Therapeutic Work with Children who have Experienced Sexual Abuse

By Monica Murphy

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Child Sexual Abuse

Sexual abuse occurs when a person uses his/her power over a child, and involves the child in any sexual act. The power of the abuser can lay in his/her age, intellectual or physical development, relationship of authority over the child, and/or the child's dependency on him/her. Sexual abuse can include acts such as touching, fondling, genital stimulation, mutual masturbation, oral sex, using fingers, penis, or objects for vaginal/anal penetration, voyeurism, exhibitionism, as well as exposing a child to, pornography or prostitution. The offender may engage the child in the sexual activity through threats, bribes, force, misrepresentation, and other forms of coercion. The majority of the time, the offender is someone well known to the child and trusted by the child/family. (SAVI 2002)

Dynamics of Child Sexual Abuse

The majority of children who experience sexual abuse are victimised by people they know: parents, guardians, relatives, teachers, etc. However, there are a number of sex offenders who are willing to exert a great amount of effort to gain access to organisations or activities that associate with children so that they are given a chance to abuse them. Most sex offenders are anonymous to the public, working alongside colleagues and neighbours who accept them as harmless.

Systemic Approach to Working with Children who have Experienced Sexual Abuse

In therapy the welfare of the child is paramount. In my experience I believe that working with the child's family – the non-abusing parents and siblings – is the best way in order to effect any real change for the child. I am fortunate enough to work in a therapy centre where we have the facilities to work systemically, providing a therapist for the child and a separate therapist for the parent/carer. Children rely on their parents/carers and need their support and help. If a child is in the care of a Health Service Executive, I find

it beneficial to work with the foster parents, residential care staff, social worker, and other relevant professionals, responsible for the child. The focus of the work is always child centred. This approach and ethos is focused on the well being of the child. I do not believe in assigning diagnosis or labels e.g. "victim" but respect the strength and resilience of children and design my work to build on these strengths, enabling children to grow into adulthood not defined by their abusive experiences but by their individuality and creativity. The systemic approach of working with parents maximises the strengths in the child's home environment which better enables the child achieve their full potential. I discovered working with children in isolation can create difficulties, as children are dependant on their parents until they become independent, so I believe looking at the needs of the child within their family context needs to be considered before therapy begins.

I believe that an effective therapeutic response to children and their families cannot be made unless action has been taken to protect the children who have been abused or who are at risk of abuse. Childhood is a precious time and children need to be protected from abuse. It is imperative to empower parents to report their concerns, suspicions or knowledge of abuse or risk of harm to a child, to the Health Service Executive and/or the Gardai in line with Children First Guidance. (2011)

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Contraindications to therapy

Therapy cannot provide a protective function; protection must always come before therapy. Therapy may not always be appropriate and may not be in the best interests of the child. The following are some of the reasons that therapy may not be appropriate for the child:

- Child is at ongoing risk of sexual, physical, emotional abuse or neglect.
- Ongoing contact with an alleged offender.
- The CSA assessment has not been completed.
- Ongoing Garda investigation and the authorities advise against the child attending.
- There is a lack of commitment to engaging and/or attending by the parents.
- There is active alcohol or substance abuse within the family.
- There are active serious mental health issues for the primary carer(s).
- There is serious instability in family circumstances.
- The child does not want to attend.
- There is serious conflict between the parents.
- The child does not have a supportive ally outside of therapy.

Parents/Carers

In my practice I consider that it is important to establish a working alliance with parents, so that we work together in order to help the child. The work with parents focuses on how to best support and protect the child who has been sexually abused and the siblings. They may need:

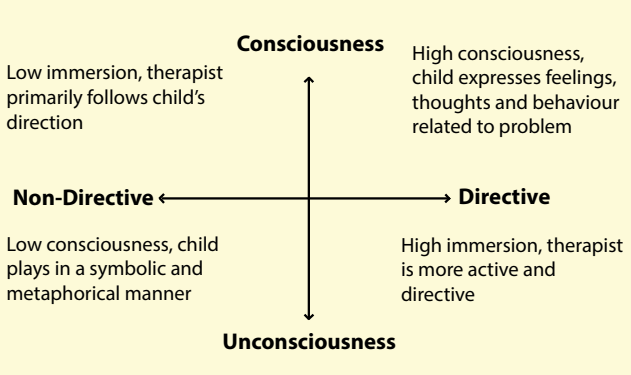
- More positive and effective ways of parenting the child.
- To find ways of protecting the child.
- To explore behavioural difficulties which may have arisen or increased since the disclosure of the abuse, the reason for the behaviours and what the child may be trying to express.
- To find ways of positively managing these behaviours.
- To explore how they responded to the initial disclosures and facilitation in effective responses to children's disclosures where the initial reaction may have been negative.
- To learn how to set positive limits and boundaries, e.g. where the child may be acting out sexually.
- To understand the dynamics of the child's experiences and accept the child's perception of the abuse.
- To explore ways of empathising, reassuring the child, responding to the child (e.g. further disclosures).
- The parents may need the space and opportunity to explore their feelings of grief, self-blame, horror, anger, injustice, disgust, guilt and betrayal.

