tionality, manipulation, anger, negative attention-seeking—may be these youngsters' way to assert boundaries, get their needs met, and exert control in ways denied to them previously.

Adolescents have the disadvantage of coming in bigger packages than younger children, and therefore running the risk of being seen as off-putting, threatening, oppositional, or opinionated, rather than assertive and autonomous. Clinicians must constantly address their countertransference responses to avoid engaging with adolescents in interactional modes reminiscent of their dysfunctional parents. Clinicians must also monitor adolescents' transferential responses and behaviors designed to elicit negative, hostile, or sexualized responses.

CHAPTER FOUR

Assessment and Treatment

ASSESSMENT CONSIDERATIONS

Most adolescents are referred for treatment because their behavior is worrisome or problematic to someone. Although on occasion I have worked with youngsters who seek therapy themselves, this appears to be the exception rather than the rule. Most of the adolescents referred to me have had presenting problems such as sadness or moodiness, self-injury or self-destructive behaviors, substance abuse, suicidal ideation, difficulty making and keeping friends, aggressive behaviors, and/or sexual acting out (including indiscriminate sexual activity or committing sexual offenses). Discussing the emotional and behavioral effects of adolescent physical abuse specifically, Farber and Joseph (1985) found six patterns of reactions: acting out, depression, generalized anxiety, extreme adolescent adjustment problems, emotional–thought disturbance, and helpless dependency. Each reaction led to specific symptomatology. For example, generalized anxiety could result in lack of trust, rationalizing and manipulating, poor concentration, impaired identity development, and academic failure. Many acting-out behaviors may be or have the potential to become life-threatening, such as practicing unsafe sex, becoming substance-dependent, and taking physical risks (e.g., driving under the influence, jumping off bridges, or walking toward traffic on the freeway). Some adolescents become severely depressed and suicidal (internalizing their distress), whereas others become hostile or violent toward others (externalizing it). Finally, parents may bring their youngsters to treatment for a range of problem behaviors that could best be summed

up as defiance, oppositionality, isolation, lack of interest in other family members, and negativity. In short, adolescents' symptomatic behaviors can be multiple, varied, and often frightening, and some clinicians stay away from the implied responsibility of trying to help youths who appear so disturbed. Although my clinical experience has been providing outpatient therapy, I often refer youth for psychiatric evaluations to determine suicide or homicide risk, the need for psychopharmacological treatment, as well as situations that require hospitalization. Abused adolescents may benefit from specialized hospital units providing structured inpatient care on issues of prior or current abuse (Cantor, 1995). In addition, referring for psychiatric consultation ensures a team approach, often helpful or necessary in the treatment of abused adolescents.

Children and adolescents are often brought to treatment by parents or caretakers who have abused or neglected them, although these adults rarely announce this at the outset. Every now and then I have been impressed with a parent's ability to engage in self-evaluation, recognize the potential impact of his or her behavior, and show interest in seeking help, no matter what personal cost of embarrassment or shame may ensue. Conversely, I have worked with parents who describe a litany of behaviors that I consider abusive, but that they have normalized as suitable caretaking behaviors.

Many of the symptoms I have listed above occur for reasons other than abuse or neglect, and it is important to approach each case with an open mind about an array of possible contributors. Although this book concerns itself with documented or verified cases of maltreatment by parents or other trusted figures, it is important to note that some adolescents do lie, exaggerate, or fabricate stories about childhood abuse for secondary gains. However, studies addressing the issue of "fictitious allegations of child abuse" indicate that few stories of abuse are fabricated, that these cases occur relatively infrequently, and that when they do occur they are likely to originate in parental coaching, adolescents' attempts to manipulate their circumstances, or children and adolescents suffering from PTSD (Jones & McGraw, 1987). In my experience, when adolescents are lying about childhood abuse, their facts become confused and inconsistent; they make their disclosures urgently (as opposed to the more common delayed or hesitant style of disclosure); they are unable to provide idiosyncratic information (including sensorimotor details); and they have obvious secondary gains (e.g., living with one parent or another, avoiding conflict with a new stepparent, etc.). My perception of fictitious allegations from adolescents is that they are a call for help and require careful and sensitive therapeutic intervention. Obviously, these youth must understand the impact of their untruth on others, set the story straight, and make reparation efforts.

However, when clinicians determine that an adolescent does indeed have a history of abuse, assessment should include inquiry and observation about the idiosyncratic impact of the abuse, how it has been processed by the client, and whether it interferes with normative functioning or has disrupted developmental transitions. It is important to suspend judgment regarding the impact of abuse: Although my experience and training naturally lead me to view abuse as deleterious to children and adolescents, I must acknowledge that some abused youngsters cope with their experiences by utilizing a range of internal and external resources that allow them to escape the most negative consequences of early abuse.[1] At the same time, it is critical to assess the issue of child abuse impact throughout treatment, because some young clients' defensive mechanisms (such as denial or dissociation) may disguise negative impact, and youngsters may not be initially prepared to engage in discussions about past experiences that they may consider shameful, irrelevant, or private. Some youngsters feel disloyal discussing their families in anything but a positive light, whereas others speak of their families *only* in a disapproving or disparaging fashion. My priority is to understand what meaning they have attributed to their abuse experiences, and to determine whether the abuse background has or does not have a link to current problem behaviors.

[1]All forms of abuse and neglect have the potential to be traumatic to children. Although child abuse always victimizes and exploits children, not all victimized children are traumatized by their experiences. Careful assessments must distinguish between victimization and traumatization responses. This distinction is critical to inform treatment goals and strategies (Gil, in press).

Although I initially attend to presenting symptomatology, I also always explore its underlying causology, in order to address this dimension of concern as well as the more obvious behavioral signs of distress. Abused adolescents find and utilize creative and inspired means of communicating their pains, their joys, their worries, and their distress. If we look and listen without making premature judgments, it is possible to reach a better understanding of the true and hidden meanings in children's behaviors. Whether these hidden or compartmentalized meanings are addressed directly will depend on a variety of factors. For example, while defensive mechanisms may have been valuable and may have spared children the direct impact of experiences with potential to traumatize, the difficult experiences can remain unprocessed and unresolved, creating reactions and expectations that influence and shape current functioning. It is when material from the past *shapes* events, interactions, belief systems, or expectations in the present that youngsters are likely to benefit from revisiting (*not* reliving) the past in a structured and purposeful way. This will enable them to disengage from it, to move toward a greater sense of personal power and self-regulation, and to make conscious choices that will influence the present and the future.

Assessment should therefore consider general developmental questions; issues regarding self-image and self-esteem; internal and external stressors; depression and suicidality; exposure to or involvement with high-risk behaviors, such as substance abuse or antisocial behavior; interactional difficulties; and family problems. Singer et al. (1993) discussing adolescents at psychosocial risk, also encourage assessment of psychoses, reproductive health behavior, traumatic brain injury, attention-deficit/hyperactivity disorder, and involvement with youth gangs. In addition, when a concern exists about prior abuse, abuse-specific issues must be assessed (e.g., problems with self-reference, attachment, dissociation, PTSD, impulsivity, guilt, violence, or sexually aggressive behaviors. Friedrich (1995b) suggests a number of generic and abuse-specific assessment instruments that can be used with children and their families. In addition, Hussey and Singer (1993) developed an excellent resource called the Adolescent Sexual Concern Questionnaire. Urging "a new appreciation of the possibilities for partnership between treatment and research," (p. 1421), Finkelhor and Berliner (1995) suggest that generic and abuse-specific measures be used together when assessing abused children and adolescents.

