Listening to the child victim of abuse through the process of therapy

A case study

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When a child has been abused by his or her father or father-figure and makes the statement 'I want Dad to come home', whose voice are we hearing in treatment, how do we interpret and respond to what the child is saying? Understanding and responding to the voices of victims of abuse is a complex issue. This paper explores the issues of listening to and responding to a young vicitm of abuse in the context of the impact of the abuse on this young person, and how these issues emerged and were addressed in the therapeutic process. Amanda, a 13-year-old girl, disclosed sexual abuse by her stepfather. In the initial months of counselling she repeatedly expressed her wish for her stepfather to return home. Amanda's response to therapy, the short-term and long-term impact issues that were addressed, and the various therapeutic techniques that were used to assist in her recovery, are traced in the context of theoretical considerations.

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When a child, who has been sexually abused by his or her father or father-figure, says in counselling ' I want Dad to come home', a number of questions are posed. Whose voice is the counsellor hearing? Is the child under pressure to say this? How do we, as counsellors, interpret and respond to what children or young people say in counselling?

This paper explores the issues of listening to and responding to a young vicitm of sexual abuse in the context of the impact of the abuse on this young person, and how the impact issues emerged and were addressed in the therapeutic process.

Since it is not possible to predict in advance the therapeutic needs, duration of treatment, and intervention techniques that each child or young person will require, the therapeutic process described here is specific to this young person.

IMPACT OF CHILD SEXUAL ABUSE

Many authors have written about the short-term and long-term effects of child sexual abuse (Sgroi, 1982; Finkelhor, 1984; 1986; Walker, Bonner & Kaufman, 1988; James, 1989; Tower, 1989; Gil, 1991; Doyle, 1995; Goddard, 1996). Abuse is not a part of the usual human experience and can therefore cause acute stress at the time of the abuse and may also lead to delayed effects as explained in the theories of post traumatic stress disorder (Cattanach, 1993). MacFarlane, Cockriel and Dugan (1990) explain that the degree of harm may increase over time because of the continuing adjustments a victim makes to his or her personality to accommodate and survive the abuse.

Initial effects may include fear, anxiety, depression, anger, hostility and inappropriate sexual behaviour. The long-term effects may include depression, self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency towards re-victimisation, substance abuse, difficulty trusting others and sexual maladjustment. Finkelhor (1986) further identified several traumagenic factors associated with child sexual abuse which result from the traumatic sexualisation of the child, betrayal of trust and the child's love, experiences of powerlessness and stigmatisation.

TREATMENT OF CHILD VICTIMS OF SEXUAL ABUSE

The purpose of providing treatment for children who have been abused is early intervention in the potential long-term effects of abuse. Early treatment for child victims of abuse can prevent the emergence of destructive and dysfunctional patterns of behaviour which may cause victims of sexual abuse to 'live crippled' (Sgroi, 1982 p. 110), and can help them become socially responsible members of society (Giaretto, 1982). MacFarlane et al (1990) state that victims of abuse need to release the dysfunctional patterns of behaviour which helped them cope with and survive the abuse. Through treatment the victim is helped to acknowledge and accept feelings and behaviours related to the trauma, and change dysfunctional behaviours (James, 1989). Treating the impact

issues of sexual abuse can 'remove impediments to the child's own natural ability to heal' (Salter, 1988 p. 222).

TREATMENT CONTEXT

The case that forms the basis to this paper was referred to the primary author in her role as senior counsellor at The Centre for Children in Melbourne, Australia. The Centre is auspiced by Australians Against Child Abuse. It aims to help children and young people who have experienced abuse or family violence to overcome the impact of abuse and violence through offering a range of innovative, child-centred, therapeutic interventions which include individual counselling, group programs, support to the non-offending parent or carer, and family therapy. The Centre also undertakes research, prevention, advocacy and education programs (Centre for Children, 1999).

AMANDA'S STORY

Amanda, a pseudonym chosen by this young person, consented for her story to be used for this article. She was 13 when she 'accidentally' told her teacher at school that her stepfather had fondled her breasts 'once or twice' in the previous two months. The police, together with the State Child Protection Services, interviewed Amanda who confirmed her original disclosure and also stated that she did not want her stepfather charged. As a result, and in consultation with the mother, the police decided not to prosecute the stepfather. The stepfather admitted to one incident of 'inadvertently' touching Amanda. He agreed to move out of the home until Amanda, her mother and he had completed individual counselling.

Protective Services referred Amanda and her mother for treatment at The Centre for Children.

