Therapeutic Work *with* Sexually Abused Children

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SAGE Publications
London • Thousand Oaks • New Delhi

First published 2002

SAGE Publications Ltd
6 Bonhill Street
London EC2A 4PU

SAGE Publications Inc
2455 Teller Road
Thousand Oaks, California 91320

SAGE Publications India Pvt Ltd
32, M-Block Market
Greater Kailash - I
New Delhi 110 048

British Library Cataloguing in Publication data

A catalogue record for this book is available from
the British Library

ISBN 0 7619 6968 3
ISBN 0 7619 6969 1 (pbk)

Library of Congress Control Number: 2001135324

Typeset by SIVA Math Setters, Chennai, India

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This book is dedicated to all children who have been sexually abused.

Acknowledgements

The authors wish to thank Alison Poyner, Senior Commissioning Editor, and Louise Wise, Editorial Assistant at Sage Publications for their contributions and support in writing this book. We are indebted to Pat Walton, University of Leicester, for her assistance in writing Chapter 12.

Randall Easton Wickham would like to thank the following: both her brother, Michael Easton and her sister, Kelly Easton for their intelligence, sensitivity and unfailing senses of humour, and to thank them for always being there when she has truly needed them; her children Celia and Katie, for their affection, spirit and patience with her while she worked on this manuscript; Phyllis Spinal-Robinson, LCSW, for friendship, supervision and co-authorship of the workbooks for sexually abused children and adolescents written in the US; her previous colleagues on the sexual abuse team and staff at Des Plaines Valley Community Centre in Chicago; most notably the following: Phyllis Spinal-Robinson, Avis Shapiro, LCSW, a highly skilled clinician; Beth Forte, LCSW, who supervised her on her first sexual abuse case; the teaching staff at SSA at the University of Chicago where she received her MA in Social Work; her co-author, Janet, for her unfailing sense of humour, dedication, hard work and fortitude; and lastly, and most importantly, all the children and families she has had the opportunity to work with, who have taught her so much. Thank you.

We also wish to acknowledge the following publications:
American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders*. Washington, DC.: American Psychiatric Association for permission to quote from DSM IV and defence mechanisms.

Sharp, S. and Cowie, H. (1998) *Counselling and Supporting Children in Distress*. London: Sage for permission to quote Table 2.1, p. 28.

Spinal-Robinson, P. and Easton Wickham, R. (1992) *Cartwheels. A Workbook for Children Who Have Been Sexually Abused*. Notre Dame, Indiana: Jalice, for permission to quote some of the Worksheets.

Spinal-Robinson, P. and Easton Wickham, R. (1992) *Cartwheels. Therapist's Guide*. Notre Dame, Indiana: Jalice, for permission to quote clinical material regarding feelings of responsibility for the abuse, p. 4.

Please note that the text is based on an integrative approach to treatment including the following orientations: psychodynamic, person-centred, self-psychology and cognitive. We also advocate a psycho-educational approach.

Please also note that the words 'carer' and 'parent' are used interchangeably in our text. We have varied gender pronouns in order to reinforce the reader's awareness that both girls and boys are sexually abused, and that there are male and female therapists. Within England and Wales, the person with overall case-management responsibility for the sexually abused child who is receiving therapy may be a social worker, a child protection officer, or some other designated worker. Only rarely is the therapist also the child's identified worker.

Contents

1 The Dimensions of the Issues

An older child:

In
my body
I
never belonged.
Childhood
an empty state,
invalidated and immobilized.

He couldn't help himself
so he helped himself to me.
An item in a menu
to be sullied, dirtied, consumed,
And thrown away.

I sacrificed everything,
but there is no celebration,
And I never had a choice
A body
childhood
A chance.

Child sexual abuse is a wide-ranging problem of long standing that needs to be adequately addressed. Society has to accept responsibility for its causes and contributing factors. While the scale of the problem of sexual abuse is beginning to be recognized and to receive considerable media attention, there are still many individuals and child care professionals who continue to minimize or deny the scope and severity of the problem. Indeed, it is only in the past few decades that the problem has been seriously acknowledged by both professionals and the general public (Sgroi, 1992).

It is essential to learn how to respond effectively to the child victim in a sensitive and timely fashion. This response requires the availability of legal, medical, social work, and therapeutic professionals who are adequately trained and committed to this important task. Although there has been some progress, British society and other western societies have not responded fully enough; the needs of the victim continue to far exceed the available resources.

