The Monsters in My Head: Posttraumatic Stress Disorder and the Child Survivor of Sexual Abuse

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Posttraumatic stress disorder (PTSD) is 1 of several possible outcomes of child sexual victimization. There is a growing body of literature regarding the prevalence of PTSD among children who have been sexually victimized. Using specific case examples, this article looks at the nature and scope of the problem, diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; American Psychiatric Association, 2000) symptomatology of children presenting with this disorder, assessment and diagnosis, treatment interventions, and implications for counselors treating this population.

A child awakens in the middle of the night, the nightmare still fresh in her mind of “him” on top of her. Her breath comes in short, quick gasps as she struggles to determine whether what she has just experienced was real or only a dream. She strains to hear if the footsteps coming down the hall are real or imagined. She pushes the thoughts out of her head. Perhaps if she sleeps under the bed, he will not find her. She wishes her mother would come in and comfort her, but she feels disconnected from her family, as if she is a stranger living in her own house. No one understands. No one cares. She prays for the morning to come so the dreams will stop, but she knows that the morning brings nightmares of its own: the looks from her sister, the speeches from her teacher about her lack of concentration in class. Her day is spent alternately trying to recall what happened and trying to forget. She finds no pleasure in the activities that she once loved. The night comes again, and the cycle continues. The monster that was once in her bed has now been replaced by monsters in her head.

There has been a growing body of literature on the subject of posttraumatic stress disorder (PTSD) in children. The literature consistently points to children’s vulnerability to the development of PTSD after severe trauma, particularly child sexual victimization. (Note. In this article, both the terms child sexual victimization and child sexual abuse are used. Child sexual victimization refers to the symptomatology experienced by the person being victimized. This term assumes the perspective of the victim. Child sexual abuse refers to the overall experience and nature of sexual abuse, including the criminal component.) When children’s bodies are used to meet adult needs, there is enormous potential for physical and psychological trauma (Monahan, 1993). Many clinicians differ on the applicability of a diagnosis of PTSD for children who have been sexually victimized. Although many authors believe that PTSD is a logical outcome following child sexual victimization, others (e.g., Finkelhor, 1990) object to using the diagnosis of PTSD as a way of always conceptualizing the sequence of events and symptoms that children who are sexually abused often face after the trauma. This article does not seek to resolve this debate, but rather seeks to shed light on the controversy. This article examines the nature and scope of the problem, proper assessment and diagnosis of PTSD in children, treatment strategies known to be effective, and implications for counselors treating this population. In the interest of time and space, this article only addresses PTSD as it specifically relates to child and adolescent survivors of child sexual victimization, while acknowledging that adult survivors of child sexual abuse may also experience the effects of PTSD.

Nature and Scope of the Problem

PTSD has long been associated with the aftereffects of war and natural disasters. This disorder was brought to mainstream attention with the return of soldiers from the Vietnam War. Many of these returning soldiers experienced recurrent nightmares, suddenly feeling or acting as if the event were recurring, restricted range of affect, and hypervigilance (Davidson & Foa, 1993). It is now recognized that PTSD is not limited to wartime but may arise from a variety of traumatic events that can occur throughout the life cycle of men, women, and children. It is estimated that 4 out of 10 Americans have experienced major trauma, and the disorder may be present...
in 9% of the U.S. population (Breslau & Davis, 1987). A growing number of Americans with PTSD are children who have been sexually abused. According to the U.S. Department of Health and Human Services (2000), 11.5% of the 903,000 children who were victimized in 1998 were victims of sexual abuse. According to Browne and Finkelhor (1986), it is estimated that between 46% and 66% of children who are sexually abused exhibit significant psychological impairment. McLeer, Deblinger, Atkins, Foa, and Ralph (1988) studied the prevalence of PTSD in 31 children who were sexually abused and found that in 48% of their sample, a diagnosis of PTSD was warranted. Many children who did not meet PTSD criteria nevertheless experienced PTSD symptoms.

Another study by Briere, Cotman, Harris, and Smiljanich (as cited in Briere, 1992) found that “both clinical and nonclinical groups of sexual abuse survivors report intrusive, avoidant, and arousal symptoms of PTSD” (p. 20). According to Briere, survivors of sexual abuse are prone to displaying PTSD-related intrusive symptoms. Other symptoms survivors of sexual abuse may experience include mood disorders, somatization, sexual difficulties, anger and frustration, self-injurious behaviors, and a pervasive distrust of others (Naugle, Bell, & Polusny, 2003). These symptoms often manifest themselves in the form of flashbacks, when the survivor is flooded with intrusive sensory memories that may include visual, auditory, tactile, or olfactory sensations (Briere, 1992). Many of these flashbacks may be triggered by abuse-related stimuli or interactions.

