SEXUAL TRAUMA IN CHILDREN AND ADOLESCENTS

DYNAMICS AND TREATMENT

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3

Treatment of the Child Victim

In this and the following chapters, treatment issues are separated from those of assessment to fit the type of case in which (1) a therapist has been asked to provide treatment after sexual abuse was discovered (and, of course, reported); or (2) an existing treatment process must be altered because abuse has been revealed. In short, situations in which the existence of sexual trauma *has been established* are referred to here.

This chapter focuses on the treatment of molested children who are, in general, between the ages of five and 11, although some of these concepts of treatment do also pertain to childhood victims of *incest* (a subject to be discussed in depth in Chapter 5). The chapter also includes methods of treatment for other members of the child's family (i.e., parents and siblings), who may not have been directly victimized by the abuse but who nonetheless may be profoundly affected by it.

THE GOALS OF THERAPY

The child's world is a very small one, composed of the building blocks of future personality integration. As children develop, they will utilize these basic elements to construct their world view or concept of "reality," their concept of the self or who they believe themselves to be, and who they are in relation to others. These perceptions of self, reality, and self in relation to the external world can vary in correspondence with the structure of a child's environment and its component

parts. The sexual assault of a child by an adult radically alters the basic elements of a child's small world. This assault can introject components such as adult sexuality, betrayal, violence, and helplessness, to cite only a few. Since young children have no adequate frame of reference by which to judge such events, they are dependent upon the interpretations of the trusted adults around them.

We conclude that one of the fundamental tasks of a therapist, as well as the other adults in the child's life, is to help the child understand the trauma in such a way that it is not incorporated into his or her construct of self or view of reality. How these traumas are defined or interpreted by the parent(s) or parent-figures, as well as by the child's therapist, will be a pivotal factor in deciding whether the trauma will be incorporated by the child or relegated to the status of an unpleasant but external kind of event that can be overcome. In the case of a child who is sexually assaulted and whose parents dismiss the event as a "tall tale," do nothing about it, or blame the child, the behavior of the parents can negatively influence the healthy development of their child. It can serve to seal over the trauma and make it one of the fundamental building blocks of the child's future personality.

When a child turns to his or her parents for help, the child is asking for support on many levels: for example, "Protect me." "Explain this event to me." "Do adults do this to children?" "Is this what I deserve?" "Is this what a love relationship is?" *"Is this what I am?"* If the adults dismiss the event or react with inadequate concern (depending upon the child's developmental level), thoughts such as "No one protects me," "I am helpless," "The world can be chaotic and violent," "People can use me sexually," or "To be loved means to be abused" may become incorporated into the child's concepts of self and reality. If significant adults react in an overly aggressive manner, the impact upon the child can be equally confusing, because such behavior can convey a message such as, "If you turn to adults for help, they get angry," or, "If something bad happens, the appropriate response is a violent one."

A clinician must consider not only what the sexual trauma means to the child and the child's family system at this moment, but how the event will affect the child's personality development. A key to accomplishing this task is to assist the child to externalize the trauma from his or her constructs of present and future self. The trauma needs to be defined as something wrong that was *done to* the child, not internalized as "I am the sort of person that these things happen to"—in other words, someone who grows up to see himself or herself as a victim or as a bad or worthless person. Finally, a therapist should

carefully facilitate the child's feelings of anxiety and anger concerning the event in such a way that these feelings can be appropriately vented. Eventually, the child will view the abuse as an event that happened to him or her, instead of an event that will define who he or she is.

THE CHILD VICTIM AND THE FAMILY

When a child is brought into treatment shortly after a sexual assault, he or she, and the family as well, are likely to be in a greatly disrupted state. A therapist should endeavor to treat the child within the context of the family. Even though the child may be seen individually in treatment, he or she is usually extremely dependent upon the family for support after such a traumatic event. Because young children are still emotionally and physically dependent upon parents and other family members for care and protection, they often reflect the family's own feelings about the events that take place in their lives. Because of this, it is vital that therapists involve both parents and siblings in the therapy process from the beginning.* This family systems work will take its form from the structure of the family and from the nature of the child's trauma. It could range from traditional, whole family therapy meetings in conjunction with the child's treatment, to meeting with individual family members separately. Even though the session format may differ depending upon the specific needs of the case, what is fundamentally important is to incorporate the family members into the treatment plan in a meaningful way, and not merely to treat the child as an isolated individual.**

The Family's Reaction

Some parents require considerable guidance in grasping what the assault meant in terms of the child's developmental level. They may project their own adult knowledge or sexual experience onto what the child went through, or they may wish to dismiss the event as being nothing because they think that the child could not have known what

* This differs from the procedure for evaluation of the child to determine whether or not abuse has occurred—as described in Chapter 2. The latter procedure may involve visits with the child alone in the initial stages.

** In the more complex cases, it is wise to use cotherapists who work together closely, in a team approach, to ensure that each member of the child's family receives proper support and attention so that each can do his or her part to meet the traumatized child's needs. This kind of team approach, if properly coordinated, can also be very helpful to prevent therapist burnout. One should never underestimate how draining severe trauma cases can be for a clinician working alone.

actually took place (in adult terms). Both responses are equally inappropriate. It is significant to note that a child's cognition is so different from that of an adult that it is practically impossible for most adults to think like a child would about an event such as molestation. Hence, one of the therapist's first tasks may be to help the parents conceptualize the assault in terms of their child's own cognitive framework.

An example of an *inappropriate* adult response is the case of a seven-year-old girl who was trapped in the bathroom at school by a man who exposed his erect penis to her and forced her to masturbate him. The child's parents reported the incident to the police and called their family doctor, asking him what they should do. They were told that she would simply forget about it because she really did not know what happened. The doctor further instructed the family not to mention the event again. The parents were, of course, greatly relieved to hear that their little girl would simply forget about the incident, and they followed the doctor's advice.

Over the next few weeks, the child developed several symptoms related to the sexually traumatic event. She began having nightmares, refused to play outside of her house, and began to have temper tantrums at school. When the girl's parents received a telephone call from her teacher, they realized that there had been a considerable change in the behavior of their daughter, who normally was a pleasant, reasonably compliant child. The parents eventually contacted a psychologist after having a conference with the girl's teacher.

What both parents and family doctor failed to realize was that although the little girl was not aware of the full sexual meaning of the assault, she was quite aware that a strange adult had trapped her in a place that she thought was safe and private, had forced her to do something that confused and frightened her, and had caused her to think that he was going to kill her.* This was also a child who had always trusted adults and believed them to be safe. So even though molestation was not the only terrifying aspect of the assault, the girl had suffered serious emotional trauma that needed to be discussed and worked through. Consequently, when the parents abruptly stopped talking about the event, she believed they did not care about what had happened to her.

A family's reaction to trauma, as referred to above, can range from emotionally bland denial of the reality of the event to confusion and

* It was also the first time that this little girl had seen a penis, the sight of which caused her considerable confusion about male and female anatomy. And because the man had used his penis in an assaultive manner, she felt even more acute anxiety and fear.

outrage. The latter emotions can be especially magnified if the parents learn that their child was repeatedly victimized over time, while they were unaware of the victimization. Such a situation tends to involve more complex family issues, which usually go beyond the fact of sexual trauma. Few parents are in any way prepared for the victimization of one of their children. Consequently, a therapist should plan, from the beginning of treatment, to assist the whole family in coping with the crisis. In turn, this will help the child to cope and, eventually, to recover from the victimization.

PARENTAL DENIAL

We have found (confirming the work of DeFrancis, 1969; Finkelhor, 1984; Peters, 1975) that many parents tend to underestimate the amount of psychological trauma that results from a sexual assault. This underestimation is probably caused by the parents' wish that the horrible event had never happened and/or their own feelings of guilt or shame. Such thinking can lead parents to believe that their child does not require treatment because he or she has been unharmed by the event. Finkelhor (1984) also found that many parents believe that they can "handle" the problem themselves. This impulse also serves to keep the problem private, as well as to shield the parents from facing the reality of the trauma. Thus, in some cases a wishful fantasy on the part of the parents can prevent a child from obtaining needed treatment and healing of the traumatic process.

Another problem-causing form that parental denial can take is pretending that, no matter what happened, the child will just forget about it. In this manner, some parents give the child subtle, indirect messages, and some directly tell the child not to mention it or "just try to put it out of your mind." This often well-intended, but misguided, attitude of the parents can lay a foundation for more serious conflicts later on, because the child *cannot* forget about it. Moreover, the parents' "let's-keep-it-quiet" attitude implies that they may be ashamed of what happened to their child. The child may sense, because of such remarks, that he or she is guilty of some misdeed, when quite the contrary is the case. The authors have encountered too many adults who were traumatized as children who, because of such silencing parental comments, internalized the childhood experience in such a way that now they perceive themselves as bad, "dirty," or lacking in worth. This process, at best, leads to a lowered sense of self-esteem and can be a cause of self-destructive or masochistic behavior patterns in adolescence or adult life. (For a fuller account of this process, see Chapter 7.)

Clinicians should let parents know that it is usually important for child victims to talk with the parents about what happened to them. Some children may not wish to tell, but most need to, and some need to tell the story more than once. When a child tells a parent about what happened, he or she is usually looking for acceptance, understanding, and a sense of parental protection. The child seeks reassurance that he or she was not damaged or soiled by the event. And when a parent responds with indifference, it can have far-reaching effects. Many parents will find that hearing about the details of their child's molestation is very painful and stressful, and as a result they will probably need considerable support from a therapist when it happens.

Emotionally Impoverished Families

Another issue which should be taken into consideration when treating child victims, noted briefly above, is that many of them come from emotionally impoverished homes, i.e., family systems that were not (and are not) able to provide for their emotional needs. In such cases, it is as important to treat the family—so it can become more functional and learn to meet the needs of the child—as it is to treat the child. If it is not possible to inspire a family to be more responsive to the child's needs, the therapist may decide upon an alternative treatment plan which incorporates a support network for the child outside the family. This network could be composed of social and clinical agencies, as well as afterschool activities or religious youth activities. Frequently, a child's ability to form one or two healthy relationships outside of an unresponsive family system, along with a supportive course of treatment, can be a crucial factor in the child's recovery. In effect, these cases may require that the role of the clinician extend beyond the treatment of trauma. The therapy process should also provide a socially, culturally, and emotionally enriching experience for the child, with the aim of helping him or her construct a healthier, more affirmative world view. An ego-enhancing process of this kind can, in turn, have beneficial effects upon therapy itself.

The Therapist and the Child's Mother

Establishing a good therapeutic relationship with the child's mother is frequently crucial to successful treatment of the child for a number of reasons. First, many mothers feel that they have somehow failed the child because the molestation occurred. As a result of this feeling of failure, some mothers may perceive the child's therapist as a threat

or as a rival. Some of these mothers are emotionally needy, dependent women (especially those who themselves were victims of abuse as children). Because this kind of mother's unmet needs for nurturance can be so overwhelming, she may not be able to permit her child to receive care and concern from the therapist. This kind of mother is usually not consciously aware of what is causing her anxiety and discomfort in respect to her child's therapy. If the clinician is not aware of the underlying anxiety of the mother, it could jeopardize the child's treatment.

A mother's anxiety over unmet dependency needs may reveal itself in one of the following types of behavior. She may intrude into the child's therapy time by talking about her own needs or about parenting issues; or, she may use the time to complain at length about the child's behavior. After the child's session, the mother may quiz the child about what happened during the session or repeatedly ask the therapist to tell her "what's going on" with the child. The mother's interference may also take a resistive form in which she is not responsible about keeping the child's appointments or complains about the imposition that the appointments are for her. If the clinician responds to the mother in the more traditional way by setting limits on her intrusions into the child's therapy or by counseling her to be more responsible, it is quite likely that she will try to undermine the treatment process or remove the child from therapy. Separate meetings with the mother on a weekly basis during the beginning of therapy, or arranging for the mother to see her own therapist concurrently with the child's visits, can usually resolve this problem.

Sexual Acting Out by the Child

When treating a child in the context of his or her family, the clinician should reflect that the child has very likely had a sexual experience far beyond the proper developmental level. The victimization may have been painful or terrifying or confusing or bizarre; but also, it could have been, at least in some ways, pleasurable for the child. And as a sequel to the trauma, a child may act out sexually toward adults and other children in the family. This acting out may also occur with playmates or at school. A therapist may find it advisable to prepare the parents of the child so that, if such acting out does occur, it will be dealt with appropriately. The therapist might also request the parents' consent for consulting with the child's teachers, should any inappropriate behavior occur at school.

