).

TF-CBT is designed to work within an average of twelve to eighteen sessions, lasting sixty to ninety minutes or more (Child Welfare Information Gateway, 2007). Extra sessions can be added as needed. The steps for TF-CBT are progressive in nature; however, Cohen has recommended that the treatment be used flexibly (Cohen & Mannarino, 2006). Thus, clients are
able to omit steps that may not apply to their situation or that they may not feel is useful to them personally. The Medical University of South Carolina sponsors the TF-CBT website that allows for internet-based certification. They state the steps of TF-CBT to be: psychoeducation, stress management, affect expression and modulation, cognitive coping, creation of a trauma narrative, cognitive processing, behavioral management training, and parent-child sessions (Medical University of South Carolina [MUSC], 2005). These steps incorporate the use of behavioral management training, which refers to identifying and modifying undesired behaviors in addition to the use of cognitive therapy, which aims to understand and change negative thoughts, feelings, and associated behaviors, and family therapy (MUSC, 2005). Family therapy emphasizes the role of the non-offending family in the healing process of the child (MUSC, 2005). The clinicians incorporate the family into each step so that progress may continue at home and non-offending parents or guardians can practice positive coping techniques alongside their child (Child Welfare Information Gateway, 2007; MUSC, 2005).

Cohen and Mannarino (2008) reframe this working model by describing its steps as PRACTICE: psychoeducation and parenting skills, relaxation techniques, affective expression and regulation, cognitive coping and processing, trauma narrative, in-vivo exposure, conjoint child-parent sessions, and enhancing personal safety and future growth. Cohen and Mannarino reinforce this acronym because it is easy for the clients and their families to remember, and it also subconsciously reminds them that PRACTICE is the way to perfect these skills and to come to adequately manage trauma-related stress (Cohen & Mannarino, 2008). It is also important to note that all stages, regardless of the acronym, expose the client to some form of in-vivo exposure, meaning that the client gradually confronts the sexual abuse throughout the treatment process (Child Welfare Information Gateway, 2007).
TF-CBT has been compared against non-directive supportive therapy, supportive therapy, client-centered therapy, and against a wait list control (Cohen J. D., 2004; Cohen & Mannarino, 1998; Cohen & Mannarino, 2008; Deblinger, 2006; King, et al., 2000). In all of these studies TF-CBT was found to be the superior treatment modality. When TF-CBT was compared against a wait-list control in order to determine efficacy and long-term validity, it was found to be statistically superior to the wait-list control group. Many of the children who participated in this study were diagnosed with PTSD or had many symptoms that were “close” to diagnosis (King, et al., 2000). King et. al. (2000) describes “close” as being one criterion shy of meeting diagnostic criteria for PTSD as is stated in the DSM-IV-TR. At the end of the study, a statistically significant number of these children could no longer be diagnosed as having PTSD or as being “close” to meeting sufficient diagnostic criteria (King, et al., 2000). When TF-CBT was compared against non-directive supportive therapy (NST), it was compared not only in terms of general efficacy and long term efficacy, but also if it could reduce inappropriate sexual behavior and depressive symptoms (Cohen & Mannarino, 1998). TF-CBT was not statistically significantly different from NST when compared six months after completion. As a result, TF-CBT was shown to be no more efficacious over the long term than NST (Cohen & Mannarino, 1998). However, TF-CBT reduced depressive symptoms and inappropriate sexual behavior among their participants in a shorter treatment window than NST. This study shows that even if TF-CBT may not actually be efficacious in the long run, it is more likely to help faster (Cohen & Mannarino, 1998).

TF-CBT was also compared with child-centered therapy in a multi-sited study in order to further the generalizability of the treatment methods (Deblinger et. al., 2006). The study took place in a rural and urban location to add to the understanding that TF-CBT would function for
children regardless of regional surroundings. The findings showed that TF-CBT, in both locations, significantly lowered difficulties in areas such as depression, school compliance, sexual misconduct, psychosomatic symptoms and other acting out behaviors over the child-centered therapy participants (Deblinger et. al., 2006). This study, like King’s comparison with a wait-list, also identified children as having or being “close” to having PTSD (Deblinger et. al., 2006; King, 2000). By the follow up survey, there were twice as many child-centered therapy clients who were still considered to have PTSD than those who participated in TF-CBT (Deblinger et. al., 2006).

