

Game-Based Cognitive-Behavioral Therapy: A Model for Treating Elementary School Aged Survivors of Child Sexual Abuse

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Game-Based Cognitive-Behavioral Therapy (GB-CBT) is an integration of two major theoretical approaches, cognitive-behavioral therapy and play therapy (Springer & Misurell, 2010; Springer & Misurell, 2012). Research on cognitive behavioral therapy (CBT) has identified effective techniques and principles for treating childhood anxiety and trauma (Barlow, 2002; Foa, Hembree, & Rothbaum, 2007; Kendall & Hedtke, 2006). Among these are the use of a directive style, present focused orientation, skills-based practice and systematic desensitization of clients to anxiety-related cues. Additionally, literature examining Trauma-Focused-Cognitive Behavioral Therapy (TF-CBT), the most extensively researched treatment for survivors of child trauma, has highlighted a number of critical therapeutic components including emotional identification, expression and regulation skills, knowledge about abuse, gradual exposure to abuse-specific stimuli and coping and personal safety skills (Briggs, Runyon, & Deblinger, 2011; Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Deblinger, 2006).

Practitioners in the field have extensively utilized play therapy techniques to address childhood difficulties as a means of building rapport, engaging children in treatment and communicating with children through their natural mode of expression (Schaefer & Drewes, 2009). In an edited volume (Drewes, 2009) authors discuss the utility of integrating CBT and play therapy for treating a variety of childhood problems. More recently, play therapy techniques have specifically been discussed in their application for delivering TF-CBT for victims of trauma (Cavett & Drewes, 2012; Drewes & Cavett, 2012).

GB-CBT integrates the major tenants of the CBT and play therapy approaches into a manualized curriculum, combining behavioral techniques such as token economies, role-plays and psychoeducation with structured play. This approach allows clinicians to establish a therapeutic environment, which promotes skill development, minimizes behavioral difficulties, and provides a positive, pleasant and motivating atmosphere. GB-CBT is based on four core principles: 1) Data driven; 2) Directive and structured; 3) Experiential learning; 4) Fun and engaging. GB-CBT is data driven in that its development was largely influenced by research outlining effective behavioral strategies and techniques for addressing childhood difficulties and childhood trauma. Additionally, behavioral measures and weekly feedback are used to inform and guide treatment planning and assess progress. GB-CBT clinicians adopt a directive and structured approach to treatment, utilizing a manual containing topical areas with a menu of games and activities and outlines for conducting sessions. The components covered in GB-CBT are rapport building, personal space, emotional expression skills, linking feelings to experiences, anger management, relaxation training, child abuse education, abuse processing, personal safety skills, and termination processing. Behavioral expectations, session goals and incentives are explicitly presented to clients. Within the context of GB-CBT, clients acquire skills through experiential learning. This requires clients to take an

active role in the learning process, provides opportunities for practicing and rehearsing skills and allows for clients to receive corrective feedback. Finally, GB-CBT uses techniques that are fun and engaging in order to motivate client participation and reduce resistance.

GB-CBT is primarily delivered through the use of developmentally appropriate games (DAGs; Reddy, Spencer, Hall & Rubel, 2001; Reddy, Springer, Files-Hall, Benisz, Braunstein, Hauch & Atamanoff, 2005). The formats of these games include competitions, collaborative play, races, card games and board games. These games are used in a manner that strives to take into account client's interests, preferences, beliefs and abilities (Misurell & Springer, 2011; Springer & Misurell, 2012).

GB-CBT is administered in both group and individual therapy formats, where skills are presented in a specific order, which build upon each other. The GB-CBT group model is typically delivered in twelve 90-minute weekly sessions and covers a fixed sequence. Each session begins with a group structure, highlighting behavioral expectations, token economies, and bathroom and time out procedures. This is followed by psychoeducation about the topic of the day, session role plays and DAGs, group processing, behavioral evaluation and reward distribution. A concurrent non-offending caregiver group is offered, also containing DAGs, to provide caregivers with parallel skill development, parenting education, and opportunities to heal from their children's trauma. This enables caregivers to support their children through treatment and to better provide for their overall needs.

The GB-CBT individual model involves working with the child and non-offending caregiver and is typically administered in 10-16, 90-minute sessions. The individual model uses a modular approach providing an ability to tailor the sequence of skills presented and amount of time spent on each topic to fit the individualized needs of the client. Each session usually begins with a meeting with the child's caregiver, during which behavioral problems and symptoms are assessed, session skills are discussed and games are presented. Next, the clinician meets individually with the child to review behavioral expectations and incentives, discuss skills taught during the previous session, provide psychoeducation regarding topic(s) of the day and present and play therapeutic games. The session continues with a conjoint meeting with the child and caregiver. During this time, the caregiver, child and clinician review session skills and play session games together. The session concludes with processing the activities, assessing behavioral performance and awarding incentives.

Initial treatment outcome studies found that GB-CBT effectively addresses posttraumatic symptoms (e.g., recurrent thoughts, flashbacks, etc.), anxiety, depression, sexually inappropriate behaviors, and externalizing behavioral problems (e.g., inattention, hyperactivity, aggression, oppositionality; Misurell, Springer, Acosta, Liotta, & Kranzler, in press; Misurell, Springer, & Tryon, 2011). GB-CBT was also found to increase knowledge of abuse and personal safety skills (Misurell et al., in press; Misurell et al., 2011). A recent follow-up study also provides evidence that symptoms, behavioral problem reductions and improved knowledge of abuse are maintained at three months

following treatment completion for GB-CBT group therapy (Springer, Misurell, & Hiller, 2012).

