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David C. Wang, Jamie D. Aten, David Boan, Wismick Jean-Charles, Kathylynn Pierre Griff, Viola C. Valcin, Edward B. Davis, Joshua N. Hook, Don E. Davis, Daryl R. Van Tongeren, Tania Abouezzeddine, Quyen Sklar, and Anna Wang

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Culturally Adapted Spiritually Oriented Trauma-Focused Cognitive–Behavioral Therapy for Child Survivors of Restavek

David C. Wang
Biola University

Jamie D. Aten and David Boan
Wheaton College

Wismick Jean-Charles and
Kathylynn Pierre Griff
Université Notre-Dame d’Haiti

Viola C. Valcin and Edward B. Davis
Wheaton College

Joshua N. Hook
University of North Texas

Don E. Davis
College of Education, Georgia State University

Daryl R. Van Tongeren
Hope College

Tania Abouezzeddine, Quyen Sklar, and
Anna Wang
Biola University

Restavek is a form of modern-day slavery that is estimated to affect 300,000 (i.e., approximately 1 in 10) children in Haiti. It typically involves a child from a poor rural family being sent to work as an indentured domestic servant for an affluent urban family. Restavek children experience a high rate of trauma, as well as other mental health concerns. The present study explored the effectiveness of a culturally adapted form of Spiritually Oriented Trauma-Focused Cognitive–Behavioral Therapy (SO-TF-CBT), a treatment model for assessing and treating religious and spiritual issues within the standard TF-CBT protocol (an evidence-based treatment for childhood trauma). This study involved 20 control participants and 38 treatment participants assigned to a 12-session protocol. Results indicated that participants who received the treatment, relative to those who did not, reported lower PTSD symptoms and spiritual struggles (relative to control participants), with medium-to-large effect sizes. Implications of these findings for future research and clinical work with restavek children are discussed.

Keywords: children, Haiti, posttraumatic stress, restavek, spiritually oriented TF-CBT

Restavek is a term derived from the French and Creole term “reste avec,” which translates to “one who stays with” (Cadet, 1998, p. 4).

This term describes a modern form of indentured servanthood that began with poor families sending their children to live with slightly

David C. Wang, Rosemead School of Psychology, Biola University; Jamie D. Aten and David Boan, Graduate School and Humanitarian Disaster Institute, Wheaton College; Wismick Jean-Charles and Kathylynn Pierre Griff, Centre de Spiritualité et de Santé Mentale (CESSA), the Université Notre-Dame d’Haiti; Viola C. Valcin, Graduate School and Humanitarian Disaster Institute, Wheaton College; Edward B. Davis, Graduate School, Wheaton College; Joshua N. Hook, Department

of Psychology, University of North Texas; Don E. Davis, College of Education, Georgia State University; Daryl R. Van Tongeren, Department of Psychology, Hope College; Tania Abouezzeddine, Quyen Sklar, and Anna Wang, Rosemead School of Psychology, Biola University.

Correspondence concerning this article should be addressed to David C. Wang, Rosemead School of Psychology, Biola University, 13800 Biola Avenue, LA Mirada, CA 90639. E-mail: david.wang@biola.edu

wealthier urban families, mainly relatives, to provide them with educational and social services that families were unable to provide otherwise (Restavek Freedom, 2011). However, today this system more accurately resembles human trafficking and involves recruiters called “Koutchye” who are paid to find restavek children for host families, which results in the complete loss of contact between restavek children and their biological families (Restavek Freedom, 2011).

Understanding Restavek

Within the child advocacy literature, restavek children are often described as “invisible children,” “children of shadows,” “forgotten children,” or “lost children” (e.g., Cadet, 1998; Kramer, 2001; Pan American Development Foundation [PADF], 2009; Padgett, 2001; Skinner, 2008; UNICEF, 2006). In Haiti, the term “restavek” is even considered an insult in that it refers to children who dress in rags or sleep on cardboard or sheets under kitchen tables (Hoffman, 2010). Data gathered by the UNICEF (2006) reported that approximately 1 in 10 children in Haiti are restavek children (approximately 300,000) with more recent numbers reporting at least 225,000 in Port-Au-Prince alone (PADF, 2009). The typical starting age for restavek children is five years old, with most children falling in the range of 5 to 17 years of age (Restavek Freedom, 2011).

