Research on child sexual abuse treatment is relatively new. Literature in the 1970’s and 1980’s focused on describing the effects of sexual abuse on children, family dynamics and descriptions of interventions. As cases began to be prosecuted, interest in child witnesses and validation became a focus. Clinicians have continued to describe and refine treatments and many approaches and techniques appear useful and have wide-spread acceptance.

Although clinical interventions for child victims of sexual abuse appear promising, there are a limited number of empirical studies completed to date. This issue of VCPN will examine how sexual abuse impacts children, assessment issues, and the empirical literature on treatment effectiveness.

How Does Sexual Abuse Impact Children?

At the outset, it is important to note that sexual abuse is an act that a child experiences. Although experiencing sexual abuse can lead to a disorder or syndrome, it is not either (Deblinger & Heffin, 1996; Finkelhor & Berliner, 1995; Saywitz et al., 2000).

It is clear that children react differently to sexual abuse. There are no symptoms that occur in a majority of children (Finkelhor & Berliner, 1995). Further, child reactions to sexual abuse are highly variable. Some children show negligible effects while others show extremely adverse reactions with serious symptomology (Saywitz, 2000). Even so, most studies find that, as a group, sexually abused children exhibit a greater prevalence of problems than non-abused children (Berliner, 1997; Briere & Elliott, 1994).

Some frequently mentioned outcomes include:
- sexual behavior problems;
- post-traumatic stress disorder (PTSD);
- alteration of basic assumptions about oneself, others, and the world;
- depression;
- anxiety;
- guilt/shame;
- somatic symptoms;
- disruption of developmental processes.

When sexually-abused children are compared to non-abused children also in treatment, two types of symptoms are more prevalent in the sexually-abused children: PTSD and sexualized behavior. PTSD has been found in approximately 32 percent of sexual abuse victims which is similar to the frequency of poor self-esteem (35 percent), promiscuity (38 percent) and severe behavioral problems (37 percent) (Kendall-Tackett, Williams & Finkelhor, 1993).

For some children, the effects of being sexually victimized are not only experienced in the immediate present, but are also enduring. Some of those who experienced sexual abuse as children exhibit a wide range of psychological and psychosocial difficulties as adults. These include features of delayed or chronic post-traumatic stress such as intrusive thoughts about the abuse, constricted affect, use of avoidance mechanisms, hypervigilence, and sleep disturbance. Many areas of adult functioning - employment, intimate relationships, physical health, emotional stability - can be affected. For more information about adult survivors, please see VCPN, Volume 31.

Factors Affecting Children’s Reactions

Many factors affect a child’s reactions to sexual abuse. One set of factors concerns the characteristics of the sexual abuse. The term “sexual abuse” refers to a wide variety of activity, ranging from “hands off” offenses such as witnessing someone ex-
attached to an offender, even a noncoercive style of abuse can produce significant psychological impairment (Beutler, Williams & Zetzer, 1994). Guilt induced by succumbing to molestation without physical force may be a factor which compounds the trauma.

The child's age and stage of development can affect the outcome. Children have different understandings at different ages. The child's comprehension of the experiences can be important in outcome (Beitchman et al., 1992). In general, older children tend to be more symptomatic than younger ones (Feiring, Tasska, & Lewis, 1998; Kendall-Tackett et al., 1993).

Gender differences have been documented in symptom patterns of sexually abused children. Girls may show higher levels of hyperarousal than boys (Feiring et al., 1998). Boys display more externalizing disorders (such as attention problems, oppositional behavior, conduct disorders, and delinquency) than do girls. Girls, in contrast, have a higher incidence of internalizing disorders such as depression or dissociation (Olafson & Boat, 2000). Kendall-Tackett et al. (1993) note that only a few studies have found consistent differences in reactions of boys and girls. They suggest further investigation prior to articulating gender differences.

The child's history is important. Has the child experienced other traumatic events? Sexual abuse can exacerbate preexisting problems or trauma effects (Liem & Boudewyn, 1999; Saywitz et al., 2000).

It is important to know something about how the child was functioning prior to the sexual abuse experience(s). A child who was functioning poorly prior to the sexual abuse might be far more compromised than a child who was functioning well (Briere & Elliott, 1994). A child's level of vulnerability also is affected by temperament, neurodevelopmental reactivity, and attachment status (Saywitz et al., 2000).

The level of support and response to disclosure is also a critical variable. Support from a parent may be one of the most powerful variables determining a child's level of recovery. Family functioning (such as parent pathology or marital conflict) is related to both short-and long-term outcome (Beitchman et al., 1992). For long-term outcome, family members, maternal warmth, and support from the nonabusive parent account for more of the variance in adjustment than abuse-specific factors (Alexander, 1992). Several authors (Alexander, 1992; Liem & Boudewyn, 1999) posit that insecure attachment can precede the onset of sexual abuse. Alexander suggests that prevention and intervention efforts address attachment difficulties.

Few studies have attempted to examine the mechanisms by which children adapt to or explain the experience of sexual abuse. One study has attempted to examine self-evaluations of shame and self-blaming attributive styles (Feiring et al., 1998). Both shame and self-blame were related to increased psychological distress, including a greater number of depressive and PTSD symptoms, lower self-esteem, and eroticism.

Mitigating factors affect the degree of damage to the child. They also affect the length of treatment. For example, treatment is generally longer when children present with multiple diagnoses when the family and/or legal circumstances are complex, and when there is potential for family reunification (if the offender is a family member) (Deblinger & Heflin, 1996).

Asymptomatic Children

Some children who experience sexual abuse do not show any clinically significant symptoms. Up to 40 percent show few symptoms on standard evaluation instruments and do not show behavioral or emotional problems (Kendall-Tackett et al., 1993). A research review (Saywitz, 2000) found asymptomatic children comprised from 21 percent to 49 percent across a variety of studies.

Some children who are asymptomatic may be children with limited exposure to sexual abuse. Others may be especially resilient children who are coping well. It is also possible that clinicians may be missing more subtle indicators of disturbance. For example, children with an avoidant coping style may suppress conflicts and discomfort, even though they are quite distressed (Finkelhor & Berliner, 1995).

It is also possible that symptoms and difficulties do not always appear immediately. For example, a child who is seemingly unaffected by the sexual abuse at age 10 may experience later difficulties in trusting a partner and establishing a positive spousal sexual relationship.

Asymptomatic children pose dilemmas for researchers and therapists. Should limited treatment resources be allocated to children who are symptom-free? Should asymptomatic children be included in outcome studies? Since asymptomatic children, by definition, can not improve, they can dilute the positive effects of therapy for children with symptoms. When treating asymptomatic children, there are no signs to indicate when treatment is being effective. If the goal in treating asymptomatic children is to prevent future problems, it is unclear how much therapy and what type of therapy is sufficient.

There is little research to guide clinicians concerning "sleeper effects" (serious symptoms which do not appear until a later date). Long-term longitudinal studies on effects of sexual abuse have not yet been published (Finkelhor & Berliner, 1995; Saywitz, 2000). Initial findings are that a majority of asymptomatic children will remain symptom-free, while 30 percent will develop problems over time (Beutler, Williams, & Zetzer, 1994).

One suggestion is to offer all sexually abused children debriefing and psycho-educational intervention. This may prevent children from developing misperceptions, unrealistic fears, and maladaptive coping patterns. This preventative groundwork may also provide a rapport and ease in seeking treatment should symptoms develop at a later date. Parents can be taught to identify signs and signals that suggest a need for formal treatment.

Symptom Remission

Most child victims of sexual abuse do not experience long-term impairment (Beutler, Williams, & Zetzer, 1994). Across all samples, 55 to 66 percent of children show significant improvement and return to normal functioning. In contrast to those whose symptoms remit, about 20 to 25 percent became worse over a two-year period, irrespective of whether or not treatment was received (Beutler, Williams & Zetzer, 1994).

Multi-Problem Children

For some children, sexual abuse is only one of many adverse life experiences. Sexual abuse can occur along with other forms of maltreatment and exposure to community violence. Sexual abuse can occur in children with preexisting psychiatric conditions. For example, children with developmental disabilities may be particularly at risk for sexual abuse (see VCPN, Volume 37).

In these complex cases, children's reactions to sexual abuse will likely be one of several focuses of treatment. Interventions targeting short-term reactions or focused on the abuse will need to be bolstered by and part of a more comprehensive approach.

Treatment outcome studies have focused upon children with less complicated diagnostic pictures and higher functioning families. Results discussed in this article are insufficient to determine the most effective ways to organize treatment for multi-problem situations.

Reunification

Sexual abuse can also be complicated by long-term issues when the perpetrator is a
parent, a sibling, or a close family member. A child may be in contact with the perpetrator or with family members who support the perpetrator. Even if the child is separated from the perpetrator, a biological offender may continue to be a significant figure in the child’s life. There are no data addressing the safest and most effective methods for resolution and/or reunification with the perpetrator (Saywitz et al., 2000).

**ASSESSMENT**

Therapists must do assessment prior to embarking on a course of treatment. Due to the wide variety of responses and mediating factors among victims of sexual abuse, comprehensive assessment is necessary in order to select appropriate treatment goals and methods (Becker et al., 1995). Assessment in child sexual abuse cases involves both an evaluation of the validity of the abuse allegations and an evaluation of the child’s psychological functioning (Deblinger & Heflin, 1996). For discussion about assessing validity of the allegations, see VCNP, volumes 20 and 39.

