RESEARCH
Sexual Abuse Treatment Practices: A Survey

—by W. N. Friedrich, Theresa M. Jaworski, Lucy Berliner, and Beverly James

Although many children are referred each year for therapy because of sexual abuse, the types of treatment they receive and the beliefs of their therapists have not been studied. There are a number of reasons for this, including the fact that sexual abuse is a heterogenous phenomenon resulting in a diverse set of outcomes.

Other contributors include the fact that sexually abused children are treated by a broad range of professionals reflecting different training backgrounds. Therapists also differ in their experience with different modalities, their focus on the child victim or the family, and their beliefs about the degree to which the treatment should be abuse-focused.

Hampering the development of consensus is the nascent state of treatment research. With almost no exceptions, studies that have empirically evaluated treatment samples of sexually abused children have not compared the relative efficacy of different treatment modalities. Research that points to the relative benefit of treatment over no treatment is only now being completed, with the results still not available.

Until empirical support for one or more treatment methods exists, it makes sense to determine the beliefs and practices of experienced professionals. This could help determine if there is a consensus, derived from clinical experience, about the best practices of sexual abuse treatment. This knowledge could also guide treatment outcome studies, providing information on an agreed upon length of treatment, for example. Information from a survey of professionals' beliefs regarding treatment can also be used to guide the APSAC Guidelines Task Force on treatment, of which one of the authors (B.J.) is currently the co-chair.

Until empirical support for one or more treatment methods exists, it makes sense to determine the beliefs and practices of experienced professionals. This could help determine if there is a consensus, derived from clinical experience, about the best practices of sexual abuse treatment.

Some of the questions about which a clinical consensus possibly exists include the following: preferred length of therapy; directive versus non-directive treatment; preferred treatment modality; the need for family therapy and family reunification; whether or not treatment needs other than sexual- abuse-related sequelae exist; and how capable therapists believe themselves to be in managing a range of treatment needs.

In addition, because of differences in training and experience, we believed that the age, gender, and background of the therapists would have shaped their experience and beliefs. Because there is no consensus as yet about most treatment practices in this area, we did not develop *a priori* hypotheses about different questions or beliefs.

Method

Sample

A convenience sample of 130 therapists, recruited from treatment programs and workshop attendees in the United States and Canada, was recruited to complete a survey of therapy practices. Social workers were the most frequent participants (N=63), among counselors (N=33), psychologists (N=13), child care workers (N=4), psychiatric nurses (N=3), and other (N=13). The majority of professionals were female (N=104; 80%).

Participants were also asked to indicate their primary treatment focus. The majority worked primarily with child victims (N=72), followed by adolescent victims (N=18), adult victims (N=12), juvenile offenders (N=5), families of victims (N=5), adult offenders (N=3), trauma victims (N=2), and undetermined (N=13).

We also obtained information on the participants' terminal mental health degree as well as years of experience in the field. The most frequent degree listed was MSW/MA (N= 93), followed by Ph.D./Ed.D (N= 13) and BSW (N= 12). The mean years of experience for this sample was 13.6, s.d. = 21.4, median = 7.0, range 0 - 30 years.

Measure

A 46-item questionnaire was developed utilizing a three point format, disagree, neutral, and agree. The topics surveyed and the number of items in each area are as follows: length of treatment (2); group therapy (3); individual therapy (4); family therapy and reunification (9); therapist characteristics and training (12); the place of uncovering/abuse disclosure (6); structured approaches (6); the relation between investigation and treatment (2); and other (2). The items were developed by two of the authors (B.J. and W.N.F.) and reflected agreed-upon areas of concern regarding treatment practices [1].

Procedure

Workshop attendees and treatment program therapists were invited to complete the questionnaire anonymously and return it to the authors. They were informed prior to completing the measure of our interest in determining professional opinion about best treatment practices.

Results

The frequency of responses were calculated for each item. We grouped the items into those where *clear consensus* existed. This was determined to be the case when at least 66.7 percent of the respondents clearly agreed or disagreed with the item. Items where agree or disagree was endorsed 50.1 - 66.6 percent were labeled *majority* responses. *No consensus* items were those where neither agree nor disagree reached 50.1 percent.

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Clear consensus

A total of 16 of 46 items fell into the clear consensus category. Six of these items pertained to therapist characteristics and training, another four items regarding family therapy and reunification, two items about structured approaches, and one each regarding group treatment, uncovering, and structured approaches.

To elaborate about therapist characteristics and training, respondents believed that therapists must have training in child development, be able to treat a broad range of child behavior problems, and be familiar with how offenders are treated. Respondents believed that female co-therapists were helpful with the group therapy of male victims, but disagreed that the best therapists had been victimized themselves or that psychiatric medications were routinely helpful.

Clear consensus was also evident in that two-thirds or more respondents disagreed that family reunification should be a routine goal, that treatment issues were similar for intrafamilial and extrafamilial cases, that family therapy should be delayed until individual therapy was complete, or that reunification should take precedence over the acknowledgment of guilt by the incest perpetrator.

The need for a goal-oriented approach also reached a clear consensus, as did the need to assess treatment outcome. In addition, respondents strongly agreed that group therapy was not appropriate for all sexually abused children, that talking about the trauma was necessary, but that most children could not be successfully treated in less than eight sessions.

Majority

Generally, therapists did not feel very competent dealing with sexually reactive or aggressive behavior.

