

*An Action Research on the Effectiveness
of Trauma Focused Cognitive Behavioural Therapy
as an Intervention for Victims of Child Sexual Abuse*



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Table of Contents

Acknowledgement	6
Executive Summary	7
Chapter 1: Introduction	9
Chapter 2: Methodology	14
Chapter 3: Research Design	15
3.1 Data Collection	16
3.2 Data Analysis	18
3.3 Ethical Considerations	18
3.4 Limitations	20
Chapter 4: Presentation of Findings	21
4.1 Research Question 1: What are the key factors in therapeutic intervention using the trauma focused cognitive behavioural therapy that could bring about a positive change among children in their context – family, community, and school?	21
4.1.1 Key factors in therapeutic interventions contributing to positive change children	22
4.1.1.1 Defining child sexual abuse and shifting the blame from the child to the perpetrator	22
4.1.1.2 Understanding the child’s perspective	24
4.1.1.3 Teaching stress management techniques to strengthen child’s coping capacity	24
4.1.1.4 Labelling emotions	25
4.1.1.5 Understanding the relationship between thoughts, feelings, and actions.	26
4.1.1.6 Understanding the magnitude of the abuse and releasing toxic thoughts and emotions	27
4.1.1.7 Rebuilding trust, communication and openness between the child and the parent	28

4.1.2	Positive changes experienced by children in the context of their family, community, and school	29
4.1.2.1	After the abuse but before counselling – The perspective of the child	29
4.1.2.2	After the abuse but before the counselling – the perspective of the parent	30
4.1.2.3	Perception of self after commencing TF-CBT – the perspective of the child	31
4.1.2.4	Perception of self after the counselling – the perspective of the parent	33
4.1.2.5	Positive changes in the context of family – the perspective of the child	34
4.1.2.6	Positive changes in the context of the family – the perspective of the parent	35
4.1.2.7	Positive changes in the context of school – the perspective of the child	37
4.1.2.8	Positive changes in the context of school - the perspective of the parent	38
4.1.2.9	Positive changes in the context of the community – the perspective of the child	39
4.2	Research Question 2: What are the factors that contributed /facilitated effectively in the process of casework/therapeutic intervention?	41
4.2.1	Rapport building	41
4.2.2	Assessments and documentation	42
4.2.3	Preparation and flexibility	42
4.2.4	Effective communication	43
4.2.5	Trust and confidentiality	44
4.2.6	Consistent attendance and active participation	46
4.2.7	Privacy	47
4.2.8	Customization and fun	47
4.2.9	Rights based approach	48
4.2.10	Collaboration with the multi-disciplinary team	48
4.3	Research Question 3: What are the strategies adopted over time by the member organization to improve the effectiveness of therapeutic intervention using TF-CBT model and how did those strategies help to improve the practice?	50
4.3.1	Trauma training	50
4.3.2	Supervision and internal training sessions	51

4.3.3	Client-centered training	52
4.3.4	Self and self-care	53
4.3.5	Financial support	53
4.3.6	Suggested capacity development strategies	53
4.4	Research Question 4: What are the domains to be more focused on, using the TF-CBT in the therapeutic process?	55
4.4.1	Emotional well-being and social well-being	55
4.4.2	Family bonding	59
4.4.3	Self-development	59
4.4.4	Safety and resilience	60
Chapter 5: Discussion of findings		63
5.1	The adverse implications of child sexual abuse	63
5.2	Regaining Control	65
5.3	Casework approaches that contribute to positive change	68
Chapter 6: Conclusion and recommendations		71
6.1	Conclusion	71
6.2	Recommendations	71
References		75

Acknowledgement

This study was made possible with the support of Family for Every Child (FFEC) a global alliance of local Civil Society Organisations. Childlink is a member of FFEC. As part of sharing knowledge on various therapeutic approaches practiced in the area of mental health of children, adolescents and young people, three members of FFEC, Childlink, Guyana, Uyisenga Ni Imanzi, Rwanda and Butterflies, India came together to conduct action research on our respective therapeutic approaches. Butterflies, research team supported the three organisations in developing the research framework. We would like to acknowledge Childlink researchers for conducting this study. We would also like to acknowledge Mr. William Gali, Senior Programme Advisor, FFEC, for his constant support.

Most importantly we would like to acknowledge the children, adolescents and young persons who gave us written consent to use their cases for the purposes of this action research study. We are indebted to them.

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Executive Summary

Child sexual abuse (CSA) has a profound adverse effect on the emotional and social wellbeing of children. In this action research, victims of CSA reported that they experienced an array of post-traumatic stress symptoms including bouts of anger, high levels of stress and irrational fears. Victims of CSA also indicated they experienced low self-esteem, low self-confidence and intense feelings of shame and guilt. Generally, most of the child respondents developed a negative perception of self. The social implication of CSA is evident in the eruptions of physical and psychological violence in the children's homes that adversely affected familial bonds. Some victims of CSA 'lashed' out in anger at their parents and siblings resulting in physical and verbal altercations. In some cases, victims of CSA isolated themselves from family members, peers, and the community as they grappled with intense feelings of guilt and shame. In a few cases, members of the community directed insults at victims of CSA and their family, in support of alleged perpetrators. CSA victims also experienced a sense of hopelessness as they struggled with intense suicidal inclinations – children indicated they saw little or no hope for the future.

Trauma focused cognitive behavioural therapy (TF-CBT) is a trauma intervention that is facilitated by trained trauma counsellors at ChildLinK's Child Advocacy Centres (CAC) – ChildLinK is one of two non-governmental organizations (NGO) in Guyana that provides this service in collaboration with members of the multi-disciplinary team (MDT) which includes police officers, medical officials, child protection case workers and State prosecutors. This research was designed to assess the effectiveness of TF-CBT as an intervention for child sexual abuse. The research utilized a qualitative methodological approach to capture the lived experiences of the victims of CSA, their parents, and the trauma counsellors that facilitated the sessions.

TF-CBT is an effective trauma intervention. Trauma counsellors versed in this intervention supported the children to identify their feelings and helped them to understand the interconnectivity between thoughts, feelings, and actions. This helped the children to improve the management of their thoughts and feelings and by extension their decision making and actions. Children were also taught stress management techniques to strengthen their capacity to cope with trauma triggers. Consequently, victims of CSA experienced an improved perception of self that translated into improved relations with family members, peers, and the community, in addition to improved academic performance. An important finding in the study was trauma counsellors' observation of the general lack of awareness among children of 'red-flags' and other risk indicators that places children at risk of child sexual abuse. TF-CBT address this knowledge deficit through one of its chapters – psychoeducation, which increases children's knowledge of 'red-flags' and prevention strategies to reduce the likelihood of re-victimization.



Parents and trauma counsellors are critical to the achievement of positive changes in the lives of children through the facilitation of TF-CBT. Children require a support network founded on trust and genuine support and parents are crucial to this outcome. In a few cases where the parents were not active in their support of the child, positive outcomes were not realized. Where parents were actively participating in the TF-CBT and incorporating the learnings at home, children and parents indicated that their relationship significantly improved, and the children also exhibited positive behaviours.

Children indicated that it took several sessions before they were able to trust their counsellors and 'open up' to them. Counsellors who demonstrated active listening skills and effective communication skills, patience and were non-judgmental, were perceived as trustworthy by the children and resulted in them revealing feelings and experiences that the children admitted that they could not reveal to their parents prior to commencing TF-CBT. Subsequent to the commencement of TF-CBT sessions, some children indicated that they felt more comfortable communicating with their parents and parents indicated that they felt more equipped to communicate more effectively with their children and demonstrate affection.

Effective trauma counselling utilizing TF-CBT requires significant investment from the organization employing trauma counsellors and the counsellors themselves. Positive changes are more likely to be realized when counsellors utilize TF-CBT modules in conjunction with other client-centered topics and strategies. Counsellors who exhibited the capacity to adjust the content of their sessions to address non-trauma related issues, but nonetheless relevant issues, were more likely to support the realization of positive changes in their clients. Children indicated that addressing these issues, in conjunction with their trauma issues, was important to them and to their recovery and wellbeing.

This research identified several recommendations to improve TF-CBT interventions. The CACs utilize the center-based approach – therefore, clients are treated at the CAC site. Given the severity of the fissures that trauma causes in family bonds, children's willingness to participate in school and engage in social groups, CACs may need to consider the feasibility and practicality of expanding its approach to the community.

1. Retrieved from <https://egyankosh.ac.in/bitstream/123456789/58711/3/Unit1.pdf>



Chapter 1:

Introduction

Child sexual abuse (CSA) is a widespread problem experienced by an estimated 8 to 31% of girls and 3 to 17% of boys globally (Gerwitz-Meydan, 2020). Guyana continues to experience an increase in reports of child sexual abuse to the Childcare and Protection Agency (CPA) – the government agency that is mandated by law, to address all child abuse matters (Childcare and Protection Agency Act, 2009 sections 3, 4 and 5). In 2015, the CPA reported that it received 676 reports of CSA. Three (3) years later in 2019, the CPA received 1,056 reports of CSA which is equivalent to a 56% increase in reported cases.

Many victims of CSA have reportedly experienced trauma and post-traumatic stress symptoms such as nightmares, flashbacks, and irrational fears (Fontes, 2018). Trauma has been conceptualized in several ways including adverse childhood experiences; child maltreatment; potentially traumatic events including exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Regardless of the different conceptualizations of trauma, what is evident is that several systematic reviews and meta-analyses have shown that individuals who experience these events have resulted in negative outcomes (Lange, Loser & Lang, 2021). Trauma experienced by children has substantial adverse effects on mental health that can persist into adulthood. Trauma symptoms can extend beyond post-traumatic stress disorder (PTSD), resulting in functional impairment, increased sexual revictimization, substance abuse, depression, anxiety, and suicidality (Peters, et al., 2021). Victims can experience CSA as a loss of power that is brutally or manipulatively taken from them by the perpetrator. This loss of power and the feeling of helplessness that it causes can disrupt CSA victims' self-esteem and self-mastery. Consequently, feelings of guilt and shame can be integrated into victims' self-concept, which could lead them to believe that they are at fault, worthless, helpless, or even deserve the abuse (Gewirtz-Meydan, 2020). Victims of CSA have also demonstrated an inclination for isolation, and some have struggled to trust others (Fontes, 2018).

The government of Guyana, through the CPA, introduced and established the Child Advocacy Centre (CAC) model in 2014, in collaboration with two (2) civil society organizations (CSO): ChildLinK Inc. and Forward Guyana. The CAC was established to provide unique and specialized treatment to children who are victims of CSA and victims of statutory rape. The CACs offers a menu of services. The main purpose of the CACs is to reduce the trauma children experience in reporting CSA, having to tell their stories once as opposed to several service providers.



- 1) Conducting detailed forensic interviews by a trained Forensic Interviewer with the skills to gather information from children using scientifically approved using techniques and best practices.
- 2) Preparing the child's forensic interview statements for police officers and prosecutors from the office of the Director of Public Prosecutions (DPP) that aid the investigation of perpetrators and is admissible in Court.
- 3) Providing court support services to children and their families during court hearings.
- 4) Providing evidence in Court through testimony in support of the victim.
- 5) Coordinating efforts with a multi-disciplinary team (MDT) comprised of law enforcement, medical services, social services, and public prosecution professionals for case management and prosecution.
- 6) Providing psychosocial support and trauma-focused cognitive behavioural therapy (TF-CBT) for the benefit of the CSA victim and their family.
- 7) Strengthening parenting skills to improve care of children and reduce revictimization.

The CAC represents the government of Guyana's commitment to collaborate with all stakeholders to fulfill its obligations under international conventions such as the United Nations Convention on the Rights of the Child (UNCRC). Article 19 of the UNCRC outlines the State's duty to implement protective measures for the protection of children and the establishment of social programmes and mechanisms to address CSA, exploitation, and maltreatment.

“State parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence... including sexual abuse... Such protective measures, should as appropriate, include... the establishment of social programmes to provide necessary support for... identification, reporting, referral, investigation, treatment and follow up...as appropriate for judicial involvement”.¹

The CACs, therefore, supports the CPA, and by extension the government of Guyana, in meeting the demand for social services. According to a 2017 ChildLinK report, there is staff shortage in the national child protection system, even where there is heavy placement of staff due to the rural/urban population (Henry, 2017). As at 2017, records indicate that the ratio of child protection case workers to child abuse cases was 1: 100, where a ratio of equal to or less than 1:25 is more manageable (Ibid).

1. Article 19: Protection from Abuse and Neglect, Child Rights International Network, <https://archive.crin.org/en/home/rights/convention/articles/article-19-protection-abuse-and-neglect.html>, accessed 16th March 2022.



One of the seminal contributions of the CACs to the national child protection system is the provision of TF-CBT to child sexual abuse victims. The CPA refers CSA victims to the CACs for client centered counselling or TF-CBT to support CSA victims to cope with trauma induced by child sexual abuse. TF-CBT can be defined as “...an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers”². It is a structured intervention developed to treat posttraumatic stress disorder (PTSD) and related emotional and behavioural difficulties in children who were victims of child sexual abuse (Webb, et al, 2014) and even in other cases of extreme trauma such as war crimes and accidents. Trauma affects everyone differently. While individuals experience a range of reactions after a traumatic event, most individuals recover from initial symptoms naturally. If symptoms persist, a diagnosis may confirm PTSD. It must be noted that “the main divide in psychological non-medication treatments for trauma related disorders such as PTSD is whether they are trauma-focused or non-trauma focused. To be considered trauma-focused, a treatment must focus on processing the traumatic event through cognitive, behavioural, or/and emotional strategies, or a combination of the three” (Williston, 2017).

TF-CBT provided in the CAC consists of eight (8) chapters, meticulously detailing a step-by-step approach for providing treatment to CSA victims. In CSA cases, an assessment is conducted utilizing the PTSD rating scale in the initial stages of the intervention to assess the severity of the trauma the child experienced.

The first chapter of the TF-CBT is called psychoeducation. This is designed to strengthen parents’ and children’s understanding of trauma and clarifies any inappropriate or misinformed information children may have obtained from the perpetrator or any other source. Psychoeducation provides information on sex education, risk reduction and red flags. Additionally, psychoeducation provides clients with information about the traumatic event, developing safety plans, strengthening parents’ knowledge and skills in positive parenting, child behaviour management strategies and effective communication.

Chapter two (2) is captioned stress management. This chapter provides three (3) techniques to help children and parents/caregivers cope with stress and anxiety. Controlled breathing is the first technique that helps children and adults manage anxiety and stress. Relaxation training is another technique that equips clients with knowledge on the difference between feeling tense and relaxed so that they can assume increased control over their anxiety. The final technique is thought stopping. This technique helps children and parents to disrupt intrusive thoughts giving them increased control over their thoughts.

2. Trauma - Focused Cognitive Behavioral Therapy, National Therapist Certification Program, <https://tfcbt.org/>, accessed 15th March 2022



Chapter three (3) is captioned affective expression and modulation. This chapter is designed to help the child and parent to improve their management of their emotional reactions to reminders of the abuse, improve their ability to identify and express emotions and equip them with increased knowledge in self-soothing activities. Feelings identification is a non-stressful way for children to talk about their feelings and strengthens the trust between the child and the counsellor.

Chapter four (4) is captioned cognitive coping and processing. This chapter helps the child and parent understand the connection between thoughts, feelings and behaviours.

Chapter five (5) is captioned trauma narration and processing. This chapter focuses on conducting gradual exposure exercises – including verbal, written, and/or other creative techniques to recount the actual abusive incident. The child recounts the abuse through a poem, journal or song. This aids in processing inaccurate or unhelpful thoughts about the abuse. It is the most important step in helping the child to control intrusive and upsetting trauma related imagery. The child's capacity to recognize and prepare for reminders of trauma is strengthened. The child is more prepared to identify unhelpful cognitions about trauma events through an increased capacity to avoid cues of the traumatic event.

Chapter six (6) is captioned in vivo exposure. This chapters exposes the child in a safe and gradual manner, to reminders in the child's environment of the abuse. For example, the child is safely exposed to darkness, if the abuse occurred in the dark. This strengthens the child's capacity to control her/his emotional reaction to environmental stimuli.

Chapter seven (7) is captioned conjoint parent/child sessions. This chapter allows the child to share their trauma narration with their parent/caregiver. This creates opportunities for therapeutic discussions about the abuse and can improve parent – child communication.

Chapter eight (8) is captioned enhancing personal safety and future growth. This chapter focuses on strengthening the child's skills in the application of personal safety skills in day-to-day situations, developing and maintaining interpersonal relationships, and increasing the child's knowledge on healthy sexuality. The counsellor finally encourages the child to utilize the various skills they learned throughout the sessions to better manage future stressors and trauma cues.

There is copious scientific evidence that substantiates the validity and effectiveness of TF-CBT in addressing trauma, particularly in children and adolescents. Current evidence-based guidelines only recommend TF-CBT for children and adolescents up to age 18 (Peters, et al, 2021). Results from a systematic review of TF-CBT suggest that youth with histories of trauma who complete TF-CBT show significantly fewer symptoms of posttraumatic stress disorder, depression and behaviour problems immediately and up to one-year post-therapy as opposed to youth who complete other trauma interventions



(Self-Brown, et al, 2016). In fact, over 22 scientific investigations have established TF-CBT efficacy for reducing many symptoms related to child trauma in children and adolescents. Randomized controlled trials have demonstrated that TF-CBT is more effective than other supportive therapy at reducing PTSD symptoms and improvement is maintained post treatment for up to two years (Webb, et al, 2014). Perhaps the efficacy of TF-CBT is due to the fact that each chapter builds on the learnings from previous chapters and gradually prepares the child for what can be considered the main chapter: the trauma narration and processing.

An example that highlights the efficacy of TF-CBT is that of a 15-year-old client who was sexually abused by a person who abused their position of trust. The child was initially ashamed, did not engage with the counsellor and was withdrawn. The use of the TF-CBT techniques proved effective in helping the child establish trust with the counsellor. Subsequently, the child became more attentive and engaging. The child was provided with information relevant to her circumstances relative to the abuse through psychoeducation. The sessions progressed organically leading up to the trauma narration and processing chapter. In this case, this child was withdrawn to the extent that sometimes she would stare out the window and just ignore the counsellor's attempts to engage with her. On other occasions she would just sit and cry. The sessions on cognitive coping and processing strengthened the child's capacity to better understand her the connections between her thoughts, feelings, and actions. She was able to identify and express these feelings that were repressed. At the point of doing the trauma narrative the child was able to fully engage with counsellor and penned her story exceptionally well.

