NO ORDINARY LIFE

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Sandy Knauer is a licensed Clinical Social Worker who specializes in treating sexual abuse. She graduated cum laude with a bachelor's degree in psychology from the University of Delaware.

Her master's in Social Work is from Delaware State University. Sandy is employed in three different clinics by the largest not-for-profit mental health agency in her home state, where she has pursued her interest in sexual abuse recovery for the past seven years. Currently Sandy and her cotherapists Fran Livingston, L.C.S.W., and Bob Davis L.C.S.W., are attempting to establish a treatment center and group home that will be devoted specifically to treating sexual abuse survivors and training other therapists to work with and value this special population. Sandy has three children and lives in Middletown, Delaware.

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Parenting the Sexually Abused Child and Adolescent

By

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Sexual Abuse Professionals

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This book is dedicated to "Bob" and the groups.
Thank you all for the love you have shown and how much that you have taught me about trust, healing, and compassion. You are truly the "magic" that makes life worth living.

PREFACE

Raising sexually abused children can be very challenging. Unfortunately, there is not much practical information available about dealing with the problems involved in parenting these exceptional children and adolescents.

When a child or an adolescent has been sexually abused all of their boundaries (spiritual, physical, and psychological) have been violated. The caregivers of sexually abused children have difficulty in knowing what behaviors to expect from their children. The caregiver may either not hold the child accountable for their negative behaviors because they feel that the child is too damaged by the abuse or they may expect the child to be as unaware of sex as the child was before the abuse. Once the survivor has been awakened to sexual activities the survivor may not possess the cognitive abilities to deal with the experience of sex. This book will help the caregiver to establish the appropriate expectations and sexual boundaries for this population.

No Ordinary Life: Parenting the Sexually Abused Child and Adolescent addresses subjects such as the signs of sexual abuse; what to do once a disclosure of sexual abuse is made, what to expect in the legal and judicial arenas; dealing with acting out behaviors such as eating disorders, self-mutilation, anger, shame; disciplining the sexually abused child and adolescent; survivors in foster care and group homes; intimacy and sexuality among child and adolescent survivors; survivors as parents; healing from sexual abuse; ways to break the cycle of incest and sexual abuse, and how to start a survivor's group. Two chapters at the end of the book include letters from the survivors' groups and a letter from an incest father.

The book not only assists in parenting the child or adolescent survivor, but will assist in reparenting the adult survivor who may have not yet dealt with his or her own abuse issues. Since the author specializes in treating sexual abuse in a multigenerational basis there is much information concerning the cycle of sexual abuse and the dynamics which are its root causes.

The author is employed by the largest nonprofit mental health provider in her home state. The most important ingredient that the author has found for successfully treating sexual abuse is the optimism that she feels for the ability of the survivor to heal. Although this book can be graphic, it is also inspir-

ing and uplifting. The respect and affection that the author feels for these special clients shines through in this informative book.

S.K.

INTRODUCTION

Of all the questions I am most asked, no one question is repeated more than, "Do you really believe that sexual abuse happens as much as people say?" Most times this question is asked by someone who wants to believe that sexual abuse doesn't happen. Perhaps this person is someone who has been personally touched by the allegations of sexual abuse. Someone that they care about may have been accused of sexually abusing someone. The thought that the abuse may have actually occurred may simply be too painful for consideration.

For whatever reasons one might have to question the validity of sexual abuse, sexual abuse *does* happen. It probably happens in much greater numbers than are ever reported to the authorities. The reasons for the discrepancy in the actual occurrence of the abuse and the reporting of the abuse will occur later in this book. Most people who are eager to deny the existence of sexual abuse will no doubt still agree that allegations of sexual abuse alone are devastating to the alleged perpetrator and the alleged perpetrator's loved ones.

At a recent adolescent sexual abuse survivor's group meeting that my cotherapist, Bob Davis, and I facilitate, the task of helping educate a nonsurvivor to what sexual abuse "felt like" was given to the group. Bob is not a survivor, while I am an incest survivor. Only a moment before the question of what sexual abuse "felt like" was raised, the group had been laughing and joking with each other in their usual style of camaraderie. The room became charged and silent. The prevailing mood was one of overwhelming sadness and despair. The facial expressions of the group members indicated just how much pain the abuse had caused each member. The group members began to share their stories. It was almost as if there existed some sort of shorthand, which allowed one member to begin to express their feelings about the abuse and another member to finish the sentence.

