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Intervention Strategies for Promoting Recovery and Healing from Child Sexual Abuse

Tara Shuman

Abstract

The deleterious effects of child sexual abuse (CSA) on youth's social, emotional, physical, cognitive, neurobiological, sexual and developmental functioning are pervasive. Early targeted interventions for both the child who experienced CSA and their nonoffending caregivers are essential for healing and recovery. Effective interventions which are tailored to the youth's developmental level can help mitigate or even prevent some of the serious and enduring negative effects of CSA, including symptoms of posttraumatic stress disorder (PTSD). This chapter is not comprehensive, but examines evidence based interventions for children and adolescents who have been sexually abused including Trauma-Focused Cognitive Behavioral Therapy. Additionally, this chapter will address systemic factors in CSA, recommending coordinated and trauma informed efforts utilizing an interdisciplinary approach, which may include a forensic medical team, investigators, prosecutors and other disciplines. This professional collaboration can prevent retraumatization of the child as the child and family navigate the sequela of CSA.

Keywords: survivor therapy, healing from trauma, CSA intervention, CSA impact, nonoffending caregiver support

1. Introduction

The sexual abuse of children continues to be an extensive international problem with serious long term consequences. There are varying definitions of CSA, with the World Health Organization defining CSA as the involvement of a child under the age of 18 in sexual activity that they do not fully comprehend, do not give consent to, or for which the youth is not developmentally prepared and that violates the social taboos or laws of society [1]. CSA may include penetrative and nonpenetrative acts. Prevalence rates for CSA vary greatly, based on differing definitions of CSA, underreporting of CSA, and differences in child welfare record keeping by country. Prevalence rates for CSA according to a 2009 meta-analysis from 65 studies in 22 countries determined that an estimated 20% of girls and 8% of boys were victims of CSA prior to age 18 [2]. The high prevalence rates and the serious long term emotional, physical, relational and sexual consequences of CSA implore the need for efficacious, trauma informed interventions for the child and family. The vast majority of CSA is perpetrated by an offender the child knows and trusts, mandating that the interventions address the family and not just the victim [3].

Additionally, multidisciplinary coordination of law enforcement, forensic interviewing, child welfare services and therapists is essential to minimize retraumatization of the child and to best promote healing and recovery.

2. Impact of child sexual abuse

There are emotional, behavioral, developmental, relational, physical and sexual sequela of CSA, especially if the child did not receive timely and efficacious interventions and/or the child was not believed nor supported when they disclosed the CSA. The effects of CSA are often dependent on severity and frequency of the CSA as well as the developmental level of the child. Additionally, many CSA survivors have been victims of ongoing and complex trauma and the effects are cumulative and likely to overwhelm the child's coping resources. Emotional impacts can include depression, anxiety, posttraumatic stress symptoms, and angry outbursts, among others [4]. Externalizing behavioral symptoms can include regressions in toileting, temper tantrums, sleep difficulties and nightmares, provocative sexual behaviors, substance abuse, defiance and noncompliance [5]. CSA increases an individual's risk for both minor and major health problems including cancer and diabetes [6]. Relational consequences can include indiscriminant attachments which put victims at further risk, and also withdrawal and mistrust. Mistrust is empirically common if the child experienced betrayal trauma where the perpetrator was a known and trusted individual [7]. Sexual sequela can include sexual acting out behaviors, hypersexuality, poor body boundaries as well as an aversion and fear of affection and sexual behaviors.

The child's relationship with the perpetrator or offender of the sexual abuse impacts symptom presentation and also disclosure. The majority of sexual abuse victims know their perpetrator [3, 7], often making it difficult for the child to disclose due to feelings of loyalty to the family or the perpetrator. The lack of disclosure often results in the sexual abuse continuing over an extended period of time and the youth not receiving needed interventions, which may exacerbate their symptoms and the negative effects of CSA [8].

3. CSA interventions for youth

There is a need for empirically supported, targeted, and child directed interventions for victims of CSA [9]. These interventions should be trauma informed, provided within the context of a strong and supportive therapeutic relationship and include psychoeducation about CSA, coping skills, exposure through a trauma narrative and safety planning. Several of the most widely utilized interventions for CSA victims and their nonoffending caregivers are presented in this chapter.