Abused adolescents are often perceived as more difficult clients than younger children. When I have asked colleagues to identify the origins of this difficulty, they suggest several factors: Adolescents are resistant; they don't cooperate or comply with treatment; they can be verbally abusive; their range of problem behaviors can appear more pathological than that of younger children; and they are often impulsive. Some colleagues have also confided that adolescents "push their buttons," bringing out a controlling, punitive side of themselves that they don't like. The end result is that those who have difficulty working with adolescents seem to feel frustrated, defeated, and useless–feelings that increase their sense of incompetence in working with this age group. Of course, no one likes feeling incompetent, and some professionals simply work harder to compensate for their feelings of failure; this, in turn, can result in battle fatigue and a lack of enthusiasm about their work.

Many adolescents exhibit a range of problems in miscellaneous settings, including their own homes, foster and group homes, residential treatment centers, schools, and institutional correctional facilities. These youngsters will signal their distress until they are able to relieve some of their pain, confusion, or isolation, and release some of their pent-up affect. It appears that among the most common sources of despair and unhappiness for adolescents are family conflict, neglect, and physical or sexual abuse.

Because most adolescents continue to be in the legal (if not physical) care of their parents, and because their emotional and physical safety is paramount, a comprehensive assessment must include interviews with the entire family. In particular, if the adolescent has been a victim in the past, or has been a victim of out-of-home abuse, the family's ability and willingness to offer support, guidance, and nurturing must be evaluated. The "Guide to Family Observation and Assessment" (Singer et al., 1993) is a very useful conceptual framework for assessing families in a systematic way. Clinicians using

this guide will observe and inquire about a number of variables including family "nationalism" (p. 18); involvement; respect; appreciation of developmental needs, abilities, and positive behaviors; parental perceptions of children as a subgroup; generational distinctions; adult/spousal alliance; family communication; family problem-solving and communication skills; family rituals; use of humor and play; domestic violence and substance abuse; sources of family stress; and family involvement with the community. There are other assessment instruments specifically designed for evaluating parent–child interactions and family functioning that might also be helpful in conducting adequate family assessments such as the Parent–Child Relationship Inventory (Gerard, 1994); Parenting Stress Index (Abidin, 1990); and the Family Environment Scale (Moos, 1979).

MY PERSONAL APPROACH TO TREATMENT

My professional persona has been shaped by a great many influences, including things I have read, courses I have attended, teachers, fellow students, and colleagues who have influenced my general approach to treatment through modeling ethical and compassionate clinical work, and my own clinical experience for the past two decades. My clinical experience has been, originally by accident and later by design, skewed: Almost all my clients seek therapy, ordered to do so by the courts, social services or probation departments, as a result of child abuse and neglect. I therefore acknowledge that I am less familiar with problems that do not have their roots in childhood abuse, and this makes me more inclined to find early abuse experiences of great significance in the treatment process.

On the other hand, I have had friends and colleagues (as well as some clients) who seem marginally affected by their abuse experiences, and at times even seem fortified by their early difficulties. The old adage "What doesn't kill you makes you stronger" may be true for some individuals, who manage somehow to balance their abuse experiences by finding ways of overcoming–and, in fact, utilizing–experiences that have been painful, exacting, or temporarily debilitating.

Lastly, it is abundantly clear to me that some people survive by denying the facts or the impact of early childhood abuse. They simply deny these early events, will not discuss them, and make conscious efforts to "forget" that which is unpleasant and no longer in their control. In addition to these individuals who consciously suppress their painful histories, others may instead unconsciously repress information, casting it likewise out of conscious awareness. Probably a clearer way of describing repression is to think of it as dissociated memory that remains fragmented and unassimilated.

Providing treatment to individuals with histories of childhood abuse is therefore complex and challenging, and must be tailored to each individual on a case-by-case basis. Techniques that work with one client may be abysmally ineffective or counterindicated with others. As a clinician, I must remain flexible and open to developing treatment interventions with my clients; interventions must be based on what they report and the insights they achieve in treatment, as well as what I observe and share with them. Therapy is never a rigid plan imposed *on* my clients, but rather consists of an exchange of ideas and suggestions, mutually generated and tested. Its success in each case is evaluated through a client's decrease in symptoms and improved general functioning.

AN INTEGRATED THEORETICAL FOUNDATION

Because abuse and neglect have the potential to harm growing children and adolescents in the numerous ways and dimensions described in this book, a number of theoretical frameworks will provide useful guidance and assistance in formulating treatment plans.

One of the most concise statements I have ever read about the therapeutic role is that offered by Elsa Jones (1991). Jones has captured many of the elements that constitute my therapeutic stance:

> As a therapist, I assume that when someone approaches me for help with the difficulties they [*sic*] are experiencing these may be linked to factors both in their past and in their present, and may have individual and "internal" components as well as interactional and contextual ones. I assume that there is a looping relation-

> ship between action and meaning, so that a change in behavior may well lead to the attribution of different meaning, just as a shift in the assumed meaning of events may lead to changes in behavior. I assume that each individual has resources and strengths, no matter how despairing they may be feeling at the moment of coming to therapy, and that it is my job to help them find access to these, without minimizing the seriousness of the troubles by which they may have been overwhelmed. I also assume that people themselves have a better idea of their own history, values, creative resources, and what solutions are likely to fit for them, than any outsider can ever have, so that the therapist's task is, as it were, to help clients roll obstacles out of their path, but not to point out the route they should be following. At the same time I am aware, on the basis of theory as well as observations in therapy and in my own life, that it is difficult to attain an overview or meta-perspective on one's own situation, so that sitting down to talk with someone else, whether a professional therapist or not, may be necessary in order to begin to look at events, connections, and previously obscured aspects of the patterns of action and relationship that accumulate around "the problem." I therefore assume that I am unlikely to know the answer to the client's dilemmas, but that my systemic curiosity, my technical skills (e.g., in asking circular or hypothetical questions), my respectful search for their own skills and resources, my widening of the area of inquiry to include wider contexts that may previously have been left out of account, my challenge to set ways of thinking, and my attempt to create a safe and containing space in which the unthinkable and unsayable can be expressed, will have the effect of freeing up the client's own ability to explore, to grow, and to resolve dilemmas. . . . In summary, I might say, then, that the therapist's major task is to introduce "news of difference" (Bateson, 1980)—that is, flexibility, complexity, options, different perspectives—into the therapeutic conversation with the client, so that the experience of being stuck and having no choice can change into one feeling freed up to create one's own preferred new ways of relating to self and others. (pp. 7–8)

I find a number of Jones's beliefs and opinions invaluable: her view that current difficulties may be linked to factors in the past and present; her respect for individual, interactional, and contextual contributors; her stress on the relationship between action and meaning; her belief in the individual's creative resources, strengths, and history; the notion that many individuals have the ability to find their own solutions; and her emphasis on the client's ability to grow, explore, and resolve dilemmas. I also value her definition of the therapeutic "job," including the clinician's attempts to help individuals find their own resources and solutions; the efforts to roll obstacles out of clients' path without pointing to specific routes to follow; and the application of therapeutic curiosity and broadening of options so that individuals can empower themselves.