The group ranges in age from eleven to eighteen years. The answers to the question, "What does sexual abuse feel like?" were varied, but all the responses were the same in one fashion: Sexual abuse is your worst nightmare magnified a hundred times. Most survivors felt that if the abuse did not occur on a regular and a predictable basis, that the unpredictability of the

timing of the abuse made the abuse that much worse. It was as if knowing that the abuse was going to occur on a predictable basis made the survivor somehow more prepared to deal with the abuse and the abuser.

One of the group members said that looking at the abuser was like "looking into the eyes of the devil." Another group member remarked that the abuse was like "taking a trip to hell." The intensity of the emotions in the room became so overwhelming that several of the group members began to cry.

Both my cotherapist and I have been very careful about having group members disclose specific details concerning their individual abuse histories. Many times, when group members disclose specific details about their abuse histories, other members of the group will begin to compare their own abuse histories. Sometimes, group members will feel that either their own abuse was so less intrusive that they don't belong in the group or that the abuse that they experienced was so much more intrusive that they are ashamed to talk about it.

As one of the group members began to talk about the abuse she had experienced and began to give specific details, another group member began to softly cry. She had experienced the exact same abuse, in the exact same way. The irony of this disclosure was that neither member had ever disclosed the details of the abuse before and the details of the abuse were very unusual. It soon became apparent that there exists a real bond between survivors that only shared survivorship can forge.

Soon the intensity of the emotions in the room became so charged, that my cotherapist and I found it necessary to try to lighten the topic and mood. Several of the group's members have a history of previous suicide attempts. To allow them to leave the safety of the group setting to go into the outside world without the support of the group and the therapists could prove to be too much for them to handle.

What can we learn from this experience? Can a nonsurvivor really be educated as to what sexual abuse feels like? If we try to generalize the experience of sexual abuse to other forms of abuse, it may be possible to imagine what sexual abuse does to a person.

Verbal abuse has a tendency to lower the recipient's self-esteem so much that oftentimes the victim will simply give up trying to live up to his or her inherent potential. Physical abuse can make the recipient so fearful that he or she becomes immobile and unable to leave the abusive setting. Sometimes, the recipient of physical abuse will later on become the abuser of another hapless victim of physical abuse. The same can be true of the victim of sexual abuse.

All forms of abuse share the emotions of fear, rage, helplessness, and sadness. Perhaps of all forms of abuse, sexual abuse seems to cause an overwhelming sense of shame. Many times, shame is what allows the perpetrator to continue the abuse without the victim telling someone about it.

It is not telling immediately after the sexual abuse has occurred that causes many nonsurvivors to doubt that the abuse has really occurred. In reality, the delay between when the abuse occurred and the disclosure of the abuse sometimes is the time needed for the victim to feel safe enough to tell of the abuse. Many states have statutes on their judicial books that allow incest victims to not disclose the abuse until they are older and out of the home setting where the abuse was happening. Incest victims often are so dependent on their abusers for their substinence that they are not safe enough to disclose at the time of the abuse. The delay between the abuse and the disclosure of the abuse does not indicate that the abuse did not occur.

I would just like to touch for a moment on *repressed memory syndrome.* Some victims will not be able to recall their abuse until many years after the abuse has happened. Without any warning, the slightest happening might trigger their memory of the abuse.

There is such controversy about the existence of repressed memory syndrome. I have never had to go looking for memories with the survivors with whom I work. That does not mean that repressed memory syndrome does not exist, however. The survivors I work with are younger, for the most part. This closeness in time to the occurrence of the abuse might account for the less frequent occurrence of repressed memory syndrome.

The older adult survivors that I work with usually have come into treatment because the pain from their sexual abuse has become so great that they can no longer deal with the feelings. Many times it is their own child being sexually abused that has brought the adult into treatment. Again, the closeness in time between the abuse happening and it being reported is much shorter than it would be in a situation involving repressed memory syndrome.

