MENTAL HEALTH

Individual Treatment of the Sexually Abused Child

–by Julie A. Lipovsky and Ann N. Elliott

The current state of knowledge regarding treatment of sexually abused children is simultaneously vast and limited. The knowledge is vast as a result of the many excellent resources published by clinicians who have shared their perspectives on treatment (e.g., Berliner & Wheeler, 1987; Friedrich, 1990; Gil, 1991; James, 1989). However, the state of knowledge is limited by the lack of an empirical foundation informing the field about the effectiveness of treatment approaches for reducing behavioral, emotional, and cognitive difficulties associated with sexual abuse experiences. The discussion that follows will highlight various aspects of abuse-focused treatment that are commonly recommended by clinicians. Several controlled treatment outcome studies currently are in progress and are designed to examine empirically the efficacy of such approaches.

Assessment

Child Functioning

The list of symptoms and psychiatric difficulties found among child victims of sexual abuse is long and varied (see Beitchman, Zucker, Hood, DaCosta, & Ackman, 1991; Kendall-Tackett, Williams, & Finkelhor, 1993 for reviews). Furthermore, sexual abuse experiences are themselves quite diverse. Therefore, it is essential that specific treatment approaches be informed by a comprehensive evaluation of the child's current presenting problems, the nature of the abuse, the context in which abuse occurred, and the consequences of disclosure or discovery. The goal of the clinical assessment is not to determine whether or not the child has actually been abused. Rather, the goal is to develop a framework for understanding the behavioral, emotional, and cognitive functioning of the child within his or her current environment in order to guide the process of treatment. The assessment process is designed to identify targets for intervention as well as factors which may mediate the child's response to the abuse and which may affect the progress of treatment.

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The effects of sexual abuse tend to occur on a continuum from neutral to negative (Friedrich, 1990), and no single syndrome has been identified as common for the majority of child victims (e.g., Beitchman et al., 1991). Therefore, a significant portion of the assessment process will be directed towards determining the impact that the abuse has had on the particular child presenting for treatment. The most commonly noted psychosocial problems among children who have been sexually abused are sexualized behaviors, anxiety, depression, poor self-esteem, general behavior problems, and Post-Traumatic Stress Disorder (PTSD; e.g., Kendall-Tackett et al., 1993). Suicidal ideation/behavior, substance abuse problems, dissociation, and faulty or maladaptive cognitions also may be present and are worthy of assessment (Berliner, 1991).

Features of the abuse experience

In addition to evaluating the child's current behavioral, emotional, and cognitive functioning, assessment focuses on the particular features of the child's sexual abuse experience. Important factors to be addressed include the nature of the relationship between child and offender, frequency and duration of abuse, level of force or threat used by the offender, and whether or not sexual penetration occurred. These factors tend to be associated with the impact of abuse (Kendall-Tackett et al., 1993). Assessment should also address whether or not the child has been exposed to other types of traumatic events or maltreatment (e.g., physical abuse, neglect, witnessing violence within the family or the community) which may affect his or her response to the sexual abuse. The context of disclosure, including familial and community responses, also potentially influences the child's adjustment. Assessment of the child's family environment and support (i.e., attitudes towards the child and the abuse) is important since research has demonstrated that maternal support mediates the effects of child sexual abuse (e.g., Everson, Hunter, Runyan, Edelsohn, & Coulter, 1989). The cultural context in which the child lives also is influential and should be examined within the assessment process.

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Information gathered during the assessment process should aid in the formulation of a treatment plan. Targets for intervention are prioritized, and strategies for intervention can then be selected.

Treatment

Common goals

While unique factors relevant to each case will provide direction and priorities for intervention, several common goals guide individual treatment with sexually abused children. First, abuse-focused treatment is designed to help the child understand the nature of the trauma and the effects that this experience has had on him or her. Second, treatment facilitates the child's ability to talk and think about the abuse without embarrassment or significant anxiety. Third, treatment addresses presenting symptoms in order to reduce the frequency and intensity of behavioral and emotional distress. Fourth, treatment fosters healthy expression of feelings about the abuse as well as about consequences of disclosure. Finally, distorted, faulty, or unhealthy cognitions are examined and modified to promote more adaptive ways of thinking about the abuse, self, and relationships. It is important to note that we view these broadly defined goals as central to individual abuse-focused treatment with children. However, additional goals are also established based upon the child's individual experience (Friedrich, 1990). For example, modification of family interactions may be warranted in order to ensure an environment that facilitates the child's healing process (e.g., Gil, 1991).