When treating this kind of acting out, a therapist will help the parents control the acting-out behavior and at the same time will advise them to be careful not to convey shame to the child. This will occur if the parents can separate the inappropriate behavior from the child's identity, i.e., "You shouldn't do that" versus "You are bad." This approach requires that they communicate, in a calm manner, that the child must stop what he or she is doing. A parent can say, e.g., "An adult [or other child] did something to you that was not right, but what you did just now was not right either." The adult can further reassure the child that he or she is a good person. In most cases, the child will feel relief when an adult places limits on acting-out behavior in a way that helps the child to understand such behavior. If limits are designed in this way, a child can begin to gain mastery over his or her acting-out impulses, rather than feel punished for "being" bad.

This point can be illustrated by a case in which a nine-year-old girl was sexually assaulted by a man who lived in her apartment complex. He had forced her to perform fellatio and engaged her in masturbatory play. Later that night, the little girl told her mother what happened; the mother called the police, who referred both the mother (a single parent) and the child for therapy because they were so shaken by the event.

After the clinician had seen both mother and daughter for two sessions, she received a frantic telephone call from the mother because the latter did not know what to do. Apparently, the man who sexually assaulted her daughter had given the child a battery-operated vibrator, which the girl had hidden in her room and had not told her mother or the police about. That evening, much to her mother's horror, she found the girl in her bedroom, masturbating with the vibrator. The mother was extremely concerned, but she wanted to react appropriately because it was clear that the girl had very mixed feelings about what had happened to her. (One of the reasons why the child was vulnerable to the neighbor's advances was that her father had left her mother for another woman. Neither the child nor her mother had seen the father for the past eight months, and because of her abandonment, the child was searching for a father figure.)

The therapist spoke to the mother for a while in order to calm her down, so that when she began talking with the daughter it would be done in a manner that would protect the child from additional trauma. The therapist instructed the mother to go into the bedroom and ask the little girl to give her the vibrator, ask her where she got it, and then explain to her that it is not a toy for children. When the mother asked her where she got the vibrator, the girl said that the neighbor had given it to her as a "special secret toy." The mother told her that it was not a toy for children, that the man was wrong to have given it to her, and that she was going to take it away.

The mother called back the therapist the next day to let her know how things went: after a minor protest, the daughter had accepted the mother's nonjudgmental stopping of the inappropriate behavior. The mother also said that her daughter even appeared to be somewhat relieved that she had taken the vibrator away from her. The little girl never mentioned the vibrator again.

After this incident, there were two other times when the little girl openly tried to engage other children in sexual play that was similar to her victimization. In both instances, the mother calmly interceded and told her daughter to stop the sexual play because what the man had taught her was wrong. She then explained to the girl that what the man did to her was wrong and that she should not do it with other children. Her mother went on to reaffirm that she was a good girl but the man was a bad man. After these events, the mother continued to reassure her daughter and, as a result of the mother's decisive intervention, the acting out stopped.

In short, this kind of "reactive" sexual acting out must be controlled as soon as it occurs. The intervention should be carefully framed, in such a way that it minimizes feelings of guilt or blame on the part of the child. Further, the child should be helped to understand that, even though some things in life are pleasurable, they are not always good for a person; so people learn not to do those things because not doing them is better for a person.

When considering a traumatized child in the context of the family, the clinician needs to consider another important factor: that the child may have been assaulted during a time when there was an existing serious problem in his or her life. (The same is often true of adult victims of assault.) The case cited above of the little girl who was sexually abused by her neighbor describes a child who was vulnerable because of a crisis in her life, namely, being abandoned by her father. She was accepting of adult attention because she had been deprived of the parental nurturance she needed. Again, one must view these children in relation to the family environment that a child requires in order to mature and grow. If some of the essential components for nurturance are not provided within this milieu, the child will be drawn to other possible sources of support that are not naturally available.

With time, many deprived children become oriented toward pleasing adults to have their normal dependency needs met, so much so that they appear (superficially) to be overly mature children. They are not,

in fact, overly mature but are starving for nurturance as a basic element of normal development. In a manifestation of magical thinking, these children feel that the only way they will receive any approximation of parental nurturance is to pay for it sexually. Unfortunately, many professionals who encounter adult-oriented or seductive behavior in children are frequently shocked by it and, too quickly, shift the focus of attention (or blame) onto this behavior. It is our experience that these professionals seldom look beyond the immediate seductive behavior to its source—deprivation.

The unfortunate tendency to transfer responsibility from a molester to the victim serves several purposes. First, it protects others in the child's world from having to cope with the recognition that an adult *like themselves* could do such a thing to a child. Each of us has a tendency to resist looking at the darker side of human nature. Second, shifting the blame to the child will serve to protect the child's parents from having to assume any responsibility for what happened to their child. And blame displaced onto the victim (not unlike what frequently takes place in cases of adult rape, e.g., "I did not rape her; she seduced me") can be particularly "convenient" if the person being accused of the assault is a respected member of the community, a family member, or a family friend.

Siblings

The siblings of a child victim usually require some clinical attention. First, the clinician should assist the parent or parents to prepare an age-appropriate explanation, for the siblings, of what happened to their brother or sister. Siblings will intuitively know that something has happened, and if the parents do not provide them with a reasonable explanation, they will try to figure out what happened themselves. Very likely, the explanation that siblings concoct or fantasize may be wilder and more emotionally damaging (should the victim be confronted with it) than the true story. Also, by not providing the other children with a reasonable explanation of what transpired, the parents may imply that the victim is guilty of some misdeed or is "tainted" in some way. The siblings may need an explanation, if the perpetrator is a known, significant figure in their lives, about why this person can no longer be a part of their lives. This is important lest they blame the victim for some imagined misdeed that caused this cared-for adult to disappear.

The siblings may require special concern because they could be the targets of sexual acting out by the abused child, as a sequel to the abuse. These siblings may also have feelings of remorse that they were

not somehow able to protect their brother or sister, or were unable to prevent the trauma from occurring; even worse, they may believe that they were in some way responsible for what happened. (For this reason, a therapist should cautiously explore what the victims themselves think about how and why the assault happened, and what could have been done to prevent it.)

Finally, the sibling of a victim might have been the one who discovered the victimization, and he or she may also have been emotionally traumatized by this encounter. Sometimes the needs of these siblings, who are victims, too, become overshadowed or ignored in the aftermath of an assault.

THE CHILD'S THERAPY

We now consider the treatment of the individual child victim. In this section we include suggestions on how a clinician should introduce herself (himself) and present the therapy situation to the child, as well as the toys and games that a therapist may wish to have available in the therapy room. Suggestions are added concerning the type of structure and limits that a therapist should consider incorporating into the play therapy. The section will also discuss significant aspects of the therapeutic process.

Usually, gaining clinical access to a child who is the victim of extrafamilial sexual assault is not as difficult as it is in cases of intrafamilial assault. Situations in which this may not be so include the following:

1. cases in which the child was repeatedly victimized over a period of time and whose family may be too disorganized to follow through in treatment appropriately;
2. cases in which the parents need to avoid dealing with their being responsible, in some way, for the child's traumatization; or
3. cases that involve a family friend or someone significant to the family, which wants to protect the person accused.

Other extrafamilial assaults can be extremely volatile situations in which outraged parents wish to take justice into their own hands. In such cases, parents need to be told—clearly—by the therapist that their child needs them to stay in control so that he or she will feel safe and protected. As one young child told her raging father, who said he wanted to murder the man who assaulted her, "Daddy, please don't

kill him, because the police will take you away and lock you up; then I'll have no Daddy to take care of me."

When beginning a therapy relationship with a child victim (as with the clinical evaluation described in Chapter 2) a therapist should explain his or her role and the nature of the therapy relationship to the child and to the family. Some parents will be rather protective of the child at this stage and wish to question the therapist in detail about his or her type of training and qualifications. A clinician should not be offended by this, because it is usually an expression of the parents' feeling of being "failed protectors" of their child when the victimization occurred. By means of this "examination" of the therapist, they are attempting to regain the feeling of being adequate guardians of the child.

The parents should be told that they will be expected to attend regularly scheduled meetings with the therapist at which the child will not be present. Extremely anxious parents or those whose child was severely traumatized may require weekly conferences of this kind. In less critical situations, biweekly or monthly meetings may suffice. Further, the clinician should express a willingness to assist the parents in coping with any behavioral problems that may arise. Parents may also find it particularly reassuring if the therapist encourages them to call if they have any questions concerning how to respond to a particular situation. The case cited previously of the little girl who was given a vibrator is an example of how such a parent consultation helped to defuse a potential crisis by assisting a frightened parent to stop some acting out on the part of the child victim in an appropriate manner.

Apart from issues concerning duty to warn or to report, the relationship between child and therapist needs to be kept confidential so that the child will be encouraged to express himself or herself. Most parents are able to understand the necessity for the confidential nature of a therapy relationship, but some may require additional reassurance in order not to feel threatened. In general, a discussion with parents concerning the nature of the therapy relationship should contain the following information:

1. Your training and qualifications.
2. General diagnostic impressions concerning the child.
3. Type of therapy to be used to treat the child and what this consists of, i.e., a description of what play and/or other forms of therapy entail.
4. Prognosis and estimated length of treatment.

5. Request for consultation with other significant adults (i.e., teachers, babysitters, etc.) in the child's life, should the case warrant.
6. A suggested schedule for the therapist to meet with the parent(s).
7. Explanation of the confidential nature of a therapy relationship with a child, as well as reassurance to the parents that confidentiality is to help the child feel safer in self-expression, as opposed to a means for keeping things from the parents.
8. A full explanation of any fees that pertain to the child's care.

A clinician should also discuss the nature of the therapy relationship with the child client. In this talk, the structure and limits of treatment should be described, as well as the possible frequency of visits and duration of the relationship. The first step is for the therapist to introduce himself or herself to the child by saying something similar to the following:

> Hello, my name is _____. Your parents have asked me to meet with you because of what happened to you. You can talk about what happened if you want to, or we can play with dolls or puppets about what happened. But if you don't want to talk or play about what happened, that's all right, too.

Next, the therapist should convey to the child that what happened has happened to other children. The message is that he or she is not the only child to experience such an assault. The therapist should also make clear that the child's own feelings concerning the trauma are significant and that the therapist views the child as a unique, important person.

The therapist may continue by telling the child that they will be meeting once or twice a week, depending upon the treatment plan. Next, the clinician should explain that what is said or done (or played) is private, and that he or she will not tell other people unless the child gives permission to do so. (This consideration differentiates the therapy relationship, which needs to be private, from the evaluative relationship that was described in an earlier chapter. Because of this difference, it is wise [but not always possible] to divide the two relationships so that another clinician does the evaluation—which is not confidential and may entail court testimony.)

A therapist should let the child know that he or she will meet with the child's parents periodically; these meetings will be held to help the parents understand what happened to him or her, and before these

meetings the therapist will discuss with the child what is to be talked about. At first, the child may not fully grasp the meaning of a statement like this, but as the therapy relationship develops and these concepts are discussed again later in the context of real events, he or she will gain a greater appreciation for its meaning.

Last, the clinician should explain the basic structure and limits of the play therapy situation. The child needs to understand that the therapy hour is basically his or her time to say, or express in play, whatever he or she wishes. There will be a variety of toys and activities from which the child can select. The decision about what to do during therapy is completely up to the child. The only thing that the child cannot do is hurt himself or herself or the therapist.

It is important that the play therapy be structured so that destructive impulses and anger are directed toward symbolic play objects and not people. A clinician also should see to it that any expressions of anger occur only within the playroom. For example, toys that have been the recipient of, or drawings that represent, the child's anger should remain in the room. And even if the child wishes to take these objects home with her or him, they should remain in the playroom. The therapist should assure the child that the play object will be kept in a safe place until he or she returns for the next session, thus ensuring that the play therapy room is seen as a safe environment in which to express such feelings of anger. In this way the child need not fear that such impulses will spill over to his or her family or friends.

We cannot overemphasize the delicate balance that is required in facilitating a child's expression of anger, while providing structure and security, in order that the expression does not cause further misunderstanding of the child. When it surfaces, the anger of some sexually traumatized children can be extremely primitive and intense, and this anger must be clearly directed toward symbolic objects and not people. Apart from these limits, the therapist can assure the child that the play therapy hour is under the latter's control.