Estimates show that up to eighty percent of children participating in TF-CBT will show significant improvement by the time their prescribed twelve to eighteen weeks is completed (National Child Traumatic Stress Network, n.d.). The only caveat to these studies is that all of them were done with families whose first language was English (Cohen et. al., 2004; Cohen & Mannarino, 1998; Deblinger et. al, 2006; King, et al., 2000). Although these studies have found TF-CBT to be generalizable across both rural and urban settings as well as across ages, from preschool to adolescent, they cannot be deemed generalizable across cultures. The unique needs of Latino, Middle-Eastern, Asian, Native American and many other cultures have not currently been addressed in the research literature (Deblinger et. al., 2006). TF-CBT was designed for the needs and communication patterns of English speaking persons and as a result this is the population with which it has been researched to date.

**EMDR**

Eye Movement Desensitization and Reprocessing (EMDR) was developed by Francine Shapiro in 1987 (Shapiro, 2001). It currently enjoys acceptance among many in the clinical field as it incorporates concepts from other treatment modalities that were created prior to the
inception of EMDR (Shapiro, 2001). In eighty to ninety percent of all participants, single incident traumas can be processed in as little as three sessions of EMDR (The EMDR Institute, Inc., 2004). Although the emphasis for EMDR is placed on the “eye” piece, this is only a portion of the entire modality. It is the entirety of this treatment that has been proven to be effective (Shaprio & Forrest, 1997). Often eye movement can be replaced by other stimulations, and should not be regarded as the integral piece of this treatment (Shapiro, 2001). EMDR, as a comprehensive approach, focuses on images, emotions, beliefs, physical responses, and relationships that are associated with being maladaptive or traumatic and then works to change them (Shapiro, 2001). For clients seeking therapy through the modality of EMDR, three goals become prevalent: helping the client learn from past negative experiences, desensitizing extremely stressful stimuli, and incorporating outlines of reference for the client to use in the event of future traumatic experiences (Shaprio & Forrest, 1997).

In 1997 the United States had over 20,000 trained EMDR psychotherapists (Shaprio & Forrest, 1997). That number, although undocumented, has greatly increased over the last twelve years. Also, it was recorded in the same statistics that over one million people had benefited from the effects of EMDR (Shaprio & Forrest, 1997). EMDR includes a process of eight phases. These steps are preformed within a treatment time frame of usually a few weeks. Phase one includes client history and treatment planning, in other words, it is the intake process. Next the client begins preparation, where the clinician explains the parameters of EMDR, and the client learns relaxation techniques. Phase three is the assessment in which the therapist identifies the trauma to be dealt with. Phase four is the desensitization that involves the client recalling the trauma and rating its emotional disturbance. Instillation, the goal of installing positive beliefs in the clients that they have previously identified, happens in phase five in order to replace the
negative beliefs identified in phase four. Phase six includes using the positive beliefs of phase five in order to combat the negative thoughts of phase four and then increasing bodily awareness to identify any new or leftover negative sensations. Closure is the seventh phase. It ensures that all clients leave each session in better shape than when they entered the office. Phase eight includes re-evaluation and takes place at the beginning of every session after the first. This allows the clinician to evaluate the client’s ability to control trauma in the period of time since they met. EMDR comes to a place of termination when the clients feel a significant change in stress related to the trauma since when they began treatment (Shapiro & Forrest, 1997; Greenwald, 1998; Shapiro, 2001; Shapiro & Forrest, 1997; The EMDR Institute, Inc., 2004).

Throughout the session, two scales are used to measure the client’s levels of stress and self beliefs (Shapiro, 2001). The first scale is called the Subjective Units of Disturbance scale developed by Joseph Wolpe over fifty years ago (Shapiro, 2001). The SUDs scale is used to measure the client’s feelings of distress from 0-10, with 0 being no distress and 10 being the most stress imaginable, when picturing the disturbing image (Shapiro, 2001). The second scale is referred to as the Validity of Cognition (VOC) scale which measures the accuracy of positive beliefs the client uses to replace negative stimuli (Shapiro, 2001). The scale rates from 1 to 7 with 1 being completely false and 7 being completely true (Shapiro, 2001). A visual scale using a range of emotional faces can be used for children who do not have the cognitive ability to subjectively measure their feelings (Tinker & Wilson, 1999) (Appendix B).