The treatment strategy in the TF-CBT has immense value for any child protection system. Children who were clients of ChildLinK's CACs have exhibited a wide range of improvement including decrease in PTSD symptoms, depression, anxiety, behavioural problems, shame, cognitive distortions, and strengthened capacity to address relationship difficulties. There has also been noticeable positive treatment response for parents. Some parents have experienced reductions in their own emotional distress as well as improvement in how they can support their children and address their children's behavioral difficulties. TF-CBT supports and strengthens the child protection system as it provides the support children need to be able to recover from the trauma. One critical way of protecting children is to provide them with the tools that will equip them to move on and to be mindful of situations that may arise in the future. The value of the CACs goes beyond the provision of TF-CBT to trauma clients. The CACs contributes to long term, transformational change - it contributes to a society where children are given life altering mental health treatment and support to heal and reconvene living their lives and the pursuit of their dreams with renewed optimism, hope and courage and be potential agents of change in their family and community.



Chapter 2:

Methodology

Research methodology is “the theoretical, political, and philosophical backgrounds to social research and their implications for research practice and for the use of particular research methods” (Robson, 2002 pg. 549). This research will be guided by the interpretivist research philosophy which recognizes that people from different cultural backgrounds and circumstances create different meaning to their social reality. Specifically, the research will utilize the phenomenological stream of interpretivism which focuses on research participants’ recollections and interpretations of their ‘lived experiences’ (Saunders & Thornhill, 2015). van Manen postulates that “The phenomenological approach asks of us that we constantly measure our understandings and insights against the lived reality of our concrete experiences, which...are always more complex than any particular interpretation can portray” (Biggerstaff, 2012 p. 192).

This action research will be guided by the view that social reality is constructed by the people’s interpretation of their experiences. To better understand the phenomena of trauma, TF-CBT and its impact on the child sexual abuse victims, it is imperative that we approach those who lived those experiences (the victims of CSA and their parents) and those who supported their healing (experts in TF-CBT who provided trauma interventions to CSA victims and their families) and provide them with the opportunity and space to tell their stories in their words and to give their interpretations of their experiences and feelings in their words.

This action research will employ the qualitative research methodology. Qualitative research is often associated with the interpretivist philosophy (Denzin & Lincoln, 2011) and has much to offer when we need to explore people’s feelings and or ask part

icipants to reflect on their feelings (Biggerstaff, 2012). This action research will gather data from 20 children who were victims of sexual abuse and received TF-CBT from ChildLinK’s CACs in Regions 5 and 6; 20 parents of the 20 CSA victims; and five (5) TF-CBT counsellors who provided services to the children and their families. Conclusions will be drawn from the data utilizing the inductive approach to theory development. The inductive approach allows for the exploration of a phenomenon by collecting data and conducting analysis to identify themes and patterns from which conclusions can be drawn or a theory is generated (Saunders & Thornhill, 2015).



Chapter 3:

Research Design

The research design is the general plan the researcher will operationalize to answer the research questions. It will contain the research questions, data collection sources, data collection and analysis techniques and ethical issues and constraints that the researcher can potentially encounter (Saunders & Thornhill, 2015).

This study will employ action research as the research strategy of choice to answer the four (4) research questions:

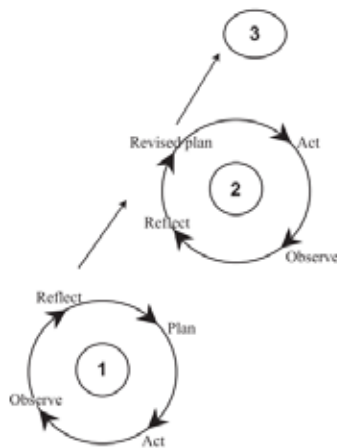
- 1) What are the key factors in therapeutic interventions using the TF-CBT that could bring a positive change among children and in their context – family, community, and school?
- 2) What are the factors that contributed to/facilitated effectively in the process of casework/therapeutic intervention?
- 3) What are the strategies adopted over time by the member organization to improve the effectiveness of trauma intervention using TF-CBT model and how did those strategies help to improve the practice?
- 4) What are the domains to be more focused on, using the TF-CBT in the therapeutic process?

Over the years, research has grown in complexity and has become more involved in practical issues, seeking practical answers to current issues (Gustavsen, 2007) and action research has emerged, and is increasingly viewed, as a potential solution. Action research aims to resolve social or organizational issues in conjunction with those who are experiencing them while simultaneously contributing to scientific knowledge. It is highly participative and democratic in philosophy and practice, where members of the system being studied are active participants in the process (McDermott, Coghlan & Keating, 2008). Action research can be defined as "...a form of collective, self-reflective inquiry that participants in social situations undertake to improve: (1) the rationality and justice of their own social...practices; (2) the participants' understanding of these practices and the situations in which they carry out these practices... The approach is action research only when it is collaborative and achieved through the critically examined action of individual group members" (Altrichter, et al. 2002 pp. 125 and 126). There are four (4) phases to action research: 1) planning, 2) acting, 3) observing, and 4)



reflecting. These phases are reflected in Figure 1 on the following page.

Figure 1: showing an action research model (Altrichter, et. al. 2002)



3.1 Data Collection

3.1.1 Sample Population

Data was gathered from forty-five (45) participants illustrated below in Table 1. Purposive sampling was utilized as the sample selection method for the action research. Purposive sampling allows the researcher to use his/her judgement to select cases that best enable the researcher to answer the research questions. More specifically, this action research utilized homogenous purposive sampling which focuses on a particular subgroup where all the sample members are similar or share a specific characteristic (Saunders and Thornhill, 2016). In this case, all members of the sample were specifically CAC clients who received a specific service: TF-CBT. The CAC provides several services including court support, TF-CBT, client-centered counselling and forensic interviews. This study focused primarily on TF-CBT clients, their parents and the counsellors who facilitate TF-CBT sessions.

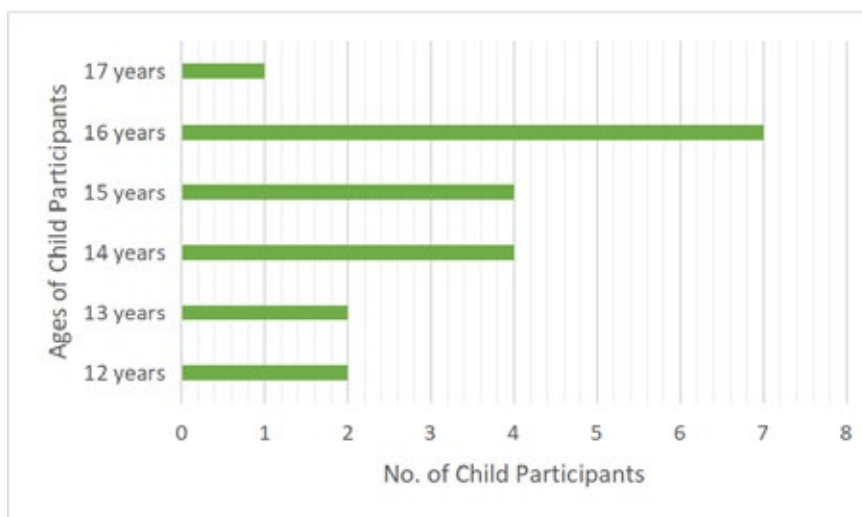
Table 1: Category of participants from which data was gathered

Category of Participants	Region	Males	Females	Total
Children who experienced sexual abuse	5	0	7	7
	6	1	12	13
Parents of CSA victims	5	1	6	7
	6	1	12	13
Counsellors	5	0	2	2
	6	0	3	3
Total		3	42	45



The child participants in this study were selected within the age range of 12 to 17. From 2015 to 2021, 669 children received forensic interview and counselling services from the CACs in Regions 5 and 6. Of the 669 children, only 73 or 11% were boys. Consequently, only one (1) male participated in the study. The frequency distribution of the age range of the children is illustrated in Figure 2.

Figure 2: Age range of the child participants



3.1.2 Data Collection Methods

The methods used in data collection for this study included interview schedule, focused group discussion (FGD) and questionnaire.

3.1.2.1 Interview schedule

Two (2) interview schedules were developed and used in the action research: one (1) for the parents of children who were victims of CSA and clients of the Regions 5 and 6 CACs and one (1) for children who were victims of CSA and referred to the CACs at Regions 5 and 6.

The children's interview schedule was designed, using primarily open-ended questions, to capture the children's feelings and thoughts on the change or lack thereof, they experienced as a result of receiving TF-CBT. Children explored their thoughts and feelings on the changes in their feelings, behaviours and perception of self after the abuse but prior to receiving TF-CBT in comparison to after they were engaged in the TF-CBT. The interview schedule also allowed children to explore their relationship with their peers, family and community, after the abuse but prior to receiving TF-CBT in comparison to after engaging the CACs for TF-CBT. Children explored the extent to which the positive change, or lack thereof, could be attributed to the TF-CBT services they received from the CAC.



The parents' interview schedule also utilized primarily open-ended questions. The interview schedule was designed to assess parents' view of the quality of services their children received from the CAC, their perception of their child's progress or lack thereof, and the extent to which the changes can be attributed to their child's engagement in TF-CBT.

The interview schedules were designed to garner the perspective of parents and children on similar issues relevant to the research questions. The tools captured parents' and children's perspective on the children's perspective of self and their relationship with their family, community members and peers and teachers at school, both after the incident of abuse and before commencing TF-CBT and after commencing TF-CBT.

3.1.2.2 Focused group discussions

Five (5) CAC counsellors participated in an FGD to assess the children's responses with focus on children's views of the TF-CBT modules that contributed to positive change in their lives. Counsellors also explored their observation of positive change engendered by each module in the lives of the children.

3.1.2.3 Questionnaire

Counsellors completed a questionnaire comprised of open-ended questions to explore strategies they utilize in their casework, their assessment of social modalities that most likely must be addressed in children to facilitate positive change in TF-CBT clients and actions ChildLinK should take to strengthen the delivery of TF-CBT services.

3.2 Data Analysis

This research utilized the phenomenological stream of interpretivism to focus on the 'lived experiences' of research participants. Consequently, the study was qualitative in its research design requiring the use of qualitative analysis methods for the qualitative data collected. The data was coded using in vivo coding which is congruent with the phenomenological approach. Thematic analysis was then utilized to strengthen the researcher's understanding of the data. The coded data was reviewed to identify emerging themes that are relevant to answering the research questions. The goal of thematic analysis is to understand patterns of meanings from data on lived experiences related to the research questions (Sundler, et al 2019).

3.3 Ethical Considerations

Research participants have the right to self-determination, that is, they have the right to choose whether they participate in the study. This entails that research participants are not only informed about the processes and purpose of the study, but that they clearly understand them (Bonnie, 1987). Consequently, counsellors engaged potential



participants in telephone conversations informing them about purpose of the research and what would be expected of them as a participant. Participants were informed that participation was voluntary. A follow up, face to face interview was then arranged, where participants were given the opportunity to seek further clarification and a consent form was developed, which parents reviewed and signed. The consent form detailed their right as a participant – it was clearly articulated that participants could withdraw at any point in the process without any repercussions.

Researchers should take necessary actions to ensure participants' privacy is protected and their responses remain confidential (Wallace and Sheldon, 2015 & Bonnie, 1987). Interview schedules and questionnaires were coded to ensure that no participant could be linked to their response.

The interviews were conducted by the counsellors who have a social sciences background and professional training in facilitating trauma therapy and client centered counselling. Additionally, the counsellors benefitted from prior training in facilitating in-depth interviews with children who were victims of CSA. The children and parents are also familiar with the counsellor. Each child was interviewed by the counsellor that engaged them in counselling and the parent was interviewed by the counsellor who engaged their child. Additionally, the counsellor also engaged the parent in parenting sessions during the child's tenure at the CAC. Therefore, the parent and child already had an established working relationship with the counsellor, and a level of trust between the child, parent and counsellor was already established prior to engagement with this action research.

The research team was led by ChildLinK's Managing Director who provided overall supervision and technical guidance throughout the research project. The Managing Director previously led four (4) ChildLinK research projects. The CAC Project Officer for Region 5 and 6 supervised the data collection process. The data collection tools were developed by ChildLinK's Monitoring and Evaluation Manager in consultation with data collection team and reviewed and approved by the Managing Director and the Region 5 and 6 Project Officer. The CAC Counsellors for Regions 5 and 6 were the interviewers who interviewed the children and the parents who participated in the research. These Counsellors are trained in facilitating TF-CBT and forensic interviews. The Senior Counsellor for the Whim, Region 6 CAC site collated the data into a spreadsheet prepared by the Monitoring and Evaluation Manager. The data was analyzed by the Monitoring and Evaluation Manager with support from the Region 5 and 6 Project Officer. The research report was co-authored by ChildLinK's Monitoring and Evaluation Manager and the Region 5 and 6 Project Officer. The report was reviewed by the data collectors and the Managing Director before final approval.

The research team took measures to ensure the health and safety of the research participants. Data collection occurred during the period where the COVID-19 pandemic was a public health concern. Participants were afforded the opportunity to



travel with private transportation to minimize physical contact with crowds utilizing public transportation, thereby minimizing the risk of transmission of COVID-19. Additionally, the research followed COVID-19 guidelines issued by Guyana's Ministry of Health – masks were provided and worn during face-to-face sessions, the required distancing was maintained while the child and parents were at the CAC, sanitizers were available to participants, and the interviews were scheduled to ensure that families participating in the interviews were not physically present at the CACs concurrently.

The research instruments were piloted prior to the commencement of data collection to ensure that no child or parent would be emotionally harmed and that the responses generated were relevant to the research questions. The counsellors, who functioned as data collectors for the research, tested the research instruments among themselves in role playing sessions. The research instruments were also piloted with three (3) children and three (3) parents. The findings from the pilot and the experiences of the children and parents during the interviews was discussed by the research team and adjustments were made to the interview schedules. No participant experienced any adverse emotional challenges while participating in the study.

3.4 Limitations

The interviews were facilitated by the counsellors who engaged the children in TF-CBT sessions. This has obvious benefits – there was an already established relationship and trust between the research participants and the interviewers. However, a potential limitation is the participant may not wish to disclose negative feedback out of concern for the implications this can have on someone (the counsellor) with whom they have a good relationship with.

Since the establishment of the Regions 5 and 6 CAC, 669 children accessed the services. Of the 669 children who accessed the services, only 73 or 11% of those children were boys. Since a significantly smaller number of boys are recipients of CAC services, only one (1) of the child participants was a boy. Additionally, only two (2) males participated in the interviews were parents. Therefore, the research did not benefit from a gender balance to sufficiently explore the views of boys and girls.

Action research is learning in action. Consequently, as data is gathered and analyzed, ideally, it is implemented and observed to determine if further investigation is required. The duration of the research did not afford the research team to test the findings.

Funding constraints did not allow the research team to expand the sample to other Regions. The research was focused on two Regions: Regions 5 and 6. Therefore, data was not gathered from more populated Regions such as Region 4, where the majority of cases originate.



Chapter 4:

Presentation of Findings

Key findings from the data are presented in this chapter. Data was captured through an interview schedule with children who were victims of child sexual abuse and also from their parents, a focus group discussion with CAC trauma counsellors and a questionnaire completed by trauma counsellors.

The findings sought to reflect the thoughts, feelings, and perspectives of the participants on their shared experiences with minimal imposition of the researcher's opinions. Consequently, direct quotes from the participants were used liberally in this chapter to authenticate and confirm that themes and conclusions that are presented fully reflect the views of the research participants.

4.1 Research Question 1: What are the key factors in therapeutic intervention using the trauma focused cognitive behavioural therapy that could bring about a positive change among children in their context – family, community, and school?

To answer question 1 children were asked to identify positive changes that they experienced in the context of their school, community, and family that they ascribe to the therapeutic interventions they received from the CAC. Children were also asked to explore their perception of self after the abuse occurred but prior to commencing TF-CBT in comparison or in contrast to their perception of self after commencing TF-CBT. Children also identified counselling sessions that were seminal in contributing to the positive change in their lives.

Parents were asked to share their observation on their child's perception of self after the abuse and prior to commencing counselling in comparison or contrast to their child's perception of themselves after they commenced counselling. Parents also shared their opinion on factors that contributed to the positive change they observed in their child.

First, we will identify key factors in the therapeutic intervention that contributed to positive change in children who received TF-CBT. CAC counsellors shared objectives and activities of each TF-CBT module and expounded on their observations of the modules on the child's healing process. Key factors in therapeutic interventions, specifically TF-CBT, were assessed based on the response of children and counsellors commenting on modules, subtopics and learnings from the sessions that contributed to positive changes in the children. Children specifically commented on sessions and



activities that they found most impactful and helped them to identify and share feelings that they could not otherwise do. Counsellors reflected on sessions with TF-CBT clients and shared their observations on clients' improvement as the sessions progressed. In the section below, we will explore the themes that were identified from the responses.

4.1.1 Key factors in therapeutic interventions contributing to positive change children

The section below will provide findings from the data that highlight and expound on key contributing factors of TF-CBT that contributes to positive change in children. The facilitation of TF-CBT provides children with a wide array of knowledge and skills that strengthens children's capacity to manage their thoughts, feelings and actions. Parents were also engaged to facilitate healing and strengthening family bonds that may have been damaged due to the trauma the child has experienced which led to challenging behaviours in the child's life. Children also learned to label emotions, especially toxic ones, and strategies to address environmental stimuli that may trigger trauma in the child. Most importantly, children learned to identify 'red flags' that can potentially lead to sexual abuse, thereby strengthening their capacity to prevent reoccurrence of CSA and to help children understand that the abuse was not their fault.

4.1.1.1 Defining child sexual abuse and shifting the blame from the child to the perpetrator

Children were asked to identify activities that were impactful in their progression throughout their TF-CBT sessions. Some children listed sessions spanning several modules, with the majority (17 or 85%) identifying the first TF-CBT chapter on psychoeducation. The psychoeducation module of the TF-CBT model focuses on sex education and risk reduction strategies. Child respondent R6WMC04 stated "psychoeducation (was most impactful) where we discussed the different types of abuse (drug, verbal and sexual abuse). I was able to know which one was which and how I can better protect myself when I would have seen signs of these in my life". Respondent R6WMC04's response indicates that prior to the TF-CBT sessions, he was not aware of the different types of abuse, and clearly the child did not know how to protect himself prior to participating in TF-CBT sessions. Therefore, the lack of knowledge and understanding of abuse places children at risk of abuse and re-victimization.

CAC trauma counsellors concurred that some children do not understand what constitutes child abuse and what are 'red flags' or inappropriate behaviours exhibited by perpetrators that may lead to child sexual abuse and this places them at risk. "For some (children) this is like an epiphany" counsellor R6WM01 stated "some children would say this happened to me before but I never thought it was abuse... I thought it was normal". Counsellor R5FW02 reiterated the vulnerability of children who cannot identify 'red flags': "Most children, they cannot identify red flags. One child told me the



bus driver used to look at me through the rear-view mirror. So, if they can identify ‘red flags’ most abuse can be prevented”. From the perspective of the trauma counsellors, children feel a sense of empowerment when they are equipped with knowledge about abuse, when they can identify red flags and when they are cognizant of risk reduction or prevention strategies. Counsellor R5FW02 stated “... (children engaged in TF-CBT) are happy for this topic (psychoeducation) because they are now able to identify red flags and know what to do next time, when these things come up”. The importance of the child’s knowledge of risk reduction strategies is important to the child exhibiting positive changes. This point was made evident by parent R6WMP02 who was commenting on the observed changes she noticed in her child: “...she is slowly moving away from being so scared. She is getting to be a little more brave... she views herself more independently. She has changed and know to protect herself”.