Is a nonsurvivor ever able to really understand what sexual abuse does to the victim? Perhaps nonsurvivors can understand if they are sensitive enough and are willing to look into the face of the survivor and experience the despair and degradation that sexual abuse causes. Maybe it is not so much an intellectual understanding that is needed, but an emotional and spiritual understanding of what it is to be a survivor.

Was my cotherapist ever able to understand what it feels like to be a survivor? I believe that as much as it is possible to understand an experience without having experienced the event, my cotherapist did understand what sexual abuse was like. The look of sadness on his face and his humbled posture indicated that, at least in an emotional sense, he did understand.

The group members have accepted him as a group member because he has had the courage to listen to their abuse histories without turning away. To the group, he has earned his membership not by being a sexual abuse survivor, but by his willingness to enter into a relationship with the group members that he knew from the onset would be extremely painful and traumatic.

If you are a survivor reading this book, it is our greatest hope that you will be able to experience a kinship with the other survivors in this book. It is this kinship that we have found that helps survivors deal with the most painful of their experiences. I have often compared this kinship to dancing on the edge of a large pit in the ground. When trying to reach down into the pit to help lift up a fellow survivor who is trapped by overwhelming feelings of despair, one always risks being pulled back down into the pit themselves. It is the reassurance of fellow survivors that allows us as therapists to have the necessary courage to reach down into the pit time after time, knowing that there is always the possibility that we may ourselves be pulled into the pit.

If you are not a survivor yourself and you are reading this book, it is our sincere hope that by reading of the experiences that survivors have shared in this book, you will develop a greater understanding and appreciation of what it truly means to be a survivor.

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I would first like to thank all of the clients who have contributed so much to what I have learned about treating sexual abuse. By sharing their stories and fears, these courageous people have been able to overcome their own abuse histories and give something back to others–hope. These clients will never know how much they will help other survivors who read this book to heal.

I would like to thank Bob Davis, L.C.S.W. (the kids in the groups have nicknamed him "Boob"–I was never able to figure out why!) for all his support and understanding. Bob, you never doubted that this book would be written or published. Thank you for believing in me when I wasn't able to believe in myself.

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Thank you to my family for putting up with all of the things that I couldn't do with you because I was busy working on "the book." Not only will this book help others to heal, it has helped give closure to this author's journey of healing.

AUTHOR'S NOTE

Although the scenarios in this book are based on actual case histories, all of the names and the details of the clients have been changed or combined in order to protect confidentiality. Any resemblance to an actual client's case history is accidental. Client confidentiality is of primary concern and importance.

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NO ORDINARY LIFE

Chapter 1

SYMPTOMS OF CHILDHOOD SEXUAL ABUSE

Since I specialize in treating sexual abuse in children and adolescents, I probably have heard just about every question pertaining to sexual abuse. The most frequently asked question is by parents of young children,– "How do I know if my child has been sexually abused?"

It's not only the child's caretakers who want to know if the abuse has occurred. The legal system wants to know if the abuse really happened so that they can protect the child and prosecute the alleged perpetrator. State family services departments, charged with keeping children safe, want to know if the child is safe in the current home setting or if someone in the family home needs to be removed in order for the child to be safe.

How do we know for sure if the child has been sexually abused? Young children present a very difficult task in that their vocabulary is so limited that they don't usually know the words to properly describe sexual abuse.

Whether the child says that the abuse did or didn't occur, there are always questions and doubts in everyone's minds as to what really happened. Since sexual abuse usually occurs with only the alleged perpetrator and the victim present, it is often impossible to tell if the abuse occurred or not. In some cases, there may be physical evidence that the abuse happened. This evidence may consist of signs such as vaginal or rectal scarring or tearing. The evidence may consist of a sexually transmitted disease that a young child would never have gotten without being exploited by a sexually active older person.

Whenever there is physical evidence, the odds of the child having been sexually abused greatly increase. With the physical evidence there is much less controversy about whether the abuse happened.

But what if there are no physical signs that the child has been sexually abused? How do we determine if sexual abuse might have occurred in our children? While there is no one sure sign of sexual abuse, if we get a cluster of symptoms, we may be able to ask the right questions of our children that will enable them to tell us of sexual abuse that may have occurred.