EMDR is considered to be one of the front-line treatments for persons with trauma related stress by the American Psychological Association, along with TF-CBT (The EMDR Institute, Inc., 2004). Also, EMDR was endorsed by the National Institute of Mental Health as an effective form of therapy for trauma (Adler-Tapia & Settle, 2008). However, EMDR
currently has little research in regard to its efficacy specifically with children (Greenwald, 1998). The modality is one that was designed for adults, and is cutting edge enough that most clinicians who use it consider it to be a “leap of faith” (Tinker & Wilson, 1999). Tinker, believes that this may be one reason that clinicians are not comfortable researching the modality on children. He states that this process elicits extremely strong emotions from adults, and would be likely to do the same in children. A fear of re-traumatizing children is cited as the main motivation for not attempting this process on a large scale population of already traumatized children (Tinker & Wilson, 1999).

The modality has proven to be efficacious among children and adolescents in three smaller scale studies (Saunders, Berliner, & Hanson, 2004). In the three studies, EMDR helped relieve memory related stress (Saunders et. al., 2004). Although these findings are not generalizable to children due to their small size, they do show that there is some research base behind using this treatment with a child population (Saunders et. al., 2004). This should fuel the possibility of further research regarding children in the future, as it is hoped to become an efficacious model for both children and adult population. Although this is not a modality that has been researched extensively with children, this does not mean that there are not clinicians who use this treatment with said population. In accordance this also does not mean that there are not children who have benefited from its intervention (Tinker & Wilson, 1999). There have been eleven studies published regarding the use of EMDR in various situations with children, only two of which have shown no significant improvement (Adler-Tapia & Settle, 2008) (Appendix C).
Relation of EMDR and TF-CBT to the Case Study

Since TF-CBT and EMDR treatment modalities have been reviewed in a more in-depth manner, it would now be beneficial to see how these interventions would look in real life. These modalities will be explored on a personal level using the case example of Julia that was presented at the beginning of the paper. Julia’s treatment for a history of sexual abuse is a subjective explanation as each therapist uses these modalities in slightly different ways. However, the main components of the treatment should remain consistent regardless of the influence of personal style in the therapeutic relationship.

TF-CBT with Julia

If Julia was placed in therapy by her grandmother at an agency utilizing TF-CBT, she would begin working with a clinician as soon as possible for a period of twelve to eighteen weeks. Julia would work both individually with the clinician and in family sessions with her grandmother. Depending on the ruling of Child Protective Services about the mother’s ability to be involved and protect her child from future harm, she may become a part of the treatment as well. Sessions for Julia will typically be sixty minutes in length, but can vary. The flexibility of TF-CBT means that although all steps will be explored in this case example, it is possible for clients to skip whole sections as they may not need the information included or it may not be relevant to the reason they are seeking treatment. For example some children are much more in need of affect education than others. While some children only use four emotional words, others may be quite good at expressing their feelings and thus would not need the affect education. Also, intake and treatment planning session are not included in the estimated number of sessions for treatment.
Julia will begin working with the therapist on issues of psychoeducation. These sessions will include information about the prevalence of sexual abuse among children. Discussions of how sexual abuse occurs to children of all genders, ages, and backgrounds and that it has nothing to do with being any “certain way” will predominate the conversations of the first, and potentially the second, session. Discussions of common reactions to sexual abuse will also be presented in these sessions. Julia will be informed that sexual abuse can be very confusing for children as some of them feel betrayed and others think that the abuse feels good and do not understand why adults are so upset about what has happened. Julia may also be given information about therapeutic groups that meet to discuss their histories of sexual abuse and that this may be something that Julia and the therapist explore in greater detail later in the treatment.

The therapist will also work with the grandmother during the psycho-education section of treatment. It is often important that the parents and guardians are aware that this is something that was not done as a result of something that the child did regardless of the reasons given by the abuser. Julia’s grandmother should also be aware of common reactions of children that have been abused as well as common reactions by non-offending adults to the disclosure of abuse. For example, some children become very reserved while others may become very emotional. The same is true for parents/guardians as many of them withdraw from the children who experienced the trauma and many others come to a place where they cannot look at a child without crying and becoming overly emotional. Also, during these sessions if Julia isn’t yet ready to discuss her own abuse, the topic will be discussed in displacement. For many children it is easier to describe how other children might feel had they been abused that how they personally feel. Julia may be educated about the issue without the therapist ever acknowledging that she is like the kids that they are discussing. Often times, when children first have difficulty discussing
their trauma and trauma begins being discussed in displacement, the topic will again become centered around the child once the child makes an admission like “sometimes I felt that way after my daddy would abuse me.”

