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Strategies to address the issues of survivors of childhood sexual abuse

Abstract

Many young men and women are experiencing the same dilemma as the young poet. In a study by Russell (1986), 38% of her sample reported at least one incident of incestuous and/or extrafamilial sexual abuse before reaching eighteen. Counselors, therefore, can expect to see a large number of clients with some sort of sexual abuse history. They are experiencing horrors of yesterday, needing help and needing it now. Counselors must be knowledgeable about the issues faced by these clients and about intervention strategies for helping them resolve those issues.

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STRATEGIES TO ADDRESS THE ISSUES OF SURVIVORS OF CHILDHOOD SEXUAL ABUSE

A Research Paper

Presented to

The Department of Educational Administration

and Counseling

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In Partial Fulfillment

of the Requirements for the Degree

Master of Arts in Education

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by

Marti Roling

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Horrors of Yesterday

Salty tears burn her pores
As she recalls the past and all its horrors.
The illusions she is seeing
Are too intense for one human being.
She's trying to reach out but doesn't know how
But she needs help and she needs it now.
If it takes much longer it could be too late
To save her from this desperate state.
(Written by a 16 year old survivor of sexual abuse)

Many young men and women are experiencing the same dilemma as the young poet. In a study by Russell (1986), 38% of her sample reported at least one incident of incestuous and/or extrafamilial sexual abuse before reaching eighteen. Counselors, therefore, can expect to see a large number of clients with some sort of sexual abuse history. They are experiencing horrors of yesterday, needing help and needing it now. Counselors must be knowledgeable about the issues faced by these clients and about intervention strategies for helping them resolve those issues. This paper addresses ten treatment issues for survivors of sexual abuse as synthesized by Sgroi (1982) and

supported by MacFarlane and Waterman (1986). These authors list treatment issues as: damaged goods syndrome, guilt, fear, depression, low self-esteem/poor social skills, repressed anger/hostility, inability to trust, blurred role boundaries and role confusion, pseudomaturity and failure to complete developmental tasks, and self mastery and control. This paper also provides a description of strategies and techniques for helping the client work through these specific issues. There is considerable overlap in both issues and strategies. For example, when working on improving social skills, most of the time the client's self-esteem will improve with enhanced social relations.

Damaged Goods Syndrome

This syndrome can have various sources and meanings to clients. Survivors may have suffered actual physical harm during the abuse. They may see themselves as less of a person due to their injuries. Survivors must be reassured that sexuality has more to do with feelings of love and sensuality than the look or functioning of a particular body part (Maltz, 1991).

Survivors may have come to believe the messages they were given during the abuse. Offenders often call their victims vile and offensive names for the purpose

of humiliation and control. Through repetition, survivors come to believe and accept these statements as truth. These beliefs must be challenged carefully. Briere (1992) suggested that, in response to the client's self-derogation, the counselor balance confrontation of the inaccurate self-perception with the need to avoid blaming the client for self-blame. He recommended using statements such as "It sounds like when you talk about ______ you automatically think negative thoughts about yourself. Why do you think that is?"

Guilt

Blume (1990) gave the following description of survivor's guilt: "If all these bad things happened to me, then I must be bad; if I didn't fight and scratch to the death I must be responsible. If I lived I must not have done enough" (p. 45). For guilt to be reduced, survivors need to understand that they had nothing to do with the abuse; that the abuser was the one who made the choice. The goal for the counselor is relocation of the responsibility for the abuse. Guilt can be attributed to several sources: silence about the abuse, feelings of responsibility for the abuse, failing to stop the abuse and any feelings of physical arousal felt during the abuse.

The counselor needs to help clients evaluate these issues to determine what assumptions clients have made.

When clarifying guilt issues, it is best to examine the issue of responsibility rather than blame (Hall & Lloyd, 1989). This is to avoid feelings of family loyalty interfering with survivors' ability to challenge their feelings of guilt.

Survivors will need to learn to test their feelings of guilt in a realistic and rational way. Hall and Lloyd (1989) use the following questions to challenge the beliefs held by survivors:

Whose idea was it to start the abuse?