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Focus on victimization

Most experts would agree that the cornerstone of treatment with child victims is the inclusion of direct focus on the victimization experiences themselves (e.g., Friedrich, 1990; Salter, 1988; Berliner, 1991; James, 1989; Gil, 1991). The therapist is active in directing the child to examine abuse-related issues, while at the same time maintaining a supportive relationship with the child. Strategies involving exploration of the abuse are expected to facilitate attainment of the treatment goals described above. Further, direct approaches communicate the therapist's ability to tolerate uncomfortable issues. This may counteract the child's feelings of shame and embarrassment by modeling acceptance of the experience (e.g., James, 1989). Treatment may utilize various modalities (e.g., traditional "talk" therapy; play therapy; drawings; puppets) to facilitate exposure to actual abuse experiences and issues associated with those experiences. It is essential that the selection of specific intervention strategies take into account the child's developmental capabilities (e.g., Lipovsky, 1992).

Direct exposure to abuse-related memories, thoughts, and feelings has most frequently been described as it relates to reducing fear, anxiety, and PTSD symptoms (e.g., Berliner & Wheeler, 1987; Deblinger, McLeer, & Henry, 1990). Both the literature on adult rape (e.g., Kilpatrick, Veronen, & Best, 1985) and child sexual abuse (e.g., Berliner & Wheeler, 1987) contain conceptualizations of assault-related fear and anxiety arising through the process of classical conditioning. Such conceptualizations posit that previously neutral cues become associated with fear and anxiety as a result of being paired with these emotions during the abuse. Thus, the presence of specific cues, including thoughts and memories of the abuse, can elicit anxiety or fear responses. Children then frequently avoid abuse-related thoughts and memories in order to reduce their experience of emotional discomfort (Deblinger et al., 1990).

Direct focus on abuse experiences encourages the child to approach uncomfortable memories, thoughts, discussions, and feelings in the absence of objective threat (Deblinger et al., 1990). This strategy is intended to enable the child to disconnect the association between specific abuse-related cues and emotional discomfort and with a subsequent reduction of distressing symptoms. This in turn diminishes the child's need to avoid thoughts and feelings related to abuse experiences and allows for an integration of the experience(s). Discussion of the sexual abuse can also reveal important cues present during the abuse itself that may trigger anxiety or other emotional responses (Berliner & Wheeler, 1987). Finally, focusing on the victimization assists the child in accepting the reality that abuse has occurred (e.g., James, 1989).

Cognitive interventions with abused children also support the use of approaches which focus directly on victimization. A long list of cognitive issues and themes has been identified as theoretically important to the functioning of children who have been sexually abused. Among these are the traumagenic dynamics of betrayal, powerlessness, stigmatization, traumatic sexualization (Finkelhor & Browne, 1985), guilt, self-esteem (e.g., Porter, Blick, & Sgroi, 1982), and attributions of responsibility and blame (e.g., Wolfe, Gentile, & Wolfe, 1989).

Direct focus on the victimization allows the therapist to determine whether particular abuse-related themes are relevant to the child and the context in which faulty beliefs developed. Therapist inquiry also clarifies children's understanding of the abuse and their reactions to it, about the offender and his or her behaviors, and about the abuse itself. Furthermore, talking about the abuse can reveal inaccurate or maladaptive cognitions, particularly those related to self-blame and responsibility. Accurate information regarding the process of victimization (Berliner & Conte, 1990), sexuality, and the development of symptoms can be provided to challenge incorrect beliefs. However, cognitive processing involves more than mere challenges to faulty thinking. The bases for beliefs should be examined and cognitive processing occurs by exploring alternatives to unhealthy assump-

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tions (Berliner, 1991).

Abuse-focused treatment also is ideally suited to promote emotional processing of the child's experiences. In addition to fear and anxiety, sexually abused children may experience anger, sadness, shame (Porter et al., 1982), and sexual feelings (Berliner, 1991) related to their abuse. Exposure not only stimulates feelings and permits emotional expression and processing, it also provides important information regarding the particular experiences which influence such reactions. The child can be directed to describe feelings experienced at the time of the abuse as well as current emotional reactions. This should facilitate identification, labeling, and ventilation of painful affect. Appropriate means for expressing discomforting feelings can be explored and practiced within the therapeutic process.

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Assessing the child's readiness

Thus far, we have discussed reasons for utilizing interventions which focus directly on abuse experiences rather than techniques which expose children to abuse-related stimuli. Direct focus on victimization can evoke strong emotional reactions in children. Therefore, children and caregivers may be reluctant to participate in treatment due to a belief that it would be best for children simply to "put the abuse experiences behind them." However, because exposure to abuse-related material is a central part of treatment, it is essential to provide a rationale to both children and caregivers for incorporating such approaches (Friedrich, 1990). Much of the above discussion can be tailored to children and caregivers using nontechnical language.

