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Issues of intervention in child sexual abuse

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Abstract

Counselors working in the mental health profession are more frequently dealing with the issue of child sexual abuse than ever before. This is true despite the specialized populations with which counselors are working. For example, counselors and other professionals working with adult alcoholics or mental patients are becoming more aware that some of their clients have been sexually abused as children or are the perpetrators of child sexual abuse, or both. This is true at my work setting, the Mental Health Institute, Independence, Iowa, due to both a significant increase in the literature available on child sexual abuse and because House File 451 added Iowa Code Section 232.69(5) which became effective July 1, 1985. This law identifies who are mandatory reporters and requires them to receive training in the identification and reporting of child abuse.

ISSUES OF INTERVENTION IN CHILD SEXUAL ABUSE

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Counselors working in the mental health profession are more frequently dealing with the issue of child sexual abuse than ever before. This is true despite the specialized populations with which counselors are working. For example, counselors and other professionals working with adult alcoholics or mental patients are becoming more aware that some of their clients have been sexually abused as children or are the perpetrators of child sexual abuse, or both. This is true at my work setting, the Mental Health Institute, Independence, Iowa, due to both a significant increase in the literature available on child sexual abuse and because House File 451 added Iowa Code Section 232.69(5) which became effective July 1, 1985. This law identifies who are mandatory reporters and requires them to receive training in the identification and reporting of child abuse.

This article proposed to address the recurring themes of intervention in child sexual abuse.

Detection and Disclosure

Detection and disclosure of child sexual abuse is the usual means by which counselors become aware that their client has been a victim of sexual abuse. This is a critical issue in itself and often determines the primary treatment issues.

Counselors must bear in mind that in nearly all sexual abuse cases there is an issue of secretiveness (Haller &

Alter-Reid, 1986). The child is often torn between revealing this secret to escape abuse and keeping the secret to avoid the consequences promised by the perpetrator. It is important to insure the child of protection and to give emotional support during such disclosure. Failing to do so can further traumatize the child (Haller & Alter-Reid, 1986).

Elwell and Ephross (1987) found in their study that the reactions of others to the initial disclosure was a significant factor in determining if the child perceived the abuse as traumatic. In fact, the literature repeatedly cautions counselors not to emotionally react or appear shocked by the child's report (Haller & Alter-Reid, 1986; Elwell & Ephross, 1987; Hazzard, King & Webb, 1986). It is also important to believe the child's report (Hazzard et al., 1986) and failing to do so can further traumatize the victim.

It is important to note the developmental level of the victim both at the time of disclosure and at the time the abuse occurred. This is important because the victims may contradict themselves or describe the abuse in terms that may not appear to make sense but are consistent with different stages of cognitive development (Gothard, 1987). For example, a victim may have one word for describing a penis in its flaccid state and another word to describe it in its erect state. This can contribute to the counselor being able to

believe the report and may be highly significant if the counselor is called in as an expert witness to testify in court (deYoung, 1987; Gothard, 1987).

Often counselors are the first ones to suspect that a child has been a victim of sexual abuse. The literature is replete with behavioral indicators of child abuse. Brekke (1987) cited thirteen behaviors and this ranges to as many as forty-five behaviors cited by Elwell and Ephross (1987). From my own clinical experience working with adolescents I have found that the majority of these behavioral indicators do not indicate sexual abuse or even child abuse in general, but rather indicate that the child or adolescent has undergone a traumatic or painful experience or a series of traumatic or painful experiences. These could most certainly include sexual abuse but could also be a result of a wide range of other painful experiences such as divorce of a child's parents, peer rejection, etc. Also, sexual abuse does not always result in trauma (Elwell & Ephross, 1987) and even though the child was sexually abused and does demonstrate a number of the behaviors indicative of sexual abuse, these behaviors may indicate other trauma. So it is important to keep in mind that behavioral indicators should lead one to suspect abuse but not to conclude it.

Some of the stronger indicators I have found of sexual abuse are: extreme flirtatious behavior toward the counselor or other adults, public display of breasts or genitals, reports of excessive masturbation, reports of sexual knowledge not appropriate for age, suicidal attempts of gestures, eating disorders, frequent complaints of a need for sexual intercourse, sudden change in behavior patterns, and, particularly in boys, exaggerated expressions of fear or aggression toward homosexuals. One of the strongest indicators is that the child or adolescent has reportedly sexually abused other children.

Once the counselor suspects child abuse and asks the child, he/she must be empathetic so as not to further traumatize the child (Elwell & Ephross, 1987), understanding that the child may have an extremely different world view which may include many pressures not to disclose. It is also important not to overly react when the response obtained is not the one expected. In my clinical experience I have observed clients deny abuse several times before disclosing. This does not mean I put pressure on the client, indeed this is to be avoided (Elwell & Ephross, 1987). Before asking a client if they have been sexually abused I tell them that I am a mandatory reporter and what that means. I tell them probable and possible consequences of their disclosure, both

short and long term. I tell them my reasons for suspecting they have been sexually abused and also possible long term consequences if they keep their secret and do not receive treatment (Brekke, 1987).