What could you have done to stop the abuse?

Poston and Lison (1989) offer clients $20 for the name of each person the survivor could have told who would have been able to put an end to the abuse. They have never yet had to pay. Another technique helpful for giving survivors an appropriate frame of reference is having them spend time with children who are approximately the same age as they were when the abuse began. This reinforces the image of how naive and innocent they were and also how unsophisticated their thought processes must have been.

Educating the client is a necessary part of the normalization process. Briere (1992) suggested that counselors can use books and videos as supplements to describe the diverse impacts of sexual abuse, affirm the struggles of the survivors, and stress the perpetrator's and/or society's responsibility for the child's victimization.

Fear

In a review by Browne and Finkelhor (1986), they reported that fear is the most common, empirically demonstrated initial response to sexual abuse. Poston and Lison (1989) suggested that the fears bedeviling most survivors are the minor phobias that hinder them from leading regular lives and keep them from enjoying life and having access to those growth experiences that could deepen their self-esteem.

Once again, the counselor can use cognitive techniques to determine what beliefs are creating the fears (Hall & Lloyd, 1989). The counselor encourages clients to keep a record of anxious and fearful thoughts and the events or thoughts preceding the fear. This is to determine what might be triggering the fear for the clients. With the heightened awareness, they can then work on substituting more reasonable and

rational thoughts. To help clients cope with these fearful situations, the counselor can teach them deep breathing and relaxation exercises (Maltz, 1991).

Sometimes the cognitive work may need to be supplemented with the counselor accompanying a client to one of the feared situations. An example would be accompanying the client to the house where the abuse took place (Bass & Davis, 1988). Poston and Lison (1989) called this "doing it scared." Survivors are taught to weigh the alternatives and then decide on a course of action. The question "What is the worst that could happen?" is asked. The goal for the client would be mastery over the fear not its elimination.

Depression

Survivors have suffered staggering losses, that may include the loss of their childhood, loss of moral integrity, loss of the good parent, and loss of the ability to trust. Survivors need help from others to mourn their losses. In ordinary bereavement, numerous social rituals support the mourners through this process. By contrast, no custom or ritual recognizes the mourning that follows sexual abuse. In the absence of such support, persistent depression is extremely high (Herman, 1992). Completing the grieving process

means divorcing the abuse from the survivors' sense of identity and self-worth. When the losses are fully mourned, the trauma of the abuse loses its power over the survivor (Sanford, 1990).

Jehu, Klassen, and Gazan (1985) reported clinically and statistically significant improvements in the client's beliefs and mood states using a cognitive approach which involved the following stages: (a) making clients aware of their beliefs; (b) facilitating recognition of any distortion in these beliefs; and (c) substituting more accurate beliefs. This process may be used to help survivors divorce their abuse from their sense of identity and self-worth. The abuse happened to them; it is not who they are.

Healing involves reconnecting with the community. Survivors who recover most successfully are those who discover some meaning in their experience (Draucker, 1992). This meaning could be increased self-knowledge or a new attitude toward life. Most commonly, women find this meaning by joining others in social action. In working for social change, survivors create their own living monument, a symbol of healing and hope (Herman, 1992).

Low Self-Esteem/Poor Social Skills

Central to work with survivors is the process of building self-esteem. The abused child grows up with many negative messages. The following list of negative statements made by incest survivors is adapted from Bass and Davis (1988): I hate myself; I do not deserve it; I can not do it; it has to be perfect; whatever I do, it will never be enough; it is not worth trying; what I want does not count; I have no right to feel good; I deserve to feel bad. These statements illustrate the survivors' negative self images. What needs to be explored in counseling is the origin of these images. This can be done by asking the following questions recommended by Hall and Lloyd (1989):

-What started this train of thought?

-What was I doing when it started? Was I remembering something from childhood? The recent past?

-What happened right before the thought?

-How would others react in this situation?

-Is this a familiar feeling? Is it from childhood?

The goal of this process is to teach clients to assess situations in a different way and to become aware of how past assumptions are affecting present behavior.