I worked with a young girl who became physically ill when she encountered the smell of chlorine, particularly prevalent around swimming pools. During the course of therapy, it was discovered that the client had been repeatedly sexually assaulted one summer by one of her older brother’s friends at a local swimming pool. The perpetrator would take the client behind the pool’s storage shed and repeatedly assault her. The smell of the chlorine would inevitably return her to that place, and she would “feel” his hands on her. Often, disclosing the abuse experience can be the only stimulus needed to trigger flashbacks.

In a survey of six separate studies by McNally (1993), which involved the application of PTSD criteria to cases of child sexual abuse, four of these studies reported no cases of PTSD, whereas the other two studies reported rates of 48% and 90%, respectively. As McNally noted, “Clearly, there is no uniform outcome associated with child sexual abuse” (p. 69).

The clinician working with this population should consider a diagnosis of PTSD as a possible outcome of child sexual abuse but recognize that such a diagnosis is not always a given in cases in which child sexual abuse has been reported.

Symptomatology

It is important for the clinician dealing with survivors of child sexual victimization to be aware of how these clients will present upon entering counseling. The clinician who suspects that a child is experiencing PTSD should be cognizant of the signs and symptoms that are possible indicators of PTSD. Frequently, fearfulness and anxiety-related symptoms have been described as sequelae of sexual abuse. Green (1985) described anxiety states, sleep disturbances, nightmares, and psychosomatic complaints in children who were sexually assaulted. Sgroi (1982) observed fear reactions in children who had been sexually abused extending to a phobic avoidance of all males (when the perpetrator is male). Kiser et al. (1988) documented PTSD in 9 out of 10 children between the ages of 2 and 6 years who were molested in a day-care setting. The most frequently observed symptoms were acting as if the traumatic event were reoccurring, avoiding activities reminiscent of the traumatic event, and intensification of symptoms on exposure to events resembling the molestation, all of which satisfied criteria for a diagnosis of PTSD.

According to Koverola and Foy (1993), one of the ongoing controversies in the diagnosis of PTSD in children who have been sexually victimized lies in the issue of whether children manifest PTSD symptoms in the same way that adults do. As Koverola and Foy noted, “One way in which PTSD in children may differ from PTSD in adults is in the nature of the traumatic reexperiencing” (p. 120). It is argued that children are more likely to experience nightmares as opposed to the dissociative flashbacks that adults experience (Koverola & Foy, 1993). These nightmares can be classified into two types of PTSD according to Terr (1989). Type I can be classified as a graphic representation of the original trauma and that results from a single incident. Type II can be classified as more symbolic representation of the event and is often classified by denial, dissociation, and numbing. Type I nightmares often appear soon after the abuse and usually decrease over time. Type II nightmares seem to be both a short- and long-term sequel of trauma, often surpassing Type I nightmares as the survivor grows older (Terr, 1989).

Dissociation, or an alteration in consciousness resulting in an impairment of memory or identity, has also been observed in children traumatized by sexual abuse (Kluft, 1985). Signs of early dissociation in children are “forgetfulness with periods of amnesia, excessive fantasizing and daydreaming, trancelike states, somnambulism, the presence of an imaginary companion, sleepwalking, and blackouts” (Wilson & Raphael, 1993, p. 578). There seems to be a close relationship between dissociation and PTSD. Liner (1989) found that children who were physically and sexually abused who were referred for outpatient treatment exhibited significantly more dissociation than did a comparison group of nonabused children who attended a child psychiatry outpatient clinic. Sexual abuse and physical abuse are the most frequent background factors in the etiology of dissociative identity disorder in adults (Wilson & Raphael, 1993). It is quite possible that the child who has been sexually victimized who presents with dissociative symptoms began the dissociation process during the course of the trauma as a way of coping. Just as the dissociation served a purpose.

Posttraumatic Stress Disorder and the Child Survivor of Sexual Abuse

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during the trauma, the clinician needs to be ever mindful of the purpose that dissociation may serve after the trauma.

An essential feature of PTSD is the avoidance of situations and stimuli that are associated with the traumatic event (American Psychiatric Association [APA], 2000). Survivors of child sexual abuse invariably make conscious attempts to avoid thoughts, feelings, or activities that bring back recollections of the abuse. Cognitive suppression and distraction are particularly common, as is behavioral avoidance (Jackson & March, 1995). Children who use these survival strategies pay a high price because these strategies inevitably spill over into other domains of functioning. According to Jackson and March, “children with PTSD often show markedly diminished interest in previously enjoyed activities and sometimes lose previously acquired skills, leaving them less verbal or regressed to behaviors such as thumb sucking or enuresis” (p. 283).