Counselors should be prepared if their clients who have disclosed sexual abuse later deny it (deYoung, 1987; Haller & Alter-Reid, 1986). This often takes place when the client begins to experience the consequences of disclosing, which is also an indication that the client is in need of more understanding support. It has been my experience that if a client's right to refuse to talk to an investigator, for example, is respected, the client usually decides at a later date to follow through with the disclosure. Victims may change their minds in order to test their counselor. It is also important to reinforce in the victim their feeling of control as it has been shown that both victims and abusers perceive their locus of control outside themselves (Wiehe, 1986).

Therapeutic Treatment

Steward et al. (1986) developed a set of 7 therapeutic goals. Although they developed these goals for children aged 2 1/2 to 6, I feel they are appropriate for older children and adolescents, depending on the client. They were:

1. To help the children translate thoughts and feelings into words.
2. To support the child's ability to say "NO" and to ask for help.
3. To allow the child to experience some adults as caring and able to listen, to comfort, and to set limits.
4. To help differentiate and limit the child's belief in his or her own power to evoke violence and destruction, or to initiate separation from a valued adult.
5. To support social and emotional skills necessary for peer interaction.
6. To support an increasingly realistic sense of competence.
7. To support mastery of normal psychosocial development milestones. (pp. 269-270)

In my work with adolescents ages thirteen to eighteen I have found these goals appropriate. Numbers 1 and 7 might at first appear only appropriate for younger children, however these remain appropriate for older children as well since some have limited intellectual functioning and arrested developmental milestones (Bruckner & Johnson, 1987).

Hazzard et al. (1986) highlight 7 themes of treatment they have consistently noted:

1. Emotional reaction of others.
2. Court testimony.
3. Personal emotional reactions.
4. Family relationships.
5. Interpersonal relationships.
6. Sexuality.
7. Self-esteem and self-assertion. (pp. 214-218)

These require some explanation. Number 1 refers to reactions of family and others in regard to the victim's disclosure. Number 2 refers to fears that the judge and/or others may not believe them as well as fears about seeing their abuser. Number 3 refers to victims developing skills to deal with their feelings of anxiety, anger, depression, and guilt. These first 3 themes Hazzard et al., (1986) termed short-term issues and the next 4 as long-term issues. Number 4 refers to victims expressing and dealing with their feelings about both parents. Number 5 refers to victims learning social skills and the ability to trust so as to enable them to develop intimate relationships. Number 6 refers to the need of victims to have accurate information about sexuality. They also found in their groups of adolescent girls that sexual behavior patterns involved either promiscuity or avoidance. Number 7 refers to the finding that as victims

became more assertive their self-esteem improved as well as their ability to deal with other issues.

Recurring Themes

In reviewing the literature and my own clinical experience I found seven highly inter-related themes most recurrent:

Detection and Disclosure

This is almost always accompanied by guilt (Elwell & Ephross, 1987; Haller & Alter-Reid, 1986; Hazzard et al., 1985; Steward et al., 1986). As previously discussed this is an important issue for a number of reasons, but especially because it can severely limit or restrict completely the movement on to other issues.

Self-esteem

Victims of sexual abuse almost always suffer from low self-esteem and the literature supports this (Bruckner & Johnson, 1987; Haller & Alter-Reid, 1986; Hazzard et al., 1986; Sprenkle, 1987; Stewart et al., 1986; Wiehe, 1986). As self-esteem improves so do almost all other treatment issues. However, it is important to remember that this may vary since not all sexual abuse is experienced by the child as traumatic.

Trust

Most victims of sexual abuse have great difficulty trusting others, especially anyone outside the family. Often

the child perceives the world outside the family as hostile (Haller & Alter-Reid, 1986; Hazzard et al., 1986; Steward et al., 1986; Pierce, 1987).

Empathy

Without empathy on the part of the counselor a child's feelings of the outside world as hostile are reinforced and treatment comes to a halt. Empathy is also an important issue of development in the victim in that it facilitates the development of social acceptance. Furthermore, it may prevent the victim from becoming a future abuser (Wiehe, 1986).

Social skills

Often victims have been shut off from the outside world and have not had a chance to develop social skills or to observe them role-modeled. Social skills are crucial to social acceptance and social acceptance is a central factor to the development of health self-esteem, especially in adolescents (Bruckner & Johnson, 1987; Hazzard et al., 1986; Steward et al., 1986).

Assertive skills

Learning assertiveness skills greatly facilitates improvement in self-esteem. Assertiveness skills also contribute to preventing future abuse (Bruckner & Johnson, 1987; Hazzard et al., 1986; Steward et al., 1986).

Expressing and dealing with feeling

Often victims are so overwhelmed from the trauma of sexual abuse that they are unable to sort out their feelings, let alone understand them (Bruckner & Johnson, 1987; Hazzard et al., 1986; Steward et al., 1986). One thing I have found helpful is to have them verbally describe the abusive incident. Repeated verbalization over time usually helps to reduce the trauma.

Conclusion

This article proposed to examine the most recurrent issues in child sexual abuse for both the male and female victim. The major perspective presented was that of the treatment of the individual victim. The article did not attempt to include another, perhaps more important, treatment issue, that of family therapy and family issues. This could be considered the next step in treatment.

Ten years ago the literature on sexual abuse was scant. Five years ago there was an encouraging outpouring of literature. Today it is gratifying to find a comparative explosion of literature on sexual abuse.

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