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A twenty-year-old adolescent victim of incest

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Summary

Author describes in this work the course of the psychotherapeutic treatment of a twenty-year-old adolescent who, at the age of 12, became a sexual abuse victim by her father. As she was growing up, she was exposed to other forms of violence and developed an insecure attachment. She became insecure, obedient, isolated, ashamed, with an enormous fear of her father. Trauma-focused cognitive-behaviouristic therapy (TFCBT) was implemented with an eclectic approach (genogram, drawing, associative cards, guided fantasies) and psychoeducation. For seven months, weekly one-hour long sessions took place. Client interrupted treatment due to changed life circumstances. Besides difficulties in psychotherapeutic work with young victims of incest, topics here are also contextual factors and consequences for the psychotherapeutic treatment.

***Key words**: incest, child abuse*

Sažetak

Autorica u radu opisuje tok psihoterapijskog tretmana dvadesetogodišnje adolescentkinje koja je u uzrastu od 12 godina počela bivati, žrtva seksualnog zlostavljanja od strane oca. Tokom odrastanja bila je izložena i drugim oblicima nasilja. Odrastajući u nasilju razvija nesigurni atachment. Postala je nesigurna, poslušna, izolovana, postiđena, sa ogromnim osjećajem straha od oca. U psihoterapijskom tretmanu primjenjena je Kognitivno biheviroalna terapija usmjerena na traumu (TFCBT), uz eklektički pristup (genogram, crtež, asocijativne karte, vođene fantazije), te psihoedukaciju. Psihoterapijski tretman se odvijao jedan put sedmično, sat vremena, u periodu od sedam mjeseci. Prekinut je željom klijen-

tice zbog životnih okolnosti u kojima se našla. Osim poteškoća u psihoterapijskom radu s mladima žrtvama incesta, tematizirani su kontekstualni faktori i posljedice za psihoterapijski tretman.

***Ključne riječi**: incest, zlostavljanje djece*

Introduction

Generally – violence is a tool for those in power to show or reinforce their control over those that lack it. almost every relationship with disrupted power balance has a potential for violence to be manifested – by a more powerful person towards the less powerful one. In the USA, one to four girls and one to six boys are abused (Mitchell, 2010). European data shows that one of five children are sexually abused (Council of Europe, 2010). Bosnia and Herzegovina has no official record on abuse. In our society, and wider, the topic of incest is still a taboo, although media increasingly exposes such cases. Not reporting it right after the first act of abuse, but after a significant time passes, makes it worse. Reasons are numerous: usually the child or a close family member are not believed it has been done; family moral norms, in the psychological sense, rule out a possibility it can happen within the family; shame if others find it out; sometimes, due to family dynamics, the child is unaware of what is happening to them, especially if there is no aggressiveness or intimidation. Depending on the age, consequences occurring are more complicated and lasting for a person who experienced abuse.

Meeting and the first session with the client

The first contact with the client was in the Centre for therapy and rehabilitation. It is a center dealing with psychotherapeutic treatment for victims of war, domestic violence and sexual abuse. Case-dependent, treatment in the Centre is conducted on outpatient basis or in the stationary. The intake team decides on it in agreement with the client or her family.

Client was brought by the police in the Centre after she reported abuse and, according to the protocol for such cases, medical examinations (including a gynecological examination) was conducted at the Clinical Centre. She stated she could not take the pressure and abuse she was exposed to anymore. The decision to report it, replaced fear and shame she felt, regardless of the consequences it could bare, with which her father threatened.

Upon intake: a beautiful twenty-year-old girl, middle height, undernourished.

She seemed sad, depressed and confused. She often sighed. She told her story quietly, intermittently crying, exhausted, with her head down, without looking at the social worker taking her statement.

Those were only bits and parts of what she would later tell in the psychotherapeutic sessions. She worried about her mother and younger brother. Experience she had did not provide her with trust in people or in what she was told: that she was safe now, that her father does not know she reported him and that he will be arrested. She comes from a family in which violence (all forms except for sexual abuse) was performed on daily

basis by her father - on her mother and brother, too. The stationary was recommended to ensure isolation and security from the perpetrator and provide conditions to start the treatment. First, the doctor estimated her to be: aware, afebrile, eupnoeic, oriented in time and space, towards herself and others, answering questions adequately, affects follow mimics, depressive, scared, confused and not suicidal. Without visible outer wounds. The intake team consists of the medical doctor, nurse and social worker. To make her feel secure, she was provided a crisis intervention. After three days, she left the Centre self-initiatively. She returned home to her mother and brother, worried the father would harm them because he still was not in jail.