Straus (1988) champions an ecological perspective in the treatment of adolescent abuse. She reminds us practitioners "must have available an array of approaches from which to select the most suitable" (p. 110), and she suggests an understanding of the background characteristics of abusive parents (ontogenic development); the interaction among family members (microsystem); the family's relationship to community and helping agencies (exosystem); and the larger cultural fabric of the individual, family, and community (macrosystem).

With this broader context in mind, I draw from other theoretical frameworks to guide my treatment approach. In particular, I am convinced that child abuse and neglect inherently cause disruptions in attachment, and that these disruptions therefore contribute to relational difficulties. The notion of secure and insecure attachment is aptly described by Bowlby (1969, 1973). Attaining secure attachment is one of the first developmental tasks of childhood, and when this task is not successfully completed, it can cause ongoing difficulties in establishing necessary intimate relationships. In particular, a child who is abused early in life may need to resolve attachment-related issues of trust and dependency; until these are addressed in some fashion, other developmental tasks may remain partially or fully unresolved.

When a clinician is considering an individual's context, various other developmental theories can also provide a deeper understanding of the issues that may need attention and resolution. For example, Erikson's (1963) theory of personality development dovetails nicely with Kegan's (1982) focus on identity and self-formation, and

together they provide the theoretical impetus for a focus on the individual's evolving sense of self and identity. Kegan (1982) and Coopersmith (1967) note together that the following elements are critical to the formation of positive identity and self-esteem: feelings of significance and belonging; feelings of virtue; attainment of love; and feelings of personal power, mastery, and control. Unfortunately, all of these are compromised by child abuse and neglect.

Since abused children are by definition victimized, the dominant story they form of their lives is often a "problem-saturated" description that has been reinforced in many ways, "leaving no space for them to perform another story" (Kamsler, 1990, p. 21). Narrative therapy has greatly influenced my thinking in this area, partly because it is so nonpathologizing, but also because it urges specific clinical interventions that provide "news of difference," so that clients can see possibilities for new solutions and new self-narratives. Thus, they can balance or rescript a fuller sense of identity–one that is not "abuse dominated," but rather competency-based.

Trauma theory, particularly as defined by van der Kolk (1987), advances the idea that unresolved trauma can cause behavioral reenactments, compulsive behaviors, PTSD symptoms, and physiological responses that can debilitate individuals or cause global impairment. Terr (1994) defines two types of trauma (Type I and Type II), which require different interventions. Herman (1992) suggests that generic PTSD does not fully coincide with what she terms "complex PTSD," which is experienced by survivors of chronic, repetitive, and severe abuse. Herman contends that many survivors of such prolonged trauma experience polarized sensations of numbing and hyperarousal, and that problem behaviors accompany both types of responses (e.g., internalized behaviors such as depression, and externalized behaviors that may put an individual in harm's way). There is a consensus among clinicians who work with trauma that the traumatic experiences must be brought into conscious awareness and processed, with a goal of integrating the material in a less fragmented manner (Herman, 1992). As Cuffe and Frick-Helms (1995) state, "the trauma-specific phase of treatment should focus on the traumatic aspects of the abuse, allowing expression of affects and working through of traumatic memories" (p. 235). However, trauma-specific treatment must be undertaken with great caution and in a structured, purposeful fashion; it should also not begin until individuals have adequate ego strength and an expanded repertoire of coping strategies.

Because the issue of child abuse or neglect almost invariably emerges within the context of family interactions, it is valuable to use a systemic approach (through one individual client, or with several or all family members present), particularly since each family member is affected by parental maltreatment. Abused children often learn to behave in ways that are designed to make them feel safer (e.g., hitting or threatening people), but that instead elicit more negative responses, which then reinforce their already developed feelings of being unworthy or unacceptable. In addition, it is ineffectual and limited to work with abused children and adolescents without making active efforts to protect young clients when they need protection; to educate abusive families by providing them with alternatives to abuse, neglect, or inappropriate and dangerous sexual violations; to set necessary limits; and to utilize a broader system of community accountability (Gil, 1995).

Because abused adolescents present with such a variety of problem behaviors, cognitive-behavioral strategies are almost always needed to help them correct thinking errors and affective dysregulation which contribute to the emergence and maintenance of problematic behaviors. The major objective of cognitive-behavioral therapy is to help clients gain new perspectives on their problems, correct faulty cognitions, and increase behavioral competencies (Zarb, 1992).

Finally, I find it impossible to deal with the issues presented by abused adolescents without viewing them from feminist, sociological, and multicultural perspectives. The reality from a feminist point of view is that women and children have long-standing histories of being disempowered, and that efforts to afford them with protection when needed have been half-hearted at best. I do fully acknowledge the fact that boys and men are also victimized in Western culture; however, they are not now, nor have they been, victimized or devalued in the proportions that women and children have been exploited throughout history. A sociological perspective ac-

knowledges social norms that allow or condone child abuse and neglect (notably, hundreds of homeless families have existed in the United States for the last 15 years, while we cry out against "street children" in countries such as Thailand or Brazil). And a multicultural perspective means that we must treat abused adolescents within the context of their own culture, and recognize that formal therapy as we know it in the mainstream United States is a foreign concept to many people whose culture does not embrace the mental health care system as a useful resource. We must remain open to strategies that respect differences as well as commonalities among cultures, recognize differing levels of acculturation, and draw upon other cultures' healing practices. We need to embrace what may be built into a specific culture as helpful, rather than imposing strategies that may feel awkward and have limited applicability.

In my own work, I make use of the various theoretical frameworks described above to develop a strong therapeutic relationship that over time can provide a safe, rewarding, corrective, and reparative experience to abused adolescents. I also construct therapeutic tasks designed to help these adolescents obtain more and better feedback from the environment, and I ensure that their sense of self is in the forefront as they learn to self-monitor, self-regulate, and develop behaviors that elicit more positive responses. When it seems appropriate and necessary to do so, I address a clients' trauma-related material in a structured and in-depth way, which is fully described in Chapter Five. Finally, I keep in mind that I may need to become a vocal advocate for my adolescent clients as well as other abused adolescents; I recognize that protection may be necessary, and that a broadened view of community accountability (including legal interventions) may also be necessary.

TREATMENT GOALS

The overriding goal of working with adolescent survivors of childhood abuse is to remove obstacles to their growth and development.

This is accomplished by using a competency-based model (Durrant & Kowalski, 1990) that includes the following specific treatment goals:

1. To address each symptomatic behavior, evaluating its potential usefulness, honoring necessary defenses, and providing alternative responses and symptom substitution.
2. To assess and address problems in developmental transitions, attempting to remove obstacles to growth.
3. To assist youngsters in the process of defining self and identity by providing them with new information, asserting their strengths and resources, and helping them identify and express their thoughts and emotions.
4. To give adolescents ample opportunity to develop a sense of competence and mastery.
5. To allow adolescents to explore the idiosyncratic meaning of past abuse, make cognitive reassessments, and detach themselves from feelings of powerlessness and lack of control.
6. When it is necessary and appropriate to do so, to help youngsters with unresolved trauma process the difficult material, in order to move toward integration and empowerment.
7. To help adolescents make decisions and learn to distinguish between those things they can and cannot control.
8. To provide a corrective and reparative experience by being trustworthy, dependable, and consistent, and providing continuity of care.
9. To advocate for change in the family context, and seek and access resources for emotional and physical protection for young clients when necessary.