Victim blaming is a significant barrier to CSA victims’ progress and is very prevalent in communities in Guyana. Trauma counsellors noted children blame themselves for the abuse and this can possibly be attributed to, with the exception of perpetrators, parents, peers and community members. Parent R6SLP03 suggested this point stating, “...people in the community was spreading rumors about her. She is the victim but treated like the perpetrator”. Child respondent R5FWC01 noted community members’ comments to her and her family, “... (neighbours) would throw hints at us. Example, (they would say) is money dem want from the boy”. Children then blamed themselves for the abuse and perceived self negatively. Child respondent R5FWC03 stated, “I saw myself as a bad person because I thought I give away myself just like that – easily”. It is therefore imperative that children understand that the abuse was not their fault – and that the child understands that it is the perpetrator, who is usually an adult, who must assume responsibility for the abuse. This can begin the process of children’s improved perception of self, and by extension their self-esteem. Trauma counsellor R6WM02 stated “I think parents at home blame (children). So (in psychoeducation sessions) children come to understand that (the abuse) was not their fault”.

As the child begins to understand that the abuse was not their fault, they must also understand that abuse can happen to anyone. Further, the child should not believe that the abuse should hinder them from giving up on their goals and aspirations. Psychoeducation provides opportunities for the child and the counsellor to engage in rich, therapeutic discussions about resiliency and hope. Counsellor R5FW01 stated “When we ask (children) ‘who can be abused?’ We go on and give them examples of celebrities who were abused, (such as) Oprah and Gabrielle Union and... look how they turned out successful”. For the child, knowledge of what abuse is, red flags, and knowing that individuals can experience abuse and still achieve success, contributes to some extent, to initiating renewed self-esteem and a renewed, healthy perception of self.



4.1.1.2 Understanding the child's perspective

As stated in the previous section, the psychoeducation sessions provide opportunities for rich discussions. This helps the trauma counsellors to gather information and strengthen their understanding about some of the prevailing issues and misconceptions the child may have. Counsellor R5FW01 stated “You get more of the interaction (during the psychoeducation sessions). You understand more of the way the way the child perceives and think about things...” Counsellor R6FW01 added, “...with these topics (psychoeducation) children get to express themselves. They get answers to these unanswered questions... especially in my (Region) there is this (taboo) about asking about sex so this is the avenue where they can ask questions and talk about these topics”. Attaining this information is critical to initiating positive change in children. Counsellors noted that most children come to the CACs with many misinformed conceptions about certain issues that will prevent positive change – some of the misinformation children harbor was planted by perpetrator while sexually grooming the child. Counsellors noted that it is important that they first understand the child's perspective on relevant issues and then misinformation can be corrected to achieve positive change. Counsellor R6FW02 stated, “When you (address) that misinterpretation, you allow them to see clearly”.

ChildLinK utilizes the client-centered approach, which recognizes that children know what is best for them. The counsellors' role is to present options to the child and support the child to understand the potential consequences of certain decisions. Therefore, understanding the child's perspective on issues relevant to the abuse is important information that the counsellor needs to develop their strategy to support the child's healing. The rich discussions that result from the psychoeducation sessions is an important contributing factor that aids this process.

4.1.1.3 Teaching stress management techniques to strengthen child's coping capacity

One of the key factors in therapeutic interventions that could contribute to a positive change among children in various contexts is the child's capacity to manage PTSD symptoms and trauma triggers. While the child may perceive the CAC as a safe space where they can express their feelings and ask questions, she/he will inevitably encounter trauma triggers in their home, community, or school environment as they go about their day-to-day routines. Children indicated the abuse hindered their ability to focus on their schoolwork, while some indicated that they lost interest in school altogether. Eighty-five (85) percent of parents indicated that their child's academic performance regressed after the abuse.

When children were asked what things they thought about most after the abuse but prior to commencing counselling, only three (3) or 15% of the child respondents indicated



that their thoughts were not preoccupied by the abuse. Other child respondents indicated that memories of the abuse and other external triggers adversely impacted their thoughts. “What used to stress me out a lot was seeing that person face” child respondent R6WMC03 said “he was always there and I just wanted to leave this world”. Another child respondent R6WMC07 stated “I thought about the abuse all the time...I was scared. I didn’t want to go anywhere. I was even afraid to go to school”. Child respondent R6WMC01 commented on the impact of the abuse on her future aspirations: “I wanted to be independent but did not feel I could achieve my goals because of my experience...” Four (4) children indicated that the abuse caused them to think consistently about suicide. “I does feel like killing myself and every time I remember the story” child respondent R5FWC03 stated “I does be cutting up my hand and I did drink kero³. I wasn’t feeling to go back to school”.

For children to progress and achieve positive change, it is imperative that they are taught stress management techniques to cope with the triggers that were mentioned earlier. The stress management techniques include thought stopping techniques, deep breathing exercises, and relaxation exercises. Counsellor R6WM01 commented on the positive change children experience due to their knowledge of stress management techniques: “...when the parents come to the sessions, the parents would say ‘Miss, you know this child wetting the bed or this child is scared. You have to leave the lights on. But after this session (on stress management) we could cut off the lights. She’s not scared. She’s not afraid to (use public transportation) by herself”. Children, according to counsellor R6WM01, “...can come back to some sense of normalcy” because they are equipped with knowledge to safely confront trauma triggers. Children expressed a small sense of victory because they were either able to resume normal activities such as going to school or leaving their home to traverse in the community or focus more on their schoolwork. This gave them a renewed sense of hope that they can resume pursuing the dreams. Child respondent R6WMC01 summed up the progress of many children when stated “I perform better because I don’t have to constantly be worried and scared because I am at a better place”.

4.1.1.4 Labelling emotions

Child sexual abuse arouses a range of emotions in children. Twenty (20) percent of parents indicated that their child exhibited bouts of anger directed at either their siblings or at them – the parents. When asked how they dealt with their emotions after the abuse but before they commenced TF-CBT, 12 or 60% of the child participants stated that they cried. There were more complex and intense emotions that caused children to cry. In response to this question, child respondent R6SLC06 stated, “I cried. I felt like leaving the home or think of ways to break my hands. Every time I was angry about something, I would look for something to cut my hand. When I see blood, I would stop cry”. Children were confused about the multitude of emotions they felt, and



this impacted their engagements with family members and others in their social circle. According to child respondent R6FWC07, “I would cry about everything and when I was too angry, I would pick fights with my younger brother. I would scream and be very rude to my mother and older sister”. One child, respondent R5FWC06, gave a response that summed up the complexity of the many emotions children felt, “Deep inside of me, I was broken into millions of pieces, but I keep it up with a smile. When people talk to me, I don’t show it”.

Trauma counsellors commented on the fact that children who endured abuse struggled to identify those feelings. According to counsellor R5FW01 “For some children, they can’t really label their feelings... They would just say ‘Miss, I don’t even know (what I am feeling)”. Counsellor R6WM02 elaborated on this point, “(We) help (children) to understand different feelings. Going through the actual abuse, they might not be able to identify them... We are trying to modulate the different feelings that are linked to the abuse”.

The child’s capacity to label their emotions is an important contributing factor to positive change in TF-CBT. Counsellor R5FW01 suggests “When (children) can identify how (they) are feeling, (we) can work on those feelings (with them)”. Counsellor R6WM02 further elaborated “Children would say, ‘Miss I am angry’. I tell them, ‘you were right to be angry. This was not something that should have been done to you. But let us work on this anger because it is not healthy”.

It is therefore evident that, for the TF-CBT to be effective, children must learn to identify and categorize their feelings to effectuate positive change in the child’s family, school and community context. This will allow the trauma counsellor and the child to work on any ensuing negative emotions. According to counsellor R6WM02 “How we deal with emotions determine how we (behave)”.

4.1.1.5 Understanding the relationship between thoughts, feelings, and actions.

Child sexual abuse cases in Guyana are generally reported several months or years after the initial abuse. In the interim, children may disclose the abuse to several persons in their social circle such as a parent, a relative or a friend. Consequently, children and sometimes the parents, may receive misinformation which is internalized by the child and adversely affects their emotional wellbeing and cognition. According to trauma counsellor R6WM02, “Sometimes parents and children come to the (CAC) with feelings and thoughts that are not helpful or inaccurate. And beliefs too”. These inaccurate thoughts and beliefs have an adverse cyclical effect on their thoughts, feelings, and actions. Trauma counsellors utilize trauma interventions to guide children and help

3. *Kero* is shortened word in Guyanese vernacular for kerosene



them to recognize the interconnectivity between their thoughts, feelings, and actions. “When (children) can pinpoint their feelings when a particular thought comes to their mind” Counsellor R5FW01 commented “they can then see how it contributes to their actions or behaviour. What comes to mind when I have these feelings? And how do I behave?” Understanding the interconnectivity between thoughts, feelings and actions equips children with the knowledge and skills to modulate their feelings and utilize thought stopping techniques to control their thoughts and consequently have greater control over their actions.

When children are equipped with knowledge on the interconnectivity between thoughts, feelings and actions in addition to the skills that helps them to identify thoughts and emotions, they can better understand that “the abuse doesn’t define me... and stand in the way of me (achieving my career aspirations)” according to counsellor R6WM01. This renewed sense of hope for the future consequently strengthens the child’s perception of self. Ninety (90) percent of the child respondents indicated that they have a positive perception of self after commencing TF-CBT at the CAC. This improved perception of self translates into positive actions and improved relationships. Twelve (12) of 14 children or 86% indicated that their academic performance has improved after commencing TF-CBT. “I am performing well” child respondent R6WMC02 commented when asked how she is performing at school after commencing TF-CBT “I pay more attention to my books as I realize that in order to achieve my dreams I need to study”.

4.1.1.6 Understanding the magnitude of the abuse and releasing toxic thoughts and emotions

Children engaged in TF-CBT complete a trauma narrative with the support of the counsellor. The trauma narrative is a detailed account of the abuse that is written by the child in their own words, and it can be done in the form of an essay, a poem or a song. It is detailed in the sense that it goes beyond stating the facts of the matter. Children capitalize on their learnings from previous sessions on identifying feelings and thoughts to give an emotional and expressive account of the event in writing. “They (the CSA victims) are putting their thoughts, feelings, and everything into what happened” counsellor R6WM01 stated “they are putting all of their emotions into this account - the scent, what the child heard. When you read the trauma narrative you should be able to be at that place where the abuse occurred... they are letting it all out – (all of the toxic emotions they experienced because of the abuse). You are actually getting it all out of your system”. To realize and sustain positive change through the trauma intervention, the child must confront the issue in the totality of its ‘ugliness’ so that all negative emotions and thoughts associated with the abuse can be identified and subsequently dealt with as opposed to being repressed and surfacing sometime in the future which can re-induce the trauma. “They (CSA victims) get to confront the event with feelings” counsellor R5FW01 stated “it (reveals the extent of) the impact (the abuse) had on (the



victim). When you can actually write it for yourself and read it back for yourself, they (the victims) get a sense of, ‘this is what actually happened to me’”.

There is tremendous value in the child ‘identifying and letting out the toxicity’ of emotions and thoughts associated with the abuse and subsequently addressing those issues. According to counsellor R5FW01, “It helps the child reduce avoidances in cues and with imagery associated with the abuse”. This is followed by the in vivo chapter in the TF-CBT model. In the in vivo sessions, the counsellor guides the child in addressing all toxic thoughts and feelings that were identified in the trauma narration sessions. “(Through completing the trauma narrative) you help (the victims) to understand that...we can get through this. So that (the trauma cues) that would tick them off and get them to have nightmares wouldn’t affect them that much” counsellor R6WM02 stated “(through the in vivo sessions) you are bringing them back to a sense of normalcy”.

Confronting the abuse, in this safe and child friendly manner and identifying and addressing all toxic thoughts and emotions associated with the abuse will strengthen the child’s capacity to confront subsequent and inevitable cues to sustain positive change so that the child can achieve their potential.

4.1.1.7 Rebuilding trust, communication and openness between the child and the parent

Parental support is an important factor in TF-CBT, for the realization of positive change in the child. TF-CBT allows for a parenting session on each chapter to be facilitated by the counsellor with the parent so that the parent can be apprised of the techniques that the child is exposed to under the TF-CBT. Additionally, the sessions with the parent are designed to prepare her/him for the conjoint parenting chapter.

The conjoint parenting session is a face-to-face session with the child and parent that is facilitated by the counsellor. This session allows for critical and cathartic discussions between the parent and child that usually repairs or strengthens the bond between the parent and child. In this session, the child reads the trauma narrative – the detailed emotional account of the abuse – to the parent. This, in some cases, results in an apology from the parent that marks the beginning of a “fresh start” for the parent – child relationship. “The child actually gets to hear (the words) ‘I’m sorry’ from the parent” Counsellor R6SL01 commented “That is shocking for some children. It is the first time some have heard their parent apologize”. Counsellors noted that in some cases, the parents recognize their actions or inaction contributed, in some way to the abuse. They acknowledge this and make a commitment to improve their parenting style. According to counsellor R6SL01 “The parent, even if they started out in denial, they are no longer in denial. They take responsibility. They understand that (they) had some part to play in this... They are able to acknowledge that mistakes have been made and things could have been done differently. But they commit to parent differently now”.



When asked, what was helpful in the counselling sessions, child respondent R6WMC04 said, "... (the) parenting sessions where I was able to communicate free and openly with my mother and talk about my feelings. That helped me a lot because now I feel we have a better relationship". Another child respondent, R6WMC03 stated that her "...mother also being part of the counselling..." was helpful to her.

According to the child respondents 16 of 20 or 80% of children reported that their relationship has improved with their parents. This data further confirms the importance of the parent and by extension, an active support system, is an important factor in TF-CBT for the realization of positive change among CSA victims.

4.1.2 Positive changes experienced by children in the context of their family, community, and school

This section focuses on the perception of children and parents as they explore the child's experiences after the incidence of the abuse but before the child commenced counselling and after the child commenced counselling. This was done to identify if there were any positive changes experienced by the child and the wider family to determine if TF-CBT can be attributed to these positive changes.

4.1.2.1 After the abuse but before counselling – The perspective of the child

Every child participant in the study was assessed using the post-traumatic stress disorder rating scale prior to commencing TF-CBT. The average pre-counselling score was 26 which falls in the range of moderately severe trauma. Despite the trauma they experienced which resulted from the abuse, it is interesting that some children still maintained a positive perception of self. With respect to children's perception of themselves after the abuse occurred but before they commenced counselling, 5 or 25% of the child respondents indicated that they had a positive perception of self. These respondents identified their interactions with their family members, which was positive despite the abuse, as an indicator of a positive perception of self. One (1) of the five (5) children, R6SLC03, stated, "I was a well-behaved child, who is very respectful at home..." Another child, R6SL06, stated, "I was always a daddy's girl...I saw myself as someone good and loving."

Most of the child respondents – 15 or 75% - indicated that they had a negative perception of self after the abuse but prior to commencing TF-CBT. The children experienced a variety of strong, negative emotions that adversely affected their sense of value and self-worth. Some children blamed themselves and felt that they were the ones responsible for the abuse. Child respondent R5FWC03, a 15-year-old female, stated, "I saw myself as a bad person because I thought I give away myself just like that – easily". Another child respondent, R6WMC01 stated, "I dislike what was happening to me, but I still blamed myself for it. I felt I was responsible for what happened to me".



Some children indicated a strong sense of hatred towards self as well as low self-confidence and self-esteem. Child respondent R6WMC06 stated, “I hated and blamed myself. I was always sad and cried a lot. My confidence and self-esteem was low”. Another child, R5FWC01, described herself as “...a horrible person...” Child respondent R6FWC03’s self-esteem was adversely affected to the extent that she stated “I felt like nothing. I wanted to commit suicide because I felt there was nothing else that can be done for me”.

There was a strong sense of shame felt by respondents and the reasons varied. Child respondent R6WMC02 felt a sense of shame because individuals who were aware that she was a victim of abuse, asked her questions about the abuse. The child perceived these questions as insinuations that she was at fault. The child stated: “I feel bad and shame because people asking me about the incident as if it was my fault”. Another child R5FWC02 had a negative perception of self, due to the shame she felt, because “...I was studying⁴ if people were laughing me.”

4.1.2.2 After the abuse but before the counselling – the perspective of the parent

Every parent respondent (100%) believed that their child had a negative perception of self. Parents observed symptoms of post-traumatic stress and emotional changes exhibited by their child and concluded that their child had a negative perception of self.

Fear was a term used by 20% of the parents to describe their observation of their child’s behavior after the abuse but before commencing TF-CBT and they interpreted the fear exhibited by their child as a negative perception of self. According to one parent, R6WMP01, her child was “...very scared. Her body shook and she was always afraid”. Children attempted to cope with their fear by isolating themselves from the community and family. From the child’s perspective, anyone was a threat to their safety. Parent R6WMP02 commented, “She was very scared, she just locked herself up in her room... it was like she was always scared of everyone”. Another parent, R6WMP07, stated: “... before the incident (abuse) my daughter used to go by her grandmother who lived right next door and did not want company to go there... (after the abuse) she was scared to go out the yard and even to visit her grandmother who lived just next door. She use to say “No, I ain’t want go because people may carry me away again”. In this particular case, the child was abducted by a taxi driver while she was going on an errand to a shop in her community. At the time of the incident, the child was under 10 years old. The driver of the taxi forced the child into his car, held a weapon against her and threatened to kill her if she said anything. The child was understandably terrified and remained silent as the driver proceeded along the road, picking up passengers. The driver sexually assaulted the child even while other passengers were in the car. In this incident, the child was traumatized by her abduction and the sexual violence perpetrated against her.

In many cases, the perpetrator was still at large even after the child had commenced



TF-CBT. This was a source of fear and stress for children, especially prior to the child commencing TF-CBT. This fear was further compounded by the social pressure the child and family faced from community members who were opposed to the child's family pursuing the prosecution of the perpetrator. Parent R6SLP03 stated, "...people in the community were spreading rumors about her. She is the victim but treated like the perpetrator. She was scared because anytime she see the perpetrator she would be very tense".

Twenty (20) percent of parents perceived the level of stress their child experienced was stimulated by the abuse which suggest to them that their child had a negative perception of self. Some children either stopped eating and one parent observed that her child lost a lot of weight. "She was in distress", parent R6SLP01 noted "(She) lose a lot of weight. It was hard on her and the family". Other children coped with the stress by isolating themselves from family members and members of the community. Parent R6WMP05 noted, "She was stressed out. She kept to herself. She blames herself. Anything she heard would make her cry. She had no control of herself or emotions".

