Implementing Trauma Focused Cognitive Behavioral Therapy (TF-CBT) among Formerly Trafficked-Sexually Exploited and Sexually Abused Girls in Cambodia: A Feasibility Study

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Introduction

This report reviews a completed feasibility study of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) conducted between May 2008 and September/October 2009 in Phnom Penh, Cambodia. This study, published in 2011, therefore describes the early stages of this pilot up until October 2009, and is therefore not reflective of the continued learning and adaptation of the counselors and of the impacts of the treatment on the more 70 children who have now completed TF-CBT. The study is described within the context of applied research and programming conducted by World Vision (WV) and the Applied Mental Health Research Group of Johns Hopkins Bloomberg School of Public Health (JHU). This collaboration, undertaken within the WV US funded Learning to Impact Forgotten and Excluded children initiative (LIFE CIC Initiative)[1] and the IMPACTS Project, had an overarching aim to develop a basket of evidence-based approaches to child protection.

This report describes the situation of child trafficking, sexual exploitation and abuse (SEA) and the shelter based protective response within Cambodia. The background to the project and selection of TF-CBT as a treatment model is also described, including a brief overview of the evidence base and the process of adaptation to the Cambodian context. A description of the methods employed in assessing the feasibility of TF-CBT, the results of the assessment and, considerations, conclusions and recommendations are all included.

Background

Situation of Trafficking and Sexual Exploitation in Cambodia

Cambodia is identified by the US Department of State as a "source, transit, and destination country for men, women, and children trafficked for the purpose of commercial sexual exploitation and forced labor" (TIP Report; June 2009, p.95,). The commonly accepted legal definition of trafficking, known as the Palermo protocol, defines human trafficking as:

> the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs (UNCTOC; 2000).

[1] LIFE CIC Initiative (formerly CIC LOL) has provided technical support to projects in Cambodia, India, Myanmar, Albania, Albania, Georgia and Mexico. In Cambodia, research has been undertaken within the Umbrella funding initiative formerly known as the Aftercare for Trafficked and Sexually Exploited Children in Cambodia project (ATSACC), and currently as the Improving Management of Programs for Aftercare of Children Trafficked and Sexually exploited project (IMPACTS).

The population of interest for this feasibility study is children who have been subjected to sexual exploitation and abuse (SEA) including, but not limited to, the context of child trafficking for commercial exploitation. Within the Cambodian context there are valid reasons for combining these children in a single conceptual category: both victims of trafficking for commercial sexual exploitation and victims of sexual abuse from within a community setting possess spoiled identities and thus are both critically in need of protection. This is highlighted by a commonly referenced Khmer proverb comparing the sexes:

> '*prus priap tuc ja mas dhlak knun bhak lan dyk sqat mas tatael, sri priap tuc sambat sa tae poe pralak ramaen tae krakhvak*.
> Men are like gold, if it is dropped in the mud it can be washed completely clean and it is still gold. But women are like white cotton cloth, once it is soiled in the mud it can be washed but never made clean again' (Ledgerwood, 1990, p.116).

The conception that girls and young women require special protection is encapsulated in the proverb: ''*mein koun krormom hak douch mean prahoc bey peang*'' or, if you keep the fermented fish carefully it will not attract flies, just as if you keep your daughters carefully they can be safeguarded against sexual predators' (Tarr, 1996, p. 51). Tarr (1996) describes the literary traditions of Cambodia as depicting 'the ideal, unmarried female who is sexually naïve and timid around males … [whereas] the latter on the other hand, are drawn to women just as ''ants are attracted to sugar'' (*kumdak skorchit srormouch*) and cannot help himself but to be engaged in sexual misconduct' (P.49). Another proverb explains that '*danler 10 min smoer nin samdr 1*, Ten rivers can't equal (fill) one ocean; i.e. ten women cannot satisfy one man; men are sexually insatiable' (P.115).

Within Cambodia's socio-cultural context, as highlighted by these examples, families and women typically seek to vigorously protect the virginity and reputation of girls and women, while conversely many men aspire to enact a masculinity defined by unquenchable and irrepressible sexual prowess. These entrenched discourses that perpetuate double standards on sexual behavior plausibly provide partial explanation for why both girls and boys are at risk of sexual abuse. Conceptions of men as insatiable and lacking self control may be interpreted as the basis for a socio-structural need for a class of sexually available women with no reputation to lose. As in many other societies, the women who come to occupy such subject positions in Cambodia are often forced to do so through violence, coercion, poverty and desperation.

While the prevalence of sexual violence and trafficking in Cambodia is evident in the Khmer, French and English press, it is challenging to gauge the numbers of victims of trafficking, sexual exploitation and abuse. An attempt to aggregate some of the existing NGO data was undertaken by Keo's 2007 & 2008 survey of ECPAT-Cambodia's then 23 NGO members who were assisting trafficking victims. From this study only 165 persons 'met the standardized assessment criteria' for being victims of trafficking (Keo, 2008). In 2009, Keo reported on data provided by 27 NGOs indicating that they had collectively encountered a total of 109 victims of sex trafficking and counted 541 victims of rape (Keo, 2009). As reported by Amnesty International (2010), the National Police Force statistics recorded 468 cases of rape, attempted

rape and sexual harassment in the last 12 months up until November 2009, but noted that these figures are 'extremely low and unreliable'.

In terms of previous studies conducted to determine the total numbers of trafficking victims globally, there is also a lack of reliable data. After an exhaustive review of 2388 initial citations of publications globally on human trafficking, Gozdziak and Bump (2008) determined that 'there is still no reliable data on the number of trafficking cases and the characteristics of the victims and perpetrators' (p.22). In Cambodia, Thomas Steinfatt's (2003) work remains the most credible effort to quantify the issue, and his study identified an estimated 18,256 commercial sex workers and 2000 trafficked and sexually exploited women and children. However there are significant limitations and methodological flaws in his study unacknowledged as limitations in his report, suggesting that Steinfatt's figures should be considered conservative at best[2].

These reports do not refer to the number of trafficked victims receiving a protective response. In Cambodia, the primary form of social welfare available to victims of trafficking and sexual exploitation, as well as to orphans and other vulnerable children and women, is the residential facility, or shelter. In Cambodia, over the past 20 years, foreign visitors have introduced shelters as an alternative to relying on extended family or friends, living in a pagoda, physical servitude, or life on the street. While the figures are sketchy, it appears that in recent years, the numbers of shelters have been increasing. According to statistics provided by the Ministry of Social Affairs Veterans and Youth Rehabilitation to UNICEF[3], the number of registered residential facilities has increased in recent years by 65%, up from 153 facilities in 2005 to 225 shelters in 2008. Furthermore the Ministry 'also recognizes that not all facilities are registered within their database', which suggests that in all likelihood there are many more shelters accommodating vulnerable persons in Cambodia.

Just as there are difficulties in estimating the scale of trafficking, sexual exploitation and abuse in Cambodia, similarly there are challenges in estimating the total numbers of children receiving a protective response. There are at least six existing major databases established for the purposes of tracking trafficking victims receiving assistance within the Ministries of Interior, Justice, Social Affairs Veterans and Youth (MoSVY), Women's Affairs, Labour and Vocational Training agencies as well as the ECPAT database (Keo, 2008). Despite the existence of these databases, Keo notes that "there is an absence of a joint effort to establish a national data repository that collates and consolidates trafficking data from various data bases" (Keo, 2008, p.27).

[2] Steinfatt's approach employed moto-taxi drivers to act as scouts on behalf of prospective clients. It is fair to suggest that an average 'John' visiting a brothel does not routinely ask for detailed staff demographic information and that such questions may raise the suspicion of brothel management who may in turn be less than forthcoming in sharing potentially self-incriminating information. For further criticism of Steinfatts study, see Swingle & Kapoor; 2003.

[3] Unpublished research concept note from 2009, Titled: Societal Attitudes towards Residential Care in Cambodia, UNICEF, 2009.

In addition to these isolated databases, NGO's also individually gather useful data on trafficking victims. In May 2010, in response to a request by World Vision Cambodia to each of the protection coalitions, the coalitions provided their network lists which included the following number: COSECAM 14 members; ECPAT 28 members; and Chab Dai, 37 members[4]. However, while the coalitions and the responsible government body, MoSVY, have lists of NGOs providing residential care, their capacity to monitor the performance of these institutions remains limited. Progress has been made towards this end as evidenced by the development of the National Minimum Standards for Alternative Care (2006) and the National Minimum Standards of Care for the Protection of Victims of Trafficking (2009) which reflect internationally mandated standards. Both of these policies however, are not yet operational in the form of regular coordinated monitoring visits conducted by MoSVY.

Preliminary Research

The feasibility study described in this report has been conducted within an umbrella funding initiative of World Vision Cambodia known as 'Improving Management of Programs & Aftercare for Children Trafficked and Sexually exploited (IMPACTS). According to the IMPACTS[5] project proposal document (World Vision, 2010), since 2005 the project has:

> …contributed core funding for 6 NGOs to provide a safety net and rehabilitative services for nearly 1000 children[6] removed from situations of trafficking, sexual exploitation or severe sexual abuse. In addition to providing funding for core after-care services, ATSACC supported its partners to implement research and to pilot interventions with the goal of identifying evidence based practices that improve the quality of after-care and the lives of children (P.6).

In August/September 2007, World Vision (WV) and the Applied Mental Health Research Group of Johns Hopkins Bloomberg School of Public Health (JHU) began a research collaboration to develop evidence-based interventions, as described in the IMPACTS proposal. The first activity was a qualitative needs assessment (Bolton et al; 2008). For this qualitative needs assessment, JHU faculty and World Vision staff trained students of sociology from the Royal University of Phnom Penh to conduct qualitative interviews with girls currently living in shelters with the goal of understanding, from the viewpoint of the girls themselves, the problems they face, what tasks and activities are important to them (i.e. what constitutes important areas of functioning), and factors associated with coping and resiliency.

[4] The figure of 79 organizations is a result of adding together the member lists provided by Chab Dai, COSECAM and ECPAT in May 2010. It should be noted that several large organizations are represented in 2 coalitions.

[5] Formally known 2005 – 2007 as ATSECC and 2007 – 2009 as ATSACC.

[6] This figure is drawn from monitoring data discretely provided by partner NGOs to the project and does not reflect referral of individuals within the partnership. For example a child received at the World Hope Crisis Assessment Centre is counted and submitted as a statistic to the project. The same child may actually be referred to another IMPACTS partners such as the Trauma Recovery Project for longer term care who will also report the child as a statistic. This plausibly may cause some inflation of figures compared to the actual number of children receiving services.

Based on these interviews, it was evident that mental distress is a common problem among formerly trafficked girls living in shelters. The mental distress were the results of their abuse experiences including memories of these events, worries about their current situation, and in particular their treatment and stigmatization by others (P.14; Bolton et al; 2008). The girls described depression-like and PTSD-like symptoms, suicidal ideation, and broader problems of mood and anxiety. The trafficking experience resulted in mental suffering as did the ongoing social consequences of having been trafficked. Rejection - by former friends, the community, society more broadly, and even their families - was the problem described most frequently by respondents. Rejection was described as the major cause of the most important problem faced by the girls – lack of a good future (Ibid). In this context it is acknowledged that a clinical intervention such as TF-CBT, is most effective when used as part of a holistic approach to recovery and reintegration. The best clinical services are only as strong as the weakest link in a project working with vulnerable children. While trafficked and sexually exploited children in Cambodia often need (but often do not receive) psychological interventions, ultimately this is just one (important) part of the broader interventions required in order to assist trafficked children in residential care to recover and be welcomed back into a social context.

Brief description of TF-CBT and rationale for selection.