Consistent with the hardship and stigma attached to the term, restavek children are frequently neglected and physically, sexually, and psychologically abused. These children work long hours without compensation (10–14 hours a day), and are basically prisoners in the homes to which they are sent or sold. Both female and male restavek children are also at a high risk for sexual abuse from males in their host families (Delorme, 2004) and are sometimes given a different title of “La Pou Sa” which means “there for that,” implying the child’s specific function as a sexual object to the males within the host family (Blagbrough, 2008). In addition, restavek children often suffer from stunted physical, emotional, and cognitive development due to malnutrition and/or emotional and educational neglect (Janak, 2000). One study reported that the average restavek 15 year-old is approximately 4 cm (1.6 in.) shorter and 20 kg

(44 pounds) lighter than the average Haitian child (Institute for Justice and Democracy in Haiti, 2014). Due to such horrific conditions, many restavek children run away or are kicked out of their “adoptive” homes and have no ability to return to their “biological” homes (Anderson, 1990), putting them at ongoing risk of abuse and harm.

Cultural Adaptations of CBT

Although restavek children experience high levels of abuse and mental health concerns, there is unfortunately little help or support available for these children. In fact, a substantial and well-recognized treatment gap exists for mental health disorders among low- and middle-income countries (LMIC; Kohn, Saxena, Levav, & Saraceno, 2004) such as Haiti, with the gap being most severe for children and adolescents (Patel, Flisher, Nikapota, & Malhotra, 2008). In an attempt to reduce this gap, an increasing amount of research has examined the effectiveness of evidence-based psychological treatments applied to these settings. The use of evidence-based treatments in these contexts, however, has been both heralded and controversial, with some studies indicating positive outcomes (e.g., Bolton et al., 2003), and with others pointing to the potential dangers of importing treatments from high-resource, western countries into situations that are both culturally and contextually distinct (Christopher, Wendt, Marecek, & Goodman, 2014; Hook & Watkins, 2015; Wessells, 2009). To address these concerns, Murray et al. (2013) recommended that researchers utilize validated treatments in conjunction with ethnographic approaches that identify and integrate local strategies of addressing mental health problems so that problems due to contextual insensitivity may be minimized.

One example of this approach is Rivera and de Arellano’s (2008) work in developing a culturally adapted form of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) aimed at treating symptoms of posttraumatic stress among children of Latino descent in the United States. Based on input from both the local (e.g., dialogue with local schools, churches, and community-based organizations) and national level (e.g., focus groups from different regions of the United States, consultation with established ex-

perts in the field), salient cultural constructs were integrated into the standard TF-CBT protocol, such as more culturally congruent child rearing practices, family focus (*familismo*), gender roles (*machismo*, *marianismo*), interpersonal variables (*personalismo*, *respeto*), complementary medicine/folk healers, and religious beliefs and practices. This culturally adapted TF-CBT protocol was administered to their entire sample of Hispanic children (aged 7–17) over the course of the 20- to 24-week period of the pilot study. Participants exhibited a substantial decrease in posttraumatic stress disorder (PTSD) symptoms such that only 9.4% of the sample met criteria for PTSD at the end of treatment; notably, the entire sample met criteria for PTSD at the beginning of treatment.

Similarly, O’Callaghan, McMullen, Shannon, Rafferty, and Black (2013) examined the effectiveness of a culturally adapted TF-CBT intervention in treating PTSD, depression, anxiety, and conduct problems, and facilitating pro-social behavior in a sample of sexually exploited, war-affected Congolese girls ages 12 to 17. In an effort to expand the limited pool of treatment providers to this population, this intervention was delivered by nonclinical facilitators who received prior training as well as ongoing supervision. Cultural adaptations of this treatment included (a) having female facilitators discuss ways to reduce risk of future sexual violence that were appropriate to the Congolese culture, (b) integrating culturally familiar games, songs, and examples into the treatment protocol, and (c) having social workers visit each participant’s guardian in an attempt to reduce stigmatization and foster family acceptance. The findings of this study indicated that at the end of the 15-session treatment, relative to a control group, the culturally adapted TF-CBT treatment group experienced significantly greater reductions in trauma symptoms. In addition, the treatment group also demonstrated highly significant improvement in symptoms of depression, anxiety, and conduct problems along with a significant increase in pro-social behavior. Moreover, the women in the treatment group were able to sustain these gains three months after termination of treatment.

Developing a Culturally Adapted TF-CBT for Restavek Children

The purpose of the present study was to develop and test a culturally adapted treatment to meet the mental health needs of restavek children in Haiti. In 2012, Wheaton College’s Humanitarian Disaster Institute (HDI), in conjunction with the Center for Spirituality and Mental Health at the University of Notre Dame-Port au Prince (CESSA), the Restavek Freedom Foundation (RFF), and Regent University’s Child Trauma Institute, began a multiphase and integrated process of developing and implementing a culturally adapted version of Spiritually Oriented Trauma-Focused Cognitive–Behavioral Treatment (SO-TF-CBT) in Haiti, following the Design, Implementation, Monitoring, and Evaluation (DIME) process developed by the Applied Mental Health Research (AMHR) Group (AMHR, 2000).