In evaluating the child’s psychological functioning, a focus should be on the strengths, coping styles, and symptoms of the child. A variety of information sources should be used and objective measures are preferred. Information is needed about the child’s environment as well as the child’s history of behaviors, emotions, and cognitions. Assessment methods can include observation, psychological testing, and interviews with the victim, with the perpetrator (if possible), and with parents. Reports from social services, from medical professionals, from mental health professionals, and from teachers can be important.

The clinician will need to learn who perpetrated the abuse, the time frame and location of the acts, the duration of contact, and what specific abusive behaviors occurred. The child’s reactions (over time and immediately), including behavioral changes and verbalizations, are critical to understand. Family support and reactions to the abuse as well as community and cultural factors will need to be assessed in order to determine what treatments are feasible and acceptable.

Therapists should also ascertain whether or not the child has experienced other forms of maltreatment. For example, there is evidence that physical abuse is more likely to accompany sexual abuse than is neglect, although either or both may be present. A child who has experienced more than one type of maltreatment may have additional treatment needs.

Care should be taken to determine whether or not the child has acted out towards other children. Children who are both victims and perpetrators of sexual abuse require different treatments than children who have been victimized but who have not become sexualized or acted out sexually. For a discussion of abuse-reactive children see VCNP, Volume 40. For a discussion of adolescent sexual offenders, see VCNP, Volume 34.

Clinicians have many choices of testing and assessment instruments for evaluating a child’s general functioning. In recent years, a number of instruments specific to child sexual abuse have been developed. These include the Child Sexual Behavior Inventory (CSBI) (Friedrich, 1997; Friedrich et al., 1992), the Children’s Impact of Traumatic Events Scales (Wolfe, Gentile & Wolfe, 1989), the Childhood Trauma Questionnaire (Bernstein et al., 1997; Fink et al., 1995), the Children’s Attributions and Perceptions Scale (CAPS), (Mannarino, Cohen & Berman, 1994), and the Trauma Symptom Checklist for Children (TSCC) (Lanktree & Briere, 1992).

Assessment of children’s play can aid the clinician. Language and expressive abilities of maltreated children are frequently compromised. Other maltreated children may be unable to participate fully in interviews because of age or limited attention span. Still others lack trust and are afraid to communicate. For such children, play provides a communication opportunity.

Clinicians can examine both the content and the process of play. Themes may provide clues to relevant issues. Characters may express emotions that have relevance to the child. Of particular interest is post-traumatic play where a child ritualistically constructs the same scenario and acts out a series of events that have the same outcome. Whether play is solitary or interactive is important, as is the quality and type of interaction. Choice and use of play materials can indicate whether the child is playing at a developmentally-appropriate age.

Many other instruments and techniques may be helpful in assessing children’s general functioning. However, some studies suggest caution in interpreting data.

Projective drawings, for example, do not appear to discriminate between children who have been sexually abused and those who are nonabused. Thus, projective measures such as the House-Tree-Person should not be used to confirm or identify children who have been sexually abused (Palmer et al., 2000). Projective drawings, on the other hand, might be useful for identifying how a child perceives his world.

Assessment can allow clinicians to group children. According to Saywitz et al. (2000), child victims of sexual abuse can be divided into one of four groups:

1. Children with no detectable difficulties on standardized measures for child behavior problems. Estimates are that approximately one-third of sexually abused children fit this description.
2. Children with a few symptoms that do not reach clinical levels.
3. Children with serious psychiatric symptoms.
4. Children who meet full criteria for psychiatric disorders.

Presumably, a different therapeutic approach would be indicated for different child groups. In reality, there is little to suggest that clinicians or programs purposefully and selectively tailor treatment interventions to meet specific needs of clients, to address particular symptoms, or to account for patient types (Beutler, Williams & Zetzer, 1994).

The usual approach to treating a behavioral symptom is to describe the symptom as to frequency and severity and the factors affecting its occurrence, then devise an intervention, implement the intervention, then reassess the symptom or problem behavior to determine whether or not it has responded to treatment. However, this approach is infrequent in abuse-specific treatment programs, according to Finkelhor & Berliner (1995).

Assessment data should be used to set realistic treatment goals. Specific treatment plans (regardless of approach) should be

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**Violence Prevention**

Will Be The Theme of the 2002 Power of Prevention Conference

May 20-22, 2002 Richmond

“Preventing Violence, Strategies for All Ages” is the title of the Prevent Child Abuse Virginia Power of Prevention 2002 annual statewide conference. Speakers will include James Garbarino, Ph.D. from Cornell University, Naomi Griffith, a national consultant on child welfare, and Sarah Sprinkel of Orange County Florida Public Schools. Sessions are geared towards human services professionals, volunteers, civic and religious leaders, public policy makers and advocates, parents, and business leaders.

For more information about the conference, contact Prevent Child Abuse Virginia, 4901 Fitzhugh Ave., Suite 200, Richmond, VA 23230. (804) 359-0716, e-mail: Conference@pcav.org Web site: www.preventchildabuseva.org
Sexual Abuse
Treatment
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generated detailing how
to achieve the goals.

Treatment programs
typically adopt one or
more of four basic goals:
- relieving symptoms
  (by encouraging the
  child to reframe ideas, teaching
  management skills, facilitating
  emotional expression, affirming the
  child’s perceptions and providing emotional
  support);
- destigmatizing (through support
  and/or by group affirmation);
- increasing self-esteem (through cog-
  nitive or interpersonal methods, role
  plays and games);
- preventing future abuse (by chang-
  ing the environment or by changing
  the victim’s awareness) (Beutler, Wil-
  liams & Zetzer, 1994).

Additional goals adopted by some treat-
ment programs include:
- developing a realistic and factual
  understanding of the abusive expe-
  rience;
- ventilation of feelings associated with
  the abuse;
- developing healthy interpersonal
  boundaries;
- learning about healthy sexuality;
- preventing perpetration or sexual act-
  ing out (Tyn dall, 1997).

Assessment does not need to be limited
to the beginning stages of therapy. Gather-
ing periodic measurements of key symp-
toms can be helpful in evaluating and modi-
fying treatment.

INTERVENTIONS

Children who have experienced sexual
abuse gain access to treatment either
through court order, through child pro-
cative services, or through voluntary efforts
on the part of parents/guardians. It is not
known what percentage of identified child
victims receive treatment (Larson et al.,
1994).

Four preconditions should be met prior
to beginning treatment with child sexual
abuse victims, according to Swenson &
Hanson (1998). These are assessment (dis-
alyzed previously) child safety, crisis stabi-
ization, and support. A child who con-
tinues to be abused will not heal and treatment
may only raise the child’s anxiety level. If a
child is suicidal, homicidal or psychotic,
stabilization is needed prior to starting
therapeutic work. The child also requires a
supportive caretaker. If the caretaker is not
supportive, practitioners should first focus
upon assisting the caregiver in adopting a
supportive stance.

The varying presentations and reactions
of children suggest that a continuum of
interventions will be needed (Saywitz,
2000). It is unlikely that any one interven-
tion will be equally suitable for all or even
most victimized children.

Should therapy be
“abuse-focused”??

There is disagreement about whether or
not abuse-focused therapies are necessary
for sexually abused children. Some ther-
apists advocate the extension of mainstream
intervention models, rather than the cre-
ation of novel interventions. Many symp-
toms displayed by child victims of sexual
abuse are similar to psychiatric symptoms
of nonabused children. These include de-
pression, anxiety, anger, and aggression
(Saywitz, 2000).

Programs that de-emphasize the abuse
experience focus instead on sex education
and general psychological counseling with
the hope that information and an increase
in self-esteem will lower the risk for further
abuse or symptom exacerbation. The ther-
apeutic relationship is seen as a healing force.

Other programs advocate an approach
that is more structured and focused on the
abuse experience. Children participate in
therapeutic games, art activities, role plays,
writing, and structured discussion (Beutler,
Williams & Zetzer, 1994). Abuse-focused
therapy commonly shares several elements:
1) encouraging expression of abuse-related
feelings such as anger, ambivalence, shame,
helplessness, or fear; 2) clarifying errone-
ous beliefs that might lead to lowered self-
estee m; 3) reducing stigma and isolation;
and 4) teaching prevention skills (Finkelhor
& Berliner, 1995).

In addition, Finkelhor & Berliner note
that certain assumptions underlie an
“abused-focused” intervention. These ideas
are:
- that there are specific effects from the
  abuse experience;
- that intervention will be both ame-
  liorative and preventative;
- that children show a connection be-
  tween the abuse and current symp-
toms;
- that distress is a legitimate reaction
to an aversive experience.

Evaluating Therapy

Evaluating interventions is a difficult
 task. Treatment outcome research contains
many problems. First, there is no widely
accepted definition of “sexual abuse” (Haugaard, 2000). Thus, studies may be
examining intervention with children who
have very different exposure to sexual ac-
tivity.

It is known that effects of sexual abuse
can differ due to the developmental age/
stage of the child. Still, studies often utilize
a wide age range of subjects. In addition,
many characteristics of the child, the fam-
ily, the therapist, and the therapy interact
and can obscure results. Improvement de-
"ends not only on how effective the treat-
ment is, but also on the nature and severity of
the child’s impairment and on the func-
tioning of the adult caretakers (Saywitz et
al., 2000).

Furthermore, research studies employ
different methods and criteria to determine
treatment progress or effectiveness. It is not
uncommon for child maltreatment re-
searchers to use new measures with largely
unknown psychometric properties (Crouch
et al., 1999).