3.1 TF-CBT

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an empirically supported treatment model for CSA developed to address PTSD symptoms and trauma in children and adolescents [4, 8, 10, 11]. Studies conducted in the last 25 years have provided consistent support for TF-CBT as the superior therapy for sexually abused children and other traumatized children when compared to non-directive or child-centered supportive therapy, as it provides essential support structures for both caregivers and children [11]. TF-CBT treats children and adolescents, ages 3 to 17, by addressing the negative effects of trauma including processing of traumatic

memories, addressing and overcoming problematic thoughts, and building coping and interpersonal skills. This short-term manualized treatment is typically provided in eight to 16 weekly 90-minute sessions, extending to as many as 25 sessions for individuals suffering from complex trauma [4, 8]. The TF-CBT treatment model was developed not only to address PTSD and depression and anxiety symptoms, but also underlying problematic distortions of thought regarding self-blame for trauma, ideas and expectations for safety, and constructs of trust in others and the world [10, 11].

The core components of TF-CBT can be summarized with the PRACTICE acronym, P: psychoeducation and parenting skills, R: relaxation skills or managing physiological reactions to trauma, A: affective modulation skills or managing affective responses to trauma, C: cognitive coping skills that build connections between thoughts, feelings, and behaviors, T: trauma narrative and processing, I: in vivo mastery of trauma reminders, C: conjoint child-caregiver sessions, and E: enhancing safety and future development [4, 8].

A primary curative component of TF-CBT is creation and processing of the trauma narrative (T) [4, 8, 10, 11]. This is the middle third of the duration of therapy, where the therapist and traumatized client focus increasingly on the specific traumas experienced. As the therapist and client progress through the components of the PRACTICE model, the therapist increases gradual exposure and helps the client and caregivers implement the skills learned to prepare them to cope with the inevitable full exposure of trauma reminders that accompany the trauma narrative [4, 8]. The trauma narrative and processing component is essential in the exposure therapy aspect of this treatment model, as it allows the child to extinguish negative emotions and reactions associated with the trauma by wiring new pathways of associations to the traumatic memories and eliciting positive and resilience-focused feelings such as pride and strength [8, 10].

In the trauma narrative and processing component, the youth develop a narrative about their CSA that includes specific traumatic circumstances, cognitions, feelings, behaviors, and other trauma-related experiences. For many of these youth, it is difficult to create a fully integrated trauma narrative, as they may only conjure up fragmented and non-linear pieces of their complex trauma memories [8]. Traditionally, these trauma narratives manifest in the form of written books about the youth and their specific trauma. The youth will complete their trauma narrative, usually ending with a chapter of what they have learned about themselves, relationships with others, worldviews, and expectations of the future, and then have the opportunity to share their narrative with their caregiver [10]. Trauma narratives can both highlight maladaptive core beliefs, and facilitate the integration of thoughts and feelings related to trauma [10]. Trauma narratives have been shown to reduce a child's fear and anxiety related to their abuse and decrease avoidant behaviors related to trauma [4, 8, 10, 11].

3.2 Play therapy

Play is the language of children and play based therapy for CSA is a developmentally attuned and expressive intervention that can facilitate emotional and behavioral regulation and healing from CSA [12]. Children who have been sexually abused frequently have difficulty with verbal recollection and expression of their traumatic experiences both due to the neurobiological impact of trauma on language centers in the brain and the developmental level of the child [13, 14] and play interventions can be familiar and less threatening. Additionally, complex trauma interferes with typical brain development, plus traumatic memories are often stored in the brain's implicit memory, which results in memories of sexual abuse

being stored in areas of the brain and body that are frequently challenging to access through verbal methods [15]. Through play therapy, children use symbolic representation to explore feelings and thoughts. Play therapy can include dolls, puppets, action figures and stuffed animal play for sexual abuse disclosure, which creates distance and an alternative to the children directly discussing their traumatic experiences, as they act it out through play. Play can be incorporated into other treatment modalities, such as play based construction of a trauma narrative in TF-CBT, and is particularly important for younger children who may not have the cognitive and language skills to fully express their feelings through talk therapy [16].

