"Treating abused adolescents"
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CHAPTER ONE

Adolescence and Abuse: An Overview

Jennifer was referred to me shortly after giving birth to her daughter, Janine. Jennifer was 13 years old, with a look of fear and excitement in her eyes. She clung to her infant desperately and begged for reassurance that she would be allowed to keep the baby. She was living with a foster mother who was willing to care for both Jennifer and Janine; this was Jennifer's seventh foster placement.

Jennifer had been sexually abused by her mother's boyfriend when she was 2 years of age. The sexual abuse was extensive, and she required medical hospitalization for a sexually transmitted disease. She was removed from her mother's care and placed in an emergency foster home for a period of time. After the court terminated the parental rights of Jennifer's mother, she was transferred to a foster/adoptive home. The adoption was almost completed when the adoptive mother became physically ill and was no longer able to care for Jennifer, now an active 4-year-old. Jennifer considered this woman her mother and remembered being carried away from her home in tears. She then moved to three more foster homes in the next 6 years and did not allow herself to care for the people she lived with. At age 10, she ran away and lived "on the street" for approximately 9 months. She was taken to a hospital with pneumonia and released to the authorities, who once again placed her in a foster home. She got into fights at school, hung out with the "drug crowd," and cut school a lot. At age 11, she ran away again and was picked up for prostitution. She was sent to yet another foster

home and this time seemed to respond well to the foster mother, who made concerted efforts to spend time with her and talk with her. Jennifer stayed in this foster home until she ran away with her boyfriend, a 22-year-old street peddler. After 8 months, her boyfriend "dumped" her and got a new girlfriend. Jennifer was again referred to protective services when she was picked up for panhandling. A medical examination revealed her to be 4 months pregnant, and she was returned to her former foster parent at her request.

Jennifer pleaded with me for a chance to love and take care of her baby. "She and I belong to each other," she stated. "No one is gonna love her like I can, and no one cares about me like she does." She was absolutely compelling and heartbreaking as she grasped her child tightly to her. "We belong to each other," she repeated. "I'll never let anything hurt her. I'll make sure she has everything she needs. I can do it–I want it."

Jennifer remained in her foster placement beyond the age of majority. Her foster mother, Glenna, became the parent she had never known; the three of them became a family, with baby Janine calling Glenna "Granny." Giving birth to Janine gave Jennifer a sense of identity and purpose. She had been unable to find the motivation to forge ahead on her own behalf, but she was adamant that she would succeed for her child in order to give her the kind of life she herself had never known. Although this type of rationale appears with regularity in work with teen mothers, in Jennifer's case it did not backfire, as it does with many other youngsters. Jennifer's motivation was fueled by her own sense of maternal deprivation, coupled with the fact that she had fortunately been able to receive love from and give love to her foster mother, Glenna. This positive relationship with Glenna was probably what gave her a model to follow–someone who could provide consistency and strength, in spite of the hard work and patience required.

Jennifer had suffered severe deprivation and loss as a child. She never knew her father; she was sexually abused as a toddler; and then her mother's inability or unwillingness to care for her resulted in termination of parental rights. Another early attachment to a potential adoptive home had been terminated abruptly when the

adoptive mother became ill (and later died). Clearly, Jennifer had lacked parental nurturing and guidance, and had never developed a sense of belonging. Her first serious romantic attachment also resulted in disappointment and pain as she was unceremoniously replaced.

In spite of the overwhelming problems she encountered in her childhood, Jennifer emerged a strong and determined youngster, who elicited and returned her foster mother's care and concern. When she learned of her pregnancy she felt "reborn," as if now she had a chance to give to someone else what she had not been given.

This youngster's resiliency is remarkable and is a tribute to the human instinct to thrive and survive in the face of great obstacles. And yet the same hardships that Jennifer faced challenge thousands of youngsters, not all of whom are able to find the inner resources, engage in a positive relationship with another, or find the motivation to persevere.

Child abuse and neglect are powerful deterrents to healthy growth and development. How some children find the strength or the willingness to keep trying boggles the mind. And yet many of us are in a position to have therapeutic relationships with adolescents who have been abused, and we have an opportunity to contribute something to their development–at the very least, a new experience about the possible rewards of human interactions.