Anger was an indicator for 20% of the parents that their children had a negative perception of self. The parents stated that their child would experience anger and "lash out" at their siblings and other members of the family, including the parents. This, in some instances, resulted in a strain in the parent – child relationship. Parents, prior to being engaged by the CAC, interpreted the child's anger as "rude behaviour". A few parents used strong terms to express their view of their child's anger suggesting that they were strongly impacted by the post-traumatic stress related anger exhibited by their children. "She was very angry and disrespectful to her siblings" parent R6SLP02 stated. "(It was) hard to talk to her and (she was) very spiteful". Parent R6WMP04 suggested that her son's anger affected his view of how others felt about him, which in turn, from the point of view of the parent, affected the way he related to her and his brother. "He felt hated and uncared for" the parent opined "He...became very disrespectful towards me and his brother".

4.1.2.3 Perception of self after commencing TF-CBT – the perspective of the child

Children's perception of self, changed significantly as result of receiving TF-CBT. Most of the children (90%) indicated a positive change – they articulated how they perceived themselves with terms such as "good", "different" and "better". Two (2) or 10% of the child respondents still viewed self as negative even after commencing counselling.

Child respondent R6SLC05 stated that she is still exhibiting anger issues. "I just would have outburst and would just go away by other family members. I am sure (its) depending

4. *Studying is Guyanese vernacular meaning 'wondering' or 'thinking'.*



on what's happening at home". In this incident, the child was under 12 years old, when she was sexually groomed by a young adult male. The child was misled to believe that the perpetrator loved her and subsequently, the child's mother observed physical marks on her child that suggested the child was involved in sexual activities. The child's mother allowed her to wear revealing clothing. Additionally, the child was allowed to go to bars and consume alcohol. Neighbours were cognizant of the sexual grooming between the child and the young adult, and the child was labelled by community members as a sexually promiscuous. Several arguments ensued between neighbours and the child's mother after the abuse. Consequently, the child mother would severely verbally abuse her. The child would retaliate against her mother's verbal assault resulting in intense and brutal verbal confrontations. This suggests that her home environment is a contributing factor to her challenges with her anger. When asked what her relationship with her parents is like, this respondent stated, "We don't have a relationship, my parents don't show that they care for me". The second child, respondent R6SLC06, who still had a negative perception of self, referred to herself as "hard ears"⁵ and "strong headed". These are terms that adults use to refer to children who they perceive as disobedient. This respondent, when asked what her relationship with her parents is like now, stated, "I don't have a good relationship with either of my parents". This suggests that parents are integral to achieving positive and sustainable changes in the life of the child. In fact, one child who stated that she now has a positive perception of self, suggested that a change in her environment – moving from her parents to live with her grandmother – was a contributing factor to her positive changes. According to this respondent, "(I am) far better than what I was. Back then my mom did not listen to me. Now my grandma would sit and explain and give better advice. In my parents' house there was no communication, no cooperation nor respect. By grandma there is love, communication, cooperation, and respect".

Other children spoke about feeling like a "better" person. The abuse contributed to children experiencing a strong sense of guilt and assuming responsibility for the abuse to the extent that many children questioned if they were a "good person". It is clear that social interactions with family members and community members contributed to the guilt, shame, and self-loathing. That is, prior to commencing in TF-CBT, it is likely that adults who had knowledge of the abuse, directed remarks insinuating that the child was to be blamed for the abuse, thereby, contributing to the child developing a sense of guilt and shame and thinking of self as "a bad person". Children articulated the change in their perception of self, using the phrases such as:

- "I know I am somebody good."
- "I see myself as a good person".
- "I see myself as a more better person..."



- “I see myself as a good person, a good daughter...”
- “(I see myself) as a better individual...”
- “I feel good about myself and more pretty...”

Children who had a better perception of self, also articulated that they have a renewed self- confidence and a renewed sense of optimism for the future. Children expressed fears that the abuse clouded their optimism and many questioned if they could ever achieve their dreams prior to commencing TF-CBT at the CACs. However, the TF-CBT interventions rekindled their confidence and optimism for the present and the future. Child respondent R6WMC03 articulated this renewed optimism and hope for the future when she said, “(I see myself as) a very happy, excited and better person, who can do anything”. Another child respondent, R5FWC05, stated, “I feel confident about myself. I perceive myself as a mechanical engineer”.

Two (2) children stated that they had renewed sense of courage. Earlier in this section, child respondents expressed a strong sense of fear due to the abuse. However, due to the TF-CBT sessions, these children regained the courage they previously had. Child respondent R6SLC02 stated, “I am much more outgoing and brave”.

4.1.2.4 Perception of self after the counselling – the perspective of the parent

Parents generally, believed their child has a better perception of self, because of the trauma intervention. Nineteen (19) or 95% of the parents stated that they observed positive behavioural and attitudinal changes in their child and interpreted this as their child’s improved perception of self. Some parents observed that their child was becoming more like their “old self” again, and this was interpreted as a positive development. In articulating this, parent R6WMP03 commented, “She is now able to see herself once again as the person she was before - no more anger issues. She is in more control of her emotions. She’s more happy”. Other parents believed, their child’s renewed optimism for the future as an indicator of their child’s positive perception of self. R5FWP05 stated, “She is back in school. She stop stress. She get over all these things. She see a bright future for herself. She said she wants to become a mechanical engineer”. Another parent, R6WMP04, stated, “Well now he’s more different. He is where he should be in life. Even in school now he wants to be a role model to the younger children... His view of himself is much better now”.

Other parents interpreted their child’s courage as an indicator of a changed perception of self. “Now she is much braver since coming to counselling” R6WMP05 commented “She’s much different, she talks more and can stand up for herself. She has regained

5. ‘Hard ears’ is Guyanese creole vernacular meaning “unwilling to listen”



that control”. Parents noted their children now have the courage to do routine things, such as travelling by themselves, and they perceive this as an indicator of an improved perception of self. It should be noted that the child’s courage in some cases was adversely impacted by seeing the perpetrator. Parent R6WMP07 noted that her child was travelling with her sister and embarked a taxi which the perpetrator operates. The child was afraid and held on to her sister, who accompanied her, “tightly”.

The child’s happiness and demonstration of other positive emotions was, for some parents, an indicator that their child has a positive view of self. “She is very happy” parent R5FWP02 said “(She is) brave. She is not studying the past. She is better now”. Parents believed, based on their observation of their child’s behaviour that the trauma caused by the abuse is “in the past”.

4.1.2.5 Positive changes in the context of family – the perspective of the child

The parent - child relationship improved in 16 of the 20 or 80% of the families due to the child’s participation in the TF-CBT according to the child participants. Prior to the family accessing the services of the CACs after the abuse, only 11 or 55% of child respondents stated that they had a good or healthy relationship with at least one non-offending parent. In some cases, prior to attending TF-CBT, parents had a strong and violent reaction to news of the abuse. Child respondent R5FWC03 stated, “They were crazy because they beat me up especially my mother. She start beat me just like that. My father slap me the next day”. In a few cases, children recalled that their parents were angry when they found out about the abuse and consequently became verbally and emotionally abusive. These parents engaged in victim blaming – blaming the child for the abuse. This weakened the parent – child relationship. Child respondent R6WMC06 described her relationship with her parents as “...not really good. We didn’t get along because they blamed me for the incident”. Another child, R5FWC05 described her relationship with one non-offending parent as “Terrible. My father didn’t treat me different but my mother prevented me from going out and mommy would raise the story up a lot”. In some homes, the parent – child relationship was poor due to limited and poor-quality communication. To articulate the limited/poor communication in the home, children provided responses such as:

- “We were not really talking. We just lived in the same house”.
- “There was no cooperation or communication in my home”.
- “We didn’t used to talk”.

One (1) child described their relationship with their parent as “good” but with “ups and downs” while another child described her relationship with her parents as “50/50”. In some cases, children noted that their parents were very understanding, supportive and non-judgmental. “It was good” child respondent R5FWC04 commented. “We were



talking. They were asking me if I am ok”.

From the perspective of the children, the parent – child relationship improved because there was more open communication which was attributed to the TF-CBT. Children felt confident and comfortable approaching their parents to initiate conversations about their concerns. The children felt that their parents would listen and attempt to understand their point of view and concerns. Children also noted that there was more happiness involved in their communication with their parents. They felt loved. Child respondent R6SLC02 described her relationship with her parents after commencing TF-CBT as “...more loving. We communicate better now”. Another child respondent, R6SLC03, commenting on the communication with her non- offending parent, stated “I talk to my mother about everything and we are very close”. Child respondent R6WMC07 stated that the TF-CBT helped her to realize that she should develop a relationship with her father. The child stated, “My relationship with my mother is good. It’s always been good but now I listen and obey her more. Since I started counselling, I have started forming a relationship with my father and it is going good”.

The performance of household chores was a source of conflict between parents and children. Six (6) children or 30% of the child respondents indicated that they struggled to complete household chores, prior to commencing TF-CBT, because they were unable to focus on tasks assigned to them. Children experienced post-traumatic stress symptoms such as flashbacks and emotional changes which hindered their capacity to focus on tasks they were assigned. When asked how they completed their chores after the abuse but prior to commencing TF-CBT, respondent R6WMC05 stated, “It was hard to concentrate as all I could think about was what happened”. “I used to do it (chores) slowly” respondent R5FWC02 commented, “because I was stressing”. Respondent R5FWC07’s response was, “I used to do some (chores) and sit down and gaze and catch myself⁶ and do some again”.

Children indicated that TF-CBT helped them to focus more on household chores that they were assigned, and this resulted in less conflict in the home as well as improved parent – child relationship. “I am more focused now. I do my chores and anything else mommy and my sister tell me to do without arguing” R6WMC07 stated. Another child, R5FWC02, stated, “I am feeling better to do housework...since coming (to the CAC)”.

4.1.2.6 Positive changes in the context of the family – the perspective of the parent

Parents were asked to describe their relationship with their child, after the abuse but before engaging the CAC. Only five (5) parents or 25 percent of the parents interviewed for the research indicated that family members had a “good” relationship with the child. While parents believed the relationship was good, there was evidence that the abuse impacted the quality of the relationship between the child and the family members.



Generally, there was less communication between the child and the family as the child isolated himself/herself. Children found it challenging to communicate their feelings and thoughts to the rest of the family. Parent respondent R6WMP02 gave this response: “Our relationship was good but she wouldn’t speak to us about what was going on. She was always crying and saying because of us being poor, people felt they can take advantage of us through her. She kept to herself and didn’t talk to anyone”. Another parent, R5FWP04, admitted indirectly that, that while the family supported the child, there was less communication in the home. The child would isolate herself from the family by retreating to her room where she usually spent more time sleeping. According to this parent, “The family was traumatized, but we accept her and she accepts the support. We still have a good relationship. Most of the time she will sleep”. This parent, in responding to another question, stated that the child started sleeping more after the abuse, which is unusual behaviour for the child. Parent respondent R6WMP06, who described the relationship between the child and the remainder of the family as “good” provided additional responses that brought this conclusion into question. This parent stated, “...her father like he don’t give her no attention. Her brother used to argue with her so she don’t really have anyone. Sometimes I would try talk to her and like it go in one ears and come out the other”. This response suggests that there was a breakdown in the relationship between the child and family members – there were arguments and the child, according to the mother, was unresponsive in their conversations. In one case, it was unclear the extent to which the poor relationship between the child and the rest of the family was as a result of the abuse or the prevailing domestic and family violence within the home. According to this parent, respondent R6SLP04, “We use to catch case (quarrel) over her attitude towards her siblings. She used to be angry with her father after everything broke up because he was abusive and when he get drunk he would insult her”.

In the remaining 75% of the cases, there was a poor relationship between the child and the parent, after the incident but prior to the commencement of TF-CBT. Generally, parents were concerned about behaviour they described as aggressive, and they also referred to the child’s tendency to withdraw from engaging the remainder of the family. According to respondent R6WMP03, “Before she thought nobody loved her. She handle everyone poorly and harsh. She lashed out at everyone and would speak to everyone in our home including me in a very rude manner”. Another parent, R6SLP02, stated, “She was very stubborn and would pick on her younger siblings, she wouldn’t listen and would lash out giving rudeness”. In describing her child’s tendency to withdraw from the family, respondent R6WMP07 stated, “After the incident and before the counseling she just be by herself. She didn’t use to dwell with anybody. She kept to herself. Whenever you ask her a question, she would appear lost and disoriented like she would just stare blankly when nothing in front of her...”

6. *Guyanese vernacular meaning ‘snap back to reality’.*



Most parents – 19 or 95% - stated that the TF-CBT contributed to an improved relationship between the child and the remainder of the family. Parents generally commented that there is more open communication and family interactions are described as more loving. Parents observed that the child is more engaging with the family and more helpful at home. Respondent R6WMP02 stated, “Since coming to counseling we are closer, more loving. She is much more respectful and help around the family. She is more open and responsive, and we are learning to communicate more as a family”. R6WMP04 stated that, in addition to the improved communication, there is more honesty between her and her child. “There is great improvement in the family. He is more cooperative, mannerly and helpful. We communicate better as a family and we are more open and honest with each other”. Another family’s relationship has strengthened to the extent that they are more resilient – they have a healthy relationship despite financial struggles. According to respondent R6WMP03, “The relationship is good. We have more open communication within the family. We talk about everything. While we are struggling financially... she does help out a lot in the home.”

4.1.2.7 Positive changes in the context of school – the perspective of the child

Six (6) or 30% of the child respondents indicated that they were no longer attending school. This was mainly due to COVID-19 induced school closures. In one (1) case, the child indicated that she recently completed her secondary studies. The children were asked to describe how they coped with school after the incident but before commencing TF-CBT. Six (6) or 30% indicated that they were struggling in school because it was difficult to concentrate on their studies due to them experiencing regular flashbacks of the abuse. Respondent R6WMC01 stated, “I... could not concentrate much as the problem kept coming to my mind”. Another child, R6WMC03 responded, “It was bad, very bad to be honest... I failed the entire third form and I didn’t care”. A third child respondent, R5FWC04 stated, “I used to try and focus in school. The thought always used to come to me. I used to be loss and (my teacher) used to ask me what`s wrong, but I never tell her”. There were children who stated that their studies were not adversely affected by the abuse. Six (6) or 30% of the child respondents stated that they were either performing well in school after the abuse or their performance was “normal” or “okay”.

Twelve (12) of the 14 children or 86% who were still attending school stated that their academic performance either improved or that they are completing all their assignments after commencing TF-CBT. Primarily, children indicated that they think less about the abuse and can therefore, focus on their studies. Respondent R6WMC01 stated, “I perform better because I don’t have to constantly be worried and scared because I am at a better place”. Another child, R6WMC03, stated, “I have improved a lot in my schoolwork, and I know I will do better. I didn’t fail and I have more focus now”. Some children are not only focused on their present academic studies but on their long-term goals, especially with reference to career aspirations. R6WMC05 “I am more focused in my studies and trying to ensure that I achieve my goals for my future”.



4.1.2.8 Positive changes in the context of school - the perspective of the parent

According to the parents, the academic performance of children declined after their initial incidence of abuse but before they commenced TF-CBT. In other cases, some children stopped attending school and engaging online studies - their parents stating COVID-19 social distancing restrictions and financial challenges as the primary reasons. Seventeen (17) or 85% of parents stated that their child's performance either declined or their child stopped participating in online classes due to COVID-19. Respondent R6SLP01 stated the reason her child stopped attending school was a combination of them migrating to a new community and financial challenges. "When we moved to Berbice we didn't have all her papers for school and we can't really afford to send her so she hasn't attended school in a while". Two (2) parents stated their children had already "...dropped out of school" when the initial incidence of abuse occurred. One (1) guardian stated that she was not aware if the child was attending school when the abuse first occurred since the child was not living with her at the time.

Some children initially loved attending school, prior to the first incidence of abuse. After the abuse, they lost interest in attending school. According R6WMP02 "...when school was open she loved school and wanted to make something of herself. However, after this incident she refused to do any schoolwork. She wouldn't attend online classes or do any work teacher sent. She just kept to herself". One child's performance declined to the extent that one of her teachers asked the child if she was being abused. "...her grades were very low" parent respondent R6WMP03 told the interviewer. "The teachers in school saw changes but didn't say anything to us as the parent. One teacher even asked her if she was being abused which she related to me. She had poor attendance with her online classes and even when she was in those classes she didn't want to be there". In one case, where the abuse was known by members of the community, the child's performance declined, and this was compounded by the fact that her classmates teased her about the abuse. Respondent R5FWP01 stated, "She dropped back a little...her relationship with friends was not good. Friends throw words at her but she continued to attend school regularly".

Twelve (12) parents or 85% of the parents of the 14 children still attending school observed their child's renewed enthusiasm about attending school and in some cases, noted an improvement in their child's academic performance after their child commenced TF-CBT. In one case, the parent noted that while the child is not attending school, her interest in schooling and learning remains strong. The child's counsellor provides academic material to support her studies. The parent, R6SLP03, told the interviewer, "...she is not going to school but she reads a lot now and the counsellor does give her material to help her academics which she takes very serious". The children who are attending school have not only showed improved academic performance after commencing TF-CBT, but their relationship with teachers and peers was strengthened. These children are more



motivated to achieve academic and long-term success. One parent, R6WMP04, stated, “There is great improvement in his schoolwork. He is more interested in catching up on his work and improving his grades. He is more motivated. His attendance in school is better. He gets along well with his teachers and classmates”. Another parent observed her child’s work ethic and enthusiasm for learning has improved significantly. Respondent R6WMP07 stated “...she would do out the work the teacher send then message the teacher and ask her for more work to do. She is much more focused”.

4.1.2.9 Positive changes in the context of the community – the perspective of the child

Children were asked to describe the difference in behaviour towards their friends and neighbours after commencing TF-CBT. Most children did not have a good relationship with the community, and in some instances their peers, even after commencing TF-CBT. Only six (6) or 30% of the child respondents indicated that they had a cordial relationship with their neighbours. Sixty-five (65) percent of the child respondents indicated that they have a cordial relationship with their friend(s). In some cases, the bond between the child, their family and the neighbours was strong. Respondent R6WMC07 stated, “We are very close with our neighbours. They are like family”. Another child, R6SLC03, stated, “My neighbor and I are very good. She would call me over and talk to me. Sometimes my mommy and I would go over and spend time with her”. In other cases, children reported that their relationship with their neighbours was relatively cordial, but not close. Some described their relationship with their neighbours as “good” or “normal”. Respondent R6SLC04 stated “...if I see them I would gyaff⁸ with them but I don` t mix too much”.