Sexual abuse of children occurs across a broad range of social, cultural and socio-economic boundaries, is an abuse of power, and attacks those who are vulnerable and at risk. When children are sexually abused, they are treated both as an object and as an adult partner, forced into sexual activities for which mind and body are not ready. When it comes to light, child and family may be subjected to child protection procedures, and the child may undergo a forensic medical examination. In a minority of cases the child may give evidence in court, either through a video link or in the witness box, at the trial of the alleged abuser. The abuse and its aftermath are inevitably deeply traumatic for the abuse victim. Therapeutic help to children suffering from the effects of sexual abuse and their (non-abusive) carers can be an important component of the child's return to a healthy lifestyle and, in due course, to secure adult functioning.

A case example illustrates some of these issues:

Anna was a six-year-old, living at home with her mother and little brother. Her parents had been divorced for many years. Anna used to be a happy child with a zest for life and a love of nature. Then she became increasingly irritable, defiant, had nightmares, and lost her appetite. Her classroom teacher said she had changed and the other children didn't want to play with her. One night Anna's mother heard cries and found Anna fondling her brother's penis. Anna began drawing willies on her bedroom wall, and started wetting her bed. In the bath one evening Anna flinched, complaining that her bottom was sore. Her mother asked her what was wrong, but Anna only cried and shook her head. Mother was aghast at her daughter's distress. She noticed that Anna wouldn't visit her uncle in the next street; she said it was boring. Mother wondered about this. With difficulty Anna blurted out that she didn't like her uncle. She proceeded to draw a picture, which the mother took to the police. Mother hated doing this and was very distressed – to think that her own brother might have abused her lovely Anna. Then there was a medical examination and interviews with the police and child protection officer, who also wanted to talk to the neighbours and to the school. Anna had to go through it all again in front of a video camera. She became increasingly distressed. At home, she withdrew and was tearful. She began having tantrums, and continued to complain of physical symptoms. Her bottom hurt more and more and she had to be treated with tablets and cream. She hated going to the loo.

When the court business was out of the way, Anna had other kids taunting her about her uncle going to prison. Anna and her mother couldn't sort out all their hurt and mixed feelings, so Anna saw a therapist and her mother saw a social worker. Anna played, drew pictures, and talked with her therapist. Mother talked a lot to her social worker, for the first time telling about how her father had abused her when she was little. Slowly Anna and her mother grew and healed and flourished; though the memory of the uncle haunted them.

Defining the problem of child sexual abuse

Sexual abuse covers a range of sexual behaviours towards children, ranging in intrusiveness from exhibitionism to sexual penetration to involvement in pornography. Frequency and duration of the abuse vary, some children being subjected to intense abuse over time. Intrafamilial abuse occurs when someone abuses the child within the family setting, and extrafamilial abuse when the abuser is not related. An early definition of child sexual abuse is as follows:

> Child sexual abuse is a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency, and subordinate position. Authority and power enable the perpetrator, implicitly and directly, to coerce the child into sexual compliance. (Sgroi, Blick and Porter, 1982: 9)

We have subsequently become aware of acts of sexual aggression perpetrated by young children.

Workers have identified a cluster of problems exhibited by sexually abused children, varying in intensity, duration and type from child to child (Berliner, 1990; Porter, Blick and Sgroi, 1982). Edgeworth and Carr (2000: 19) cite studies confirming that 'Sexual abuse has profound short- and long-term effects on psychological functioning', two-thirds of sexually abused children developing psychological symptoms, with a quarter developing more severe difficulties (Berliner and Elliott, 1996; Kendall-Tacket et al., 1993; Wolfe and Birt, 1995).

Being the victim of child sexual abuse

How children respond to the abuse depends on:

- the context, frequency, duration, and type of abuse, especially if penetrative;
- whether the abuse is perpetrated by known people or strangers;
- the child's age, stage of development, ego strength and physical and mental health at the time of the abuse;
- the child's coping mechanisms and resilience, including whether the child has a secure background;
- the carers' reactions and coping mechanisms; and
- environmental support and response. (Elliott and Place, 1998: 93; Johns, 1997; Trowell, 1999: 109)

Some children recover satisfactorily. Other, more damaged, children require therapeutic help if they are not to be affected adversely by what has happened. It seems to be agreed that sexually abused children may:

- have distorted views about the purposes of sex;
- not understand the norms for child and adult (sexual) behaviours;

- see adults as abusers and not as protectors and nurturers;
- experience medical problems connected with their mouths or genitals, or as a result of sexually transmitted diseases, AIDS, drugs, or pregnancy;
- have mental health problems caused by fear and coercion;
- exhibit emotional difficulties and problems with trust, boundaries and affect;
- become victims, or abusers; and
- exhibit symptoms of Post Traumatic Stress Disorder (PTSD), chronic stress and traumas. (Wieland, 1998: 24)