This book is about adolescents with histories of current or past abuse. It describes how the lessons of abuse affect them, and how they "act out" in attempts to get attention and help. It also describes how we can help, and how helping adolescents is often difficult because they fight our best efforts. Their resistance, however, must be understood in the context of safety: As long as they continue to feel unsafe and distrustful, they will stay on guard. When they feel cared about, they may feel more frightened than ever. Finally, when they recognize that we won't be scared away or discouraged, they may give us the opportunity and privilege to be of assistance. A recent *Time* magazine article ("Generation Excluded," 1995) discusses the Carnegie Council on Adolescent Development's (1995) report entitled *Great Transitions,* and notes a "disturbing portrait of

America as a dismissive and preoccupied parent, a country trying to wish away the troubles of its teenagers" (p. 86). The report shows that it is at the phase of adolescence that parental involvement in school activities drops off. One of the report's prescriptions is for health professionals to increase their efforts to educate and treat adolescents. I think it behooves us all to become better informed and more involved in assisting adolescents who experience an array of concerns: some emerging during adolescence and others experienced during childhood and related to parental maltreatment or underinvolvement, lack of guidance and structure, family conflict, or family dysfunction.

Before I go on to examine the extent and impact of abuse of adolescents, it is useful to consider what we mean by "adolescence" itself, as well as some of the assumptions we all make about adolescents.

WHAT IS ADOLESCENCE?

The development of "adolescence" has political and social roots that are only a little over 100 years old (M. A. Straus, 1994). At one time (before the period spanning the 1880s to 1920s), individuals who would now be considered adolescents were expected to work as soon as they were strong enough physically (Katz, 1981). They contributed much to the economic and social stability of their families (M. A. Straus, 1994). Marriages were frequently arranged, and what one's family needed determined one's future (Gillis, 1981).

The Industrial Revolution (M. A. Straus, 1994) resulted in considerable social policy reformations: The juvenile and adult justice systems were separated, high school was made compulsory, and the first child labor laws were passed (Janus, McCormack, Burgess, & Hartman, 1987; M. A. Straus, 1994). It also increased the need to be educated in order to be economically successful (Barker, 1990; Janus et al., 1987). In addition, new types of industrial jobs made the labor market smaller; in order to prevent teenagers from competing with adults for jobs, childhood was extended. People therefore entered the work force later in life because they stayed in school

longer. This change precipitated the invention of the enticing concept of "adolescence" (Barker, 1990; Janus et al., 1987; M. A. Straus, 1994). Once the concept was defined, there was a need to create special programs and institutions for this newly created age group.

Demographic changes and myths about "Americanism" also sustained the significance of adolescence (M. A. Straus, 1994). Parents and communities focused on providing education to ensure later success for their children (Barker, 1990; Janus et al., 1987). Also, the humanitarian laws mentioned above reinforced the extension of adolescence: Less emphasis was placed on the customary periods of apprenticeship and more on youngsters' development. This shift in focus helped shape today's adaptive alliance between parents and children, which allows for successful growth and transition into young adult life (Janus et al., 1987).

"Adolescence" is generally defined as the period of life between the ages of 10 and 21 (Flannery, Torquati, & Lindemeier, 1994), though slight variations are frequently reported. For the purposes of this book, "adolescents" are defined as young persons between the ages of 13 and 18. Those aged 17 and under are legally regarded as minors; 18-year-olds are legally regarded as adults.

Adolescence is a compelling phase of life. It is alternately described as exciting, chaotic, tumultuous, unsettling, risky, conflictual, joyous, and momentous. Adolescents as a group can be tremendously creative, compassionate, challenging, provocative, responsible, reckless, carefree, studious, focused, hostile, violent, passive–aggressive, or calm and peaceful. The range of adolescent behaviors is vast, and yet various assumptions often define our expectations of this age group.

SOME ASSUMPTIONS ABOUT ADOLESCENTS

On occasion, I have heard reports of television and newspaper surveys that indicate that adults become frightened when they see groups of adolescents, fearing assaults, burglaries, or other dangerous behaviors; apparently these fears are exacerbated when youngsters

are black, Hispanic, or Asian. Adults also expect adolescents to be challenging or demanding, or to defy authority. Often clinicians hesitate to take referrals of adolescents, citing reasons such as personal discomfort, or pessimism about what can be accomplished.

Another assumption about adolescence is that it is always disordered, difficult, perilous, tumultuous, and painful for youngsters; however, many adults view their own adolescence as "the best years of their lives." Is adolescent turmoil fact or fiction?

Adolescents seemingly find and lose themselves at the same time (Janus et al., 1987). Turmoil proponents say that profound disruption of one's personality organization is normal at this stage and causes mood swings, unpredictable behavior, thought confusion, and rebelliousness. They believe that adolescents are unable to grow into mature, mentally healthy adults without it. According to psychoanalytic theory, a weakened ego combined with strong instinctual drives prevents teenagers from being balanced and harmonious: Their drives may lead them into delinquency, but repression of their drives leads to phobias and depression. M. B. Straus (1994) notes that being "normal" during adolescence is in fact abnormal. Similarly, Erikson (1963) believed that turmoil is requisite for normal development. He introduced the term "identity crisis," noting that expected fluctuations of ego strength cause increased conflicts, which lead to confusion, role struggles, and subsequent identity formation.