Development of a positive self-image is vital to combat the low levels of self-esteem found in these clients (Cahill, Llewelyn, & Pearson, 1991). To help clients build a positive self-image, Courtois (1988) recommended the counselor point out clients' survival skills and personal strengths. Hall and Lloyd (1989) suggested having clients keep an ongoing list of things they like about themselves. Blume (1990) summarized being healed in this area: "...to finally define herself not through her past but her potential, not through what was done _to_ her but through what she is making of herself--these are the ultimate reclaimings of her self-esteem, of her _self_" (p. 119).

Survivors' lack of trust and low self-esteem create problems for them when they attempt to establish relationships with others. Many adults who were abused as children find themselves unable to share personal information or to disclose their feelings. This inhibits their ability to develop deep, meaningful relationships with others (Leehan & Wilson, 1985).

Survivors need to learn to identify the type of person who could serve as a friend. They also need to develop communication skills to express feelings and ideas so they can get their needs met. Group work

provides an arena for practicing these skills (Gold, 1986). Through the group, they can experience how past experiences have colored their perceptions of and responses to people and situations in the present. Through this experience, they can learn appropriate responses.

Whitfield (1987) recommended using the technique of share-check-share to help survivors decide who is a "safe" person to hear their stories. Survivors first tell a bit of their story and then check the listener's response. If the listener does not listen or begins to judge or give advice, survivors then make the choice of whether or not to continue their story. Other clues would be eye contact, sympathy, and consistency. Whitfield recommended practicing this technique in a group.

Repressed Anger/Hostility

There are several reasons that survivors feel the need to repress their anger. First, is that much of the anger is at their abusers who may be relatives or friends, people they are "supposed" to love. Guilt moves in to repress the anger. Second, they have learned that anger is destructive. It can lead to further abuse. Finally, there is the fear that if

their anger was allowed to surface, it would never stop (Leehan & Wilson, 1985). Survivors' task in recovery is to acknowledge their anger and express it in a productive way (Blume, 1990).

The first step is anger recognition. Clients may be unaware what anger feels like. As they begin to recognize anger in the present, they move to deal with anger at the past (Leehan & Wilson, 1985). The task is to convince survivors that they do have bottled up feelings and to legitimize those feelings. Feelings are not good or bad - they are part of being human. The goal is for the client to learn effective, satisfying, and appropriate means of expressing those feelings.

After dealing with the anger of the past, survivors' next task is to connect their current anger to its cause. Usually anger comes from unmet expectations. Clients need to get in touch with their expectations. Are they reasonable? The task is self-understanding and learning to express that self to others. Hall and Lloyd (1989) gave the following suggestions for expressing anger in a physical way:

-find an isolated place to scream.

-throw stones into a lake or river.

-draw pictures in the sand then scrub them out.

-punch a pillow or cushion.

-rip up newspapers, phonebooks.

Inability to Trust

Leehan and Wilson (1985) stated that survivors' inability to trust is the basis for almost all other problems these individuals face. Abused children and adults have learned not to trust themselves or others due to the inconsistency of their lives. During childhood, survivors sort people into two categories: those who can be trusted and those who cannot. As they grow older having only two categories becomes dysfunctional, and this system needs to be gradually replaced by a more complex understanding of the motives and behaviors of others (Gold, 1986). Clients need to relinquish their habit of thinking in dichotomous categories.

Sexually abused clients need to learn that trust is a process and not a judgment made instantly (Meiselman, 1990). The counselor can help clients by having them examine their process of making decisions involving interpersonal trust. To do this, clients must evaluate each course of action and predict the outcomes of the various choices. The purpose of this

exercise is to give clients the tools they need to more accurately evaluate the trustworthiness of others.

As work on the fundamental issue of trust continues in individual therapy, the counselor should consider including survivors in group therapy (Meiselman, 1990). Group provides survivors with the opportunity to work out relationships with a variety of people and may provide a much-needed network of friends.

The counselor can play a crucial role in clients' ability to learn to trust. Due to the betrayal of trust and the abuse of power experienced by survivors, it is imperative that the counselor establish a relationship where survivors feel believed and are assured of confidentiality. Another assurance if that of choice: it is up to the clients when and how much to disclose.