Child survivors of sexual victimization experiencing PTSD also may show evidence of restricted affect, accompanied by feelings of detachment or estrangement from others (APA, 2000). Children who have been sexually victimized who begin to talk about their experiences may do so with a blunted affect and with a detached demeanor. The clinician should not take this restricted affect as a sign of dishonesty regarding whether the abuse occurred, but rather as a possible sign that abuse has occurred.

Children often reexperience or reenact part or all of the traumatic event. The traumatic event of sexual abuse can be reexperienced in the form of distressing, intrusive thoughts or memories, dreams, or flashbacks. McNamara (2002) stated that reenactment is the rule in children who have been traumatized. Reexperiencing symptoms set PTSD apart from other psychiatric syndromes; in no other symptom are portions of the traumatic event recapitulated (Jackson & March, 1995). Reexperiencing occurs both spontaneously and in response to traumatic reminders, as noted earlier.

Traumatic play is often an essential feature of PTSD in children who have been sexually victimized. *Traumatic play* refers to “the repetitive acting out of specific themes of the trauma” (Jackson & March, 1995, p. 282). According to Pynoos and Nader (1993), when children incorporate rescues that lead to a happy ending, otherwise known as *intervention fantasies*, play may represent an attempt at mastery. The child who has been sexually victimized may reenact aspects of the abuse in his or her play; however, in the child’s version, perhaps the “victim” becomes empowered by a magic wand and he or she is therefore able to make the abuser disappear. According to Jackson and March, “traumatic play is clearly maladaptive when it interferes with play’s normative uses or leads to risky or aggressive behaviors” (p. 282).

Child survivors of sexual victimization are said to develop a “sense of foreshortened future” (APA, 2000, p. 468), believing that they may never grow up or fulfill other adult tasks (Terr, 1990). Many survivors often possess a self-image of “badness,” implying that they are not worthy of having a future in which there is happiness, marriage, and children. According to Jackson and March (1995), there is little empirical literature that supports this element as a necessary element of the PTSD symptom picture.

Hyperalertness and hypervigilance are also common features of PTSD associated with increased physiological arousal. Children with PTSD who have been sexually abused may show symptoms of increased arousal, such as sleep disturbances, irritability, difficulty concentrating, exaggerated startle responses, and outbursts of aggression (Friedman, 1991). According to McNamara (2002), these symptoms persist for more than a month. A study by Chaffin, Wherry, and Dykman (1997) looked at the coping strategies used by 84 children, ages 7 to 12 years, who had been sexually abused. These authors found that internalized coping strategies used by children who had been sexually abused were strongly associated with increased guilt and PTSD hyperarousal symptoms.

The stress and coping literature generally concludes that males are more vulnerable than females to the negative effects of stress (Hetherington, 1984); however, it is unclear whether this gender difference holds for all stressors, particularly child sexual abuse. Kempe and Kempe (1978) concluded that the impact of sexual abuse was usually more severe for males than for females; however, they provided no empirical evidence for this conclusion. Do males, then, have a higher rate of PTSD from sexual abuse than do females? Kiser et al. (1988) found gender differences in the PTSD presentations of ten 2- to 6-year-old children who were sexually abused in a day-care setting. The boys in the study initially presented more clinically significant symptoms than did the girls. A partial follow-up 1 year later suggested that the girls were more symptomatic at that time than were the boys. A similar study by Burke, Moccia, Borus, and Burns (1986) looked at the behavioral reactions of boys and girls to a traumatic event and found that boys reacted more intensely and their symptoms resolved slowly, whereas in girls a recurrence of symptoms developed at a later time.

Friedrich and Reams (1987) further found gender differences among children between the ages of 3 and 12 years who had been sexually abused. These authors concluded that girls display greater internalization and boys greater externalization when dealing with the trauma of child sexual victimization. It is clear, however, that there is no consensus on whether there is a higher incidence of PTSD in males or females who have been sexually victimized; however, the literature seems to suggest that girls who are victims of father–daughter incest frequently become symptomatic and meet the diagnostic criteria for PTSD (Wilson & Raphael, 1993).

**Assessment and Diagnosis**

The type, duration, and frequency of trauma determines the likelihood of PTSD development, and as such PTSD may result from a single or repeated traumatic event exposure...
(Famularo, Fenton, Kinscherff, & Augustyn, 1996). Children who are sexually abused seem to develop PTSD at a higher rate than do children who have been physically maltreated or who have experienced parental neglect (Famularo, Fenton, Kinscherff, 1993). How, then, does the clinician properly assess, diagnose, and treat those child survivors of sexual victimization experiencing PTSD?