After the child receives psychoeducation the treatment moves on to stress management. During this time frame Julia and her grandmother, will learn breathing techniques that can help Julia to cope in moments in which she feels overwhelmed and anxious. Deep breathing is taught so that the client puts their hand on their stomach and then breathes deeply enough to see a visible change in the placement of their hand. This is taught in addition to visualization and thought stopping techniques. Visualization is demonstrated for Julia by creating a place where she feels safe and that she can be alone. Julia then slowly walks to this place in her mind and describes the details of getting to said place in a calm voice so that the idea is soothing. Thought stopping is also taught so that Julia has a choice of which method she finds most effective. In thought stopping Julia would practice interrupting negative thoughts with positive ones; this is often done by snapping a rubber band on one’s wrist or using some other external cue. Some older adolescents find that the relaxation breathing is “silly” and so they find the other methods more valuable (Medical University of South Carolina, 2005). Regardless of what method Julia chose, she would be asked to practice this behavior at home and to write down the moments in which she used the exercises and the circumstances leading up to her distress. Once the therapist deems that Julia is able to appropriately use these relaxation techniques both in the office and in other places in moments of stress, they will move on to the stage of affect expression and modulation.

In this third phase, Julia is asked to think of, and eventually learn, a wide range of emotions. It is hoped that through this education Julia will be able to identify more emotions and
will be able to describe how she is feeling in a more accurate manner. Emotional identification is achieved through flashcards of faces, homework associated with how she feels throughout each day and worksheets that ask her to name emotions and rate them on a scale. Helping Julia be able to rate her feelings on a scale also allows the clinician to identify whether feelings of anger or sadness are lessening.

The fourth, fifth, and sixth phases center on processing the trauma. For Julia, this would begin her processing of the sexual abuse by her father. During cognitive coping, the fourth phase, Julia would begin to recognize some of the thoughts that she has surrounding her sexual abuse. She would then begin to identify them as intrusive, helpful, and unhelpful thoughts. She would also begin to assess the validity of her cognitions. For example, if Julia said she was abused because she was ugly the therapist would ask her what made her ugly. If Julia said that she was ugly because she had brown eyes then the clinician would walk through this thought with Julia, pointing out that plenty of people have brown eyes, and asking if this also makes the ugly and thus if they should be abused.

In creating the cognitive narrative, the fifth phase, Julia and the clinician would work on creating a timeline of the abuse and then putting it in writing or some other form of expression. This portion of TF-CBT is considered to be the crux of treatment (Cohen J., n.d.). After building Julia’s time line, she would write out her narrative including details and any dialogue that she remembers. After she has completed the narrative, it is then used to help with cognitive processing, the sixth step. Cognitive processing uses cognitive coping skills to confront further emotional beliefs surrounding the abuse. Julia would be confronted about her feelings of shame and responsibility in an attempt to help her realize that the abuse was truly not her fault and that these intrusive thoughts are both unhelpful and unwanted.
Once Julia had completed her narrative and dealt with her negative thoughts surrounding her abuse, the clinician would then help her to implement behavioral changes that would aid in processing of the trauma. Some of these changes may include things like Julia putting herself to bed or having a favorite stuffed animal to sleep with. These changes may also include joining a group like was discussed in the first session or beginning an after school club that would provide her with a new outlet and new friends. In the final stage, Julia would be asked to share her narrative with her grandmother. The client is typically allowed to refuse, but is often strongly encouraged to share the narrative with an important family member. After this sharing has occurred, the family may participate in some family therapy sessions or the family may begin group support meetings as well. The family is typically terminated shortly after the narrative is shared and follow up contacts are made in order to ensure continued success.

TF-CBT is a treatment modality that is both flexible and open for creativity. Although the steps of TF-CBT are consistent and present in all cases in which it is used, they can look very different. The hypothetical work with Julia above is only a brief taste of the possibilities that exist within using TF-CBT in the treatment of sexual abuse. However, walking the case study through the steps of the modality provides a deeper understanding of how these phases are to be used and incorporated into treatment. TF-CBT allows for a gradual processing of extremely emotional material so that clients can learn to cope with the trauma most effectively. Allowing the children to learn techniques to deal with stress before allowing them to deal with their own personal trauma, gives the children the ability to learn through detachment, before being thrown into the overwhelming stress of their personal experiences.
EMDR with Julia

The eight phases of EMDR are typically completed within three to five sessions depending on the complexity of the trauma and the responsiveness of the client. During phase one the therapist meets separately with Julia’s grandmother and explains the process of EMDR and its expected outcomes. The therapist also details the advantages and disadvantages of EMDR, as well as its success in the treatment of trauma. The clinician takes a detailed family and developmental history on Julia and determines any risk factors that may impede Julia’s success with EMDR (Tinker & Wilson, 1999). Finally, the therapist establishes the behaviors, feelings, and attitudes that are distressing to Julia and her grandmother and helps to identify changes that they wish to see in these areas. These changes become the treatment goals.