The DIME approach offers a single integrated process for developing and implementing culturally adapted evidence based practices in contexts where there is a lack of culturally validated programs and research. The steps of DIME include the following: (a) a qualitative assessment to identify and describe the most important mental health and psychosocial problems from a local perspective; (b) the development, adaptation, translation, and validation of assessment instruments (e.g., community surveys used to screen potential participants, tools to monitor and evaluate the effectiveness of services and changes in severity and/or prevalence of symptoms); (c) baseline assessments (using instruments developed from the previous step) at the population level to gauge prevalence and severity of symptoms; (d) the development of program goals and objectives, along with the types of interventions used for achieving these goals and the evaluative mechanisms to determine whether these goals are achieved; (e) the selection, adaptation, and implementation of specific interventions; and (f) an assessment of intervention impact (Murray et al., 2013; AMHR, 2000).

Accordingly, the first step of our work in Haiti entailed a qualitative assessment among members of the local population to identify and describe the nature of the most important mental health problems among restavek children. Three major organizations involved in direct work

with restavek children, along with government officials and members of leadership from the Université Notre Dame d'Haïti–Port au Prince, participated in a series of semistructured field interviews to assist us with this goal (in all, 1753 restavek children from 87 local schools were represented through all who participated in this assessment process). Results from these field interviews indicated that trauma was a particularly salient mental health concern; several participants noted that the majority of the restavek children they worked with endorsed a history of one or more types of trauma (e.g., sexual abuse, physical abuse, and domestic violence). Notably, symptoms and behaviors consistent with posttraumatic stress disorder were commonly observed among these children (e.g., aggressive behavior, social avoidance/isolation, problems with attention and concentration, depressive symptoms, low self-esteem, and difficulties trusting other people).

Given the prevalence and salience of trauma-related symptomatology among these children, our team decided that a trauma-based intervention would be most appropriate for this population. Because of the abundance of efficacy research and cross-cultural effectiveness research on TF-CBT, and because of the prominence of religion and spirituality within the Haitian culture (83.2% of which is either Roman Catholic or Protestant, with many Haitians practicing elements of voodoo as a stand alone practice or in addition to another religion; Central Intelligence Agency, 2015; Rey & Stepick, 2013), Spiritually Oriented Trauma-Focused Cognitive–Behavioral Therapy (SO-TF-CBT) was identified as our treatment of choice.

TF-CBT is a conjoint treatment for both children and parents or caregivers (if available) developed by Cohen, Mannarino, and Deblinger (2006) that uses cognitive–behavioral and exposure techniques to prevent and treat posttraumatic stress, depression, and behavioral problems. The primary goal of TF-CBT is to reduce symptoms of PTSD among children and adolescents; it is designed to be delivered in 12 to 16 sessions within an outpatient context, depending on the needs and abilities of the child and caregivers. The components of TF-CBT can be summarized by the acronym PRACTICE: Psychoeducation and parenting skills, Relaxation, Affect modulation, Cognitive coping and processing, Trauma narrative, In vivo mastery of

trauma reminders, Conjoint child-caregiver sessions, and Enhancing safety and development.

TF-CBT is considered the most well researched treatment for PTSD among children and adolescents (Silverman et al., 2008), meeting Chambless et al.'s (1996) criteria for a *well-established* treatment, with at least two group-design experiments conducted in at least two independent research settings and by two independent investigatory teams, finding that treatment was statistically significantly superior to psychosocial placebo or to another treatment. It has at least 12 randomized controlled trials supporting its efficacy in treating not only PTSD, but also depression, anxiety, shame, and behavioral problems (Dorsey & Cohen, 2015). However, although TF-CBT has demonstrated consistent positive outcomes in the reduction of PTSD symptoms, it is less clear whether it is equally effective in treating other conditions such as reducing behavior problems or symptoms of depression (de Arellano et al., 2014). Notably, in addition to clinical trials, research on TF-CBT has also included effectiveness research. For example, Webb, Hayes, Grasso, Laurenceau, and Deblinger (2014) presented evidence supporting the effectiveness of TF-CBT implemented in community settings across the state of California; specifically, they found that even community mental health clinics and clinicians who had little previous experience with TF-CBT could be trained to effectively treat traumatized school-age children.