Evaluating children who have been sexually victimized and assessing their treatment needs requires thoughtful and purposeful planning. As with any client, it is important that an assessment is made of all resources available to the clinician. These resources may include reports from outside sources, such as physicians, teachers, social workers, family, clergy, and legal services. Assessment instruments are also helpful in diagnosing PTSD in children who have been sexually victimized. Miller and Veltkamp (1995) researched various measures designed to aid the clinician in diagnosing PTSD. Instruments such as the Children’s Post-Traumatic Stress Disorder Inventory (Saigh, 1994), the Childhood PTSD Interview (Fletcher, 1991), When Bad Things Happen (Miller & Veltkamp, 1995), and the Trauma Symptom Checklist for Children (Wolpaw, Ford, Newman, Davis, & Briere, 2005) are all designed to aid the clinician in properly assessing and diagnosing PTSD in children who have been sexually victimized.

The role of play and drawing in the assessment and treatment of posttraumatic stress goes beyond the simple idea that drawing permits an easy access to children who might otherwise find it difficult to speak about their abuse experiences. According to Nader and Pynoos (1990), in the specialized treatment of children experiencing PTSD, drawing is more than just a window into the child’s mental representation of traumatic material. Nader and Pynoos contended that visual and other perceptual experiences of the event become embedded and transformed in a child’s play and drawings. “Thus, play and drawings serve as an ongoing indicator of both the child’s processing and his or her resolution of traumatic elements” (Pynoos & Nader, 1993, p. 538).

As with any disorder, the criteria for PTSD in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; APA, 2000) must be met before an accurate diagnosis can be made. PTSD must often be differentiated from other DSM-IV-TR diagnostic categories. According to Peterson, Prout, and Schwarz (1991), common diagnostic differentials include anxiety disorders, depressive disorders, adjustment disorders, antisocial personality disorders, schizophrenia, factitious PTSD, and malingering. Because of a wide array of potential clinical symptoms following severe trauma, errors in diagnosis, particularly differential diagnosis, are common among patients with PTSD.

Children who have been traumatized frequently exhibit symptoms of disorders other than PTSD, and children with other disorders not uncommonly have PTSD as an intercurrent diagnosis. Famularo et al. (1996) conducted a study in which PTSD in children who had been maltreated was found to be statistically related to other formal psychiatric diagnoses. The results of their study suggest that “children diagnosed as PTSD demonstrate concurrent ADHD [attention-deficit/ hyperactivity disorder], anxiety disorders (panic, phobic, overanxious, simple phobia), and a tendency toward mood disorders (major depression, dysthymic)” (Famularo et al., 1996, p. 959). Borderline personality disorder has also been etiologically linked to PTSD (Bemporad, Smith, Hanson, & Cicchetti, 1982). Famularo et al. (1996) also found a high correlation between childhood diagnosis of PTSD and at least transient suicidal ideation. These findings suggest that when a diagnosis of PTSD in children who have been sexually victimized is made, it is highly probable that another disorder is also present, as well as suicidal thoughts, for which a suicide risk assessment should be administered.

Treatment Interventions

According to Friedrich (1990), “although the PTSD diagnosis seems to be relevant for some sexually abused children, its greatest utility is probably that it identifies the existence of specific behaviors that should be addressed in therapy” (p. 24). Likewise, “assessment for PTSD in children who are believed to have been sexually abused can be useful both for intervention as well as forensic purposes” (Walker, 1993, p. 131). Walker further stated that the treatment of PTSD in children must contain some of the same components as those for the treatment of PTSD in adults, which includes empowerment. It is essential that the child becomes empowered to take back that which has been taken from him or her through the violation of sexual abuse. It is important to recognize that children have limited control over their surroundings and over situations, but by allowing them to make decisions that are within parental limits, the child can begin to regain power over his or her life and future (Walker, 1993).

According to the International Society for Traumatic Stress Studies, “cognitive-behavioral approaches have the strongest empirical evidence for efficacy in resolving PTSD symptoms in children” (Ovaert, Cashell, & Sewell, 2003, p. 294). Peterson et al. (1991) contended that from a behavioral perspective, it is the child’s response to memories of traumatic events that produces the primary manifestations of PTSD. It is further assumed that secondary features of the disorder are also, directly or indirectly, caused by the child’s reactions to his or her memories; therefore, the primary focus of a behaviorally oriented approach to PTSD is the child’s memory of the original trauma (Meiser-Stedman, 2002; Peterson et al., 1991).

For adults or children, almost all therapeutic approaches to PTSD incorporate some review and reprocessing of the traumatic events. The emotional meaning the child attaches to the abuse, as well as the personal impact, is embedded in the details of the experience, and the therapist must be prepared to hear everything, however horrifying or sad. Special
interview techniques may be necessary to assist children to explore thoroughly their subjective experiences and to help them understand the meaning of their responses (Pynoos & Eth, 1986). By encouraging children’s expression through drawing, play, dramatization, and metaphor, the therapist attempts to understand the traumatic links and looks for ways to recruit children’s fantasy and play actively into communication about their abuse experiences.

