WORKING WITH SEXUAL TRAUMA: Some principles of individual therapy with adolescent and pre-adolescent victims of child sexual abuse.

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This paper describes some basic principles of individual psychotherapeutic work with adolescent and pre-adolescent victims of sexual abuse. It first considers some general principles of individual work with victims, regardless of their age. Secondly it considers some issues that are particularly relevant to work with adolescent victims. It concludes by suggesting that individual therapy of this kind should be open ended and underpinned by an “open door” policy which respects the maturational needs of the victim.

The purpose of this paper is to describe some of the general principles that I have found to be important when working in individual therapy with adolescent and pre-adolescent victims of child sexual abuse (CSA). Most of the literature on individual work with victims of CSA is concerned either with younger children (e.g. Bannister, 1985; Hunter, 1986; Long, 1986; Waterman, 1986) or with adults (e.g. Douglas, 1988; Herman, 1981). Little has been written specifically about adolescent and preadolescent victims and, most of the literature about this age group is concerned with group therapy rather than individual therapy (e.g. Blick and Porter, 1982; Furniss et al., 1988).

Over the last four years I have seen over 40 adolescent and preadolescent victims of CSA, as part of the work of the child sexual abuse team (CSAT) at Dundee Royal Infirmary. Most of these victims were girls and all the work described here is with female victims. The work of the team has been described in detail elsewhere (Bryce et al., 1988). Wherever possible, all victims of CSA referred to the team are offered the opportunity of individual therapy: time for themselves to talk with a therapist about their feelings and confusions about what has happened to them and about how they see themselves both now and in the future. This description of “individual therapy” may seem rather vague and imprecise, but it captures the range of the different types of individual therapeutic contact that I have had with the victims. Quite often, factors outside the control of either the victim or myself have curtailed therapy (e.g. precipitate geographical moves by the victim's family, parental (usually maternal) reluctance for the victim to have any sustained individual contact with a professional). As a result, my individual contact with victims has ranged in length from a single session to weekly sessions for four years. The average length of contact has been three to four months.

Moreover, the nature and extent of the sexual abuse suffered by victims has varied enormously. At one extreme, some victims had been subjected to incestuous relationships of many years duration which included genital, anal and oral sex, while others were the victims of apparently one-off episodes of ‘extra-familial’ abuse. However, in keeping with Finkelhor (1986), I have not found it useful to assume that the nature or extent of abuse bears any necessary relationship to the trauma it engenders in the victim. (See also Will et al., 1988).

The structure of this paper is as follows. The first section considers some basic principles that underpin my individual work with victims of CSA of any age. The second section describes issues of
particular relevance to the adolescent age group. Finally, the third section makes some points about the length of individual therapy. The place of individual therapy with victims within the overall context of a child sexual abuse programme is considered elsewhere (Bryce, et al., 1988).

Some basic principles of individual work with victims of CSA

VICTIMS ARE ALSO YOUNG PEOPLE

The most fundamental principle of work with victims of CSA is not to approach them as though they are a unique species of client whose needs are radically distinct from those of other young people. As I shall describe, much of the work with victims is concerned with precisely the same kind of issues as work with any other group of young people: they will have to tackle the same maturational tasks as any other adolescents. So, the same Joyce Morrison sort of maturational focus appropriate in individual work with young people (e.g. Evans, 1982) is equally appropriate for victims of CSA.

However, the anxiety produced by the prospect of working with a youngster who has been sexually abused often results in professionals feeling deskilled and demoralised and unable to draw on the skills they may have already developed in working with other young people. As a result the worker may become mystified, and start to believe that working with victims is highly specialised work that can only be done by experts. While I do not wish to underestimate the stress that this work can and does engender, it is vitally important to demystify this. The same skills that apply to any individual psychotherapy with adolescents, apply equally to work with adolescents who have been sexually abused.

The need to get the victim to talk repeatedly about the sexual trauma is probably the most extreme form of this tendency to see victims of CSA as a unique species. It is not uncommon for professionals to focus their work with the individual victim exclusively on the trauma, in the mistaken belief that their aim should be to get the youngster to repeatedly re-experience the trauma (perhaps) in the hope that this will somehow allow her to ‘get it out of her system’. In practice, this usually has consequences that are at best insensitive - vital concerns that the youngster may have about her current situation are overlooked - and at worst may lead to the youngster gradually assuming the identity of a professional victim.