Poston and Lison (1989) stated that trust in the world and of people in that world and confidence in their own perceptions come slowly to survivors. With recovery comes acceptance of the fact that, whereas people and situations can be safe or unsafe, trustworthy or not, survivors have the power within themselves to distinguish which is which and to make healthy choices for themselves.

Blurred Role Boundaries and Role Confusion

In healthy families, boundaries are clear enough to protect the separateness and autonomy of individuals and permeable enough to insure mutual support and affection. In an abusive family, victims are often isolated from the outside world, but enmeshed with the abuser. They have no separate self - no boundaries. Nothing is truly theirs. The abuser steals all control of their bodies and lives (Poston & Lison, 1989)

Clients need to become aware of boundaries, what they are, and what purpose they serve. The counselor provides an appropriate model by explaining the boundaries of the therapeutic relationship. As clients witness the counselor's unconditional caring, as well as his or her unwillingness to move outside of the constraints of the therapeutic structure, they develop a model for relationship delineation and respect (Briere, 1992).

Boundaries have to do with choice and power - choice of boundaries and the power to enforce those choices. Survivors need much assurance that they have the ability and the right to say no, to set boundaries. Dickson's (1982) book A Woman in Your Own Right provided an excellent guide for exploring the issue of

assertiveness in everyday life. The book lists eleven basic human rights. This list can be given to clients as a constant reminder of those rights - the right to make choices, the right to say no, the right to boundaries.

Pseudomaturity and Failure to Complete Developmental Tasks

Childhood is a time to learn to trust the world. It is a time for growth and experimentation. Sexually abused children do not experience these times. They have become adults to keep the child within safe. They find a role that provides them with protection. The role may be caretaker, warrior, diplomat, superachiever, or scapegoat. To play their role, survivors sacrifice their childhood for survival (Sanford, 1990).

Often the survivors of sexual abuse have missed important aspects of childhood - play, parties, overnights. With the help of the counselor, clients can plan play activities. Activities can range from flying a kite to spending a day at an amusement park. The goal is for clients to experience their ability to be childlike.

Maltz (1991) recommended having clients read Healing the Child Within by Whitfield (1987). The book dealt with helping clients befriend and forgive their

"inner child." Survivors need to give themselves permission to do those things they missed as a children.

Self Mastery and Control

Abuse robs the victim of a sense of power and control. The guiding principle of recovery is to restore power and control to the survivor. Power begins by focusing on the control and care of the body and moves outward toward control of the environment. In establishing control of self-care, clients are asked to plan and initiate action. Through these choices and decisions, survivors enhance their sense of competence and self-esteem (Herman, 1992).

To give survivors a sense of hope and progress, Dolan (1991) used a solution-focused recovery scale with survivors. This scale measures the progress already made by clients and gives options for the choice of what direction they would like to have therapy proceed. Looking for small signs of healing provides a positive orientation and hope.

By learning problem-solving and decision making strategies, clients are able to see that they do have control over many events in their lives. Instead of just letting things happen, the counselor can teach clients the necessary skills to make rational choices

and decisions. In childhood, survivors may have experienced inconsistency in the responses elicited by their behavior. For this reason, their ability to anticipate the consequences of their behavior is often impaired. When teaching decision-making it is important to stress the need to consider possible consequences (Leehan & Wilson, 1985).

Conclusion

Treatment for clients who present with a history of childhood sexual abuse should be tailored to meet the needs of the individual client. However, Sgroi (1982) has synthesized ten treatment issues she sees as relevant for all survivors of childhood sexual abuse. This review has been an attempt to link these issues with effective treatment strategies. Many of the issues and treatment techniques overlap. For example, while learning the skill of decision making, which is relevant to the issue of self mastery and control, the decision can be based on what clients would like to do with their leisure time, which is relevant to the issue of pseudomaturity. The inability to trust is described as a basis for almost all other problems faced by survivors. These clients have been betrayed, often by those in a position of trust. As members of a helping

profession, a position of trust, it is our responsibility to be well-informed about the therapeutic issues, goals and processes relevant to the treatment of these clients.

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