One treatment goal is to bolster children’s observing ego and reality-testing functions, thereby dispelling cognitive confusions and encouraging active coping with the abuse experience. A second goal is to help children anticipate, understand, and manage everyday reminders, so that the intensity of these reminders and their ability to disrupt daily functioning recede over time (Wilson & Raphael, 1993).

Another goal is to assist the child in making distinctions among current trauma, ongoing life stresses, and previous trauma and to decrease the impact of the recent trauma on present experience (Walker, 1993). Helping children recover from the most immediate posttraumatic reactions may directly increase their ability to address the posttraumatic changes in their lives.

Ovaert et al. (2003) found that group therapy was valuable in decreasing PTSD symptoms in children. Patients participating in the study said that by being able to share their traumatic experiences with those who could sympathize with them was an important part of their treatment. Being able to express feelings verbally helped patients to better able to deal with emotions elicited by the traumatic experience. According to Foy, Erickson, and Trice (2001), “it [group therapy] offers advantages over individual therapy in providing a safe, shared therapeutic environment where children who have survived terrible experiences can normalize their reactions and provide support for each other while processing their traumas” (p. 250). Group therapy helps children to build trusting relationships with those involved in therapy. The hope is that children will integrate these skills into their everyday lives and begin to repair the damage to trust relationships caused by the sexual abuse experience.

Psychopharmacology may be indicated in those children whose PTSD arousal symptoms and/or sleep disturbances have increased to the extent that additional impairment in other areas of functioning is experienced, including altered self-concept and personality. In cases of severe anxiety or depression, psychopharmacology may be necessary to bring the child to a stable level of functioning before other treatment interventions can be used.

A wide range of psychotherapeutic and educational techniques have been proved successful in alleviating the PTSD symptoms and distress experienced by children who have been sexually abused. Individual psychoanalytically oriented play therapy and psychotherapy have been used effectively with youngsters who have been sexually abused, as well as group therapy, whereas family treatment modalities have been used with some families that are dysfunctional and abusive (Coons, Bowman, Pellow, & Schneider, 1989). According to Yule (1989), group counseling affords the opportunity to reinforce the normative nature of the children’s reactions and recovery, to share mutual concerns and traumatic reminders, to address common fears and avoidant behavior, to increase tolerance for disturbing affects, to provide early attention to depressive reactions, and to aid recovery through age-appropriate and situation-specific problem solving. Ultimately, the clinician must help the child to see that his or her pathological defenses, personality traits, and distorted object relations that have served to master the abusive experience and to control or ward off further assault are not serving him or her in nontraumatic, nonabusive environments. This can only be accomplished when the counselor helps the child to link these PTSD symptoms and defenses back to the original traumatic experiences, which are uncovered, remembered, reframed, and assimilated in the safety of the counseling setting. Family therapy, when warranted, can also help the family understand the manifestations of the symptomatology of PTSD, the meaning the child has attached to the abuse experience, and how to effectively intervene to help the child return to a healthy level of functioning.

Case Examples

These case examples serve to help clinicians understand the etiology and manifestation of PTSD in children who have been sexually victimized. Although the diagnostic criteria remain the same for each case, treatment interventions used and the implications for counselors treating this population are as unique as the children who present for treatment. Without sufficient understanding in how to treat PTSD in these children, counselors will only feed the monsters that live inside these children’s heads. The names of the children cited have been changed and all identifying information left out to protect confidentiality.

Andrea

Andrea is a 15-year-old, White female adolescent who presented to a residential treatment facility for treatment of behavioral issues related to sexual abuse. Andrea presented to treatment with a long history of physical and sexual abuse at the hands of her uncle and several of her mother’s boyfriends. Andrea’s abuse started at the age of 5 years and continued until she was finally removed from her mother’s custody and placed in the custody of the Department of Children’s Services at the age of 6 years. Andrea meets the diagnostic criteria for PTSD in the following ways.

Andrea seems to have regressed to the developmental level that she was at when the abuse occurred. Andrea sucks on a pacifier, insists on drinking out of a sippy cup, and talks in “baby talk” when addressed. Andrea often has intense psychological distress whenever another child goes into crisis or is aggressive or if adults raise their voice around her. Andrea’s response to
Ben is a 13-year-old, White male adolescent who presented to residential treatment for issues related to sexually offending his 2- and 6-year-old nieces. Ben also presented with his own sexual abuse history, having been placed in the custody of his older brother by his mother a few years earlier. This brother had been convicted and served time as an adolescent for his older brother's children. Ben was also sexually abused by a friend of his brother and, according to Ben, carried on a "relationship" with this 35-year-old man. Ben was diagnosed with PTSD as a result of his own sexual abuse, as well as diagnosed with having sexually abused a child. Ben met the criteria for PTSD in the following ways.