Phases of the therapeutic work

Treatment required a complex, multidisciplinary approach. For this case, a small team was formed: psychotherapist, doctor, social worker and lawyer. Each team member has set tasks from their domain. Plan is made individually. Increasingly used in sexually abused children treatment, trauma-focused cognitive-behavioristic treatment was implemented. Treatment is conducted in phases, so to gradually expose to the traumatic context decrease anxiety, reduce and overcome symptoms of avoiding, creating capacities of incorporating experiences, which would open possibility to work on distorted cognitions and reach a modelling of adaptive confrontation (Bilić V. et all, 2012). ***The first phase*** is a preparation for the next phase where trauma should be worked through. Techniques and interventions are used, appropriate to the age and type of traumatic experience. In the ***first*** phase, therapist and psychotherapy represent supporting figures and a safe place where clients can remember their painful childhood memories and explore to them (Corey, 2004). In ***the working through phase*** the aim is a gradual confrontation with traumatic experiences until there is no emotional agitation or avoidance. Gradualness is very important. According to (Cohen and Mannarino, 1997) it takes one third of the entire treatment duration. A change of cognitive distortions is implemented; the intensity of “triggers” and negative emotions are reduced; the sense of control over memories is developed or increased; new coping strategies are learnt; they learn again to understand traumatic event and consequences of trauma through psychoeducation. All of that is needed to “design” trauma integration, positive self-image development and an optimistic vision of the future. It is not an easy job and it requires time, patience and understanding. In working with children, it is necessary to take care of the traumatic event hierarchy development. Each step needs to be sufficiently difficult to challenge anxiety, but simple enough for a child to believe that they can overcome it. After they successfully confront that step, it continues towards a scarier memory, and ending with the scariest one. In the ***first*** phase, traumatic memories are several times reconsidered so that the child would be become sufficiently confident to confront them without fear. It is important to reduce the feeling of anxiety over time (Cohen and Mannarino, 1997).

To enter the phase of exposure to trauma, the quality of family relationships and social resources, existing beliefs and values and the child's life circumstances stressfulness are important (Bilić V, et al, 2012). However, TFCBT is not a therapy of choice in cases of an explicit resistance, compromised intellectual abilities, and especially suicidal tendencies, severe depression and changed, dangerous behaviour for the environment and the individual. The feeling of anger and difficulty to express are a part of the sexually abused children symptomatology. (Bilić V, et al, 2012). ***Psychoeducation*** teaches them what traumatic event is, the usual reactions of children and parents, the symptoms and possible related disturbances, and information on every step of the treatment. Correction of misleading beliefs about sexuality and information on healthy sexuality in cases of sexual abuse and compulsory consent of parents (in juvenile children) are important in psychoeducation in the field of sexual education.

In sexually abused children boundaries are breached, fluid. Sexual abuse does not respect boundaries (Buljan Flander G, Kocijan Hercigonja D, 2003).

For the beginning of the work with the client, key moments were to build relationship, trust and empathy and insight into resources - increasing the existing and building the new. Her self was not built, she did not have a self-image, and those parts that were present, were a negative image without self-confidence, validation, without seeing anything positive she had. Her attachment is insecure. Also, she had other consequences of a sexually abused person in a form of a posttraumatic stress disorder (PTSD) (insomnia, lack of concentration, flashbacks, constant anticipation of danger, lack of appetite) depression, anxiety, consequences in the field of sexuality, physical consequences such as frequent stomach-aches, interpersonal relationships, social functioning, with present cognitive distortions and symptoms of a dissociation and avoidance.

In the first phase it has been worked on the preparation for phase when she should enter the trauma. During the first sessions, genogram showed the existing relations in the family and that the client had a supportive person, her grandmother, that loved and supported her a lot. Grandmother did not live with them but the client had a phone contact with her and occasionally visits. Several techniques for identification and differentiation of emotions were used: character drawings, associative cards. Working on emotions is important for recognising relationships between negative emotions and reminders of trauma, adopting skills that enable talking about emotions with others but also for emotional management. Guided fantasies that were sometimes projective, in a sense of enlightening some resources she would later use while facing stressful situations, or trauma triggers. She has built her "safe place" and used it when she felt lack of energy, fear of the father, after having nightmares she could not cope with. For the purpose of learning coping skills with daily stressors, dealing with traumatic event(s) during therapy and reducing intensity of symptoms related to trauma, in this phase breathing skills and progressive muscle relaxation were learnt.