Spiritually Orientated Trauma-Focused Cognitive Behavior Therapy (SO-TF-CBT; Walker et al., 2010) is an adaptation of TF-CBT that was developed to help children and adolescents of various faith backgrounds to work through potential spiritual issues that may arise and become intertwined with their trauma history and/or the psychological sequelae that follows. Damage to one's spirituality has been frequently observed as a consequence of trauma, particularly those that are interpersonal in nature and that occur repeatedly over time (Courtois & Ford, 2009). Trauma has been known to bring about the onset of spiritual and religious struggles (Aflakseir & Coleman, 2009; Harris et al., 2008; see also Exline & Rose, 2013), which may entail negative religious cognitions about the self, God, and the world that provide maladaptive explanations about the cause of, responsibility for, and/or future implications of

traumatic events (Wortmann, Park, & Edmondson, 2011). Notably, spiritual struggles have been shown to partially mediate the relationship between trauma exposure and PTSD symptoms (Wortmann, Park, & Edmondson, 2011). However, for others, religious and spiritual resources represent a significant source of strength to help trauma survivors cope with and find meaning from their past experiences (Walker, Reid, O'Neill, & Brown, 2009).

Therefore, recognizing that the spirituality of trauma survivors may function as a source of pain or as a potential resource for healing, a multilevel assessment of the client's spirituality and religion (e.g., general spiritual background, religious affiliation, level of religious commitment) is conducted in SO-TF-CBT, and themes that emerge from this assessment are addressed throughout the process of the standard TF-CBT protocol (Walker, Courtois, & Aten, 2014). To illustrate, in the affect modulation component of TF-CBT, the effectiveness of skills such as thought stopping, positive imagery, and coping self-talk may be enhanced through the inclusion of stories, songs, or passages from sacred texts drawn from the client's personal religious tradition. Similarly, in the cognitive coping and processing components of TF-CBT, it may become necessary for therapists to restructure religiously themed cognitive distortions related to the trauma, such as the belief that God would abandon or become angry with the client if they were to discuss the trauma with their therapist (Walker et al., 2010).

The second step of the DIME process included the development, adaptation, translation, and validation of mental health assessment instruments for the local population in Haiti. The research team adapted and tested a series of assessment tools for use with children in and around Port-au-Prince, Haiti. In conjunction with feedback from local stakeholders, the following assessments were chosen: (a) the Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001), (b) the Loving God & Punishing God Scales (De Roos, Miedema, & Iedema, 2001), and (c) the Negative Religious Coping Scale (Pargament, Feuille, & Burdzy, 2011).

Because of practical limitations of assessing the entire population of restavek children in Haiti, we were unable to fully complete the third step of the DIME process (i.e., measuring

baseline assessments in the population to gauge prevalence and severity of symptoms). However, in the current investigation, we do report baseline assessments for our primary variables among our study participants. We describe Step 4 (i.e., program goals and objectives), Step 5 (i.e., the selection, adaptation, and implementation of specific interventions), and Step 6 (i.e., assessment of intervention impact) in the method and results sections of this paper.

Study Aims and Hypotheses

The primary research question of the present study is whether a culturally adapted SO-TF-CBT intervention, relative to a control, would lead to a reduction in posttraumatic stress symptoms among child survivors of Restavek in Haiti. Because SO-TF-CBT also targets potential religious and spiritual issues related to trauma, a secondary research question examined the effects of this intervention on participants' tendencies to experience spiritual struggles. In the interests of better addressing the mental health treatment gap among this population in Haiti, our study also investigated, as a secondary goal, whether this treatment could be effectively delivered by people with less formal mental health training. Specifically, we examined three distinct delivery methods: (a) community-based lay counselors, (b) NGO staff volunteers, and (c) undergraduate students from a local university. The primary hypothesis was that the intervention group as a whole (regardless of which party administered the treatment) would demonstrate significantly fewer symptoms of posttraumatic stress as well as decreased spiritual struggles, compared to the control group.

Method

Development of Intervention

SO-TF-CBT adaptation and contextualization.

The adaptation and contextualization of SO-TF-CBT into the Haitian context was an ongoing process with several key steps. The initial phase involved Haitian professionals who were proficient in English providing an opening round of recommendations for revision after reviewing the materials prior to translation. The materials were then translated into Haitian Creole by in-

dividuals who were native language speakers. This initial set of materials was integrated into a comprehensive training program given to the community stakeholders (e.g., CESSA and RFF staff members) that included not only the translated SO-TF-CBT training protocols, but also a toolkit that summarized the current scientific literature and knowledge base on how Evidence-Based Practices can be adapted to better meet the needs of cultural groups in international disaster and humanitarian settings. For example, this toolkit included materials on the Ecological Validity Model (Bernal, Bonilla, & Bellido, 1995), which posits that cultural adaptation work should take into account the following eight dimensions: language (e.g., idioms, words), persons (i.e., potential ethnic/racial similarities and differences between participant and helper), metaphors (e.g., symbols and concepts shared), content (inclusive of cultural knowledge, values, and traditions), concepts (are treatment concepts consonant with culture), goals (does treatment support adaptive values from culture), methods (i.e., cultural adaptation of treatment methods), and context (i.e., consideration of changing contexts in assessment during treatment).