These treatment goals may be met in numerous ways and by using various creative strategies. The next section presents a number of strategies and techniques that I have found useful in the process of working with adolescent survivors of childhood abuse.

SPECIFIC TREATMENT STRATEGIES AND TECHNIQUES

Decoding a Symptom and Understanding Its Value/Helpfulness

I have always found it useful to decode symptoms—that is, to attempt to find the creativity and resourcefulness conveyed through a young client's behavior. Even a particularly distressing behavior, such as an adolescent's setting a fire in his or her bedroom, may be viewed as a cry for help. The metaphor of a fire, with the potential to burn out of control or destroy the environment, may be viewed as the youngster's plea for limits and safety. The response must include both the setting of limits ("It is not acceptable for you to do this—we will check your room and clothes for matches every day, you will be grounded for a week, and you will research and write a paper on the danger of fires") and the provision of additional safety and attention ("We need to talk about how to be more helpful to you with your concerns and worries about yourself—we will be spending more time with you, helping you with your homework, or just talking together before you go to sleep").

Some inquiry must be directed at the potential benefits or advantages gained through the symptomatic behavior. For example, Marcia was a 14-year-old referred for self-injury. When I asked her what happened before, during, and after the cutting, she described feeling relieved and safe after she cut her arms. When I asked Marcia to say more about her relief, she stated, "Well, like, finally I just had to feel the pain on my arms, and when I felt that, I didn't feel sad any more." I pointed out to her that it sounded as if it was easier for her to feel physical pain rather than emotional pain. She responded, "Oh, yeah. I get really scared when I'm sad that I might try to kill myself." Her cutting behavior, in paradoxical form, kept her safe from hurting herself. Once we were able to identify the usefulness of the symptom, it was easier to devise a plan (1) to provide an alternative behavior for avoiding painful or scary feelings; and (2) to begin to deal with the sadness in a way that didn't overwhelm her, by having her engage in incremental exposure that would allow her to build tolerance.

Connecting the Dots: Looking at How Past Lessons Influence Current Problems

How do past experiences influence or shape current functioning? In part, it has to do with how children learn through observing or participating in life situations and interactions with significant primary caretakers. If a child grows up in a family in which violence is the status quo, the child is learning not only about how people interact with each other, but also about family and gender roles, conflict resolution, love and affection, and power differentials. The child is also developing expectations about the future, as well as belief systems about reality. For example, a child who knows that violence is an organizing principle within intimate relationships may expect violence to be intertwined with his or her relationships. One abused child confided, "People who love you hurt you," and in that brief sentence summed up his life experience and his expectations about change. He was a child who acted out in school, eliciting negative behaviors from teachers and caretakers. Because he believed that he would be hurt by those who cared, he provoked his caretakers until they acted in familiar ways that reaffirmed and solidified his belief system. Unable to trust, he anxiously awaited or negotiated the next assault—not because he wanted or enjoyed physical pain, or wanted to feel vulnerable, but because he genuinely believed that his fate was predetermined. For him to alter this firm belief system, he had to have a corrective experience: Someone who cared for him would not injure him, even when relentlessly provoked.

"Connecting the dots" is a familiar activity to most children. It consists of drawing lines from one dot to another on a piece of paper until a clearly identified picture seems miraculously to appear. I often offer this metaphor to adolescents who are trying to clarify their feelings and thoughts about their backgrounds. Facts become dots. Reviewing the significant facts of their life and making associations between past and present events (i.e., the lessons learned and car-

ried forward) can provide them with new understanding and increased insight. Here's an example of this process with a youngster who was left to fend for himself starting at age 7:

ADOLESCENT: You don't understand. They bug me all the time. They treat me like I was a kid. I don't need that. I've been taking care of myself forever. They're a day late and a dollar short.

THERAPIST: You remember that time we talked about connecting the dots?

ADOLESCENT: Yeah, vaguely.

THERAPIST: Okay, I'm sure as I tell you about it a little more now, your memory will become more clear. Remember that I said that sometimes there are connections between past and present?

ADOLESCENT: Yeah.

THERAPIST: And that we might not be able to see those right away?

ADOLESCENT: Yeah.

THERAPIST: Okay. Now I'd like you to see what you think is the connection between the trouble you're having with your foster parents right now, and what happened when you were a child.

ADOLESCENT: Nobody was around when I was growing up.

THERAPIST: Your mom kind of left you on your own a lot.

ADOLESCENT: When I was about 7, she was never home. She slept away from the house a lot, and she thought that I was smart enough and brave enough to stay home alone.

THERAPIST: And were you?

ADOLESCENT: Damn straight I was.

THERAPIST: And what else were you?

ADOLESCENT: What do you mean?

THERAPIST: Well, you were brave and smart, and what else?

ADOLESCENT: Nothing else . . .

THERAPIST: Do you remember what you looked like at that age?

ADOLESCENT: I was little. I remember that, because kids used to make fun of me.

THERAPIST: And how did you feel about that?

ADOLESCENT: It made me mad.

THERAPIST: And what else?

ADOLESCENT: I don't know . . . made me feel like there was something wrong with me.

THERAPIST: Okay, so in addition to being smart and brave, you were also a small kid, who sometimes got angry when kids made fun of his size and at other times felt like there was something wrong with him.

ADOLESCENT: Yeah.

THERAPIST: And what else?

ADOLESCENT: Well, I just remember feeling alone, lonely maybe. I looked out the window and everybody else was doing something with somebody, but I was locked in all by myself.

THERAPIST: So when you were a kid you were smart, brave, and angry. You felt different sometimes, and felt lonely too.

ADOLESCENT: Yeah, I guess so.

THERAPIST: Well, that's what you've told me so far.

ADOLESCENT: Yeah.

THERAPIST: And how did you feel about your mom being gone?

ADOLESCENT: I didn't care.

THERAPIST: So sometimes you didn't care. How did you feel the rest of the time?

ADOLESCENT: I don't know. I was mad, I guess – mad that I didn't get to do anything and I had to be locked up all the time.

THERAPIST: And what was your mom doing?

ADOLESCENT: Hah. Who knows? She never clued me in.

THERAPIST: So you didn't know why she was away so much.

ADOLESCENT: She had boyfriends, I know that.

THERAPIST: And she preferred to be with them?

ADOLESCENT: Who cares? I could take care of myself just fine. I didn't need her.

THERAPIST: And you haven't needed anybody since, have you?

ADOLESCENT: No. I don't even know why I just can't be on my own.

THERAPIST: Remember the last time you ran away, where you ended up?

ADOLESCENT: Yeah, but that was just a fluke. It won't happen again.

THERAPIST: Well, I hope not, but one of the reasons you live with adults is so they can watch out for you. It's not always safe on the street, as you found out.

ADOLESCENT: I know, I know.

THERAPIST: So do you remember how you felt before you started feeling like you didn't care about your mom?

ADOLESCENT: Not much.