In addition to providing the child with information about the process of therapy, it is essential that the therapist assess the child's ability to tolerate exposure to abuse-related material (Friedrich, 1990) and be sensitive to issues of psychological safety (e.g., MacFarlane & Krebs, 1986). Thus, exposure generally progresses at a gradual pace (Deblinger et al., 1990), with the therapist continually monitoring the child's emotional reactions. Children may communicate their distress verbally or behaviorally and the clinician should respect the child's need to distance him or herself from abuse-related issues if the process of therapy becomes emotionally overwhelming. With highly anxious or avoidant children the exposure process can begin with indirect discussion of abuse issues, including using books about sexual abuse, asking the child how other abused children might feel, or talking about peripheral issues rather than central ones. Other approaches may involve setting time limits on abuse-focused work (eg., Friedrich, 1990) or beginning with minimally distressing topics and gradually increasing the time or intensity of involvement. Reasons for avoidance should be identified and addressed directly when they interfere with the child's ability to process abuse-related materials (e.g., Lipovsky, 1992).

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Specific anxiety reduction strategies can be taught and implemented to facilitate abuse-focused therapy and to empower the child (e.g., Berliner, 1991). Skills such as relaxation, deep breathing, and guided imagery (e.g., Berliner & Wheeler, 1987) are important tools for children to employ in managing their emotional distress. Cognitive strategies, including mediated self-talk (e.g., Deblinger et al., 1990), thought stopping, and covert rehearsal (e.g., Berliner, 1991) also can facilitate the child's ability to cope with uncomfortable feelings.

Other treatment approaches

While direct exposure to victimization experiences will comprise the bulk of abuse-focused treatment, it generally is not, in and of itself, sufficient to meet all goals of intervention with sexually abused children. For example, many of the behavioral problems that sexually abused children display are best understood from a social learning perspective, and may require behavior management strategies for amelioration (Berliner & Wheeler, 1987). Such strategies identify contingencies within the child's environment which may serve to reinforce undesirable behaviors, or punish desirable ones. Careful monitoring of the conditions under which behaviors occur and subsequent alteration of the environmental contingencies may be required to intervene. It is important to stress the importance of maintaining a broad perspective when working with sexually abused children, and of recognizing that abuse-focused work may be only one component of treatment. Further, there may be situations within which exposure to the victimization itself may not be a priority for intervention. First, circumstances surrounding disclosure must be managed and the child's living situation stabilized prior to initiating abuse-focused work. If the child does not have the support of a nonoffending parent and/or is in out-of-home placement, it may be necessary to focus initially on those issues rather than on the sexual abuse itself. Second, if the child's physical safety needs are not currently being met, abuse-focused treatment may be difficult or contraindicated. Children require an environment in which they are protected from the perpetrator and are receiving emotional support to be able to tolerate abuse-focused treatment. Third, it is important to recognize the possibility that sexual abuse is not the most disruptive experience in the child's life. Therefore, assessment should determine how to prioritize issues to target within the overall treatment.

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Conclusion

This article described the rationale and conduct of abuse-focused treatment. Many issues were not addressed explicitly, including the importance of involving caregivers in treatment (see Cohen & Mannarino, 1993; Deblinger, 1992), attending to developmental issues, incorporating instruction in prevention skills (e.g., Deblinger et al., 1990), and interventions directed towards the family (e.g., Berliner, 1991). Many of the references cited in this article will serve as useful resources for the interested reader.

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In conclusion, most clinical descriptions of therapeutic intervention with sexually abused children emphasize the importance of direct focus on the victimization itself. There are several theoretical rationales to support this type of intervention. Currently, several controlled outcome studies are examining the efficacy of treatment approaches that incorporate exposure techniques, instruction in the use of stress management skills, and cognitive processing (e.g., Berliner & Saunders, 1992). The challenge for the field will be to continue to design and implement research studies such as these to evaluate the effectiveness of treatment approaches for sexually abused children.

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New Series of Articles to Begin

Editors of *The APSAC Advisor* are pleased to announce that a new series of articles on cultural issues in child maltreatment begins in this issue. The series will address such topics as the rationale for cultural competence, a research agenda for improving our knowledge base on the effects of cultural variables, and techniques for enhancing one's own cultural awareness. Veronica Abney, MSW, a member of APSAC's Board of Directors and SCAN Team Coordinator at UCLA's Neuropsychiatric Institute, will serve as Associate Editor for the series.

To date, cultural issues in child maltreatment have been addressed in *The APSAC Advisor* primarily through the work of the People of Color Leadership Institute (POCLI), headed by Joyce Thomas, RN, MPH. We have been very happy to be the "home" for the POCLI section thus far. POCLI will continue to publish its own work periodically, in tandem with the new series.

We are delighted to be able to offer a wealth of resources on this important topic. Please let us know how this or any other aspect of *The APSAC Advisor* can be most helpful to you.