First, let us consider which interventions
have the best record of effectiveness for
children suffering from general psychiatric
symptoms. According to a review by
Saywitz et al. (2000), these are:
- Cognitive-behavioral therapy (CBT)
  for childhood anxiety;
- Coping skills training for childhood
depression;
- Parent management training based
  on behavioral techniques for exter-
  nalizing behavioral problems;
- Cognitive problem-solving training
  for externalizing behavioral prob-
  lems.

Tests of these interventions have shown
positive outcomes for children with symp-
toms often seen in sexually abused children
(anxiety-related symptoms, depression
and behavior problems). Overall, behavioral
and cognitive-behavioral interventions
have the greatest research support (Saywitz
et al., 2000). However, it should be noted
that approaches such as family therapy or
psychodynamic therapy have not been well
evaluated and there are almost no empiri-
cal studies on play therapy.

Sexual Abuse-Specific
Cognitive Behavioral Therapy
(SAS-CBT)

Cognitive behavioral therapy (CBT)
seeks to change negative patterns of
thought and behavior. CBT teaches the
client how thoughts and feelings affect behav-
ior. Practical behavior solutions are also
applied to specific problems.

SAS-CBT specifically focuses upon clinical
issues which are common in sexually-
abused children. According to Cohen and
Mannarino (1998), these are:
- Depression (specifically targeting
  feelings of helplessness, concern
  about not being believed, self-blame
  and distorted cognitions, feeling
damaged or different and lower self-
estee m);
- Anxiety (teaching anxiety reduction
Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse (Final Draft Report: July 30, 2001), prepared by the National Crime Victims Research and Treatment Center and the Center for Sexual Assault and Traumatic Stress.

Available from: Benjamin E. Saunders, Ph.D., National Crime Victims Research and Treatment Center, Medical University of South Carolina, 165 Cannon Street, Box 250852, Charleston, SC 29425 (843) 792-2945; Fax: (843) 792-3388; E-mail: Saunders@Musc.edu (document may be downloaded at http://www.musc.edu/cvc/)

These guidelines are intended for use by practitioners who work with child abuse victims, supervisors, agency administrators, program developers, payers, and others concerned with mental health treatment. The guidelines provide criteria for judging the available treatments, and a set of general guidelines for treatment based on the best scientific literature. The guidelines allow readers to quickly examine the theoretical basis, components, empirical support and reference materials for many available treatment protocols.

For each of the 24 treatments examined, the guidelines offer: a brief description of the treatment, the theory and rationale, a description of treatment components, the projected duration of treatment, sources for treatment manuals or protocol descriptions, treatment outcome study references and a classification rating.

The classification rating ranges from “1” (well-supported, efficacious treatment). To “6” (experimental or concerning treatment). The rating reflects the treatment’s theoretical soundness, clinical support, acceptance within the field, potential for harm, documentation, and empirical support. This is a draft document and it is still undergoing a review process. It should NOT be cited as authoritative or final in its current form. Comments can be delivered electronically to Dr. Saunders at: Saunders@Musc.edu

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Techniques such as thought replacement, positive imagery, relaxation, teaching management of intrusive thoughts and procedures to enhance safety:  
- Behavioral difficulties (educating children about the connection between thoughts, feelings and behaviors, educating children about age-appropriate behavior, behavioral interventions for inappropriate behaviors, teaching problem-solving skills).

Parental issues are also addressed so that nonoffending parents can cope effectively and respond optimally to their children. These issues include:
- Decreasing the parent’s emotional distress (addressing distorted thoughts such as blaming oneself for the child’s victimization, resolving feelings towards the perpetrator, anger management, anxiety reduction, dealing with stigmatization, increasing the level of support);
- Enhancing the parents’ support for the child (help with managing the child’s symptoms, appropriate limit-setting);
- Management of child behavioral difficulties.

In addition to focusing upon specific issues, SAS-CBT uses specific interventions. This model is based upon the premise that cognitions, behaviors and emotions are highly interdependent. The theory is that symptoms develop and are maintained, at least in part, by conditioned and learned behavioral responses and by maladaptive thinking patterns. Since these functions are interdependent, improvement in any one area will positively impact other areas as well.

Cognitive-behavioral methods are an integration of newer techniques which directly target cognitions and emotions through use of established and proven behavioral techniques (Deblinger & Heflin, 1996). Techniques include:
- Gradual exposure;
- Social skills training;
- Cognitive reframing;
- Thought-stopping;
- Positive imagery;
- Problem-solving skills training;
- Self-monitoring;
- Contingency reinforcement;
- Modeling;
- Role-playing;
- Social reinforcement;
- Positive feedback;
- Education regarding child sexual abuse, healthy sexuality and personal safety skills.

The SAS-CBT approach stresses gradual exposure and processing of thoughts and feelings. Parents and children are initially seen separately. After symptoms have decreased and coping skills are developed, there are joint sessions between parent(s) and child.

Some of the behavioral techniques useful with adults need to be modified for use with children. For example, elements of systematic desensitization and prolonged exposure were combined into a technique termed “gradual exposure.” Gradual exposure encourages children to confront feared stimuli. However, a detailed hierarchy is unnecessary. Children are encouraged to endure low-level anxiety-provoking stimuli before confronting more distressing stimuli. By the end of therapy, the child should be able to confront abuse reminders and discuss abuse-related memories without experiencing significant distress. New, more adaptive associations of pride or bravery may replace some of the extreme negative emotions.

Parents may suffer similar anxiety as their children and may benefit from learning more adaptive thoughts and feelings. Parents are also taught how to handle their children’s reactions. In the latter stages of therapy, family sessions that include siblings may be conducted to enhance family communication.

Education of both child and parent about safety skills, typical reactions to sexual abuse, and healthy sexuality occurs throughout treatment. Treatment ranges from 12 to 40 sessions (Deblinger & Heflin, 1996).

Goals and intervention strategies are designed collaboratively by therapists and clients. Thus, children and parents are able to assume control over the treatment process. This may help alleviate feelings of powerlessness, a frequent symptom of survivors of sexual abuse.

SAS-CBT offers a treatment rationale, clear and understandable therapy plans, and realistic expectations for outcomes.

This approach may particularly appeal to children and nonoffending parents who feel that the abuse has taken control of their lives (Deblinger & Heflin, 1996).

For example, a nonoffending parent may be dismayed when their sexually abused child uses foul language or engages in inappropriate sexual behavior. These behaviors can result from modeling from the offender. Thus, the child has acquired these behaviors through observational learning. Therapy can target the cognitions and belief systems accompanying these behaviors as well as help the child perform more functional responses.

Involvement of nonoffending parents and guardians in therapy can benefit the child immensely. Conversely, negative reactions by parents can exacerbate difficulties. Parental participation in therapy communicates to the child that this adult is committed to the child. Also, therapy can help the child develop skills for talking with the parent or guardian about the abusive experience(s). Therapy can offer the adult training and assistance in identifying specific ways to help the child (Deblinger & Heflin, 1996).

Deblinger & Heflin feel that SAS-CBT can be particularly helpful to clients from minority groups. Deblinger & Heflin cited the opinion of Sue & Sue (1990) that some minority groups, African American, Native Americans, Hispanics, and Asian Americans, prefer therapy approaches that are directive, structured, and allow the client to assume an active role. These characteristics are applicable to SAS-CBT.

There have been a number of research studies which have examined the effectiveness of SAS-CBT.

Cohen and Mannarino (1996b) followed 49 recently sexually abused children ages 7 to 14. Children were randomly assigned either to the SAS-CBT or to a nondirective

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Sexual Abuse Treatment
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supportive therapy (NST). Children and nonoffending parents were provided 12 individual weekly treatment sessions. Results indicated that the SAS-CBT recipients improved more than the NST group on several clinical assessment instruments. The SAS-CBT approach was also more successful in treating sexually inappropriate behaviors.

Deblinger, Stauffer, & Steer (2001) compared the effects of cognitive/behavioral group therapy to supportive group therapy for 44 children ages 2 to 8. Both therapy groups were effective, but changes for the cognitive behavioral group were larger.

Similar studies also favor abuse-specific CBT over other forms of treatment (Cohen & Mannarino, 1996; Cohen & Mannarino, 1997; Saywitz, 2000). Why is SAS-CBT treatment effective? There is consensus that direct discussion of traumatic events is usually necessary to resolve symptoms associated with trauma (Cohen & Mannarino, 1998b).

Saywitz notes that not all symptoms responded equally well to CBT. It should also be noted that some children deteriorate over time, even with SAS-CBT. For example, in a study of 80 children ages 4 to 13, some symptoms became worse over time in 5 to 15 percent of both treatment groups (Berliner & Saunders, 1996).

Nondirective Supportive Therapy (NST)

While nondirective therapists encourage exploration of alternatives, they rarely give suggestions or advice. It is felt that regular contact with a supportive, caring therapist and a lack of a structured format will allow children to formulate their own solutions. Those with an NST approach will focus on:

- Providing nonjudgmental empathy and support through listening and the creation of a strong therapeutic bond;
- Encouraging identification, clarification, exploration, acceptance and/or resolution of upsetting feelings;
- Reestablishment of trust and positive interpersonal expectations based in the therapeutic bond (a "corrective emotional experience").

At least one research study (Cohen & Mannarino, 1996) suggests that older children are able to introduce conversation about abuse issues and discuss these during treatment. Older children who discussed their abuse in the NST approach experienced improvement similar to children who had received an abuse-focused approach (SAS-CBT). However, the NST approach was less effective in decreasing depressive symptoms.