Many others disagree with the idea that turmoil is an expected and unavoidable aspect of adolescence. M. B. Straus (1994) states that the struggle between parents and their children is conventional, but not necessary. Individual development can take many routes, some of which are smooth while others are more turbulent, but not completely full of emotional turmoil. Each teenager faces and handles these challenges in different ways.

Experimental research does not support controversial turmoil theories. Findings suggest that most adolescents feel happy, strong, and self-confident, and do not have serious conflicts with their parents (Hill, 1993; M. B. Straus, 1994). Only 20% report problems with social and personal areas (Offer & Sabshin, 1984), and only one in five families experience frequent disputes (Hill, 1993). Only 20% of

nonpatient adolescents report turmoil severe enough for them to run away from home (Janus et al., 1987). The clinical samples that Erikson (1963) used in formulating the identity crisis theory, although convenient, were biased and did not represent the typical adolescent (M. B. Straus, 1994).

Though adolescents and their parents may frequently disagree about hairstyles, clothing, and curfews, serious conflicts are rare, and typically occur when adolescents suffer from a psychiatric disorder. It is not unusual for adolescents to experience some inner turmoil, characterized by misery or self-deprecation, but not all adolescents experience these emotions, and some manifestations are mild (Rutter, Graham, Chadwick, & Yule, 1976). As for the effects of so-called "raging" hormones and emotions on behavior, these not only are small but are influenced by nonhormonal factors, such as gender, temperament, age, pubertal status, and pubertal timing (Buchanan, Eccles, & Becker, 1992, as cited in Flannery et al., 1994).

In short, not all adolescents have major identity crises; however, not all families are carefree (M. B. Straus, 1994). In order to avoid subscribing to damaging myths about adolescent turmoil, clinicians must consider the normal range of development in context. When adolescent development is assessed, it is advisable to use a broad lens to consider all the aspects of development that undergo changes during this life stage (see Chapter Two for a full discussion of these).

UNDERSTANDING THE BASIC NEEDS OF ADOLESCENTS

When I have attended lectures about adolescent development or adolescent issues, it is my impression that people often restrict their discussions to a particular dimension of adolescent development, such as cognitive or personality development. Only recently have I seen efforts to consider adolescence in a broader context that includes physical, cognitive, emotional (attachment), personality, moral, sexual, and spiritual development (Newton, 1995). There is a great deal of impetus for growth and change during this stage of life, and young-

sters are negotiating often opposing drives (e.g., biological development and moral development).

Clinicians must examine the various developmental dimensions that are in flux during this period, as well as identifying obstacles to development in specific dimensions. For example, some emotions, behaviors, and thought processes, though seemingly inappropriate, may be developmentally typical; other behaviors, emotions, and thought processes may be developmentally inappropriate.

Schrodt and Fitzgerald (1987) have documented several normal "problems" in dealing with adolescents. They may distort time, have an exaggerated sense of loyalty to their peers, mistrust adults, be extremely self-conscious, and periodically suspend logic. They may also have insufficient motivation for change, lack persistence, and have difficulty verbalizing their concerns.

Unless we understand the developmental needs of adolescents, what we see and hear from them will be difficult to understand (Barker, 1990). Understanding the typical progression of phases and tasks in adolescence serves therapists well in many domains (Corder, 1994); most notably, it provides them with identifiable and feasible goals when they are devising treatment plans. Therapists may also become more empathetic and patient in dealing with adolescents when they see their behavior in a larger context.

Viewing an adolescent in the context of his or her life stage may also prevent misunderstandings and miscommunications between the therapist and the adolescent, which might hinder the therapeutic process or lead the adolescent to terminate therapy. For example, periods of developmental challenges may cause maladaptive responses in the clinical setting (Forehand & Wierson, 1993). Developmental issues affect perception, conceptualization, and interpersonal styles (Bierman & Schwartz, 1986, as cited in Barker, 1990).

Finally, it is not only the adolescent's developmental issues that need attention. Therapists must also understand their own difficulties with their developmental tasks as adolescents before they begin to conduct therapy with adolescents (Corder, 1994).

UNDERSTANDING OBSTACLES TO ADOLESCENT DEVELOPMENT

The obstacles to a gradual and even developmental process are many. When working with adolescents with specific symptoms, we may be able to surmise the origin of their problems. For example, when Walsh and Rosen (1988) studied 52 adolescent self-mutilators in treatment settings, they found that their backgrounds were replete with aversive events, such as sexual abuse, significant loss, and conflict with peers. Indeed, they found that a history of sexual abuse was the most useful in discriminating between mutilators who had been suicidal and those who had not.