This training program followed a dialectical process, whereby the participants were engaged in assessing the material as it was taught; during this process, feedback was procured on (a) the training materials, (b) the cultural considerations in using this material to train others, (c) the assessment tools used, and (d) the clinical process of the proposed treatment. Notably, an important cultural issue emerged from our discussions concerning the cultural norm in Haiti of supervisor dominance—where supervisors typically focus on the incompetence and errors of the people they supervise. In response to this, we engaged in lengthy discussions about the necessity to build confidence in supervisees, the destructiveness of attacking subordinates, and the importance of adopting a strengths-based approach to counseling and supervision as a defining policy of the program. In the end, an initial version of the treatment program manual was produced.¹ A survey was then conducted by a panel of experts in Haitian culture and mental health (composed of members of CESSA staff and RFF staff), who administered

a final review of the materials leading to a final revision.

Culturally adapted SO-TF-CBT training of local counselors. The counselors who administered the SO-TF-CBT treatment were drawn from the local community and were required to be a part of a community organization that would support their participation in the program. They were composed of three different groups: lay counselors from area churches, NGO staff volunteers, and undergraduate student volunteers. The lay counselors from area churches were required to receive explicit endorsement from the pastors and priests of their churches to participate; have at least a 6th grade education; have completed prior training on mental health counseling, family counseling, or trauma; and have at least three years of experience in providing mental health counseling services specifically to restavek children. The NGO staff volunteers were drawn from seven local nongovernmental organizations and community organizations that serve restavek, orphaned, and/or abused children. They each possessed a bachelor degree in mental health, psychology, or a related field, and had at least 1 year of experience working with restavek children. The undergraduate student volunteers were recruited from the School of Ethnology and School of Human Resources of the State University of Haiti. They each completed at least two years of undergraduate work and also received prior training in mental health counseling, family counseling, or trauma.

Counselors from all three groups were trained and supervised by CESSA staff who took part in the process of culturally adapting SO-TF-CBT. These training staff in turn received ongoing supervision by the director of CESSA and participated in a series of workshops of their own that provided training in different didactic techniques, supervision skills, and basic models of clinical supervision. Training staff also completed a mock workshop to demonstrate their teaching skills. These efforts culminated in a 2-day workshop taught by the training staff to

¹ Titled, "Therapy Spiritiyelman oryantasyon tromatize-Fokis Cognitive Behavioral Therapy: Manyel de tretman pou pwofesyonel Ayisyen ki travay nan domèn moun ki malad nan pati tet Psikolog."

the three groups of counselors—the first covering basic helping skills and the second covering culturally adapted SO-TF-CBT.

Participants and Procedure

The children who received treatment in our study were recruited from the Restavek Freedom Foundation residential program, the local community (these children were assisted by RFF staff), and elementary schools (in conjunction with a school program led by an RFF collaborator) in Port-au-Prince, Haiti. The control group consisted of children recruited from the same elementary schools as those represented in the treatment group; they had been specifically identified by schoolteachers and/or school administrators as having experienced some form of trauma (physical or sexual). For the treatment group, participants' age ranged from 6 to 20 years old, gender was predominantly female (68%), and self-reported religious affiliation was predominantly Catholic (29%) and Protestant (68%). For the control group, participants' age ranged from 10 to 17 years old, gender was also predominantly female (60%), and self-reported religious affiliation was again predominantly Catholic (35%) and Protestant (45%).

All participants received pretreatment assessments and those designated to receive treatment were assigned to one of three treatment groups—led by lay counselors, NGO staff volunteers, or student volunteers. Initially, treatment started with 28 counselors and 58 children; at the end of the 12-week treatment, 24 counselors and 38 children remained. Several children could not complete the treatment because of external factors such as displacement. Two of the four counselors did not complete the program because of their children dropping out of the program; the two other counselors dropped out because of life situations not related to the program. Because of many interruptions that occurred throughout the delivery of the program (e.g., national holidays, teacher strikes, national exams, a 'chikungunya' mosquito-borne viral epidemic), some participants required up to 6 months to complete the treatment program, at times receiving more than one session per week.