The child respondents provided several reasons for the lack of interaction at the community level. Two (2) children stated that they “...do not mix”⁹ - it is not clear why this is the case. Similarly, some children indicated that they do not interact with their neighbours but did not provide any reason. “I don’t like my neighbor” R6WMC03 stated matter-of-factly. Another child, R6WMC03, cited COVID-19 for her limited interaction with members of her community: “I don’t really mix up as its COVID time”. In one (1) case, the community was aware of the abuse and this adversely affected the relationship between the child and their family and neighbours. According to child respondent R5FWC01, “... (neighbours) would throw hints at us. Example, (they would say) is money dem want from the boy”. Another child respondent, R5FWC05 indicated that neighbours had knowledge of the abuse. And even after the child commenced TF-CBT, the relationship between the child, her family and the community was adversely affected. The child told the interviewer that her relationship with her neighbours was “not that ok, because they believe that I did it off of my own”. Two (2) child respondents indicated that they live in communities where neighbours are located at a considerable



distance. “We live far away from other houses” R6SLC06 child shared, “so there’s not much interaction with them”. Another child, R5FWC06 told the interviewer, “I don’t really come out the house, there is not a lot of people living in the area”.

Generally, children were able to maintain good relationships with friends. Thirteen (13) or 65% of the child respondents stated they have a cordial relationship with at least one friend. Respondent R6SLC01, who recently moved to Berbice, stated that she “... don’t have any (friends) here”. Respondent R6WMC01 stated that she does not usually interact with members of the community or her peers. However, she is close with her family members. According to this child, “I don’t really go out, so my friends are the ones who live in the house with me”. In one case, it appears the child’s abuse may have been known by some of her peers and consequently, the child’s confidence in friends was adversely affected. Respondent R6WMC02 stated “I only have one friend right now but we don’t really talk as I learnt through this incident that even though persons say they are your friends they do things sometimes that make you doubt their true intention”.

Of the 65% of children who still had a good relationship with friends, some maintained a close relationship with their friends despite the abuse. It is not clear if the friends of these children were cognizant of the abuse. “I have a good relationship with my friends” R6WMC07 stated “we talk about everything”. Another child, R6WMC03 stated, “Things are good and I have more friends now”. In one case, the child respondent R5FWC04 indicated that she maintained a “good” relationship with her friends her friends had no knowledge of the abuse. The child stated, “...they don’t ask anything because they did not know”.

Summary

The data suggests that the facilitation of TF-CBT was effective in contributing to positive changes in the lives of children. Trauma had a significant impact on children’s perception of self which cascaded into a wide range of negative implications for children’s emotional and social well-being. These impacts also had adverse implications for their academic performance and future aspirations.

The shame and guilt children felt, weakened their self-esteem, sense of worth and sense of value. Some children resorted to self-harm to cope with the shame and guilt that they felt. Others exhibited bouts of anger for several reasons – one of which was to attract attention that they wanted. These bouts of anger as well as self-harm and suicide attempts were also a source of conflict in the home. Parents admitted that they were not sure how to address the post-traumatic stress symptoms their child experienced and that the intervention provided by the CACs was instrumental in positive changes exhibited by their children that they, the parents, clearly observed.

8. ‘Gyaff’ is Guyanese vernacular meaning ‘speak’ or ‘converse’.

9. ‘Mix’ is Guyanese vernacular meaning ‘socialize’ or ‘interact’.



Children felt intense emotions that they were unable to identify. The TF-CBT sessions helped the children to label these emotions and therapeutic activities were utilized to help the child to deal with the negative emotions that they experienced. Children were also able to understand the connections between their thoughts, emotions and actions. This was instrumental in them achieving positive behavioural change as they were guided to understand the social harm their actions caused as well as understanding the reason why they exhibited certain behaviours. Importantly, children were also able to understand that negative emotions such as anger were unhealthy coping or defensive mechanisms that could be adjusted.

The data also revealed that children were generally unaware of the different types of abuse and grooming strategies employed by perpetrators. TF-CBT modules provided children with prevention strategies that strengthened their confidence that they are better positioned to prevent re-victimization, giving them a sense of security and safety and renewed their sense of optimism and hope for the future.

The importance of the role of parents in the therapeutic process was another instrument factor that contributed to positive change. It was critical that children and parents resolve differences – and this involved these parents acknowledging making mistakes and committing to improving the parent - child relationship and supporting the child's recovery.

4.2 Research Question 2: What are the factors that contributed /facilitated effectively in the process of casework/therapeutic intervention?

This question provides insights on Counsellors' processes and strategies in their casework. Counsellors provided the step-by-step process they employ to execute their casework and provided their assessment of the effectiveness of their casework processes. The effectiveness of the counsellors' casework process will also be evaluated in comparison to children's responses from their interview schedule.

4.2.1 Rapport building

Establishing rapport between the counsellor and the child is an important factor that contributes to effective casework. Nineteen (19) or 95% of the child respondents indicated that they were either "scared" or "nervous" and one child indicated that she felt "lil shame" at their first session. Several child respondents suggested that they were initially "nervous" feelings inhibited their willingness to "open up" to the counsellor. When asked to describe how they felt at the beginning in the initial session, respondent R6SLC02 stated "I felt nervous. I didn't know whether I should speak about my problem or not". Respondent R6WMC01 responded by stating "...only thing (is) I was nervous and scared to open up..." R5FWC03 stated "It was hard, because I was afraid to talk anything".



Thirteen (13) or 65% of the child respondents indicated that it was either the second or third session that they began to feel comfortable to speak freely with their counsellor. The remaining six (6) or 30% of the child respondents indicated that it took them at least four (4) sessions to feel comfortable speaking to their counsellor freely. One (1) child indicated that she felt comfortable speaking freely to the counsellor from the inception.

After rapport was established, children indicated that they felt comfortable speaking to the counsellor. It is therefore evident, that establishing rapport with the child is a critical first step that establishes trust between the counsellor and the child. This will allow the child to share their thoughts and feelings and build the child's motivation to actively participate in the sessions so that the care-plan objectives can be completed.

4.2.2 Assessments and documentation

Accurate assessments and documentation throughout the entire casework stages are important factors that contribute to effective casework. Assessments provide important information about the child and family that is utilized to develop the child's care-plan, thereby outlining the actions required for casework. A Case Record (CR) 1 form is completed at the initial stages of the casework to collect basic demographic data.

A PTSD rating form and the Rosenberg self-esteem form are administered after the rapport building session to assess the child's self-esteem and level of trauma respectively. The rating on this PTSD scale will determine if the casework requires a client-centered focus or a trauma focused intervention.

The CR 2 form allows the Counsellor to conduct a continuous assessment of the child throughout the sessions. This form covers an array of domains including parenting capacity, child development needs, and the child's capacity for counselling. It is updated periodically throughout the sessions. The CR2 form serves as a monitoring tool to assess the progress of the child and frequent review of the form helps the counsellor to determine if adjustments to the child's care-plan is required. These forms and other narratives that comprise the child's case file are important documents needed for effective case work. Counsellor R5FW02 indicated that data provided in this form provides information about the additional needs and services that the family may have. Hence, with this data the parents can be referred for other services if necessary. Additionally, this data is used to develop the intervention plan for the child. It determines if client centered topics must be incorporated into the trauma modules.

4.2.3 Preparation and flexibility

Preparation and mastery of the content to be facilitated at the various sessions contributes to effective casework. This is especially critical in chapters following psychoeducation. Counsellors stated that psychoeducation usually allows for interactive discussions on sex and related sensitive issues that children felt uncomfortable discussing with their



parents. However, children are less inclined to talk about pain and trauma. Commenting on this in the FGD, counsellor R6WM01 stated “The other modules go straight into the abuse. That’s where (the children) are talking about the trauma and what is happening to them. For many (children), they wouldn’t want to talk about the trauma over and over. With (psychoeducation) topics, it’s where they can express themselves”. Preparation is important because it ensures that the child is engaged in the session’s activities and the child finds the material interesting and relevant to their needs. Counsellors noted that preparation requires reading the child’s case files and the counsellor’s notes from the previous session, prior to the next scheduled session.

Trauma counsellors suggested that casework can be adversely affected if the case plan is adhered to in a rigid manner. A measure of flexibility is required for effective casework. Counsellors indicated that they assess children’s feelings prior to commencing planned activities to identify any potential issues that may need urgent attention. Counsellor R6WM01 stated “(The) client may come to the (CAC) with an issue that needs immediate attention... for this reason planning does not always work because children also deal with different issues at home and (at) school which may or may not be linked to the traumatic event... The counsellor (will) now help the child work through the issue and push back the planned session for another time”. Children indicated that the opportunity to address their immediate issues was important to them and this suggests that it supported the effective casework because they felt valued and felt comfortable sharing in subsequent sessions related to the TF-CBT modules. When asked what activities the counsellor did that made them feel comfortable sharing information that they did not share with others, child respondent R6WMC02 stated, “So far at the beginning of each session I was asked how I was feeling. I see this as a very important thing as I am not asked this question many times and I was allowed the time to speak about how my day is going and how my week was so this activity was a nice experience for me”. Another child respondent R6SLC04 stated, “...we talked about how I was feeling during each session and get to talk through all the different issues I had”. This practice, according to the counsellors, is a standard practice they employ, and it has proven effective over the years.

4.2.4 Effective communication

Effective communication was a common theme that emerged from children’s responses when they were asked what made you comfortable with your counsellor and were your sessions helpful? Thirteen (13) or 65% of the children indicated that the counsellor’s verbal and non-verbal communication made them feel comfortable to share and engage with the counsellor. Children were particularly pleased with the counsellor’s emphasis on ensuring that they understood what was being discussed and the children appreciated the fact that the counsellor ensured that they understood what the child was trying to communicate. Child respondent R6WMC04 stated, “She listened to me, understand me



and explain things I did not understand”. Another respondent, R6SLC06, stated, “The way she listened and spoke about things”. R5FWC02 stated “(S)he talks good things. She does listen to me, plus me does listen. The (counsellor) always nice and kind and she laughs. If I don’t understand something she explain it over and over and ask if I understand”.

The counsellor’s tone of voice and the general mood of the session also contributed to effective and engaging counselling sessions. In response to the aforementioned question, child respondent R6SLC03 stated, “The counsellor tone in the way she spoke to me. She always made jokes to make me feel comfortable”. Another child respondent, R6WMC07 added, “The way the counselor talked to me made me feel welcome”. In fact, 10 or 50% of the child respondents used the phrase “the way she talked” or “the way she listened”, referring to the counsellor, as the reason they were comfortable in the sessions. The counselling component of casework therefore requires that the child or the client feels comfortable with the counsellor. The counsellor’s tone of voice and manner of speaking are important to children who are traumatized. The child may find it difficult to speak if the counsellor’s speech and tone are not perceived as warm and friendly. R6WMC01 stated “She explained everything to me as she speaks in a quiet manner that I can understand and relate to as I get scared when persons raise their voice at me. Everything I learned I was able to teach and explain certain things to my sister”.

Some children identified the specific tone that made them feel comfortable. The tone of the counsellor’s voice and their delivery conveyed a non-judgmental tone, and this was recognized and appreciated by the children. Child respondent R6WMC06 convey this point, stating, “the way the counselor talked to me... I didn’t feel like I was being judged”. Respondent R5FWC02 also conveyed this point, stating “...the way she does be talking and I’m learning. She never judge me or call me names”.

Counsellors exhibited friendly and welcoming non-verbal cues which were also recognized and appreciated by children. Respondent R6SLC04 referred to the counsellor’s “friendly appearance” that helped her to feel comfortable. Respondent R6WMC07 alluded to a ‘welcoming’ body language conveyed by the counsellor in addition to the counsellor’s pleasant manner of speaking that made her feel comfortable to engage with the counsellor: “Because she was welcoming, she talked nice, I wasn’t afraid to let it all out”.

4.2.5 Trust and confidentiality

Children stated explicitly or alluded to trust as a factor that helped them to engage with the counsellor and consequently facilitate effective casework. In response to the question, what made you feel comfortable with your counsellor and why were sessions helpful, child respondent R6SLC05 stated, “Because I can trust her. I can’t trust anybody else”. Another child respondent R5FWC05 stated “I feel comfortable to tell my



counsellor everything because I trust her”. To further probe on the factors that made children willing to ‘open up’ to a counsellor about sensitive topics such as their abuse, the interviewer asked children what made it easy for you to talk about difficult things in the counselling sessions, three (3) or 15 percent of the clients stated trust as the factor. One child, respondent R5FWC07, stated, “Because I feel safe”. Feeling safe, alludes to a level of trust that was established between the child and Counsellor.

When asked are there things that you feel you can share with your counsellor, all 20 or 100% responded in the affirmative. Here again, the respondents are alluding to a level of trust and comfort that was established with the counsellor.

There were several factors that contributed to the establishment of trust between the children and the counsellor. Thirteen (13) or 65% of the child respondent alluded to the communication skills of the counsellor as one of the reasons they developed a level of trust in the counsellor. The children noted, as mentioned in the previous section, that the counsellor made every effort to understand them and to ensure that they understood what the child was trying to convey. Additionally, children pointed out that their counsellor exhibited kindness in their speech and deportment. Some mentioned that the counsellor was calm and did not express any sense of alarm when the child spoke. One (1) child perceived kindness in the counsellor because the counsellor did not try to coerce the child in to speaking but patiently allowed the child to speak on her terms and when she was ready and comfortable. Respondent R6WMC06 stated, “My counsellor was very kind and took time to explain everything I did not understand. She did not have to pull the answers from me and that made me very willing to talk”. This respondent implied that she perceived that the counsellor did not “pull” answers from her – in other words, the counsellor did not try to either coerce or force the child to speak. This contributed to the establishment of trust between the child and the counsellor. Other children used terms such as ‘friendly’ and ‘warm’ to describe the counsellor and this, they indicated helped them to develop a level of trust in their counselor. What is therefore evident, is, the counsellor’s verbal communication and the perceived ‘friendliness’ of their countenance was an important factor in establishing trust. Another child, in describing the counsellor’s perceived verbal and non-verbal communication described the counsellor as ‘welcoming’.

One (1) child identified another factor that contributed to the establishment of trust – the counsellor’s willingness to “open up” to the child. “She opened up to me also...” child respondent R5FWC01 stated, and this made the child feel comfortable ‘opening up’ to the counsellor, thereby allowing for progress in the counselling aspect of the casework. Children appeared to look for genuine concern in the counsellor, or in any individual for that matter, as a motive for ‘opening up’ to that individual. Children alluded to the fact that they felt ‘judged’ by others, including their parents. No child indicated that they felt ‘judged’ by their counsellor.



Confidentiality contributes to the establishment of trust between the client and the counsellor thereby contributing to effective casework. Children and parents indicated challenges they experienced because members of the community were aware of the abuse. One parent stated their child was treated as the perpetrator by members of the community even though the child was the victim. Another child admitted that neighbours would “throw hints” at her and her family with reference to the abuse. Counsellor R5FW02, in expounding on casework process stated, “I help...the family understand that what happens at the CAC is confidential and they should not be afraid to speak out”. All 20 participants were assured of the confidential nature of their engagements with the CACs and they all felt comfortable sharing intimate details of their abuse with their counsellor.

4.2.6 Consistent attendance and active participation

Counsellors stated that each TF-CBT module builds on the progress that was realized in the previous module. Consequently, active and consistent participation by the parent and child is an essential factor that contributes to effective casework in TF-CBT. There are indications in the data that children valued their participation in the sessions, the children did achieve positive change in their lives and both parents and children attributed the positive change to participation in the counselling. Active participation is evident in consistent attendance and motivation by the client to complete all assigned counselling related activities.

Parent respondent R6SLP03 commenting on her child’s participation stated, “She practices and talks to us about how the counselling went”. Children provided responses that indicated their active participation in the sessions and the learnings and benefits due to their participation when they were asked about activities they did that helped them to share feelings with their counsellor that they could not share with anyone else. Child respondent R6WMC01 stated, “I shared with the (counsellor) from my journaling where I recorded my feelings. I was able to see my progress in the different feelings I had over time. I was also able to be more open with my grandma and sister”. Respondent R6SLC06 replied, “...we did journaling where I was able to express how I was feeling at a particular time and we tried to work through those. I was also allowed to speak about my feelings freely and openly during every session”. The journals were done daily by the children. They were allowed to share their entries with their counsellor at the weekly sessions. The journals are voluntary and therefore, an indicator that the child was motivated to actively participate in the process of casework since these journals was written by the children in their free time. The effectiveness of casework is dependent on the extent to which clients are willing to participate.

When children were asked what contributed to the positive changes they observed in themselves, all 20 children or 100% attributed the counselling to positive changes. Some children further elaborated. Child respondent R6WMC02 responded “By



attending sessions about the different topics such as what is sexual abuse and solving problems, relaxation techniques which helped me to better handle my emotions”. Another respondent, R6WMC04 stated “I believe since I started counselling, I have nothing bad left on the inside of me. I am dealing with my problems and overcoming all the negative things that has happen in my life”.

All 20 parents or 100% of the parent respondents attributed positive changes they observed in their child to the counselling when they were asked what changes they see in their child and what they believe caused these changes. One parent, commenting on her child’s changes, noted that her child has changed and learned new knowledge to the extent that she can impart knowledge to her. “She is more exposed (and) more intelligent. She has more value in herself. She says a lot of things that make so much sense due to these session(s). She teaches me a lot she has a sense of responsibility”.

ChildLinK’s TF-CBT is center-based – services are delivered only at the CAC and there is no fieldwork. While the efficacy of TF-CBT is evident in the experience of the research participants, their active participation and consistent attendance remains an important factor in the effectiveness of the trauma interventions.

4.2.7 Privacy

For effective casework, specifically facilitating TF-CBT, the level of privacy that the counselling room allows the client and the counsellor to enjoy is important to facilitating trauma interventions. Children indicated that the level of privacy influenced their level of comfort engaging with the counsellor in the sessions. Commenting on factors that made the various sessions comfortable, respondent R6WMC01 stated, “Sessions were... comfortable... The room was also private as what we spoke about could not be heard by persons outside the room”. Respondent R6WMC02 concurred, “...the room... offered some amount of privacy where I could have expressed myself”. Therefore, it is evident that children cannot express themselves unless the child is assured that there is sufficient privacy.

4.2.8 Customization and fun

Trauma interventions are effective when the sessions are customized to meet the specific needs of the child. As mentioned earlier, counsellors usually assess the child at the beginning of each session to determine if there are any pressing concerns. If there is a pressing concern, then it becomes the priority for the session. This is intentional to place the focus of the counselling for the needs of the specific child in the session. The responses of children indicated that they observed that sessions were customized for them, and this made them feel valued. Child respondent R6WMC07 suggested this when she told the interviewer that her counsellor, “...always made the session feel like it was just for me and my issues...” Respondent R6SLC04 alluded to this point when she



said, "...we talked about how I was feeling during each session and get to talk through all the different issues I had..." When sessions are customized to meet the specific needs of the child – even those that are not trauma related - children ascribed relevance to the sessions which strengthened their motivation to attend and participate.

