# ADULT SURVIVORS

## *TREATMENT FOR THE LONG-TERM EFFECTS OF CHILD ABUSE*

*—by John Briere*

Recent studies suggest that perhaps one fifth of all adults were sexually abused by their mid-teens, and roughly equivalent numbers were physical maltreated to the point of, at minimum, bruises or bleeding (Briere, in press). Other types of victimization are everyday experiences for many children, including psychological abuse, emotional neglect, maltreatment by substance abusing parents, witnessing domestic violence, and the diffuse effects of cultural racism and sexism on child development.

A variety of long-term psychological and psychosocial problems appear to arise from childhood maltreatment. As outlined in various reviews (e g., Briere, in press; Browne & Finkelhor, 1986), these include posttraumatic stress, cognitive distortions, anxiety, depression, somatic concerns, dissociation, eating disorders, sexual dysfunctions, and impaired self-relatedness. Also present may be behavioral difficulties, including relationship problems, various forms of aggression against others, substance abuse, suicidality, self-mutilation, and indiscriminate sexual behavior.

Given the known prevalence and effects of the various forms of child abuse and neglect, one might assume that mental health practitioners have a wide variety of resources to draw upon in their work with adult abuse survivors. Unfortunately, because child abuse and its effects have been acknowledged only recently, there is a great paucity of information regarding how to treat post-abuse trauma. In fact, prior to the last five years there were almost no book-length treatises available on abuse-focused psychotherapy.

With the recent advent of a small group of volumes (e.g., Briere, 1989; Courtois, 1988; Gill, 1988; Jehu, 1988; Maltz & Holman, 1987; Meiselman, 1990), however, it has become possible at least to identify those treatment approaches that may be most effective in the resolution of long-term abuse effects. The reader should recall, however, that the crucial work of therapeutic outcome research has, in most cases, yet to be done.

***Social perspective***

A major difference between traditional therapeutic approaches and modern abuse-focused treatment is the latter's consideration of social dynamics. As noted above, child abuse is so common that the clinician is inevitably confronted with the social contributions to child victimization. As a result, feminism, child advocacy, and similar social perspectives are common among abuse-focused therapists. Such philosophical bases tend to support interventions that engender survivor empowerment and self-determination, as opposed to passive involvement in therapy. Aspects of this perspective are present in many of the approaches presented below.

***Trauma-related interventions***

Trauma theory, adapted from work with victims of major stressors such as war or natural disasters, emphasizes the defensive and adaptive components of response to child abuse. Childhood victimization is seen as an event that would induce significant psychological disturbance in almost anyone, such that later "abnormal" behavior is reinterpreted as situationally appropriate coping responses, and/or normal reactivity to an overwhelmingly aversive event. Often, such postabuse reactions are conceptualized as involving "posttraumatic stress," or its later elaborations into dysfunctional personality traits.

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Trauma theory posits that memories of victimization are often repressed, compartmentalized, or otherwise dissociated from thought in order to reduce painful abuse-related affect. Trauma-based interventions therefore tend to focus on two tasks: 1) the recovery of previously repressed memories of childhood maltreatment, and 2) the "working through" of feelings and thoughts associated with new abuse-related awareness. This approach is thought to permit integration of previously split-off cognitions, affects, and memories, resulting in decreased need for "symptoms" to control abuse-related distress.

In practice, survivors spend considerable time "revisiting" childhood trauma — struggling to recall and re-experience those aspects of their early life that they, in some sense, want least to confront. Fortunately, as this process continues posttraumatic memories gradually lose their distress-producing potential, and survivors are better able to gain perspective on the basis for their current difficulties.

***Cognitive interventions***

Victimization early in life appears to distort subsequent assumptions and perceptions of self, others, the environment, and the future. As a result, the survivor may experience guilt, low self-esteem, helplessness, hopelessness, and overestimation of the amount of danger present in the environment.

Cognitive therapeutic approaches typically involve working with the survivor to update her/his abuse-related assumptions. The survivor learns to recognize and alter cognitive distortions and erroneous beliefs through what is referred to as "cognitive restructuring." As noted by Jehu (1988), this procedure helps clients "a) to become aware of their beliefs; b) to recognize any distortions they contain; and c) to substitute more accurate alternative beliefs" (p. 57).

The survivor is encouraged to examine the objective and historic basis for his/her most painful abuse-related assumptions. For example, Jehu (1988) suggests intervention in beliefs like "I am worthless and bad," "I must have been seductive and provocative when I was young," and "I am inferior to other people because I did not have normal experiences" (p. 319). In each of these instances, a cognitive restructuring approach might lead to therapist responses such as "I wonder how/where you learned to see yourself like that?" "What about being abused makes you inferior?" and "Last week we talked about how scared and helpless you felt as a child — how does that fit with what you're saying now about being seductive?" Thus, the therapist offers gentle challenges to survivors' abuse-distorted view of themselves and others, so that survivors may begin to construct a world view less influenced by childhood oppression.

***Modified psychodynamic interventions***

Abuse-focused psychotherapists often draw on psychodynamic principles in their work with survivors, although not all such practitioners identify themselves as psychodynamic. While hopefully eschewing Oedipal interpretations, the clinician may find it useful to consider recent work in object relations and attachment theory when addressing the survivor's impaired self-reference. Similarly, psychodynamic concepts of transference, projection, and self-other differentiation may be of considerable assistance in helping the survivor to resolve problems in her/his relations with others. It is important, however, that such perspectives and techniques be examined carefully for the remnants of less enlightened Freudian contributions, such as anti-survivor biases, victim blaming, sexism, homophobia, etc.