Ben had experienced repeated sexual abuse at the hands of one of his brothers, while experiencing physical abuse at the hands of his other brother. Ben had no contact with his biological father or mother at the onset of treatment; however, 5 months into treatment, Ben's mother began making contact by phone and letter, indicating that she wanted to be in Ben's life. His mother never followed through with her promises of contact and eventually moved and changed her number, terminating all contact with Ben. Ben felt helpless and powerless to change his circumstances, choosing to sexually offend as a way to "empower" himself.

Ben often experienced flashbacks and visual hallucinations in which he saw men in black trench coats. During these episodes, Ben would feel as if the sexual abuse was recurring. Ben would tremble, cry, and often crawl into a corner, pulling himself up into a ball. Ben experienced physiological reactions to external cues, often becoming nauseous or vomiting after witnessing a peer become angry or aggressive or when faced with discussions related to sexual behavior or sexuality. In the beginning of therapy, Ben would avoid discussing his feelings, thoughts, or experiences related to his own abuse. He was uncomfortable discussing his own sexually deviant behaviors but was often more comfortable discussing his sexual offenses than he was his own sexual abuse. Ben felt detached from his family and others, becoming more estranged from his family of origin as his treatment progressed. Ben vacillated between wanting to be with his family and wanting to avoid any contact with them, given that they reminded him of his own abuse. Although Ben had goals for the future, he often felt as if he would never achieve them and viewed himself as a "failure."

Ben was plagued with nightmares during his stay in residential treatment. He often had difficulty falling asleep and concentrating. Ben's outbursts of anger and irritability seemed to be more acute following individual therapy sessions in which both his sexual offenses and personal sexual abuse history were addressed. Ben startled easily and was hypervigilant regarding his surroundings.

Treatment interventions focused on addressing Ben's feelings of helplessness and powerlessness by helping him feel more empowered and in control without his having power and control over others. Other interventions included helping Ben address his cognitive distortions related to his own abuse and the abuse he perpetrated and teaching him more appropriate coping skills. Interventions regarding healthy sexual relationships and impulse control were central to helping Ben successfully transition back into his community. Psychotropic medication was used to help Ben reduce his anxiety level, as well as help him sleep at night.
Gerry
Gerry is a 10-year-old, White boy who presented to residential treatment with a history of sexual abuse by his older brother. Gerry is small in stature, physically resembling a 6- or 7-year-old child. Gerry presented with a history of inappropriate sexual behaviors directed toward his younger siblings. Gerry is a quiet child who often blends into the crowd. Gerry met the criteria for PTSD in the following ways.

Gerry’s history of sexual abuse by his brother lasted for over a year. Given his small stature and the fact that his brother used threats of physical force to keep Gerry quiet, Gerry stated that he often felt powerless to stop his brother from abusing him. Gerry’s reexperience of the traumatic event manifested in his sexualized play with his younger siblings. Gerry complained of nightmares and became visibly shaken when discussing his sexual abuse history.

Gerry’s affect was blunt and flat, and he presented to therapy with a detachment from his surroundings and his family. Gerry lacked the ability to emotionally bond to his family, stating that he felt unable to love them. Gerry refused to talk about his own abuse and the inappropriate sexualized play with his siblings. Gerry initially presented to treatment with a diminished interest in activities that he once enjoyed, such as organized sports. Gerry preferred to play video games alone rather than socialize with others.

Gerry had difficulty falling asleep and difficulty concentrating in school. He was hypervigilant and became agitated whenever changes in his environment occurred. Gerry’s family presented as highly disorganized, with his father placing Gerry in an infant role, while his mother placed him in a parentified role. This role confusion contributed to Gerry’s anxiety, and he responded by further withdrawing emotionally from his family, increasing the estrangement.

Treatment interventions focused on helping Gerry bond with his family by increasing the amount of therapeutic one-to-one time with both his mother and father. Gerry’s attempt to control his own feelings of helplessness were re-created in his sexualized play with his siblings, in which he attempted to gain control by placing them in the role of victim. Interventions focused on helping Gerry normalize his feelings of helplessness and powerlessness. Because of Gerry’s small stature, other interventions focused on ways that Gerry could protect himself from future abuse, given that his perpetrator would eventually return to the home.

Communication issues were a common theme in both individual and family therapy. The use of bibliotherapy and creative expression, such as drawing and writing, helped Gerry express his feelings about his abuse to his counselor (the author) and his family. Gerry was placed in a leadership role among his peers to facilitate the development of feelings of healthy power.