For example Maria, aged 18, had been subjected to extensive and horrific sexual abuse throughout her childhood. The professionals, who were currently working with her, requested a consultation with the CSAT, because they felt stuck and unable to help her. It transpired that two workers, one male and one female, had spent hours with Maria getting her to talk about her abuse. Maria was now an expert at this and had written a long and graphic account of her abuse, which both workers had read. They now felt paralysed, feeling that they could not possibly offer anything to someone who had experienced such appalling trauma. On discussion, it emerged that Maria’s life was in chaos and that the workers had become very muddled over fundamental issues to do with their respective roles. However, it had not proved possible for these issues to be addressed in an adequate way, because ‘letting Maria talk about her abuse’ had become the exclusive focus of the work. Unintentionally, the workers had been fostering Maria’s identity as a ‘professional victim’, as
opposed to seeing her as a young person with pressing maturational needs.

In the initial stages of therapy most victims are usually concerned with the more immediate demands of their current situation rather than with the abuse itself. If the therapist focuses exclusively upon the abuse, she runs the risk of being quite insensitive to the impact of these issues and hence runs the risk of treating the victim as a walking wound, rather than as a youngster who is deeply distressed about her current situation. In the period immediately following the disclosure of the abuse, the victim may be pre-occupied by two common consequences of disclosure rather than by the experience of the abuse. Her exposure to the disbelief of family members and/or professionals and her fears of family disintegration or rejection by the family.

**DISBELIEF**

If the family's reaction to the victim's allegations is one of disbelief, this often confirms fears that the victim has had prior to disclosing that she is being sexually abused. The fear of not being believed is often the reason that victims give for keeping their abuse a secret. For example, a 13 year old girl was unable to tell her mother about her abuse by a cohabitee, because mother had frequently accused her of trying to break up the co-habitation. Tragically, the girl's fears were confirmed when she disclosed the abuse. Her mother refused to believe her and disowned her, claiming that her daughter's accusation was merely a malicious attempt to drive the cohabitee out of the family. This is one of many cases in which the victim has feared that her mother will not believe her because the mother/child relationship has been difficult prior to the disclosure. In such circumstances, the early stages of therapy are often dominated by the profound feelings of helplessness and depression that such disbelief engenders.

Not surprisingly, victims who are anxious that their mothers do not believe them, often show similar fears about professionals. For this reason, virtually all the literature on individual work with victims stresses that it is vital for the therapist to make it absolutely explicit that she believes the victim's allegations. (See, for example, Bannister, 1985; Ciba Foundation 1984; Giaretto, 1977). This might seem self-evident, but it is a mistake to assume that the victim will take the therapist's belief in her allegations for granted, especially if her experience with other professionals has led her to believe that her word is doubted. Since most victims have had their trust in adults shattered as a result of their abuse, they usually start therapy wondering if they can trust the therapist and will soon pick up if she has any doubts about the truth of their allegations. Hence the need for explicit and often repeated assurances on the part of the therapist that she believes what the victim has told her. Despite such repeated assurances, the victim may continue to question and test out the sincerity and trustworthiness of the therapist.

**FEAR OF FAMILY DISINTEGRATION AND REJECTION BY THE FAMILY**

Many victims of sexual abuse have been subjected to threats from the perpetrator designed to discourage them from disclosing that they are being abused. These threats often include the twin spectre of family disintegration and rejection by the family. For example:
'If you tell, you will be taken away from the family'
'If you tell, I'll go to prison'
'If you tell, your Mum won't believe you and will be very angry with you'.

There is, of course, a reality to such threats, since family disintegration is often a consequence of the disclosure of CSA. In some cases, either the victim is removed from home for her safety, or the perpetrator is barred from the home or imprisoned. These real consequences of disclosure are usually more pressing concerns for the victim in the early stages of therapy than the reason for the break-up of the family, namely the abuse itself. Victims frequently feel responsible for the break-up of the family and this reinforces underlying feelings of guilt about the abuse which are discussed below. Moreover, if the victim herself is taken into care, this may be experienced as a confirmation of her feelings that she has been responsible for the abuse.

For example, Donna, a girl of 10 was received into care following her allegations that she was being abused by an uncle who lived next door. She became very angry with the social worker who had initiated the care proceedings and was able to express what she was feeling with the direct question: 'Why am I in a home if it's not my fault?'