Clinicians should also exercise considerable caution in respect to touching a traumatized child. Such a gesture, although well intended, could be misinterpreted by the child as a sexual advance or threat on the part of the therapist. The reader need only reflect that most of these children have already been sexually stimulated by an adult with no adequate means of appropriate emotional release. Consequently, they are extraordinarily sensitive to any form of touching by an adult, and many young victims who have experienced protracted molestation may not be able to discriminate between sexual and nonsexual touching.

Should this be the case, we recommend that a therapist initially explain to the child that he or she knows the child has had a relationship with an adult (or adults) that involved touching, but this relationship (with the therapist) will not include touching. In this new relationship, the therapist and child will communicate by means of talking and playing. The clinician can explain to the child that he or she and the child, in the context of their new relationship, will learn to express the whole range of emotions from affection to anger in this new way. In particular, a therapist must clearly communicate to the child that he or she does not need to exchange touching or sexual behavior for a positive relationship with an adult. Hence, the therapist can frame the treatment relationship in a manner that will permit the child appropriate expression of feelings.

The Play Therapy Room and Suggested Toys

The therapy room should be a place designed to be comfortable for children. It should be warm but neutral, so that a child will be freely drawn to the toys that attract him or her. The room should be modestly appointed so that the child will not become anxious about making a mess or spilling something. There should be a selection of toys that are *below* the child's age level (in case the child needs to become involved in regressive behavior), as well as a selection of age-appropriate toys for various types of play activities. The following is a listing, by categories, of certain toys that may be useful in a play therapy room.

RECOMMENDED THERAPY ROOM EQUIPMENT

Regressive Toys:
- Baby bottle
- Clay
- Finger paint (some very traumatized children may be fearful of finger paint)
- Soft, cuddly stuffed animals

Drawing Materials:
- Crayons
- Paint
- A large roll of butcher paper is recommended, so that the child can take whatever sized paper is desired

Dolls:
- Boy and girl dolls with removable clothes (we have Raggedy Ann and Andy dolls)
- Baby doll

Board Games & Card Games:
We have: "Uno" cards, a deck of playing cards, "Aggravation," checkers, and chess, among others

Toys to Encourage Discussion and Fantasy:
Puppets:
Boy and girl animal puppets (we have boy and girl frogs)
Obvious villain puppet (we have a snake and a devil puppet)
Obvious good figures, e.g., parent (mother and father), police, doctors and nurses, Prince Charming (we have a unicorn and a nurse puppet)
Assorted neutral animal or human puppets to which the child can assign various roles
Doll house (with furniture and family-member dolls)
Sand tray
"The Ungame"
"Imagine"

A therapist may also have, in the play room, a cuddly teddy bear or a soft stuffed animal for use with those children who have been so severely traumatized that they are too terrified to communicate with another person. Such children may become mute, dissociate, or break down into primary-process babbling because they are so fragile. In these cases, a therapist may wish to place a soft, cuddly object beside the child and talk with him or her in a soothing manner about a neutral subject. This kind of safe, nonhuman object can help the child to make the transition back to communicating with people.

An example of the use of a safe, nonhuman object is illustrated in the case of a five-and-a-half-year-old boy who was referred for treatment. He had been repeatedly sodomized by three men who enticed him while he was playing unattended at a neighborhood playground. When his mother and a policeman brought him to the therapist's office, the mother reported that he was practically mute. She said that the boy had uttered a few sentences to her about the assault, but had since become almost nonverbal. When the boy's mother left the room, he sat on the edge of a chair staring off into space. The therapist made several attempts to engage him in play and discussion, which were unsuccessful. He later got out of the chair and huddled on the floor, looking away from the therapist.

After a few minutes, the clinician's small cocker spaniel dog, who had been asleep under her desk, woke up. This extremely anxious little boy had not noticed the dog when he first entered the therapist's office. The clinician, thinking that possibly the child might feel safer with the dog, slowly rolled the dog's ball in the direction of the little boy. When

the dog went after the ball, she noticed the boy sitting on the floor; the dog took the ball in her mouth, carried it over to the boy, and tried to engage him in a game. The therapist quietly watched, hoping that the little dog, who is extremely gentle, could make some contact with the child. The dog first sat quietly beside the boy and then nudged him several times with her nose, trying to show him the ball. When the boy remained silent and motionless, the dog dropped the ball and pushed it toward the boy with her nose. As the ball rolled directly in front of the boy, she bumped him once more. Then the boy, with slow, awkward motions began to pet the dog and cautiously rolled the ball back.

The boy spent the rest of the first session quietly sitting next to the dog and petting her. The therapist decided not to intervene in any way in the interaction between boy and dog. At the second visit, the boy hesitantly greeted the therapist and immediately engaged the dog in play. Slowly, over a period of several weeks, he was able to make the transition from playing with the dog to interacting with the therapist. This case indicates how it is possible to bring a child back into contact with people by means of a substitute object.

Some severely traumatized children attempt to cope by means of such primitive defenses that they are not capable of responding to traditional forms of interpretive play therapy. In these situations, the clinician should provide the child with a therapy environment that is safe and nurturing and that will enable the child eventually to arrive at an emotional level that permits the more traditional play therapy techniques. For these severely traumatized children, the initial therapy goals need to be set modestly, in recognition of the child's traumatized psyche.

For example, in the case of the abused boy, the first goal of therapy was for the boy to tolerate being alone in a room with an adult. The next goal was that he attempt to communicate with the therapist in some fashion. From this point, the therapist sought to make therapy a positive and enriching experience for the boy. These goals were achieved only after months of work. Not until these initial steps were taken could the child begin to participate in interpretive play therapy relating to the trauma.

Treatment Dynamics

Children, in general, will respond in one of two ways to a sexual assault or trauma: (1) there will be behavioral or somatic symptoms

that become overt immediately after the assault; or (2) there will be a delayed or "silent" reaction, which is usually depressive in nature.

Somatic Symptoms

Some of the *somatic* effects that may rapidly appear following molestation include amorphous aches and pains, gastrointestinal disturbances, sudden changes in normal toilet habits, and enuresis (in younger children). Child victims frequently withdraw from their accustomed activities and relationships by becoming phobic, sometimes refusing to play outside the home, or by becoming school-phobic. Burgess and Holmstrom (1974), DeFrancis (1969), Gibbons and Prince (1963), Tufts New England Medical Center (1984), and Finkelhor (1987) have noted in their studies that a majority of child victims had at least mild to acute posttrauma symptoms.

Night terrors and nightmares are commonly experienced by traumatized children; many are afraid to sleep alone and insist upon sleeping with parents. We do not recommend that a sexually abused child sleep in the same bed with a parent or parents. If the child has been sexually traumatized and cannot tolerate being alone at night, it is a good idea for parents to make up a separate bed in their bedroom, thus maintaining appropriate parent-child boundaries until the child is ready to return to his or her own room for sleep. We also recommend using night lights, as well as keeping a bell or whistle beside the child's bed to summon a parent should he or she become fearful. We have also found it useful to give the child a stuffed animal, saying that the animal has special powers against bad things. The child is encouraged to take the animal to bed and, if he or she becomes afraid, to hold the animal close and make the scary things go away.

We have found, as did Peters (1976), that a fairly lengthy period of play therapy may be required, in many cases, before the child is able to express feelings about the assault. As indicated in Chapter 1, one reason that some find it extremely difficult to express anger toward the adult who traumatized them is that most children are trained not to express such feelings. Children are trained to obey adults and not "talk back" to them. When one further considers that many children were lured into the situation in which they were molested by someone known and trusted, one realizes that the assault has put them in a double-bind situation. The child was assaulted because he or she obeyed an adult. The child may have angry feelings but cannot express them because speaking out against adults is forbidden.

Many children are not able to overcome this double-bind experience. So they resolve the conflict by internalizing the anger and confusion and becoming depressed. If the parents react in a manner that gives the child the message "just forget about it," it confirms the child's notion that anger toward adults is discounted or not allowed, thus deepening the sense of hopelessness. Or, if the parents go to the opposite extreme—becoming overly restricting or supervising the child's behavior excessively—a child may misperceive this overprotective parenting as punishment for angry thoughts. Either extreme parental reaction may serve to cause the child to block his or her true feelings concerning the abuse and prevent the working through of the trauma.

Delayed Reactions

In cases of *delayed* or depressive responses to sexual traumatization, the clinician may need to spend from four to six weeks (or more) playing with the child, conveying the message that his or her feelings are accepted and that the play room is a safe place to express those feelings. We have found that some of Milton Erickson's interspersal techniques, in which the message that a therapist wishes the client to receive is introjected subtly throughout the conversation with the client (Erickson, Rossi, & Rossi, 1976), can be extremely helpful. In addition, a clinician may tell the child something such as this:

> I know that you have thoughts and feelings about what happened to you. You may wish to share them with me now, or you may want to tell me about them later. If you don't want to tell me now but, instead, wait until later, that is all right with me.

This is a version of an Ericksonian technique called the "illusion of alternatives." It is a way of giving a person the illusion of having alternatives by "permitting" him or her to choose between doing something now or doing it later; the alternative of not responding at all is not offered.

Another indirect technique that can be used in treating a child who is fearful of disclosing what has happened to him or her is that of storytelling, in which the clinician tells a story about a hypothetical child in a similar situation as a way of interpreting the child's conundrum. For example, in the case of a child who is afraid to talk about the molestation, the therapist might tell a story about a child to whom something happened that was scary and embarrassing; but an adult understood how the child felt, so the child was able to tell this adult

what had happened. The storytelling process is especially effective because it fits nicely into the concrete style of children's thinking; the story provides an illustration of how the child might resolve a problem that may be too complex for his or her cognitive ability. In short, a story may serve as a cognitive roadmap to a solution for the child's dilemma. It has been our experience that children respond very well to indirect methods of therapy such as these.

As Treatment Continues

With time, the child will begin to communicate, to the therapist, what he or she thinks or feels about the assault. As indicated above, the therapist can facilitate this by means of Ericksonian or other indirect techniques, but we advise strongly against the use of intrusive or confrontive therapy approaches. As the clinician plays and talks with the child, he or she should be alert to what the trauma meant to the child and to the child's view of the world. As with adult victims, the sexual aspects of the assault may not have been the primary source of the child's traumatic feelings. Just as they do when confronted by the victimization of an adult, persons who know the child may focus on the sexual details, because they are bizarre or shocking, and fail to realize that most victims are primarily preoccupied with the following recollections: either (1) they could have been killed; (2) they felt totally helpless or used; (3) someone whom they trusted has just betrayed them; or (4) the one person who paid attention to them has been lost to them forever.

This is not meant to imply that the sexual issues are not important. They are important but may not be the primary issues that the child victim must face as a result of the trauma. Therefore, each of the issues listed above should be interpreted for the child so that he or she can understand them in the context of his or her developmental level. A therapist seeks to find out *how the child perceived the trauma* and begin there, instead of beginning with his or her own perception of the trauma. As with many other situations in which two people interact, one can never assume that two people share the same "reality."

When thoughts or feelings pertaining to the trauma surface in symbolic form in therapy, they may be expressed in some of the following ways. A child may act out stories that have the theme of "good people" suddenly changing into "bad people," or situations in which one must guess who the good people are and who the bad people are. In such stories, the child is attempting to resolve the anxiety that was caused

by believing that someone was nice who later molested him or her, as well as apprehension about how to protect himself or herself in future.

A child may dirty himself or herself in some manner and ask the therapist's help in cleaning it off. When doing this cleaning with the child, the clinician can directly interpret the behavior by interspersing a message such as, "You want to feel clean again after what happened." The therapist could add that the child will, indeed, feel clean again. To reiterate, we have found that it is usually best if such interpretations are made (whether directly or indirectly) in a matter-of-fact tone of voice and simply introduced here and there in the course of conversation with the child.

A child may also become involved in trying symbolically to undo the traumatic experience by repeatedly taking apart toys, spreading out the parts, and putting them back together. He or she may insist upon taking apart each toy that can be disassembled (and some that cannot) and putting it back together, or the child may focus on one toy. During such undoing and reconstructive play, the therapist should convey a message to the child that contains the following elements: broken or hurt things can be fixed and need not stay broken; people may feel broken but they can get better and feel whole again, too.

Some traumatized children may focus upon one specific game and utilize this game for significant periods or throughout the course of therapy. The game becomes a symbolic vehicle by means of which the child works through the trauma. Frequently, the child will change the basic rules of the game to suit his or her needs. By repeating the game over and over, the child may be seeking confirmation that he or she has a constant relationship with the therapist, even though his or her own world is in chaos. One little girl reminded her therapist at the beginning of each session how many card games they had played; by the time therapy ended, they had played 257 games. Some children are compelled to win each game—either by changing the rules or overtly cheating—as a means of erasing their sense of helplessness resulting from the trauma. This creative rule making or cheating usually subsides as the child begins to recover his or her sense of competence. What is essential is that, if a child chooses one game or play activity repetitively, the clinician will continue to engage in the activity until the *child* decides to move on.