Another 9 items were supported by the majority of respondents. Four of these pertained to therapist qualifications and indicate that the respondents felt they could treat a broad range of child, adolescent, and adult issues. They also were generally supportive of male co-therapists. Two items reflected family issues and respondents were supportive of caregiver involvement in the child's therapy, but in disagreement about the need for a divorce to occur following father-child incest. Finally, they believed that treatment issues were affected by race, that an abuse focus was more effective, and that the investigatory phase can lead into good treatment.

No majority

That left 21 items for which there was no majority agreement or disagreement. These were distributed across all of the categories assessed. For example, there was a failure to clearly support group therapy or individual therapy as the preferred treatment modality, and there wasn't a consensus about family-based treatment being the most effective, either. Respondents did not endorse one treatment mode over the other, including structured or cognitive-behavioral treatment. Generally, therapists did not feel very competent dealing with sexually reactive or aggressive behavior. Even a time-honored clinical rule about the need for confrontation in juvenile offender treatment was not clearly endorsed one way or the other.

Differences among professional groups

We next examined whether therapist background was related to differential endorsement. First, we examined therapist role identification using chi-square. Because of number frequencies in each cell, we only examined the three largest professional groups, social workers, counselors, and psychologists. Analyses indicated significant differences ($p \leq .05$) for three items. Psychologists were more likely to agree with the need for child therapists to know about offender treatment practices, and differed from both social workers and counselors alike in remaining neutral about the primacy of individual therapy approaches. The final question pertained to competence in treating issues of adolescence, to which social workers and psychologists were less likely to agree.

The next contrast was by primary treatment focus, analyzing whether child, adolescent, and adult therapists differed in their responses. Chi-square analyses indicated no differences across all three groups.

Discussion and Summary

This initial survey of therapists' attitudes and practices revealed a considerable level of agreement as well as areas about which there is no clear consensus. An example of the lack of clear consensus is the finding that no single therapy approach is recommended as the primary method of choice. Fairly similar levels of respondents were neutral about any one mode being the preferred treatment. This included individual, group and family approaches, along with no clear consensus for either a cognitive-behavioral approach or a structured, time-limited approach. This finding is actually rather heartening given the variable impact of abuse and the absence of empirical support for any treatment modality.

Other findings include a consensus regarding the need for therapists to have broad-based clinical skills, training in child development, the need to establish treatment goals, and the utility of psychological assessment in planning treatment. However, the majority of the respondents do not believe that a victimization history makes you a better therapist. These results certainly indicate the need for well-trained professionals who operate in a planful, task-oriented approach.

A treatment debate persists regarding how

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central a discussion of the abuse needs to be for treatment to be successful (Friedrich, 1990). These respondents generally seemed to think that uncovering was a worthwhile therapy task, although there was less certainty about whether or not treatment-success depended on it.

Another debate revolves around whether family reunification is a positive or necessary goal. The fact that most respondents supported the need for family therapy early on in treatment would suggest that a family focus is seen as important. However, the majority did not feel family reunification should be a routine goal. It may be that therapists preferred examining the merits of reunification on a case-by-case basis rather than as a generic policy.

Although the respondents did not agree generally to any one treatment mode, there is literature that supports the use of cognitive-therapy for the treatment of PTSD-specific symptoms in latency-aged child and adolescent victims.

Although some consensus emerged in this study, several cautions need to be raised. First, the sample size was small and not randomly obtained. Second, there are numerous questions about treatment practices that were not asked and need to be asked, in the absence of empirical support. For example, although brief therapy (less than eight sessions) was not seen as optimal in the majority of cases, we did not ask questions designed to provide information about varying lengths of therapy for different ages, genders, and abuse and premorbid histories.

Another caution is that only after the surveys were returned did we realize that our wording of several items was unclear. For example, Question 5 was designed to determine whether therapists agreed that different issues presented themselves at different stages in the life cycle, e.g., adolescence, onset of sexuality, parenting. However, that was not clear from the wording of the question. Other confounds were present as well.

In addition, although the respondents did not agree generally to any one treatment mode, there is literature that supports the use of cognitive-therapy for the treatment of PTSD-specific symptoms in latency-aged child and adolescent victims (Deblinger, McLeer, and Henry, 1990). In future surveys it would be useful to determine whether practitioners are aware of and agree with the relevant literature. While individual therapy was not the treatment of choice for preschoolers, play therapy or family therapy may be, but these modalities were not asked about in this survey.

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Therapist experience and training background were surprisingly unrelated to the various survey items. Whether or not their primary focus was with children, adolescents, or adults, or whether they identified themselves as social workers, counselors, or psychologists, there were only three significant differences. The fact that 2 of these 3 differences could be chance alone underscores similarities across professionals of differing role and therapy focus.

This study was prompted by the ASPSAC Guidelines Task Force on Treatment of Sexually Abused Children, but the findings, while useful, are not being suggested as guidelines. Future research would do well to obtain a larger random sample, word questions more precisely, develop clinical vignettes, and examine more carefully therapist experience, e.g., number of clients treated. Reader input would be appreciated.

References

Deblinger E., McLeer, S., and Henry, D. (1990). Cognitive behavioral treatment for sexually abused children suffering post-traumatic stress: Preliminary findings. *Journal of the American Academy of Clinical and Adolescent Psychiatry. 29*(5). 747-752

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Endnotes

[1] A copy of the measure can be obtained by sending a self-addressed, stamped envelope with your request to APSAC, 407 S. Dearborn St. Suite 1300, Chicago IL 60605

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