Juveniles who sexually molest others have frequent histories either of parental loss or of family dysfunctions that are likely to affect child development, such as parent's violence against either the spouse or the children, parental substance abuse, and parents' experience of physical and sexual abuse in their own childhoods (Gil & Johnson, 1993; Ryan, 1991; Steen & Monnette, 1989). In fact, I have often heard informal reports from juvenile correctional institution personnel, which estimate that 90% of the youths referred to their program have histories of parental abuse or neglect.

It stands to reason, therefore, that youths undergoing specific types of stresses – such as abuse or neglect; physical illness; parental death, loss, or divorce; birth of siblings; and parent/caretaker dysfunction – require careful attention and support. Obviously, these circumstances may overload an already full schedule of difficult demands placed on them by the normal developmental process. Coping with external stressors overtaxes the available resources allocated for developmental tasks. Some adolescents appear to dig deeper, developing new resources; others are fortunate enough to seek out and obtain assistance from others in their environment, including adults in position of authority, religious or spiritual leaders, peers, or extended family members; still others derive support from formal and informal therapies and other means of survival, such as music, literature, sports, or academics. Adolescents who (for whatever reason)

are unable to do any of these things may have severe difficulties coping with a range of normative or non-normative stressors.

As clinicians, our tasks in working with adolescents are not unlike those in working with younger children: to remove obstacles to developmental growth, and to attempt to ensure environmental conditions that will promote and enhance the developmental process. Many adolescents' problems occur because they have had difficulty in completing a developmental task (Barker, 1990). In work with children of any age, understanding family and social pressures or supports is pivotal to understanding the youngsters' difficulties and helping them to develop more reliable and secure support systems.

THE EXTENT OF ADOLESCENT ABUSE

In 1986, the American Humane Association's *Highlights of Official Child Neglect and Abuse Reporting* documented that of approximately 1.7 million cases of child maltreatment, 24% involved youths between 12 and 17 years of age. In 1978, the American Humane Association's report, *National Analysis of Official Child Abuse and Neglect Reporting,* demonstrated that adolescents aged 12–17 were the reported victims of 27.3% of all abuse/neglect cases. Using secondary data from the 1988 Study of National Incidence and Prevalence of Child Abuse and Neglect, Powers and Eckenrode (1992) also found that adolescents constituted a large proportion of all estimated cases of maltreatment; that more adolescents were more often emotionally abused than young children; that adolescent maltreatment more often involved female victims; and that more adolescent females experienced physical abuse than males.

According to a more recent incidence study (U.S. Department of Health and Human Services, 1995), almost 2 million reports of child abuse and neglect were received by child protective service agencies and referred for investigation in 1993. Nearly half of the victims of maltreatment (49%) suffered from neglect; 24% were physically abused; and 14% were sexually abused. Adolescents accounted for a lower percentage of reported victims than younger

children did: 51% of victims were 7 years of age or younger, and 26% were 3 years of age or younger, whereas 20% were 13–18 years old (teenagers). The 1993 data regarding age were similar to those found in the previous 4 years of data collection. Fifty-one percent of the victims were female, and 45% were male; 54% were European-American, 25% African-American, and 9% Hispanic.

In a study of nonclinical and unreported adolescents totaling 3,998 students (Hibbard, Ingersoll, & Orr, 1990), 20% reported some form of physical or sexual abuse, with more girls than boys reporting sexual abuse. Although some problem behaviors were common among all adolescents, higher emotional and behavioral risk scores were confirmed among abused adolescents.

The true incidence of adolescent abuse may far exceed the documented statistics, for a number of reasons. Barth and Derezotes (1990) state that "the extent to which under reporting influences our estimate of the incidence of physical abuse, sexual abuse, neglect, and psychological maltreatment in adolescence is unknown" (p. 3). The actual *incidence* of adolescent maltreatment may not be lower than that of child maltreatment, but the *reporting* of it may, because of changed public perceptions of risk as children mature. Adolescents are often seen as having an increased ability to fight, run away, or otherwise fend off abuse. Moreover, there may be a pervasive belief that adolescents deserve the punishments they receive or that they can sustain physical punishment without damage. Finally, teenagers are often viewed more as potential victimizers than as potential victims, in spite of reports from the National Crime Survey and Uniform Crime Reports showing that teenagers are at substantially higher risk than their elders for all crimes except homicide (Moone, 1994), and that they are often targeted for stranger abduction (Finkelhor, Hotaling, & Sedlak, 1990).