Based on the wide range of trauma symptoms that were reported in the qualitative study, a literature review was undertaken by World Vision to explore treatments with proven effectiveness with similar populations and traumatic experiences (Wallace, 2008). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was identified as the treatment with the strongest evidence base for effectiveness in treating trauma amongst children and adolescents who had experienced a range of traumatic experiences, including sexual abuse. TF-CBT has been identified as a well-supported and efficacious treatment for sexually abused children in several major reviews (Cohen, Berliner, and Mannarino, 2000; Saunders, Berliner, and Hanson, 2004). In multiple randomized controlled trials TF-CBT has been shown to be more effective than child-centered supportive therapy and non-directive supportive therapy for decreasing symptoms of posttraumatic stress disorder (PTSD), anxiety, depression, shame, and dissociation related problems (e.g. Cohen and Mannarino, 2004). According to the American Academy of Child and Adolescent Psychiatry (1998), TF-CBT has been proven effective for children exposed to a variety of traumatic events and has received the strongest empirical support from studies with abused children (Saunders et al., 2004). In a rigorous review of “best practices” in the field of child abuse, TF-CBT was chosen by the Kauffmann Project (2004) as the only “well supported efficacious treatment”.

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is a psychotherapeutic model that integrates elements of cognitive behavioral, humanistic, attachment, family, and empowerment therapies into a treatment designed to address the unique needs of children with PTSD and other problems related to traumatic life experiences. TF-CBT is a structured intervention where the child learns new and better ways to handle negative feelings and problem behaviors as well as more helpful ways to think about what happened. The therapy has a trauma focus so that the child learns to talk about what happened and becomes able to share her/his experiences. There is often resistance in the beginning because the child may

have strong feelings when they remember or think about the trauma. It is understandable that the child may want to avoid remembering or worry that having to remember will make things worse. But remembering the experience in a safe environment is the best way to reduce the negative feelings. When the feelings become less strong and more manageable it makes it possible to put the trauma into perspective and make it a part of the past. This treatment includes individual components for children ages 5-18, and for their parents or primary caregivers when they are available and willing to participate.

The TF-CBT components that are specific to working with children include:

Psychoeducation. This component helps children learn about traumatic stress, typical reactions to traumatic events, why they happen, and what is involved in the therapy. An important piece of information shared is that most children will recover especially if they have effective treatment.

Relaxation. This component helps children learn how to physically relax their body in ways that can help them when they are anxious and/or afraid.

Affective regulation. This component helps children identify typical trauma-related emotions such as fear or anxiety, sadness or grief, anger, and shame and learn specific skills to handle these negative emotions in constructive ways.

Correcting unhelpful thoughts or "cognitive processing". This component helps children identify unhelpful trauma-related thoughts/beliefs such as: "this is all my fault", "I am not worth anything". They learn more accurate and helpful ways to think about what happened.

Trauma narrative. Through this component, the therapists help children talk about what happened in a slow, safe way. This allows the children to stop avoiding the trauma and learn how to handle trauma reminders.

Safety/social skills. Through this component, the therapists help the children learn new ways to feel safe, and develop safety plans if needed. Trauma often also affects a child's ability to navigate social relationships, so skills may be taught to help with this.

When working with caregivers, an additional component is added that focuses on positive parenting. The therapists help the parent/caregiver learn how to handle the child/youth's difficult to manage behaviors and behaviors that interfere with family relationships. Many children complete TF-CBT in 12-15 sessions, though some need fewer sessions, and others need more. TF-CBT is flexible and individualized to the needs of each child.

Based on this information, and the decision to further explore the use of this therapy, World Vision staff attended a TF-CBT training in the United States to better understand the treatment components, and discuss how adaptations might be piloted in a low-resource cross-cultural context.

Objectives of this Study

To test the feasibility of TF-CBT as implemented by Khmer counsellors working in two Cambodian shelters with sexually-exploited girls. As part of this feasibility study we evaluated

not only the impact and acceptability of the study for the child participants but also the experiences of the US-based trainers, Khmer counsellors, shelter supervisors and WV Cambodia staff.

Methods

Study Sites

The feasibility study was conducted in shelters associated with two participating NGOs, World Vision Cambodia and Hagar Cambodia. A brief description provided by each program follows:

- World Vision Cambodia: operates a Trauma Recovery Program that serves children who have suffered commercial sexual exploitation or severe sexual abuse. The program has existed for over 12 years, and has undergone geographical changes as well as an expansion of its services. The project has assisted over 800 female youth aged from 4 to 20 years. TRP strengths and resources include a solid reputation for strong community linkages and a comprehensive package of services from recovery to rehabilitation and advocacy for trafficked children.
- Hagar Cambodia's Children's Program: began in 1998 and assists children aged 4-14 who have survived abandonment, human trafficking, sexual exploitation and domestic violence ensuring their recovery, economic empowerment, and successful reintegration into society. In Hagar's two recovery shelters, 84 children are cared for by loving Cambodian house parents and receive intensive medical care, education and counseling. An additional 93 children who are unable to return to their family of origin are cared for in community foster families. Hagar's education programs and long-term support and follow up empower children for a financially independent and resilient future (P.10, Bass et al, 2010).

Both participating agencies have a full time expatriate supervisor responsible for clinical supervision and a counseling team. Both the expatriate supervisors and the national counsellors participated in the pilot, and were supported logistically by the IMPACTS project. The feasibility study, while led by JHU, has similarly been supported in implementation, data collection and analysis by the IMPACTS project.

Selection process for participation in the TF-CBT pilot:

The TF-CBT trainers (Murray, Dorsey & Skavenski) suggested two criteria to aid in TF-CBT case-selection for the feasibility study:

- Caseload: It was recommended that each counsellor pick up 1 TF-CBT case as a "training case". It was felt that this was necessary given the novelty of the model in this setting and the counsellors' skill level. This decision was also made to build a good supervision structure. Specifically, at this time, Sue Taylor from Hagar was the only person available to provide TF-CBT related supervision. 1 case per counsellor would minimize the burden

on this supervisor, an important consideration given that the supervisor was also learning TF-CBT and the accompanying supervision techniques;

- Case identification: Ideally this would have been done using a previously defined cut-off score with the locally validated assessment tool. However, since cut-off scores were not yet determined, it was recommended that for the "training cases", a shelter supervisor would identify girls displaying significant symptoms based on their own judgment. While at Hagar a clinical supervisor was available to identify these cases, at the time it was not clear who would take on this role at TRP. The case identification process, as it was implemented, was a variation on this initial recommendation – with the counsellors initially identifying girls and the clinical supervisor reviewing their choices.

Training of TF-CBT Counsellors and Supervisors

First on-site training

A first on-site TF-CBT training was planned with the following goals:

- Review the initial qualitative data to understand why TF-CBT was chosen as a treatment;
- Introduce the basic cognitive-behavioral conceptualization of trauma treatment for youth;
- Introduce the theoretical constructs and principles underlying TF-CBT;
- Familiarize trainees with the research that has made TF-CBT an evidence-based treatment;
- Familiarize trainees with the components within Trauma-Focused Cognitive Behavioral Therapy (TF-CBT);
- Provide trainees with practical knowledge on implementing the core components of TF-CBT in a culturally flexible yet adherent manner;
- Raise awareness of the various adaptations that have been made to TF-CBT to implement it across diverse populations and settings;
- Get trainees to participate in role-plays with colleagues to practice using the skills and components within TF-CBT; and
- Discuss special populations, circumstances and challenges with traumatized youth populations in Cambodia and how TF-CBT may or may not be appropriate.

The training was held from July 14 – 18 2008 by Murray in Phnom-Penh with 25 counsellors from 5 organizations. After the review of the qualitative assessment findings, the remainder of the 1st day was spent in small groups in order to give counsellors an opportunity to discuss concerns/feedback on doing trauma therapy with the girls. This processing of the concerns and feedback was particularly important given that many of the counsellors were potentially survivors of traumatic experiences themselves. The subsequent 4 days of training were used to teach the first four components of the TF-CBT treatment. A wide range of teaching methods were used including didactic review of slides about each component, trainer role-plays, small-group role plays, games and quizzes. The process of TF-CBT training was done in a way that encouraged collaboration with local counsellors to allow for cultural adaptation. Appendix A includes a brief overview of how each component was taught.

The initial training varied from the recommendations of the TF-CBT trainers in several ways: 1) it was limited to 5 days rather than the suggested 2 weeks, 2) it was limited to only one trainer rather than the suggested two trainers (both 1 and 2 were because of budget limitations), 3) and the numbers of trainees who participated was higher than had been recommended. As a result, the training was only able to cover the first four components of TF-CBT (PRAC: Psychoeducation, Relaxation, Affective modulation and Cognitive processing). Given that the entire model could not be taught, time was spent at the end of this training reviewing the plan forward. A specific concern was that that counsellors would use PRAC without knowing the full model, but it was also recognized that it was important to give counsellors the opportunity to practice the skills they had learned through this training. As such, the following "next steps" Training Outline was suggested.

Suggested Training Outline

Phase I	Phase II	Phase III	Phase IV
July	Aug-Oct	Oct/Nov	Nov-?
Live Training	TF-CBT Practice Groups	2nd Live Training	TF-CBT Practice Groups

Practice Groups:

After completion of the first training, fortnightly practice groups were organized to be run by the WV Cambodia non-clinical, IMPACTS staff. The number of participating counsellors dropped below twenty because one partner, World Hope which specializes in crisis assessment, felt that TF-CBT was not applicable in their setting. The role of the practice groups was for counsellors to develop their understanding of the PRAC components and to practice using these components in role plays. The TF-CBT Trainer provided practice group agendas prior to each practice group meeting and the agenda was followed by the staff and counsellors. Notes were taken during each training and prior to each meeting these were sent to the TF-CBT Trainer for review, feedback and advice. After several months the clinical supervisor from Hagar commenced regularly joining the trainings and gradually assumed a leading role in their delivery.

Second on-site training

The objectives of this Second live training included:

- To train counsellors in conducting TF-CBT; and
- To train two pre-identified ex-patriate staff in the supervision of TF-CBT.

Based on the first training experience, and the expected intensity of the second training (i.e., learning of new skills such as the Trauma Narrative and Cognitive Reprocessing), a number of changes were suggested by the TF-CBT trainers: 1) It was recommended that the second training be extended to at least 7-8 days; 2) it was suggested that in order to create a supervisory structure that could make TF-CBT more sustainable, an additional day should be spent training local leaders on TF-CBT supervisory techniques. These local "leaders" were to be chosen and arranged for before the start of the second training; 3) it was suggested that the number of counsellors be reduced to allow for greater individualized training; and 4), it was

recommended that it would be important to bring a second TF-CBT trainer to assist with the training and learning of skills.

A number of more specific needs around translation were outlined including: a) the need for the slides from the first training to be reviewed with a translator to produce a "final" version; b) the slides for the second training should be sent ahead of time so that they could be translated then back-translated by an independent translator and sent back to the trainers for review; c) the translations from the TF-CBT web should be reviewed for accuracy; and d), at least 2 translators would be needed for the second training. These translators should be interviewed by JHU via telephone before the training, during which time critical concepts would be discussed. In addition, these translators will meet with the trainers before the second training to review the slides and the translation process.

The second training of counsellors took place from March 10th – 20th 2009 in Phnom Penh, from 8am – 3pm daily. In attendance were 15 trainees and two TF-CBT trainers[7]. The training included a review of the first four components of TF-CBT (i.e. PRAC). The remaining TF-CBT components were newly taught and included the Trauma Narrative, Cognitive Reprocessing, and Enhancing Skills (see Appendix B for description of the components). As with the first training, teaching was done through a variety of methods including didactic explanations, demonstration role-plays and small-group role-plays. Following the same approach as the first training, all components were broken down into concrete steps using specific techniques. In addition, time was spent developing counsellor self-care plans in recognition of the high levels of exposure that counsellors have to trauma material during TF-CBT treatment.

The training of supervisors was scheduled to occur after the counsellor training from approximately 4pm – 5:30pm on five separate days. This training was supposed to be attended by the clinical supervisors from Hagar Cambodia and World Vision TRP. However the clinical supervisor for TRP was unable to join for the entire training and later visited the US for several days in order to complete the TF-CBT training under the supervision of JHU. Supervision meetings were not held every day due to prior commitments or emergencies that pulled the Hagar supervisor away. The supervision trainings included role-plays to see supervisor's level of mastery of the TF-CBT skills as well as training on how to run the TF-CBT supervision groups. The goals and techniques of each of the previously taught four components were reviewed and role-played.