Play Therapy

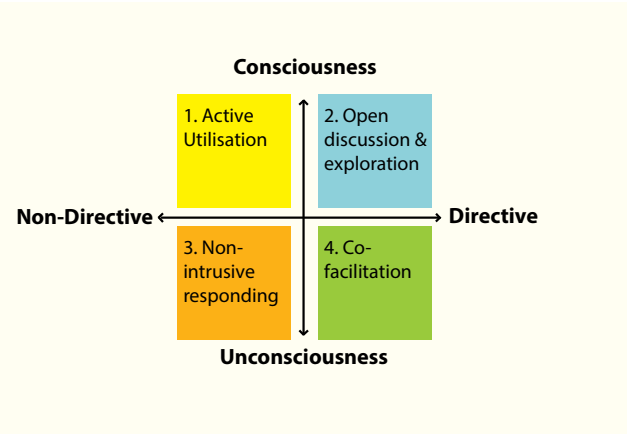
In the past it was believed that play had no real purpose other than to use up excess energy. There are many developed theories now which relate play to the development of children. The Play Therapy Dimensions Model has been developed by Lorri Yasenik and Ken Gardner, certified play therapy supervisors and co-directors of The Rocky Mountain Play Therapy Institute.

Principles

The principles of the model are directiveness and consciousness.
"Directiveness" takes account of the degree of the therapist immersion and the level of interpretation by the therapist. The "Consciousness" considers the child's representation of consciousness in play and the play activities and verbalisations.
The four quadrants derived from the two principles are shown below:



This approach integrates both non-directive and directive approaches to play therapy. Therapy should be developmentally appropriate for each child; it should work from where the child is, not from a theory.



Children must be approached and understood from a developmental perspective. The natural medium for children is play activity. Their world and their experiences are communicated through play. Child sexual abuse may impact on the child's overall development. The child may need to rework key developmental stages disrupted by the abuse. Therapy provides the child with the opportunity to process and clarify distortions on a cognitive, motor and affective level. Symbolic play is a way the child can explore their experience of abuse, safely distanced from the reality of the experience. The distancing through play is crucial for the safety of the child. Appropriately distanced from the pain, the child can explore the experience and come to resolution and integration.

"The high value our culture places on rational, logical, scientific thought often leaves me, like many other child therapists, feeling vaguely guilty when our time with children is spent 'just playing.' And yet, in case after case, although the so-called real issues that led the child's family to bring her to therapy are rarely addressed directly, and although we spend our working hours unprofessionally crawling around on all fours, growling, or hiding under tables, the child gets better. There is genuine communication going on, in a medium native to the child, although all but forgotten by most adults." (Birch, 1997).

Therapeutic Relationship with Children

The primary role of therapy is to provide a safe environment in which healing from trauma can be facilitated. The therapeutic relationship is central to healing. The therapist's congruence, intuition and use of themselves, are more important than any skills or techniques. The techniques evolve from the relationship and need to be used appropriately. Most approaches agree that the quality of the therapeutic relationship is a crucial determinant of treatment outcomes. The Gestalt approach of Violet Oaklander (1978) to working with children stresses the most essential aspect of working with children is the therapeutic relationship. Bugental (1992) emphasises the presence of the therapist is crucial. Yalom (1995) also stressed the importance of being there for the client during the session. "Therapy is a journey taken by therapist and client, a journey that delves deeply into the world as experienced and perceived by the client" (Corey, 1996)

Initial Session

In my work I often find that children are anxious at the initial session. The aim of this session is to connect with and engage the child. I talk about the reason the child is coming to therapy in an age appropriate way. This is done in a matter of fact way, avoiding going to a tragic level. The traumatic experiences and behavioural problems are all explicitly named. It is important to use the same words the child used to disclose. This can sometimes be difficult but it also removes the burden of telling, from the child. I reassure the child that they don't have to talk about the issue. I explain to the child about what we do in therapy

and reassure the child that a lot of children come to therapy because when something like that happens, children often get mixed up and therapy is where they can sort all that out. This reassures the child that they are not alone. I explain to the child that we can sort out all these mixed up feelings through play and explain that they are in charge of the play and that I am in charge of the safety and the time.