Play therapy for CSA can be directive and focused on the CSA or nondirective and child centered, focused on building rapport and establishing safety in the therapeutic relationship [12]. Play can be used to engage children who have experienced CSA and their caregivers in the therapy process, to teach specific personal safety and coping skills, to create a fun therapeutic environment and to facilitate communication between the child and the therapist [16]. Historically, the efficacy of play therapy for CSA has been difficult to quantify, however, play therapy is beginning to develop an evidence base that is more than anecdotal, and is establishing play therapy as an effective empirically supported intervention for CSA [17, 18].

3.3 Art therapy

Trauma informed art therapy is effective for children who have experienced early relational trauma, such as intrafamilial sexual abuse, which may result in symptoms of PTSD [19]. Art therapy interventions can provide a voice and sense of self-agency to CSA survivors as they creatively and abstractly represent their traumatic experiences and use metaphors and visual symbols to describe their sexual abuse [20]. Through visual arts, youth who have been sexually abused can express overwhelming emotions without requiring words [21].

Healthy emotional expression as well as emotional regulation for children who have experienced CSA can be promoted through art therapy [21]. Children who have been sexually abused may present with dissociative tendencies, limiting their ability to create a verbal trauma narrative and art therapy can provide a medium of construction of the trauma narrative that is not dependent on verbal processing [22]. Art interventions, such as drawing, painting, sculpting, collaging, etc., employed in forming and processing of a trauma narrative can act as a catalyst for children who have experienced CSA to explore thoughts, feelings, trauma memories, and perceptions through visual, tactile, and other sensory means [23]. With child sexual abuse, it is especially important to explore the non-verbal memories that recall fragmented sensory and emotional experiences of the trauma [24]. Art therapy is a visual and sensory modality that assists youth who have been sexually abused with accessing traumatic material stored in implicit memory, which is body-based form of memory that is distinct from explicit, narrative and conscious memory [20]. Art therapy may provide a bridge between implicit and explicit memory that allows children who have experienced CSA to express feelings and memories that are not accessible by verbal means [23].

3.4 Group therapy

To treat CSA, there are numerous efficacious group interventions which aim to decrease symptoms of CSA while also providing future risk reduction skills [25]. Group therapy for CSA is a treatment modality that is frequently used and is often the treatment of choice for CSA. CSA group treatment has growing interest for a variety of reasons, such as an increase in demand for trauma focused mental health

services and a need for a cost-effective approach [26]. Group modalities for CSA include TF-CBT groups, art therapy groups, support groups, psychoeducation groups, and process groups, among others. Children in CSA group therapy benefit from the support and understanding of peers who have had similar experiences. Group therapy provides an important sense of universality for CSA victims which can help combat feeling of isolation, social stigma, shame, guilt, and anger [27]. Universality is a key component of CSA group treatment and can assist with normalization of feelings of powerlessness, betrayal and helplessness, while simultaneously providing skills for resilience [27]. The relational consequences and mistrust that are often a result of CSA can be mitigated in group therapy for CSA as group members begin to connect through the opportunity to interact with supportive therapists and other CSA victims [28].

TF-CBT was initially provided as individual treatment although TF-CBT is frequently provided in a group format and group TF-CBT has also been identified as an efficacious treatment modality for CSA [29]. The group format of TF-CBT promotes cohesion by destigmatizing traumatic experiences. Children learn new skills together and can support one another to implement these skills [29]. When children are attending their group, caregivers are attending collateral group sessions to learn the TF-CBT components [10, 29]. Parenting and coping skills are taught to provide more consistency in the home and psychoeducation regarding trauma is provided [10, 29]. TF-CBT groups for CSA can decrease trauma symptoms such as anxiety, depression, avoidance, hypervigilance, and intrusive thoughts in youth [25]. Group therapy for CSA has shown to be effective for improving overall psychological distress, development of coping skills, and reducing sexual and other behavior problems [25]. Additionally, group TF-CBT has supported youth in developing stronger personal safety skills and decreasing emotional reactions in caregivers [25].