Prior to accepting Amanda for treatment, the Centre expressed concerns about the decision not to prosecute the stepfather. The Centre's view is that prosecution of the offender promotes validation of the child's disclosure and can assist in relieving the child of responsibility for the abuse. Despite the Centre's concerns, no further action occurred. The Centre eventually agreed to provide therapeutic services to Amanda and her mother with the stepfather living out of home and also agreed to work collaboratively with the stepfather's counsellor. This is a necessary aspect to any comprehen-sive treatment program (Ryan & Lane, 1991), and arrangements for sharing of relevant information with the family members and the counsellors were established. In this case, the collaboration between the clinicians who worked with the mother, child and stepfather was crucial in the outcomes for Amanda.

WHAT IS THERAPEUTIC INTERVENTION?

Therapeutic intervention is a sequence which is not linear but a process of moving 'back and forth' in response to a child's needs (Oaklander, 1997 p. 293). It must be sensitive and carefully planned, allowing for the development of a trusting relationship with the counsellor while an assessment of the specific impact issues is undertaken (James, 1989; Doyle, 1990; MacFarlane et al, 1990; Gil, 1991; Webb, 1996). It must also focus on the trauma of the abuse when the child or young person is ready to address these details (James, 1989).

The first step in developing a therapeutic intervention plan for any child is a comprehensive and thorough assessment of the child and family (Walker et al. 1988 ; James, 1989 ; Mannarino & Cohen, 1990; MacFarlane et al, 1990; Gil, 1991). The assessment must be based on the individual needs of each child which determines the impact and specific abuse related symptoms and its meaning for each child (Mannarino & Cohen, 1990, MacFarlane et al, 1990). Assessment begins from the first contact and is a continuous process on which ongoing therapeutic intervention is based. Counselling, which alternates with assessment, helps the victim address the impact issues through the provision of information and opportunities to explore what the abuse meant for the person. MacFarlane et al (1990) write that counselling also needs to help victims of abuse to gradually understand and take control of the layers of feelings associated with the abuse. Healing is not likely to occur until the victim has worked through the trauma of the abuse and the details of the traumatic events (James, 1989; MacFarlane et al, 1990). To integrate the abusive experience, it is necessary that victims are helped in therapy to explore and acknowledge their pain by 'returning to the pain' of remembering the abuse (James, 1989 p. 4).

SHORT-TERM IMPACT ISSUES FOR AMANDA

Initially Amanda was seen weekly for individual counselling to help her develop trust, become comfortable in the therapy, and to see it as a place for her to talk about issues as she felt and experienced them. These sessions were partly structured to assess her level of develeopment and to assess the impact issues of sexual abuse for her. During these sessions, the short-term impact issues identified for Amanda were:

Extreme confusion about her love for her stepfather, whom she had experienced as a loving father-figure for much of her life. His abuse of her had shattered her trust in him. She had initially hoped that the abuse would stop without any action on her part. After her disclosure, she was extremely fearful of losing his love (see, for example, MacFarlane et al, 1990; Sgroi, 1982).

Deep guilt, self-blame and betrayal, about the impact her disclosure had on her family. This included the family disruption and emotional turmoil for the whole family and her belief that she had deprived her mother of her marital partner and her younger stepsister of her father. She also felt she had betrayed her stepfather by 'telling' on him and worried that he would not trust her again.

Intense grief following her disclosure. She mourned the loss of a 'father' in the home and of the loving, caring, father-daughter relationship she had experienced with him, and also the loss of the previous family stability, family structure and relationships. She constantly verbalised her wish for her stepfather to return home and for everything to return to 'normal'.

At the beginning of therapeutic contact with Amanda, it appeared to the counsellor that she would easily have retracted her disclosure if she could be assured that this would help her family return to its former state.

Addressing the short-term impact issues

MacFarlane et al (1990) state that initial therapeutic intervention must assist in stabilising the immediate, short-term issues which result from the disclosure. During this time the above mentioned impact issues were a major concern for Amanda. She constantly verbalised her confusion about her love for her stepfather, guilt and grief about her family disruption, and her struggle to be a teenager. She deeply regretted her disclosure and frequently verbalised her wish for her stepfather to return home.

Working with Amanda on the initial effects of the abuse required a careful balance of listening, supporting her and providing information, not only about sexual abuse and sex offending, but also about age-appropriate teenage activities and experiences. Amanda's attention until then had been focussed on accommodating the abuse and she had lost contact with age-appropriate development (Summit, 1983). For the professional, responding to these various needs and balancing the different demands is what Brock refers to as 'walking a tightrope' (1993 p. 113). The counsellor also had to acknowledge Amanda's wish for her stepfather to return home, and remind her that this decision had to be made by her mother. At that time, the mother was certain that the stepfather was to remain out of home because she was not reassured of Amanda's safety.