During phase two, the therapist meets with Julia and introduces EMDR through an activity called, “safe place” (Tinker & Wilson, 1999). The therapist asks Julia to pick a place and time when she feels safe and happy. For Julia, this place and time may be when her grandmother sits Julia on her lap and reads her stories in the living room. It is important for the therapist to get as many details about Julia’s safe place as possible: the smells, sounds, images, physical sensations of her body and her emotional feelings. The goal is to help Julia develop a concrete picture of the safe place in her mind so that when she feels overwhelmed or afraid she can immediately return to this place. Once Julia has identified a concrete picture of the safe place, the therapist asks her to hold this image and all its related positive feelings and sensations in her mind, while she follows with her eyes, an object the therapist moves back in forth for fifteen to twenty seconds. Next, she asks Julia to take a deep breath and re-identify the good emotional feelings and physical sensations the image elicited. The safe place activity helps Julia to understand the process of EMDR and the positive feelings and sensations treatment can bring
forth. Once Julia can recreate the safe place and feels comfortable following the back and forth motion of an object with her eyes, she is considered ready to move on to the next phase. At this point, it is important for the clinician to remind Julia that this safe place is somewhere that she can return to at all times whenever she feels that what they are talking about becomes too overwhelming.

Phase three is the assessment phase. The clinician’s goal in the assessment phase is to help Julia identify a concrete image of the trauma, while keeping a careful eye on how Julia is responding emotionally to the process. First, the therapist asks Julia to identify the traumatic image, which in Julia’s case, may be her father tucking her into bed and touching her private areas. Next, the therapist asks Julia to say one negative thought associated with this image. Julia may state, “I am bad.” The therapist uses the SUDs scale to help Julia rate the distress of the image and its associated belief of, “I am bad.” Following the identification and rating of the negative thought, the therapist asks Julia to choose a positive thought that counteracts the negative thought. For example, “I did nothing wrong when my daddy touched me.” Finally, the clinician, using the VOC scale, asks Julia to rate her agreement with the truth of the latter statement on the scale of 1-7, with 1 being not at all believable and 7 being 100% believable. The clinician continues to use both the negative thought and positive thought throughout the treatment process as a way to measure improvement. Improvement can be tracked throughout the session, with the overall goal of reducing the SUDs score and increasing the VOC score (Tinker & Wilson, 1999). If Julia is having trouble conceptualizing a 1-7 scale, the therapist can use a techniques like a scale with faces picturing different degrees of emotion ranging from depressed to ecstatic or the child can show the amount of her belief using hand gestures of small, medium, or big (Tinker & Wilson, 1999).
Phase four, five, and six involve desensitizing the traumatic image and associated feelings, installing the positive thought of “I did nothing wrong” to replace the negative thought, and scanning the body for any other distressing feelings or sensations (Tinker & Wilson, 1999). In order to transition through these phases, Julia is asked to describe in detail the traumatic image in much the same way as she described the safe place, using all five senses. When Julia has a detailed image of the trauma in her mind, the clinician asks her to identify the negative thought she previously stated when remembering the image (“I am bad”). The therapist asks her to identify on the SUDs scale, the level of distress she was experiencing. Once Julia has done this, the therapist asks her to state her positive thought, “I did nothing wrong,” and rate the thought on the VOC scale. The ratings from both scales are written down as a point of reference in order to determine whether her level of anxiety is increasing or decreasing as this process is repeated.

Next, the therapist has Julia hold all of these distressing thoughts, feelings, and images in her mind while following the therapist’s object for fifteen to twenty seconds (as had been done previously with the safe image), then take a deep breath and notice how she feels. The therapist then asks Julia to rate what she is feeling on the SUDs and VOC scales, and repeats the process. When repeating the process, the same image is used until the particular image has been completely desensitized. Most children, after a few rounds of eye movements, recognize their feelings of distress lessen and their positive thoughts become increasingly believable. If EMDR is successful, by the end of the session, Julia’s SUDs scale should be no more than two and her VOC scale should be seven.