Art therapy groups for CSA are an expressive arts group treatment modality that incorporates creativity and can facilitate processing of traumatic experiences with other youth who have experienced CSA. Various types of abstract and representational art can be created in group and shared with group members in order to increase catharsis and connection/cohesion between group members. For example, group members may draw characters (animals, superheroes, objects) that represent themselves, their perpetrators and protective caregivers and then be asked to tell detailed stories to the group about these characters [20]. In this group art activity, a child may identify as an animal living in their safe place, until a predator presents and harms the animal (i.e., a fox attacking a rabbit, a bee stinging a kitten). Allowing the child to identify with the animal provides distance and separation from the event so as to prevent the children from being retraumatized or overwhelmed by trigger reminders [20]. An eight session art therapy group for latency age girls who had been sexually abused focused on four themes: establishing group cohesion and fostering trust, exploring feelings associated with the abuse, sexual behavior and the prevention of revictimization and termination of the group [30]. Group members utilized painting, drawing, clay sculpting, and dramatic role plays during this art therapy group. Outcome measures from this group art therapy intervention for girls who had been sexually abused evidenced a reduction in symptoms of anxiety and depression [30].

Support groups for CSA provide cohesion, connection with others with a shared experience, and psychoeducation about CSA. CSA support groups may focus on body boundaries, personal safety, CSA education, and coping skills and typically do not have a disclosure or trauma narrative as part of the group curriculum [31]. This may be due to the shorter length of treatment and/or group treatment provided outside of a clinical setting, such as at a school. Due to limited time and the need

for youth to not become emotionally triggered in a school setting, support groups typically do not have group members share details about their victimization.

4. Interventions for NonOffending caregivers

Nonoffending caregivers are primary supports for children who have been victims of CSA and the need for specific and tailored interventions for nonoffending caregivers is increasingly recognized in the literature and caregiver support has been identified as a crucial factors in children's recovery from CSA [32]. Caregiver interventions following sexual abuse of their child aim to reduce caregiver distress, increase adaptive caregiver coping as well as enhance support of the child [33]. Nonoffending caregivers have been referred to as "overlooked victims" in child sexual abuse cases [34]. A recent qualitative study with nonoffending caregivers of children under 13 who had been victims of CSA found that the majority of caregivers reported mental health services were necessary and beneficial for themselves to help them cope with the impact of their child's CSA [33]. Interventions for nonoffending caregivers may include group and/or individual treatment focusing on psychoeducation, information, supports, parenting guidance, and dealing with their own victimization (if relevant). When intrafamilial CSA occurs, the nonoffending caregiver has the essential role of assisting the CSA victims and other children in the family so that safety and security can be restored [35]. Simultaneously, the caregiver is likely experiencing shock, grief, fear and a myriad of other emotions, which are often overwhelming, while they are tasked with shepherding the child who has experienced CSA on their journey of healing and recovery. Nonoffending caregivers often need support, guidance and direction because in addition to the crisis of the CSA, they may be faced with a lack of financial support, legal proceedings, and possible conflict with and separation from extended family whose loyalties may lie with the perpetrator [35]. Caregiver support is an important mediating variable in outcomes for victims of CSA [32].

4.1 Nonoffending caregiver support groups

Support groups for nonoffending caregivers of children who have been sexually abused can provide critical psychoeducation and social support for the caregiver during this vulnerable time of rebuilding and redefining their family [32]. Nonoffending caregiver support groups offer a safe place to begin the difficult recovery process, to normalize feelings and thoughts about their child's CSA and to begin to build a support network with other families [34]. In the group, group therapists teach caregivers the relationship between thoughts, feelings and behaviors and provide guidance on thought restructuring which enables caregivers to deal with their own symptoms as well as modeling appropriate coping skills for their children and coaching their children on these skills. Additionally, caregiver support groups can provide practical information on social services, legal services, housing, school intervention and other needed resources [34].