It was particularly important at this time that the stepfather was not living in the home as it gave Amanda the physical and psychological security to work through and verbalise her understanding of the various aspects of the abuse (Sgroi, 1982).

LONG-TERM IMPACT ISSUES

As the short-term issues were addressed, the more complex, longer-term impact issues became evident.

The traumatic sexualisation of Amanda at the pubertal stage of her development was a major issue (see Finkelhor, 1986), and it became evident that the abuse had been more intrusive than she had initially disclosed.

The betrayal by her stepfather when she began to realise that it was her stepfather who had betrayed her by abusing her love and trust in him. She therefore had to re-examine her future relationship with him.

Trust in adults – Salter (1988) states that children need and expect adults to be reliable and trustworthy. The abuse confused Amanda about her step-father's paternal role, and her mother's ability to protect her which affected her trust in them and in other adults.

Blurred role boundaries – sexual abuse disorients a child and generates extreme role confusion because the child's role is elevated to that of an adult (see Sgroi, 1982). For Amanda this was evident in her wanting to be involved in making decisions for her mother and her family.

Therapeutic intervention ... must be sensitive and carefully planned, allowing for the development of a trusting relationship with the counsellor while an assessment of the specific impact issues is undertaken.

Addressing the long-term impact issues

After weekly contact with Amanda for three months, she was then seen fortnightly to help her address the longer term effects of the abuse. It became evident that she had not acknowledged the full extent of the abuse which James (1989) states is essential for full recovery from the impact of abuse. With the focus in counselling on the details of the abuse, Amanda began to gradually verbalise more details of the abuse including incidents of more intrusive sexual contact. She also began to verbalise her many fears in regard to sexual intercourse. She denied that sexual intercourse had occurred but was afraid that it would be the ultimate betrayal of her mother. She felt that it would also mean that her stepfather's behaviour was not accidental as she had constantly led herself to believe and that it was deliberately progressing in intimacy. She was not able to understand if the abuse was evidence of his love for her and if her acceptance of it was evidence of her love for him. She vacillated between openly describing incidents to being completely defensive.

During this time, the counsellor's contact with the stepfather's counsellor revealed that the stepfather had admitted to *one* incident of attempted sexual intercourse. To help Amanda acknowledge and deal with this aspect of the sexual abuse, the counsellor let Amanda know that her stepfather had already talked to his counsellor about the details of the sexual abuse. (This information was crucial in the work with Amanda and significantly facilitated her ability to move on therapeutically. The importance of collaboration between the clinicians was thus confirmed.)

Once Amanda felt the counsellor 'knew' these details and that she would not be betraying her stepfather, she was able to verbalise the full extent of the sexual abuse. She then disclosed many incidents of attempted sexual intercourse and her fear that it was only a matter of time before full penetration would have occurred. (This information was also crucial in helping the step-father's therapist break through the stepfather's denial and promote his response in therapy.)

In recounting these details, Amanda's emotional and cognitive perceptions which had become 'blurred and blunted' as a result of accommodating to the abuse began to shift (MacFarlane et al, 1990 p.169). She realised that her stepfather had fully intended to make her his sexual partner and she expressed deep sadness and hurt at this realisation. She gradually began to see how he had betrayed her trust and had exploited her love. Slowly, her earlier feelings of betraying him and her guilt about disclosing the abuse dissipated.

During this time, her behaviour at home became difficult and defiant, a manifestation of the emotional and cognitive adjustments she was making. She was described by her mother as argumentative, moody and experiencing

outbursts of anger and crying. She began to verbalise that she could not trust her stepfather and admitted that when she had said 'I want dad to come home', it had been to appease her family and her own deep guilt for the abuse.

To further promote Amanda's resolution of these issues and to help her overcome the isolation and stigmatisation that may accompany sexual abuse, she was invited to attend a teenage girls' sexual abuse group program run by the Centre. Many professionals (Giaretto, 1982; Sgroi, 1982; Mandell & Damon, 1989; MacFarlane et al, 1990; Doyle, 1997) have documented the benefits of groups for treating victims of sexual abuse. On completion of the group program, Amanda reported that the group had helped her feel less alone and less 'different', and had helped her realise that whilst she would not forget the abuse, she could let go of the traumatic memories and move forward.

THERAPEUTIC INTERVENTION WITH MOTHER AND DAUGHTER

Therapeutic work with the mother and daughter is essential in correcting the role reversal and the breakdown of communication and trust that sexual abuse may create (MacFarlane et al, 1990; Sgroi, 1982). This was a painful process for both Amanda and her mother. While her mother remained appropriately caring and highly protective of Amanda, she struggled with the perception of her daughter as a 'sexual rival'. Amanda also had difficulty with wanting to tell her mother *everything* and not hurting her with the intimate details. Since her mother had not read the signs that abuse had been happening, Amanda questioned her mother's protective ability.

