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Questions and Answers about Child Sexual Abuse Treatment

An Interview with Judith Cohen, MD

Dr. Judith Cohen is a member of the National Child Traumatic Stress Network and Medical Director of the Center for Traumatic Stress in Children, Department of Psychiatry, Allegheny General Hospital. A board-certified child and adolescent psychiatrist, Dr. Cohen has written and lectured extensively on the evaluation and treatment of children exposed to traumatic events such as physical and sexual abuse, accidental or violent death of a loved one, and natural disasters. Employing evidenced-based therapies (many of which she has co-developed), including trauma-focused cognitive-behavioral therapy (TF-CBT), Dr. Cohen has offered treatments for abused children, multiply traumatized children and children suffering from traumatic grief and loss. Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is an empirically validated treatment for child sexual abuse that has evolved as the clear standard of care for children and adolescents who have experienced abuse and trauma.

Q: How do I know if my child who has been sexually abused needs treatment?

A: If your child displays any of the signs and symptoms of traumatic stress (see Q&A child sexual abuse) then you should take him or her for an evaluation. A therapist who has experience working with children who've been sexually abused can determine whether your child needs help. Some children will not need any help at all – many will need some help. Some may just need a therapist to provide information so they can understand more about what happened to them. When we evaluate children, we look for symptoms of traumatic stress, depression, or anxiety. We also try to find out if they have any unrealistic beliefs or ideas about the event (called cognitive distortions). For example, it's common for children to blame themselves for the abuse, or to feel that they could have prevented it. It's important to explore these kinds of "distorted" ideas because they can continue to cause problems in a child's life. When we evaluate a child, we also look for any signs that the child is having difficulty in school or life because of the abuse.

Q: How can parents know if a treatment for child sexual abuse is effective?

A: As with any other medical treatment, psychotherapies should be studied scientifically to test their effectiveness. Treatments that have been studied and shown to be effective are known as "empirically validated" treatments. This means that a treatment has been compared carefully to other treatments being used for the same condition, and that it has been shown to work.

Q: What treatment do you recommend?

A. No single treatment is appropriate for every child. Esther Deblinger, PhD, Anthony Mannarino, PhD, and I developed Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and have used it with a wide variety of children and adolescents over a number of years. The Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized TF-CBT as a model program. Because well-designed scientific studies have shown it to be so effective in treating children who've been sexually abused, SAMSHA is encouraging its broader use by practitioners, and the National Child Traumatic Stress Network is training clinicians all over the country in this approach.

Q: How widely has Trauma-Focused Cognitive Behavioral Therapy been studied?

A: We've completed five large-scale studies that included more than 500 children. We are in the middle of two more studies. The evidence is very strong that the children who received this treatment did significantly better than those who received the other treatments included in the study.

Q: Are any other treatments also effective?

A: Some other commonly used treatments, such as Child-Centered Therapy, have been shown to help, too, just not as much when compared directly with Trauma-Focused Cognitive Behavioral Therapy. Many of the treatments that therapists use haven't been studied scientifically. However, it's likely that many trauma-focused treatments which use similar components to TF-CBT are effective at treating sexually abused children.

Q: What are the elements of effective therapy?

A: Trauma-Focused Cognitive Behavioral Therapy is a structured treatment that takes place over as short a period as twelve weeks. A child and (whenever possible) the child's parent or supportive caregiver participate. The treatment begins with *education*. The therapist shares information with the child and caregiver about common reactions and symptoms that may result from sexual abuse. This helps children understand that their reactions and feelings are normal and that treatment can help them. It helps non-abusing parents to accept that the abuse wasn't their fault or the child's fault.

It's common for parents to react to their child's abuse by becoming either too permissive or too protective. The therapist helps them maintain normal routines, household rules, and expectations. If the perpetrator has been one of the parents, the whole structure of the family may have changed, and the remaining parent needs support to be consistent and keep family life as secure as possible.

Another step in the treatment, called *affect regulation and relaxation*, helps the child to identify his or her negative feelings such as anxiety, jumpiness, and sadness that can occur after a trauma. The therapist gives the child techniques to modulate these feelings and to

soothe him or herself. This is important so that the child does not begin to withdraw from life to avoid having these feelings.

Another part of the treatment helps children to analyze the connections between their thoughts, feelings, and behaviors. Children who've been sexually abused often feel bad about themselves. They may blame themselves or believe that nothing good will ever happen to them again. We begin by helping children examine their thoughts about everyday events. We then move into exploring their thoughts, beliefs, and feelings about the abuse.