Kolko (2000), in a research review cites a study (Celano et al., 1996) comparing abuse-specific treatment targeted to the traumagenic dynamics of self-blame, stigmatization, and betrayal to an unstructured treatment. Both interventions resulted in significant improvements in PTSD symptoms, traumagenic beliefs, and general psycho-social functioning. However, the abuse-specific intervention was more effective in increasing caretaker support and reducing caretaker self-blame. Kolko concludes that the study "provides modest evidence for the benefits of treatment developed specifically to address the problems of sexual abuse victims" (p.142).

Play Therapy

Play therapy is often utilized with maltreated children. It is the modality recommended for preschool children, for children who have difficulty verbalizing, and for children who are lacking in trust.

Play therapy uses play as a mechanism for allowing sexually abused children to use symbols such as toys to externalize their inner world, project their thoughts and feelings, and process emotional and cognitive material from a safe distance. Through post-traumatic play, children gradually expose themselves to stories, scenes, or behaviors they fear, avoid, or may simply misunderstand. The trauma-focused play therapist witnesses the child's reality, provides unconditional acceptance of the child's feelings, thoughts and reactions, challenges cognitive distortions, and promotes empowerment and resiliency (Gill, 2000, personal communication). Play therapy addresses impaired attachments which may mediate the abuse and its aftermath by providing a new attachment figure (the therapist) who is positive, consistent, and provides the opportunity for corrective emotional experiences (Reams & Friedrich, 1994).

"Play provides an important context in which children can increase their repertoire of questions and answers, techniques and responses for analyzing and manipulating the world, both the external world of objects and people and the internal world of feelings and thoughts" (Garbarino & Manly, 1996, p.123). Child's play can be "captured" and limited by the child's own emotional life when the child's emotions are constrained by or preoccupied with themes of trauma, loss, or threat. Free play allows children to express emotions, consider affect-laden material, and practice mastery of trauma and conflict.

To liberate a child's play, Garbarino & Manley (1996) suggest starting from the child's point of view. Once there is a "meeting of the minds" in the child's terms, the child can move from the restricted range of play to the broad range of unrestricted play.

Another goal of play therapy is to improve the child's intrapsychic view of relationships. Changes include children learning a more positive view of themselves, improving self-concept. Maladaptive coping styles, no longer needed, can be replaced by better skills (Reams & Freidrich, 1994).

There is a voluminous literature on how to structure play therapy. Unfortunately, there is very limited empirical literature examining its effectiveness.

A 1994 study by Reams & Friedrich examined the effectiveness of 15 weeks of directive individual play therapy with 36 preschool children enrolled in a therapeutic nursery. This particular study found no consistent support that time-limited play therapy improved the adjustment of maltreated preschool children who were attending the therapeutic preschool. However, the positive effects of the therapeutic preschool may have obscured therapy gains of the treated children.

Bonner, Walker and Berliner (1999, as cited in Draft Report of the Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse, 2001 – see block for description and availability) compared two group treatment approaches for children ages 6 to 12 with sexual behavior problems. One group treatment was based upon cognitive behavioral therapy and the other was based on dynamic play therapy. The treatments consisted of twelve weekly sessions. Both approaches were deemed equally effective in reducing children's sexual behavior problems at the two-year follow up.

According to Ray et al. (2001), a meta-analysis of 94 research studies on play therapy supports the efficacy of play therapy for a wide variety of problems. Of the 94 studies examined, one published study and one dissertation dealt with filial therapy with non-offending parents of children who had been sexually abused. Two doctoral dissertations focused on play therapy with child sexual abuse victims.
One published study (Reams & Frederich, 1994, discussed above) and one doctoral dissertation used maltreated children as subjects. An additional two dissertations and one published study used child witnesses of domestic violence. One dissertation and one published study examined play therapy with children exposed to trauma from a hurricane. The remaining studies do not appear focused on maltreated or traumatized children. Thus, while initial findings on effectiveness of play therapy with non-abused children shows some positive effects, the treatment approach appears to be untested with child victims of sexual abuse.

Additional Approaches

Several approaches to treating sexually abused children have published information about the model and the treatment techniques but VCPN staff was unable to find empirical studies supporting the treatment effectiveness of the approach.

Eye Movement Desensitization and Reprocessing (EMDR) is an approach that has shown success with child trauma victims who have experienced disasters. EMDR is a multi-component procedure that purports to facilitate blocked processing of traumatic memories, to promote more adaptive cognitions regarding the trauma, and to offer alternative positive cognitions, coping strategies, and adaptive behaviors (Chemtob, 2001 in Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse – see review this issue).

Trauma-focused Integrative-Eclectic Therapy (IET) is a psychosocial intervention based on data suggesting that persistent effects of trauma and maltreatment are best understood as a function of the child in the family context. The security of the parent-child attachment is regarded as a key component in the child’s adaptive functioning and resilience in the face of adversity. This approach seeks to enhance the non-abusive parent-child relationship through the use of child-directed play activities. The approach uses cognitive-behavioral techniques but also addresses the parent-child relationship (Friedrich, 2001, in Guidelines for the Psychosocial Treatment of Intrafamily Child Physical and Sexual Abuse).

Multisystemic Therapy (MST) is an approach that targets key factors within a child’s social ecology that relate to the child’s problem behaviors. It was originally developed in the late 1970’s to address youth antisocial and delinquent behaviors. MST has also been utilized for youth with substance abuse problems, for violent and chronic juvenile delinquents, for youth presenting with psychiatric emergencies, and for juvenile sexual offenders. Studies in these populations support the short- and long-term effectiveness of MST as well as its potential to produce significant cost sav-

ings by avoiding out-of-home placement.

In comparison with control groups, MST has demonstrated improved family relationships, improved family functioning, improved school attendance, decreased adolescent drug use, 25 to 70 percent decreases in re-arrest rates of juveniles, and 47 to 64 percent decreases in days in out-of-home placement (Swenson & Henggeler, 2001, Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse). One Virginia treatment program, The Child Advocacy Project in Gloucester (see spotlight this issue), is using Multisystemic Strategic Therapy which is a treatment approach which shares the same theoretical basis as MST.

MST uses a social-ecological and family systems framework, viewing behavior as multidetermined. Problem behavior may be maintained by any of the systems (e.g., family, peer, school, community) in which the youth is involved. Interventions include individual, family, and systems interventions. Treatment is intensive for 4 to 6 months, is present-focused and action-oriented, and requires involvement of the youth, family and other people in the youth’s ecology.

Emphasis is upon interventions that empower the family, and having the family do for themselves rather than have the therapists do services for them. Interventions are implemented in the home and community at times that are convenient for the family.

One study (Brunk, Henggeler & Whelon, 1987) has evaluated the effectiveness of MST compared to parent training with physically abusive and neglectful families and there are ongoing studies of MST with physically abusive families. However, no studies of MST with sexual abuse victims were found.

Victim support groups are frequently offered to adolescent and preadolescent children who have been sexually abused (see Virginia’s Picture, this issue). The groups may be unstructured (participants introduce the topics) but are more frequently structured (therapists or facilitators plan activities and discussion about a topic each session). Victim support groups, even those based upon well-articulated theoretical frameworks, have not been adequately assessed (Ratiner, 2000; Szwartz et al., 2000).

Kolko (2000), in his review, cited two studies of group therapy using wait-list controls (McGin & McKinsey, 1995, Verleur et al., 1986). Participants in group therapy showed some improvements and these studies provide some evidence for the efficacy of group treatment. However, findings are limited by the absence of comparisons to alternative treatments, lack of multivariate statistics, and no follow-up data.

Berliner and Saunders (1996) examined the impact of structured educational groups for adolescents based on cognitive-behavioral procedures with and without a component of stress inoculation and gradual exposure (procedures which are designed to minimize fear and anxiety). Both conditions showed symptom improvements over a two-year follow-up period and neither treatment was superior to the other (cited in Kolko, 2000).

Likewise, family therapy and parent training have not received much research attention, despite the fact that parental support has consistently been found to be a cru...
VCPN staff contacted 23 (62 percent) of Virginia’s Sexual Assault Crisis Centers in the Spring of 2001. We questioned the Centers about their work with child victims of sexual abuse and about their community’s resources for child victims.

Most of the Centers surveyed (20 or 87 percent) receive the majority of calls and requests from adult victims. However, for three of the Centers, half or more of their calls concern children as victims.

Over 80 percent of Centers offer a 24-hour “hotline,” referrals to community child practitioners, crisis intervention for the child and follow-up support and/or counseling for the child. One center, Laurel Shelter in Gloucester, operates a teen hotline especially for children and teenagers. Teens who wish to talk with someone in their own peer group can call on Wednesday evenings between 5:00 and 8:00. Teens can, of course, call at any time to talk with a regular hotline worker. The special teen hours are advertised in flyers placed at local schools, hospitals, and doctor’s offices.

Other services offered by half or more of the Centers are assisting police or attorneys, offering on-site support or therapy groups for children and youth, offering counseling or support for parents, and performing case management services for children.

A number of Centers offer emergency shelter for child sexual abuse victims if the mother also stays. These centers are ones that provide emergency assistance for victims of domestic violence as well as serve as sexual assault crisis centers.

Nine Centers offer psychotherapy and counseling services on-site. Four of the 9 Centers have a licensed professional offering these services.

VCPN interviewed Gary Rafala, a licensed professional counselor in Culpeper. Rafala, a private practitioner, contracts with the Sexual Assault Victims Volunteer Intervention in Warrenton, Virginia. Rafala, along with social worker Ann Tate, LCSW, offer both group and individual therapy.

