CHILD VICTIMS

PROMISING TECHNIQUES AND PROGRAMS IN THE TREATMENT OF CHILD SEXUAL ABUSE

—by William N. Friedrich

More than ever before, sexually abused children are being seen in therapy by individuals who not only know that sexual abuse of children exists and is a very common contributor to the child's clinical presentation, but who have also attended workshops and/or read books on the therapy of these children and their families. This represents considerable progress over the past ten years.

Thus, on one hand, it is possible to state that we are better able to treat sexually abused children and their families. However, it is also possible to make a contradictory statement. Given that there is an almost total lack of empirical research documenting successful outcome of treatment in this area, it is possible to state that we still do not know how or if our treatment is helpful to these children.

While we may believe that clinical evidence supports our effectiveness, until we can demonstrate this empirically, we fail our clients because we can never be *sure* that what we are doing works. Without empirical proof of the success of our efforts, therapists will legitimately question their own utility, will not be able to learn from the efforts of others and, in this day and age of tightening psychotherapy finances, will find it increasingly difficult to secure funds for therapy for children who need it.

Treatment literature

A number of published studies have attempted to examine treatment outcome in this area, but most of these studies would probably not have been published in mainstream psychotherapy or psychological journals. The available studies lack such essential elements as random assignment to specific treatments and the use of standardized pre-, post-, and follow-up assessment measures. Sample sizes also tend to be very small. For example, although group therapy is seen as valuable treatment, only two published studies, one with six young girls (Nelki and Watters, 1989) and another with ten adolescent girls (Furniss, Bingley-Miller, and Van Elburg, 1988) have attempted to evaluate pre- and post-functioning, utilizing either an unstandardized symptom checklist or a semi-structured interview. No effort was made in either study to compare one form of treatment with another or to utilize more subjects and standardized outcome measures.

In addition, the available literature includes two behaviorally-based single-subject treatment designs. One reports on the treatment of a 15-year-old girl's functional blackouts presumed to be related to an incestuous experience (Dollinger, 1983). The second reports on the successful treatment via parent training of the negative emotional arousal and verbal ruminations in a 5-year-old sexual abuse victim (McNeill and Todd, 1986).

Although not an outcome study, another paper utilized a standardized behavior checklist with eight young children to document the variable course of improvement and deterioration in sexually abused children who had either received or not received treatment (Friedrich and Reams, 1987), with treated children showing greater resolution of behavior difficulties. A more recent paper reports on 19 girls, ages 3 to 16 years. Short-term cognitive-behavioral treatment was utilized and the authors found significant improvement from pre- to post-test on both internalizing and externalizing behavior problems (Deblinger, McLeer, and Henry, 1990). The authors of this study utilized a PTSD formulation in designing their cognitive-behavioral treatment.

> ***"Our field is overdue in the rigorous evaluation of our efficacy as therapists."***

A final study examines the effects of a wide variety of interventions on a group of 42 treatment resistant sexually abused preadolescent boys (Friedrich, Luecke, Beilke, and Place, under review). A large number of individual and family-based standardized measures were used to assess these children prior to therapy and at the end of therapy, and a smaller subset of children three months after the end of therapy. While this paper documents positive behavior change over time in two thirds of these boys, it is impossible to state whether or not therapy or the passage of time was the critical element in these boys' improvement, because no comparison group was utilized and no random assignment to treatment groups was done.

Our field is overdue in the rigorous evaluation of our efficacy as therapists. In a survey of 758 child sexual abuse treatment programs, Cicchinelli, Keller, and Gardner (1987) found that fewer than half of the programs responding indicated that they regularly use standardized or program-specific tools at any time to evaluate clients, and fewer than a third use measures to determine outcome. Two programs in our country that appear to be quite large, based upon their descriptions in the clinical literature, are programs developed by Henry Giaretto (Giaretto, 1982) and the Midwest Family Resource Center in Chicago (Trepper and Barrett, 1986). However, neither program has published peer-reviewed empirical outcome data that can be used to guide our treatment planning.

Large numbers of children and their families are being seen, and child-sensitive treatment programs can be developed that allow all children in need to receive timely treatment. We should no longer tolerate the absence of data on most effective treatment modalities. If you are involved in a treatment program that sees more than a handful of children a year, it is important for you to lobby your program to begin evaluating your treatment effectiveness.