This sort of response by victims has led some professionals to question whether removing a child from home is justified, since it may compound the child's sense of victimisation and can, it is argued, be more harmful than the abuse itself. I do not share this view. If the alternative to removal into care is that the child continues to be subjected to sexual abuse, then the child must be protected. Distressing as this may be for the victim, the consequences of long standing CSA to the victim's development are often catastrophic and not removing the child colludes with the abuse and its effects. Moreover, if the victim is protected, it is possible to work with her and provide her with support to work through the feelings of loss, abandonment, anger and guilt that are engendered by the abuse and removal into care. (I was able to do this over four years with Donna, mentioned above). In contrast, it is virtually impossible to do any meaningful therapeutic work if, as sometimes happens, a CSA victim remains at home, in the abusive situation, because there is insufficient evidence to remove her from home.

In such circumstances, victims will rarely accept the opportunity to leave the home. Instead they 'accommodate' to the risk of abuse as described by Summit (1983). For example, Kim, a 14 year old girl, had recently disclosed abuse by her father, which had occurred some years previously. Her mother had not believed her, but Kim accommodated to this by investing her mother with the ability to detect and stop any further sexual abuse that her father might attempt. She also contended that, despite the fact that she had kept the abuse a secret for several years, she would be able to confide in her mother at the first sign of any further exploitation.

FEELINGS ABOUT THE ABUSER

It is wrong to start therapy by assuming that all victims hate their abusers, since some victims have profoundly mixed feelings which may compound their feelings of guilt about the abuse. It is therefore important to try to establish, early on in therapy, just how victims
do feel about their abusers. This is especially important if there has been no violence, threat or physical coercion involved in the abuse, since it is more likely that some positive feelings towards the abuser may remain.

For example, Jill was a nine year old girl who had been abused by her maternal grandfather for several months. Her mother had also been abused by this man as a child. The relationship between mother and daughter was very poor with little or no warmth and Jill was very fond of her grandfather who, apart from the abusive element of the relationship, offered her affection and warmth that she otherwise lacked. She was furious with her mother for stopping contact with her grandfather and the relationship between mother and daughter continued to be difficult.

It is important to address a victim's feelings of ambivalence towards the abuser, first because to deny them is counter-productive to therapy, since they constitute an important aspect of the victim's emotional reality. Secondly, it is important to acknowledge the guilt that positive feelings for the abuser are likely to engender and to help the victim put this guilt into perspective.

A crucial point to bear in mind when working with ambivalence towards the abuser, is that it must not be mistaken for willingness to participate in the abuse. Many victims find this distinction hard to make, and for this reason may find it extremely difficult to talk about this area, since they feel that to acknowledge positive feelings for the abuser is equivalent to accepting responsibility for the abuse. If the professional working with the victim is unwilling or unable to discuss this possibility with the victim, this will only serve to confirm the victim's misperception. This in turn will compound the victim's irrational sense of guilt about and responsibility for the abuse.

The essential point to bear in mind is that the positive feelings for the abuser are usually a reflection of the fact that the relationship with the abuser provided some emotional nurturance for or otherwise deprived child. For example, both Jill and Anna, mentioned above, had very little nurturance from their mothers. In both cases, the relationship with the perpetrator initially provided this much needed nurturance and the abusers then exploited both girls' emotional deprivation, and their attendant needs for nurturance, by initiating the sexual abuse. So although their emotional needs were exploited, both girls received something they both needed in the relationship with the abuser. Hence their ambivalence about the abuser.

In working in this area, the essential principle is to help the victim understand the roots of her ambivalent feelings towards the abuser. This usually involves teasing out the different components of the relationship, clarifying the general emotional neediness that attracted the victim towards the perpetrator, often relating that in turn to the poor quality of the victim's relationship with her mother, and then helping the victim to see that the sexual abuse was an exploitation of her emotional neediness by the perpetrator. This exploitation contaminated the good relationship but did not obliterate all the positive feelings the victim felt for the perpetrator. Gradually, the victim can be helped to understand that her positive feelings for the perpetrator do not mean that she was responsible for the abuse, and gradually the ambivalence towards the abuser can be tolerated without overwhelming feelings of guilt.
POWERLESSNESS

Associated with the feelings of guilt that underpin the issues that I have already described, many victims have a very low sense of self-esteem accompanied by feelings of worthlessness and badness. Such feelings are a consequence of feeling violated and disempowered. Finkelhor (1985) has vividly described how several aspects of the traumatic experience of being sexually abused can contribute to the feeling of powerlessness.