The Teen Sexual Assault Support Groups facilitated by Tate are six-week groups. Week one is a general introduction. The issues of safety, support, boundaries, and group rules are covered. Participants are encouraged to keep a journal of recovery. Week two focuses on the effects of sexual abuse. Girls discuss how to deal with feelings, develop coping skills, and enhance self-esteem. The third week is a review and practice of coping skills. Teens also identify sources of support and how to use them. The group discusses family dynamics and how to better communicate with parents.

The fourth week of the Teen Sexual Assault Support Group, Tate encourages the group to “connect with inner wisdom”. They discuss values and self-definition and societal pressures. Week five is centered upon a profile of abusers. The group examines the question “What is a healthy relationship, anyway?” and discusses how to deal with abusers. The last session is devoted to closure. The group focuses on moving beyond crisis and reclaiming life. Community resources and legal issues are covered.

Over 70 percent of the Centers surveyed offer group therapy or support groups for non-offending parents. Rafala shared his structure for the Parent Support Groups offered at Warrenton’s Sexual Assault Victims Volunteer Intervention. The parent support group meets at the same time as the teen support group, thus the topics are coordinated with what the teens are exploring in their support group.

Group one is an introduction and includes a discussion of confidentiality. Common problems related to parenting and coping mechanisms are the focus. In the second group, the events bringing parents to group are discussed. Common reactions to sexual abuse are considered. In the third group, ways to be helpful and supportive to child victims are considered. The fourth group covers societal pressures on girls and ways to encourage independence. Issues of self-esteem are discussed. Week five concentrates upon the impact of sexual abuse on non-offending parents. The final week is a closing and covers resources in the community that can offer further help.

More information about structuring groups is available from Gary Rafala, 139 West Davis Street, Culpeper, VA 22701, (540) 829-0036, E-mail: rafala@summit.net.

Several centers offer in-school programming. Both New Directions Center (Staunton, VA) and the Center for Sexual Assault Survivors (Hampton, VA) offer groups in schools for teens. Margaret Crummett, Sexual Assault Services Coordinator for New Directions offers “TEEN VOICES” groups in several area high schools. She co-facilitates the groups with Tara Jensen, Domestic Violence and Sexual Assault Counselor for teens. “It is hard to gain access to schools,” says Crummett, “but we have established positive relationships with principals and guidance counselors.” Crummett’s groups are offered to girls referred by guidance counselors. The eight-week group considers both domestic violence and sexual assault issues. “We examine healthy and unhealthy relationships, date rape, and the dynamics of sexual assault,” explains Crummett. “I give the girls literature and we do quizzes and activities.”

For more information, contact Margaret Crummett at New Directions Center, (540) 885-7273 or FAX: (540) 885-0686.

Alison Allen, MSW of Hampton’s Center for Sexual Assault Survivors says “Schools can be a built-in support system for children and youth.” She offers groups both at schools and at the Center. Groups at schools are time-limited. Groups at the center open every 8 weeks to new children, allowing the option for those currently attending to continue. Soon Allen will be offering a group for boys who have been victimized.

For more information, contact Alison Allen, MSW, at The Center for Sexual Assault Survivors, 1017 Todds Lane, Hampton, VA 23666 (757) 838-1829, Fax: (757) 838-6884.
The Women’s Resource Center of the New River Valley in Radford, VA offers individual therapy in schools. Debbie McClintock, MA coordinates the program. “The program works extremely well!” enthuses McClintock. “There are two of us who work in the schools. All the guidance counselors have come to see a difference.”

Scheduling sessions can be a problem, McClintock relates. “Schools don’t always have space. You might be meeting in a supply closet,” she comments. “I generally meet for 6 to 10 sessions. We must rotate which ‘non core’ course the student misses, as some teachers count attendance towards the grade. It is more crucial at the high school level because of tests and assignments.”

McClintock tries to work with parents or get them involved with a counselor from the Women’s Resource Center. “I think parents want to be involved,” says McClintock, “but many do not follow through. Of my caseload of 45 children, I’ve worked with 21 grownups.” She continues, “Some parents are overwhelmed and can’t deal with the concept that their child has been hurt. I wouldn’t deny a child help simply because the parents were not supportive. Offering therapy in schools allows us to attend to the child’s needs in their usual environment.” Seeing the child in their school normalizes the service and feels comfortable for the child.

McClintock has noticed that the parents who are very active in counseling are most often adult survivors of sexual abuse. “They are working hard, but they are doing their own work, rather than focusing on supporting their children,” she says. McClintock adds, “Even with parents who are child-focused and do a good job, children deserve someone objective to help them process.”

Sessions do not usually resemble typical outpatient therapy. Assessment and record-keeping are minimal. The session length can vary from 15 to 20 minutes to more than an hour. The services are free to the children and McClintock and the other clinicians do not have to adhere to procedures of managed healthcare. Services are coordinated with other agencies. McClintock attends monthly multidisciplinary team meetings that include staff from the department of social services, the police, medical professionals, and schools.

For more information, contact Debbie McClintock at The Women’s Resource Center of the New River Valley, (540) 639-9592, Fax: (540) 633-2382, e-mail: wrckids@juno.com Web site: wrcnrw.org

The year 2000 report from the Virginia sexual and domestic violence data collection system (VA data) had 82 percent of Virginia’s 37 Sexual Assault Crises Centers reporting. These centers assisted 450 sexual assault victims under age 18. Children under 18 were 23 percent of the total number of victims served. Most (84 percent) were girls. Most (59 percent) were teenagers, 31 percent were ages 5 to 12 years, and 10 percent were under age 5. Of the 450 children, 391 (87 percent) received counseling from the Center and 111 (25 percent) received legal support from Center staff. Other services offered at Centers included academic support, medical services, recreation, skill development and systemic advocacy.

For more information about Virginians Aligned Against Sexual Assault, contact Shani Reams, 508 Dale Avenue, Suite B, Charlottesville, VA 22903 (434) 979-9002, Fax: (434) 979-9003, E-mail: scvaasa@ntelos.net Web site: www.vaasa.org

Spotlight on Rocky Mount

The Child Abuse Review Team of Franklin County

The mission of the Franklin County Team is to coordinate the investigation, prosecution, treatment, and advocacy services for victims of child abuse and neglect. The mechanism is the Child Abuse Review Team (CART).

Joyce Moran, Executive Director of the Southern Virginia Child Advocacy Center, explains the approach, “Our multidisciplinary team started in 1996 as an informal way to provide better coordination for child abuse cases. We became a formal team in 2000 and opened the Southern Virginia Child Advocacy Center in August, 2001.” CART and the Child Advocacy Center are funded through a Victims of Crime Act (VOCA) grant from the Virginia Department of Social Services.

The review team (CART) and the Child Advocacy Center serve children birth to 18 years of age who are alleged to be victims and whose cases are currently under investigation by the local department of social services or by law enforcement. They also serve children whose cases have a valid finding by the local department of social services and children who have been identified as a crime victim by law enforcement.

CART coordinates medical, social, and legal services for these children and their families. They staff cases on a bi-monthly basis and have developed a protocol for timely coordination of services.

Service response has been enhanced through state, national, and in-house staff training. VOCA funds were used to purchase equipment to improve evidence collection for law enforcement and to provide a child-friendly atmosphere in facilities where children are interviewed and examined. CART has provided funding for children to attend a support group and to receive counseling and treatment services.

The team is also involved in community education and awareness activities. CART members have given presentations both locally and state-wide.

For more information about this multidisciplinary team approach, contact Joyce Moran, Executive Director or Susan Howard Miller, CART Resource Officer, Southern Virginia Child Advocacy Center, 300 S. Main St., Rocky Mount, VA 24151, (540) 484-5566, Fax: (540) 484-5567 E-mail: caps@cablenet-va.com

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Web site: www.vaasa.org
The Child Advocacy Project began in 1998 with a grant of $53,000, awarded by Victims of Crime Act (VOCA) and administered by the Child Protective Services Unit of the Virginia Department of Social Services.

The grant funded two positions: a master’s level therapist and a bachelor’s level case manager/volunteer coordinator. Both are required to be specialists in the treatment and prevention of child abuse using Multisystems Strategic Therapy as a basis for the program’s service delivery system. The program is provided at no cost to the children and adults served.

In addition to having the clinical skills, the therapist is trained forensically so that court testimony can be provided. The program also offers pre-trial preparation of child victims and their families and ongoing consultation/collaboration with involved legal professionals.

The VOCA grant of 1998 allowed the CB to begin serving abused children and recovering adults throughout the ten counties. The number of clients served during the first year (127) more than doubled the second year as 264 were served. In 2000, the original VOCA grant was renewed and funded at $61,250. In 2001 it was renewed and funded at $79,742. One additional VOCA grant ($33,000 in FY2000) and one TANF grant ($33,533 for FY2001) were also awarded, allowing three master’s level therapists to be hired to provide additional services.

In addition to the legal services and treatment of victims, the program has sponsored training conferences, workshops, and seminars on the recognition, treatment, and prevention of child abuse. In three of the counties, the CSB has collaborated extensively with professional colleagues in the development of sexual abuse protocol teams which meet monthly. The CSB has collaborated with two physicians to develop a tele-medicine capacity with the Medical College of Virginia so that children can be assessed and treated quickly without delay or extensive travel.

Child Advocacy Program provides individual, family and group therapy to adult survivors of childhood sexual abuse, at no cost. Volunteers have been recruited and trained and provide a variety of support services which include peer counseling, support for children in court, child care for non-offending parents while they attend therapy, and community presentations.