<u>Process of Monitoring and Supervision</u>

Simultaneously with the development and implementation of the counsellor and supervisor training in the TF-CBT model, a system of program monitoring and general supervision was

[7] The second training regrettably excluded some reasonably skilled counselors from NGO ARM based in Battambang on account of budget constraints which limited the projects capacity to provide effective supervision considering their distance from Phnom Penh. These counselors successfully completed their initial training in PRAC and participated in the bi-weekly training groups.

developed. To guide this process, a set of standards for appropriate implementation of TF-CBT in the Cambodian context were developed through the following process:

- A treatment-specific monitoring form was drafted by the TF-CBT trainer in collaboration with WV Cambodia staff. Suggestions for a monitoring system were also discussed.
- The monitoring system was reviewed with counsellors at Hagar and WV to assure correct completion and understanding by WV Cambodia staff.
- WV staff reviewed the forms at the TF-CBT Practice group meetings, and emailed feedback and suggestions back to JHU. At this time it was also suggested that all counsellors should read the translated TF-CBT web extractions.
- Monitoring forms were encouraged to be used for ALL cases throughout Phase II, when the counsellors were first using the PRAC skills they had been trained on. This was done for a number of reasons. First, part of the goal of the monitoring form was to capture what the counsellors were doing in sessions. Therefore, if they reported doing something with a child and it was not on the monitoring form, they were encouraged to write it in so that JHU could track adaptations. Second, the monitoring forms were drafted based on information gathered about what counseling techniques were currently being employed. However, the team felt that this should be an iterative process where completion of forms led to the modifications of the form if needed. For example, if significant omissions of counseling techniques existed in the monitoring form, they could be added.
- Each TF-CBT practice group was encouraged to have 2 hour meetings on a minimum of six occasions before the second training. Each meeting had agendas prepared by JHU (Murray) and sent to the WV Cambodia team. Notes were taken at each practice group and sent back to JHU (Murray) in order to appropriately design the next meetings' agenda. In total, 11 fortnightly training groups were held.

Supervision

For Hagar: It was recommended that the clinical supervisor for Hagar Cambodia would run 2 separate supervision groups on a weekly basis with the Hagar counsellors – each group consisting of 4 counsellors. This would allow for appropriate time to practice the new skills taught during the training, as well as time to walk them through each of their training cases. This was projected to require 2 one-hour meetings per week of her time.

For World Vision TRP: The clinical supervisor for Hagar assumed responsibility for the supervision of TRP counsellors until such a point when the TRP supervisor completed the additional training in the US. The clinical supervisor ran 1 supervision meeting at TRP with the 5 counsellors. This was recommended to take 1 hour per week of her time – plus any travel time to get to TRP.

Consultation with JHU: Initially with the Hagar Clinical Supervisor, and then later including the TRP Clinical Supervisor also, weekly supervision calls were made via skype with the TF-CBT Trainers. The purpose of these calls were to conduct a thorough case review of all the individual clients, the counsellors themselves, as well as consultation on how to use TF-CBT supervision to ensure that the counsellors adhered to the TF-CBT model. Another objective of these calls was to continue the clinical supervisor's on the job training on how to provide TF-CBT supervision.

Table One

Approximate intervention delivery and supervision time requirements	
Counsellor	60 minutes leading session with clients 2.5 hour participating in supervision groups (x 3 groups) Bi-weekly participation in a 3 hour skills and role play training.
In-Country Supervisor/s	7.5 hours leading supervision groups (3 groups total) 2 - 4 hours per week to write session case notes and email to JHU. 60 minute participation in Internet telephone call with JHU.
JHU staff	3-5 hours per week reviewing case notes, sending training plans. 2 hours per week leading Internet telephone supervision calls.

Evaluation Tools

Child Exploitation Psychosocial Assessment Tool (CEPAT)

In addition to investigating the feasibility and usability of TF-CBT by Cambodian counsellors, the feasibility study also sought to investigate the impact of the intervention on the girls who were treated. Although a formal impact evaluation study was not possible, pre and post-TF-CBT interviews were conducted to learn about how their individual symptoms changed over the course of the treatment period. The interviews were conducted using the Child Exploitation Psychosocial Assessment Tool (Bass, et al; 2010), which was developed drawing upon the data from the qualitative study (Bolton et al; 2008). The qualitative results suggested that most of the girls suffered from multiple problems, therefore, it was decided that several measures were required to capture the range of problems experienced by the girls. The primary problems that were identified from the qualitative assessment were depression, post-trauma anxiety and shame (Ibid). To address these domains, we selected the Center for Epidemiological Studies Depression Scale for Children (CES-D), the Posttraumatic Stress Disorder – Reaction Index (PTSD-RI), and a scale about shame entitled My Feelings About the Abuse. In addition, we selected the Children's Hope Scale to represent the resiliency factor of hope. The choice of these instruments was partly based on how similar the items were to the issues described by the girls in the qualitative study.

Once the measures were chosen, World Vision staff adapted them with guidance from JHU. Where items in the questionnaire were similar to issues described by the girls in the qualitative study, we used the terms and phrases from the qualitative study to translate those items. For terms and phrases in the standard instruments for which there were no mention in the qualitative data, we relied on bilingual English Khmer translators to determine the appropriate local wording. The final step of the adaptation process was to identify and add frequently mentioned and important problems from the qualitative study, that were absent in the standard instruments. The CEPAT was subsequently piloted by the counsellors to detect any problems with the interview procedure, to determine whether the instrument was acceptable and understandable to both the counsellors and our target populations, and to give the interviewers practice in interviewing.

The reliability and validity of the CEPAT was then tested to determine the extent to which it accurately and appropriately discriminated between girls with significant and non-significant psychosocial problems, as assessed by the Cambodian counsellors currently working with the children. The counsellors who worked on this study were those specifically working at the shelters, and who therefore had the opportunity to assess the children on an ongoing basis. The result of this brief validity study was a reliable and valid psychosocial assessment tool, with a few exceptions: With the removal of a single mental health question, the scales developed to assess depression problems, post trauma problems and shame showed strong reliability and validity (Bass et al; 2010). The hope and functional impairment scales were less consistent and require additional investigation but were retained for the feasibility study because they were considered to provide additional information.

Qualitative Interviews with Clients and Counsellors

Following completion of the TF-CBT treatment with all of the clients, graduates of the Sociology Department at the Royal University of Phnom Penh were trained in conducting in-depth qualitative interviews with each girl to learn about their experiences with TF-CBT in their own words. The questions asked of each girl included:

- What are all the good things (things you liked) about the TF-CBT project?
- What are all the difficult or challenging things about the TF-CBT project.
- What are all the bad things about the TF-CBT project?
- What are all of the ways the TF-CBT program could be improved?
- What are all the ways you/your child/your family has changed since the beginning of this program? Please tell us about all the changes, whether or not they are due to the program.
- Which of these changes do you think were due to participating in the intervention?
- Is there anything else you want to tell me about your thoughts on and/or experience with this program?

The counsellors were also interviewed in order to gain their perspective on TF-CBT. The questions asked of the counsellors included:

- What are all the good things (things you liked) about the TF-CBT project?
- What are all the bad things about the TF-CBT project?
- What problem did you face in learning and implementing TF-CBT?
- What changes would you suggest to the program?

<u>Analysis process</u>

Review of clinical notes and reports

The JHU team received English and Khmer versions of all session notes, case notes and supervision reports that were translated, when necessary, by the WV Cambodia team. The case note review included an examination of overall successes and challenges the counsellors were

having as well as any specific success and challenges faced with each component. Areas examined in the component review included: Completion of each of the treatment goals within that component; Counsellors' explanations of each component; Implementation of activities; Appropriateness of activities chosen and Transition from one component to the next. The JHU team also observed adaptations which included areas such as session length, how many sessions were spent on each component and activities used by counsellors to achieve the component goals.

As part of the weekly supervision call, the TF-CBT trainers received and reviewed case notes on selected cases by email and/or phone with the clinical supervisors. These supervision sessions included reviews of the TF-CBT components and counsellor progress.

Analysis of CEPAT data

The CEPAT is made up of 4 distinct sections: 1) general demographic information; 2) assessment of functional impairment through questions on various tasks and activities of daily living; 3) assessment of mental health and psychosocial problems; and 4) assessment of general hope and resiliency. The section on mental health and psychosocial problems is further subdivided into scales covering the domains of depression, post-trauma feelings, and feelings of shame. Below is a table indicating the CEPAT questions that correspond to each of these sections and subscales.

Scale Name	Scale Description	CEPAT Items
Functional Impairment	Tasks and activities of daily living	10 items – A01-A10
Depression	Symptoms of CES-D and additional symptoms from qualitative study	36 items – B01-B36*
Post trauma	Symptoms from PTSD-RI	22 items – B65-B86
Shame	Items from Shame scale and additional items from qualitative study	13 items – B87-B99
Hope	Items from Hope scale	9 items – C01-C09

*Note, for this analysis B08 was removed and B04, B12, B16 required reverse scoring.

The scale assessing impairment in daily functioning (questions A01-A10) includes 10 tasks and activities that girls in shelters regularly do. For each activity, the respondent is asked how much difficulty they have had in doing the task compared to other girls of their age, with responses ranging from 0 'no difficulty' to 4 'often cannot do it' at all. A total functional impairment score can be generated for each respondent by summing the scores of these 10 items, with the resulting scale ranging from 0 (no difficulties with any of the tasks and activities) to 40 (often cannot do all of the tasks and activities).

For the component of depression (questions B01-B36) 35 questions are presented to the respondent to indicate, in the last week, how often they have experienced each of the signs and symptoms, ranging from 0 'never' to 3 'most/all of the time'. A total depression score can be generated for each respondent by summing the scores of these 35 items, with the resulting scale ranging from a possible score of 0 (never experiencing any of the symptoms) to a possible score of 105 (experiencing all the signs and symptoms all the time). Note that one of the questions was been removed (B08) because it was not understood by the girls. Three of the questions (B04, B12, B16) are written as strengths rather than problems because that is how they were described in the qualitative study, so their scores need to be reversed prior to creating the total depression-symptoms scale.

Questions B38 through B51 ask the respondent to recall and identify the different types of traumas they have experienced. For each type of traumatic experience, the respondent is asked to indicate yes/no according to whether or not it has happened to them.
The post-trauma symptoms scale was generated based on questions B65-B86, which ask the respondent to indicate the frequency of post-traumatic stress feelings in the month prior to the assessment, with responses ranging from 0 'never' to 4 'most/all of the time'. The sum of the scores for these 22 questions range from a possible score of 0 (never experiencing any of these symptoms) to a possible score of 84 (experiencing all of the symptoms most/all of the time). Using the same 0 to 4 response categories, the psychosocial problems section covers feelings of shame associated with sexual violence and abuse (B87-B99). A scale generated from these 13 questions will range from a possible score of 0 (never experiencing any of the symptoms) to a possible score of 52 (experiencing all of the symptoms most/all of the time).

The final section of the CEPAT includes 9 questions on hope and resiliency (C01-C09). These questions ask the respondents to indicate the frequency with which they experience each positive hope and feeling about their future. These questions are also asked on a 0-4 point scale, with responses ranging from 0 'never' to 4 'most/all of the time'. The summary score of these 9 items provides information on the degree of hope and resiliency of each respondent, with lower scores indicating less hope and higher scores indicating more.

Quantitative Analysis of Results
Given the small number of study participants, analyses of statistical significance were not conducted. Rather, a brief demographic description of the sample is presented along with a review of their trauma histories. Additionally, pre- and post-treatment scale scores and amount of change for each scale are presented. The data are presented for the total sample and separately by shelter.

Qualitative discussions with participants and counsellors
The in-depth interviews with the participants and counsellors were reviewed for common themes. The responses to each individual question were reviewed and results were consolidated based on frequency of response to different themes.