Measures

Child PTSD Symptom Scale (CPSS; Foa et al., 2001). The CPSS is a 17-item assessment of PTSD symptomatology and symptom severity in children ages 8 to 18 who had experienced a traumatic event. It is a child version of the Posttraumatic Diagnostic Scale (PTDS; Foa et al., 1997), a well-validated measure of PTSD severity and diagnosis for adult survivors of a variety of traumas. For each of the 17 symptoms that constitute the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*) PTSD diagnosis, participants are asked to circle the frequency each symptom has bothered them during the past month. Items were rated on a 5-point Likert scale, ranging from 0 (*never*), 1 (*sometimes*), 2 (*once a week or less*), 3 (*2 to 4 times a week*), to 4 (*5 or more times a week*). Sample items include, "Nightmares," "Jumpy," "Upset by Reminders," and "Avoid Activities." Added together, the 17 symptom items yield a total PTSD symptom severity score ranging from 0 to 68, as well as severity subscores for each of the three symptom clusters: Reexperiencing, Avoidance, and Arousal. The CPSS demonstrated high internal consistency ($\alpha = .89$ for the total score) in its initial validation study using a sample of 75 school-age children 2 years following the 1994 Northridge, California earthquake. The CPSS also demonstrated convergent validity with the Child Posttraumatic Stress Disorder Reaction index (CPTSD-RI; Pynoos et al., 1987) as well as divergent validity with depression, as measured by the Depression Self-Rating Scale for Children (DSRSC; Birlleson, 1981) and anxiety, as measured by the Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings, & Conners, 1997). For the present study, the Cronbach's alpha coefficient was .80.

The Brief RCOPE (Pargament, Feuille, & Burdzy, 2011). The 7-item Negative Religious Coping subscale of the Brief RCOPE (NRC) is currently the most common instrument used to measure spiritual struggles. Spiritual struggles encompass divine conflicts over spiritual matters with God/Higher Power, inner conflicts about spirituality or religion, and interpersonal conflicts with family members, friends, clergy, community members, or the larger culture concerning matters relating to

spirituality or religion. Items are rated on a 4-point Likert scale, ranging from 0 (*not at all*), 1 (*somewhat*), 2 (*quite a bit*), to 3 (*a great deal*). Sample items include “I wonder whether God has abandoned me,” “I question God’s love for me,” and “I wonder whether my church has abandoned me.” The Negative Religious Coping subscale has demonstrated good internal consistency over a wide range of studies with differing samples such as African American women with a history of partner violence (Bradley, Schwartz, & Kaslow, 2005), adolescents with sickle cell disease (Cotton et al., 2009), cancer patients (Cole, 2005), and residents in Massachusetts and New York City following 9/11 (Meisenhelder & Cassem, 2009). Cronbach’s alpha scores reported across studies that have utilized the NRC ranged from .60 to .90, with a median of 0.81 (Pargament, Feuille, & Burdzy, 2011). It has also been used in international contexts, such as a study of adults from the United Kingdom (Lewis, Maltby, & Day, 2005) as well as a study of Pakistani university students, for whom the scale had been translated into Urdu (Khan & Watson, 2006). For the present study, the Cronbach’s alpha was .65.

Results

Our final sample consisted of 38 participants in the treatment group and 20 participants in the control group. Baseline and posttreatment scores for all the measured variables across treatment and control groups are presented in Table 1. Before conducting our primary analyses (i.e., whether individuals in the treatment groups demonstrated significant differences in PTSD symptoms and spiritual struggles), we first investigated whether the measured variables were significantly different across the con-

trol and treatment group at baseline. No significant differences were observed for PTSD symptoms, $t(56) = 1.57, p = .123$, though differences in spiritual struggles approached significance, $t(56) = 2.00, p = .050$, at baseline. As noted earlier, 20 of the original 58 participants in the treatment group dropped out of treatment because of life situations not related to the program. No significant differences, however, were observed at baseline for PTSD symptoms, $t(56) = 1.23, p = .225$, or spiritual struggles, $t(56) = 0.95, p = .349$, between those who completed treatment and those who dropped out.

Continuing to the primary analyses of our study, a mixed-design ANOVA with trauma symptoms as the dependent variable, treatment (treatment, control) as the between-subjects factor, and time (pretest, posttest) as the within-subjects factor revealed a main effect of time, $F(1, 56) = 92.54, p = .000, \eta_p^2 = .62$. This main effect was qualified by an interaction between time and treatment, $F(1, 56) = 6.20, p = .016, \eta_p^2 = .10$. Next, a mixed-design ANOVA with spiritual struggles as the dependent variable, treatment (treatment, control) as the between-subjects factor, and time (pretest, posttest) as the within-subjects factor revealed a nonsignificant main effect of time, $F(1, 56) = 0.01, p = .937, \eta_p^2 = .00$, coupled with a significant interaction between time and treatment [$F(1, 56) = 9.72, p = .003, \eta_p^2 = .15$]. The effect size of the Time \times Treatment interaction (with trauma symptoms as the dependent variable) was medium-to-large ($\eta_p^2 = .10$) whereas the effect size of the Time \times Treatment interaction (with spiritual struggles as the dependent variable) was large ($\eta_p^2 = .15$). For partial eta squared, an effect size of 0.01 constitutes a small effect,