THERAPIST: Because I imagine that a 3-year-old or 4-year-old would find it hard not to have his mom around?

ADOLESCENT: I don't remember much about that.

THERAPIST: Any memories about you and your mom early on?

ADOLESCENT: The only thing I remember is that once she took me to a merry-go-round and it was just her and I, and she bought me cotton candy, and I sat next to her on a big horse and she held my hand even when the horses went up and down.

THERAPIST: And she never let go?

ADOLESCENT: Well, when it was over.

THERAPIST: But I mean while you were on the merry-go-round?

ADOLESCENT: Right.

THERAPIST: And how did that feel?

ADOLESCENT: Good (*mumbling*).

THERAPIST: I'm sorry, I didn't hear.

ADOLESCENT: It felt good.

THERAPIST: Why do you think it felt good?

ADOLESCENT: Because we were together, just the two of us.

THERAPIST: A mother and her young boy.

ADOLESCENT: Yeah.

THERAPIST: And that was the only moment you remember being close to her?

ADOLESCENT: That's it.

THERAPIST: That sounds like an important memory to you.

ADOLESCENT: I guess so.

THERAPIST: But maybe sad too, because you realize that you were alone so much of your childhood–a time when parents are taking closer care of their children.

ADOLESCENT: She was okay.

THERAPIST: I know. It just sounds as if she was unable to take proper care of you.

ADOLESCENT: She didn't have to. I could do it myself.

THERAPIST: So she expected something unrealistic from you, and you rose to the challenge?

ADOLESCENT: What do you mean?

THERAPIST: Well, most parents don't expect their 7-year-old sons to fend for themselves.

ADOLESCENT: I know some people who do that to their kids.

THERAPIST: Yeah, so do I. But that's too bad. Most kids need their parents to be around–show them the way, protect them, take care of them.

ADOLESCENT: Do we have to keep talking about this? It's boring.

THERAPIST: I think it's boring and maybe also a little uncomfortable for you, because it brings up sad or mad feelings. Just one last thing, and we'll get off this subject. Do you see any rela-

tionship between your feeling like you had to take care of yourself as a child, and the fact that you are feeling angry at your foster parents about trying to watch you too much?

ADOLESCENT: Well, first of all, it's too late for that. I grew up already. Secondly, they are not my parents, and I don't think they should be treating me like I was their kid. I'm not. I have my real mother, even though she doesn't care about me.

THERAPIST: Okay, so we'll stop talking about this now, but I think you've made a good beginning. I think there is a relationship between what happened to you as a child and what is happening to you now, and it has something to do with thoughts and feelings you've kept to yourself for years.

Eventually, this boy was able to see that he had defended himself against tremendous loneliness and fear by developing a facade of toughness: As long as he didn't care whether his mother showed up or not, he avoided disappointment. He took care of himself by needing no one, and he was now terrified of trusting the foster parents (who, by the way, had offered to adopt him) or allowing himself to depend on them for anything. As long as he was self-sufficient, he was safe. This process of connecting the dots allowed him to understand that there was a way in which he was responding to his mother as he interacted with his foster parents, and a way in which these responses interfered with the possibility of his building new and rewarding interpersonal relationships. We continued to work on past issues only as they were found to be obstacles to current functioning.

I think it's also worth noting that some youngsters overemphasize the significance of past events on current functioning. Ralph, for example, a 15-year-old youth who is best described as a "class scapegoat," was always being teased and beaten-up in school. Although he never precipitated arguments with school friends, he was constantly involved in altercations. When we met, I asked him why he thought he was always getting hurt by classmates at school.

"I don't know why. Kids just don't like me. They're always calling me names, and I don't know how to fight back." I continued to explore his perceptions of his predicament and finally, in a resigned manner, he said, "I've been getting beaten all my life. My dad used to beat me all the time when I was a kid. When he died I figured it would stop, but no, now it's just other people who do it. I guess I just bring out the worst in people."

There was something in this youngster's mannerisms that elicited strong countertransference responses in me: It was difficult for me to empathize with him, I felt frustrated and annoyed, and I even experienced wanting to reject him (i.e., refer him to another therapist). Once I processed my reactions I realized that this youngster presented himself as a helpless victim whose fate was sealed. He epitomized the concept "learned helplessness," and he had learned to see his life through a single lens: He was an abused child and he would always be abused by someone.

I worked with Ralph for about 9 months, and contrary to my initial expectations, he was one of the most rewarding cases I ever saw. We did some specific work on his self-view, view of others as more powerful than himself, and restricted view of interactions as including a victim and a victimizer. He responded very well to group therapy, and finally developed relationships with peers that did not entail violence and humiliation. As others regarded him more positively, his self-concept changed as well. There was a dramatic change in his physical posture and his pitch and tone of voice. Ralph agreed that although his past had included violence and pain, it was possible to establish rewarding and safe interactions with others.

I did focus a portion of the therapy on Ralph's prior abuse and Ralph was able to have a cathartic release which he found very helpful. In all the years he had been beaten, Ralph had never cried (or made any sounds) because Ralph learned early on that his father would beat him more when he did. In one of our sessions Ralph wept openly, and grieved for the childhood he had not had. This session, more than any other, allowed Ralph to become more emotionally available to myself, the therapy process, and presumably to others.

Finding Alternative Responses

Although challenging established belief systems, ascertaining their origins, and gaining new understanding and insight are important steps in the process of disengaging from the past and feeling more in control of current functioning, insight is not sufficient to cause change. Once the dots are connected and the relationship between past and present is made explicit, the next challenge is that of finding healthier coping strategies and using defensive strategies only when these are realistically needed. Abused adolescents seem to have reflex responses to certain situations, based on their prior experiences. When youngsters have had painful experiences with women, for example, their expectations may be that all women will be hurtful or uncaring. Consequently, such a youngster may see a female therapist, and his or her guard goes up. This is an automatic, generalized response, often without conscious awareness–not unlike the reaction of certain animals that expel noxious or venomous fluids when they sense danger.

What I encourage adolescents to do is to begin to monitor their own feelings and their physical and emotional responses. They might begin by recognizing that they feel "uncomfortable" or "funny," when they are alone in a room with an adult, or when they have to interact with an older or younger person. Then, once the acknowledgment is made, they explore their reactions, amplifying their awareness of how their bodies react and what kinds of feelings get generated. Tolerating these uncomfortable feelings is an important strategy for change through self-control: If youngsters can recognize that certain things are happening to them, they can then "sit with" the feelings and watch what happens.

I make the process of affect tolerance a type of game that adolescents can view as a challenge. I say something like this:

> "When you feel that uncomfortable feeling, and you've pinpointed lots of helpful information about how you know you're in an uncomfortable situation, I want you to 'stand your feelings' as long as you can. And I'm sure as time goes by, you'll be able to tolerate these feelings and sensations for longer and longer periods of time. For now, I will set a timer for 30 seconds, and when the bell rings we can talk together and you won't need to feel your feelings any more. Obviously, with kids who have done this successfully for a period of time, I set the timer for longer. But since you're new at this and not so experienced, we'll set it for a little bit shorter time."

I set the timer for a short span, and then challenge them to go beyond the initial bell. Youngsters in group therapy often compete with their more experienced counterparts, going well beyond the initial period of affect tolerance. This tangible way of helping children expand their abilities to tolerate their affect is usually very beneficial. Youngsters need to know that they will not die from feeling their feelings, they will not overwhelm others, and they will be able to tolerate their feelings–all contrary to what they may suspect.