TYPES OF ADOLESCENT ABUSE

"Child abuse" is a generic term for child maltreatment; it encompasses specific types of abuse as defined by law. Although reporting

statutes vary from state to state, and the wording of definitions is also diverse, I quote the following formal definitions from the U.S. Department of Health and Human Services (1995):

> Maltreatment–An action or failure to act by a parent, caretaker, or other person, as defined under State law, having caused or allowed to cause physical abuse, neglect, medical neglect, sexual abuse, or emotional abuse harm, or risk of harm to a child. (p. B-4)
>
> Medical neglect–The harm by a caretaker to a child's health due to failure to provide for appropriate health care of the child, although financially able to do so, or offered financial or other means to do so. May include perinatal exposure to drugs. (p. B-4)
>
> Neglect or deprivation of necessities–A type of maltreatment that refers to the failure to provide needed, age-appropriate care, although financially able to do so, or offered other financial or other means to do so. (p. B-5)
>
> Physical abuse–A type of maltreatment that refers to physical acts that caused or could have caused physical injury of the child. (p. B-5)
>
> Psychological or emotional maltreatment–A type of maltreatment that refers to acts or omissions, other than physical abuse or sexual abuse, that caused, or could have caused, conduct, cognitive, affective or other mental disorders, such as emotional neglect, psychological abuse, mental injury, etc. (p. B-5)
>
> Sexual abuse–A type of maltreatment that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, prostitution, pornography, exposure, or other sexually exploitative activities. (p. B-6)

Adolescents may be victimized in any of the above-mentioned ways. Moreover, some are victims of several types of abuse, and these youngsters may suffer greater consequences. In a study comparing physically and sexually abused adolescent inpatients, Hart, Mader, Griffith, and deMendonca (1989) found that adolescents who had been both physically and sexually abused displayed more drug abuse, reported more symptoms of distress, had more interpersonal problems, exhibited lower self-esteem, and engaged in more self-destructive behaviors.

There is ongoing discussion about the likelihood of youngsters' being more vulnerable to one or another type of abuse, based on their age and developmental needs. Finkelhor and Dziuba-Leatherman (1994) have devised a "dependency continuum for child victimization types," noting that "the main status characteristic of childhood is its condition of dependency, which is a function, at least in part, of social and psychological immaturity" (p. 177). They claim that it is the *violation* of the dependency status that results in forms of victimization: Physical neglect can only occur with a dependent person; family abduction is a dependency-specific victimization involving the removal of a child from a caretaker. Other forms of victimization, defined without reference to dependency status, exist for both adults and children (e.g., stranger abduction or homicide). Sexual abuse, according to Finkelhor and Dziuba-Leatherman, can occur with or without dependency-related status. Finkelhor (1995) states that sexual maturation makes children (especially girls) more vulnerable to sexually motivated crimes. As further discussed in Chapter Three, some parents become sexually interested in their youngsters when their bodies mature, whereas some parents and out-of-family molesters may find younger children more desirable as targets of sexual abuse (Quinsey, Rice, Harris, & Reid, 1993).

COMMON REACTIONS TO ADOLESCENT ABUSE

Many abused adolescents present with a range of emotional and behavioral problems that might be addressed by the juvenile justice system, alternative services programs for runaway youths, or mental health departments. They may run away, steal, fail or skip school, fight, set fires, abuse drugs, or behave in other ways that cause them to be identified for services. Often these youths do not report themselves as in need of help, and are not identified by professionals, who perceive them as less vulnerable than younger children because of their age and size.

Many professionals do not view adolescent abuse as a signifi-

cant problem. Child protective services workers with large caseloads and heavy demands on their time must make determinations about risk and imminent danger. If two reports of child abuse are phoned in at the same time, and the callers document concern regarding a toddler and an adolescent, chances are that the worker will appropriately prioritize the toddler for immediate response. Adolescents often have more resources than younger children, and may be able to get themselves to an emergency room for medical attention, seek shelter at a runaway facility, walk into a juvenile probation office, or seek help from others (extended family members, teachers, or family friends). Toddlers are unable to mobilize themselves in this manner and therefore require the immediate attention and protection of protective services workers. And yet when adolescents run away, or leave their families in the midst of crisis and conflict, they often resort to illegal means of self-care–prostitution, drug dealing, or other criminal activities. Often these youngsters find gang activity to provide valuable components of family life and feel accepted and cared for within gangs, regardless of whether the gang is or is not engaged in criminal activity.