A basic experience of powerlessness occurs when a child's territory and body space are repeatedly invaded against her will. This is exacerbated when coercion and threats are elements of the abuse. Powerlessness is then further reinforced when the child attempts to stop the abuse, but is unsuccessful e.g. when the perpetrator pays no heed to the child's protests. This may then be compounded if a child does manage to make a disclosure but is not believed or taken seriously: her sense of powerlessness will be further intensified. Conversely, if a child is able to bring abuse to an end or at least exert some control over its occurrence, this may mitigate the experience of being disempowered.

Such a mitigation is rarely complete, and the victim's feelings of powerlessness usually play a major role in therapy, particularly in its early stages. Thus the therapist is frequently confronted with testing-out behaviour by the victim, who is unable to trust the therapist not to exploit or reject her. Thus victims may fear the intimacy of the therapeutic situation, initially experiencing it as a site for further abuse, and may distance themselves from it by not attending sessions or by being verbally aggressive or remote from the therapist.

For example, Donna, the ten year old mentioned above, remained in therapy for four years, until she was established in an alternative, and permanent, family placement. At different stages, during this course of therapy, she went through periods of sitting with her back to me, making it clear, from the start of the session, that she was not going to talk to me that day. On one such occasion, she took great delight in 'slaughtering' me at a game of dominoes.

The victim's fear that the therapist will reject her may lead to the kind of testing out behaviour shown by deprived youngsters in individual psychotherapy. A common source of such fears of rejection is the idea that the therapist will be disgusted by the details of the abuse and will blame the victim.

Donna, again, showed such a pattern of response. In one session, early in her therapy, she told me that, during a recent visit home, she had been left in the company of two adult males, who had danced with her, while her mother and step-father had gone to bed. Her own self esteem was so low that she expected me to blame her for what had happened. She knew that I would see it as an example of her being placed at risk, and so she prefaced her account by saying 'You're not going to like this'. The rest of this session was taken up by our addressing her fear that I would disapprove of her and hold her responsible for what had happened.

Some additional issues in working with adolescent victims
In this section I shall consider some issues which are more specific to work with adolescent victims of CSA. They appear to me to be equally important when considering both CSA that has occurred only during adolescence and CSA which is only revealed at adolescence although its occurrence predates this period. I shall consider three main areas: first, the disclosure of abuse, secondly the victim’s current sexual development and thirdly the victim’s relationship with her mother. I shall end by considering the issue of the length of therapy.

THE DISCLOSURE - WHY NOW?

It is important to establish, early on, the answer to the question ‘why now?’: what is it in the adolescent’s life which has prompted her to disclose the abuse at the time that she has? One common precipitant of disclosure is the adolescent victim’s increasing needs for independence and relationships outside the home, especially relationships with boys.

For example, Julie, a 17 year old girl, had been abused by her stepfather over the previous 18 months to the point of intercourse. The abuse finally came to light when she began to resist her stepfather’s advances and he physically assaulted her. Julie had been going out with a boyfriend for several months and her fondness for this boy contributed decisively to her decision to try to end the abuse. Prior to her disclosure, the step-father had been obsessively jealous of Julie’s relationship with her boyfriend. He would take every opportunity to denigrate the young man and would phone Julie several times every evening from his work, in a desperate attempt to keep tabs on her movements.

In Julie’s case, the tension between the demands of her step-father and her own maturational needs to be more independent finally led to her abuse being disclosed. In other cases, the stress of keeping the abuse a secret can finally prove intolerable.

For example, Paula, aged 14, who had been sexually abused by her step-father for four years, felt that the strain of keeping the abuse a secret was interfering with her ability to concentrate on her schoolwork. She had previously coped with the abuse by concentrating on her academic achievement, which was the main source of her self-esteem. When this began to be threatened, she could no longer tolerate her situation and told a colleague of her mother’s about the abuse. Once again, it was when the abuse began to come into conflict with a major maturational task of adolescence - the development of a school/work identity - that disclosure occurred.

CSA AND ADOLESCENT SEXUAL DEVELOPMENT

Clearly the maturational task that may be most obviously affected by CSA is the development of a sexual identity. One major difference in work with adolescent victims, as opposed to child victims, is that adolescents are much more able to consider how their experience of abuse might affect present or future relationships with boyfriends or with marital partners.