Counsellors also incorporate creative and fun activities into the sessions, despite TF-CBT sessions focus on sober issues. Some of these activities are utilized in client-centered counselling activities. They include, according to counsellor R6WM01, "role play...colouring, poetry, (and) making crafts" and "sculptures using play dough". These activities are well received by the children and contributes to the effectiveness of the sessions. Child respondent R5FWC06 commented on some of the creative activities: "Making stuff such as craft. She thought me to make the desk organizer and I have made many other in different pattern for me and my sister". Respondent R6WMC02 response suggests that sessions that are customized to address each child's unique needs utilizing creative and engaging activities impact children in a positive way that helps them to cope with day-to-day challenges. The child noted that her counsellor "...always make sessions easy to understand by doing fun activities. On days when I come in feeling sad or disappointed, I always leave with a reason to smile".

4.2.9 Rights based approach

ChildLinK's CAC counsellors apply the rights-based approach principles in their casework implementation, and this has proven effective. Counsellors help children to understand that the abuse resulted in a violation of their rights and that they have a right to be protected from sexual abuse and they should be protected and treated with dignity by adults. The rights-based approach is highly participative recognizing clients' capacity to contribute to their own development. CAC counsellors support children to reclaim their self-mastery and autonomy by presenting them with options and supporting them to make healthy choices. "We give (the children) the options and (they) have to choose" counsellor R6WM02 stated.

Children are empowered at the intrapersonal level when they understand that the abuse was not their fault. This helps them to cope with feelings of shame, low self-esteem and low self-confidence that may experience due to sexual abuse. When child respondents were asked to describe their experience with their counsellor, R6WMC02 said, "My counsellor...made me understand that as I am a child, that the fault was not my own... I am now able to feel confident about myself and I feel I can do anything I put my mind to achieve".

4.2.10 Collaboration with the multi-disciplinary team

The CACs operate in the Guyana's wider child protection system where the CPA is mandated by law to address all child abuse matters, including child sexual abuse. CSA cases must be reported to the CPA. The CPA subsequently refers CSA cases to the



CACs for forensic interviews, client centered counselling, and TF-CBT. The CPA plays an important role in trauma interventions through the referral process, where cases are referred to the CACs. Without the referral process, the CAC cannot engage CSA victims in trauma counselling. Additionally, CPA collaborates with the CACs to contact and engage clients at the community level to ensure that clients are attending sessions at the CAC. The CAC is primarily center based. Consequently, CPA's engagements with clients at the community level is critical to clients' active participation in the process.

CAC counsellors' engagement with the children allows for them to be called to testify as expert witness in child sexual abuse cases. Their expert testimony can prove critical to the outcome of cases. Further, CSA victims are concerned about the prosecution of alleged perpetrators, especially in cases of violent rape. Two (2) parent participants in this study, noted the impact of the child seeing the perpetrator, noting that the sight of the perpetrator can possibly reignite the child's trauma. The collaboration among the MDT, plays a critical role in the prosecution of perpetrators which is in the best interest of the child.

Summary

This section explores factors that contributed effectively to the process of casework in trauma interventions when using TF-CBT. The CACs function in Guyana's child protection system. Therefore, collaboration with the members of the MDT is foundational. Since the CAC is a center-based service, referrals and field support from the CPA, supports consistent attendance by the clients and their families. Thorough and efficient investigations by the police will contribute to children's well-being by holding perpetrators accountable. Each MDT members' quality of service is a reflection on the entirety of the child protection system – therefore, clients' frustrations with one member can impede the work of others.

Counselling is the central dimension of the CAC casework. Consequently, it is imperative that rapport is established and strengthened throughout the process to facilitate active sharing and participation. Accurate documentation contributes to effective case monitoring. Accurately assessing the child's progress or recognizing counselling strategies that are ineffective and adopting new ones that are apt for the client is imperative to achieving positive changes and also maintaining the confidence of the child and the parents in the process. Parents are very observant of the progress their child makes; it is important that these changes are evident so that they see the importance of providing their child with the financial resources to travel to the CACs for counselling, which for some parents is an expensive venture. The counsellors' delivery is crucial to active participation from the child. Children noted extensively, the verbal and non-verbal cues that counsellors exhibited and articulated the significance of the counsellors' mannerisms and approach to their willingness and motivation to participate.



Finally, the data indicates the importance of a flexible approach, where the child's immediate need is treated with priority as this assures the child that the counsellor is approaching the sessions with their best interest in mind. This strengthens the child's trust in the counsellor allowing for optimal effectiveness in the counselling component of the casework. As the children stated, it is because of the level of trust that the counsellors inspired, which unfortunately many children could not identify in loved ones, that allowed them to be vulnerable with their counsellors by sharing sensitive thoughts and feelings, without which, positive changes could not have been realized.

4.3 Research Question 3: What are the strategies adopted over time by the member organization to improve the effectiveness of therapeutic intervention using TF-CBT model and how did those strategies help to improve the practice?

In order to answer question 3, counsellors were asked to detail training opportunities that they were exposed to and comment on the impact it has had on their capacity to deliver therapeutic interventions. Counsellors also suggested capacity development strategies they believe can strengthen ChildLinK's counsellors' capacity to deliver trauma interventions. Additionally, training reports were reviewed to catalogue the different capacity development activities that were executed since 2014 – the year of the CACs were established.

Over the years, ChildLinK has utilized capacity development as its strategy to improve the effectiveness of therapeutic interventions. ChildLinK has engaged experts in the field of trauma and TF-CBT to provide training to counsellors. Internally, ChildLinK has utilized senior counsellors to provide supervision, training and facilitate case management sessions to improve the skills of counsellors.

4.3.1 Trauma training

The CAC was opened with two weeks of training from the NCAC from the US in 2014. In 2015, ChildLinK subsequently engaged a US based international trainer and consultant with expertise in child sexual abuse and domestic violence to facilitate one week in country training sessions with trauma counsellors, Police Officers and CPA caseworkers on forensic interviews and facilitating trauma sessions. A follow up face to face training was also conducted in 2016 for one week and online sessions were held in 2018. These sessions focused on strengthening counsellors' skills in identifying trauma levels utilizing assessment tools; counselling strategies for difficult cases; and customizing sessions to meet the needs of each child. Sessions focused on the theory and application of specific TF-CBT modules such as cognitive coping, relaxation techniques and affective identification and regulation.

The sessions facilitated by the consultant also focused on the provision of services to various ethnic groups in their cultural context. This was an important area of focus



given Guyana's context - Guyana's population is comprised Guyanese of Indian, African, Chinese, and Portuguese descent, indigenous citizens and mixed races. Additionally, there is growing population of migrants from Venezuela, Brazil, Cuba and several African States.

ChildLinK also engaged the Baltimore CAC based in Baltimore, Maryland, USA to facilitate one week online training sessions focusing on trauma and TF-CBT in January 2021. The sessions facilitated by the Baltimore CAC focused on trauma and coping mechanisms of children and non-offending parents involved in child sexual abuse cases. According to counsellor R5FW02, "...the sessions helped me to feel more confident working with both children and parents... and increased my knowledge of facilitating parental sessions".

Counsellors indicated that these sessions contributed to their improved theoretical knowledge on the concept of trauma, TF-CBT, therapeutic techniques, facilitating parenting skills sessions and therapeutic intervention strategies.

4.3.1.1 Online training

All counsellors in ChildLinK completes the Medical University of South Carolina (MUSC) a virtual training course on TF-CBT modules and facilitating trauma therapy utilizing TF-CBT. Each CAC counsellor is given access to the online portal which includes reading material and video lectures on facilitating TF-CBT. In addition to increasing the knowledge of counsellors on trauma and facilitating TF-CBT, counsellors indicated that the online course increases their understanding of the interconnectivity of the various TF-CBT modules, consequently strengthening their capacity to seamlessly transition their clients through the various trauma modules.

4.3.2 Supervision and internal training sessions

Each ChildLinK CAC site is managed by a CAC project officer who has overall responsibility for the management of the CAC site and its team. The CAC site project officer is usually the most experienced and trained counsellor at the specific site. Additionally, each site project officer has received training in facilitation. Project Officers facilitate internal training with CAC counsellors to strengthen their capacity to apply the learnings from the online training and other trainings that the counsellors were exposed to. CAC Project Officers engage counsellors in activities such as role playing to engage them in practical, hands-on activities designed to strengthen their application skills.

Counsellors also given the opportunity to observe sessions facilitated by site project officers. In addition to that, counsellors are given the opportunity to access old case files so that they can monitor the progress of cases and observe the strategies and techniques employed and the change that was realized.



Supervision is provided by CAC project officers and includes the facilitation of internal case management sessions. In these sessions, counsellors shared challenges associated with cases, especially challenging ones, and the CAC site project officers guide the counsellor to identify solutions to these challenges. There are instances where a counsellor may not be making progress with a particular case. It is in the case management sessions, that the counsellor can secure support and guidance to proceed. Case management is also conducted with CPA caseworkers. The CPA caseworkers support CAC counsellors by conducting home visits to clients who are not attending counselling regularly to help them reengage their counsellor.

Prior to the COVID-19 pandemic, CAC site project officers and their teams from the various CAC sites across Guyana participated in quarterly peer reviews. The peer review sessions are similar to communities of practice where participants share learnings, strategies and experiences to strengthen the collective practice of trauma counsellors.

Currently, ChildLinK commenced a virtual book club to encourage professional development and growth. Books that are relevant to trauma and TF-CBT are selected. Trauma counsellors read various chapters and present learnings and engage in discussions on the presentations.

Supervision and internal training sessions are designed to strengthen counsellors' mastery of the TF-CBT content and apply the theories and learnings in counselling sessions.

4.3.3 Client-centered training

ChildLinK has a wider programme apart from the CACs that focuses on several strategic areas including reintegration of children to family-based care, child abuse prevention, and integrating children with mild autism into mainstream schools. ChildLinK's CAC counsellors participate in capacity strengthening opportunities which are implemented under various projects to increase their knowledge and skills in childcare counselling and parenting skills education. Training in these areas is applied in our client-centered counselling. However, CAC trauma counsellors indicated that these learnings are applicable to their trauma clients. Counsellor R6WM01 alluded to this stating, "Based on the child's score trauma work can begin with the different modules/chapters while incorporating some client centered activities such as creative interventions (people in my world), journaling, painting, crafts (among others)".

Training in client-centered topics provides trauma counsellors with a range of options in activities and techniques that are effective in its therapeutic application and relevance that add value and strengthen the effectiveness of the therapeutic interventions. When child respondents were asked to identify topics that were helpful, positive or satisfying for them, nine (9) or 45% of the respondents mentioned at least one (1) client-centered topic.



4.3.4 Self and self-care

CAC counsellors participated in capacity strengthening sessions on trauma, secondary trauma, and self-care. Counsellors were introduced to additional theories and perspectives of trauma and adverse childhood experiences and its impact on children. The concept of secondary trauma was explored and its potential impact on the individual.

The sessions focused on tools to strengthen counsellors' knowledge of self and factors that influence self. Johari window and the seven shapers model were tools that were explored at the sessions to explore the various internal and external factors that influence the holistic well-being of self. Counsellors were introduced to self-care activities and sensitized on its benefits. This improved the counsellors' ability to care for themselves and cope with the emotional strain or secondary trauma that may occur due to exposure to their clients' stories of abuse. Consequently, counsellors were able integrate these learnings in their day-to-day activities to decrease their stress level. This has obvious benefits. Counsellor R6WM01, commenting on the sessions on self-care and secondary trauma, stated, "I was able provide self-care for myself while at the same time finding different coping techniques to help me to deal with the trauma cases I work with... because if I am not at my best, I can't help children...".

4.3.5 Financial support

Trauma counsellors assess the situational context of each child to determine if financial assistance is required. Many families that engage the CACs in Regions 5 and 6 are headed by low-income earners. Additionally, the commute for some children utilizing public transportation can be expensive. Some parents have stated that they would like to send their child to receive counselling, however, they cannot afford the transportation cost while simultaneously covering other basic costs such food, school related expenses, and so forth. To address this concern, counsellors assess each case to determine if CAC funding can support transportation cost. This is indirect but important strategy to improve TF-CBT since the CAC services are center-based and attendance is critical to the provision of TF-CBT.

4.3.6 Suggested capacity development strategies

Trauma counsellors provided several suggestions to strengthen the skills of counsellors to provide improved TF-CBT. Counsellors stated that the capacity development sessions should focus on a more in-depth exploration of trauma and TF-CBT. Counsellor R5FW01 suggested that ChildLinK should continue to engage international CAC practitioners for further in-person training sessions where ChildLinK's CAC counsellors can be exposed to new learnings, best practices, and methodologies in facilitating TF-CBT. Counsellors indicated that ChildLinK should be ensure that the modules that the CAC practitioners utilize should be the most current module.



The CACs should be a ‘one stop shop’ where all services provided by the MDT members can be accessed in one facility according to counsellor R5FW01. This, counsellors agreed, will allow the CACs to have the scope to develop the physical space into a more child friendly space. It may possibly put an end to the current stigma attached to the CACs where “only children that need counselling goes”. This, the counsellors suggested, is critical to the delivery of TF-CBT since the provision of TF-CBT is dependent on the child’s attendance.

Summary

ChildLinK has primarily utilized training and capacity strengthening activities and case management as strategies to improve the effectiveness of trauma interventions. The CAC model utilized in Guyana was inspired by the CAC model employed in the United States of America. Fittingly, ChildLinK has engaged CAC and trauma professionals from the USA to facilitate training sessions with our counsellors. Additionally, the training included application of trauma counselling in various ethnic and cultural contexts.

The capacity strengthening opportunities has improved the effectiveness of trauma interventions by introducing counsellors to the theoretical perspectives of trauma and TF-CBT and the facilitation of TF-CBT. The training sessions were extensive and included strategies for engaging difficult cases. This is further enhanced by internal training sessions where senior and experienced counsellor draw from their experience to engage counsellor in practical sessions to strengthen counsellors’ capacity to apply learning and build their confidence to engage their clients.

Exposing trauma counsellors to client-centered training opportunities has added significant value to TF-CBT, as the client-centered activities has proven to be an effective supplement to the TF-CBT modules. Children especially, indicated that several client-centered sessions were not only engaging but impactful. The client-centered activities were useful in helping counsellors to address day-to-day issues that children experienced so that they can better focus their attention to TF-CBT sessions.

Self and self-care sessions has helped counsellors to effectively manage their mental and emotional health so that they are mentally and emotionally positioned to engage clients. As stated earlier in the report, clients are very observant of the counsellors’ body language and tone and these verbal and non-verbal cues are important to making the child feel at ease to share their stories.

The provision of financial support is necessary to engage children and families. Finance is also pivotal for ChildLinK to expand our strategy to improve trauma interventions.



4.4 Research Question 4: What are the domains to be more focused on, using the TF-CBT in the therapeutic process?

For the purpose of this research a domain will be defined simply as an area of interest (Caimbridge University Press, nd). TF-CBT is designed to contribute to healing from trauma related symptoms. Therefore, domains identified, will be areas that are pertinent to, and an indicator, that TF-CBT clients have progressed as a result of the intervention.

The data was reviewed to identify challenges that children experienced due to sexual abuse - this was done from the perspective of the parents and the children, as well as issues that children identified that they were able to manage due to their exposure to TF-CBT. The challenges were examined to assess its impact on the child's overall well-being, which would therefore suggest that it requires the attention of trauma counsellors. A range of questions posed to children and parents in their interview schedule were examined. Research question 4 also required a brief examination of positive changes that counsellors and the children achieved due to the therapeutic interventions.

4.4.1 Emotional well-being and social well-being

The data suggests that emotional well-being is the most prominent domain to be focused on when using TF-CBT in the therapeutic process. We will define emotional well-being as the emotional quality of day-to-day experiences, the positive and negative affect of which, makes the life of an individual pleasant or unpleasant (Misheva, 2016)¹⁰. Social well-being will be defined as the assessment of an individual's circumstances and functioning in all aspects of society (Bekalu, McCloud & Viswanath, 2019)¹¹.

Children experienced a range of emotional challenges due to the trauma caused by the abuse they experienced. These emotions had a negative effect on children's thoughts and actions which had rippling effects on several domains including social well-being, family bonding, peer to peer relationships, and future aspirations as well emotional well-being sub domains such as self-esteem and self-confidence. We will examine the various facets of children's social and emotional well-being that were adversely affected by the abuse with reference to the data.

4.4.1.1 Emotional changes

The trauma caused by child sexual abuse induced several emotional changes in children that adversely affected their emotional well-being. Children were asked how they dealt with their emotions after the abuse but before they commenced TF-CBT. Ten (10) or 50% percent of the child respondents indicated that they dealt with their emotions by crying. Some mentioned that they "cried a lot".

Some children experienced anger as a result of the abuse and they exhibited this anger in socially unacceptable ways such as self-harm. For example, child respondent R6SLC06



stated, “Every time I was angry about something, I would look for something to cut my hand. When I see blood I would stop cry”. Children also directed their anger at others, especially their siblings and parents. This adversely affected the child’s social well-being, particularly their standing in their family. Many conflicts resulted in the home from the anger children experienced. When asked how her behaviour was after the abuse but prior to commencing TF-CBT, child respondent R6WMC07 said, “I was bad. My behavior was bad. My sister could not speak to me because I was ready to fight. When my mother talk to me I wouldn’t listen, or I would pretend not to hear. I would answer her back word for word”. Commenting on her son’s anger, parent respondent R6WMP04 stated, “He was very aggressive towards the family and would always give back answers. (He was) very rude and disrespectful”. One child, R6WMC03, described herself, prior to counselling as “...an unruly, disrespectful child (who) make my parents lives a living hell since I felt like I was in hell”. Another child described her relationship with her siblings, which was influenced by her anger as one where there is physical violence and substance abuse. According to R5FWC03, she would “drink rum, fight and cuss my brother. Me and he does fight”.

Some children considered suicide as an option to address the emotional changes. When asked how she dealt with her emotions after the abuse, child respondent R6SLC01 stated, “...I thought about suicide...” Parents struggled with these emotional changes as well and in some cases, this resulted in conflict in the home among family members. The parent of child respondent R6SLC01 stated her response to her child’s attempts at committing suicide, “We use to fight a lot because she wanted to kill herself and I couldn’t handle that. She is my daughter and I don` t want her to take her life”.

These emotional changes adversely affected the child’s emotional well-being resulting in them ‘acting out’ in ways that was harmful to themselves and impacted their social well-being, with specific reference to their families where there was conflict in the home. Neither the family members nor the child was capable of understanding or addressing the complexity and severity of these emotional changes.

To guide children back to a sense of normalcy or positive change, counsellors worked with children to strengthen their self-mastery – that is, to strengthen their control of their own thoughts, feelings, and impulses. Parent R6WMP03 articulated this point when responding to the question, how she perceived her child sees herself, “She is now able to see herself once again as the person she was before - no more anger issues. She is in more control of her emotions. She`s more happy”. Children alluded to their strengthened self-mastery indicating that they no longer exhibit bouts of angers or cry often. Below, we will examine three sub-domains of emotional challenges that suggests emotional and social well-being should be a focus when utilizing TF-CBT.