In over 20 years of working in the area of child abuse prevention and treatment, I have had occasion to interact with many professionals and discuss their views about the work they do. Regarding child sexual abuse, I have heard professional comments that demonstrate differential responses to adolescent victims. For example, I heard one professional say, "That girl knew what she wanted and knew how to get it," in regard to a case of incest in which the father gave his daughter expensive gifts. In another case, in which the adult offender was female, I overheard an investigator call the adolescent victim "a lucky bastard" because he had had sexual intercourse with the 35-year-old mother of one of his friends.

I have also seen personal biases dictate responses. For example, two 16-year-olds engaged in heterosexual activity were seen as "healthy teens," whereas two 16-year-olds engaged in homosexual activity were referred to child protective services. Moreover, when adolescents are physically abused, varying responses occur as well. For example, a child with a black eye was once asked, "What did

you do to bring that on?" Another adolescent girl was told that she had to "mind her parents better and not make them get so frustrated and angry."

Obviously, child neglect is most pertinent to young children who cannot meet their own needs. And yet adolescents may also suffer from parents who are inattentive and uninterested, and who choose to construct separate lives from their adolescents. One parent referred for counseling had set up a separate home for her 16-year-old because she did not want to share a home with the boy. She did not understand what the problem was, since the boy had been living "on his own" since he was about 10. Amazingly, the youngster had managed to get many of his needs met at school through positive relationships with his teachers. He excelled in school, and his pseudomature behavior projected an image of self-confidence and well-being that belied his feelings of loss, isolation, and longing.

Psychological abuse is probably one of the most common forms of child abuse, and yet only a handful of states consider it significant enough for intervention. There has been considerable controversy about how to define this particular form of abuse and how to intervene. However, several researchers suggest that psychological abuse, unaccompanied by physical or sexual abuse or neglect, also contributes to many long-term emotional and behavioral problems (Garbarino, Guttman, & Seeley, 1986).

In addition to varied professional responses at the intake level, legally mandated professionals may fail to report cases of adolescent abuse, so many situations go undetected and unreported. They may hesitate to report because they believe intervention will be minimal, or they have had past experiences in which their cases were not accepted. Also, they may be concerned about betraying adolescents' confidence, or they may fear incurring the wrath of angry youngsters or their irate parents.

We are left, therefore, with a significant problem that is often ignored or minimized, as well as a system whose interventions occur sporadically and appear cursory at best. At the same time, the long-lasting effects of childhood abuse continue to be documented as serious and far-reaching (Briere, 1989).

THE EFFECTS OF CHILDHOOD ABUSE ON ADOLESCENTS

Bagley (1995) states that

> prolonged and intrusive sexual abuse imposed on the physically immature body and the developmentally immature psyche of a child frequently creates an adolescent who cannot find adequate solutions to the dilemmas of identity development. . . . As a result, the adolescent is extremely vulnerable to stress, and may develop in severe form a number of the psychological disorders (e.g., suicidal ideas and behavior, depression, eating disorders, alienation from school and peers, sexual problems, acting-out behaviors, and substance abuse) that have an increasing prevalence among adolescents. . . . (p. 135)

Finkelhor and Dziuba-Leatherman (1994) cite the growing literature indicating that victimization has short- and long-term effects on children's mental health; they point out that sexually victimized children appear to be at a nearly fourfold increased lifetime risk for psychiatric disorders, and a threefold risk for substance abuse. Kolko (1992) also demonstrates increased rates of mental health morbidity for physical abuse; Briere and Runtz (1993) for psychological maltreatment; and M. A. Straus (1994) for corporal punishment. The proposition that childhood victims are more likely to grow up to victimize others, Finkelhor and Dziuba-Leatherman (1994) state, is firmly established.

Kendall-Tackett, Williams, and Finkelhor (1993) reviewed over 40 methodologically sound research studies of sexually abused children, seeking to ascertain whether a "profile" of sexually abused children would emerge. They found no such profile or "child sexual abuse syndrome," but did find that several symptoms appeared consistently across studies. These included symptoms of posttraumatic stress disorder (PTSD), especially fear and anxiety; depression; and problem sexual behaviors. Friedrich et al. (1992) state that open sexual behavioral problems are the most consistently identified effect of child sexual abuse. Schetky (1990) notes that the research on long-term effects of sexual abuse has also found psychiatric hospitalization, substance abuse, self-abuse, somatization disorder, eroticization, learning difficulties, dissociative disorders, conversion reactions, running away, prostitution, revictimization (even at the hands of mental health professionals [Kluft, 1990]), and impaired interpersonal relationships.