More information is available from: J. Patrick Dorgan, Ed. D., Director, Child Advocacy Program, P.O. Box 427, 9228 George Washington Memorial Highway, Gloucester, VA 23061, (804) 695-1767, Fax: (804) 693-7407, E-mail: outstf@innu.net
The Interdisciplinary Child Advocacy Project  
Wytheville, Virginia

Wythe County Department of Social Services began the Interdisciplinary Child Advocacy Project in July, 2001 with a grant from the Virginia Department of Social Services. The grant is funding services outside of the normal services offered by social services and enhancing services already offered.

Michael Hall, Director of Wythe County Department of Social Services, explained the new services. "There is money available for about 14 forensic mental health assessments for abused children. This is a very thorough assessment and it becomes the basis for mental health services," Hall notes that there are limited service providers in the Wytheville area. There is no resident psychiatrist who specializes in children and families must often travel to Roanoke for therapy services. The grant, however, is allowing local providers to obtain further training. For example, on November 5 providers attended a week-long training, the John Reed Child Abuse Seminar.

The grant is funding two other efforts. One is materials for children who are determined to have been abused. Each identified child is given a "911 safety tote bag" and taught safety skills—how to dial 911 in an emergency, how to identify dangerous situations and how to create a safety plan. The tote bag also contains a teddy bear and coloring books.

The second new effort is providing education materials for non-offending caretakers and parents. These materials are designed to increase the parent/caretaker's ability to offer children support.

For more information on Wytheville's Interdisciplinary Child Advocacy Project, contact Michael Hall, Director, Department of Social Services, 275 South Fourth Street, Wytheville, VA 24382, (540) 228-5493, Fax: (276) 228-9272, E-mail: amhl97@western.dss.state.va.us

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Children's Hospital of The King's Daughters  
Norfolk, Virginia

For the past six years, a multidisciplinary staff at Children's Hospital of The King's Daughters has been delivering comprehensive services for victims of child maltreatment. An impressive array of services is available.

These include:
- Medical Evaluations
- Psychological Services

The medical team consists of both pediatricians and forensic nurses skilled in the evaluation of children who may have been sexually abused. Examinations needed within 72 hours of the alleged assault occur in the Emergency Department and are performed by a pediatric forensic nurse examiner. A hospital social worker is available for family support. Less urgent examinations are performed in a clinic setting with a fellowship-trained forensic pediatrician, forensic nurse, and medical social worker.

Compassionate clinicians set about several tasks. First, the parent or guardian completes a caretaker questionnaire, giving general medical and social history and listing any physical, emotional or behavioral changes in the child as a result of the suspected abuse. The medical staff speaks with the parent or the investigator(s) privately to determine the details of the suspected abuse. The parent or legal guardian is asked to give written permission for the examination, photographs, and specimen collection.

Examination procedures are explained to both the child and the parent. A head-to-toe general physical examination is completed, noting any bruises, abrasions, lacerations or scarring. An external genital exam is performed. Only adolescents receive internal vaginal examinations. A specialized piece of equipment with a magnifying light called a Colposcope is used to examine and photograph the external genitalia and anal areas. The Colposcope does not touch the child. Cultures for infection might be taken from the genitals, anus or throat using small cotton swabs.

In the emergency department, forensic nurses record all findings which are then reviewed by the medical director who writes a report that is forwarded to the appropriate investigative agencies. In the clinic, the doctor and the medical social worker combine their information into one report that is sent to investigative agencies. It is important to note that a forensic medical evaluation is only part of an overall investigation for possible sexual abuse. It cannot, by itself, determine if a child has been abused.

Two other medical services are available. A second-opinion consultative service is available to investigative agencies. It provides expert medical opinion on cases previously evaluated by other medical professionals. Also, inpatient consultative services are available for hospitalized children with suspected abuse issues.

Psychological assessment is an important component of a comprehensive evaluation. This assessment focuses on the impact of the maltreatment on the child and family. Licensed psychologists and licensed clinical social workers help determine the emotional condition of the child and his or her coping abilities. The child's perceptions of the maltreatment, of himself and of his family are important. The degree to which a child may be able to participate in court and what accommodations may be needed in the legal arena are considered.

Parents can also be evaluated if there is concern about their ability to care for and protect their children. Evaluations of parenting capacity are used by social services and courts to understand the parents' functioning and help decide upon safety plans, treatment recommendations and a course of action for the family.

A one-time forensic interview can be scheduled at the request of an investigative agency or prosecuting attorney. The interview allows investigators the opportunity to gather information related to the alleged abuse, assess credibility of the child's statements, and determine if additional services are needed. The program offers child-friendly facilities for the interviews and state-of-the-art videotaping. Investigative observers can be accommodated via closed-circuit television and the use of a one-way mirror.

For more information about the Child Abuse Program, contact Children's Hospital of The King's Daughters, 935 Redgate Ave., Norfolk, VA 23507, (757) 668-6100.

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VOCA (Victims of Crime Act) federal funds are awarded to public and private non-profit agencies to deliver direct treatment services to abused children. Forty programs geographically distributed throughout the state received $1,220,851 in 2000-2001.

The Interdisciplinary Child Abuse and Neglect Advocacy Projects provide federal funds to three community coalitions for the development and enhancement of a community-based infrastructure for the investigation, prosecution, forensic medical management, and treatment of child abuse and neglect. The grants were available to public and private, not-for-profit community coalitions for the period of January 1, 2000-June 30, 2001.

Further information about these grants is available from Linda Struck, Virginia Department of Social Services, 730 East Broad Street, Richmond, VA 23219-1849, (804) 692-1259.
Clinicians have many issues to consider when structuring treatment for child sexual abuse victims. VCPN staff interviewed a number of experienced clinicians about their orientation and practices. Each clinician offered much information and enthusiasm for their work. Space limitations mean summarizing the information. The excerpts below do not reflect the thoroughness of the responses but are instead meant to offer ideas and starting points for consideration.

What sort of assessments do practicing clinicians prefer?

A number of clinicians perform minimal or ongoing evaluations, consisting of interviews and mental status exams. Cassandra McLaren, LCSW, and a trainer for the Department of Criminal Justice Services remarks, "Generally, I do not do much with paper-and-pencil assessments. I view assessment as an ongoing process. I interview the child and the parent(s) and assess the child's play. I want information about the history of the problem, the child's development, the family dynamics, and how the child is in other settings, such as school or with friends."

Others, such as Ann Stewart, Ph.D., a clinical psychologist at James Madison University, advocate an initial comprehensive assessment. Stewart uses an ecological model in a developmental context. She examines IQ, temperament, social and emotional growth using multiple informants (teachers, parents, self-report). She prefers to use the BASC (Behavior Assessment System for Children). "If there is a concern about anxiety or depression, I also like to use the CBCL (Child Behavior Checklist) which can be used several times throughout therapy to measure progress," says Stewart.

Stewart notes that it is essential to determine risk for further abuse. "Healing is possible only when safety is assured," states Stewart. Stewart does not utilize a specific profile for determining risk for further abuse, but examines the data, comparing it to known risk factors in the literature.

Sara Zimmerman, a Licensed Professional Counselor in Harrisonburg, Virginia, prefers to obtain information in advance of the first appointment. She uses the Achenbach Child Behavior Checklist (CBCL), completed by parents or caretakers and by teachers, as a tool. Zimmerman also suggests using a semi-structured interview as a guide to obtaining background information and developmental history.

Eliana Gil, Ph.D. of Fairfax, Virginia uses several formal measures for assessment. "I use the Trauma Symptom Checklist, the Achenbach Child Behavior Checklist, and the Child Sexual Behavior Inventory," says Gil. "I also rely on drawing. The Draw-A-Person Inventory is helpful as it is having the child draw a self-portrait. The self-portrait can be done both pre- and post-therapy. Gil is a play therapist and she uses "play genograms" where the child can utilize miniatures to describe a story. "I obtain interesting information from this technique!" notes Gil. Recently Gil is using the Angier/Andy Child Rating scales and finding them useful as well.

How do you set treatment goals?

Clinicians were in agreement about goal-setting. Joan Duhaime, LCSW, of Chesapeake, Virginia recommends that treatment goals be established jointly by the parent, the child, and the clinician. "Since my treatment always includes the parent, it is natural to include the parent in the goal-setting," says Duhaime. Gary Rafala, Ed.S, LPC, LMFT of Culpeper, Virginia agrees, "I start with having parents identify specific behaviors or symptoms and target treatment interventions to these," he comments. Stewart adds that goals will vary according to the child's developmental stage and are mediated by the particular trauma the child endured. "The goals for the child, for the caretaker and for collateral may be different," she observes.

Zimmerman advocates assessing common problem areas for child victims of sexual abuse. "These include unusual fears, generalized anxiety, decreased self-esteem, anger and sexual behavior problems. Many children show impaired social functioning and distorted cognitions. Teens may have substance abuse problems." Zimmerman always includes education and information as a treatment goal. "Education about child sexual abuse can help both the parent and the child normalize the behaviors. It can also help parents predict areas of future concern," Zimmerman remarks.

McLaren, like Zimmerman, has general goals as well as child-specific goals. "All children need to obtain an understanding of what happened to them and how it affected them," she states. "At the conclusion of therapy, the child should feel differently about the events. Our job as a therapist is to help the child find a new viewpoint, to make sense from their developmental perspective, of what happened to them, that is, how it affected them, and how they felt about it."