Other interventions focused on Gerry’s inappropriate sexual behaviors with his siblings. Developing empathy for his siblings was crucial in increasing the affective bond between Gerry and his family of origin. Gerry’s ability to dissociate from his surroundings and his family was addressed, and alternative coping skills were explored.

Counselor Implications
Counselor implications for working with someone who presents with issues similar to those of Andrea include carefully considering and accounting for Andrea’s desire to stay stuck at the developmental level of a 5- to 7-year-old, while attempting to facilitate developmentally appropriate coping skills. Further implications include helping Andrea find adequate support resources, given her lack of familial contact, as well as working through the issues of abandonment and loss regarding her brother. Although Andrea desired to stay at the developmental level she was in when she was victimized, she also presented as highly sexualized and often dressed inappropriately for her age. She often talked suggestively toward others, yet when approached by anyone in what could be construed as a sexual way, she reacted within her PTSD diagnosis by having outbursts of anger, crying, and experiencing memory lapses.

Green (1980) described the tendency of some women physically abused as girls to reenact their “victim” status by ultimately choosing physically abusive mates. This tendency toward revictimization may be regarded as evidence of the PTSD symptom of reenacting the trauma. The future possibility of revictimization may increase the child’s likelihood of experiencing PTSD as an adult survivor. Furthermore, Russell (1986) found that between 33% and 68% of the women who were sexually abused as children (depending on the seriousness of the abuse they experienced) were subsequently raped, compared with an incidence of rape in 17% of nonabused women, supporting Green’s position that children such as Andrea may grow up and seek out sexually abusive partners. Naugle et al. (2003) discussed several risk factors, including situational factors and personal characteristics of both the victim and the perpetrator, that increase the risk that child survivors of sexual abuse will be revictimized as adults. Therefore, it is important for counselors working with someone like Andrea to educate her on developing and maintaining healthy sexual relationships into adulthood. The counselor dealing with this population should be aware of the risk of revictimization and help to prepare his or her child clients in an attempt to lower that risk.

Working with Ben’s presenting issues of PTSD was further complicated by his sexual offending. This counselor (the author) often had to balance having Ben review and reprocess his own sexual abuse experience with the inevitable sexual arousal and subsequent deviant sexual fantasies that would arise following such a discussion. Responsibility for his own offenses versus lack of responsibility for his own abuse was often a tightrope this counselor walked. The meaning that Ben attached to his own abuse experience was integral to helping Ben develop empathy for his victims. Given that Ben’s fam-
ily life and subsequent placement following treatment was so unstable, much intervention was directed toward helping Ben cope with this lack of stability, without sexually offending others, and helping him incorporate developmentally appropriate coping skills to cope with his own sexual abuse, while interrupting his sexual assault cycle. Furthermore, Ben also manifested psychotic symptomatology when he felt threatened, either physically or sexually by others. Ben used this pathological defense as a way to protect himself. Interventions focused on helping Ben feel empowered to protect himself from future assault using appropriate strategies.

Like Andrea, Ben needed help in understanding the nature of healthy sexual relationships. Ben viewed his last abuser as a “lover” and a partner in a meaningful relationship rather than as what he was: a sexual predator. This distorted perception of what constitutes a healthy sexual relationship can be traced back to Ben’s sexual victimization by his older brother. Not only was Ben’s perception of romantic relationships skewed by his trauma, but his perception of appropriate sibling relationships was altered as well. Ben’s PTSD symptomatology, which included visual and auditory hallucinations (such as flashbacks of his own victimization), complicated interventions to help him process his sexual abuse history, given that such discussions often triggered these symptoms.

Implications for counselors working with a child who is diagnosed with both PTSD and sexually deviant behaviors face unique challenges. Reliving the abuse experience in someone who has sexually deviant behaviors may send that child into a cycle of sexual perpetration, increasing the likelihood that the child will seek to feel power over his or her own abuse by abusing others. Often, it is the child’s own sexual abuse history that initially motivates the sexual offending behaviors, as was the case with Ben. The feelings of powerlessness and helplessness Ben experienced as a victim were compensated for by his attempts to have power over others sexually. The counselor working with someone like Ben should help empower the survivor of sexual abuse by helping him or her to understand how to protect himself or herself from future victimization without hurting others.

Implications for counselors treating a child who presents with issues similar to those of Gerry are threefold. The first implication deals with Gerry’s dissociative symptoms. It is important that counselors trace the origin of such dissociation to target the purpose such dissociation may serve. In this case, Gerry’s dissociation and subsequent detachment from his abuse experiences and his family served to protect him from the feelings he experienced during and after the trauma. His efforts to avoid the feelings, thoughts, or conversations regarding his sexual abuse experience only served to deepen his dissociation and detachment. Facilitating affective bonding with his family often acted as a trigger to Gerry’s anxiety arousal. The counselor addressing dissociation in a child with PTSD must be careful to be prepared to help the child cope with the feelings that may arise once the child begins to reconnect with the abuse experience and significant others.