Table 1
Descriptive Statistics for the Measured Variables by Treatment and Control Groups

Group	Dependent variable	<i>N</i>	<i>M</i>	<i>SD</i>	Possible range	Actual range
Treatment groups	Trauma symptoms—Pretest	38	39.68	8.72	0–68	19–55
	Trauma symptoms—Posttest	38	15.81	11.05	0–68	0–37
	Spiritual struggles—Pretest	38	8.55	4.29	0–21	0–21
	Spiritual struggles—Posttest	38	6.45	3.90	0–21	0–17
Control group	Trauma symptoms—Pretest	20	35.80	9.47	0–68	19–57
	Trauma symptoms—Posttest	20	21.75	12.55	0–68	1–43
	Spiritual struggles—Pretest	20	6.45	2.63	0–21	2–11
	Spiritual struggles—Posttest	20	8.45	4.12	0–21	0–18

0.06 a medium effect, and 0.14 a large effect (Cohen, 1988, p. 283).

Finally, to investigate whether there were significant differences in symptom reduction across the three treatment subgroups led by different counselor types, an additional mixed-design ANOVA was conducted with trauma symptoms as the dependent variable, counselor type (lay counselor, student counselor, NGO counselor) as the between-subjects factor, and time (pretest, posttest) as the within-subjects factor. Results indicated a significant main effect of time, $F(1, 35) = 109.54, p = .000, \eta_p^2 = .76$, with a nonsignificant interaction between time and counselor type, $F(2, 35) = 1.97, p = .15, \eta_p^2 = .10$. Finally, another mixed-design ANOVA with spiritual struggles as the dependent variable, counselor type (lay counselor, student counselor, NGO counselor) as the between-subjects factor, and time (pretest, posttest) as the within-subjects factor revealed a significant main effect of time, $F(1, 35) = 106.48, p = .004, \eta_p^2 = .22$, as well as a significant interaction between time and counselor type, $F(2, 35) = 3.71, p = .035, \eta_p^2 = .18$. Post hoc analyses (Tukey's HSD test) indicated that participants who received treatment from NGO counselors demonstrated significantly greater reductions in spiritual struggles compared to those who received treatment from student counselors ($p = .028$).

Discussion

To our knowledge, this is the first study of a standardized mental health intervention for Restavek children in Haiti. In light of the prevalence of trauma and symptoms of posttraumatic stress among this population, an evidence-based trauma intervention for children was selected, adapted, and administered by three groups of trained local facilitators. Findings indicate that the culturally adapted spiritually oriented TF-CBT intervention significantly reduced symptoms of posttraumatic stress among the children who participated in our study, over and above symptom reductions associated with the natural recovery process, with a medium-to-large effect size. This reduction in symptoms among those who received treatment was significantly greater than those of a control group, which also observed reductions in trauma symptoms (on average, symptom reduc-

tion among the treatment groups was 70% greater than those in the control group).

Among children who received treatment, these gains in trauma symptom reduction were also accompanied by a reduction in spiritual struggles. This finding is in stark contrast with the control group, which on average, actually observed increases in spiritual struggle over time. Damaged spirituality has commonly been observed among both survivors of trauma as well as those who work with survivors of trauma—particularly when the trauma is more interpersonal in nature and occurs repeatedly over time, such as those experienced by Restavek children (Van Deusen & Courtois, 2014; Dombo & Gray, 2013). For example, research has documented that children with trauma histories evidence more anger and distrust of God than those without trauma histories (Elliott, 1994). Similarly, in a separate study, female survivors of severe trauma reported experiencing God as unloving and wrathful (Doehring, 1993). To illustrate, damaged spirituality may take the form of distorted or maladaptive schemas about the divine, or the relationship between oneself and the divine (e.g., “God has abandoned me,” “God does not love me,” “I am being punished by God”). Findings of our study provide preliminary evidence suggesting that trauma treatments adapted to openly integrate spiritual and/or religious themes may be effective in achieving the dual purpose of not only reducing trauma symptoms, but also ameliorating the damaging effects of trauma on one's spirituality. Especially for indigenous cultures that primarily rely on religious and/or spiritual frameworks to explain or find meaning from suffering caused by trauma, it is possible that such interventions may be found to be more effective than their conventional, nonreligious counterparts. Future research may aim to compare the effectiveness of SO-TF-CBT against standard TF-CBT in reducing trauma symptoms as well as enhancing spirituality. As it stands, the present study represents the first study investigating the effectiveness of SO-TF-CBT—whether it is within the context of an LMIC or a Western, high-resource country.