Many very young trauma victims go through a regressive period in the course of treatment. This period usually comes early in therapy, but may occur later in the less-frequent cases of delayed response to a crisis. During this regressive period, the child may wish to feed himself or herself (or be fed) with a baby bottle. Or he or she may choose to

play with finger paints or clay in a primitive manner. The clinician may interpret this behavior to the child by saying, for example, "Sometimes when we are upset or frightened, it feels safe or helps to do baby things for a while, and to go back to a time when things felt safe."

If the child becomes regressive during play therapy sessions, it may be wise to let the parents know that the child may exhibit equally regressive behavior at home or in school. This may take the form of asking for a baby bottle, or perhaps requesting old toys that the child had played with at an earlier age, or some other kind of infantile behavior. The parents should not become overly alarmed at such behavior, because it will usually pass in a few weeks if they and other adults respond appropriately. While they can set limits on the behavior, they should allow the child the security of this period of regression after a sexual trauma. And since regressive behavior can be very frightening to parents, they may require considerable support and reassurance from the therapist during this time. A clinician can explain regressive behavior to a parent in a reassuring manner by pointing out that the child is attempting, by means of regression, to return to a pretrauma developmental stage; by so doing, the child is trying to reestablish a solid foundation for his or her psychological needs.

Eventually, most child victims will express their anger about what was done to them, but they may require a great deal of help in doing so. Considering the powerful injunctions that *prevent* children from expressing anger toward adults, a therapist may wish to intersperse carefully constructed statements which can assist the child's anger to surface. These messages should convey that, in certain circumstances, children have a right to be angry at adults and to express this anger. What was done to him or her was wrong, and the therapist understands this anger. But the clinician should also explain that it is not all right to hurt people when one is angry. The child's anger, in the context of therapy, will be appropriately directed toward toys or symbolic objects, but never toward people or animals. This period in which a child expresses anger is a critical one; and while a therapist must facilitate the expression, it is important as well to contain it within the play therapy structure.

Even though controlled empirical research on the longitudinal effects of child sexual traumatization on adult personality development is only beginning, we cannot ignore the startling fact that a considerable number of adult sexual offenders were sexually assaulted as children.* For that

* Although many research studies of the effects of sexual trauma on the child's psychological development have been conducted, none (to the authors' knowledge) contained adequate control groups or a sample appropriately stratified according to the various types of sexual abuse that children have suffered.

reason, we believe that how a child victim's feelings of helplessness and rage are worked through may have a significant impact on later adult development.

A clinician further needs to consider that, in some cases of child sexual abuse, there may be several victims of the same molester who know each other. Although it is important to consider each case as a separate one, the therapist should be mindful that these children may know each other and talk to each other about "what happened." So despite the fact that a clinician may have taken the appropriate steps to work with the child's parents and significant others in the child's life, the child may be in contact with another child victim who may be giving him or her other, conflicting messages. Therefore, if a therapist learns that there are other victims whom the child knows, he or she may wish to attempt to find out something about them and their own treatment in order to help the child deal with the information that he or she may receive from these children.

TWO CASE STUDIES

These descriptions illustrate therapy with two nine-year-old girls who were victims of protracted sexual abuse and neglect. The two children, although victims of similar types of abuse, had quite different needs in terms of therapy and case management.

The Case of Amy

Amy had fairly good parenting until her mother left her father when she was three-and-a-half. Her father was the "rescuing/caretaking type" of person; therefore, as long as her parents remained together, her life had been stable. Unfortunately, when Amy's mother took her and ran away with another man, her world changed dramatically for the worse. The mother, who had a history of drug addiction before her marriage, quickly returned to using drugs. Amy's father tried to find Amy, fearing what might happen to her if she was left to her mother's care, but his attempts to locate her were unsuccessful.

After about three years, Amy's mother was heavily involved with drugs, had had a series of often abusive relationships with men, and engaged in occasional prostitution to support her drug use. Amy couldn't

remember which of her mother's boyfriends was the first to molest her. Even so, she clearly remembered the first time that her mother gave her to a man to "play with" for money: it was just after her seventh birthday. The man had intercourse with her. Amy said that his name was Ron and that what he did to her hurt a lot. She said that he came back to see her about once a month. Soon, Amy was regularly being forced by her mother to engage in prostitution and pose for pornography. Amy wondered what happened to her father and why he never came to see her. She said she thought that he had forgotten about her.

One night, Amy's mother was arrested in her apartment for selling drugs and for prostitution. Amy was taken to the children's shelter, and it was there that the horrible story of her prolonged sexual abuse came out. When Amy's mother was eventually released on bail, she left town and was never seen or heard from again. Shortly thereafter, Amy's father was found and given custody of Amy.

Soon after Amy came to live with her father, he realized that she had serious emotional problems. While Amy was with her mother, her school attendance had been minimal. At the age of nine, she was functioning at approximately the level of a six-year-old. She frequently wet the bed and soiled her pants when under stress. Her behavior would vary between being seductive and accommodating to having infantile tantrums. For this reason, her father asked the social worker who was assigned to the case for a referral to a child therapist.

When Amy's father first brought her to therapy, she was very reluctant to remain in the office alone with the psychologist. After a lot of reassurance from her father, she agreed to be alone with the therapist but only if the latter promised to leave the door completely open. During this first meeting, Amy postured anxiously and sat as far away from the therapist as possible, totally avoiding eye contact. The therapist thought it would be wise to test Amy before beginning treatment, for several reasons. Above all, some decisions needed to be made about Amy's school placement: she clearly couldn't function in a regular school classroom. Her father was worried that he would be unable to care for her at home and that she might require placement in a special school or, possibly, need to be hospitalized. On several occasions, Amy had come into her father's bedroom at night and had made sexual advances toward him. Such behavior shocked him and made him wonder if he could properly care for her at this time. In addition, the clinician needed to have answers to some specific diagnostic questions concerning elements of Amy's bizarre behavior in her office.

The results of Amy's psychological testing showed her to be a child who was fundamentally intact—in that there was no evidence of a thought disorder or psychosis. The testing also revealed that Amy was suffering from such overwhelming anxiety that she would emotionally "shut down" and withdraw from the world as a defense. This process explained her rigid posturing during the first interview. The tests also indicated that Amy perceived the world as a hostile, dangerous place in which she attempted to survive by alternating between hypervigilance and emotional blocking and withdrawal. Testing further suggested that Amy viewed herself as totally helpless, with no power to influence or change her world. Amy's IQ test results showed her to be a child of above-average intelligence. And, considering all that she had been through, under normal circumstances she would probably have been functioning in the superior range. Even though Amy was fundamentally bright, her level of achievement in basic tasks was two years below grade level.

When testing was completed, the therapist met first with the father and then with the school. It was decided to place Amy in a small class for emotionally handicapped children (in her regular school), and to supplement this with special tutorial work. Because Amy's bizarre, avoidant behavior and sexual acting out clearly appeared to stem from environmental forces rather than underlying pathology, the therapist wanted to try working with the father and with the school to create a structured, nurturing milieu in which Amy could recover from her protracted trauma and catch up developmentally. Although Amy was so emotionally fragile and so badly traumatized that she could have been hospitalized, the clinician wanted to try to avoid institutionalizing her—with the attendant stigma of being labeled pathological. Although some of the professionals who were involved in Amy's care were dubious, the therapist believed that the child could respond to therapy in conjunction with a more healthy home environment.

Initially, the therapist met with Amy twice a week and the father once a week; she routinely spoke with Amy's school and the day care center by telephone. The clinician worked very closely with Amy's father to help him deal appropriately with her sexually inappropriate behavior, as well as to help him accept that even though his daughter was nine chronologically, she was functionally much younger. The therapist also had to help Amy's father come to terms with his rage at his former wife, as well as his own guilt for not taking more initiative toward finding his daughter sooner.

During this initial phase of therapy, Amy could barely tolerate being alone in the room with the therapist. She would repeatedly go to the

door of the office and silently open, close, and reopen it. When Amy did this, the clinician would reassure her by telling her that the door would always be unlocked. She was welcome to open it to make sure it was, in fact, unlocked. The therapist would ask Amy if she wanted to talk about doors and what they had meant to her in the past, but Amy would look away and sit stiffly in her chair.

In general, Amy was very accommodating and submissive with the therapist. After the first month of treatment, she invariably carried a soft, stuffed doll with her. For several months, she was incapable of making any form of demand. If the therapist asked her what she would like to do, she would first look away and posture; but if the therapist suggested a play activity, she would obligingly participate in it. When asked about what she was thinking or feeling, she would become unresponsive. It was as though, for her, to think, to request, or to consider her emotions had long ago been forbidden.

Amy's play therapy activities remained regressive for a significant period of time. She would rock in her chair while holding a soft toy or her doll, and drink juice from a baby bottle. If stressed, she would posture or act bizarrely or speak nonsense. It became clear that posturing and odd behavior were how Amy attempted to drive people away who threatened her. Whenever she would do this sort of thing, the clinician would provide her with as much emotional space as possible, while at the same time interpreting Amy's behavior and providing her with alternative ways to get her needs met. The therapist also made sure that Amy's father and others who were working with Amy understood what this kind of behavior meant, so that they could respond to it in similar fashion.

Amy remained in this regressed, infantile state throughout several months of therapy. Although she began to make solid gains educationally and emotionally (outside of the therapy sessions), she continued to function at about the six-year-old level in treatment. The therapist believed this to be a good indication that Amy had stabilized. She was utilizing the therapy time to regress and, in that way, regain an emotional foundation while making progress intellectually—where she felt strongest.

Slowly, Amy's play changed from infantile and regressive activity with soft dolls and stuffed animals to making up stories in a doll's house with themes of feeding, cleaning, and generally caring for children. Then she began to initiate repetitive, projective play in which she was the doctor who examined and treated a little girl who had been hurt. It became clear that she was reenacting the medical examination that she had been given after she was removed from her mother's custody. Amy would very methodically examine the girl doll to make sure all

her hurts were taken care of. During this play, the therapist interpreted what was happening for Amy, while interspersing the messages that she is all right now and is a good girl.

Amy continued to improve at school, and in little over a year was achieving at the correct grade level. She was still quite socially withdrawn and fearful. The clinician decided that enlisting someone from the Big Sister program would be a useful adjunct to therapy, to provide Amy with additional female role modeling and to help her develop more social skills. Because Amy's experiences with her teachers and with the therapist had been positive, she responded well to the Big Sister. In time, her behavior at school improved to such a degree that she was placed in a regular classroom.

Eventually, Amy began to take an interest in the board games in the clinician's office; she particularly liked chess. Each time she played chess with the therapist, she was determined to win even if she had to cheat blatantly. When the game progressed as though Amy was likely to lose, she would become extremely angry and begin a tantrum, grabbing pieces from the therapist to ensure that she could win. It was clear that, through the game, she was beginning to express her need for control as well as her anger toward her mother and the adults who abused her. The therapist allowed Amy to win and used the opportunity to let her know what the underlying dynamics of her behavior were.

Naturally, this was a fortuitous development in therapy. The clinician welcomed Amy's displays of anger, even though they were often directed toward her (the therapist). They signified that Amy was changing her view of herself—from accommodating victim to that of a person who had been wronged. The therapist now aimed toward facilitating this expression of anger, but also toward helping her develop socially appropriate coping mechanisms. To accomplish these aims, the therapist explained that Amy could change the rules of the game if she wished; but first they should talk about the proposed new rule and agree to it before resuming the game. Amy responded well to this idea and began to create new games (and new rules for old games) that were reflective of her abusive experiences. She and the therapist went on to create games and rules that represented her current life and issues with which she was currently struggling.

Amy's individual therapy continued until she was 12½. By then, although she was still a fairly shy girl, Amy had developed a healthy self-image, had made some friends, and was an active member of a soccer team. Even though the clinician discontinued regular therapy sessions with her, the process of closure was conducted in a way that would permit Amy to return to therapy as an adolescent if she needed

to. This was done so that if she did return to treatment, she would not see it as a failure or as taking a step backward in her life.

The Case of Jean

Jean was the same age as Amy had been when she entered treatment. She was the victim of similar types of sexual abuse, but the treatment process took a markedly different course.