Phase seven is the closure phase. The therapist has Julia once again recall her safe place to insure that she is completely relaxed before leaving the session. Typically, with children, the clinician will reserve the last twenty minutes or so of the session to do something the child
enjoys, such as games or coloring (Tinker & Wilson, 1999). During this time, the therapist encourages Julia to notice the positive changes that have occurred in the session and praises her for all of her hard work. It is hoped that this closing section will make the session less stressful for the child and will give them something to look forward to in the next session (Tinker & Wilson, 1999).

The final phase of EMDR is the reevaluation phase. During the reevaluation phase, the therapist evaluates how Julia has been responding to EMDR (Tinker & Wilson, 1999). The clinician asks Julia and her grandmother how the past week has been and whether Julia has experienced any distressing symptoms since the previous session. If so, these distressing images are targeted through the process of EMDR. The therapist also has Julia recall the traumatic image to insure that Julia’s VOC remained at a seven and her SUDs continued to be no greater than two. If this is so, the therapist moves on to address any other distressing images or thoughts Julia may hold about the abuse by repeating the phases of EMDR. Once all the traumatic images have been targeted and Julia is consistently reporting lower SUDs ratings and higher VOC ratings, termination becomes a topic for discussion. The therapist insures that the family knows they can return if the images resurface, as may occur due to stress or difficult developmental periods.

Comparison of TF-CBT and EMDR

TF-CBT and EMDR have many similarities and differences. Shapiro states that EMDR is its own treatment modality and is efficacious in its own right, while Cohen states that EMDR is a form of TF-CBT and should be considered efficacious as it falls under the category of TF-
CBT (Cohen J., n.d.; Shapiro, 2001). However, the treatments share and differ on aspects that are very important (Appendix D and E).

The central differences between TF-CBT and EMDR are the ways in which the models have the clients work through the trauma. TF-CBT is a broad spectrum modality with flexible phases, typically taking three to six months to complete (MUSC, 2005). TF-CBT aims to not only change the behaviors surrounding the trauma but how the trauma has affected other areas of the person’s life. This is much the purpose behind the affect regulation and behavior modification section (MUSC, 2005). They allow the child to learn adequate emotional coping skills for this and future traumas, in addition to behavioral skills that will diminish the negative effects of the current trauma and that will have the ability to help keep them from incurring future trauma. TF-CBT also stresses the importance on the clients knowing that they are not alone in this trauma; but rather, that there are other children who have experienced similar events and feelings, in order to combat the negative cognition that it was a result of something the child personally did (MUSC, 2005). TF-CBT also heavily emphasizes the importance of non-offending parents or guardians in the child’s therapy. Parents are seen individually within the TF-CBT process and are also seen in conjoint sessions with the child. Although parents and children are not seen together every week, there are sessions in which, from the beginning parents are brought in. Children are also asked upon completion of their trauma narrative to share the narrative with the parent or guardian. TF-CBT finds it, not only healing for the children, to express their stories to another party, but also healing for the parents as they more fully grasp the impact and reality of their children’s abusive experience (MUSC, 2005).

EMDR is a centralized modality focusing on specific incidents of the traumatic experiences. EMDR is a rigid treatment modality that must be performed in sequential steps or
the efficacy is questionable. Due to the necessity of creating the safe place prior to processing trauma and rating distress after the processing of trauma, performing the steps of EMDR out of sequence would not be beneficial. EMDR is also a cyclical treatment modality in which separate images repeat the same process, one image at a time. For example, if five separate images need to be processed, five complete sessions of EMDR occur. EMDR has eight phases and is typically completed within a few sessions (Shapiro, 2001). The length of the actual treatment is dependent on how often the client receives EMDR. EMDR has the child begin the difficult work of focusing and identifying the trauma within the first session (Tinker & Wilson, 1999). The importance of parents or guardians is not overly emphasized, although their opinions for the differences that they would like to see in their child are taken into consideration (Tinker & Wilson, 1999). Due to the limited number of sessions, parents are not usually seen in conjunction with the child or by themselves (Shapiro, 2001).