Results

Review of on-site trainings

Summary after 1st training: Overall, the counsellors seemed to have a very positive outlook on TF-CBT. Most counsellors had difficulty moving away from more general counseling techniques such as giving advice towards the goals of the different TF-CBT components. For example, with the TF-CBT cognitive triangle the counsellors tended to suggest a new thought feeling or behavior to the client instead of having the client come up with it themselves. The counsellors performed better when instruction included a specific technique broken down into concrete steps to perform in session. The small group role-plays were critical as many counsellors were shy to practice new skills in the larger group. There were 5-6 (out of a total of 25 counsellors that demonstrated very good capacity for picking up TF-CBT skills. Although not surprising, the biggest challenges were the trainer-to-counsellors ratio, and the limited time for the training. This allowed for only some components of the model to be reviewed, and for limited capacity for the one trainer to individually instruct all counsellors.

Summary after 2nd training: Overall, counsellors seem to have grasped the early skills (i.e. PRAC) from the first 5-day training, the practice groups, and the 4 day review in the second training. Counsellors also acquired the skills for introducing, beginning, and conducting the Trauma Narrative. All counsellors demonstrated skill with acquiring details about traumatic events and with obtaining thoughts, feelings, and physiological sensations. Most counsellors struggled with the Cognitive Reprocessing component, with only the strongest counsellors demonstrating some skill acquisition during role plays. Most counsellors struggled with most aspects of the component, from identifying alternative healthy or more helpful thoughts to how to use the cognitive reprocessing techniques in practice with clients. Between the two techniques that were taught, counsellors demonstrated greater skill with the Responsibility Pie (as opposed to the Best-Friend role-play). Given the difficulties encountered with this component, one additional day of training would have been beneficial as it would have allowed more practice as well as sufficient time to cover safety (Enhancing Safety component).

The major challenge to this second training was a reduction in time available to complete the planned training due to a public holiday and a request by TRP and Hagar for training days to close at 3pm, instead of the originally planned 5pm, in order for the counsellors to have time to attend to other duties. These changes made it impossible to complete the originally planned training activities.

Clinical recommendations after 2nd training:

1. Counsellors or other staff should be trained in the assessment tool so a system is set up for identifying cases that are appropriate to receive TF-CBT in full.
2. Counsellors should pick up only 1-2 “training” cases before beginning the feasibility study.
3. These 1-2 “training cases” would be closely supervised in group form by the local supervisors. Local supervisors would in turn be supervised by JHU staff, which would provide for ongoing supervision training.

4. In order to supervise WV TRP, the clinical advisor will require additional training in how to supervise TF-CBT since he was not present for the full live training and the additional supervisory training sessions.
5. Before the TRP clinical advisor is fully trained, it is proposed that the Hagar clinical advisor lead all the counsellors in weekly supervision meetings.
6. As clinical supervision is provided, it will be critical to have regular contact with JHU staff both to provide further direction in how to run the supervision groups and also to work on completing the supervision training. Specifically, time will need to be spent teaching the clinical advisors the last two components of Cognitive Reprocessing and Enhancing Safety Skills.
7. Supervision and fortnightly meetings should focus on the following clinical challenges:
    - Normalizing and validating skills.
    - Reduction of "advice-giving" and "doing the work for the client" which are more general counseling skills that do not fit with the TF-CBT model, but that the counselors do regularly.
    - Sticking to asking "what happened next" during the TN (rather than additional extraneous questions).
    - Separation of TN and Cognitive reprocessing from that of the Cognitive Triangle.
    - Beginning exposure throughout PRAC.
    - Allowing the client to identify start and finish points of timeline.
    - Reminding clients that the TN is about recording bad things, and therefore reducing the noting of positive life events.
    - Emphasize the need to write down verbatim accounts during the TN.
    - Coming up with appropriate alternative thoughts for Cognitive Reprocessing.
    - Assisting counsellors with how sessions flow from one to the next.
    - Discussing how to use homework and in-between session practice to reinforce skills that are taught (e.g., relaxation, cognitive coping).

<u>Review of supervision</u>

Throughout the feasibility study, JHU scheduled weekly supervision calls with the Hagar clinical supervisor. The purpose of these calls was to review cases, ensure fidelity to the treatment model, problem solve around any areas of difficulty, monitor for staff burnout and vicarious trauma and support the clinical supervisor in transitioning counsellors from basic counseling to the TF-CBT treatment model. These calls also served as additional training in which components were reviewed step by step to build on the clinical supervisor's knowledge of the model. This training also included specific instructions and examples of how to teach these components to the counsellors during their weekly supervision meetings.

Supervision during the feasibility study had some challenges. First, due to a second supervisor from TRP not being available for the on-site trainings, the Hagar clinical advisor was expected to supervise all the counsellors and cases by herself. This was an inappropriately large load for someone new to TF-CBT and to the TF-CBT supervisory process. Supervising the counsellors from TRP in addition to Hagar, required additional time for transport and resulted in scheduling challenges. Second, supervision with the JHU trainers was supposed to take place regularly via

skype but there were frequent difficulties with the connection resulting in many missed supervision sessions. Third, the calls between the clinical supervisor and the US trainers often only allowed for 1 hour given scheduling and internet challenges, even though there was often a need for more than one hour per week. Fourth, a major challenge was obtaining consistent and strong translators to attend supervision meetings. This resulted in large amounts of time being spent translating from the counsellors to the clinical supervisor, and back to the group. And finally, one of the challenges for both the counsellors and the clinical supervisor was getting used to the TF-CBT approach of providing 'objective' reporting of cases rather than 'subjective'. As a result it was sometimes difficult for JHU to get a clear sense of what was happening during the treatment sessions and how to improve and/or re-direct.

Review of session notes

The initial stage of the session note review conducted from afar examined the counsellors' overall successes and challenges with implementing TF-CBT as well as implementation modifications they made over the course of treatment. A second review was done on site with the actual forms and access to translators to more closely examine the skills gained within each of the TF-CBT components. It is important to keep in mind that these analyses were conducted only by review of translated case notes and the thoroughness of these varied considerably.

Results from this review show that all counsellors were successful at effectively engaging their clients in treatment and succeeded in completing the treatment model within a period of 15-19 sessions. Many, if not all, of the cases were already long term clients that were transitioned from longer term basic counseling to TF-CBT treatment. All counsellors were able to effectively make the transition with these clients into the new treatment model.

Challenges faced by the cousellors included a tendency to focus on the child's weekly crisis (which is typical in basic counseling as opposed to a focus on the TF-CBT treatment model) and a tendency to complete all implementation activities instead of choosing a few that are appropriate for that particular client given their age, presentation and developmental level. The counsellors also tended to implement sessions that took twice as long as a typical session yet accomplished less than expected. Counsellors did not regularly incorporate gradual exposure, re-reading of the trauma narrative where appropriate, homework, review of the previous session and the use of techniques learned in previous sessions in sessions to follow. Finally, the documentation of suicidal ideation was minimal.

A number of implementation modifications in both the session structure as well as in the implementation of the component goals were also noted during the review. First, counsellors often spent a longer amount of time (minimum of two sessions) on each of the PRAC components to ensure that each client received the full benefit from all activities. These components are usually only one session or less each. In consultation, the trainers tried to reduce these back down to 1 session each, but were unsuccessful. In between sessions, counsellors often also held review sessions with the child during which the counsellor went through the components and activities that were taught up to that point. This was also a modification not usually in line with TF-CBT and was corrected via internet telephone calls. The

sessions held on the PRAC components typically ran for eighty minutes instead of the sixty minutes that was recommended during the training. Sometimes it takes longer for counselors to complete the components, but trainers "encouraged" more detail reporting in exactly what the counselors were doing that was taking so much longer.

Counsellors also modified the activities used to implement the goals of each component. These types of cultural modifications were encouraged, and most of them fit nicely within the TF-CBT model. Activities often included cultural games or techniques and/or drawings or flashcards to convey messages in a non-verbal form. For example, counsellors often used books that they had developed that portray a child or animal who has faced a traumatic experience in order to identify, normalize and validate the child's trauma related symptoms. During psycho-education counsellors also used specific timelines that related to local holidays such as Khmer New Year and *Pchum Benh* to help the child understand how long the treatment would last. In order to teach the relaxation component counsellors used a variety of culturally appropriate techniques such as a guided imagery walk through Angkor Wat and yoga. Some counsellors were also able to incorporate the children's religious beliefs and practices into relaxation. In order to teach the difference between stress and relaxation counsellors also used cards and visual aids that they had developed to show the child the difference between a relaxed situation and/or person and a stressed situation and/or person.

Counsellors also developed flash cards and drawings for use in affective modulation and cognitive processing. These flash cards included expression cards that helped the child identify the difference between a thought, feeling and behavior. Finally, to teach safety skills, the counsellors used what they refer to as the five fingers of safety.

The second stage of review included a more specific focus of success and challenges faced by counsellors within each of the eight treatment components. The findings are as follows:

Psycho-education

Successes

- Counsellors did an excellent job setting up a timeline for treatment that the child would understand. Culturally specific examples of these include:
    - "Now I have a new special program that required 16 times. It will start from now till *Pchum Benh*[8]"
    - "If we start from Human right holiday, we are going to end during *Pchum Benh*''
- In the initial session, counsellors paid particular attention to explaining and transferring the child from a more general counseling format to TF-CBT.
- Counsellors spent time engaging and getting 'a hook[9]' for the child. This was usually through activities such as bracelet making that the children enjoy.

[8] An annual Cambodian traditional religious and ancestral celebration.

[9] Counsellors were encouraged to find a hook, or point of shared interest on a light, fun topic or pursuit that can be incorporated into sessions with the children.

Challenges

- A majority of the counsellors did not explain the eight components of treatment to the child.
- One counsellor used thoughts, feelings and behaviors to explain the treatment instead of using the eight components.
- Counsellors did not use the thoughts, feelings, behaviours columns in psycho-education to teach about trauma symptoms but instead used them in a general sense to explain the difference between thoughts, feelings and behaviors.
- Only one counsellor gave statistics around childhood sexual abuse and trauma, which is a common technique used in psychoeducation.
- Only one counsellor explained who traumatic events happen to and why they happen.
- Counsellors used technical terms such as trauma narrative but did not explain what the terms mean to the children.
- A majority of counsellors did not mention confidentiality in their first session.
- Counsellors appeared to mix components and brought in material from different components into psycho-education. Case notes for psycho-education included parts of relaxation, affective modulation and cognitive processing. For example:
    - Several counsellors linked the thoughts feelings and behaviors to specific non-trauma related situations that the child has been through.
    - One counsellor had the child state their thoughts and got feelings and behaviors for each of the thoughts instead of as stand alone columns.
    - A few counsellors brought in activities from affective modulation and had the child list a range of feelings.

Relaxation

Successes

- Counsellors had a strong understanding of the activities including how to explain deep breathing, cooked and uncooked noodle, guided imagery, and thought stopping.
- Counsellors used culturally appropriate and creative relaxation techniques for relaxation such as yoga and a guided walk through Angkor Wat.
- Many counsellors did a good job incorporating the crisis of the day/week into the component.

Challenges

- Only two counsellors explained what stress is, what the physiological signs of stress are, what the child's body feels like when they are stressed and the rationale for using relaxation.
- During this component, counsellors either only taught one exercise or they taught all of the exercises instead of choosing the 1- 3 that are most appropriate for that particular client.
- A majority of the counsellors focused only on the activities that they were taught and did not ask the child what they already do to relax or focus on methods of relaxation that help a client in the specific environment where they are most anxious.

- Counsellors typically did not engage the child enough in this process and often did the work for the child. For example:
    - "I asked the girl to close her eyes and think about a happy time such as when her mother bought her new clothes, and took her for a walk to go to the pagoda. She met her friend and talked to her friend- you want to get them to come up with things that they use or think about that makes them happy."

  In the above example, a therapist is actually suggesting a situation that they assume the girl finds relaxing because the therapist does.

Affective Modulation

Successes

- Counsellors had a strong handle on the application of the inside-outside feeling activity. Case notes reflect that this activity was particularly engaging for their clients also.
- Many counsellors were creative in methods to build the child's vocabulary. Activities included: using story books, flash cards that the counsellor created, feeling faces, etc.