No one is sure who Jean's father was. Her mother, April, had become deeply involved with drugs and motorcycle gangs when she was in her late teens and early twenties. During this time, she was extremely promiscuous both heterosexually and homosexually, and was a heavy polydrug user. In fact, there were large blocks of time for which April had no recall. Jean had first been removed from her mother's care when the mother and a boyfriend were apprehended while trying to sell stolen merchandise. When Jean was taken into placement she was malnourished and showed signs of both physical and, possibly, sexual abuse. Eventually, at the age of three, she was placed with relatives, an aunt and uncle who had two grown children. These relatives had a difficult time with Jean for several years. She would have uncontrollable temper tantrums, during which she would scream, kick, spit at, or bite anyone who attempted to control her. She had severe night terrors and for more than a year could not tolerate sleeping alone. In addition, she was sexually provocative with adults and cruel to other children and animals. After the first two difficult years, Jean seemed to settle down and respond well to the relatives' stable environment.

Even though Jean remained an oppositional child who was sometimes difficult to reach, things were going fairly well until she was six and her mother reappeared, claiming to be a changed woman. From the moment her mother appeared, Jean desperately wanted to live with her. Jean's aunt and uncle agreed that she had almost a different personality when she was with April; in fact, she was both submissive and affectionate toward her mother. The aunt and uncle did not recognize this as the accommodating and pseudomature behavior that is characteristic of abused children, but instead took it as a sign of a potentially healthy relationship with the mother. After much pleading from Jean and many promises from April, the aunt and uncle permitted the girl to return to her mother's care. Soon the mother took Jean and moved away, presumably because she had found a job in a nearby city.

Jean's aunt and uncle did not see the girl again until she was almost nine years old. She had been found when the police raided a house

that was notorious for drugs and wild motorcycle gang parties. The mother managed to escape the raid, but the little girl was discovered in a bedroom with two men who were subsequently convicted of child molestation and possession of narcotics. It was learned later that Jean had been the victim of this kind of abuse for several years. The mother had left her in the care of boyfriends who molested her, who had forced her to engage in group sex at parties, and who had given her drugs. A man with whom April lived, a biker, often had intercourse with Jean—including sodomy.

Eventually, Jean was returned to the custody of her aunt and uncle, who were granted full legal custody. The aunt and uncle sought treatment for Jean because, when returned to their custody, she would have uncontrollable temper tantrums much like the ones she had when she first went to live with them. At night, Jean could not sleep alone, and only slept fitfully if her aunt and uncle allowed her to sleep with them. She was occasionally sadistic and/or sexually inappropriate with other children. Her behavior toward her teachers ranged from the placating to the oppositional. She was unable to do grade-level work at school because of poor retention and a lack of concentration. Jean also insisted that she wanted to return to April because her mother needed her.

When Jean first came to therapy, she did not appear anxious about leaving the aunt and uncle or about meeting alone with a stranger. When she entered the therapist's office, she walked around the room carefully inspecting books and toys and various articles of furniture. She then sat down across from the therapist, crossed her legs in a very suggestive manner, and said, "And now what can I do for you?" She was clearly attempting to defend against her fear and anxiety in this new situation with a strange adult by taking an aggressive approach. The clinician responded by stating, in a friendly manner, that she was meeting with her to help her adjust to living with her aunt and uncle, and to help her with what had happened in the past. Jean's reply was that this wasn't necessary because she was going to go back to live with her mother no matter what she would have to do to accomplish it. The therapist told her, in a kindly but firm way, that she could not go back to live with her mother because she had been abused there. After this exchange, the therapist asked her some general questions about her school and her friends and Jean answered appropriately.

When the clinician met with the aunt and uncle, she learned that Jean's acting out—in particular the sadistic and provocative behavior—had become very serious. They were afraid that if things got much worse they would not be able to keep her. In their view, the tantrums were one thing when Jean was a three-year-old, but now that she was

bigger they were afraid that she would hurt another child. They added that Jean was especially cruel toward very young children.

The therapist suggested to them that it would be advisable for her to do a complete evaluation of Jean, including psychological testing, before formulating a treatment plan for the girl. In the meantime, she recommended that Jean not be permitted to play with other children without supervision. The therapist asked for their authorization to talk with the school concerning the girl's special needs; to this, the couple consented readily.

During the psychological testing, Jean was hostile but able to perform the more concrete tasks such as those of the WISC-R and the Thematic Apperception Test (TAT). The WISC-R responses showed her to be a bright, extremely angry child who was attempting to defend herself against overwhelming anxiety and aggressive impulses by hypervigilance and compulsive attention to details. Her hostility, intended to ward off feelings of helplessness and inadequacy, was manifested in a steady barrage of criticism of the WISC-R subtests as "stupid, dumb," and so forth, even though in most instances she dealt with them competently.

It became clear that one of the ways in which Jean had survived the abusive experiences of her past was to develop a pseudomature "mantle of competence"; while this enabled her to function surprisingly well, she was extremely fragile beneath the surface. When she felt that this form of protection was under attack, she would quickly counterattack. And because the WISC-R was perceived as a kind of threat to her competency, Jean could only challenge the source of the threat.

Her TAT responses were full of violence. Many of the stories that she told had happy endings in which superpowerful people were able to vanquish enemies; others expressed themes of people ganging up on other people to get even for past misdeeds. The Rorschach test proved to be too much for Jean, and the testing had to be halted short of completion. One inkblot evoked an image that seemed to spill out over the card and onto the desk. She responded to the blot by saying "Broken, burned bones . . . burned bones and blood—no, broken burned leaves." She slammed the card down on the desk and began tearing leaves off a plant that was sitting on the desk, while she chanted, "Burned bones and leaves." The therapist put the card away and guided Jean toward a neutral activity.

The prognosis for Jean did not look good initially. Nevertheless, the clinician thought that by working with the girl's defenses (i.e., her compulsiveness and desire for competence) it would be possible to get some control over her provocative acting out, which would allow her to be more receptive to treatment. The acting out was seen as an attempt

at mastery over her earlier abuse by replicating the abuse in some form; at the same time it served to identify and describe aspects of what had been done to her.

The therapist considered, too, that a treatment plan encouraging regression or the ventilation of anger would be a mistake at that time for several reasons. First, Jean did not have the foundation of normal infant and early childhood experiences as, for example, Amy had had, and thus her ego structure was extremely vulnerable. Second, Jean's defenses were *barely* functional and she frequently lost control in very primitive ways. By contrast, Amy's bizarre posturing and avoidant behavior (while superficially more pathological) actually kept her primitive destructive impulses in check. And because Amy's super-ego was fundamentally healthy, once she felt safe she could utilize a regressive process to catch up developmentally. When the latter was achieved, she could go on to express her anger through a constructive therapy process that was truly cathartic. For Jean, a therapy process that encouraged catharsis would not, at that time, have served recovery but, rather, would have unleashed boundless primitive rage.

The initial goal for Jean's therapy was to shore up her ego by ego-building experiences that Jean could accept, in view of her negative self-concept. The clinician also wanted to try to break through the pattern of mastery-by-identification-with-the-aggressor; to accomplish this, she met with one of Jean's teachers and her parents, persuading them to agree to a consistent behavior modification program with daily reports sent home from school.

The therapist also helped Jean's teacher to understand that as a result of the girl's anxiety, her attention span was not that of an ordinary nine-year-old. Thus, her work needed to be broken down into smaller increments than were given to other students in the class. She also recommended that because Jean's impulse control was still very poor, she would have to be supervised constantly. The therapist also explained to the teacher that the girl would probably require a program such as this, with periodic changes, for at least one year.

The clinician began twice-a-week sessions with Jean. She carefully structured these sessions so that they would be both ego-building and super-ego-strengthening. The therapy hour was divided into three 15-minute activity sessions followed by a cleanup period. Activities ranged from putting puzzles together to simple drawings and games. They were meant to be challenging enough not to bore Jean, while simple enough not to provoke her by being stressful. When she would act out, the activity was stopped, and if she made inappropriate remarks the conversation was changed to focus upon (1) the intent of the

message that she was trying to send and (2) how the other person might feel when she made that kind of remark. The therapist would then steer the discussion to how Jean must have felt when she was abused.

As therapy progressed—in parallel to the behavior modification program at school and the work of the parents at home—Jean's behavior improved significantly both at home and school. Nevertheless, she continued to act out and to be provocative with the clinician. It became clear that Jean split her world into all bad versus all good. In this context, she was beginning to focus the anger she felt toward her mother onto her therapist—a positive sign; even so, this division of people and things into good or bad meant that she was merely focusing her negative thoughts in one direction in order to function adequately in another. On a brighter note, it also meant that Jean was beginning to develop enough ego strength to tolerate new departures in therapy.

Jean still had an idealized fantasy of her mother, and for Jean to express anger toward her was to risk loss of the fantasy. With a view to breaking through this all-bad/all-good way of judging things, the therapist began telling Jean stories, both during and interspersed between the play activities. The theme of these stories was that sometimes good people make mistakes and do bad things, but one must recognize that doing something bad doesn't make the person totally bad. One can still like the person.

At first, Jean dismissed the stories as "dumb," but began to show more interest when the therapist created serialized stories about one mother and her daughter, and the latter's friends. Soon Jean was asking the therapist questions about the characters of the stories, wanting more details. Then she would ask hypothetical questions about what the characters in the story might do in this or that situation.

One day, Jean asked the clinician to tell about her own childhood and about her school. When the therapist told the girl about the school, she was particularly careful to tell about times when she did not do well and things she did that got her in trouble, as well as the good things that happened. Jean listened intently for a while and then exclaimed, "You got in trouble? . . . You couldn't have gotten in trouble. You are too goodie-goodie, too perfect!" The therapist reassured her that she had done lots of things that were wrong and had made many mistakes. Jean stared at her in true amazement. It was clear that some of the girl's former ways of thinking were dissolving before the therapist's eyes. It was one of those moments that made months of struggle with a very difficult little girl worthwhile.

Jean was full of questions about the clinician's childhood experiences. She would then tell about something she herself had done or felt, and

ask the therapist what she would have done or how she would have felt. The structured activities were continued for a short while longer, but it was clear that Jean was ready to move on to expressive, projective play. She began playing in a doll's house, where she would obsessively reenact "night parties" with lots of scary men. She became quite conflicted about this play and periodically would act out. For example, during one session she described a scene in which a man locked her in the bathroom with him; she ran to the dish where the therapist kept some candy, stuffed her mouth with the candy, and then began throwing it around the room.

The therapist crossed over to her and took the candy dish away, telling her that she understood that the dolls had brought back painful memories; it was all right if she stopped. Jean would not have to get angry or say that something scared her in order to stop the game. The clinician went on to tell Jean a story about a little girl who had been hurt so much that she became afraid to be afraid, and how the girl later learned to tell people that she was afraid. By the end of the story, Jean had calmed down and could tell the therapist how frightened she was. Jean's therapy continued to make good progress. At the time of this writing, she is thirteen years old. She comes in once a month for therapy and is participating in a girls' group.

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4

Treatment of the Adolescent Victim

Adolescence is one of the most complex and turbulent stages of life. This difficult period can often try the patience of the wisest of adults to its limits. When a sexual trauma is introjected into this naturally problematic time, it can pose extremely complex questions for the therapist. In cases of adolescent sexual abuse, a therapist is frequently called upon to help the adolescent victim resolve issues relating to his or her still-evolving sense of self, as well as issues relating to the adolescent's developing sexuality. Furthermore, the adolescent's family relationships, as well as peer relationships, may be heavily burdened by the fact of the assault.

This chapter will focus first on some of the major issues that confront a therapist who treats an adolescent victim of sexual assault.* It continues with an explanation of the phenomenon known as the rape trauma syndrome and recovery cycle. There follows a discussion of questions posed by the "silent rape," in which an adolescent victim attempts to hide the assault from her parents. Also considered are the many issues that are raised when an assault was the adolescent victim's first sexual experience. Finally, the chapter presents methods of therapy for the victim, in light of the strained and often anger-filled relationships that

* The principal focus of this chapter is the assessment and treatment of adolescent girl victims. While adolescent boys are targets of molestation, by far the majority of victims are girls. See Chapter 6 for a discussion of treatment and assessment issues regarding latency-age boys; these issues pertain largely to adolescent boys as well.

develop between an adolescent and her family, and the impact that the abuse can have upon a family system. Case examples are presented in which the adolescent was abused as a child, including one in which the assault was a gang rape.*

OVERVIEW

It is frequently difficult to treat an adolescent rape victim, who may resist therapy for many reasons. The adolescent may be struggling to prove to herself that she is still "all right" and not emotionally injured by the assault, and thus, like many adult victims, may refuse to admit she needs help. Another issue that can delay treatment is that frequently after an adolescent has been sexually assaulted she may go through a period of self-destructive acting out or a period of intense self-loathing; this may make it impossible for her to participate in a healthy, constructive process such as psychotherapy. Furthermore, the adolescent may have been doing something that was forbidden or wrong which led to the sexual assault, so her guilt may cause her to resist treatment.