Gil suggests limiting goals to three at a time. "Common goals are to reduce the extreme anxiety that results from sexual abuse, to redirect intrusive thoughts and to alleviate depression and withdrawal. Sexual aggression is not uncommon in younger children," Gil adds.

How do you balance rapport-building and trust necessary for treatment with the need to help the child learn to be safe and not naively trust everyone in authority?

Rafala comments, "I believe that I must demonstrate my willingness to be trusted. I discuss this issue openly with older children." Duhaime agrees, "I acknowledge that it is difficult to trust others and that I hope it is possible to change that in our relationship." McLaren comments, "I talk very openly about this issue. I let children know when I talk with others or need to share information. The teacher is a part of the process. We are working together."

Involving parents in the therapy is a technique advocated by several of the therapists. Some have the parent remain in the room, perhaps completing paperwork or reading. "I want both the child and the family to realize that there are no secrets about the therapy," says Zimmerman. Stewart also addresses the issue of secrets directly. "I use 'The Child's First Play Therapy Book' by the American Psychological Association," says Stewart. "It helps the child understand the differences between confidentiality and secrets."

How might therapists convey to children that they are able to hear about the abuse without being intrusive?

Many clinicians struggle with this issue!" says McLaren. "Often the child is uncomfortable and does not want to talk about the abuse. The therapist does not want to be another person who forces, coerces, or manipulates the child. Still, it is vital to talk about what happened." McLaren allows children to delay talking but informs them directly that talking about the event is necessary. Sometimes she will ask a child to talk for a short time, 10 minutes or less, and then take a break with an activity the child chooses. Duhaime also advocates making the sexual abuse an open topic. "I start early. I let the child know that part of our work is talking about being touched."

Others favor allowing the information about abuse to emerge gradually. Rafala asks older children, "Do you feel you are ready to talk about this?" Stewart uses a variety of materials to assist the child in expression. She comments "Themes will occur in the child's play around nurturance and safety issues. I follow the child's lead. To intrude could hurt the child and not be helpful."

Gil echoes Stewart's sentiments. "Play therapists take a non-directive stance and are much more neutral than many other approaches," comments Gil. "I don't reassure the child. Rather, the child is allowed to set the direction. Slowly but surely, the
child will build confidence,” Gill explains. 
Zimmerman varies her approach according to the child’s stage. “There are books and stories we can read together to introduce the topic. I tend to be fairly direct. I have learned that if one is direct, the children settle into the task and offer more information.”

Therapists noted that the child does not need to feel compelled to share all the details with the therapist. If others know the story, then therapists can gain information from secondary sources (police reports, CPS, attorneys, parents). It can be a relief to the child to know that the therapists has all the information about the abuse and the child does not have to provide the entire account.

Some resources suggest that consistency in treatment is extremely important for maltreated children. How are therapists approaching this issue?

All therapists were in agreement that “consistency” was not a particular issue. “I tend to downplay gaps in therapy,” says Rafala. “I don’t want clients to be dependent.” “Rigid consistency does not work!” exclaims Duhaime. “What is consistent is that you can come to the office to talk and to work on issues and we will make time for that, because it is important.” Zimmerman notes, “It is the relationships outside the office that need consistency.”

McLaren noted that lack of consistency is often due to the family being overwhelmed by what has occurred or avoided. “I try to encourage regular attendance,” she says, “because the child has taken a risk by sharing with me. It is hard, then, if I disappear from their life or if I am seen only randomly, after I have attempted to introduce myself as a person they could learn to trust.”

How do therapists view apologies from the offender?

Zimmerman, who also is a Virginia Certified Sex Offender Treatment Provider with the Shenandoah Valley Sex Offenders Treatment Program, is firm. “I will not facilitate an apology unless the offender has completed treatment. I also want the offender’s therapist present. The child’s readiness to hear the apology is crucial. Apologies must wait until everyone in the system is ready.” Rafala is also cautious. “I avoid rushing into an apology. It could result in further abuse. Apologies tend to give control and power back to the abuser.”

McLaren, like Zimmerman, has extensive experience treating offenders. “If an offender is not in treatment, it is not fair or appropriate for contact of any sort with the victim. If an offender has completed treatment, a ‘Restitution-Clarification’ meeting is possible,” she states.

Duhaime agrees that victim-offender contact is risky and stresses the need for offender treatment. She notes, however, that the abuse is not the total of the relationship between the offender and the child. “If the relationship is an important one for the child, an apology could be helpful. If the offender wishes to apologize, I spend considerable time with the child determining if and how an apology should be offered. The child must set the stage and conditions if an apology is to occur.”

Should foster parents be included in therapy?

This issue is difficult. Foster care is meant to be temporary, and some children don’t want foster parents knowing intimate details about their life. Other children form close relationships with foster parents and confide in them.

Despite the potential difficulties, all therapists include foster parents in the therapy. Stewart explains, “It is critical to include foster parents. I view it as a team effort. The child must expand the idea of family.” Duhaime agrees. “I include foster parents,” she says, “because I want them to have the knowledge and the skills to help the children.” McLaren remarks, “I include the foster parents as if they are a parent and work very closely with them. This person who is responsible for the child needs to know information about the child.” Rafala obtains permission from the child before including foster parents. “My approach with foster parents is more educational and less personal than with biological parents,” he states. “I don’t share as many specifics about the child.”

How do therapists deal with self-esteem issues?

Each therapist has developed favorite ways to help children recover a positive “sense of self”. Zimmerman encourages parents to spend time with the child doing activities that both enjoy. She explains, “I teach parents to notice positives and to be very specific rather than global when they praise their child.” Duhaime responds with a similar theme. “Catch them being good!” she exclaims. “Teach parents to take a difficult situation and pull something positive from it.” Duhaime sometimes instructs parents to “goof” or “share a goof” with their child. “Children love it when they see parents’ goof! The parents can then share how they solved the goof, the feelings they had, and talk about the situation,” says Duhaime. “It’s even better if the ‘goof’ comes from dad,” she adds.

“I keep self-esteem in the back of my mind every single session!” exclaims McLaren. “Noticing a good job and documenting accomplishments is a part of our weekly sessions.” McLaren also advocates for child clients to join groups such as 4-H, sports, classes or school clubs where the child can experience success and a sense of belonging.

Rafala likes to talk in terms of skill-building. “Part of self-confidence is knowing what you want. With older girls I like to have them list the ‘perfect guy’ and ‘perfect gal’. It’s an exercise that leads to interesting discussions.”

“There are many psycho-educational materials available,” notes Stewart. She has collected favorites over many years. “Some I use consistently are ‘Red Light/Green Light’, ‘High Tops/Flip Flops’, ‘Cartwheels’, and the scriptography books by Channing Bete.” Duhaime likes to have children create a scrapbook of activities. “Scrapbooks are a very tangible way to track progress,” she comments.

Any final thoughts?

McLaren summarizes, “The therapist’s office is the one place where the child can disclose any feelings, be they good or bad, about the abuse experience and not be judged for those feelings. It is our job, our responsibility, to provide that setting; and in order to provide it the children need to receive the message from us that talking about and processing the abuse experience is why they come to see us. If we avoid the topic, or allow them to avoid it, we are doing them a disservice. Respectfully, mindfully, bring them back to the process.”

Summary

Regardless of specific orientation, psychotherapy involves innovation. The wise practitioner knows that no one approach is suitable for all. Proficient providers adapt to individual client needs and use a variety of techniques.

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special factor in children’s adjustment (Saywitz et al., 2000).

One study evaluating a family therapy approach was found (Bagley & La Chance, 2000). A Canadian program based on principles established by Henry Giartetto, compared a treatment group (n=27) to an untreated comparison group (n=30). Treated children received an average of 78 hours of individual therapy, 37 hours of dyadic therapy, 32 hours of group therapy, and 14 hours of family therapy. At two-year follow-up, treated adolescents had recovered to levels of self-esteem found in normal samples, had fewer depressive symptoms, and problem behaviors had improved. Untreated adolescents had deteriorated during the two-year period.

Community interventions such as support groups in schools, churches, or through sexual assault centers are offered in many areas of the country. Some of Virginia’s sexual assault centers sponsor such efforts (see Virginia’s Picture, this issue). While there are advantages of offering treatment in clinical and private practices where confidentiality and privacy can be assured, services in community settings provide access to more victims and draw upon natural sources of support (peers, guidance counselors, teachers, adult leaders). Studies have not addressed the best setting in which to offer treatment (Kolko, 2000).

Research Reviews

In 1995, Finkelhor and Berliner undertook a comprehensive review of all empirical studies to date of treatment of sexually abused children. Twenty-nine studies were identified. Overall, studies showed improvements during treatment. However, only 5 studies were designed to show that recovery was due to treatment rather than the passage of time. The studies, as a group, suggest that some behaviors are more resistant to change than others. In particular, aggressiveness and sexualized behaviors are resistant to change. Some children with these symptoms do not show improvement.

Finkelhor and Berliner also concluded that there were few, if any, reliable differences between the treatment modalities examined. Saywitz (2000) appears to agree with the conclusions of Finkelhor & Berliner. She notes that once the immediate abuse-focused work with the family is complete, the moderate and long-term treatment needs of the child may be indistinguishable from non-abused children with similar symptoms. She says there is “little empirical evidence to support a need to develop novel intervention models that treat sexually abused children as a special class of patients” (p.5).

Becker et al. (1995) also reviewed empirical research on child abuse treatment. They concluded that both individual and group treatment can have a significant impact on many of the short-term effects of sexual abuse. The only study reviewed that compared different approaches (Downing et al., 1988) found that psychodynamic and behavioral approaches were equally effective with 6-to-12-year-old girls.