Perhaps the most important contribution of psychodynamic theory is its focus on the therapeutic relationship, wherein the survivor can be expected to project his/her fears, needs, fantasies, and cognitive distortions onto the therapist. Because many of the survivor's most pressing issues relate to

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early childhood trauma, this projection will often take the form of abuse-related transference — the client will tend to perceive the therapist as if he or she were the survivor's original abuser, and respond accordingly. The therapist, in turn, is expected to provide caring, supportive, and clarifying interventions which, over time, allow the client to relearn important interpersonal lessons about trust, safety, boundaries, and individuation. Thus, psychodynamic processes can serve as powerful routes to early abuse-specific states, during which time important new learning and further psychological development may take place.

***Group therapy***

As important as individual psychotherapy may be in the intensive treatment of post-abuse trauma, there are certain therapeutic goals best met by group therapy. These include decreased isolation and stigmatization, the development of interpersonal trust, connection with a supportive group of individuals who have similar histories, and the opportunity to help as well as to be helped — a process that supports self-esteem and lessens the sense of being a mere recipient of treatment. Group therapy may be especially effective as an adjunct to (rather than a replacement for) individual psychotherapy in work with survivors of more severe childhood trauma. Group treatment alone, for example, may stimulate flashbacks, severe anxiety, new memories, and other intense or extended psychological phenomena that may not be optimally addressed in a group context. Individual therapy without group treatment, on the other hand, may run the risk of depriving the client of important experiences to be derived from interactions with other survivors. There are several books that specifically address the structure and process of group treatment with abuse survivors (e.g., Briere, 1989; Courtois, 1988), as well as a number of important articles detailing specific group treatment approaches (e.g., Courtois & Leehan, 1982; Herman & Schatzow, 1984).

***Couple's therapy***

Clinicians working with survivors have recently discovered the importance of addressing the survivor's relationship with her/his partner or spouse. Because survivors may have difficulties with trust, intimacy, and/or sexuality in relationships, the survivor-partner dyad (if there is one) may be a source of considerable stress for each member. Clinical interventions that focus on this relationship may assist the survivor by a) decreasing the tension and dysphoria brought about by relationship discord, b) increasing the likelihood that the relationship can become a significant source of support, and c) allowing the survivor to work through chronic interpersonal difficulties in a relatively safe context. The partner may also experience benefits, including support and education regarding the basis for his/her lover's sometimes disturbing behavior. The reader is referred to Follette (in press) and Maltz and Holman (1987) for specific information on the conduct of survivor-oriented couple's therapy.

***Self-help programs***

All of the interventions cited thus far share at least one characteristic: the involvement of trained mental health professionals. There are many survivors, however, who have derived significant growth and development through self-help groups or associations (e.g., the "twelve-step" programs). Such programs offer the survivor a strong support network of others with similar interests and needs, as well as a concrete system of interventions and rules for living that provide structure and guidance. In the past, child abuse survivors gravitated to such groups by virtue of their focus on issues especially relevant to post abuse trauma, such as alcoholism, drug abuse, or eating disorders. More recently, however, specialized groups such as Incest Survivors Anonymous have come into being, potentially offering the survivor more specific assistance for her abuse-related difficulties.

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Some abuse-specialized clinicians are uncomfortable with such programs, citing, for example, the frequent focus on Christianity, forgiveness, institutionalized self-blame, explanatory concepts that stress addiction as the primary cause of most other difficulties, and the tendency to demand conformity to an inflexible set of expectations. While these concerns have merit, self-help programs offer benefits typically unavailable from mental health specialists: participation is free, support is potentially on a 24 hour basis, stigmatizing labels (i.e., psychiatric diagnoses) are conspicuously absent, and the focus on abstinence from self-destructive behaviors often provides needed external controls. For these reasons, it is often helpful to refer survivor clients to self-help programs when indicated, while simultaneously providing abuse-focused psychotherapy.

***Self-help books***

The last approach presented here represents a relatively new development in the abuse field: abuse-specific self-help books. These volumes are written directly to the survivor, and provide assistance in several areas: they normalize the survivor's self-perceptions by emphasizing the commonness of child abuse; they explain the various "symptoms" and difficulties experienced by survivors in a nonstigmatizing, legitimizing manner; they offer concrete advice regarding common abuse-related problems; and they convey hope by stressing growth and recovery. Although sometimes used independent of therapy, these books are frequently quite useful during the treatment process. Among the best books in this area are those of Bass and Davis (1988), Gil (1983), and Lew (1988).

***Conclusions***

As was noted at the outset, the field of child abuse trauma is in its relative infancy. Interventions in this area are, by definition, new and of untested utility. Nevertheless, the approaches outlined in this paper appear to have merit, especially when applied from a perspective that honors the courage, strength, and right to dignity inherent in survivorhood. Although each of these approaches "belongs" to a specific system of therapeutic thought, the complexity of long-term abuse effects requires the clinician to adapt a variety of different techniques to the specific needs of abuse survivors. Ultimately, by virtue of the prevalence of child abuse in the general population, further work in this area may yield new approaches to a number of the mental health problems currently confronting psychotherapists.

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