Amanda and her mother were seen jointly once a month. To facilitate the re-establishment of their relationship, they were helped to focus on Amanda's developmental needs such as teenage interests, social networks and school issues. Amanda realised her mother genuinely cared about her and also had the expertise to help her resolve problems related to friends, boyfriends and school problems. Her mother too felt empowered to respond once again as a parent. Gradually their relationship strengthened.

THE MAKING OF A VICTIM

THE OFFENDER'S GROOMING

Many therapists who have treated and conducted research with sex offenders have written about the careful and deliberate grooming the sex offender undertakes of the targeted child and his/her parent prior to the abuse (Conte & Berliner, 1988; Conte, Wolf & Smith, 1990; Ryan & Lane, 1991; Eldridge & Still, 1993; Ross, 1994; Elliot, Browne & Kilcoyne, 1995).

As the relationship between Amanda and her mother strengthened, issues of how each of them had been 'groomed' began to be addressed. Amanda also described times when her stepfather made her feel special during his supervised contact with the family. It was encouraging to note that her mother had picked on these same incidents quite independently of Amanda and had already confronted the stepfather soon after these incidents had occurred. This further promoted Amanda's trust in her mother.

Effective treatment helps the child or young person work through what the experience of abuse meant for him or her and helps them see their potential as people and not as victims.

CONCLUSION

After several years of therapeutic intervention, the change in Amanda is subtle but significant. Towards conclusion of therapy with Amanda, in a session with her mother and siblings, she confidently verbalised the confusion she had experienced at the beginning of counselling. She admitted to the guilt she had experienced about the impact her disclosure of abuse had had on her family and cried as she said,

> I was so worried about what you all felt about me, blaming me for telling on Dad and for him not being home, so I kept saying I wanted him to come home.

She said she had not really wanted him home and had felt unsafe in his presence for a long time. She also said,

> In the beginning I felt like I was a nobody, I was nothing. It took me a long time to believe in myself and to learn to like myself again.

Effective treatment helps the child or young person work through what the experience of abuse meant for him or her (James, 1989) and helps them see their potential as people and not as victims (MacFarlane et al, 1990).

For the primary author, it has been an opportunity to consolidate the knowledge and skills required to work with sexually abused children and young people (Brock, 1993). It required

> a broad awareness of sexual abuse issues, research trends, community resources, risk factors for offending, social effects of abuse and disclosure, and offender susceptibilities (Ryan & Lane, 1991 p, 335).

The counsellor's conceptual framework had to be constantly revised and reframed as new information and insights emerged (Sgroi, 1982).

The course of treatment is complex and often riddled with challenges. For the counsellor, the issue of prosecution of the stepfather (especially after Amanda disclosed more intrusive sexual abuse) remained a problem. One difficulty is that disclosures of abuse in treatment may be regarded as inadmissible in legal proceedings because of the assumed influence of the counsellor. Another problem is the counsellor's role in recommending prosecution of the offender when a child and his or her parent chooses not to proceed with prosecution. These issues are not easy to resolve. They are even more complex when the various parts of the child protection system (the protective services department, criminal prosecution and therapeutic services) do not work in harmony .

The impact of the abuse does not only begin after disclosure. The process of victimisation (Berliner & Conte, 1990) and the process of offending (see Ryan

& Lane, 1991; Salter, 1988; Finkelhor, 1984) begins long before the abuse occurs. Desensitisation and 'progressive approximation' to cognitive, emotional and physical acceptance of sexual abuse is a gradual sexualisation process which may take many years of specific grooming of a victim by an offender (Berliner and Conte, 1990 p. 18). The victim may develop defences to accommodate and survive this process and these may be incorporated into the child's personality and may become dysfunctional (MacFarlane et al, 1990; Summit, 1983). This may be a reason why children may deny, retract, minimise or make contradictory statements. 'Unravelling the web of intra-familial abuse ... and understanding the aspects of sexual victimisation which keep children locked in that silent world' requires careful listening and knowledge (MacFarlane et al, 1990 p. 155). This is the foundation of effective child protection ... 'upon which we can give children their rights as people and ensure their voice is heard' (Bannister, Barrett & Shearer, 1990 p. xv). Listening to Amanda, responding to her needs and identifying and addressing the impacts of sexual abuse as they emerged in the therapeutic process was professionally challenging. Therapeutic intervention provided her with the time and opportunity to emotionally and cognitively process her experience of the abuse, to become empowered enough to communicate what she really wanted, and finally, to begin to reclaim control of her life. □

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