One of the most common signs of sexual abuse in young children is a noticeable change in the child's regular behaviors. Carmen is a seven-year-old Hispanic female who previously participated in classroom activities and had satisfactory grades on her report card. When the teacher would ask the class a question, Carmen began to withdraw and avoid the teacher's eye contact. The teacher noticed that many times Carmen seemed as if she were in a trance or a daze. Carmen would seem to be daydreaming so intently that it was very difficult to get her attention. It seemed at times as if Carmen was in another place instead of the classroom. On several occasions the teacher noted that Carmen seemed to be rubbing her genital area against the leg of her desk.

The school notified Carmen's mother and asked if there were any problems at home that may have been troubling Carmen. Mother, a recently divorced single parent, replied that she knew of nothing new that had happened to Carmen. Mother did mention to the teacher that Carmen had recently begun wetting the bed and refused to sleep in her own room unless the light was left on all night. Carmen had had nightmares on several occasions and refused to go back to sleep unless she was able to sleep in her mother's bed.

Carmen had begun to display physical ailments that were being treated by the family's pediatrician. The doctor had diagnosed urinary tract infection two times since Carmen had begun school four months previously. Carmen had also begun to complain of being constipated.

Both the family pediatrician and Carmen's mother had attributed the urinary tract infections to washing Carmen's underwear by hand and not getting all of the detergent out of the fabric. The constipation had been explained as being the result of being in a new classroom and being too shy to ask to use the bathroom.

Almost all of Carmen's behaviors could have been explained by saying that Carmen was stressed by being in a new setting. In reality, Carmen was being molested by her own father. Father was attempting to have both vaginal and anal intercourse with Carmen. Since Carmen was so young and still so small, father was not able to complete the sexual acts.

When Carmen asked her father what he was doing to her, he replied that this was something that all fathers did to help their daughters grow up. Father emphasized to Carmen that if she told anyone what he was doing to her, she would get in trouble. Father also told Carmen that if people found out what he was doing, Carmen would get him in trouble and he wouldn't be able to see her anymore. Since Carmen's parents were divorced and Carmen was not able to see her father very much anyway, she did not want to say something that would cause her father to be absent from her life anymore than he already was.

When I first saw Carmen, it was to try to figure out why Carmen's grades were so poor and why Carmen couldn't seem to focus or retain what she had learned. When her mother described Carmen's behaviors, I began to suspect sexual abuse. One of the first things that I do when I see a child that I suspect may have been sexually abused is to teach the child "good touch–bad touch." Teaching the child how to determine whether a touch is appropriate or not is the best way of teaching the child how to protect themselves from sexual abuse. I also use good touch–bad touch as a way of allowing the child to disclose sexual abuse that may have already happened to the child.

Forensic drawings of children similar in age to the child with whom I am working can be very useful. Forensic drawings are nude drawings that are anatomically correct with all the body parts. I will draw a line from the different body parts on the nude drawing of the child. I will then write down on the forensic drawing whatever it is that the child calls that particular body part. From that moment on, I will use the exact language that the child uses when they refer to certain body parts. This enables me to speak to the child in a manner that they will understand much more clearly.

The child and I will discuss which parts of the body are private and who should be allowed to touch the various parts of the body. The child and I also will discuss various circumstances that might change whether a certain part of the body can be touched or not. For example, it may be appropriate to have someone hug you around the shoulders if you are fully dressed. Is it still appropriate to have someone hug you around the shoulders if you are only wearing a bathing suit? I always allow the parents to view the anatomical drawings before I use them with the child. At the end of the session I will ask the parents to come into the session to help the child determine what is appropriate touch for that particular child and family.

One of the final components of teaching good touch–bad touch is having the child identify private parts of the body that only the child, a parent under certain circumstances, and the doctor or dentist can touch. Usually the areas that are especially private include the vagina or penis, the buttocks, the breast area, and the mouth. Most families don't think to include the mouth. We don't like to think of sexual offenders involving our children in oral sex, but this happens all too many times.

If the parents want to use the anatomical drawings to teach good touch–bad touch and the drawings are not available, they could use a simple drawing of a child from a child's coloring book. By drawing lines to the different body parts, the child could use familiar language to identify the various body parts. It is not necessary to have the forensic drawings to teach good touch–bad touch.

After the child has identified the four most private areas (the buttocks, vagina or penis, breast area, and the mouth), I will ask the child what he