Children could be randomly assigned into individual versus group therapy, enabling a determination of which therapeutic method is more effective. Another study could contrast children who are seen either individually or in group, versus children who are seen in the same modality, but in which a carefully planned parent training element was an additional component. This would enable a contrast between victim-focused and victim- and system- focused therapy.

A number of valid outcome measures exist, and these can be made part of the pretreatment assessment and the post-treatment termination interview. Additional follow-up 6 to 12 months later is recommended, whether by conducting telephone interviews or by paying the families to complete a similar set of measures to the ones that they completed at pre- and post.

Promising Approaches

In the absence of reliable outcome data, I describe approaches in this section based on my belief that treatment should be specific, should be sensitive to the child's needs, and should emphasize the interpersonal either via group or family-based interventions. In addition, since multiple systems are routinely involved in these children's lives, I believe that proactive treatment coordination is a necessary part of the treatment process.

Research on the impact of sexual abuse in children indicates that a significant percentage of sexually abused children do not exhibit overt distress. While internal, less noticeable distress does exist in some of these nonbehaviorally disordered children, sexually abused children frequently fall between nonreferred children and psychiatric outpatient children with regards to severity of behavior problems (Friedrich, Beilke, and Urquiza, 1987). Thus, lengthy treatment of

continued on next page

FRIEDRICH (continued from page 5)

a nonsymptomatic child may not be sensitive to the child's real needs.

Much child therapy is nondirective, often because therapists fear that more directive therapy will further victimize the child. But specific, directive therapy is likely to be more effective, although this clinically-based observation is subject to empirical validation. Because sexual abuse does not result in a homogeneous syndrome or constellation of behaviors, we may be able to make very productive use of techniques focused on a variety of specific effects. In the absence of clear indications that long-term intensive psychotherapy is required, it is important to develop minimal interventions for some children, such as preparing the child for court testimony (Kids in Court Program). Other interventions may target the child's parents, teaching them to monitor their child's behavior, and providing support and possible consultation around behavioral techniques. The child and family could return on an as-needed basis after the initial brief therapy, possibly at developmentally important times such as major life transitions and the onset of dating.

An extensive literature exists on specific behavioral treatments for such common abuse sequelae as sleep disturbance, toileting difficulties, depression, and aggressive behavior. In addition, treatment can focus on those child-based and family-based variables that exacerbate the abuse impact, such as pre-existing conduct disorder in the child, impaired peer relationships, marital distress, and depression in the parent. Sexual abuse concerns can be made a focus initially in the therapy, which may help create a more supportive and safe environment for the child's future development. Sexual behavior problems are abuse-specific sequelae that are baffling to many therapists. However, inappropriate sexual behavior can be managed behaviorally, as can intrusive thoughts that result in the child's increased distractability in the school setting. Several specific treatment suggestions for sexually aggressive children are available (Friedrich, 1990; Johnson and Berry, 1989).

Because a wide variety of specific approaches targeting a variety of specific behaviors is often required, outcome can be evaluated using Goal Attainment Scaling (Justice and Justice, 1979). Specific goals are targeted initially and progress towards them is determined at the end of therapy. This enables outcome assessment of a wide variety of children and their families, each receiving various treatment.

Many child victims are involved in group therapy, and my experience suggests that this can be a very effective technique for the majority of victims and their parents. Empirical research is needed to clarify which is most effective with which clients: short-term or long-term group therapy, and group therapy that is specific or less specific to the child's abuse experience. Agencies that see large numbers of children could research the above questions. The efficacy of 10-session versus 24-session therapy can be contrasted with a sample of children randomly assigned to either. As another manipulation, both the briefer and longer-term technique could have either less or more direct content focused on the sexual abuse experience, allowing an examination of four different approaches at once: brief-direct, brief-indirect, extended-direct, and extended-indirect. A study with 15 to 20 children in each group assessed on several variables obtained at pre-, post-, and follow-up would be both valid and highly publishable.