Challenges

- A few counsellors did not ask the children for their own vocabulary for their feelings and instead simply gave them feeling words.
- Counsellors often forgot many of the stages of affective modulation. While, most counsellors remembered to get the list of feelings they often forgot to link the feeling to a color, situation and to identify where the child experiences that feeling in their body as well as scaling the feeling.
- Counsellors that were able to accomplish all of the goals of affective modulation only did this for one or two feeling words. In general most counsellors only focused on one feeling word for the affective modulation activities.
- Only one counsellor was able to use the same feeling in a different situation to show a range of intensity in a feeling.

Cognitive Processing

Successes

- Only two counsellors seem to have had a fair understanding of this component.

Challenges

- Case notes did demonstrate that counsellors had first differentiated thoughts, feelings and behaviors in order to ensure the child understood the difference.
- Several counsellors gave their clients a new thought instead of getting the child to come up with a new thought, feeling or behavior on their own. In other words, they did a lot of the work for the clients. For example:
    - 'If you are to think that "beating someone up is useless because it will cause someone injury" instead, then you will not be angry. And if you are not angry then you will not stare at each other and you are able to talk to one another'
    - 'I led the girl by changing her thoughts, and then I asked her to scale the intensity of her feelings. Initially, she chose #10 as her level of disappointment in response to the thought "The teacher dislikes me".

Counsellor: If you change your thought to "My teacher is not coming because she is busy". What is the feeling that you now have?"

- Cognitive processing was typically done in two to three sessions. In the initial session counsellors would only connect the thoughts, feelings and behaviors and would work on changing the negative thoughts during the second or third session. However, counsellors often used a crisis of the week or a situation that was too closely related to the trauma (e.g. sister blamed me, worried about losing court case) to teach the connection stage but would not change it, therefore leaving the child with their initial negative thought, feeling and behavior.
- A majority of the counsellors only changed one triangle with the child if any.
- Several counsellors were able to change the thought, feeling and behavior but only to other negative thoughts, feelings and behaviors. They did not continue with the process until the child was able to reach a more positive/helpful thought, feeling or behavior.
- Counsellors did not regularly use this exercise to project to the future (i.e. the next time the child is in this situation they should try to think the new positive thought or do the new positive behavior so that they feel better and there may be less negative consequences).

Trauma Narrative

Successes

- Counsellors were able to successfully obtain the child's timeline and for cases with multiple traumas counsellors often used scaling with the child to determine which events on the timeline bothered the child the most.
- Counsellors handled avoidance by using normalizing and validating statements as well as repeating analogies useful for explaining why we need to talk about bad things.
- Many of the counsellors gave consistent praise throughout the process.
- Counsellors allowed the child to select which chapters they wanted to write and in caes where the child was avoiding writing the story, the counselor would gently encourage them by giving the child a limited selection from the timeline and then asking the child to choose.

Challenges

- Counsellors often forgot to explain what was supposed to go on the timeline and/or did not describe what they meant by trauma or "bad things".
- The timeline, cover page and about me chapter were often spread out among two sessions which is likely much longer than needed.
- One counsellor gave a child the choice of three titles for their book instead of letting the child come up with their own title.
- The about me chapter was often not noted in the counsellor session notes or missed all together. We were unable to tell whether this meant that the counselors were not completing this, or were not recording it in the monitoring form.
- Only two counsellors recorded doing gradual exposure work which included reading back the timeline at the beginning of every session to ensure that they have all traumas listed as well as re-reading the chapters written from previous sessions.

- The analogies used needed to be better compared to the actual TF-CBT process. For example, counsellors often used the analogy of the cut on the foot. In this analogy the counsellor should compare the process of cleaning out the cut with the process of telling their trauma story. This comparison should sound something like "When you clean out a cut it stings a bit which is similar to talking about your story it can sting and be uncomfortable but after we clean out a cut it will get better just like we know that after children tell their stories about the bad times they will get better." However, counsellors are simply stating what happens to the actual cut on the foot when it is cleaned and do not discuss TF-CBT or the process of telling their stories. This may be because of cultural tendencies to imply rather than explicitly state an issue, but this is unclear.
- Almost all of the narratives were missing important details and most importantly missing the "hot spots".
- Many of the narratives were summaries of events over long periods of time (e.g., weeks or months) as opposed to detailed accounts of one event/day. This resulted in vague subjective accounts of events as opposed to a detailed 'objective' account. For example, for sexual abuse that occurred multiple times counsellors would clump these events into one chapter instead of separating the events out to the first, worst and last incident of sexual abuse.
- Many of the chapters that were outlined on the timeline were missing from the actual narratives. Several counsellors even limited how many chapters the child could write from the timeline.
- Counsellors did not go through the narratives and get the child's thoughts and feelings throughout each chapter. Instead counsellors asked the child for a general thought and feeling at the end of the chapter.
- Counsellors asked a lot of questions throughout the narrative instead of only saying "what happened next". For example:
    - Child: I was wearing a striped shirt and long trouser and wearing mask.
      Counsellor: why were you wearing mask?
      Child: I was afraid of transmitting diseases. There were a lot of patients in the hospital. My sisters and I walked in the patients' room and my father waved his hand to come near him. He asked us "How are you?" and my elder sister responded, "we are fine".
      Counsellor: Did you hear or smell anything in there?
    - What did your aunty do when you arrived?
      Child: Aunty was crying, telling us the story and letting us see the uncle's face. There was only screaming sound. Mum was also screaming.
      Counsellor: How did you feel?
      Child: I felt so pity for my uncle and felt regret. I thought that he should not die like this. I cried.
      Counsellor: What happened next?
      Child: I looked at the dead body and saw his pale face. His eyes seemed not close needy.

Counsellor: Did you see his stomach that was piercing by bamboo container?
Child: No, I did not. I only looked at his face and neck.
Counsellor: What time was it?

- After reprocessing counsellors did not make any notation that they went back to get the child's final chapter about what they have learned, what is different about them now and/or what they would tell other children who have gone through similar things.

Cognitive Reprocessing

Successes

- Two counsellors appeared competent in using the responsibility pie, one counsellor was able to use strategic logical questioning and one counsellor did a great job with lists and definitions.

Challenges

- Case notes on this component were often missing from the records that we received.
- Overall there was a lack of thoughts and feelings to work with as counsellors only went back and got one thought and one feeling per chapter.
- Several counsellors only used cognitive triangles for this component.
- Counsellors did not report that they had explained the purpose of this component and what inaccurate and unhelpful thoughts were.
- Almost all of the counsellors only attempted to reprocess one thought.
- Several counsellors did not use thoughts related to the narrative and instead chose other unrelated thoughts to reprocess. For example:
    - "Valueless & worried about going home and getting mistreated again". I draw 2 to circles and the child color, how big is her responsible".
- Counsellors struggled with the best friend role play. One counsellor did not prepare the child with questions prior to using the role-play and a second counsellor used two unrelated thoughts at the same time during the role-play.
- A few counsellors simply gave the child a new thought and told them to think this way instead. For example:
    - "You should think that he still has mother and she will be support you and your brother and you support your mother to earn income. So, it can help you a bit, right?"
- Counsellors chose techniques that were not appropriate for the thought that they were trying to reprocess. For example:
    - Used responsibility pie for the thought "now I am valueless".
    - Used triangles from cognitive processing for ingrained inaccurate and unhelpful thoughts.

Safety Skills

Successes

- Several counsellors used creative ways to teach safety skills. For example, they developed the five fingers of safety technique.

Challenges

- The safety skills component was very limited and several cases were missing information on this section.
- Counsellors did not use role-plays to help the child practice what to do in an unsafe situation.
- In many cases clients were not asked to make a realistic list of safe people and/or places to go if they feel they are in danger.
- Safety skills did not include any information on healthy sexual behavior.
- Counsellors did not make this a participatory process with the child and instead simply told them what to do in order to keep safe in the future.
- Overall it was very difficult to tell what, if anything, the majority of counsellors did for this component with the exception of a few counsellors

Co-joint

There are no case notes on this component. For many of the children, given the geographical distance from their parents, and the lack of safety in their familial relationships, it was not considered appropriate to conduct co-joint sessions. It is not clear if counsellors re-read the entire narrative at the end with the child and/or gave the child an opportunity to ask questions of the counsellor in lieu of a conjoint session.

Review of quantitative CEPAT results

There were 12 participants assessed prior to initiation of the treatment; 11 girls and 1 boy. Their demographic information at baseline is summarized in Table 1. Table 2 presents their trauma histories and Table 3 presents their pre- and post-intervention scores on the mental health and psychosocial outcomes from the CEPAT scales. Because the CEPAT is not validated for use with boys, his baseline and change scores have been excluded from Table 3.

The data is presented to provide context and general information about the types and severity of problems experienced by participants in the feasibility study sample. Because of the small sample size, these results alone cannot be regarded as proof of impact of TFCBT.

Table 1: Demographics prior to treatment initiation

Demographics	**Total Sample (N=12)**
Age in years, (%)	
12 years	2 (17%)
13 years	2 (17%)
15 years	5 (42%)
16 years	1 (8%)
17 years	1 (8%)
20 years	1 (8%)
Highest grade achieved, N (%)	
1st grade	1 (8%)
2nd grade	3 (25%)

3rd grade	2 (17%)
4th grade	4 (33%)
5th grade	1 (8%)
6th grade	1 (8%)
Ethnicity, N (%)	
Khmer	8 (67%)
Khmer Muslim	1 (8%)
Vietnamese	3 (25%)
Months in Shelter, (%)	
4-6 months	4 (33%)
7-12 months	3 (25%)
18-36 months	3 (25%)
60-72 months	2 (17%)

Table 2: Trauma Exposures (N=12)

	N (%)
Being in a natural disaster	2 (17%)
Being in a bad accident	4 (33%)
Being in a place where there was fighting between armed groups of people	5 (42%)
Being hit, punched, or kicked very hard at home	5 (42%)
Seeing a family member being hit, punched or kicked very hard at home	5 (42%)
Being beaten up, shot at or threatened to be hurt badly	5 (42%)
Seeing someone being beaten up, shot at or killed	4 (33%)
Seeing a dead body	6 (50%)
Having an adult or someone much older touch your private sexual body parts when you did not want them to	9 (75%)
Hearing about the violent death or serious injury of a loved one	7 (58%)
Having painful and scary medical treatment in a hospital	8 (67%)
Forced to have sex with someone	8 (67%)
Being sold	3 (25%)
Being kidnapped	6 (50%)
Being starved	3 (25%)
Being restrained, tied up, shackled	1 (8%)
Being in a place where you could not escape	8 (67%)
Being forced to watch pornography	1 (8%)
Being forced to pose or participate in pornography	2 (17%)
Being left alone with no one around you that you know	4 (33%)
Being forced to use/to take drugs	2 (17%)
Being forced by a group to have sex/to have sex with a group	1 (8%)

Table 3: Baseline and follow-up average mental health and psychosocial scale scores and average amount of change.