Another way of examining the data is to examine which children improve with therapeutic intervention and which show no or limited improvements. Few studies have taken this approach. If children respond differently to abuse (and it appears that they do), then treatment interventions that directly address the child’s response may be more effective than a generic approach or a treatment geared to a response pattern different than the child in question. For example, if a child is feeling considerable shame and stigmatization, interventions addressing this cognitive mind-set may produce greater improvements than would an approach not directed towards this reaction.

Research On Factors Related To Treatment Outcome

Length of Treatment

It is not clear what length of time is needed to achieve optimal effects. Most research studies have brief interventions of 6 to 20 sessions (Finkelhor & Berliner, 1993). This question was examined by Lanktree and Briere (1995). Lanktree and Briere examined the outcomes of abuse-focused therapy for 105 children. Assessment was performed at 3 months, at 6 months, at 9 months, and at 1 year. Symptoms did reduce over time, although not all symptoms improved at the same rate. Most symptoms improved within the first 3 months and continued to improve. However, anger and sexual concerns did not show improvement until after 6 months. Thus, sexualized behaviors may be less amenable to change than are other symptoms. Symptom reduction in all areas may require longer treatment than the short-term therapy that is typically offered.

Treatment Dropout

Those designing research might assume that all children in a given treatment group receive similar treatment. In reality, children treated on an outpatient basis may miss sessions, attend sporadically, or drop-out prematurely. Leaving treatment prematurely and/or treatment dropout has not often been addressed in research studies, according to Finkelhor and Berliner (1995). Two studies (Staufert & Deblinger, 1993; Deblinger, 1994, both cited in Finkelhor & Berliner) found drop-out more likely with boy victims, with children who had fewer symptoms, in minority clients, and when only the parent received treatment. Dropout was less likely if the offender was a father.

Reactions of Parents

Parental support has consistently been associated with the adjustment of sexually abused children. Indeed, the degree of parental support may be a better predictor of the child’s psychological adjustment than are abuse-related factors (Cohen & Mannarino, 1998a).

While a majority of parents are supportive and protective, a substantial number are not (Pintello & Zuravin, 2001). Even when mothers are supportive, they may exhibit both inconsistency and ambivalence in their responses (Elliott & Carnes, 2001). A mother’s support has been hypothesized to be a function of factors such as her degree of dependence upon the perpetrator and whether or not the mother was a victim as a child. However, research has been inconsistent as to the effect of these factors. In contrast, evidence strongly suggests that a substantial number of nonoffending parents experience significant distress such as anxiety and depression (Elliott & Carnes, 2001).

Studies are recent and limited, but suggest that providing support and skills to non-offending parents can lead to better adjustment in sexually abused children (Elliott & Carnes, 2001).

Individual versus Group Therapy

Group therapy is often advocated for victims of sexual abuse. There is a belief that group treatment best addresses stigmatization and social isolation (Ratine, 2000). Group therapy is the treatment of choice for teenagers, because of a belief that peers relate better to peers than to adults who may be considered to be authority figures. Group treatment is also perceived by some administrators as cost-effective.

To date, there appears to be no empirical evidence that group treatment for children is superior to individual or family therapy. Indeed, many of the practitioners interviewed by TCPN advocated that children be involved in both individual and group treatment and did not view the treatments as interchangeable. Due to complicated family issues and confidentiality con-
Cultural Diversity

There has been recent interest about how to adapt treatments to diverse populations (see VCPN, volume 62). Unfortunately, there are no published studies that compare the outcomes of children of different ethnic groups who have received similar psychological treatments (Christophersen & Mortweet, 2001). The lack of empirical data make it speculative to decide when and where cultural differences might be important in treatment planning.

Revictimization

None of the empirical studies dealt with the question of continued victimization. One possibility for children who deteriorate, with or without treatment, is that the sexual abuse continues, perhaps with a different perpetrator.

Timing of Treatment

There is little in the literature addressing the timing of treatment. Some children are referred immediately upon discovery. Others are not referred until months or even years after the abuse. It seems sensible that earlier treatment is preferred and would be more effective. However, no data was found comparing treatment response of children referred immediately to those whose treatment was delayed.

Prevention

A complete review of child sexual abuse prevention projects will be undertaken in an upcoming VCPN. Children who have been sexually abused appear to be at heightened risk for subsequent victimization. Therefore, prevention training is a sensible part of treatment.

SUMMARY

There is a substantial body of literature on psychotherapy that confirms its utility with a wide variety of childhood disorders.

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Special Thanks to...

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Available from: American Psychological Association Order Department, P.O. Box 87194, Washington, D.C. 20090-2984 (800) 374-2721 or (202) 336-5510, Fax: (202) 336-5502, TDD TTY: (202) 336-6123, E-mail: order @apa.org
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This is a book everyonr has been waiting for! This book provides a comprehensive, very readable review of therapies with proven effectiveness for childhood disorders. These include disruptive behavioral disorders (such as conduct disorder, oppositional disorder, and attention-deficit disorders), anxiety disorders, habit disorders, tics, sleep disorders, enuresis, enuresis, pain management and adherence to medical regimens. Notably absent is the management of childhood depression, obsessive-compulsive disorders, and post-traumatic stress.

VCPN staff highly recommend this book to our readers engaged in intervention and treatment services.


Available from: CWLA c/o CSSC, P.O. Box 7816, 300 Raritan Center Parkway, Edison, NJ 08818-7816 (800) 407-6273, Fax: (908) 417-0482, E-mail: books@cwla.org Web site: www.handbooks.net/cwla

This book seeks to help caregivers, child care workers, and foster parents understand how traumatic experiences affect children and how to foster the healing process. It describes the stages of recovery from trauma, intervention methods for panic attacks, and metaphorical storytelling. There is also a chapter about how to increase resiliency in children. The final chapter discusses dealing with past trauma and self-care for adult caretakers.

Measurement of Stress, Trauma, and Adaptation edited by B. Hudnall Stamm, Ph.D., 1996, 445 pages, $55

Available from: Sidran Press, 200 East Joppa Road, Suites 207, Baltimore, MD 21286 (410) 825-8888, Fax: (410) 537-0747, E-mail: sidran@sidran.org Web Site: www.sidran.org

This is an exceptional resource! It contains detailed information for 98 instruments which measure trauma-related symptoms and responses. Some are well-developed instruments that are available commercially but others are available free or from the developers. Each review offers a wealth of information about the instrument including copyright information, an estimate of the psychometric maturity of the instrument, numbers of studies in progress, published research, contact information as well as the basics of the instrument's use. Clinicians and researchers alike should find this a valuable resource for choosing outcome measures and assessment instruments.


This workbook for girls 10 and older is a useful adjunct to therapy. It is written in an appealing format and simple language. It covers issues pertinent to both group and individual therapy.

Back On Track: Boys Dealing with Sexual Abuse, Leslie Bailey Wright and Mindy B. Loiselie, 1997, 128 pages, $14 plus $5 shipping and handling (soft cover).

This workbook is for boys age 10 and older. The introduction says this workbook is "part of the Book of Hearing" (a wonderful book that changes how you hear things). There are ideas, exercises, stories, and examples. The chapters can help sort out feelings, figure out coping skills, learn about abuse and discover how to stay on track.

Available from: The Safer Society Press, P.O. Box 340, Brandon, VT 05733, (802) 247-3132, Fax: (802) 247-4233, E-mail: ssfl@sover.net Web site: www.safersociety.org
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Initial data on children who have been sexually abused suggests that psychotherapy is helpful with this population as well. Sexually abused children, as a group, improve over time in treatment and treated children have fewer symptoms at posttest than untreated children. Since not all children improve, it is important to begin to examine cases where there is no improvement in order to learn more about what factors predict treatment failure.

There is a wide variety of psychotherapeutic approaches available to clinicians. Only a few of these have been subjected to empirical testing. While approaches such as SAS-CBT appear promising, it is not clear that these approaches are more effective than other methods (Briere, 1996). Therapists need to carefully describe approaches that appear effective so that investigators can determine what treatment elements are crucial to improvement. Agreement concerning outcome measures is also needed.

The diversity of children's reactions to sexual abuse means that no single intervention is likely to be equally effective for all. Treatment plans will need to be modified and individualized. Different types of treatment and different levels of care will be required. Due to the complexity of the problems, interventions in more serious cases need to involve multiple levels (child, family, and community) (Becker et al., 1995).

Non-offending parents and caretakers must be part of the treatment process (Saywitz, 2000). Parents may need assistance with their own reactions in order to better assist their children. Also, available evidence suggests that a nonoffending parent may enhance the support available to a child and may delay or reduce the likelihood of severe negative effects (Beutler, Williams, Zetzer, 1994).

Girls appear to respond better to mental health treatment than boys do, for reasons not yet understood (Olafson & Boat, 2000). Therefore, there is a need to examine treatments for girls and boys separately and to learn more about how to optimize treatment for male children. Little empirical data is available about the treatment response of sexually abused adolescents. There is great need to learn about the effectiveness of interventions with this age group.

Although much research remains, the effectiveness of some treatments for some of the problems exhibited by child sexual abuse victims has been empirically demonstrated. Other treatments are based on accepted theory and have wide acceptance by practitioners and considerable anecdotal support, but still lack validation. Clinicians have guidance available through professional associations and other groups that have reviewed literature and offered protocols, guidelines and standards. These efforts increase the likelihood that child victims of sexual abuse will receive the best treatment available, given our current knowledge.

References Available Upon Request

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