McCann, Pearlman, Sakheim, and Abrahamson (1988) discussing childhood abuse, state that because individuals "hold certain beliefs and expectations (schemata) about the self and others, which both shape and are shaped by the experiences of the world" (p. 78), disruptions occur in the schemata concerning safety, trust, power, and esteem. These disruptions in turn cause symptoms such as chronic anxiety and fear, confusion, overcaution, inability to trust others, chronic passivity, a sense of futility, depression, profoundly negative self-esteem, and feelings of guilt and shame.

Cuffe and Frick-Helms (1995) group the psychological issues involved in treating abused children into five cluster areas: guilt; betrayal; pseudomaturity and boundary confusion; self-mastery; and fear and other symptoms of PTSD. They note that 30–50% of sexually abused children can be diagnosed with PTSD, which is characterized by high levels of fear and anxiety, recurrent or intrusive memories, behavioral reenactments in play or behavior, emotional detachment and numbing, and an acute startle response.

Friedrich (1995a) finds that the impact of trauma occurs in three primary dimensions: attachment, self-regulation, and self-perspective. Attachment problems cause interactional problems in which children are often hesitant, emotionally distant or detached, and distrustful and hypervigilant. Self-regulation problems contribute to behavioral problems, such as violence, impulsivity, and sexual acting out, and explain the "lability and variability in the presentation of the sexually abused child" (p. 4). Lastly, Friedrich (1995a) states, "Self-perspective takes into consideration the child's developing sense of self and how aspects of the abuse experience are integrated into this sense of self and become part of one's self-representation" (p. 4). Putnam (1990) finds many disturbances of the self in abused children, including negative self-image, underdeveloped sense of identity, self-deprecation, a belief that they deserve the abuse, body image

disturbances, self-destructive behavior, fragmentation, and concerns about control.

Friedrich (1995a) and Schetky (1990) note neurophysiological effects—for example, depletion of catecholamines, which they postulate results in psychological constriction and numbing, followed by a period of hyperarousal. These individuals may have a greater tendency to reexperience the initial trauma in the form of flashbacks or nightmares. Schetky (1990) suggests that the numbing and constriction that often follow trauma may also have a physiological base. Friedrich (1995a) notes that although the neurophysiological response to trauma is difficult for clinicians to identify or quantify, some symptomatic behaviors may be related, including sleep disorders, PTSD, attention-deficit/hyperactivity disorder, emotional lability/reactivity, compulsive behaviors, oppositionality, and dissociation. These symptoms have been documented in many studies of child sexual abuse victims (e.g., Waterman & Ben-Meir, 1993), as well as victims of other types of child abuse (Hart & Brassard, 1987; Wolfe, 1987; Jaffe, Wolfe, & Wilson, 1990).

It is important to note that child abuse does not appear to affect each victim in a predictable or consistent fashion (Cicchetti & Rizley, 1981). Certain variables may ameliorate or exacerbate the effects of the abuse. These include the duration of the abuse, relationship to the offender, affective content, type of sexual abuse, sex of the victim, age of the victim, age difference between victim and offender, sex of the offender, parental variables, and treatment (Schetky, 1990). Schetky summarizes:

> Long-lasting negative effects of childhood sexual abuse appear to be correlated with abuse by a father or a stepfather, use of force, and being unsupported by a close adult. It is highly probably that sexual activity that is intrusive and of long duration is most disruptive. School-age children seem to be at greatest risk for developing behavioral problems related to the abuse, at least in short-term studies. Girls are more likely than boys to show acute distress following sexual abuse, but data are lacking on which to make adequate comparisons between male and female victims in terms of long-term effects and adjustments. . . . Family support remains a critical variable with regard to outcome. (1990, pp. 40–41)

Although the most extensive research to date has been done on sexually abused children, Wolfe (1987), focusing on physically abused children, also finds them to have a greater than average risk of developing emotional and/or behavioral problems—particularly because of the disruption in the children's critical areas of development, such as attachment, self-control, and moral and social judgment. Wolfe further notes that physically abused children have problems in specific dimensions: the behavioral dimension (problems of self-control and aggression), the socioemotional dimension (deficits in social sensitivity and relationship development), and the social-cognitive dimension (issues in cognitive and moral development).

MITIGATING VARIABLES AND RESILIENCY

At the beginning of this chapter, I have chronicled the history of Jennifer, a 13-year-old single mother who had undergone physical abuse, sexual abuse, neglect, and emotional abuse. Remarkably, she was able to form a positive attachment to a foster mother, whose relationship with her extended beyond the formal foster parenting agreement.