Another part of the therapy is overcoming *learned fears*. This means unlearning the connection a child has made between the abuse, her negative feelings about it, and *trauma reminders*, other things and events she's associated with the experience. Desensitization may be necessary when a child continues to have intense reactions to particular things, places, people, or situations that remind him or her of the trauma. To avoid reactions to these *trauma reminders*, a child may limit his or her experiences. For example, a child may avoid going into the basement of the house where the abuse occurred because she associates the basement with negative feelings about the abuse. Reactions to trauma reminders may also generalize. A child may begin by being afraid to go into the particular basement where the abuse took place, and gradually become afraid of going into any basement, and then into any room that is downstairs or that in any way resembles a basement.

In the case of a child afraid to go into any basement, our treatment would help the child overcome the fear of basements by having the child gradually imagine being in a basement without feeling upset. In some cases, the therapist might actually go into the basement with the child to be sure she can tolerate the experience.

One of the most significant parts of the treatment is the *trauma narrative*. The clinician helps the child to tell a coherent account of what happened, how it felt, and what it meant. By putting her memories in order, the child no longer feels haunted by them. The therapist helps identify and correct the child's distorted ideas and beliefs about the abuse. For example, an adolescent was in treatment for abuse that had occurred when she was five years old and the perpetrator was fifteen. She was still blaming herself for "letting," the abuse occur. By creating the trauma narrative she realized she had been blaming herself for something she hadn't had the power to prevent. By telling the story to her therapist, she corrected her own false understanding. The mother had also felt confused about who was to blame. By sharing this story with her mother in a joint therapy session, the daughter helped her mother to understand what had really happened. The therapy healed not only the young woman but the mother-daughter relationship as well.

Q: How can I find a clinician trained in this treatment?

A: We've been training practitioners for twenty years, so there are quite a few clinicians who know how to use this approach. We've trained more than 2500 NCTSN members so far and are continuing to train more. You can begin by calling your nearest NCTSN site.

Q: If Trauma-focused Cognitive Behavioral Therapy isn't available in my town, what should I look for in treatment?

A: The treatment should be trauma-focused and directive. Treatments that are open-ended and just supportive have been shown to be less effective. The treatment should contain at least some of the elements described above and that have been shown to be most helpful. Since reactions to trauma reminders can pose big problems in children's lives, any effective approach will have a systematic approach to helping the child cope with trauma reminders. In order to identify cognitive distortions, such as the child's blaming herself for the abuse, the clinician should address the relationship between thoughts, feelings, and behaviors.

We've found that the work that goes on in creating a trauma narrative -- talking about and making some sense out of the abuse itself -- is very important. Therapies that do not talk about the traumatic events have been shown to be less effective. But a treatment needs to prepare the child for the trauma narrative by giving him or her tools and techniques for mastering fear and the other negative emotions likely to come up.

Some treatments are not only ineffective but dangerous, such as "holding therapy," or "rebirthing therapy." If something sounds gimmicky, or too good to be true, trust your instincts. Avoid any therapist too quick to attribute any sort of symptoms of unhappiness or anxiety as "proof" of sexual abuse. Avoid a therapist who holds himself up as a "guru" or as having powers beyond that of other therapists. Hypnosis, sodium pentothal, or other treatments that a therapist clams will bring back repressed memories are dangerous and unreliable and should be avoided.

Q: What qualifications should I look for in a practitioner?

A: A clinician may be a psychiatrist, psychologist, or social worker, and should be licensed. The practitioner should have a lot of experience in treating child trauma including sexual abuse.

Q: A parent asks this question: "My preschool daughter was touching herself down there and her teacher suggested that she be evaluated for child sexual abuse. The teacher seemed to think that any sexual behavior was a sign of abuse.

A: Masturbation among three-year-olds is usually normal behavior. Researchers who've studied children's behavior closely have found that a wide range of sexualized behaviors can happen among children of various ages for many different reasons. If your daughter told the teacher that she had been abused, or if she was inappropriately touching other children, for example, forcing them to imitate adult-like sexual behaviors, that might be reason for concern. But even that is not "proof" of sexual abuse, since a child today may also be imitating something he or she saw on TV or on the internet.

Q: Is the treatment the same for a child who's been abused for years versus a one-time event?

A: In our studies, we did not find that the number of abuse episodes or the period of time over which the abuse occurred affected the child's response to treatment. Certainly there are some children who've been chronically abused who will need more than twelve sessions. Many children who've been chronically sexually abused have also experienced physical abuse and other forms of trauma, stress, and adversity, so are going to need more help. But every child can get better.

Established by Congress in 2000, the **National Child Traumatic Stress Network (NCTSN)** is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

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For more information, visit the National Child Traumatic Stress Network (NCTSN) at **www.NCTSN.org.**