An adolescent's family may also resist the therapy process. Many parents' wishful thinking may lead them to believe that the assault did not really harm their child, and thus the parents may avoid seeing symptoms of the trauma. The parents may be overly focused upon their adolescent's acting-out behavior and not realize that she has suffered a terrible emotional wound. Unfortunately, when she hears such anger, it only serves to deepen the adolescent's self-blame and intensify her potential for even more self-destructive acting out.

Even in cases in which the adolescent's acting out has led directly to her victimization, she is nonetheless a victim who is totally unprepared for the horrible reality of the assault. The attack itself is generally totally unexpected, and the adolescent struggles with disbelief and terror as she attempts to deal with the life-and-death reality of the event. Adults who are close to the adolescent must keep a careful check on their anger or frustration at the adolescent's risk-taking or rebellious behavior that may have led to the assault, as well as bear in mind that despite an adolescent's claims that she "knows it all" and has her right to independence, she is still very much a child trying to grow into adulthood. Communicating with a traumatized adolescent can require a delicate attempt to reach the hurt, frightened child inside without offending her appropriate striving for independence. Both aspects of

* In respect to adolescents, rape is more prevalent than molestation, and the former term will be used to refer to the kind of assault being discussed in this chapter.

the adolescent's psyche must be worked with in order to conduct successful treatment, and such a feat is not easily accomplished.

AFTEREFFECTS OF RAPE

Some of the psychological perplexities that are engendered by sexual assault are so fundamental that one hardly ever thinks of them. One of the most basic of these dilemmas is the loss of territorial boundaries. A sexual assault is an assault on the ultimate territorial boundary, one's skin. There are only three situations in which our bodies can be penetrated against our will: when we are shot, stabbed, or raped. The involuntary penetration of this very primitive boundary causes the victim to experience a sense of not feeling whole. It is common for a victim to feel a puzzling sense of personal fragmentation and disorientation caused by this kind of temporary disruption of the territorial boundary of the skin.

This sense of loss of personal integrity or wholeness can be particularly devastating to an adolescent who is still in the process of defining who she is and individuating from her parents. Adolescents have a deep need to perceive themselves as whole, separate people, and disruption of this perception may cause serious repercussions in the girl's later development. Consequently, from the beginning of treatment, a clinician should work toward helping the adolescent to rebuild a healthy sense of personal boundaries and of selfhood.

A second fundamental psychological issue that rape calls into question is the victim's perception of her ability to control her environment. This is a process that begins around the age of two, when a child learns the word "no." This process of learning how much control one has over one's environment is in full operation during adolescence. Then, suddenly, the adolescent is confronted with a situation in which she is totally powerless to stop something from happening. Such an experience of total helplessness can be devastating to a young person who is still struggling to discover what degree of command she has in the various aspects of her life.

A third dilemma that arises from the rape trauma concerns the victim's basic trust in others. As most children grow and change, they hold onto the assumption that others will not harm them. This is especially true of adolescents, who are further convinced that their parents' warnings about the perils of the world are stupid and that, no matter what happens, they can "handle it."

A fourth issue is that of the adolescent's developing sexual identity and the role that sex will eventually play in her life; both may be severely affected by being raped. Unlike the sexually mature adult rape victim, who can in most instances clearly distinguish between rape and consensual sex, the rape of an adolescent may have been one of her first sexual experiences. Consequently, an adolescent victim may later confuse sex with rape.

Finally, another perplexity that the adolescent must struggle with is the question, "Why did such a thing happen to me?" Adolescents are narcissistic and egocentric by nature, and they tend to view causality in terms of themselves; hence, they are also vulnerable to self-blame at this developmental stage. A therapist should be alert to the fact that young victims tend to internalize or blame themselves for an assault more often than adults do. Too often an adolescent victim comes to the tragic conclusion that she was raped because she was "bad" or "no good"; or that she was punished for some misdeed; or, now that she has been raped, that she is worthless. A therapist should carefully explore the entire subject of causality and blame with an adolescent victim to make sure that she does not incorporate the assault in such a manner that leads her to believe that she is bad or worthless. In some cases, the clinician may need to devote considerable time to this issue.

A therapist should note that, even in the turbulent lives of most adolescents, there is some sort of order. But after a sexual assault, the adolescent is left to contemplate an inexplicable, random, violent event. The randomness of life is difficult enough for an adult to decipher, but it is even more puzzling for an adolescent, who is less capable of coping with an abstract concept such as randomness. Furthermore, an adolescent's natural grandiosity, which tends to make her see the world largely in terms of herself, hinders her ability to put her own role in the rape incident in proper perspective.

A therapist should also consider the fact that if the adolescent has been previously victimized as a child, this second assault may serve to solidify her self-perception that she *is a victim*, a worthless object of such events. We believe (with Peters, 1976; Browne & Finkelhor, 1986; and Yates, 1987) that adolescents who were victimized as children are at higher risk of being victimized again than are adolescents who were not child victims. In these cases, the clinician should find out whether or not the adolescent victim was reenacting the earlier situation with the unconscious fantasy that the conclusion would not be a sexual trauma this time.

RAPE TRAUMA SYNDROME AND RECOVERY CYCLE

The rape trauma syndrome and recovery cycle are processes that serve to protect the psyche during the trauma itself and help it return

to a normal, stable level of functioning after the assault. These processes are fundamentally similar to the grief process as described by Lindemann (1944). During therapy, a clinician needs to facilitate the adolescent victim's progression through the trauma response and recovery cycle, as well as assist her family to understand the process, so that the family can provide her with appropriate emotional support and guidance. If the adolescent victim receives the treatment and support that she needs, she may not be left with the deep emotional scars caused by the untended psychological wounds that are often the most serious injuries caused by sexual assault.

Specific Components of the Syndrome and Stages of the Cycle

Most victims of rape are totally unprepared for the assault. It takes the victim by surprise and, for a few moments, the victim's mind tries to come to grips with the significance of what is happening to her. Thoughts race through her mind such as "This must be a dream," "This must be a bad joke," or "This can't be real." When the cold reality of "Oh my god, it's real" descends upon the victim, she may become momentarily hysterical, but soon her main concern will be survival: "I'll do whatever you want; just don't kill me."

Figure 1 shows the stages of the trauma response and recovery cycle.

Rape Trauma Response
The attack
Disbelief
Realization of the reality of the attack
Cognitive survival state

[RELEASE OR ESCAPE]

Posttrauma Recovery Cycle
Shock
Denial of what happened
Depression
Mood swings
Anger
Philosophical reflection
Laying to rest

Figure 1. Adapted from Everstine, D.S., & Everstine, L. *People in Crisis.* New York: Brunner/Mazel, 1983, p. 168.

When the victim comprehends what is happening to her, she will go into a cognitive survival stage (Everstine & Everstine, 1983, 1986). This is a strangely cold, unemotional state of mind, which persons who are struggling for their lives endure. During this time, the victim's emotions are kept in abeyance so that she can attend to her more pressing survival needs. There also may be time and sensory distortions. Things may seem to go in slow motion during the assault. If the victim struggles or is injured during the assault, she most likely will not feel the full intensity of the pain, because she is by then in a dissociative state.

When the victim is released, she will most likely enter into a shock phase. Some victims present in a hysterical or emotional manner, but it has been our experience that most adolescent rape victims remain in shock from 24 hours up to three or four days. While the victim is in this state of shock, she may have extremely flattened affect. She may appear dazed, confused, or even blasé. Such behavior can easily be misunderstood by the untrained observer as being unaffected by or not caring about the assault. Too often, well-intentioned parents who desire to see their child as being "all right" misread the adolescent's blunted affect; or, parents who may already be angered by their adolescent's acting out may misinterpret their daughter's symptoms of shock as additional evidence of her being irresponsible. In both instances, a therapist should carefully explain to the parents that the adolescent is by no means indifferent, and then clearly describe the clinical components of this state.

When the victim comes out of shock, for a time she will be in a state of denial during which she attempts to show that the rape has not changed or seriously affected her life. During this denial phase, the adolescent may make statements such as, "I won't let him take any more from me" or "I can handle it." It is best if the therapist takes a position that is supportive of the victim, but also helps her to face the fact that something serious did happen, so that she can proceed with the recovery process instead of staying frozen in her denial. The latter state usually lasts from a few days to a few weeks.

Next, most adolescent victims will enter a state of depression, which is anger resulting from the assault turned inward. Often significant people who are close to rape victims have considerable difficulty in grasping why many victims do not express intense anger after a rape. A few victims are capable of instant anger but most are not. Loved ones, who are frequently enraged by the assault, may misread the victim's lack of expressed anger and react with suspicion and dismay. This may be further complicated by the fact that during this depressive

stage some adolescent victims go through a phase of promiscuousness or self-destructive acting out, which is a function of the depression and of loss of sense of self-worth. Some adolescent victims perceive themselves as soiled or no longer of value because of having been raped; others may experience an eating disorder or simply gain weight mysteriously as an expression of their conflicts about sexual identity. If an adolescent goes through a self-destructive or self-loathing phase, her parents will need considerable support from the therapist to ensure that the manner in which they handle their daughter's acting out does not intensify her feelings of worthlessness.

It is worth noting that not all adolescent rape victims respond to being raped by promiscuous or self-destructive acting-out behavior. Although it is our experience that most adolescent victims will go through an acting-out phase in some form, there are adolescents who behave in a quiet, withdrawn manner. This type of girl may avoid social contact with boys; and, in some extreme cases, she may develop a school phobia or an agoraphobia. Unfortunately, many adolescents who respond to an assault in a quiet manner are often misperceived as needing no psychological care. This can occur in a family in which the parents' desires for their daughter to recover quickly may cloud their vision so that they do not see her suffering. It is also easier, in such cases, for the parents to avoid dealing with their adolescent's developing sexuality, a subject that some parents find extremely difficult. In fact, the daughter's withdrawal from social (boy–girl) contacts may be a relief to such parents. Or, as Burgess and Holmstrom aptly put it:

> One of the issues that parents must come to terms with is their child's sexuality. With a rape, there is the reality confirmation that their child has been exposed to a sexual situation, and it becomes important to know how the child is treated in terms of this knowledge. For example, do the parents (1) ignore this fact and not mention the rape; (2) become extra protective of the child in normal boy–girl relationships; or (3) deny the impact of the situation? (1978, p. 78)

As the depressive phase of the recovery cycle fades, a victim will go through a period of mood swings. This phase can be quite frightening to the victim because she gets glimpses of her former self before the assault and then some seemingly minor event will propel her back into depression once more. The girl may need considerable reassurance from the therapist that this is yet another stage in the post-trauma recovery cycle that will pass.

After the period of mood swings will come a period of intense anger. If the earlier, depressive stage was properly worked through in therapy, this anger can be directed toward an appropriate object—namely, the victim's assailant. However, when there is the lack of a solid clinical foundation for directing this anger, there may be problems in some of the central male relationships of the girl's life. For example, she may displace her anger onto "safe" males, such as her father, boyfriend, or brother.

This phase of the post-trauma recovery is one in which those who are close to the victim may also need considerable support. Because the adolescent may appear to be angry about everything, the people around her, especially the males, feel they cannot do anything right. The family may need considerable help in not personalizing this anger and in seeing it for what it is—a symbolic expression of the victim's rage at her attacker. Family members may also feel unjustly accused by the victim if the anger is expressed toward them a long time after the rape took place. In many cases, the victim's anger reaches the surface when the family's anger has subsided. Through wishful thinking, they may have underestimated the duration of the traumatic process.