4.2 Nonoffending caregiver individual therapy

Following disclosure or discovery that their child has been sexually abused, nonoffending caregivers may experience depression, posttraumatic stress and increases in anxiety [36]. Shields and colleagues found that following child sexual abuse disclosure, 24% of caregivers met diagnostic criteria for depression or PTSD or both [36]. Parental distress was associated with decreases in positive

parenting and caregiver involvement with the victim. Individual therapy for the nonoffending caregiver can be beneficial to address mood symptoms, trauma reminders and to increase coping and implementation of parenting skills. This individual treatment can be provided in conjunction with group treatment. If a caregiver has their own history of CSA, they may also benefit from individual therapy to process how their child's victimization is triggering their own CSA experience, especially if the caregiver did not receive interventions for their own CSA victimization [34].

4.3 Caregiver involvement in TF-CBT

TF-CBT incorporates individual and caregiver-focused interventions to inform families of the reactions and effects of trauma in children. Caregivers can be parents, foster parents, relative caregivers or other supportive adults actively involved in the child's life. This caregiver component enhances the positive impact of treatment in terms of decreasing caregiver and child depressive and anxiety symptoms, as factors such as caregivers' emotional distress and caregiver support of the child have been found to be strong and significant mediators to treatment response [10]. Parental and caregiver support is a primary component of the PRACTICE interventions of the TF-CBT model and the caregiver is actively and collaboratively involved in the entire course of treatment with approximately half of the treatment time focused on caregivers [8, 10]. Through both individual caregiver sessions and conjoint sessions with their child, caregivers learn to be present while their child discusses the CSA and how it affected them and caregivers learn skills to be supportive of their child as they work through the recovery process. Through the PRACTICE components, caregivers are taught strategies to express and modulate their affect as well as being taught ways to manage intense emotions in their child [10]. Additionally, caregivers learn parenting and child behavior management skills specific to children who have been victims of CSA. Prior to terminating treatment, skills to safety plan for CSA victims and promote positive future engagement are addressed with caregivers [11].

5. Systemic factors in CSA

Following disclosure or discovery of suspected CSA, a child and family's life may have an influx of professionals involved with the aim of child protection, assessment and promotion of the victim's physical and mental health, prosecution of the perpetrator, and family healing and recovery. Ideally, these efforts are coordinated in order to minimize deleterious impact on the CSA victim and family. In the United States, Child Advocacy Centers (CAC) were developed in response to the desire to limit redundant interviewing of the victim and to coordinate investigative and therapeutic response to CSA [37]. These CACs utilize a multidisciplinary team of medical, mental health, child protective and law enforcement professionals in a "one stop shop" approach to CSA with interagency communication and collaboration. In 2011, The National Children's Alliance in the United States (U.S.), developed Standards to ensure that children across the U.S. receive consistent, evidence based services that help them recover from CSA and other types of child abuse [38]. These Standards are updated every five years, with the most recent Standards from 2017 and to date there are more than 880 CACs in the United States, spanning all 50 states. In 2018, 367,797 children in the U.S. were served by CACs, with an increase in 29% from 2008 to 2018 [38]. However, even with this increase, there are still over ten million children living in the U.S. in areas without a CAC. Additionally,

internationally, many countries lack the funding and infrastructure to implement a coordinated and multidisciplinary response to CSA.

Increased caregiver and child satisfaction were found with these coordination efforts in evaluation and intervention with CSA [37]. CACs can serve as a model for coordinated multidisciplinary services that reduce retraumatization of the CSA victim due to limiting the child having to repeatedly disclose their CSA experiences to police, lawyers, doctors, therapists, investigators and judges [38].

6. Conclusion

This chapter highlighted several empirically supported and highly utilized interventions for CSA. Rather than being a comprehensive review of the literature, this chapter covered best practices for CSA intervention and treatment with attention to both the child and the nonoffending caregiver as it is imperative to simultaneously address the needs of the child and the caregiver to promote healing and recovery from CSA. Multiple modalities for individual, group and collateral caregiver intervention were presented, illuminating their efficacy and implementation for CSA. Selection of a specific treatment modality should be individualized based on cultural and contextual variables for the child and family, the frequency and severity of abuse, the child's and the caregiver's symptomology as well as the treatment setting and the training and experience of the provider. Additionally, the need for coordinated multidisciplinary investigative and therapeutic responses to CSA was highlighted in order to limit the negative systemic impact on the child and family, with CACs presented as a model implemented in the U.S. to address this need.

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