10. *What determines emotional well-being? The role of adverse experiences: Evidence using twin data* (2016)

11. *Association of social media use with social well-being* (2019)



4.4.1.1.1 Self-esteem

Children's self-esteem was adversely affected due to the abuse, and this could possibly be connected to the guilt and shame children experienced due to the abuse, as postulated by (Gewirtz-Meydan, 2020). Children who experienced shame and guilt, usually blamed themselves for the abuse. Child respondent R5FWC03 conveyed this point in her response to the question, how she perceived herself after the abuse but before commencing counselling: "Shame, because I never expect that. I saw myself as a bad person because I thought I give away myself just like that - easily". In child respondent R6WMC06's response, she suggests a link between self-loathing and self-esteem. The respondent stated, "I hated and blamed myself. I was always sad and cried a lot. My confidence and self-esteem was low". Another respondent, R6WMC03 stated, "I saw myself as nothing. I wanted to commit suicide because I felt there was nothing else that can be done for me". This respondent's self-esteem was low because she perceived herself as "nothing". This low self-esteem contributed to a sense of hopelessness – she felt there was nothing that can be done for her. Her emotional distress caused her to surmise that suicide may be an option.

This feeling of guilt and shame was harmful to their emotional wellbeing and adversely affected children's social relationships, particularly in their family, which resulted in physical violence in some cases. The self-esteem issue and the ensuing shame and guilt was addressed by the TF-CBT intervention, which suggests that it should be made a priority. Respondents were able to perceive self in a positive and optimistic way after commencing TF-CBT. According to R5FWC03, "I see myself more high- my self-worth gone up way up high". Respondent R6WMC05 reiterated the positive change when she stated, "I feel good about myself. And more pretty. (I feel) that I will be somebody good in the future".

4.4.1.1.2 Fear and isolation

Fear and isolation adversely affected children's emotional and social wellbeing. In some cases, the fear children experienced caused them to isolate from others and to believe there was genuine danger where there may have been none. Two (2) parents mentioned their child's fear and the isolation it caused earlier in the discussion. One child locked herself in her room and the other child was afraid to leave her home to the extent that she refused to visit her grandmother who lived next door. When children were asked to describe their behaviour after the abuse and prior to attending counselling, seven (7) children or 35% provided answers that either suggested that experienced fear or isolated themselves from others. Respondent R6WMC01 stated, "I was always scared that something like this would happen again". R6WMC05 told the interviewer, "I kept to myself and I was scared".

Fear likely contributed to the isolation – respondent R6WMC05's comment seems to indicate that the respondent coped with her fear by secluding herself from others.



Therefore, we can conclude that fear children experienced adversely affected their desire to engage with others socially. Some children feared that they would be ridiculed by others due to the stigma attached to sexual abuse. So, while they engaged with others, they were mindful to withhold information about the abuse. Respondent R6WMC02, when asked to describe her behaviour prior to commencing TF-CBT stated in response, “I kept to myself, locked myself up in the room and cried. I spoke with my friend but not about everything because sometimes when you tell them things about you, they does go and tell their other friends”.

The fear children felt had implications for the emotional and social well-being. Children isolated themselves as a coping and protective measure. This hindered their desire to conduct routine tasks such as visiting a relative next door. They struggled to engage socially, with family members in particular and their relationship with peers was guarded. Those who engaged with others decided that they could not be open with others they would probably otherwise trust.

4.4.1.1.3 Distress

Children experienced high levels of stress as they coped with the abuse prior to engaging TF-CBT. For some children, it was their inability to manage their thoughts as they dealt with memories and flashbacks of the abuse. This resulted in adverse implications on their social and emotional well-being as some children admitted that they “lashed out” at others as they tried to live with stress. When asked how she dealt with her problems after the abuse but prior to commencing TF-CBT, respondent R6WMC06 told the interviewer, “I used to take on everything and become very stressed out. I tried to forget everything and when I couldn’t I would take it out on everyone”.

Stress hindered some children to complete routine tasks such as chores and schoolwork. The stress hindered their capacity to focus as they found themselves ‘lost’ or consumed in thought. Child respondent R5FWC02, when asked how she completed her chores prior to counselling but before commencing TF-CBT stated, “I used to do (my chores) slowly, like sickly, sickly because I was stressing”.

Children experienced several emotional challenges because of the abuse adversely affecting their emotional well-being. Children struggled to control their emotions and reacted in anti-social ways that contributed to disagreements between the children and their parents and siblings, which in some cases resulted in physical violence. Some children felt secluded themselves and felt isolated from others. Fearing the consequences of stigma associated with sexual abuse, children felt uncomfortable engaging with persons they trust under normal circumstances. They lived with a fear that the abuse would be discovered and that they would either be ridiculed or blamed. When asked how they dealt with problems, some children stated they kept their problems “bundled up inside”. One child indicated that she felt there was no help for her. Consequently,



in addition to coping with issues affecting their emotional well-being, children were further burdened dealing with what they perceived as necessary isolation to protect themselves which had adverse effects on their social well-being.

4.4.2 Family bonding

Family bonding is a domain that requires focus in TF-CBT sessions. Prior to engaging in TF-CBT, only 11 or 55% of the child respondents indicated that they had a good relationship with their parents. After the children commenced counselling, the percentage increased to 80%. The data identified instances where the relationship between children and parents became strained due to the abuse. One respondent stated earlier in this report that her parents responded violently to the news of the abuse. "... they beat me up especially my mother. She start beat me just like that. My father slap me the next day". Another child, respondent R6WMC06 stated her relationship with her parents was "...not very good...because they blamed me for the incident". Earlier it was stated that children "lashed out" at their parents after the abuse occurred as they struggled to cope with the ensuing stress and anger they felt. One child stated that she intentionally "...make my parents lives a living hell since I felt like I was in hell". Consequently, it was evident that abuse, in many cases, disrupts the bond that families have established over the years.

Counsellors stated that parents are sensitized on the various TF-CBT modules that children complete so that the parents can understand the work that is being done with the children and that they too can develop relevant skills to better protect their children and improve their relationship with their children, especially during their 'recovery process'. The trauma module captioned conjoint parenting, presents the opportunity for the child and the parent to engage in a face-to-face session where the child can express their story to their parent. This usually is an important step in repairing the bond and the trust that was damaged prior to commencing TF-CBT. A respondent described the conjoint parenting session as the "...joined parenting session where both myself and mother was able to express our feelings in a calm environment". After commencing TF-CBT, children and parents described their communication and interactions with terms as "more loving", "more open" and "more honest".

Two (2) respondents stated that they still had a negative perception of self after commencing TF-CBT. In both instances, the children suggested that their relationship with their parents was not good. For the child to heal holistically, it is important that the non-offending parent is an active participant in the therapeutic process.

4.4.3 Self-development

The data indicates that post-traumatic stress impedes children's perception of self and by extension, their self-development, and more specifically their aspirations. Children felt a sense of hopelessness due to sexual abuse – some felt that nothing could be done



for them. Additionally, their struggle with the post-traumatic stress symptoms was, in some cases, so overwhelming that it was difficult for children to focus on activities that were important to their self-development such as their academics. A child participant's response was provided earlier where the child stated, "I... could not concentrate much as the problem kept coming to my mind". Another child said she failed a particular school term and did not care. A third child told the interviewer, "I used to try and focus in school. The thought always used to come to me. I used to be loss and Miss used to ask me what's wrong, but I never tell her". To further strengthen this point, children were asked to share things they thought about and talked about the most after the abuse before commencing TF-CBT. Sixteen (16) or 80% of the child participants indicated that their thoughts were dominated by the negative implications of the abuse. Respondent R6WMC06 commented on the impact of the abuse on her aspirations: "I wanted to be a doctor. I wanted to excel in my schoolwork and work on improving my grades then this incident happened and I shut down. Nothing mattered". Another respondent, R6WMC01 stated, "I wanted to be independent but did not feel I could achieve my goals because of my experience..."

After commencing TF-CBT, children's focus generally was placed on their aspirations. When children were asked what the things are that they are thinking about the most now, 85% of the child respondents indicated that, currently, they are thinking mainly about their aspirations. Respondent R5FWC02 stated, "...now I'm thinking of being a teacher and like somebody good with school. Since I start coming (to the CAC), I does think about that". Respondent R6WMC07 told the interviewer she thinks and talks about "...how much I want to be a teacher and working getting there. I talk about going out with my friends and trying to have fun because I am not scared anymore".

For children to realize positive and holistic change through trauma interventions, self-development must be addressed. Counsellors' work with children in therapeutic interventions helped children to cope with fears that the abuse may trigger and subsequently, they were able to subdue their fears and focus on their aspirations.

4.4.4 Safety and resilience

A child's sense of safety is critical to their recovery from trauma. Prior to commencing TF-CBT, some children isolated themselves, in part, due to fear. The case mentioned earlier of the child participant who was afraid to visit her grandmother who lived next door illustrates this point. When children were able to subdue their fears, they were able to resume to a sense of normalcy and reconvene pre-trauma activities and routines – and as mentioned in the previous section, they were able to resume their focus on their aspirations.

Children felt a sense of safety because of the protection strategies they learned from participating in TF-CBT. When asked which sessions were most satisfying to them, child respondent R6WMC04 stated, "Psychoeducation, where we discussed...how I can



better protect myself when I...(see) signs of these in my life”. Respondent R6WMC05 also stated, “topics such as... sexual abuse and how to protect myself against sexual and any type of abuse”. Parents also noted their child’s ability to protect themselves and noted that this new knowledge helped the child to feel more secure and confident. As mentioned earlier, parent respondent R6WMP02 made this observation about her child: “...she is slowly moving away from being so scared. She is getting to be a little more brave... she views herself more independently. She has changed and know to protect herself”. Child respondent R5FWC04 provided a similar response. She said, she sees herself, “as a better individual and (with) all the counselling and support I got that this will not happen to me again”. This suggests that an important part of the recovery process, especially from the perspective of the child, is the knowledge to protect themselves so that a reoccurrence will be unlikely. When the child feels safe – when she/he feels that they have knowledge that can contribute to prevention of sexual abuse and a support system, they are more likely to exhibit positive behavioural and attitudinal changes. Counsellors also acknowledged that children’s lack of knowledge of ‘red-flags’ and protection measures places them at risk of sexual abuse. It should be noted that there is not a particular TF-CBT module that contributes to this holistically – rather, each module incrementally contributes to this development.

Resilience also requires focus in trauma interventions. Resilience can be viewed as individual’s ability to cope with challenges without experiencing re-traumatization (Grant and Kinman, 2014). Children’s resilience is strengthened when using TF-CBT throughout the eight-module process, especially through stress management and cognitive coping modules. Resilience is necessary in Guyana’s context since the investigation and prosecution process is relatively slow. Therefore, children are likely to see the perpetrators in various social settings and must cope with this reality or in some cases, a daily basis. There are also various stimuli that can induce intense memories of the abuse and trigger traumatic symptoms in the child. TF-CBT modules prepares children for this eventuality – and in many cases, children are able to cope. When asked, how they perceived themselves after the abuse and after commencing TF-CBT, children provided responses that pointed to the importance of resilience. Child respondent R6WMC02 stated “...when persons tell me negative things, I don’t listen to them. I turn those negative comments to positives and I work harder on myself”. Prior to commencing TF-CBT, children were fearful of the opinions of others, fearing they may face rejection and ridicule if their peers and community members learned about the abuse. In a few cases, children had mentioned that their friends and/or the community were aware of the abuse and directed negative remarks at them. Respondent R6WMC02 noted that after she commenced TF-CBT, she was able to turn negative comments into positives – an indication of her newfound resilience. She is now able to cope with pressures of negative social interactions in a positive and constructive manner. Child respondent R5FWC03 provided a similar response, “I don’t worry with people with their nonsense. I just keeping my head up high”.



Summary

This section of the report provides an analysis of the domains that requires attention when utilizing TF-CBT. Emotional well-being requires foremost attention since the emotional changes and the post traumatic symptoms primarily hinder this domain. Additionally, the hinderance of children's emotional well-being has adverse implications on other domains. Children experienced emotional instability exhibited by bouts of fear, anger and shame. Children's anger was directed at themselves through self-harm and at their parents and siblings which resulted in 'fights' in the home. The anger children experienced and exhibited contributed to the weakening of family bonds where siblings ended up in skirmishes. The reaction of parents also contributed to weakened family bonds as some parents reacted violently to their child's bouts of anger, in many cases, because they lacked knowledge of trauma and its effects on the emotional well-being of individuals. In cases where parents did not react violently, they did not know what course of action to take to help their child. Consequently, the child's anger persisted despite the parents' best efforts to support their child.

Shame adversely affected children's concept of self, resulting in lower self-esteem and self-confidence. This had adverse implications on children's social well-being as they chose to isolate themselves from friends and family members. Some children admitted that they could not go to school or dropped out of school because they could not cope with the potential remarks they would receive. This also adversely impacted their self-development and future aspirations as children viewed themselves as bad people, not worthy of anything good.

Fear affected children's emotional and social well-being. Some children experienced bouts of irrational fear, where they were afraid of everyone and resorted to isolate themselves from family, friends and the community. They became less trusting and, in some cases, blamed family members and their socio-economic status for their vulnerability. Fear had implications on their self-development because children's ability to focus on their studies was overwhelmed by their perceived potential threats to their safety and security.

Safety and resilience remain critical domains that require attention. Children showed signs of positive change when they felt that the knowledge they received from TF-CBT contributed to their safety. Children felt confident that they can now protect themselves from future harm and by extension, realized the extent to which their lack of knowledge placed them at risk of abuse. The confidence and assurance that the risk of abuse was minimal due to their increased knowledge was an important factor that supported their progression to a sense of normalcy. Children also found value in their new-found resilience – they had increased control of their emotions and thoughts and were now better positioned to confront adverse social interactions. This resilience strengthened their confidence in themselves and their capacity to resume their quest for lifelong fulfillment in their future career and other areas.



Chapter 5:

Discussion of findings

This action research focused primarily on evaluating the process and application of TF-CBT to determine the contributing factors in trauma interventions that contribute to positive change in the lives of child sexual abuse victims and determine if there are gaps in the delivery of trauma interventions using TF-CBT.

To attain answers, data was gathered from child sexual abuse victims, their parents and the counsellors who facilitated the TF-CBT. Interview schedules, questionnaire and focus group discussion was the research strategy utilized to gather the data. These were apt research strategies given the interpretivist research philosophy and assumptions adopted by the research team. A review of the data utilizing thematic analysis allowed for the identification of several themes which will guide the discussion of the findings.

5.1 The adverse implications of child sexual abuse

The research identified several adverse effects of child sexual abuse on children which TF-CBT must address to facilitate positive change. The cognitive triad of the perception of self, the perception of how the individual is viewed by their others in their world and the perception of the individual's prospects in the future are important factors that contribute a healthy perception of self. Each dimension will be expounded upon below.

5.1.1 Perception of self

Child sexual abuse has an adverse impact on the child's perception of self which the children articulated as low self-esteem, low self-confidence, and low self-worth. The association between a history of CSA and the development of negative self-concept has been theoretically and empirically explored. Studies have found that children who experienced CSA tend to have significantly low levels of self-esteem (Gewirtz-Medan, 2020).

In the presentation of the findings, the damage that was done to their perception of self and the erroneous measures some children took to address their low self-esteem and self-worth, such as attempted suicide or self-harm, was clearly articulated. The views given by children in this study is congruent with the literature on the impact of child sexual abuse on the development of self. The construction of self is an on-going experience that challenges individuals to organize past and present experiences to provide a sense of meaning and coherence. Traumatic experiences in childhood, such as child sexual abuse, can interrupt this development (Kramer, et al., 2015). Child sexual abuse affects



the child deeply, to the core of their spirit (Foster & Hagedorn, 2014).

Children saw themselves as ‘a bad person’ and consequently expressed a strong desire to be ‘a better person.’ Children were convinced that they were the ones who needed to ‘change’ before they can feel better about self. The extent to which parents, who labelled their child’s exhibitions of post-traumatic stress symptoms and emotional changes as disobedient, contributed to the child believing they were ones who needed to change was not determined by this study and perhaps, needs further research. What is clear is, some children defined self as a disobedient individual, possibly because of remarks parents and other siblings made to describe them, prior to commencing TF-CBT.

What the research pointed out was, children assumed a level of responsibility for the abuse and placed the blame for the incident on themselves. It was during the TF-CBT sessions that the children understood that the abuse was not their fault – that an adult, whose responsibility was to protect them rather than abuse them, was solely responsible for the abuse. This realization was an important step in healing the psychological and emotional damage done to self.

5.1.2 Child’s perception of their world

Each child experiences trauma differently. However, some children articulated some experiences that were common among them. The trauma they experienced adversely affected the way they perceived their world around them. In other words, their sense of safety and security was shattered, and they perceived potential danger everywhere. Children learn that they can evoke either acceptance or rejection from others and that their environment can either be friendly, secure, and satisfying or hostile and frustrating (Gewirtz-Medan, 2020).

Consequently, some children isolated themselves as far as possible – even from non-offending loved ones. This constant perceived threat of danger hindered them, in some instances, from engaging non-offending loved ones. It also hindered their desire to engage socially with friends at school. Even though some of the school activities were online – due to the COVID-19 pandemic at the time – children still expressed no desire to engage with others. One of the reasons provided for this was their fear of social rejection and ridicule. In fact, there were a few children and parents who mentioned the social ridicule and stigmatization they experienced from community members and the peers of the child when the abuse was known to the community. Researchers such as Brier, 1989 & Finkelhor & Browne, 1985 concluded that, in addition to child sexual abuse affecting the way children think, feel, and behave, it also affects the child’s view of the world (Krayner, et al., 2015).

It is worth noting that TF-CBT does not create an illusion in the mind of the child that their world is a completely safe space and that everyone can be trusted. Rather, TF-CBT



helps children to identify ‘red flags’ that may potential threaten their safety and also discern between individuals that they can trust and individuals that warrant suspicion.

5.1.3 Child’s perception of their future

Children believed that the abuse affected their prospects in areas such as their career or finding a life partner. Consequently, children viewed their future with a notable measure of pessimism due to the abuse. With reference to their pessimistic view of finding a life partner, the cultural norms in some local communities, which stigmatizes pre-marital sex, even in the context of sexual abuse does not condone ‘sexual impurity’ regardless of the circumstances. However, to some extent, children’s belief that they may not be able to find a life partner may be influenced by their sense of shame and guilt that was caused by the abuse. With reference to children’s career aspirations, children indicated that their interest in school was lessened. Their attendance and academic performance declined.

Counsellors helped children to realize that abuse can happen to anyone. One child in the study, indicated that she thought abuse only happened to her, and was surprised to find out that there were others like her. Additionally, counsellors helped children to understand that there were individuals who were abused and still went on to lead a successful life. When children realized that it is possible to regain normalcy and even thrive, they gradually became more optimistic of their prospects in life. This was evident when children indicated that they were investing more time and giving additional effort to their studies.