Second, because Gerry’s traumatic experience was reexperienced through his sexualized play with his siblings, it is important for the counselor to address the potential for Gerry to become an adolescent or adult sex offender in the future should he not find more appropriate ways to cope with future feelings of powerlessness and hopelessness. Gerry’s sexualized behaviors were manifested more out of a reaction to his own sexual abuse rather than as a motivation to control others. Unlike Ben, Gerry had not yet crossed the line from sexual victim to sexual perpetrator. Counselors should understand the distinction between trauma-specific reenactment and sexual offending behaviors.

Third, Gerry’s family of origin presented with complicated issues. The tendency for his father to “baby” him, while his mother often looked to him as a peer, triggered more anxiety in Gerry. Empowering Gerry to facilitate discussion and ask his father to treat him in a developmentally appropriate role increased Gerry’s confidence to disclose future abuse and communicate with his parents. It was important for the counselor (the author) to educate and model for Gerry’s parents developmentally appropriate roles in which to place Gerry and his siblings. A large portion of Gerry’s therapy focused on empowering his parents to protect him and his siblings from future abuse and providing them with basic parenting skills.

In all three of these cases, each child was diagnosed with PTSD; however, the interventions and implications for counselors differed, given how each child presented to therapy. Although these interventions were case specific, there are some implications for counselors treating this population that are not case specific but also warrant discussion.

There are legal implications for the counselor treating a child who has been sexually victimized who is experiencing PTSD. According to Walker (1993), “in forensic cases, a diagnosis of PTSD sometimes makes the difference in whether a case can proceed to trial or not, especially when the alleged perpetrator denies the abusive behavior” (p. 131). Walker was quick to add that a diagnosis of PTSD in and of itself does not prove beyond a reasonable doubt that a child was sexually victimized.

A diagnosis of PTSD may help to explain the denial and retraction of the abuse experience by children who have been sexually victimized (Dutton, 1993). The avoidance phase of PTSD is often characterized by the child’s repeated denial of the abuse experience. This may even occur after the child has disclosed the abuse, in the form of retraction (Bradley & Wood, 1996). By articulating to the court the avoidance phase of PTSD, the counselor can help to bolster the child’s credibility in a legal hearing.

Another implication for counselors has to do with the reviewing of the abuse experience, especially if the counselor uses implosive therapy or flooding. Flooding the child with memories of the abuse experience may only intensify the PTSD symptoms, particularly avoidance, and therefore hinder treatment. The counselor who uses this technique should proceed with caution and be prepared to deal with the possible flood of emotions this technique might release.
Diehl and Prout (2002) found that PTSD symptomatology in children who have been sexually abused can negatively affect survivors’ self-efficacy. The abuse experience alone can leave the child survivor feeling that he or she has little to no control over his or her actions, emotions, thoughts, and behaviors. Counselors should keep in mind that by helping the child survivor effectively cope with and manage the effects of PTSD, they may in turn help increase that child’s feeling of power over his or her own destiny. In other words, although the child survivor had no control over the abuse, he or she does have control over how that abuse affects and/or defines his or her sense of self.

The accuracy of the diagnosis of PTSD has serious implications for counselors. It is crucial that the DSM-IV-TR (APA, 2000) criteria be met for a diagnosis of PTSD. The counselor must also be cognizant of the likelihood of psychiatric co-morbidity in childhood PTSD. Differential diagnosis is critical, given that a child may manifest symptoms of numerous disorders, never meeting the full criteria for any one specific disorder. The accuracy of assessment and diagnosis is crucial when formulating a treatment plan. If the diagnosis itself is not accurate, then how beneficial will the subsequent treatment be to the child?

Finally, the likelihood and severity of PTSD in victims of child sexual abuse depends on several variables: (a) the age and developmental level of the child; (b) the child’s preexisting personality; (c) the onset, duration, and frequency of the abuse; (d) the severity of the sexual abuse; (e) the relationship between the child and the perpetrator; (f) the family’s response to the disclosure; (g) the institutional response (e.g., police, social workers, attorneys); and (h) the availability and quality of the therapeutic intervention (Friedrich, 1990; Salter, 1995).

PTSD can strike at any time in the lives of children who have been sexually victimized. The intrusiveness of the memories of the abuse is more than their young minds can handle, and they are constantly trying to find a way to escape the monsters in their heads.

References


Posttraumatic Stress Disorder and the Child Survivor of Sexual Abuse