Similar to previous intervention studies in LMICs with a lack of access to mental health professionals (Bolton et al., 2007; Ertl et al., 2011; Schaal, Elbert & Neuner, 2009), our results show that trained local facilitators from

varied backgrounds with varying levels of experience in mental health (i.e., community-based lay counselors, NGO staff volunteers, undergraduate students), are similarly capable of applying SO-TF-CBT successfully without significant differences in the effectiveness of reducing trauma symptoms. Although some differences were observed concerning the degree of reductions in spiritual struggles across certain treatment groups (i.e., children who received treatment from NGO counselors vs. student counselors), these may in part be accounted for by differences in endorsement of spiritual struggles between groups at baseline (the mean spiritual struggles score of children in the graduate student group at baseline was 7.37, whereas mean scores for the other treatment groups ranged from 9.58 to 10.00). Interestingly, spiritual struggles scores for the control group increased over the timeframe of the clinical trial, despite observed reductions in trauma symptoms during this same time period. This may suggest that the damage of trauma on one's spirituality may tend to persist or worsen—even after the natural recovery process has led the survivor through the resolution of some trauma symptoms.

We believe that a critical factor contributing to the positive findings of our study was the cooperation and endorsement of the local stakeholders and treatment facilitators. Feedback from SO-TF-CBT training was strongly positive, with NGO supervisors commenting on how their staff have grown to “better understand the behavior of children, identify their problems, and communicate properly with them” as a result of the training. Others commented on the helpfulness of being better equipped to more effectively work with parents and primary caregivers, to help them better understand and support their children. One treatment facilitator explained, “I learned to do my job better, manage children better, and develop more positive relationships with [co-workers] of the organization.”

Limitations and Directions for Future Research

The findings from the present study should be interpreted in light of several limitations, many of which concern the methodology of the study. First, the study utilized self-report measures,

which are subject to response bias. Future research could utilize other sources of information, such as other-report or behavioral measures (Dorn, Hook, Davis, Van Tongeren, & Worthington, 2014). Second, we utilized a small, convenience sample. Although our study included a control group, participants were not randomly assigned to either the treatment or control group, as the control group consisted of children from the same elementary school. Thus, other factors besides the actual treatment may have contributed to the changes seen between groups. Third, there was a substantial amount of dropout among participants in the treatment group. Although we were able to identify several reasons for the dropout observed, and informal assessments revealed high levels of satisfaction for our treatment, future research could explore ways to improve treatment adherence. Also, as previously mentioned, some baseline values of measured variables were different across groups. Finally, we did not compare our experimental treatment group to another standard treatment group—thus, we cannot definitively conclude that there is something uniquely important about spiritually adapted CBT, relative to any kind of mental health therapy or support. It is possible that simply receiving some type of support or therapy improves outcomes. Altogether, these factors reduce the internal validity of our findings.

In addition to the limitations above, an area of refinement for the treatment model was discovered during the process of administering the clinical trial, as treatment facilitators began to present several cases during supervision where the child was experiencing current maltreatment. Similar to many culturally adapted TF-CBT models, the original treatment model focused on managing and living with past maltreatment and did not include strategies for self-protection and coping in present, ongoing situations. Future work with this population should include an expanded treatment model that incorporates child coping and self-protection strategies. An example of this approach would be Murray, Cohen, and Mannarino's (2013) work modifying TF-CBT for treating youths with ongoing trauma. They noted that working with ongoing traumatic experience requires balancing a need to repeatedly learn how to distinguish real danger from overgeneralized trauma reminders. The authors also noted that

many times, children experience ongoing trauma because they have grown to rely on abusive sources for care. This care environment can lead to hopelessness in the youth and families involved as well as the therapist. In response to these challenges, Murray, Cohen, and Mannarino suggest employing the following additional strategies: (a) prioritize safety; (b) enhance engagement; (c) distinguish real danger versus trauma reminders; and (d) provide advocacy.

Conclusion

In sum, the present study investigated a culturally adapted spiritually oriented cognitive-behavioral treatment for child survivors of restavek in Haiti. Our findings supported the hypotheses that this treatment decreased symptoms of PTSD and spiritual struggles relative to a control condition. This study also provides an example of culturally sensitive collaboration and implementation of evidence-based practices.

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