Functional Impairment *(range: 0-40)*	**Total Sample (N=11)**	**Hagar (N=6)**	**WV TRP (N=5)**
Baseline score, mean (se)	7.0 (1.9)	6.5 (1.9)	7.6 (3.8)
Follow-up score, mean (se)	7.5 (2.3)	7.5 (3.8)	7.6 (2.8)
Amount of change (%)	0.5 (7%)	1.0 (15%)	0 (0%)
Depression *(range: 0-136)*			
Baseline score, mean (se)	46.4 (4.9)	43.8 (5.3)	49.4 (9.2)
Follow-up score, mean (se)	36.5 (6.3)	36.5 (6.7)	36.6 (12.2)
Amount of change (%)	-9.8 (21%)	-7.3 (17%)	-12.7 (26%)
PTSD *(range: 088)*			
Baseline score, mean (se)	38.2 (5.0)	36.3 (5.7)	40.4 (9.4)
Follow-up score, mean (se)	28.1 (5.4)	27.5 (4.4)	28.8 (11.4)
Amount of change (%)	-10.1* (26%)	-8.8 (24%)	-11.6 (29%)
Shame *(range: 0-52)*			
Baseline score, mean (se)	23.9 (3.6)	19.2 (2.9)	29.6 (6.5)
Follow-up score, mean (se)	13.5 (3.0)	15.5 (3.6)	11 (5.2)
Amount of change (%)	-10.5** (44%)	-3.7 (29%)	-18.6** (63%)
Hope *(possible range: 0-36)*			
Baseline score, mean (se)	25.5 (1.6)	25.0 (1.8)	26.0 (2.9)
Follow-up score, mean (se)	23.5 (2.0)	22.2 (3.3)	25.0 (2.1)
Amount of change	-2.0 (-8%)	-2.8 (-11%)	-1 (-4%)

* difference between baseline and follow up is statistically significant p<.10
** difference between baseline and follow up is statistically significant p<.05

Summary of Quantitative Findings:

The children in this sample (11 girls, 1 boy) were on average 15 years of age, with most having completed grade 4 or less. The range of time in the shelter varied, with somewhat more than half being there a year or less. The children reported a wide range of traumatic experiences in their lives; they reported sexual abuse as well as other related traumatic experiences such as being kidnapped and/or held in a place they could not escape. In addition, half or more the children reported seeing a dead body, hearing about the death or serious injury of a loved one, and/or having scary or painful experiences with the medical system. This data on traumatic experiences shows us that it is important to recognize the full range of such experiences these children may have had, including but not limited to the traumas of trafficking and sexual abuse.

Looking at the change is symptom scores from before to after TF-CBT was completed, the degree of improvement was sizable, with about 20% average improvement in depression symptom severity, 26% average improvement in PTSD symptom severity, and 44% average improvement in symptoms of shame. Small changes were found in both the functional impairment and the hope scales, with the latter showing a reduction in hope. Given the very small number of subjects (eleven) it is not clear whether there were real changes in either scale and whether these were positive or negative. The only conclusions we can draw from this small sample is that the changes in both the functional impairment and hope scales were much

smaller, if any, than the changes in the other scales. Determining the size and direction of change in these scales will require a larger sample in a future study. Overall, given the small sample size, these results should be interpreted as preliminary evidence that TF-CBT produced real improvements in depression, PTSD, and shame among this sample of children. Without a larger sample, and in the absence of a comparison or control group, it is not possible to make any firmer conclusions. The findings are promising and indicate the more rigorous studies of TF-CBT are warranted to truly understand the intervention impact on a range of outcomes.

Review of qualitative interview results with clients

Qualitative interviews were completed with the 12 children who completed the TF-CBT program. Each child was asked the following two questions:

1. What are all the things that have changed in your life/for you since you began the program? Not just because of the program but everything that has changed even if it not related to the program.
2. What are all the things that have changed in your life/for you because of the program?

For both questions the interviewers were trained to probe the responses to get both good and bad changes, though the children primarily talked about the positive things they gained from the program. The interviews were translated into English for analysis. Below is a summary of frequently mentioned responses:

- The most frequently described change the children saw in themselves (n=9) was a reduction in arguing and aggression. They described this as having stopped arguing or getting angry with other people, stopped cursing others and they used to feel aggressive, angry and confused but not anymore.
- Several of the children (n=5) talked about their improved ability to study and specifically to focus on their studies. Many of the children (n=5) talked also about having strategies to relax (i.e. the wet noodle exercise, breathing), and strategies to deal with their problems and solve them by themselves (n=4).
- Several of the changes were related to interactions with other children. Several mentioned their improved ability to play and interact with friends (n=4) and having more patience generally and more patience specifically when other children give them problems (n=4). Others talked about their new ability to help friends who have stress or are in trouble (n=3).
- Some of the children talked about changes in their thoughts and feelings – specifically saying that they do not miss their family and homes as much (n=4), do not think too much now (n=3) or think about the past (n=2), and do not feel lonely or isolated anymore (n=3). A couple (n=2) said that they now see themselves as a good person

whereas before they did not. Two children mentioned not having thoughts of suicide anymore, though one admitted to having some thoughts when she has conflict with other children.

- A few of the children (n=3) talked about feeling brave now to confront their problems and tell their story, while others said they no longer have feelings of revenge when someone gives them trouble (n=2). Two children mentioned feeling like they now know they are not the only ones facing these problems. Two children also mentioned that they take better care of themselves now, specifically in their clothing and bathing.

Review of qualitative interview results with counsellors

Qualitative interviews were completed with the 11 counsellors who completed the TF-CBT program. Each counsellor was asked the following four questions:

1. What are all the good things about TF-CBT?
2. What are all the bad things about TF-CBT?
3. What problems did you face in learning and implementing TF-CBT?
4. What changes would you suggest for the program?

For all four questions the interviewers were trained to probe to get information beyond the initial responses. The interviews were translated into English for analysis. Below is a summary of the frequently mentioned responses:

1. What are all the good things about TF-CBT

When asked about the good things about TF-CBT, a majority of counsellors (n=7) talked specifically about having lots of materials, clear instructions and step-by-step methods which allowed them to be prepared each time they met with the children. One noted that 'we are not confused, we know how to work with children now'. Four mentioned more generally that now they have a better understanding of what counseling services are and the steps for counseling, including how to ask better questions.

With regards to how the intervention directly helps the children, five counsellors mentioned that the program helped the children feel increasingly brave about sharing their experiences and telling their stories. Whereas before they may have felt afraid, now they have confidence with the counsellors. Four counsellors said the program helped the children better understand their own feelings, thoughts and behaviors and the program itself made it easier to work with and create relationships between the counsellor and child. Two counselors also talked specifically about how they can now know the children's stories in detail and depth.

Counsellors also talked about how the intervention helped them as well. Four counselors described using what they had learned to help themselves release stress and relax while three talked about feeling more confident and having new skills.

Other benefits including the support from their supervisor, having a process that helped them evaluate whether their client got better, and the program allowed them to have creativity when talking with children. One counsellor also mentioned that the program was good because she could use it with deaf children since it used a lot of pictures.

2. What are all the bad things about TF-CBT?

Three counselors said that the program made them busy because they had to meet with each child several times and sometimes for more than one hour, so it affected their other work. Two counsellors also said that the program required a lot of study and practice.

Four of the counsellors talked about difficulties with getting the children to tell their trauma narratives, because the child feels afraid or it makes the child have feelings. Two counsellors said they had situations where the girl didn't want to speak or it was difficult to speak.

Three counselors said that hearing the stories made them feel sad. One counsellor indicated that when she wasn't clear what to do, she felt afraid to use the therapy because it might 'lead me wrong and will affect their [the child's] thoughts.'

Some counsellors mentioned feeling that the program was too strict with not enough flexibility, some sessions were difficult to understand, it took a lot of preparing and planning before each meeting, and that with the trauma narrative there was a lot of writing.

In terms of systems, two problems were raised by one counsellor each. One said that it was difficult to choose a case because if the case they chose was not so serious they felt TF-CBT was not as useful. The child didn't need any therapy but they were just waiting to get back home. The other counsellor mentioned that it was a problem working with a Vietnamese child who did not know the Khmer language.

Two counsellors indicated there were no bad things with TF-CBT.

3. What problems did you face in learning and implementing TF-CBT

Some responses were similar to those previously described: including that it affected their ability to implement other activities because of the need to focus only on TF-CBT, it takes a long time even to start a session (i.e. need to play with them first), and it was difficult and time consuming to write the case notes and re-write the trauma narrative (3). Individually, they also mentioned that there were not enough materials when they practiced the intervention in the shelter. Three counselors still felt afraid after the training and practice sessions – afraid they

would not do the sessions well and the children would not understand. One also mentioned that even when they understood the training and practice, they did not know how to start with the child – e.g. it took a long time to explain to the child because the child started to tell their detailed story. One concern was that because the counsellor had to write down and record everything that was said during the trauma narrative, the child didn't think the counsellor was focusing on them but rather was focused on the writing. This was a particular problem if the child was illiterate, requiring the counsellor to write a lot.

Four counsellors mentioned difficulties in working with younger children who did not understand the connections between feelings, thoughts and behaviors, noting that it sometimes took much longer (over 2 hours) with younger ones. Some of the girls did not seem to change or were difficult to change, were still fighting with none another and looking happy but actually still crying. One counsellor noted that it was difficult to change the children's thoughts, to have them think in a positive way, while another noted that they felt they needed to have a professional or other method to make children change their thinking and that this would take a long time.

Finally, as with the previous question, two counsellors indicated concern with the intervention affecting the children's feelings, especially telling their story in detail. Sometimes the child didn't want to tell their story and the counsellor sought support from their supervisor to help in the sessions between the counsellors and children. A counsellor noted that it was sometimes difficult to control their own feelings when the children showed feelings, while another noted that it was difficult to probe because it made the children bored.

4. What changes would you suggest for the program?

In terms of the training, two counselors said that even with translator, it was difficult to learn the new method, and that they needed more time. Two counsellors specifically mentioned providing more time for the TF-CBT leaders for the retreat, so they can relax. Three also said that the rules were too strict and limiting and that they felt under pressure. One requested not having tests after the study because they were tired.

Two counsellors wanted more materials and a new manual so they can practice more, while one counsellor wanted more practice role play on the safety-plan session. Three counsellors talked about more support and supervision, with one saying they needed a supervisor to understand the process of TF-CBT.

Two counsellors reiterated the point made in the previous question that case notes completion was difficult and requested a reduction in the amount of detail needed. Another suggested alternative methods for doing the trauma narrative, including drawing pictures for those children who have difficulty telling their stories. Finally, one counsellor suggested the intervention should last more than 16 weeks.

Review of qualitative interviews with clinical supervisors

The interviews with the clinical supervisors, examined the same basic questions as with the counsellors:

1) What were the good things about TF-CBT?
2) What were the bad things about TF-CBT?
3) What were the challenges in implementing TF-CBT?
4) What changes would you suggest for the program?

Below is a review of the results of the interviews with the two expatriate supervisors for each of the 4 basic questions:

1) Good things about TF-CBT:

In a low resource-high needs environment, as expected, the clinical supervisors expressed appreciation for the time bound nature of the model.

> 'I think [with TF-CBT] being a time limited intervention, [it] is more conducive to counseling triage, whereas some of the other clinical models, such as psychodynamic, psychotherapeutic… there is no end in sight.'

As indicated by the following statements, another strength of the model, from the perspective of clinical supervisors, was their enhanced ability to provide effective supervision as a result of the structure of the model.

> 'Performance monitoring… highly structured. It enables clear criteria, can be used with organizational theory such as organization performance systems management objectives… I think feedback from staff has been positive, it addresses capacity gaps in terms of social work, psychology, [and] counseling. [It] provides staff with highly structured care milestones, breaks the clinical component down into clear sections. Being based in Rogerian clinical thinking it assumes unconditional positive regard which is valuable in addressing self esteem in traumatized girls/children. And I think the supervision assists with issues of coaching support, technical skills development, transference, and vicarious traumatisation.'

> 'The other thing I like about it is that it builds in a structure of supervision, regular supervision. [This is] something I have been trying to do, for many years, so now it becomes a regular part of the program and they expect it.'

Just as the structure was seen as aiding supervision, it was also recognized as positive for providing guidance for the counsellors.

> 'The good things are that it is a tight structure to follow… Clearly defined steps, and the steps all build on one another up to the trauma narrative, when you have the skills [to cope with re-telling the trauma]. I see that as being helpful for the girls.'

> 'It covers most of the clinical bases necessary in treatment, reduces clinical duplication, separates clinical from case management. I think the psycho-ed component, I think the philosophy of TF-CBT… aligns with the organisational values of recovery and self determination'.

> 'It is much easier for the counsellors to know where they are going. Trauma Narrative and then Cognitive Restructuring, they have a goal, it is clear, and this gives them more confidence to work at that depth.'

The clinical supervisors also expressed their perspective that, as a result of the counsellors training in the model, the counsellors were now working more deeply with clients, with better outcomes.