Other approaches that show promise but await empirical research include:

- Pair-therapy, in which two developmentally similar victims are seen together. This is useful for children who cannot tolerate the intensity of a larger group, or who would easily be scapegoated in a larger group (Selman and Schultz, 1990).
- Parallel group therapy, in which children and nonoffending parents are seen in different groups processing similar issues, may be successful in correcting both individual issues and parent-child relationships (Mandell and Damon, 1989).
- Using a child who has completed therapy as a "graduate assistant" to aid in the treatment of another child may have therapeutic benefits to both children (James, 1989).
- Relaxation training warrants further investigation as a means of alleviating the child's acute distress following sexual abuse.

Cognitive behavioral therapy with children is a proven approach for treating conduct disorder, attention deficit hyperactivity disorder, and depression. There is every reason to believe that a cognitive behavioral approach modified for use with sexually abused children would be effective in relieving the feelings of powerlessness and the negative attributions about their efficacy as individuals often reported by victims. A study comparing cognitive and noncognitive approaches could expand on the initial study conducted by Deblinger, et al. (1990).

> ***"Because sexual abuse does not result in a homogeneous syndrome or constellation of behavior, we may be able to make very productive use of techniques focused on a variety of specific effects."***

Most therapists agree that family therapy is necessary, but we don't know what components of family therapy are important. Is it the repair of the nonabusive parent-abused child relationship? Is it the removal of the father from the family? Is it the resolution of the abuse and victimization history of the nonabusing parent? Empirical evaluation of each of these important components of therapy will help us direct our interventions more effectively.

In short, victim-focused treatment benefits from the use of specific interventions that borrow from the available child treatment literature. Treatment is enhanced further by parent-training, group therapy including pair groups and parallel groups, and family-based therapy. The more specifically the treatment is targeted to the child and parents' strengths and needs, the more respectful it is and the more likely to be effective. For a partial listing of centers doing innovative clinical work with sexually abused children and their families, contact the author.

References

Cicchinelli, LF, Keller, RA, and Gardner, DM (1987). Characteristics of child sexual abuse treatment programs. Paper presented at the annual Family Violence Research Conference, Durham, NH (July).

Deblinger, E, McLear, CV, and Henry, D (1990). Cognitive behavioral treatment for sexually abused children suffering post-traumatic stress: Preliminary findings. *J. of the Am Acad. of Child and Adol. Psychiatry. 29*, 747-752.

Dollinger, SG (1983). A case report of dissociative neurosis in an adolescent treated with family therapy and behavior modification. *J. of Consulting and Clinical Psychology, 51*, 479-484.

Friedrich, WN (1990). *Psychotherapy of sexually abused children and their families.* NY: Norton.

Friedrich, WN, Beilke, RL, and Urquiza, AJ (1987) Children from sexually abusive families: A behavioral comparison. *J. of Interpersonal Violence*, 2, 391-402

Friedrich, WN. Leucke, WJ, Beilke, RL, and Place, V (under review). Psychotherapy outcome of sexually abused boys: An agency study.

Friedrich, WN, Reams, R (1987). Course of psychological symptoms in sexually abused young children. *Psychotherapy: Theory, Research and Practice 24*, 160-170

Furniss, T, Bingley-Miller, L, and Van Elburg, A (1988). Goal-oriented group treatment for sexually abused adolescent girls. *British J. of Psychiatry, 152*, 97-106

Giaretto, H (1982). *Integrated treatment of child sexual abuse: A treatment and training manual.* Palo Alto: Science and Behavior Books.

James, B (1989). *Treating traumatized children. New insights and creative innovations.* Lexington, MA: Lexington Books

Johnson, TC and Berry, C (1989). Children who molest: A treatment program. *J. of Interpersonal Violence 4*, 185-203.

Mandell, JG and Damon, L (1989). *Group treatment for sexually abused children.* NY: Guilford.

McNeill, JW and Todd, FJ (1986). The operant treatment of excessive verbal ruminations and negative emotional arousal in a case of child molestation. *Child and Family Behavior Therapy. 8*, 61-69.

Nelki, JS and Watters, J (1989). A group for sexually abused young children: Unraveling the web. *Child Abuse and Neglect. 13*, 369-377

Selman, R and Schultz, L (1990). *Making a friend in youth.* Chicago: U. of Chicago Press.

Trepper, TS and Barrett, MJ (1986). *Treating incest: A multiple systems perspective.* NY: Haworth.

William N. Friedrich, PhD, is Associate Professor of Psychology at the Mayo Clinic, 200 First St. SW, Rochester MN 55905.