Children who have experienced sexual abuse may be very mistrustful of adults. As therapists working with children we need to be aware of this and realise that children will not instantly see us as different from abusive adults. In the playroom the child is allowed to play freely and explore the room. The child's leads and I follow, only joining the child when invited or directed. The child is the expert of his or her experience, not the therapist and in my work with children, they have taught me to be extremely cautious when making interpretations about the child's subjective world.

Children have the right to respect and dignity and the space for healing intervention to occur. I contract directly with the child, having firstly explored that the parents are committed to this. In the contract the issues of confidentiality, the time and frequency of sessions are addressed. This is all done in a friendly child centred way, encouraging the child's active participation.

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Play Sessions

The parent always attends the session with the child. The sessions begin together and issues that may have emerged during the previous week are addressed and named. In the playroom the child directs the sessions and my role is to be fully present and responding appropriately. Children respond differently and some immediately engage in the playroom, directing the work. Other children are much more reserved and anxious and find it difficult to engage and may need some encouragement and reassurance. As therapists we need to go delicately as the resistance needs to be respected. Working through resistance is very subtle and trusting our own intuitive sense and also trusting the child's own sense of knowing that the therapist is someone they can trust. This may be a slow process. Acceptance and respect for the child are vital and help provide the space to allow the child make sense of their experience and come to terms with what has happened.

Some children present with little understanding of personal boundaries, which may leave them open and vulnerable to further abuse. It is imperative that as therapists we set the limits and establish consistency and safety with very clear boundaries around safety. The child often feels vulnerable and powerless to protect themselves and in reassuring the child that it is the adult's job to keep them safe enables them to feel safer. Referring back to the safety rule if the child is acting out or engaging in high risk play, or sexualised behaviour or attempting something that may not be safe for the child is imperative. If a child continues with risky behaviour during a session, consistency is essential and sometimes it requires explaining to the child that if the behaviour continues the session will have to finish because it is not safe. The child may also test the boundaries by refusing to finish a session. Remaining consistent with the boundaries of safety and time creates a safer space for therapy to happen. In this work boundaries are often an issue because the child's personal boundaries have all been broken by the offender, so it is important for us to remember containment can be a big part of the process.

Children may sometimes attempt to physically hurt the therapist. It is necessary to explain the safety rule and attempt to redirect the anger, allowing the child the opportunity to express the anger in a safe way for example towards a bean bag, explaining it is okay to be angry but it is not okay to hurt somebody. This modelling provides the child with healthy ways to express their anger without hurting themselves or others.

It may be appropriate also to talk to the child about ways of avoiding getting into trouble when they are feeling angry, such as, setting up an angry corner at home where they can go when they are feeling angry. Children often have difficulties expressing anger. Hurt or fearful feelings are often buried beneath anger.

Common issues that emerge in therapy:

Self-Blame

- Some children feel they are responsible for what happened to them, they often blame themselves.
- Some children feel guilty because they did not try to stop the abuser. Many children tried to protect themselves, but failed. As a result they do not try anymore. This is a type of learned helplessness.
- Children may experience a deep sense of shame, feel "different or damaged", and alone.

Fear

- Children who have been abused are often left in fear of those they know and trust.
- The world is no longer a safe place.
- They may be afraid that the threats the abuser has used will come true.

Powerlessness and Vulnerability

- Children feel powerless to protect themselves; they were unable to stop the abuse.
- If no-one believes them or helps, they are left powerless.
- The feelings of powerlessness and vulnerability often result in children being fearful, depressed and at risk of abuse happening again, even as adults.

Betrayal

- Children learn that a trusted person has hurt them causing them to feel angry, betrayed, confused and depressed.
- Children often feel confused because they love the abuser.
- Children who have been betrayed often have trouble trusting others and forming healthy relationships.
- Children who have been sexually abused may have difficulty with normal sexuality and sex in a relationship.

Loss

- The innocence and trust of childhood
- Normal patterns of growth and development
- The ability to develop healthy relationships with others
- On disclosure, there may be removal from homes and families, the community, and other caregivers.