Once young clients become proficient at this skill, we begin to talk about what they can do instead of squelching the feelings they have. Usually this involves acknowledgment, acceptance, honoring, processing, and coping or self-soothing in a healthy manner. Although these steps sound reasonable and facile, they are difficult steps to take and maintain.

Acknowledgment, the first step, means that youngsters recognize and acknowledge to themselves or others that something is troubling them. I always give youngsters the choice of telling or not telling about something they have just acknowledged to themselves. Some adolescents prefer to discuss issues privately in individual therapy, or may choose to raise them instead in the safety of a group setting.

Acceptance of feelings implies that youngsters allow themselves to have a feeling without judging it. So often adolescents (and adults) evaluate their feelings according to whether they "should" or "should not" have them, or whether they think they are "right" or "wrong." As long as feelings are appraised in this way, it is more difficult for an individual to say, "I have this feeling right now. I'm not sure why it's here, or what happened to bring it on, but I feel really weird, and I want to explore it some more."

I then instruct youngsters to honor their feelings by saying to themselves (or others), "I honor my feelings by letting them be, by not trying to make them right or wrong, and by knowing that they are there for good reasons. There is a lesson to be learned from this particular feeling's presence at this time."

Processing means an active exploration of feelings, with attempts to trace their origins (predisposing factors), triggers (precipitating factors), and forces that might keep the problem current (perpetuating factors).

The last step, coping or self-soothing, assumes individuals' innate ability to cope with difficult emotions in a healthy manner, and to draw upon inner resources to comfort and reconstitute themselves.

The following example, reconstructed from my memory of a group therapy session, as well as from sketchy clinical notes, illustrates how I encourage youngsters to tolerate and work through uncomfortable emotions. The young clients in this group had been in therapy for over a year, so they were familiar with the concepts outlined above, and were cooperating very well with one another and with the group leaders. Observe how a relatively innocuous issue elicited strong emotions that were processed in the group:

THERAPIST 1: Okay, okay, guys, I think we need to move on. I think you all did a good job of catching up with each other after our break, and it's time to get started.

THERAPIST 2: Who remembers what we talked about in our last group?

CLIENT 1: I know, I know, it was about that boundary thing and how we're supposed to respect each other's space.

THERAPIST 1: Good, that's right. We talked about boundaries. Who remembers more?

CLIENT 2: Wait, wait. Before we start, I need to tell S. that he gots a cool haircut.

THERAPIST 1: Okay, now remember, that's the kind of comment we do during snack time. We've moved on now to the group discussion.

CLIENT 2: I know, I know, I just forgot to tell him, that's all.

CLIENT 4: Thanks, dude.

THERAPIST 1: Okay, now what else do you remember about what was discussed last time?

[This discussion goes on for another 10 minutes.]

CLIENT 5: I think there's something wrong with B [Client 3].

THERAPIST 2: Ask B. directly if you think there's something wrong.

CLIENT 5: Is there something wrong with you?

CLIENT 3: No, man, leave me alone. (*Obviously disgruntled and uncharacteristically withdrawn*)

THERAPIST 2: You've been very quiet, B. Take a minute and see if you can let us know what's going on inside you.

[We wait about 5 minutes, and B. cries.]

THERAPIST 1: Obviously, something is troubling you right now.

CLIENT 3: I just feel weird, that's what.

THERAPIST 2: Okay, you feel weird. Say some more about feeling weird.

CLIENT 3: My feelings . . . they got hurt.

THERAPIST 2: Your feelings got hurt. Did that happen in the group or before you got to group?

CLIENT 3: During the group.

THERAPIST 2: Okay, you're doing a good job acknowledging that something's wrong. That's the first step. And whatever it is, it happened here in the group.

CLIENT 3: Okay.

CLIENT 6: Maybe he didn't remember about last week and he felt bad.

THERAPIST 1: That's a good guess. Check it out.

CLIENT 6: Is that it, B.?

CLIENT 3: Nah.

THERAPIST 2: If you can, tell us when you first noticed your feelings getting hurt.

CLIENT 3: (*After a long pause*) When he told S. that his haircut was cool.

CLIENT 2: Huh? How come you tripped on that?

CLIENT 3: See . . . I don't want no problems with you, man.

THERAPIST 2: Okay, for now, I want you to stay focused on yourself. We'll talk to [Client 2] later. Do you know what it was about S. complimenting M.'s haircut that hurt your feelings?

CLIENT 3: It just reminded me, that's all.

THERAPIST 2: Reminded you of what?

CLIENT 3: Of all the times people have tripped on my hair and ragged on me about it.

THERAPIST 1: Who tripped on your hair?

CLIENT 3: My dad, my mom, my brother, my teachers, my friends.

THERAPIST 1: Wow, that's a lot of people. How come?

CLIENT 3: 'Cause my hair was really, really curly, and it didn't look like anybody else's in my family.

THERAPIST 1: I don't notice that your hair is particularly curly.

CLIENT 3: That's 'cause I blow-dry it and put mousse on it.

THERAPIST 1: So you take great care to make sure your hair looks the way you want it.

CLIENT 3: Yeah.

THERAPIST 2: And do kids still rag on you?

CLIENT 3: No, not really . . . but I always think they will.

THERAPIST 2: So back to the comment about M. How did you hear that?

CLIENT 3: This is gonna sound crazy, but when S. said he liked M.'s hair, all I heard was that he didn't like mine.

CLIENT 2: I never said that!

THERAPIST 1: I think he knows you never said that. He's just saying that that's what he heard because he's sensitive to hair comments.

CLIENT 3: Whenever anybody brings up hair, I don't like it. I freak, man.

THERAPIST 1: And when you freak, what does that feel like?

CLIENT 3: I just get quiet and my feelings hurt.

THERAPIST 1: How do you feel, mostly?

CLIENT 3: I don't know. Sad, I guess.

THERAPIST 1: And what do you do with the sad feeling?

CLIENT 3: I try to tell myself not to feel it, 'cause it's stupid, and 'cause nobody did nothing to me.

THERAPIST 1: And when you try to stop your feelings, does it work?

CLIENT 3: Not always. Sometimes.

THERAPIST 2: When does it work?

CLIENT 3: When I forget about it by doing something else.

THERAPIST 2: Any other time?

CLIENT 3: Sometimes . . .

THERAPIST 2: And what happens if you let yourself feel the feeling for a while?

CLIENT 3: I get more sad.

THERAPIST 2: Is that all?

CLIENT 3: Well, I get quiet.

THERAPIST 2: And what happens when you are quiet?

CLIENT 3: Well, not here, but other places the kids forget about me.

THERAPIST 1: What do you mean?

CLIENT 3: They don't notice me after a while.

THERAPIST 1: And how does that feel?

CLIENT 3: Not good.

THERAPIST 1: How?

CLIENT 3: Kind of bad.

THERAPIST 1: Okay, so what else can you do rather than getting quiet when you have an uncomfortable feeling?

CLIENT 3: I know, I know, talk about it.

THERAPIST 2: Now how would that help?

CLIENT 3: You know.