Child victims of sexuality, beyond their emotional and physical developmental levels, are violated in every sense of the word: physically, psychologically, emotionally, and spiritually. Browne and Finkelhor (1986) usefully identify problems that may be caused by the *sexual* component of the abuse:

- *Traumatic sexualization* Conventional sexual behaviour is skewed. The child may develop atypical sexual behaviours as a young person and adult.
- *Stigmatization* The abused child may feel 'bad', blaming themselves for bringing trouble upon the family and maintaining the secrecy enjoined by the perpetrator. The child's self-esteem may be jeopardized, and some children subsequently turn to self-harm, substance abuse, or even suicide. The child may dissociate from the abusive situation.
- *Betrayal* The child's trust in adults may have been violated, and suspicion of other people and their intentions may intrude.
- *Powerlessness* Powerlessness can promote victimization, depression or suicidal behaviour. 'The experience of powerlessness may also lead to the internalization of a victim-persecutor internal working model for relationships, which sows the seeds for the child later becoming a perpetrator when placed in a position where an opportunity to exert power over a vulnerable person arises.' (Edgeworth and Carr, 2000: 19–20)

Survival becomes the key, and the abused child's developing sense of self and self-esteem is severely threatened. It is clear that victims of child sexual abuse may suffer long-term negative consequences as a result of their abuse (Fergusson and Mullen, 1999: 54–7).

The need for more research on the effectiveness of treatment and outcomes

The current trends in the literature suggest that there will be more research available on the outcomes of treatment with children who have been sexually abused. Hodges states that there is not much available research on child psychotherapy. 'Increasingly, child psychotherapists working in some areas of the NHS are under pressure to give evidence of the usefulness and cost-effectiveness of their work.' (1999: 119)

The challenge of providing therapy

Therapy needs to be proven and effective, taking place alongside the important work of carers, educationalists and healthcare workers, and should be separate from child protection procedures (Valios, 2000). Although there is growing awareness of the need for, and value of, therapeutic work with abused children, there is a constant struggle to create, and maintain, resources. The provision of therapeutic services to children in England and Wales is patchy (Audit Commission, 1999; Sharland et al., 1996) and there is a paucity of effective research to help practitioners decide on the most appropriate treatment methods. Only a fraction of abused children and their families are helped (Hunter, 1999: 133), service provision being left to the discretion of the local authority where the child lives (Children Act 1989, schedule 2).

When therapy is available, it is incumbent on all concerned to identify the issues that are to be worked on in the therapeutic setting. Trowell (1999: 114–15) lists the following:

- abuse issues;
- current disruptions, losses, separations;
- earlier childhood issues;
- psychopathology, such as PTSD, depression and suicidal thoughts, anxiety and panic attacks, separation anxiety, attachment disorders, conduct disorders, eating disorders;
- future plans, self confidence, self esteem; and
- family and social relationships.

There is emerging consensus that there are four major areas of therapeutic work (Gallo-Lopez, 2000; Rasmussen and Cunningham, 1995):

1 Treating children as people in their own right, with space to express and explore their own concerns (the child-centred approach) (West, 1996).
2 Treatment of traumatic sexualization, stigmatization, betrayal and powerlessness (Finkelhor and Browne, 1985) with implications for self-image, cognitive work and ventilation of feelings.
3 Helping the child to regain age appropriate functioning, self-confidence and self-respect, aided by therapeutic regression if necessary (based on developmental and child growth theories).
4 Impacting on the child's world by helping the child's (non-abusing) carers and school or daycare staff to respond effectively to the child's needs (systems or ecological theory).

Contextual requirements are that:

- the child is living with appropriate, nurturing carers and is not being abused;
- if old enough, the child has admitted the abuse; and
- the (non-abusive) carers and perhaps the siblings also receive counselling and advice related to the child's abuse.

Therapeutic sessions with the child, within a child-centred framework, call for non-directive as well as focused work either individually or in a group, with another therapist working alongside the child's carers and ecosystem.

Summary

Unfortunately, the sexual violation of children is an inescapable fact. Its effect varies, depending on the nature of the assault(s), the child's developmental stage and level of resilience, and quality of family support. Some children are so badly damaged, psychologically and maybe physically, that remedial help is necessary for child and carers. Therapeutic paradigms are emerging for individual and group therapy with children, plus help for carers and siblings. The professionalism of the therapist is vital and integral to the whole book, and we pay particular attention to it in the next chapter.