The final philosophical and laying-trauma-to-rest stages, in which the victim sums up how the assault has changed her life and how she will go on from here, are in many cases difficult for a victim to complete during her adolescent years. The reason is that this task requires dealing with abstract philosophical concepts that adolescents are usually not capable of understanding cognitively. The clinician should note that adolescents live in a world that is primarily governed by their emotions. They view things mostly in terms of their still-forming concept of self—i.e., in an experiential manner. Even though many adolescents sound very adult in their abilities to grasp philosophical concepts, this may be mere verbiage if the concepts being discussed have not been fully internalized by the adolescent. The adolescent typically learns by doing, while an adult is more likely to try conceptualizing before acting. Hence it is not a good idea for the therapist to project an adult's cognitive process onto an adolescent victim. Adolescents are more likely to conceptualize the philosophical, laying-to-rest phase of the trauma recovery cycle in a superficial manner; if so, it represents a temporary but not a real closure to the recovery process. For example, few 16-year-old girls can fully grasp why they went through a period of promiscuous acting out after being raped, but later, at age 20, they may be more capable of understanding their behavior and of coming to terms with it more adequately.

The significance of these delayed reactions is that an adolescent victim may need to return to therapy for a brief period of time during her late teens or early twenties. If the therapist feels that may be necessary, he or she can assist the victim in going through the trauma recovery cycle at her current level of understanding. In addition, the door should be left open for the adolescent to return to therapy again later on, if needed.

THE SILENT RAPE

Even though it is said that approximately half of all rapes are committed against adolescents, we have observed that the adolescent may be the least likely person to report what has happened to the authorities. Sadly, many adolescent victims do not tell their parents or family members. When one takes into consideration what an ordeal a rape victim goes through during the trauma response and posttrauma recovery cycles, it is particularly tragic if *no one* around her knows what has happened to her. Some rapes are undetected for long periods of time and, as a consequence, parents may misread an adolescent's apparently strange behavior. For a therapist, it is worth considering that some of his or her adolescent cases—referred for a myriad of reasons—may be those in which the girl is a "silent" victim of rape.

Some of the symptoms that adolescent rape victims present are the following, according to Hilberman (1976) and Everstine and Everstine (1983).

1. sudden personality change
2. rapid drop in school performance
3. withdrawal from school or social activities
4. flagrant promiscuous behavior
5. sudden phobic behavior
6. withdrawal from social activities
7. obvious self-destructive, risk-taking behavior
8. drug abuse
9. eating disorders such as bulimia or anorexia
10. sudden unexplained alienation from peers or family

Any of these behaviors should be viewed as an adolescent's cry for help. When a therapist inquires whether an adolescent client has been sexually assaulted, he or she should be aware that many adolescents may not feel safe telling strange adults about what has happened to them. Hence, if the girl's initial reply is evasive or negative, the clinician should not assume that the reply is accurate or complete until he or she has had time to establish a relationship with her. In these instances, the therapist may wish to make a neutral-sounding statement to the adolescent such as, "You are just getting to know me and I am sure there are some things that you may not feel comfortable telling me just now. Later on, when we know each other better, you will probably want to tell me about them."

In general, it is important for psychotherapists to reflect that literally thousands of "silent" adolescent victims of sexual assault are not recognized as victims. Instead, they are shamefully mislabeled as delinquent, promiscuous, bad, or "sick" kids.

TREATMENT OF THE ADOLESCENT RAPE VICTIM

The Family

As in the case of an adult rape victim, the response of those who are involved with the victim's emotional needs can be one of the critical factors in determining how well an adolescent will recover from a sexual assault. The need for her parents to behave in an appropriate manner cannot be overly emphasized. It is true that, in many cases, an adolescent's acting-out or risk-taking behavior may indirectly or directly have led to her being assaulted. Even so, the adolescent probably did not have the faintest notion that her behavior would lead to rape, despite the fact that her parents may have perceived the risk beforehand and may have tried to warn her of the dangers of her behavior.

Unfortunately, parents who are already angry at their daughter for some reason may rashly take the position that the daughter deserved being raped because of recent acting-out behavior. This insensitivity is doubly unfortunate; first, because it assumes that the adolescent was capable of realizing that her behavior could lead to rape; and, second, an acting-out adolescent may have been doubly traumatized by the rape because her risk-taking behavior was the result of preexisting problems in her family. The victim has already been taught a ghastly lesson and does not need to have it reiterated by those whom she needs for love and support.

It is advisable for a clinician to meet with the adolescent victim's parents as early as possible in the treatment process. One should bear in mind that they are victims of the assault as well, and they may need considerable help in coming to terms with what has happened to their family. Some of these meetings should be without the daughter's presence because the parents may need a private setting to express their feelings about what has happened; also, some of these feelings may best be not expressed in front of the victim.

During these parent sessions the therapist can go over issues such as: (1) the parents' feelings and prejudices concerning rape; (2) the parents' feelings of helplessness or failure for not being able to protect the child; (3) how their daughter's behavior may have led to the rape; (4) how they should discuss the relevant issues with the daughter; (5) their daughter's sexuality; and (6) how to discuss the subject of the rape with (when appropriate) siblings. These are all difficult subjects, and many parents of victims will require guidance from a therapist.

Rape, despite our culture's many steps forward toward understanding it, remains a profoundly misunderstood subject about which many people still hold unfortunate stereotypical ideas. The clinician should help the victim's parents understand that their daughter may need to learn to be more cautious and responsible for her actions; nevertheless, teaching her this will not be accomplished by angry outbursts. And no matter how much they may wish to shelter their child, they cannot always protect her from some of the cruel facts of life.

Sex is a difficult subject for most people to discuss; many parents dread the day that they will have to have "that discussion" with their adolescent child. Above all, the rape of a daughter forces the parents to deal with her sexuality; and because the rape may have been her first, or one of her first, sexual experiences, it is imperative that she is helped to separate the meaning of the assault from that of consensual sex. This is not always a simple task, but it can be made much easier if the parents are receptive to hearing about her feelings concerning the subject. The "Let's-pretend-it-never-happened" approach simply will not do.

Next the parents should be given an explanation of the rape trauma syndrome and recovery cycle, in order that they may more fully understand their daughter's behavior after the assault. Finally, they should be given an estimation of the length of time that will be required for the victim's recovery from the assault, lest they make the unfortunate assumption that their daughter should return to normal as soon as the bruises heal. In our experience, a minimum of six months in treatment can be expected. In some cases, several years of therapy is necessary.

Sources of Complication

There are factors that can make the treatment of adolescent rape victims possibly more complex. First, the adolescent may have known her assailant or assailants; e.g., they may attend the same school. If she reports the assault, she may be the brunt of cruel gossip or threats by an assailant or his friends. One must bear in mind that during the entire criminal proceedings, an accused assailant may well be free and attending school. Second, if the victim does not report the rape or the case cannot be prosecuted, the victim may have to face her attacker or attackers daily. Either situation can be excruciatingly painful for the victim. A therapist will need to help prepare the victim to decide what she should do in these situations.

An adolescent may have been the victim of a gang rape, and may or may not know who the assailants were. To complicate matters, she may be one of several victims whom she may know or not know. It is our opinion, along with Burgess and Holmstrom (1978, p. 67), that each assault requires separate clinical attention. The clinician should not treat a gang rape as one event in order to avoid listening to the gruesome details of each assault. Instead, a therapist should strive to be aware of his or her own inner feelings about such events and be careful not to unknowingly silence a victim from working through her feelings concerning each rape and each assailant. In case there were more than one victim of the gang rape, the interactional and relationship issues are multiplied. In such cases, each victim will have to work through her feelings concerning her relationship to each other victim during, as well as after, the assault, if the others had been friends before the assault.

Listening Without Judging

The therapist should not aggressively press for details of a rape, so that he or she is not misunderstood as being morbidly curious or as having no regard for the girl's personal boundaries. Instead, the therapist should convey concern and a willingness to hear the details, bearing in mind that there is a subtle but vast difference between encouraging and pushing. Because of the profound damage that rape inflicts upon a rape victim's sense of personal integrity, it is vital that the clinician communicate to her a sense of respect for these already compromised boundaries.

A therapist's best strategy is to assume a nonjudgmental role that is supportive of adaptive coping, while nonsupportive of pathological

coping mechanisms. If the adolescent victim is not capable of admitting to the clinician or to herself how traumatized she was by the rape, it is recommended that this "I'm-fine-and-the-rape-didn't-hurt-me" attitude not be challenged. If the therapist questions this facade, the girl is likely to perceive such a challenge as a second assault. If not carefully thought out, any statement that is intended to make the victim face the seriousness of her situation may, in fact, drive an already terrified adolescent away from the therapy relationship. Or, as one young client put it, "Thank you for not telling me how messed up I was. You know, if you had said it then [just after she had been raped], I would have never come back to see you. I would have hated you." Even at 15, this victim knew how vital it was for the therapist to respect her boundaries.

That the adolescent should take precautions so that she does not become a victim again, is another sensitive issue that must be dealt with during the course of therapy. Even so, a therapist should not bring up the subject in such a manner that it ascribes blame for the past assault onto the adolescent. Instead, one can reframe the subject of responsibility and blame by suggesting that the adolescent should value herself, and because she values herself, she should take good care of herself. A shift as radical as that in her frame of reference may take considerable time if the adolescent has already internalized the idea that she *is* a victim or a worthless person. If this is the case, the clinician should intersperse information that contradicts such an unfortunate self-image whenever possible during the (entire) course of therapy.

Acting Out

Some adolescent rape victims tend to sexualize relationships with boys or men, often in a very inappropriate manner. This usually occurs because the young girl has cast herself in the victim's role, and because her self-esteem has reached such a low ebb that she perceives her only value to the opposite sex as being sexual. Unfortunately, this inappropriate seductiveness becomes self-confirming when boys or men who do not know what has happened to her misinterpret what she is doing.

When treating a young person who does this kind of acting-out behavior, a therapist should be cautious lest the girl mistake his or her reaction for being critical. Instead, the clinician should focus on how the girl views herself. During this process, the therapist can try to provide her with information from which she can begin to build a new,

more healthy self-image, thus facilitating more appropriate future behavior.

When Unresolved Trauma Is Revived

When entering adolescence, a young person undergoes dramatic cognitive growth; as a result, concepts that were once beyond the person's understanding suddenly come into focus. When that happens, any previous sexual trauma that was not revealed or resolved by the child can suddenly revive for the adolescent. In other words, a child of six may not understand the full sexual or social meaning of having been molested, but a 14-year-old will. The effects of a previously unrevealed sexual assault may suddenly return to the surface, often in the form of inexplicable behavioral or personality changes. In fact, it is more likely that an adolescent will reveal past sexual trauma by her behavior than by directly telling an adult. To make matters worse, many adolescents who have experienced unresolved childhood trauma may not know why their behavior has changed, nor even that it has. They may project their internal turmoil onto the adults in their lives and perceive the ensuing conflicts as due to the adults' unfairness or lack of sympathy. When a family system reaches this sad state, the conflicted parent-child interaction can perpetuate itself, even though both parents and adolescent believe that they are merely reacting to the misguided actions of the other.

Because of these potential dynamics, clinicians should pay close attention to cases in which adolescent clients display sudden behavioral changes, particularly during early adolescence. The symptoms of an unresolved childhood sexual assault are quite similar to those noted earlier in the discussion of "silent rape," namely changes such as an inexplicable drop in school performance, withdrawal from school or other social activities, promiscuous behavior, self-destructive behavior, substance abuse, sudden alienation from the family, runaway behavior, or the onset of an eating disorder—particularly bulimic binging and purging. We have encountered a significant number of cases in which an eating disorder that emerged in adolescence could be traced to childhood sexual assault.

Unresolved trauma may surface slowly, but in our experience the overt symptoms often emerge quite rapidly—usually in conjunction with an adolescent's awakening to the opposite sex, as well as to her own burgeoning sexual development. As one 16-year-old put it, "I don't know what happened when I turned 14. Something snapped and I just didn't care anymore. I was mad at everyone and I hated myself."

When this girl began therapy at age 16 because of her beyond-parental-control behavior, substance abuse, and two suicide attempts, she did not mention that a group of teenage boys had gang-raped her when she was nine years old. When this event was revealed in the course of taking the girl's history (and after considerable exploration), the girl mentioned it matter-of-factly and quickly added that she had not told her parents at the time (or later) because she was afraid of the boys. She went on to claim that the event was not such a "big deal" anyway, because at the age of nine she did not know what was really happening to her. This girl's blasé attitude was clearly a defensive maneuver to help her avoid dealing with a painful, terrifying event.

It took considerable reassurance before the girl could begin to disclose her true feelings about the assault, namely the belief that there was something about her that caused the boys to choose her to be raped. She had gone to a garage with them, willingly, because she was flattered that older boys wanted to play with her. Then, later on, when her mother had discussed the subject of sex with her for the first time, the mother told her that only "bad" girls have sex with men to whom they are not married. This unfortunate but well-intentioned talk occurred only a few months after the assault; it prevented the girl from telling her mother what happened to her because she believed that her mother would think she was bad. When this information was revealed, the girl's adolescent acting-out behavior was cast in a new light, and the therapist was able to work with her and her family to resolve the trauma.