The client occasionally brought in dreams that had a content of nightmares of the survived. Those topics cannot be neglected and simultaneously deepened because conditions for a deeper working through the trauma were not yet created. Interventions were very careful with psychoeducation on trauma, recognition and definition of emotions. During the work in the first ten to twelve sessions (approximately three months) there were some current events that required counselling and crisis intervention. The client, her mother and brother, were exposed to verbal attacks by the family and her father. The role of her mother, who "woke up" in a support and care for the client, was important. Now, for the first time, her mother provides a selfless support. She was also in the psychotherapy with another psychotherapist. The relationship between the mother and the daughter was disturbed. The client was extremely angry at her mother for not protecting her when needed.

Parallel work with the both of them resulted in the client showing compassion and understanding for the mother's situation. Finally, she had a mother as a support to carry on. It was a significant point in the work because it is vital to involve parent(s)/guardians for several reasons: reducing problems in behaviour and depressive symptoms in the child (Deblinger et al., 1996); parent's emotional reaction to trauma is the strongest predictor of the treatment result (along with the type of treatment) (Cohen and Mannarino, 1996). Parent's support is significantly related to reducing the symptoms in children (Cohen and Mannarino, 1997). Empathy and support she received made her braver. Working on restructuring of negative cognitions she had was important. She confirmed what she thought about herself and how she saw the world around her. The aim was to develop, or at least try to, suitable attributions and cognitions about the event, and avoid consequences related to distorted interpretation of the traumatic event and self-image. It was a difficult work. Usually it was self-blaming ("everything is my fault, why did I not report it before, maybe I should not have reported it now, etc."), then exaggeration of danger ("what if he goes out and from the prison find someone to kill us") -she had a great fear of father as she remember previously experienced violence. One of cognitive distortions was from the domain of the changed perception of the environment: she occasionally mentioned that "Everybody knew what was happening and they did not get involved" and states "They knew father did many other bad things to others, as well."

During the psychotherapeutic work, client's memories of sexual abuse in early childhood were not reached. It is possible that there was no incest at that time, or that trauma is buried deeply, which happens in painful experiences in order to "survive". There is also the abuser-manipulator who intermittently loves and threatens, convinces the child in lies and craziness, so the child-victim is not quite sure what really happened (Courtois, 1988).

In the working through phase, the client resisted or avoided to talk about anything related to the abuse. At that time her father was released and tried from the freedom. Encountering her father again, even in the presence of the police, triggered her fears

and images of the experienced. The client described that encounter on four pages. She wrote she could stand his gaze. She felt safe because the mother and the police were there. That night she did not slept well. She noticed she had a lower level of anxiety, more awareness of being protected. These client insights are important for the continuation of working through the trauma. We continued on making a description of the traumatic event. The aim it to expose and process. Interventions depended on the reactions the client showed. The client came weekly to sessions, which positively affected reducing anxiety in sessions. Regularity and continuity of sessions are important because long periods between sessions increase fear intensity. Positive effects of previous psychotherapeutic work are obvious: though present, level of anxiety is lower, there is less feeling of guilt and more self-efficiency. That was an important insight. Slowly she began to feel proud for reporting abuse. She found a temporary job in a store. Living together with mother and brother gave her sense of belonging and security while father was in jail. Occasionally she seemed satisfied. What could be felt in each session, was the presence of insecurity and fear of the court trial verdict but also great expectations that the justice will be served. Punishment meant justice and justice provided freedom and possibility of life in a better future. Punishment is something her father earned, and in her fantasy "suffered" for what he had done. She completely denied possibility that it may be inadequate or he might be freed. Denial was her usual defence mechanism. These moments in session were another confirmation of the state of the self and the need for a long-term work of the self: the question of identity, possible borderline personality disorder, body-image distortion, atypical depression. A psychological evaluation was necessary.

Suddenly she got into the end phase because the court decision was inadequate. Due to new circumstances the previous phase was not completed. When she heard the verdict was not even a minimal sentence, the client went into an emotional crisis. She was lost. She went back into the state of a total fear, helplessness, lack of trust towards the world and the environment she lives in. That changed the psychotherapeutic course: partially set back, unfinished and in crisis. Due to severe counter-transfer reactions the psychotherapist became aware of, it was impossible to find adequate "tool" to repair the new situation. The client has, after several crisis intervention sessions, self-initiatively interrupted the treatment. She got married suddenly and thoughtlessly as a way of protection from the father. She did not respond to the proposed continuation of therapy.

Conclusion

Though still a taboo, sexual abuse of children is not a new topic. The case describes the complexity of growing up in a violent environment, exposure to violence and its permanent consequence. Often recovery depends on the influence of context in which the child is growing up.

Psychotherapists working with child sexual abuse are at risk of severe counter-transfer reactions and possible unconsciously occurring roles in the client but also the therapist (Gruden, 1992). Supervision of the professionals is an essential for the work in this field.

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