THERAPIST 2: I just wanna make sure you know.

CLIENT 3: Well, when I talk, I can figure things out better, and I stay part of the group.

THERAPIST 2: That's terrific. That's exactly why it helps to talk. How are you feeling now?

CLIENT 3: Okay, mostly.

THERAPIST 2: Still sad?

CLIENT 3: Not as much. Some.

THERAPIST 2: And how do others feel?

CLIENT 5: My mom makes fun of my freckles and I hate it. I'm always waiting for somebody to say something about them.

THERAPIST 1: And how do you feel when somebody says something about your freckles?

CLIENT 5: Bad.

THERAPIST 2: Anybody else got something they feel sensitive about?

[The discussion continues. Finally, Therapist 1 summarizes the session in the following manner:]

THERAPIST 1: And I want to thank S. for noticing that something was wrong with B. and for asking him. What B. shared with us today was relevant to everyone in the group. That is, there are times when we feel sensitive about something (like hair, freckles, weight, or other things), and because we are sensitive we can read into comments that are made. Like when S. complimented M. on his haircut, B. thought that was a putdown of him, because no comment was made about his hair. He read a criticism into S.'s compliment to M., because he expects that people are going to criticize him about his hair. It's like when someone says, "You look good today," and you say, "What do you mean, *today*?" At face value that's a compliment, but on the receiving end you're making it something else. Right? I also want to thank B. for choosing to talk about his feelings out loud and becoming a part of the group.

In this group session, therefore, B. acknowledged his vulnerability to comments about hair; he remembered being teased about his hair from the time he was very young (the predisposing factor); he reacted to a positive comment that one group member made about another group member's hair (the precipitating factor); and, although he initially became sullen and withdrawn (perpetuating factor), he was able to respond well to a group member's attention and chose to trust the group with his difficult emotions, thereby breaking the response that perpetuated negative feelings. B. was able to acknowledge and honor his feelings, as well as process them, so that he could advance toward healthier goals: remaining part of the group rather than withdrawing, and expressing himself rather than retreating and wallowing in unpleasant thoughts and feelings.

Addressing the Facts and Impact of Abuse

Acknowledgment of the type, extent, and impact of childhood abuse is one of the earliest steps that abused adolescents must take in order to put the past behind them and exercise more control over their lives. Many adolescents don't like to rehash their past experiences; others talk about them incessantly, emphasizing their victimization and appearing victim-like in their current lives, even when the abuse has long since ceased.

When adolescents are resistant to talking about their pasts, I

agree with them that the goal is to move on. The question, then, is "How do we help abused individuals move on?" Clearly, there is no single way that helps everyone, but there are some basic steps that facilitate moving on–especially acknowledgment and processing. Abused individuals need to achieve clarity about what happened to them, develop a realistic view of how those early events may or may not have repercussions in aspects of their current functioning, and achieve closure. In other words, youngsters must confront either their denial of facts, or their fixation on events that cannot be relived. I often tell adolescents, "You cannot go back and relive what happened to you as a child. What you do have control over is what happens to you from this point forward." Just as individuals may develop various types of denial, such as rationalization, minimization, and partial admission, acknowledgment also may be fractional or incomplete and may remain so for short or long periods of time. Often denial is challenged by other events, such as a child abuse report from a younger sibling, a police investigation, or other legal involvement, as well as through the process of maturation.

There are many reasons why adolescents deny abuse. Loyalty appears to be one of the most common reasons: Adolescents may feel that if they "tell," they are badmouthing their parents. Conversely, youngsters who can only find fault with their parents may be stuck in making their disappointment known to others in an effort to stay safe, get help, or get even.

Dealing with Issues of Denial

It's important to recognize that denial does not occur in a vacuum; adolescents often find it necessary to protect themselves against painful truths. I tend to accept and expect denial in adolescent clients early in treatment. I assume that if I become trustworthy enough, or create a safe enough setting, denial will decrease or subside altogether.

I find it absolutely counterproductive to engage in power struggles with adolescents (or others) regarding "facts" early in treatment. Realistically, therapeutic trust usually precedes full admission of personal or painful information.

If I'm working with adolescents who are referred because they have committed a crime (such as a sexual offense), I always obtain a copy of the police or probation report; I simply read the facts to the adolescent, asserting that these are facts we will need to discuss at some later time, although I don't expect them to feel comfortable doing so at this point in treatment. As a matter of fact, when I worked at A Step Forward in Concord, California, my colleague Jeff Bodmer-Turner (who specializes in the treatment of adolescents and adults who have committed sexual offenses) and I would meet with families of adolescents, and tell the adolescents that their job initially was to listen to everyone's concerns and reactions. They would not be required to make any statements until later in treatment.

Another idea that has served me well is to allow peers, rather than authority figures (e.g., probation officers, social workers, or therapists), to confront denial. I have facilitated many group meetings with new members in denial, in which the task of the group has been to discuss the many ways in which denial is useful. It appears to be helpful to make explicit that denial serves as a necessary psychological defense in the short run, and that acknowledging the truth and asking for help will have positive consequences in the long run.

When Should Trauma Be Processed?

With resistant youths, or with youngsters who speak dispassionately and continually about the abuse, I may emphasize different things. Although these two types of youths appear quite different at first glance, they are mostly cut from the same cloth. The child who vehemently refuses to discuss the past, or who denies either the facts or their impact, may be trying to defend against painful feelings. Likewise, the youngster who talks incessantly and provides explicit details without affect–that is, as if the abuse happened to someone else–may also be protecting against painful feelings. As long as this second youth keeps talking to different people, and providing often shocking facts regarding his or her abuse, no true processing occurs. Both youngsters remain preoccupied with issues of past abuse, and this preoccupation probably interferes with functioning in some small or large way. At a minimum, rigorous self-

disclosure may keep people at arm's length; again, this may be viewed as safer than actually trusting people, getting feedback, or moving beyond the reporting of facts.

Often, abused adolescents have been traumatized by their experiences; as previously discussed, they may develop symptoms of PTSD (e.g., intrusive thoughts and flashbacks, auditory hallucinations, physical sensations, emotional outbursts [or, conversely, numbing], and nightmares in which the original trauma material appears). These symptoms may be triggered by a range of environmental stimuli, and an adolescent may defend against the symptoms by dissociating, particularly if his or her primary defense at the time of the trauma was dissociation.

The issue of directly addressing past abuse in therapy elicits heated debate among mental health professionals, and rightfully so. In my experience, the question of whether or not the abuse material should be addressed directly must be answered by the client himself or herself and by the nature of the presenting problem. I believe that abuse will probably need to be processed directly in a structured way when the following conditions exist:

1. Acute or chronic PTSD symptoms.
2. Worrisome symptomatic behaviors (e.g., self-injury, substance abuse, suicidal ideation, aggressive sexual acting out), and/or a social history of a chaotic, violent, or neglectful background.
3. Chronic reenactments of abuse dynamics (e.g., revictimizations, offending behavior, learned helplessness).
4. Vigorous denial of any history of abuse, or of the impact of those experiences; or indiscriminate, affect-free disclosures of victimization.