5.2 Regaining Control

This research identified several factors of TF-CBT that contributes to positive changes in children, which indicates that the TF-CBT model, at least in Guyana’s context, works. Trauma causes CSA victims to feel as though they have lost control of many aspects of their lives, including their emotions, and this drives some children into a sense of hopelessness. With specific reference to the loss of control over emotions, parents either directly indicated or alluded to the fact that their child had lost control of their emotions. This, they believed, was evident in their child’s anger that they displayed at home. Children clearly articulated that they were angry and suggested that they could not control their anger. This led some to be aggressive to others and one child said she inflicted harm on herself to cope with her anger. Parents also indicated that the fear that their children exhibited was an indication that their child had lost control of their emotions. Additionally, children referred to the fact that they were unable to control their thoughts – they would momentarily be lost in thought. Some children stated that thoughts of the abuse constantly came to their mind. The therapeutic interventions provided by the CACs helped children to regain the sense of control that they lost. Several factors of the TF-CBT interventions contributed to this.



5.2.1 Defining abuse and its implications for safety and security

Counsellors believed that children were not aware of concepts such as child sexual abuse and sexual grooming and this placed children at risk. One counsellor opined those children who are engaged in psychoeducation sessions asked a lot of questions because this was their opportunity to ask questions about sex that they could not otherwise ask since sex and sexual abuse are viewed as taboo in many rural communities in Guyana. Children also provided responses suggesting that they felt uncomfortable having these conversations with their parents and very comfortable talking to their counsellor about sensitive subjects.

It was clear, based on their responses, that many children did not know about sexual grooming, prevention strategies, sexually transmitted diseases and infections and other sex and sexuality related topics. While they did not state directly that this was a contributing factor to the abuse, children did suggest that because of the psychoeducation topics they covered during TF-CBT sessions, they felt safer and more confident that there would not be a reoccurrence of the abuse.

5.2.2 Putting the ownership on the perpetrator

Shifting the blame from the child to the perpetrator was one of the initial and important steps in helping children to 'regain control'. Children feared that the abuse could happen again but also felt a sense of ownership for the abuse. That is, children to a large extent, felt that they were the ones responsible for the abuse occurring. It is likely that this may be one of the reasons children isolated themselves – since from their perspective, they felt their actions was the main contributing factor to the abuse. They therefore concluded that they can protect themselves by isolating themselves from others. The case of a respondent who claimed that she would not leave the house again out of fear that persons may come and take her away again seems indicative of this. What the child seems to be suggesting is, if I allow myself to venture into the public, my action may result in a perpetrator abducting me.

Counsellors helped children to understand that the abuse was not their fault, and the perpetrator should take ownership of the harm they experienced and be held accountable for their actions. For some children, this appeared to be an epiphany and removed the child sense of guilt and shame they felt. Consequently, children were able to regain a healthier perception of self and higher levels of self-esteem and self-confidence.

5.2.3 Identifying emotions and thoughts and realizing the connection

Child sexual abuse evokes a wide spectrum of emotions that can be overwhelming for children. Feeling overwhelmed with emotions can contribute to individuals exhibiting dysfunctional behaviours as a coping mechanism (Kramer, et al., 2015). Counsellors suggested that victims of child sexual struggle with identifying the wide spectrum of



intense emotions that the abuse evokes. Consequently, this is exhibited by the children in several ways including fighting.

Counsellors guided children in identifying emotions and harmful thoughts and helping them to realize the connections between thoughts, emotions, and behaviour. As (Beck, 1964) posited, people's emotions and behaviours are influenced by their perceptions of reality and the events that transpire therein. Therefore, an individual's feelings is not influenced by a situation per se, but how the individual perceives the situation (Fenn & Byrne, 2013). Counsellors, therefore, helped children to identify negative emotions and thoughts evoked by the abuse and adopt techniques and behaviours that helped children insert control over their emotions and thoughts. Various thought stopping techniques and stress management techniques contributed to this development. More importantly, counsellors indicated that their role in the process was to empower the children with the knowledge and skills so that they can take increased ownership of their thoughts and emotions and ultimately their behaviour. The positive change that the children were to realize would have to come from the individual child. TF-CBT ultimately aims to teach children to be their own therapist by helping them to understand their emotions and current ways of thinking and behaving and equipping them with tools and skills to change their cognitive and behavioural patterns (Fenn & Byrne, 2013).

Children alluded to the fact that understanding the connections among the cognitive triad and learning techniques that helped them to insert greater control of their thoughts and emotions helped to strengthen their resilience. In other words, they exerted more emotional and mental restraint when confronted by adverse situations.

5.2.4 Confronting the trauma

Positive change cannot be sustainable until children confront the direct negative thoughts and emotions that the abuse evoked. The trauma narrative and in vivo exposures modules are pivotal in this process. The trauma narrative affords the child the opportunity to utilize their skills in identifying emotions and thoughts that they developed from previous sessions and vividly express those negative thoughts and emotions in words. This allows the child to release the negative emotions in a safe, child friendly manner. In vivo exposure, the counsellor supports the child in safely confronting potential environmental trauma triggers to strengthen the child's resilience and application of coping techniques. These modules are critical to sustaining positive change over a prolonged period.

5.2.2 A support system founded on trust

Child sexual abuse is a violation of the child's trust among other things. Children require a support system founded on trust to regain control and sustain positive change. It is imperative that the child and the counsellor establish a relationship of trust if TF-CBT



is to be effective. There is research that posits that the relationship between the child and the counsellor is the main factor that contributes to change, and other factors are less significant (Hill, 2012). The data revealed that children felt comfortable sharing sensitive details of the abuse and other issues because they felt that they could trust the counsellor and the counsellor was genuinely trying to help them. Children admitted that there are things that they feel comfortable telling their counsellor, especially as it pertains to sex, that they believe that they feel uncomfortable telling their parents. This trust that was established is also attributed to the fact that the children did not feel judged by their counsellor. One child indicated that the counsellor engaged her as though no abuse had occurred.

Another important individual that comprises the child's support system and contributes to positive change in the life of the child and the child regaining control is their non-offending parent(s). The relationship with the non-offending parent(s) and their participation in the TF-CBT sessions plays an important role in the child's recovery. Parents are not only influential in their child's recovery, but evidence from other research suggests that there is a correlation between serious emotional distress experienced by parents after the abuse and emotional distress experienced by the children themselves (Hill, 2012). According to the data, children whose parents were participative and supportive of the child throughout the TF-CBT, experienced positive, sustainable change. Parents and children described their relationship with their parents as more open, honest, and loving after the child commenced TF-CBT. This improved communication and relationship fostered a healthier and safe relationship that was less stressful for both the parent and child and environment conducive to sustainable behavioural change.

In essence, trauma caused by the abuse not only harms the child's perception of trust but also erodes the victim's trust in their support system. In many cases, children isolate themselves from members of their support system such as parents and other well-meaning relatives. This can possibly place the child at further risk of abuse. The data presented in the findings suggests the TF-CBT helps the child to re-establish trust in their support system. Further, TF-CBT, helps critical members of the support system, specifically the parent(s) to better understand the child's challenges induced by the abuse and equips them with knowledge to support the child's recovery.

5.3 Casework approaches that contribute to positive change

Continuous training and development is a critical factor that will result in effective casework and consequently lead to sustained positive change in the lives of children. While CAC counsellors in Guyana generally have a background in social work and related social sciences study areas, TF-CBT is a specialization that requires exposure to specific trauma intervention content and practical training. CAC counsellors indicated that they felt more confident facilitating after they were exposed to TF-CBT materials



through the Medical University of South Carolina as well as after they were engaged in role play and other practical activities facilitated by senior CAC staff. Periodic refresher trainings by international TF-CBT experts were also considered an important resource by the CAC counsellors that contributed to strengthening their expertise in TF-CBT. While counsellors were exposed to several in-house and external capacity strengthening sessions, it is notable that counsellors still recognized the need for additional and current material to strengthen their expertise. Clearly, the CAC counsellors recognize the importance of continuous training and capacity strengthening opportunities. Therefore, organizations that employ the TF-CBT model, are advised to invest in consistent training opportunities for their counsellors. This is also important in Guyana's context, where our academic institutions, at least as at the time of the writing of this report, does not offer academic courses and related practicums that can build the capacity of a TF-CBT counsellor.

Additionally, the data suggests that CAC and TF-CBT counsellors also utilized material in counselling strategies that are external to the TF-CBT modules such as Erik Erikson's stages of psychosocial development theory and Carl Rogers' client-centered therapy theory. TF-CBT counsellors stated that they utilized these materials from training sessions designed to work with other target groups such as children who are at risk of abuse, children who are being reintegrated from institutional care to family-based care and children with a disability.

The selection of a qualified and competent Project Officer to manage a CAC site – where TF-CBT is facilitated – is crucial to the effectiveness of the services offered and the wellbeing of CSA victims. The findings noted the seminal roles and responsibilities that the CAC Project Officer plays in the CAC operations. For example, the CAC Project Officer must have the leadership skills to sustain staff morale even as CAC counsellors may struggle with the effects of secondary trauma. Additionally, the CAC Project Officer provides coaching and mentoring to counsellors to strengthen their counselling skills and provides guidance to find solutions in difficult cases. The CAC Project Officer also engages the members of the MDT, to maintain strong relations with these important stakeholders. This is important because the CACs do not operate in isolation – it is an important part in the wider child protection system, and therefore, must establish and maintain synergies with other stakeholder agencies for optimal performance. The CACs receives referrals from both the police and the CPA, and provides support to the Court and public prosecutions, who at times, under extenuating circumstances, refers cases to the CAC.

TF-CBT counsellors must be versed in self-care and recognize its importance to their continued optimal performance. The counsellors must take ownership of their self-care regimen. However, this does not free CAC management from providing packages and a measure of flexibility for the counsellors to take the necessary measures to maintain their mental health and emotional wellbeing.



Recordkeeping also contributes to effective casework. Accurate data collection, filing and storage allows the counsellors to monitor their clients' progress and develop and implement intervention plans. CAC management should provide counsellors with the required resources for recordkeeping, and where necessary, training and coaching to ensure that counsellors have apt knowledge and skills to maintain records. Records are not only essential to the individual cases but are invaluable sources of institutional knowledge that can prove to be essential in potential research projects and in the training of future CAC counsellors.

5.3.1 Strategies for improved therapeutic interventions

Responses from counsellors and a review of training reports indicated that ChildLinK mainly utilized training and capacity strengthening and case management to improve therapeutic interventions. Counsellors indicated these training sessions improved their knowledge of trauma and TF-CBT theory and facilitation. Case management improved their confidence in their skills and allowed them access to technical support in difficult cases.

Counsellors indicated an interest in more extensive opportunities. They suggested practice exchanges with more established CACs in developed countries that would allow for observation of the facilitation of best practices in the field. Additionally, counsellors indicated that they would be interested in scholarships that would allow them to enroll in specific academic courses with more extensive and in-depth theoretical and practical learnings.

There was also a concern for children with disabilities who may access the services. In Guyana's context, children are usually not diagnosed but stigmatized and, in many cases, ostracized. Consequently, this places them at risk of abuse. Over the last few years, ChildLinK's CAC received several referrals for children exhibiting symptoms that appears to be a case of a child with a disability. Counsellors stated the challenges they experienced facilitating the cases and therefore, training opportunities in TF-CBT capacity building in facilitating sessions with children with a disability should be explored.



Chapter 6: Conclusion and recommendations

6.1 Conclusion

Trauma intervention utilizing TF-CBT has effectuated sustained positive change in the lives of both the children and parents engaged in the sessions. The TF-CBT model systemically and progressively guides the child through a process where they can identify negative thoughts and emotions that contributes to dysfunctional behaviours and equips the child with the tools and skills so that they can utilize them to make decisions that will sustain the positive change that they have achieved and safely confront trauma triggers and other negative external situations that can potentially arise in day-to-day activities.

In Guyana's context, strict adherence to TF-CBT module is not a practical approach. Counsellors must be cognizant of other strategies and techniques that are applicable to children's day-to-day issues that are not trauma related. It is imperative that TF-CBT sessions are perceived by the child as relevant to their needs for their sustained active attendance and participation. Additionally, parents' participation is pivotal to the entire process. The data clearly demonstrated that positive changes in the life of the child is unlikely unless the parent is an active and motivated participant in the process.

ChildLinK must explore continuous capacity development for its counsellors to not only reinforce their current knowledge and skills but introduce them to new and more advanced trauma intervention strategies and techniques. ChildLinK must recognize that the needs of children, like society itself, is gradually evolving and becoming more complex. Consequently, the skills and knowledge possessed by trauma counsellors must evolve and adapt to meet these rapidly developing and inevitable changes.

6.2 Recommendations

Recommendations were developed from the analysis of the data including direct suggestions made by children, counsellors, and parents.

1. Expand CAC programme and partnerships – The data clearly conveyed that TF-CBT is effective when children/clients believe it is relevant not only for the



trauma related issues but children's current non-trauma related issues. Children either dropped out of school after the abuse or their desire to participate in academics was significantly reduced. When asked what recommendations they would like to see implemented to improve the counselling services, some parents indicated they would like to see the CAC provide help with schoolwork. Children indicated that their interest in school was rekindled after commencing TF-CBT but admitted that they had a lot of 'catching up to do' because of their absence or lack of participation for the period they were addressing their trauma and emotional changes prior to commencing TF-CBT. Therefore, the CAC can explore a partnership with the Ministry of Education to provide educational support services to children to help them progress in their academic pursuits.

2. Counselling as a prevention tool – Counselling can be provided to children with low self-esteem in schools as a prevention strategy against child sexual abuse. Children with low self-esteem are especially at risk of child sexual abuse and should be referred for counselling. Additionally, the nursery and primary curriculum should be amended to include sessions on how children can protect themselves from child sexual abuse and how to report CSA. The psychoeducation TF-CBT module provides content that defines CSA, identifies 'red flags' and includes prevention strategies. Inculcating this information into the primary and nursery curriculum can potentially contribute to a reduction of incident of CSA since CAC counsellors noted that children who lack information on red flags and psychoeducation related topics are at high risk of CSA. Additionally, CSA victims who engaged in the psychoeducation sessions felt more confident that they are now equipped to protect themselves from another incident of abuse.
3. Expand support services to parents – There were instances where parents alluded to poverty and financial challenges that impacted their capacity to provide their children's basic right to an education. The parent plays a critical role in the child's recovery. Therefore, the CAC needs to establish partnership with other agencies where they can refer parents to secure practical assistance that contribute to tangible improvements to the parents' capacity to meet their child's basic needs that can impact the child's career prospects. Children indicated that they wanted to return to school but parents also acknowledged financial struggles that they face. Given the importance of the role of parents in the safety of their children, the CAC must lobby for increased reach to parents to equip them with knowledge of CSA prevention and reporting. Parents can be engaged through several avenues such as pre-natal clinics and parents and teachers' association. This study presents evidence that parents play a pivotal role in a child's healing from CSA. Similarly, parents can play an important role in the prevention of CSA if they are engaged in strategic avenues.



4. Recognize and address trauma in parents – When asked how the CAC services was helpful to them, one parent said it helped her to deal with her stress, another parent said it helped her to deal with her trauma, and a third parent mentioned that the CAC provided a safe space for her to get help with her problems. When parents were asked to share their recommendations for improving forensic interviews, one parents said that parents should not hear certain things because they too are traumatized. The CAC counsellors should therefore consider assessing the trauma level of parents and have a parenting skills officer accessible to provide support if necessary. As stated in the discussion, research indicates that there is a correlation between emotional distress experienced by the parent and the emotional distress experienced by the child. To support the child’s recovery, the parent’s mental and emotional well-being is a key contributing factor.
5. Expand the CACs beyond center-based services – The CAC should adjust its center-based approach to allow for home visits. The findings suggests that while children are traumatized due to the abuse, parents and other close family members are also adversely affected if not traumatized to a lesser extent. There were instances where the emotional turmoil that ensued due to the abuse, resulted in conflicts in the home which adversely affected family bonds. Additionally, the findings indicated that positive changes attributed to the trauma intervention are more likely when the parent(s)/caregiver(s) is an active participant in the intervention. Consequently, the CACs should expand its services to include home visits where families can be engaged in family counselling sessions to address issues that may have adversely affected family bonds.
6. Provide counsellors with updated and in-depth trauma modules – Counsellors expressed a desire for more current and extensive TF-CBT modules to expand their knowledge base of the trauma related theory and facilitation strategies and techniques. While the current information they have has proven adequate so far, counsellors are mindful of the increased cases that are being referred to them and the increased complexity that comes with it. Therefore, to be prepared for inevitable complex eventualities, counsellors wish to be prepared and equipped to address those challenges.
7. Capacity building in creative intervention techniques – Counsellors indicated that they utilize alternative therapeutic options in their TF-CBT cases such as art therapy. Children indicated that these sessions were enjoyable. This suggests that creative alternatives counsellors utilized helped to maintain the child’s interest and attendance in the TF-CBT. Consequently, ChildLinK should invest in exploring various alternative therapies and provide capacity building/strengthening opportunities so that TF-CBT counsellors will have a wider variety of options and competencies to enhance the quality of service they provide.



8. Provide counsellors with academic courses and practice exchange opportunities – Counsellors indicated an interest in scholarship opportunities to recognized universities to enroll in courses that are relevant to trauma and TF-CBT. This would strengthen counsellors’ knowledge in trauma, cognitive functioning, and other psychological competency areas. Practice exchanges would allow counsellors to engage with international experts in TF-CBT and observe firsthand, the application of TF-CBT best practices. Additionally, trauma counsellors can benefit from training in client-centered topic areas such as goal setting and peer pressure. The data indicated that children responded positively to sessions focused on client-centered topics which addressed day-to-day challenges that the children experience. Further, CAC trauma counsellors benefitted from participation in training sessions where the focus was on topics that covered in ChildLinK’s wider programmatic focus such as child abuse prevention and reintegration. These learnings expands and diversifies the counsellor’s knowledge base thereby equipping counsellors to address a variety of non-trauma related issues a child may experience.
9. Children with disabilities – Children were referred to the CAC exhibiting symptoms of a disability but were undiagnosed. Counsellors do not have training in disabilities and the application of TF-CBT to children with a disability. ChildLinK should explore training opportunities or engaging CACs with experience and expertise in this area to explore what options are available to support children with disabilities.
10. Address stigmatization and public perception of CAC facilities – Counsellors noted that there is a public perception of the CACs that it is a place where “bad children” go to get counselling. Some children feel intense pressure coming to the CACs to receive counselling because of the potential remarks they believe they will receive from their peers. They expressed to the counsellors that they told their friends that they were volunteering at the CACs and not participating in counselling. The CAC model is center-based and therefore requires consistent attendance to be effective. ChildLinK needs to implement a public relations campaign to address the stigma around sexual abuse and counselling.



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