> 'I think the other good thing is that it looks at changing the beliefs that would never have come out [through previous approach to counseling]. Challenging unhelpful thoughts that linger with children for a long time and hinder them from moving on in their life.'

> 'According to the counsellors, the clients are reporting to them that they are…, I am tying to think of examples: 'I feel my life has changed', 'this is the first time I have ever told my story'. On two levels clients have said they feel their lives have changed, they have expressed release of stress of holding on to it, especially after letting balloons go [at the close of treatment]. And they also have skills that they can use to help themselves [the counsellors].

2) Negative things about TF-CBT:

Just as the structured modular approach of TF-CBT was identified as strength for providing guidance, clear goals, and aiding supervision, the structure was also identified as a potential obstacle to a client centered approach.

> 'In this culture [if] people become competent at the stages without a good understanding of trauma, they won't be able to adapt the model to meet the needs of various client groups. So essentially it will become another tick the box … lose the spirit [of the approach], become less client driven [and] more therapist driven.'

The potential for counsellors to focus on the goals, or the approach, rather than on the client, was therefore identified as a negative possibility, particularly within the Cambodian socio-cultural context.

Training counsellors to implement the model was also identified as time intensive by both supervisors. In particular this was noted by the Hagar Supervisor who provided supervision for both groups throughout much of the pilot (while the TRP clinical supervisor was completing his training).

> 'Time level intensive, high input, low output for the first 3 months.'

> 'I was doing two for Hagar, one for TRP, three supervision groups. 6-8 hours and then you have to write up all the notes. That's alright, its been good, that is the only way to do it, the outcome has been good but it has been taking a lot out of my week.'

> 'Supervision times took a lot longer than estimated. Especially as we got into cognitive triangle and the [trauma] narrative because it took a lot longer allowing for translation and the counsellors needed…wanted to share everything they had done. They did not have confidence to share a summary, they needed to be able to, they had to go through the whole of their session, and it was actually necessary because sometimes they needed correction.'

> 'We had to go through every little detail because there were often times when they were wrong or needed to be corrected.'

Another negative about TF-CBT identified was that:

> 'There are currently 3 or 4 other agencies saying that they are doing TF-CBT so it creates confusion amongst counsellors.

As some of the materials for TF-CBT are freely available over the internet, there are several organisations in Cambodia professing to use TF-CBT as their clinical model. However it seems that these agencies are implementing a form of the model and using the name TF-CBT, without the support of qualified TF-CBT practitioners and trainers. This was identified as having the potential to cause confusion.

It is interesting to note that several of the strengths of TF-CBT were also identified as weaknesses. The structured approach, while providing focus and assisting supervision could potentially eclipse the focus upon the client. While the time bound nature of TF-CBT was identified as a time saver, it was also described as a time intensive intervention.

3) Challenges in Implementation

With the increased investment in piloting a clinical model within a low resource environment, it is to be expected that the focus of resources and attention on the clinical domain, might deplete the supply of existing human and financial resources available. In other words the focus of considerable energy for improvement in one area may necessarily draw resources away from other areas that need attention, thereby causing inadequacies, inefficiencies and other organizational problems to emerge.

The clinical supervisors noted the following changes related to organizational capacity and the need for structural changes in order to accommodate the introduction of the TF-CBT model:

> [TF-CBT] requires an organizational structure with established program management systems in place. [It] requires senior management to have a good understanding of clinical as well as the other components … for example reintegration, advocacy. In the absence of any case management model it will fail. It probably requires an organization with a budget of over 2-4 million [per annum]. [It] requires people with [a] minimum social work degree, experiences in project management, aid and development, plus skills to provide management and supervision.
>
> Case wise, there are not really bad things, but it has taken a lot of time for me in the supervision and reporting. Doing the two lots has taken a lot of extra time.
>
> It can bring a bit of division between those who are trained and those who are not. It means there is a need to train more. [This is] Not necessarily bad, just others who have not been trained listen in and say that they want to really do it as well.

In reflection of these structural challenges identified, one organization undertook a change management quality performance process, and both organizations sought to redefine the job descriptions of their counsellors practicing TF-CBT. This was initiated in order for them to be freed up to spend more time on clinical work, as opposed to broader case management responsibilities.

In addition, another challenge identified related to gaining the supervisory support, as apart from the two in-country trainings, this was provided through email correspondence and conference calls via skype.

> 'I think I perhaps haven't had enough support in the supervision, and I have not had a lot of feedback. I have sent all the notes off but have had little feedback about how it is going. I just keep going.'
>
> 'Yes because I need to keep the momentum with all the counsellors. I mean I was learning TF-CBT as well, I had only done the online course and read the book, so really I was going, working with my limited experience in TF-CBT, but having the knowledge and experience in casework and counseling, but not specifically TF-CBT.'

4) Suggested changes

The clinical supervisors were offered the chance to consider what could be changed about the pilot. One of the supervisors suggested increased focus upon:

> '…operational considerations. Understand what will success look like for the various stakeholders in terms of successful implementation of the model, for example donors, marketing, support offices, staff, clients, management.'

> 'Once again without a case management (approach) it would be difficult to implement the model successfully… and it requires a fairly well developed program and a program that has its pure focus on clinical counseling, such as TPO, or a recovery program that has clear business units, for example clear reintegration, clear clinical. What I am trying to say is that's important otherwise counsellors will just end up doing case management [instead of spending time counseling]. In order to implement the model you first need to re-do peoples JD's [job descriptions] team business plan if they have one, re-do monthly management reports, free up staff to learn and attend training, and then have time to practice, have a dedicated clinical supervisor, have the budget for reflection, weekends, days for staff to go away between the implementation of the model… clinical supervision for all supervisors with expatriate clinical psychologist external to the organization.

The supervisor further elaborated that it would take:

> '12 months to roll out properly, it would take 3 – 6 months before starting the model so you could put the necessary organizational structures and set up your teams to accommodate the model. All of this is contextual [to our organization]. However [the] challenges facing most trafficking programs described above are the norm rather than the exception.

Another challenge, and an area for change identified related to a lack of written down instructions for implementing the model.

> 'There is nothing actually written down. PowerPoint slides only. Apart from the manual I have written there is nothing else. I asked the counsellors to write everything down each session but there is actually nothing written. I think there should be a work book.'

> 'I would like to have seen some clearer notes to work with. We need simple notes because everything has to be translated. The goal of each step, the method, that kind of thing. What we are trying to achieve. I think we have done that now, but it is only as good as the notes each counsellor wrote. I have the notes from each session (preparation notes), but that is not in one format that we can use again. I mean we can, but it is not in a book that they can pick up.'

> 'Yes I have developed that [a manual] from the online training, the live training, and added resources that assist in meeting the goals of each stage. That's all I can think of. I was surprised that there was less…if I was doing some training I would have thought that there would be a book to take away with you, not just a power point.'

Discussion

Overall, children in the study reported positive outcomes as a result of the TF-CBT pilot. Children felt that TF-CBT helped decrease their trauma symptoms (i.e. reduction in anger and aggression), improved their ability to function (specifically in school), improved their social relationships, changed their negative patterns of thinking causing a decrease in loneliness and isolation and made them feel braver to face their problems. While, the pilot study was not large enough to evaluate the effectiveness of TF-CBT in a scientifically rigorous way, the results are in line with the outcomes that we would expect to see in the *early* stages of successful implementation of TF-CBT[10].

Counselors reported a positive impact on the children and their ability to tell their stories, and also felt that the treatment helped them in their own personal lives. On a positive note counselors also reported that the training provided them with step-by-step instructions resulting in a better understanding of what counseling is. As is the case in many low resource settings, counselors in Cambodia had minimal previous experience or training in formal counseling or therapy techniques. It is also acknowledged that some of the difficulty experienced in keeping adequate case notes in Khmer was because three of the counselors were first language Vietnamese speakers. The training the counsellors received through this feasibility study not only helped them with implementing TF-CBT, but also helped build skills in general counseling (i.e. client engagement) that they can then use with all clients served by the shelter.

Overall counselors reported many positive aspects of the program. However, they also noted that the work involved in the feasibility study often affected their ability to complete other job tasks. This response is expected when a new role is integrated into a trainee's current duties. This observation has been noted in many settings in which AMHR has worked as well as in western settings when counselors are first learning new techniques. The acquisition of a new skill is often done in a step wise process and while it can take counselors more time in the beginning of the training and implementation process, this time usually decreases greatly after the counselors have had a few cases and have a stronger grasp of the skills required to implement TF-CBT. Some talked about challenges in getting the children to tell their trauma stories. This is a very natural and common occurrence, as people who have been through something traumatic rarely want to talk about it. This "avoidance" is a common symptom, and something that TF-CBT specifically helps the child overcome. Finally, a few counselors stated that hearing the traumatic stories had an effect on them personally. Again, this is a very common challenge for all people who work with individuals that have experienced trauma, and particularly counselors new to talking directly about the trauma. For this reason, we incorporated regular discussions about self-care.

[10] The participating NGOs and counselling staff requested that it be noted that the feasibility study findings are based only upon the first round provision of TF-CBT to 12 clients. Since September/October 2009, training and provision of TF-CBT has continued and the counselors, now more experienced, are now in their 4th cycle of TF-CBT and have provided TF-CBT to over 70 clients under the continuing guidance of the JHU team.

The local clinical supervisors reported many positive features of the feasibility study including the time bound nature of the treatment model, their enhanced ability to provide effective supervision as well as the overall structure of supervision which they felt provided guidance for the counselors and resulted in counselors working more deeply with clients (i.e. increased outcomes). TF-CBT is known as a brief treatment that is structured in its treatment and supervision format yet flexible in the way in which it is applied with the clients. Trainings on specific TF-CBT supervisory skills are provided to the clinical supervisors to assist them in maintaining a structured supervision in which counselors give an objective report on their cases. This structured version of supervision assists supervisors in providing feedback and guidance in an effective and efficient manner. The results from the clinical supervisors qualitative interviews suggest that these methods have in fact been useful and enhanced their ability to provide quality clinical supervision.

Conversely, supervisors also reported the structure of the model and time bound nature as a negative aspect of the program. Supervisors were concerned that, given the culture in Cambodia, counselors would simply follow the steps of the treatment model without thinking through why they were using specific techniques with a client. This is a common concern, and in the experience of AMHR, in both developed and developing country settings it seems to require time and supervision to correct. AMHR has designed the training and supervision structure as an apprenticeship model. Weekly supervision includes ongoing instruction in a way that encourages counselors to think through each case on an individual basis. For example, in supervision counsellors are often questioned as to what techniques they are using and why. Supervisors were also concerned that the pilot was too time intensive and often took them and the counselors away from other important job tasks. As stated previously, when a new model is introduced in any setting in which new skills are being acquired, it often takes longer in the beginning to implement and requires some task shifting within the current jobs. As this study included the first cases for counselors, and everyone was still learning the model, it is expected that it would take more time for supervision and implementation. Over time, the time required for supervision and implementation of TF-CBT will decrease as staff become familiar with the processes. This concern was also raised by the Hagar supervisor, who, during this study, had to supervise all counsellors by herself, which is a larger task than recommended. This problem was a direct result of the supervision structure, which was not the one recommended (or used elsewhere). AMHR had recommended different supervision models that were not possible given the staffing and resources, but in our experience should have resulted in a reduced load for any one person and resulted in improved uptake and integration of TF-CBT.

Many of the challenges raised by the supervisors were organizational. One supervisor reported that a program like TF-CBT requires a highly established organizational structure, a high budget, and highly skilled counselors. Although these circumstances may make the process easier (and more similar to a developed world context), in our experience, evidence based treatment like TF-CBT and including TF-CBT have been successfully implemented without requiring these. We commonly use counselors with the equivalent of a high school education and without any counseling training and/or experience. Therefore, while the use of Masters level counsellors

may be ideal for TF-CBT, it is often not realistic in low resource settings and not necessary. This study, and previous studies, demonstrated that counselors were able to successfully implement TFCBT and felt positive about the new skills they were learning.