Another significant difference between TF-CBT and EMDR is the emphasis on the clinical relationship that is created between the child and therapist. Due to the differences in the lengths of the treatments, clients who participate in TF-CBT report a higher satisfactory rate with their clinicians, while children who participate with EMDR report feeling less connected to their clinical figures (Shaprio & Forrest, 1997). The importance of clinical relationship differs to every client; however, typically clients with a greater satisfaction not only with the therapist but also with the overall treatment, report increased positive cognitions upon treatment completion (Adler-Tapia & Settle, 2008).

Despite the differences between TF-CBT and EMDR, both share the goal of decreasing a child’s distressing thoughts, feelings, and behaviors associated with the trauma. TF-CBT and EMDR share some similar phases and although they are carried out in different methods; their
overall purpose is the same. TF-CBT and EMDR both create safe places for children to turn to in moments of distress. EMDR creates this safe place in the first visualization in the first session, whereas TF-CBT creates this safe place through the process of visualization and relaxation in the phase of affect regulation (Cohen & Mannarino, 2008) (Appendix E).

TF-CBT and EMDR both heavily emphasize the creation of a trauma narrative. This is the primary linking point between the treatment modalities and Cohen has stated that this may be the key to the efficacy behind the treatments (Cohen J., n.d.). EMDR creates the trauma narrative through intensive exploration of images associated with the traumatic event (Saunders, Berliner, & Hanson, 2004). The client is asked to remember the traumatic image using his five senses and his emotional understanding of that traumatic moment. TF-CBT creates the trauma narrative on a more concrete basis. Some children actually write out the narrative in the form of a literary work, while others dictate the narrative, and still others paint the narrative (Cohen & Mannarino, 1998). During the exploration period, clients are asked to describe in detail their experiences, including any sensory details they remember from the trauma as well as any potential dissociative thinking during that time frame (Cohen & Mannarino, 1998). Much like EMDR, clients who receive TF-CBT are also asked to share their trauma narrative once it is complete (Shapiro & Forrest, 1997). While children who receive EMDR are only asked to share their traumatic images with the clinician, children who receive TF-CBT are often asked to share it with their parents/guardians as well (Cohen J., 2005; Shapiro & Forrest, 1997). Despite the differences between EMDR and TF-CBT throughout each treatment process, the creation of the trauma narrative is the crux of processing traumatic events, specifically in child sexual abuse. Creating a successful narrative is central in helping the child to combat negative cognitions and be fully desensitized to the past traumatic events (Cohen J., n.d.).
Conclusion

The attempt of this paper has been to identify and explain Trauma Focused Cognitive Behavioral Therapy and Eye Movement Desensitization and Reprocessing Therapy. In addition, both modalities have been explored from a perceptive of a literary review, a research comparison by statistical illustrations, and a case application. Through these multifaceted methods, it is hoped that an understanding has been reached that while EMDR and TF-CBT are different treatment modalities; both share important aspects and bring new and different approaches to the treatment community of trauma therapy. While EMDR has not been studied in children at length, it can be expected to be proven efficacious for use with child survivors of sexual abuse in the near future. Cohen, Mannarino, and Deblinger have gone to great lengths to prove TF-CBT efficacious with multiple age groups, in a variety of settings, with multiple trauma experiences but specifically with child survivors of sexual abuse. What is important to note is that in spite of the research to be done or that has been done, efficacious treatments for a highly vulnerable population have both arrived and are on the horizon. Regardless of which of the two modalities Julia’s grandmother would have chosen in the presented case example, it is the hope of this paper that Julia would have received treatment that guided her to process the trauma of her sexual abuse and helped her move forward to live a long and content life.
Works Cited and Consulted


http://www.nctsnet.org/nctsn_assets/pdfs/Q&AChildSexualAbuseTreatmentJC10007.pdf


Appendix A:

Alternate Validity of Cognition Scale for Young Children

7

5-6

3-4

1-2
## Appendix B:

### Comparison Studies with TF-CBT

<table>
<thead>
<tr>
<th></th>
<th>TF-CBT</th>
<th>Wait List Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy and Long term Validity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prior PTSD Diagnosis</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Significant reduction of PTSD Diagnosis</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>TF-CBT</th>
<th>Non-Directive Supportive Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy and Long term Validity</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Reduce inappropriate sexual behavior</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Decrease in depressive symptoms</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Statistical Improvement after 3 months</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Statistical improvement after 6 months</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>TF-CBT</th>
<th>Client Centered Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy and Long term Validity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Reduce inappropriate sexual behavior</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Generalizability among age of children</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Generalizability among urban or rural setting</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lowered Difficulties in areas such as depression, school compliance, sexual misconduct, and psychosomatic symptoms.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prior PTSD Diagnosis</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Significant reduction of PTSD Diagnosis</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix C: Research Summary for EMDR