Some victims have said that they will never be able to trust males and recoil from physical contact out of fear of being overpowered and exploited.
For victims who are interested in establishing heterosexual relationships, the issue of whether or not to tell their partner about the abuse often assumes considerable importance.

For example, Julie, aged 17, who is described above, had severe apprehension about disclosing the fact that she had been sexually abused to her boyfriend. She felt that she wanted to tell him but feared that he would be disgusted and reject her. Since this was a serious relationship for both of them, and they were thinking of getting engaged, (they are now married), Julie inevitably began to think of the dilemmas that the future would hold if she did not tell him. 'How could I explain to my husband, if we have children, why I would never leave them alone with my step-father'. The prospect of a future fraught with such secrecy appalled her and she plucked up the courage to tell her boyfriend.

In my view, this represents important prophylactic work. From my contact with an incest survivors group, I have been struck by the great stress that keeping the secret of CSA can place on a marriage. Similarly, adult victims who are experiencing sexual problems in their marriages, may be loth to let their partners know about the roots of their sexual difficulties. By this time, the partner may have established a relationship of many years standing with the perpetrator (e.g. the victim's father or stepfather) and there is often considerable anxiety on the victims' part that their partners will either turn on them for 'lying for years' or will wish to 'kill or maim' the perpetrator. To avoid such chronic stress, I feel that it is always advisable for a fiancee or husband to be told the truth as soon as possible, provided, of course, that the victim is prepared to do so.

An even more difficult issue for adolescent victims is the fear that history will repeat itself and that their own children will be sexually abused. This most commonly occurs when the victim's own mother was herself abused as a child and the victim is aware of this. As knowledge about CSA becomes more widely available, this will be a question that is going to be asked by many victims. For several victims that I have worked with, this question has usually carried with it the implication: 'How can I ever trust a man again.

THE VICTIM'S RELATIONSHIP WITH HER MOTHER

A great deal has been written about the anger that many victims of CSA feel towards their mothers because they have not protected them and this is seen by several workers as suggesting that the mother/daughter Furniss, 1983; Giaretto, 1977). In my own experience of working with adolescent victims, I have rarely encountered explicit expression of anger towards mothers and the more common response has been a very different one. Many victims have expressed fierce loyalty to their mothers, which has endured during therapy and cannot, I think, be dismissed as a superficial reaction formation against underlying feelings of anger. I have encountered this loyalty towards mothers even when the victims knew that their mothers themselves knew that abuse was going on, that is, in cases where the mother could, to some extent, be seen as being implicated in the continuing abuse.

One hypothesis that could explain this unexpected finding, is that these 'loyal' daughters had occupied an inappropriate parental role in the family and were reluctant to give it up. This is in keeping
with some of the earliest descriptions of the incestuous family (such as Lustig et al., 1966) which stressed that the victim often occupied a maternal role more global and extensive than her role as father's sexual partner. The loyalty and indeed protectiveness that these victims feels towards their mothers is a result of their role reversal with their mothers, towards whom they feel protective, solicitous and loyal.

For example, Angela, aged 15, was an illegitimate child, born before her mother's marriage to her step-father who sexually abused her for several years. Angela and her mother had been through many traumas together and shared a closeness that was not present in the mother's relationship with her other children or with her husband. When Angela revealed the abuse to someone outside the family, the mother steadfastly refused to listen to one word of what Angela said. In her role of parent to her mother, Angela felt she had to protect her mother from upset or worry. As a result, she had suspended her adolescence refusing to go, out with her friends to discos and the like, saying that she much preferred staying in at home. She said that she had upset her mother so much by the disclosure that she was determined never to give her cause for worry again (see Morrison and Will, 1987).

Similarly, the mother of Jenny, aged 13, who had been sexually abused outside the family, expressed the view that her daughter had gone to the abuser's house of her own accord, implying that Jenny had been a willing participant in the abuse. Far from being angry with her mother, Jenny felt that she required punishment. So when the question of a children's hearing being called was mooted, Jenny supported this idea, seeing it as the kind of punishment she deserved. As with Angela, Jenny, from an early age, had been given and had taken inappropriate responsibility for her mother's welfare and was very powerful in her ability to regulate the relationship between mother and cohabitee.