Destructiveness

- Self-Harm
- High risk play
- Frightening displays of rage
- Involvement in criminal activity, substance abuse, prostitution
- Eating disorders
- Suicidal or homicidal tendencies

Hopelessness

- Children who have been abused may lose faith in themselves, others and their future.
- Having experienced the world as unsafe and unloving, they fall into despair and give up hope that their needs will be met.

Final Stage of Therapy

The length of therapy cannot usually be determined ahead of time, but the decision to continue or not, is discussed with the child and the parents. Once the child has reached the point of resolution therapy will no longer be required. Children in long term play therapy generally indicate when they are ready to finish. The child begins to revisit earlier themes; the play is less repetitive and becomes more focused. The play is less chaotic and appears to be more about the child's day to day experiences. The child is ready to move on when they are functioning adaptively.

1. The therapist will have noticed the child's functioning is adequate with peers, at home, in school.
2. Many of the presenting issues and behaviours will have ceased or improved.
3. The child is demonstrating an ability to experience and tolerate feelings.
4. The child has integrated the abusive experience into a wider view of the self.
5. The abuse is seen as part of the history that influences, but does not define the child.

Since therapy relies heavily on the therapist's relationship with the child, ending therapy may signify a change and a loss for the child. In keeping with the therapeutic process, this stage is an opportunity for the child to work through how they feel about ending therapy. Regression is common at this stage. In allowing time for closure, it makes it less likely that child will feel

rejected. Children may often invite the parent to the playroom for a number of sessions before finishing. This is often a very positive way for the child to disengage from the therapist and engage the parent in a safe healthy way. Encouraging the parent to take over enables affective attunement with the child. This gives the child enough time to end appropriately and the opportunity to review all the work they have done.

Children have shown me their innocence, strength and resilience and their ability to process their trauma and move forward not defined by their experience of child sexual abuse. Their authenticity, ability to be present, creativity and acceptance is a lesson for any of us as therapists. I personally feel privileged in my work with children and I have learned so much from them, the experience of working with children has been one of my greatest learnings.

"We cannot make a world in which children will not experience loss, but we can offer them support as they do so" (Monroe 2003)."

The therapeutic relationship is central to healing. The therapist's congruence, intuition and use of themselves, are more important than any skills or techniques.

Monica Murphy is a Humanistic and Integrative Psychotherapist. She is an accredited psychotherapist and supervisor with the Irish Association for Counselling and Psychotherapy (IACP).

She holds a Master of Arts in Humanistic and Integrative Psychotherapy (University of Limerick) and a Bachelor of Arts in Counselling and Social Studies (Cork Institute of Technology). She also holds a Diploma in the Psychology of Counselling (University College Galway). She is also qualified as a Reality Therapist by the William Glasser Institute. She has a Certificate in Therapeutic Work with Children, as well as numerous other courses and trainings. She has previously worked in pre-school education, private practice and a family resource centre.

She currently works with the C.A.R.I. and has worked with children and families, affected by child sexual abuse, for 17 years. She has a wide range of experience in the area of trauma and child sexual abuse. She also has experience in working with children who act out sexually.

REFERENCES

Birch, M. (1997) Land of counterpane: Travels in the realm of play. The Psychoanalytic Study of the Child, 52, p57-75.

Bugental, J. (1992) The Art of the Psychotherapist. Norton and Co.

Corey, G. (1996) The Theory and Practice of Counselling and psychotherapy. Wadsworth. California.

Dept of Children and Youth Affairs (2011) Children First Guidance. Government Publications Dublin.

Jennings, S. (1995) Playing for Real. International Play Journey, 3, p132-141.

Mc Gee, H. Ganavan, R. De Barra, M. Byrne, J. Conroy, R. (2002) The SAVI Report. Liffey Press.

Monroe, B. (2003) Introduction. In Rowling, L. (2003) Grief in school communities: effective support strategies. Buckingham: Open University Press.

Oaklander, V. (1978) Windows to our children: A Gestalt approach to children and adolescents. Utah: Real People Press.

Piaget, J. (1972) Play, dreams and imitation in childhood. London: Routledge.

Weininger, O. (1978) Play and the education of the young child. Education, 99 (2) p127-135.

Yalom, I. (1995) Theory and practice of group psychotherapy. New York: Basic Books.

Yasenik, L. Gardner, K. (2012) Play therapy dimensions model. Jessica Kingsley.