CASE STUDY

The following is a case study of an adolescent girl whose childhood sexual assault was not revealed for many years. Jackie was 16½ when she was referred for therapy. She said that she did not know when the sexual abuse first occurred, but thought that she was probably two or three years old. In any event, she did remember that being sexually abused had always been part of her life. She did not realize that there was something "wrong" or different about her experience until she was about 11 or 12. Then she "just began hating everyone," especially herself. By the time Jackie first entered treatment, at 16, she was at least 30 pounds overweight.

Although Jackie was a bright girl, her grades were poor in grammar school. She barely passed in junior high; and now, in high school, she was virtually failing in a majority of her classes. Her attendance was poor, and when she was in class she was argumentative and disruptive.

According to Jackie, she first began experimenting with drugs in grammar school. By the time she was in junior high, Jackie drank and used cocaine, marijuana, and amphetamines regularly. Socially, she had a few girlfriends, but she was not particularly close to any of them. She had a reputation for possessing an explosive temper, and she had been thrown out of school several times for fighting. Jackie's relationships with boys were paradoxical. She rarely dated, and when she did it was usually with boys who were younger or less mature than she was. Nevertheless, she claimed that she preferred boys to girls as friends. Jackie said she felt that boys were more reliable and interesting than girls and she enjoyed their company more.

Jackie's relationship with her family was strained at best. Her mother, Corinne, shook her head in dismay when describing Jackie in contrast with her other two children, both of whom were good students and attending college. Corinne added that neither of the other children had been a behavior problem apart from average "kid stuff." She said that Jackie had basically been a happy little girl until she was about three years old, when she suddenly became difficult to deal with. At first, Corinne thought Jackie was going through a "difficult" stage. But, when the tantrums and oppositional behavior did not stop, she simply resigned herself to the idea that the first two were easy children to raise, while this one was just a more difficult child by nature.

Jackie's father, Larry, said that he had a better relationship with his daughter than did her mother. He said he understood her somewhat because he had a bad temper as a young man and had to learn to control it. But even Larry admitted that he was not close with his daughter, and when she was in one of her "moods" even he kept his distance.

Jackie spoke with considerable detachment when she referred to her mother and older sister, describing them as "simps" and "goodie-goodie bitches" who spent all their time shopping and looking at themselves in mirrors. Jackie's relationship with her brother was better. Although they were not close, she enjoyed doing things with him when he came home from college.

Jackie's childhood molestation did not come to light until she was 16. One evening when she was visiting a girlfriend, the two girls got very drunk and decided to tell each other their "heaviest secrets." With an indifferent tone, Jackie told her friend that for years she had been having sex with one of her father's best buddies. Over the next few days, Jackie's friend became more and more worried about what she had learned from Jackie. Eventually, she told her own mother who, in turn, became concerned and called Jackie's mother. When she heard

this, Corinne knew that, horrible as it was, the story was true. This was confirmed when Jackie's older sister, who was at home when the call came with the news, said that the same man had tried to molest her when she was about eight. The sister had told him to go away or she would tell someone. The two women decided to wait until Jackie's father came home from work. When he had heard the story, the parents decided to talk with Jackie and then to report everything to the police.

When Jackie's parents let her know what they had learned, they were surprised and offended that Jackie was cool-tempered and somewhat hostile toward them. Jackie told them that it probably would not have happened if they had been around more when she was little, instead of spending all their time working in their business while leaving her with the molester and his wife.

When the father's friend was first accused of the molestation, he vehemently denied it, calling Jackie a "slightly retarded delinquent." Later, when other girls in the neighborhood whom he had molested came forward, he pleaded *nolo contendere* to the criminal charges.

Jackie was referred to our clinic by the district attorney who was prosecuting the criminal case. When Jackie began therapy, she was angry and suspicious. She would start her therapy sessions by announcing that she had absolutely *nothing* to say to another stupid adult, and then talk nonstop for the whole session. Because Jackie was so angry and defensive, the therapist decided to see her individually and meet with her parents separately in regard to parenting issues.

Jackie's parents naively expected her to "snap out of it," now that everyone knew about the molestation and people were doing something about it. They felt personally attacked when Jackie's behavior did not suddenly improve. In fact, her behavior got worse because she felt so exposed, vulnerable, and confused when the molestation became public knowledge.

The first step that the clinician took in working with Jackie's parents was to help them formulate reasonable expectations of a girl who had been through so much. Even though they wanted to, they simply could not place the same expectations on Jackie that they had on their other two children when they were Jackie's age. The therapist let the parents know that Jackie would need several years to catch up, developmentally, and to recover. Further, they would most likely be the targets of future anger as Jackie progressed. The therapist supported the parents by letting them know that they had tried their best, and that she (the therapist) would be there to help them, as parents, get through the process. The parents seemed relieved by this offer of support and guidance, and even though they were not told what they wished, they left the session with a sense of direction and some clearer expectations.

Jackie's therapy sessions continued to be turbulent, as she struggled with questions of why her parents had not known that she was being abused, and why her siblings (who were frequently at the father's friend's house with her) were not molested; and why they couldn't do anything about what was happening. It took considerable clinical work before Jackie could understand and accept how young and vulnerable she and her siblings were at the time when the molestation began. It took time for her to realize that she had been too small even to know what was being done to her. Only when she had thoroughly worked through the guilt and accountability issues, and had described some of the molestation in graphic detail, was she able to face the fact that she did have a form of relationship with this man. In retrospect, she acknowledged that in her mind the molestation had been a funny game that they played together; and, that she had not been aware of what these games were or that there was anything wrong with them.

The therapist saw Jackie as a teenager who was intensely vulnerable and depressed. She was utilizing her anger to protect herself from experiencing other emotions. Jackie's drug use could be seen as an attempt at self-medication to cope with her depression. The therapist approached the issue of Jackie's drug use directly, telling Jackie that she was using drugs to try to stop emotional pain; and that if she was to get her life back under control and "not let that man take any more" from her, as she claimed she wanted, she was going to have to stop using drugs and learn to develop coping strategies that worked. The clinician told Jackie that if she wasn't prepared to make a voluntary commitment to stop, she would insist on regular urine tests as a required part of treatment. The therapist was careful to make sure that the message conveyed to Jackie was not a punitive one, but instead clearly communicated that she cared about her and would not passively sit by and let her do destructive things to herself.

During this critical phase of treatment, the therapist worked closely with Jackie's parents to help them learn to set appropriate limits with their daughter in a manner that conveyed concern and consistency. The parents' previous way of interacting with their daughter, in terms of setting limits, was to first underreact to her behavior because they did not want to deal with her temper, then to overreact in an extrapunitive manner out of frustration, and then to feel guilty because they had overreacted. The therapist believed that it was essential to Jackie's treatment that her parents express their responses to Jackie's acting out more evenhandedly. A key factor in helping them to do this was to

help them deal with their feelings of guilt for being so involved in starting a (now very successful) business that they allowed their daughter to be exposed to the molester. The clinician guided them toward redirecting their emotional energy into Jackie's healing process, rather than toward past wrongs that could not be undone. The clinician was eventually able to help the parents to see that there were going to be periods of acting out that would be unpleasant, but that these were necessary aspects of Jackie's eventual recovery.

At first, Jackie responded to the new rules and limits with strident defiance, but soon she settled down—still occasionally testing limits. She began to make slow but visible progress once the family began to respond to her in a more consistent manner. She learned to identify emotions within herself and then, in turn, try to think about how she should behave, rather than simply act out defensively. Learning to express herself emotionally was a difficult process for Jackie: for example, phrases such as "I need . . ." and "That hurts" virtually stuck in her throat. Consequently, she would assume a belligerent posture that caused her to be completely misunderstood. To Jackie, showing another person her emotional needs meant that this person had power over her and could hurt her with the knowledge.

Another significant issue in Jackie's treatment was that she felt marked by the abuse. She believed that people could tell she had been molested just by looking at her. This feeling kept her from dating or trying to make herself attractive; since she already felt "soiled," she was sure that no boy would want her. The therapist thought that some work in a girls' group would be a useful process to help Jackie work through some of her fear of being stigmatized. (Jackie often said that because of what happened to her, she felt like "a real freak.") When the therapist discussed the idea with the person who was conducting the group, it appeared that Jackie might fit in well. The group had four members at the time, and two were also victims of the man who had molested Jackie. When the clinician suggested this group to Jackie, she was quite taken with the idea and was particularly fascinated by the notion of talking with the other girls who had been abused by the same man as she.

Later, Jackie admitted that the thought of meeting with a group of strangers had been a bit frightening. Even so, the experience turned out to be extremely helpful to her. She was able to realize that she was not the only young girl who struggled with certain issues. Something else transpired in the group that, ultimately, helped her relationship with her parents immeasurably. Jackie learned that when two of the girls in the group—one of them a victim of the same man as she—

had tried to tell their parents about being molested, the parents had not believed them. When Jackie heard that, she acted out against her parents in a way that typified her conflicts about attachment, dependency, and intimacy.

On the following weekend was her mother's birthday. An expensive dinner was planned for this occasion at an elegant restaurant. Jackie had never revealed to either parent the details of what the molester had actually done to her. She decided that this dinner was the ideal time to do so and started to tell her mother the horrible details. Her mother responded by saying, "For God's sake, I don't want to hear about that now." Naturally, a big scene ensued. Jackie stormed out of the restaurant, leaving her mother in tears. The therapist received two phone calls, one from a wounded Jackie who argued that she had finally tried to share what had happened with her mother and her mother had cruelly rejected her; the second call came from Corinne, who said that Jackie had intentionally tried to ruin her birthday party. The therapist, knowing that neither of these accounts accurately reflected what transpired, suggested some joint mother-daughter sessions. During these sessions, she helped Jackie and her mother gain an understanding of what had happened at the dinner. Jackie had wanted to tell her parents about what had been done to her for a long time but was afraid of exposing herself emotionally and causing her mother to reject her. So, unconsciously, she chose a totally inappropriate time and a public place with friends and relatives present, thus ensuring that her mother would respond negatively. Then Jackie could assume her angry, self-protective posture and storm out of the restaurant.

Once Corinne realized that what had transpired in the restaurant was not an attack but the defensive maneuvers of a frightened adolescent, she responded in a very appropriate and nurturing manner. Even then, Jackie went through considerable struggle before she could permit herself to be emotionally vulnerable to her mother without lashing out at her.

After this incident, Jackie's therapy proceeded quite well. By the time she was in the second semester of her senior year in high school, the clinician had been meeting with her only once a month and was preparing to end therapy when Jackie began to act out once more. She began to have temper tantrums at home; one day she hit her sister when the sister made a negative comment about her. Jackie also started cutting school again and, despite the fact that her grades were now Bs and she had been accepted for admission to a local junior college, she began to refuse to do her homework, claiming that school was just for stupid jerks. Besides, everything her parents said was "stupid," "dumb,"

or "wrong." The parents became panicked, seeing all the girl's progress begin to unravel.

The therapist realized that Jackie's sudden burst of acting out was being caused by her fear of graduating from high school, where she had just learned to feel secure and confident. Unconsciously, rather than face the risk of a new social environment—namely, college—Jackie was setting herself up to fail in her senior year so that she could remain in a familiar, comfortable environment. To resolve this transitional crisis, the clinician began to see Jackie weekly again and to meet more regularly with her anxious parents. During these sessions she confronted the girl with how she perceived her current behavior. The therapist also tried to help Jackie feel more confident about the social and emotional gains she had already made. In addition, she assured Jackie that the end of regular therapy sessions did not mean that she could not come back to see her if she had a problem in the future. The therapist continued to see Jackie until she had successfully completed high school and had been enrolled in college for half a semester.

Adolescence is a turbulent time of life when a young person is learning to "push limits" in an effort to begin the process of separating from his or her parents and set forth on the path to selfhood. Those who become the victims of sexual assault at this critical stage of development may become thwarted in fulfilling this quest. As a consequence, the treatment of an adolescent victim consists in helping her to resume the healthy developmental tasks of identity-formation and individuation. The therapist tries to sustain the delicate balance in an adolescent's struggle to replace the thoughts and feelings of a child with those of an adult. Another balance is fostered between the adolescent's need to depend upon her family versus her need to become an independent person. These tasks, when performed to the best of the therapist's ability, can be rich in intrinsic challenges and rewards.

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