<table>
<thead>
<tr>
<th>Year of Study</th>
<th>Study</th>
<th>Number of Subjects</th>
<th>Settings</th>
<th>Fidelity Assessed</th>
<th>Total EMDR Sessions</th>
<th>Post-tx Follow up</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>Rubin et al. Effectiveness of EMDR in Child Guidance Center</td>
<td>39</td>
<td>Guidance Center</td>
<td>Yes</td>
<td>5 sessions</td>
<td>6 months</td>
<td>No significance</td>
</tr>
<tr>
<td>2002</td>
<td>Jaberghaderi et al CBT vs EMDR for sexually abused Iranian girls</td>
<td>147</td>
<td>University</td>
<td>No</td>
<td>Up to 12 sessions of EMDR of CBT (Mean 6.1)</td>
<td>2 weeks</td>
<td>A decrease in PTSD symptoms</td>
</tr>
<tr>
<td>2003</td>
<td>Fernandez et al Group Protocol with elementary school treatment for disaster trauma</td>
<td>236</td>
<td>Italy School</td>
<td>No</td>
<td>2 psychoeducational groups using butterfly hugs</td>
<td>30 days</td>
<td>Call from teacher, all but 2 had no symptoms at 30 days</td>
</tr>
<tr>
<td>2006</td>
<td>Jarco et al. Group protocol with children who experienced a flood in their hometown</td>
<td>44</td>
<td>Pedras Negras, Mexican Temporary Shelters</td>
<td>No</td>
<td>Two 50-60 minute groups</td>
<td>4 weeks</td>
<td>Significant decrease in CRTES scores and SUDS scores</td>
</tr>
</tbody>
</table>

Appendix D:

Comparison Chart of TF-CBT to EMDR

<table>
<thead>
<tr>
<th>TF-CBT</th>
<th>EMDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-18 Sessions</td>
<td>3-5 Sessions</td>
</tr>
<tr>
<td>60-90 minutes</td>
<td>60-90 minutes</td>
</tr>
<tr>
<td>Eight Phases</td>
<td>Eight Phases</td>
</tr>
<tr>
<td>Phase One: Psychoeducation</td>
<td>Phase One: Client history and treatment planning</td>
</tr>
<tr>
<td>Phase Two: Stress management</td>
<td>Phase Two: Client preparation-explain the parameters, learn relaxation techniques</td>
</tr>
<tr>
<td>Phase Three: Effective expressing and modulation</td>
<td>Phase Three: Assessment, identify the trauma to be dealt with</td>
</tr>
<tr>
<td>Phase Four: Cognitive coping</td>
<td>Phase Four: Desensitization that involves the client recalling trauma. Rate emotional disturbance.</td>
</tr>
<tr>
<td>Phase Five: Creation of a trauma narrative</td>
<td>Phase Five: Instillation of positive beliefs, replace negative beliefs</td>
</tr>
<tr>
<td>Phase Six: Cognitive processing</td>
<td>Phase Six: Use positive beliefs to combat negative beliefs, increase bodily awareness</td>
</tr>
<tr>
<td>Phase Seven: Behavioral management training</td>
<td>Phase Seven: Closure</td>
</tr>
<tr>
<td>Phase Eight: Parent-child sessions</td>
<td>Phase Eight: Reevaluation. Takes place at the beginning of every session after the first.</td>
</tr>
<tr>
<td>Overarching goal: Desensitize the trauma and increase everyday functioning</td>
<td>Three goals: learn from past negative experiences, desensitizing extremely stressful stimuli, and outline reference for client to use in future traumatic event</td>
</tr>
<tr>
<td>Therapeutic Approach: Behavioral management training and cognitive therapy, associate behavior and family therapy</td>
<td>Therapeutic Approach: Comprehensive approach focuses on images, emotions, beliefs, physical responses, relationships that are associated with being maladaptive-then working to change these.</td>
</tr>
<tr>
<td>No official scales used to measure change</td>
<td>Two scales used to measure change: Subjective Units of Disturbance Scale and Validity of Cognition Scale</td>
</tr>
</tbody>
</table>
Appendix E: Session Layout of TF-CBT and EMDR

**Legend**

TF-CBT----- Written in Black

EMDR ----- Written in Red