While an established organizational structure and a large budget are ideal, we have found that studies such as these are feasible with lower budget than indicated by the supervisor, and less advanced organizational management structures. In actuality, it may be that it is more challenging for larger organizational structures to adapt their structures to meet arising staffing needs. What we have found to be critical is clear communication, thoughtful consideration of the task-shifting, and flexibility in roles depending on the performance of those trained. There needs to be the flexibility within programs to promote those who excel to occupy supervisory and training positions. Another challenge voiced by a supervisor was the need to learn along with the counselors and also help the counsellors. Given the high supervision load and additional commitments this one supervisor held during this feasibility study, it is understandable that she felt she needed more support. Some of the suggestions of the supervisors related to these challenges involved better and more thorough planning, set-up of clear job descriptions that allowed for case management, clinical work, and supervision, and more organizational system attention. Multiple changes in the design and implementation of this project hindered some of this clear organizational set-up and preparation, and as a pilot process, it is also acknowledged some of the challenges encountered were not anticipated.

Conclusions

1. **Implementation of the Child Exploitation Psychosocial Assessment Tool (CEPAT) was helpful in seeing where children started and ended during the study.**
   There were only 12 children (including 1 boy for whom the CEPAT tool has not been validated) assessed so the information provided from the CEPAT administration is a general illustration of the types of problems the children experienced pre and post-intervention. Given the small number of cases, it is not possible to say anything definitive about the implications of the results. Additional research aimed at further development of the CEPAT tool as part of a larger evaluation study is needed to quantify the impact of the intervention. However, within the feasibility study, the CEPAT tool proved helpful in identifying children who had the highest need for TF-CBT and in monitoring changes in their scores.

2. **Counsellors feel that the treatment was needed and helpful.**
   Counsellors reported that they like TF-CBT as an intervention and found it helpful in addressing the problems they were seeing.

3. **This study suggests that TF-CBT could be effective in reducing trauma and shame symptoms of the girls living in the shelters.**
   Both qualitative and quantitative reports suggested a decrease in the girls' trauma and shame symptoms. The qualitative results also showed that many of the girls felt that they had an improvement in their ability to function (i.e. go to school, form healthy

social relationships, etc.). These results are very positive, but it is also important to remember that the N is very small. A larger impact evaluation would be needed to comprehensively test the effectiveness of TF-CBT.

4. **Counsellors uptake and integration of TF-CBT may have been more successful if the full apprenticeship model of training and supervision could have been employed.**
   AMHR's original design for training and supervision could not be realized in the project due to various challenges. Unfortunately, this led to alterations and sub-optimal design and implementation of the training and supervision structure. For example, the shortening of the 1st and 2nd trainings resulted in counsellors not receiving adequate training on some components. Case note reviews showed that these components were areas where the counsellors had the most difficulty with implementation and adhering to the model.

5. **Counsellors were able to su*ccessfully make the transition from general counseling to TFCBT treatment with their clients.***
   In the 1st training, many counsellors struggled with veering back to general non-directive counseling skills rather than TF-CBT techniques. By the end of the feasibility study, there were many counsellors that were successfully adhering to TF-CBT skills. This shows that with training and supervision, most local counsellors with little formal therapy training were able to acquire the skills. There were some counselors that struggled more to make the transition, but it is difficult to say from this case whether that was partly a factor of the shortened 1st training with only one trainer, or subsequent large practice groups with only one supervisor, or a range of other factors. In other words, it is likely that with additional attention, these counselors may have eventually succeeded in the transition. In the experience of AMHR, it is normal for some counselors from a range of contexts to struggle with changing their approach.

6. **In Cambodia TF-CBT training should be highly structured and 'concrete.' Once counsellors have acquired the basic skills the flexibility of the model can then be introduced through supervision.**
   During the trainings, counsellors experienced difficulty applying the goals of each of the components in a flexible manner. Training methods were adapted to provide counsellors with specific, concrete steps for implementation of each of the goals of the components with the understanding that they would learn more about the flexibility of the model and its application through supervision once they had acquired the basic skills. The case note review revealed that several counsellors started to show signs of flexibility and creativity in their implementation of these components by the end of the feasibility study. This is a skill that often comes with time, and something that supervision and practice will likely continue to improve. For those that do struggle with flexibility, this may not necessarily reduce the intervention effectiveness. However, we would encourage the supervisor to work specifically on this skill with those counselors.

7. **Supervision is a vital and necessary part of the TFCBT training process.**

This project confirmed again that supervision is critical to ongoing learning and cultural adaptation of a mental health treatment and to capacity building. The supervision structure in this project was less than ideal, and perhaps focusing more on the design of this would have led to faster, cost-effective, and more adherent implementation. Specifically, for much of the study, only one expatriate staff person was available, requiring a large amount of her time to run all the supervision. It is ideal that local counselors be identified as supervisors rather than expatriate staff, however this was not initially possible in the feasibility pilot. Language was a barrier for supervision as the counselors were first language Khmer (N=9) and Vietnamese (N=3) and possessed quite variable competencies with regards to the English language. The expatriate staff responsible for supervision also had not provided TF-CBT to clients firsthand, a situation that is likely to have greatly affected their ability to understand and resolve implementation problems.

Recommendations at the conclusion of the Feasibility Study (AMHR and WV)

1. Continue ongoing supervision

Counsellors continue to require ongoing supervision so that they can acquire all skills necessary to implement TFCBT in a way that adheres to the treatment model. Although the learning process was started through the feasibility study, each counsellor only saw one client during the study period and still had numerous questions about implementation.

2. Continue ongoing technical support for supervisors with the TF-CBT trainers

Long distance technical support for the supervisors is still necessary. As clinical supervision is provided, it will be critical to have regular contact with AMHR staff both to provide further direction in how to run the supervision groups and also to work on completing the supervision training. Specifically, additional time will need to be spent teaching the last two components of Cognitive Reprocessing and Enhancing Safety Skills.

3. Set up a more sustainable supervision structure

The supervision structure was a short-term solution and filled a need, but was not appropriate for a sustainable model. The expatriate supervisors will not always be with the organizations, they were not sufficiently fluent in the local language, and had never seen a TF-CBT case. If TF-CBT continues, local leaders should be identified and trained in TF-CBT supervisory skills to a higher level than was achieved with this study.

4. Further development of the CEPAT tool.

Presently, the validation study conducted on the CEPAT allows for identification of traumatic experiences and the tracking of children's responses on the syndrome scales. The scale scores, are not normed to the general population however and it is suggested that a more extensive validity study of the CEPAT tool would provide data on cut-off scores and a better understanding of the local utility of the measure.

5. **<u>Conduct an impact evaluation on the effectiveness of TF-CBT in Cambodia before considering scale up of TF-CBT based services.</u>**

   Preliminary data (with a very small number of children) from the feasibility study has shown that trauma is a significant problem that needs to be addressed in these specific populations in Cambodia, and that TF-CBT may be an effective mental health intervention. However, while preliminary data from this feasibility study suggests an improvement in symptoms, there are limitations within the study design due to the methods employed and the small sample size. Therefore the efficacy of TF-CBT cannot be stated for certain. It is the view of AMHRG that this should be demonstrated before expending resources to scale up TF-CBT trainings and treatment services. Further studies should employ a revised version of the TF-CBT training, supervision, and implementation processes based on the recommendations of this report.

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Appendices

Appendix A: PRAC Components

Component 1: Psycho-education

- Introduced the concept that it is important to talk openly about the traumatic event, and normalize and validate the event and related problems/symptoms from the beginning of treatment.
- Reviewed a specific technique on how to use a trauma book to implement psycho-education. These are books that other kids have written or counsellors designed where a child in the story has experienced something similar, had similar symptoms, and was helped by counseling.
- Given the focus of TF-CBT on Thoughts, Feelings and Behaviors, another technique discussed was how to use the T,F,B columns to implement psycho-education. In this technique counsellors are to create a list with the child/youth on what they saw as their symptoms/problems and then normalize/validate these sypmptoms as part of trauma.
- Reviewed the purpose of these tools and why we use these tools to help children.
- Role plays were done by the trainer, and then the counsellors broke into practice groups so that each counsellor could try implementing psychoeducation.

Component 2: Relaxation

- Presented the goal of relaxation which is to reduce physiological reactions to stress.
- Introduced and role-played with the larger group different techniques used in this component including cooked/uncooked noodle (young child version of Progressive Muscle relaxation), deep breathing, and guided imagery
- Counsellors implemented different guided imagery and progressive muscle relaxation techniques with the entire group, followed by counsellors breaking up into practice groups.

Component 3: Affective Modulation (AM)

- Trainer presented goals of AM including:
    - Identify a variety of feelings in the child's vocabulary
    - Connect feeling to a situation
    - Connect feeling to the body/face
    - Develop intensity scale for feelings, and rate different feelings/situations
    - Develop a different "language" for feelings (e.g., colors, plants, pictures, animals…etc.)
- Trainer reviewed 3 specific activities/techniques, draw a person, feeling brainstorm and inside/outside feelings, for implementing this component.. Each one was presented, then role-played by the trainer, and then practiced by the counsellors in small practice groups. Cultural specific examples of implementation and ideas for intensity scales were discussed.

Component 4: Cognitive Processing

- Trainer presented the idea of thoughts, feelings and behaviors being connected, and how we show/teach this using a triangle.
- A large group walk-through of developing one cognitive triangle, and then changing the triangle was done by the trainer with the entire group.
- Specific steps were outlined:
  1. ID situation
  2. Do a triangle
  3. Make connection between T F & B
  4. Pick one to change "let's imagine…" "What if…"
- Trainer did a role play, followed by the counsellors practicing in small groups. The first "practice" was just to create a triangle based on a mundane situation/event, and distinguish thoughts, feelings and behaviors.
- The 2nd practice was to take the triangle previously created, and make the connection between T,F, And B for the girl.
- The 3rd and final practice was to use the triangle of the mundane situation/event, and try to change a T, F, or B in order to change the triangle.

Appendix B: Trauma and Additional Components

Component 5: Trauma Narrative (TN)

- The trainers introduced the steps of how to get the details of an event, and then how to add in thoughts and feelings throughout that event. Role plays were done using positive events from the counsellors own lives. Counsellors specifically practiced how to get details of an event by only using the phrase "what happened next" so as not to lead the story-teller.
- Trainers presented how to get a time line or table of contents for the events that would then be included in the narrative and how to introduce the TN to clients. Examples of analogies used to explain to the child/youth why we need to talk about the "bad stuff" were given, and each counsellor wrote down analogies they would use (some being the same as examples, and some original ideas).
- The TN component was broken down into the following steps:
    - Praise child's work on timeline
    - Tell child we will use timeline to make a book of stories about the bad times
    - Get a name/title for the book and illustrate with a picture
    - 1st chapter is developed about the author/client
    - Have client pick a place to start on the timeline
    - Get the details using steps they've already learned ("what happened next" approach for getting details)
    - Praising the child throughout
    - Find the "hot spot" and pull the child through it
    - Return to the TN and get thoughts and feelings throughout
- To practice these steps, the trainers had the counsellors first use a positive event in their own life to get the details, and ask about thoughts and feelings. Following this, small groups were used to practice getting the details of a trauma-related event.

Component 6: Cognitive Reprocessing

- Trainers presented the overall goal of cognitive reprocessing as helping the child to change unhelpful and/or inaccurate thoughts to more helpful and/or accurate thoughts (with the ultimate goal of the child then being able to improve the connected feelings and behaviors).
- Steps of cognitive reprocessing included:
    - Review the TN to look for unhelpful and/or inaccurate thoughts
    - Choose an unhelpful thought to focus on – one that seems to be contributing significantly to symptoms
    - Brainstorm more helpful thoughts you would like to see the child get to and/or what you would like to tell the child
    - Choose a technique that you think would work to reprocess the thought
- Two techniques were taught including best friend role-play and the responsibility pie.

Component 7: Enhancing safety skills

- Trainers reviewed slides and discussed different activities that can be done to enhance safety. A large proportion of time was spent on talking about how each client has different safety related needs. Large group role-plays were done to show counsellors how to teach this skill in an interactive way with the child.