From a review of Jennifer's history, it is difficult to fathom how and why she was able to cope and develop as well as she did. But the variable that struck me the most was her ability and willingness to trust. She had significant losses early on—she had felt great sadness at the loss of her biological mother, and the subsequent attachment she formed to her would-be adoptive mother, whom she also lost abruptly. Although she then made some efforts to detach herself from caretaking figures, she was responsive to positive attention and seemed to thrive as others talked with her and listened to her. Her ability to trust others after such acute violations of trust speaks volumes about her survival instinct. I believe that the presence of a significant other who provides consistency of empathic care and continuity of attention is one of the most important variables in mitigating the negative effects of childhood abuse, particularly because children seem to await positive interactions with great patience, and are often quite receptive to genuine concern.

Several times I have been impressed with how adolescents describe a teacher, a physician, a friend's parent, or some other adult who took the time to ask after them or converse, or who found their company worthwhile. Some youngsters greatly value the experience of someone's reaching out to them, being available to them, or sticking by them no matter what. This gives clinicians some important guidelines for maximizing the effectiveness of therapeutic contact.

Sanford (1990), in her well-titled book *Strong at the Broken Places,* describes the commonalities of many of the child and adult survivors of childhood abuse she has worked with:

> Despite popular and professional expectations, these survivors have not inflicted trauma on themselves or others. Their thoughts and feelings about childhood trauma are normal, given the abnormality of their experience. Their problems are not radically different in scope or intensity from those of many others I have worked with who were not traumatized as children. They leave therapy having resolved the issues that brought them and continue to live useful and rewarding lives. (p. xiv)

Motivated by her observations that some adult survivors fare better than others, she conducted a nonempirical and descriptive study of 20 healthy adults, each of whom extensively experienced at least two types of trauma (including physical and sexual abuse, parental substance abuse, extreme neglect, and the witnessing of domestic violence). Many of the adult survivors she interviewed found satisfaction and a sense of well-being in turning to work for a sense of identity and fulfillment—in doing so, they developed economic freedom, made social contacts, became productive and creative, and found jobs in which they could become helpful to others. In addition, they found and maintained their spirituality; they found strength in self-help programs; and they transformed their experiences into a greater appreciation of life, compassion for themselves, and caring for others.

Since some children seem to fare better than others, it is useful to consider mitigating variables. Waterman and Kelly (1993) studied

what factors lessened the negative effects of trauma in 82 children, and conducted a 5-year follow-up of 40 of the original 82. They found that the following factors combined to promote healing: (1) a warm, supportive, nonpunitive, child-centered family; (2) less family tension and fewer stressors; (3) coping through mobilizing and reframing to increase family power; (4) close but not enmeshed families; and (5) decreased overt conflict and anger during problem solving.

Clearly, as clinicians, we are poised to provide valuable assistance to adolescents who can avail themselves of reparative and corrective experiences that might alter widespread negative beliefs about who they are, what the world has to offer, what interpersonal contacts can be like, how much personal power they have, and what they can or cannot change. In order to be helpful to adolescents with histories of current or past abuse, we must recognize the disruption in their developmental dimensions, the impact of trauma on them, and the nature and type of their psychological defenses. In addition, we must be aware of their resiliency issues and coping strategies, and constantly decode problem behavior in a way that is helpful to these youngsters.

THE PURPOSE OF THIS BOOK

The growing research on the impact of child abuse will continue to inform us regarding the type and extent of long-term consequences for victims of different ages and both genders, and for victims of different forms of abuse. Clinical observation will provide us with complementary data on common presenting problems and symptoms. And as we continue the dynamic process of learning about the population of abused adolescents, we must make efforts to deepen our understanding, formulate educated hypotheses about how to be helpful, incorporate research components that evaluate our clinical work (Finkelhor & Berliner, 1995), and exchange thoughts and ideas with our colleagues about how to mitigate the pervasive negative effects of childhood abuse.

The purpose of this book is to highlight the problems and concerns of adolescents who are currently abused, or who have histories of past abuse. My approach is to combine the information provided in the literature with my clinical experience to create, examine, refine, and implement useful strategies, grounded in a theoretical framework that includes material from developmental, attachment, systemic, and trauma theories. In particular, I believe that those adolescents' current behaviors, which may be identified as provocative or symptomatic, must be understood in the context of their past or current abuse. The basic premise is that child abuse interrupts and disrupts the developmental process, and that several developmental tasks are not fully addressed; therefore, these must be revisited during the treatment process.

In addition, I believe that *given certain discrete circumstances,* it is necessary to focus the therapy on past traumatic experiences that continue unresolved, and to do so for a specific period of time and in a structured manner. I propose a model of treatment that is primarily empowerment-based with a goal of increasing overall functioning, and is informed by therapy with adult survivors, particularly as proposed by Briere (1989, 1992), Courtois (1988), myself (Gil, 1988), and Herman (1992).