Below is a sampling of GB-CBT games covering a variety of skills including rapport building, emotional expression skills, relaxation training, child abuse education, and abuse processing.

Getting to Know You Stack

Establishing rapport at the beginning of treatment is essential for client engagement and participation. This is particularly important when working with children who have experienced sexual abuse given that in many instances their trust in others has been violated. “Getting to Know You Stack” is a game that has been played in individual therapy and in group therapy for non-offending caregivers. This game uses cards containing questions worth 1 point and 2 points. One point questions are meant to generate more basic or surface-level responses (e.g., what is your favorite holiday, when is your birthday, what is your favorite food?), while 2 point questions are designed to elicit more elaborate and thoughtful responses (e.g., what was the saddest day of your life, what do you want to get out of therapy, what would you change about your family?). Clinicians along with clients, one at a time, pick the top card of the stack and read both questions aloud, choosing to answer the one point question, the two point question or both questions for three points. After answering the question(s) that are chosen, the corresponding points are recorded and the next player goes. The object of the game is to get as many points as possible by sharing and learning about one another.

Feelings Trivia Game

Identifying and discussing feelings is an important precursor to understanding and processing experiences. The “Feelings Trivia Game” has been played in group therapy to help children with sexual abuse histories to express a wide range of emotions. This game uses “how would you feel” scenarios to provide prompts for children to generate lists of feelings. Children are first divided into smaller teams and are asked to work with their team to generate as many feelings that they can come up with for each scenario. After all scenarios are read, teams are awarded a point for each unique feeling that was generated across all scenarios. Sample scenarios are included below:

How Would You Feel If...

1. The kids in your class were making fun of you?
2. You got a big present for your birthday?
3. You got yelled at by your parents/caregivers?
4. You were all alone in your room at night and hear a loud bang?

Relaxercise Game

Children that experience abuse and trauma often have difficulty monitoring and regulating their physiological stress reactions. The “Relaxercise Game” has been used in individual and group therapy to help children become more aware of their ability to impact their physiological state. For this game, children are taught to obtain their baseline heart rate by counting their pulse for 10 seconds. After providing this

information to their clinician, children are asked to engage in exercise for 30 seconds (e.g., jumping jacks, pushups, running in place). Following this, children are asked to obtain their stressed heart rate for 10 seconds and report it to their clinician. They are then instructed to utilize relaxation techniques that they have learned in therapy (e.g., deep breathing, progressive muscle relaxation, visualization) for a minute in an attempt to decrease their heart rate to its baseline state. Children are provided with reinforcement for using techniques effectively. After this relaxation period, children are asked to check their heart rate again and report it to their clinician. Clinicians discuss children's ability to effectuate a relaxed state following a stressed activity. This game is played until mastery is obtained.

Life-Size Wheel of Knowledge

An important part of treatment for children who have experienced sexual abuse is psychoeducation about abuse. This serves to debunk myths and misconceptions, normalizes abuse-specific responses and provides information that promotes safety. "Life-Size Wheel of Knowledge" has been used in individual and group therapy to provide education about sexual abuse, physical abuse and personal safety skills. This game utilizes a wheel drawn on a sheet of paper, with six evenly spaced sections. Each section is labeled one to six and has one of three categories associated with it (i.e., sexual abuse, physical abuse and personal safety skills). Each player receives his or her own wheel. Players take turns rolling a die and answering questions from the category corresponding to the number rolled. If the question is answered correctly, the player completed that section of his or her wheel, which is marked accordingly. If the question is answered incorrectly, the clinician provides the correct answer and the player must attempt another question from this category on his or her next turn. The object of the game is for each player to complete all six sections of his or her wheel as fast as possible.

What's the Story?

Gradual exposure to abuse-related material helps children to become more comfortable thinking about and discussing their own abuse experiences. "What's the Story?" is an introductory activity to abuse processing in which children actively contribute and are able to relate to similar experiences of others. This activity has been played in individual and group therapy using fictional stories of abuse scenarios. There are two versions of this game. One version is for younger children (i.e., 5-7 year olds), in which key details, are left out in the form of blanks. Before each story is read, children are asked for responses for filling in the blanks or word categories (e.g., name of child, positive feeling, type of abusive behavior, negative feeling). Once all of the blanks are filled in, the stories are read aloud. The second version is for older children (i.e., 8-10 year olds), who are told that they are going to work together with the clinicians and caregivers (conjoint therapy) to create a story about a child who has experienced abuse. Children are told some brief information about the protagonist (e.g., 8-year-old girl named Samantha) and the type of abuse that he/she experiences (e.g., sexually abused by her grandfather), and each participant will be asked to add a sentence or two at a time, until the story is completed. Clinicians (group) and/or a clinician and caregiver (conjoint therapy) usually create the first story by themselves to provide an example of the important details to include. In both versions of the game children are asked to remember

as many details about the stories as possible and are rewarded for correct recall of details after the stories are completed and/or read. Physical and sexual abuse scenarios have been utilized, which describes the protagonist's physical and emotional experience before, during and after the abuse, culminating with a positive therapeutic experience and resolution.

Conclusion

Undergoing treatment for child sexual abuse is often a difficult process in which the child and their family must think about and confront emotionally charged and uncomfortable material and memories. The GB-CBT approach uses techniques and strategies that provide motivation, spark interest, and create a safe and enjoyable forum to process trauma and learn a host of research-based skills.

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