In both these cases, the inappropriate parental positions that these girls occupied in the family both predated the abuse and had a profound effect on how they coped with their mother's reaction when the abuse was disclosed. The disclosure reinforced their roles as maternal protectors, since the revelation that abuse had occurred was a major stress on their mothers, a stress, moreover, for which Angela and Jenny both irrationally held themselves responsible. As a result their pseudo-parental roles in their families became drastically reinforced so that the normal adolescent social development came to an abrupt halt. Therapy with both girls was aimed at helping them become aware of the inappropriateness of their roles in the family, often in quite blunt terms e.g. 'you're sacrificing your own life for your family' and by capitalising on the normal adolescent drives towards maturation e.g. they both responded to the idea that they were often envious of their peers who were out having fun, while they stagnated at home. Gradually it became possible to encourage them to explore their feelings about, on the one hand being parents to their mothers, and, on the other, being told off and treated like children by them.

HOW LONG SHOULD THERAPY LAST?

As I have already indicated, the length of individual therapy, in the cases I have treated, has varied widely from as little as one meeting to as much as weekly sessions for four years. The early drop-outs
have been adolescents who have used their initial session(s) to give an account of their experiences, but who have been either unwilling or unable to continue to explore the feelings associated with their abuse. In two cases, victims have re-made contact with me, following critical events in their life. For one 17 year old, this was precipitated by the first 'Childline' television programme.

In the case of Donna, who attended for four years, it was probably important that, throughout her therapy, she was the subject of a compulsory supervision order and was brought to sessions by her social worker. This external source of authority was very useful in helping her maintain her attendance during some very stormy periods when powerful transference issues were addressed. There were many occasions when, had the choice been left to Donna, she would not have come and her therapy would have ended precipitately.

It is not uncommon for the family to 'abandon' the victim to individual therapy. This usually follows one or more family meetings where the exploration of feelings in a family setting has been very difficult and has been strongly resisted by family members. Often the suggestion that the victim could benefit from the opportunity of discussing her feelings in individual sessions is met with enthusiasm, unmatched by that aroused by the suggestion of continuing with concurrent family work. In these circumstances the less than ideal outcome of individual work with the victim with no family work is the best that can be achieved.

Not uncommonly, the outcome is worse. The family may be ambivalent about even the victim's attending for therapy. Mothers and fathers will say that the victim should put the past behind her, forget about the abuse and stop attending for therapy which just 'stirs up' a lot of painful memories. In these circumstances, encouragement by other professionals, such as the victim's social worker, is rarely sufficient to prevent the victim's dropping out of therapy.

The most extreme form of lack of familial support for the victim to attend occurs when the victim's allegations are not believed by the family and, in the absence of any corroborative evidence, she remains in the same household as the perpetrator. I do not believe that it is possible for the therapist to sit on the fence in these circumstances. If I believe the victim's allegations, I make this clear to the victim and to the family, who are almost invariably outraged by my suggestion that the victim requires help to deal with such a difficult situation at home. Few victims are able to maintain attendance in the face of disbelief from the family, but, nevertheless, they may benefit from having their allegations taken seriously by the therapist.

LIFE CRISES AND THE OPEN DOOR POLICY

Both my own experience of working with adolescents and what I have learned from contact with an incest survivors group, suggests that the effects of child sexual abuse on the victim alter as she proceeds through maturation, experiencing important life cycle events such as her first serious sexual relationship, marriage and the birth of children. Such events often represent critical periods in which the traumatic effects of the abuse are experienced in new and often devastating ways. I have described above how the prospect of becoming engaged led to Julie's having to confront the question of whether or not to tell her boyfriend about her abuse.
Becoming a parent can also precipitate confusing emotional conflicts for victims. Thus, one incest survivor described to me, very graphically, the tension in her relationship with her ten year old son and related her difficulties with him to his burgeoning male sexuality. She could not dissociate her son's masculinity disempowered by her sexually abusive father.

Experience of situations such as these have led me to the conclusion that an adequate therapeutic service for victims of child sexual abuse must offer more than merely helping victims with the immediate aftermath of disclosure. The effects of child sexual abuse are such that they may become reactivated at different stages in the victim's development. The therapist should be prepared to respond to such developmental crises by maintaining an 'open door' policy for patients. It may well be that the therapy for adolescent and pre-adolescent victims should best be seen as an inevitably episodic process. A certain amount of work can be done with the prepubertal child, but it is only with puberty that the dilemmas posed by the reality of her sexuality can be fully addressed. The same principle probably holds throughout the life cycle, but more clinical experience and research is required before we can feel confident about this. However, one thing is certain, there will be no shortage of victims who require help.

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