When traumatic material is addressed and processed, this must be done in a safe environment in which the therapist helps the client to acknowledge, honor, and work through difficult thoughts, feelings, and questions, and guides the process with a focus on the goals of integration and self-control. Clinicians will have varied ways to accomplish these goals, and extraordinary care must be taken to pursue these issues only with adolescents who have learned an array of coping strategies, have a fortified sense of self, and have reinforced their internal resources so that they can create safety for themselves. Herman (1992) cautions that the single most frequent therapeutic error is failing to address the patient's traumatic material, and the next most frequent clinical error is premature, or overzealous pursuit of traumatic material. Chapter Five provides a detailed description of the structured processing of trauma.

Cognitive Reassessments: Shifting Perceptions

One of the areas requiring constant attention is that of cognitive reassessment, particularly as developmental maturation takes place, or new experiences provide data that support or contradict prior perceptions. Cognitive reassessments can be either positive or negative. For example, one young adult woman was raped by a man who was captured, tried, and convicted. During the trial, other women testified to being raped; this young woman was shocked to learn that the other victims had been raped at gunpoint, and that the police suspected this rapist of having killed yet another of his victims. Once she acknowledged how close to death she had been during the rape, particularly in light of the fact that her rapist was suspected of actual murder, she had a relapse in which acute PTSD symptoms resurfaced and debilitated her for 3–4 months. In this case, her cognitive reassessment had a negative impact, in that she felt worse – more vulnerable, more anxious – after she realized the grave danger she had escaped.

Conversely, a 49-year-old woman was relieved and empowered once she reevaluated her childhood abuse with full adult cognitive capacity. She had always believed that she had caused the abuse because she had not been able to say "no," choosing instead to pretend to be asleep. Once we discussed how falling asleep was a way of saying "no," she stopped blaming herself and shifted responsibility to the man who had molested her. "After all," she asked rhetorically, "what kind of man takes advantage of a little girl who's asleep?" This reevaluation allowed her to view herself, and her attempts to stop the abuse, in a new and more positive way.

Expanding Self-Image and Positive Identity

As the second example just above suggests, new input about earlier experiences and why they occurred may allow adolescents to view themselves in a more positive light. Andy, a 15-year-old boy abandoned by his parents when he was quite young, had always harbored a belief that there was something inherently wrong with him: "Why else would my folks split on me? I must have been a real piece of work!" This youngster needed a lot of evidence to counter this belief system (which protected his parents' image while it sacrificed his own).

Andy had been 4 years old when his parents disappeared, leaving him and his younger sister in a motel room. One of my therapeutic interventions directed him to spend time around 4-year-olds. He had a friend with a young brother and offered to babysit with his friend a few times. After "hanging out" with his friend and his brother, Andy reported that the 4-year-old was "cool, liked to play, and was easy to get along with." He was struck by how small his friend's brother was, and wondered whether he himself had been that small (he had no photographs of himself as a child, which often made him wonder how he had looked). I also asked Andy to try to spend some time with the child when his friends' parents were around. After doing so, he stated, "They were cool with him. The dad yelled once but then he was cool, and the kid was really glad to see the dad when he got home, and the mom made him eat the food on his plate but she gave him small amounts." I asked whether the child had been "bad," and, if so, what his parents had done when he was bad. Andy looked up at me with surprise in his face, saying, "He's not bad, he's just a kid, and when he did something wrong his parents just told him to chill out." This was a very powerful, concrete lesson for Andy, who realized that children were not inherently bad. They were, however, inherently dependent, eager to please, and loving toward their parents.

Andy and I then discussed the circumstances precipitating his entry into the foster care system. I asked his social worker to track down records about the youngster's placement, and she retrieved

important information: Andy's parents had been "in the system" for years. My client and his younger sister were only two of five children who had been removed from the mother and father's care. The parents were drug addicts who often engaged in illegal activities to get money to buy drugs. They had been arrested a few times for fraud and for passing bad checks. The social worker who conducted the evaluation and filed for termination of parental rights noted that the parents viewed having children as a way of establishing an income without working. The previous three children had been removed for gross neglect and physical abuse; they had been adopted separately.

Andy's social worker, his foster (later adoptive) parents, and I met to discuss how much of this information would be useful for Andy to know. Because of his persistently negative self-image, and the fact that he conserved an idealized vision of his parents (at his own expense), we decided to give him all the facts we could, including the fact that his three older siblings had also been taken away and placed for adoption. We spent considerable time making this decision and discussing whether Andy's knowledge of the older siblings' existence might cause him more distress. Our decision was that there was a greater advantage to his knowing the truth, in that it might help him view himself more objectively – not as a child who was bad, but a child whom his parents could not care for, just as they hadn't been able to care for the others.

As his therapist, I was assigned the task of relaying this information about his childhood to Andy. He was intensely interested in whatever minimal information there was about his parents, who had long since been "unknown" to the system. His foster parents had always felt that they would support Andy's efforts to locate his parents once he turned 18; Andy had known his parents' names since he was very young.

Andy asked whether I was sure that his parents had three older children, and asked what their names and ages were. I gave him whatever sketchy information was available, and he seemed very interested to hear that his siblings would now be in their 20s, although there was no information on their adoptive parents. He sat quiet for a while after hearing the full story for the first time.

"So they just couldn't handle having little kids around," was his first comment. "Some people simply aren't cut out to be parents," I responded. He went on: "Wow, what a racket, trying to get paid for having kids." "Unfortunately," I told him, "I've run into that kind of welfare scam a couple of times."

Over the next few months there was a dramatic change in Andy. His realization that his parents had abandoned not only him and his sister, but three of his older siblings as well, allowed him to see himself differently. "I wonder if I was like my buddy's brother," he said at one of our meetings. "What do you think?" I asked. He replied, "Well, probably, because we like the same kind of things, and he even looks a little like me . . . maybe I would have looked like that when I was little." Andy had identified with his friend's brother and was reevaluating his views about children, their inherent goodness, and the fact that some individuals actually enjoy being parents and do their jobs well.

Believing that there was nothing inherently bad, unlovable, or unworthy about himself gave Andy a new perspective on his strengths and positive characteristics. He began to excel academically, and his acting-out behaviors declined. He also became more emotionally available, not only in the therapy sessions, but with his friends and foster family as well. Eventually, Andy and his sister were formally adopted by his foster parents, and it was as if he and the parents had chosen each other. "I finally feel like I belong to somebody, like somebody really wants me," he said, "no matter how jerky I act sometimes."

Developing an Orientation toward Personal Safety

Andy, the youngster in the preceding example, was a "good kid" who struggled with his negative self-image. As a result, he often made poor choices and used poor judgment about whom to befriend. He had originally been referred to treatment because of joy-riding. His academic performance had always been adequate, but his behavior at school was sporadically problematic.

After the therapy interventions mentioned above, I began working with Andy on acting on his own behalf instead of sabotaging himself. "Now that you've figured out that you were born a good kid, always were a good kid, and continue to be a good kid, you need to make decisions that support that point of view." We reframed this attention to himself as a way to keep himself safe and not put himself in harm's way: "Now that you're getting older, it's your turn to make decisions for yourself. Experiment with making sure you know what your options are, and which of the options supports your new view of yourself as opposed to your old view of yourself." Andy agreed to this and became excited about finding opportunities to make good choices.

One clear example was choosing to approach his foster parents and broach the subject of adoption. His foster parents had brought the topic up for years, but Andy had always refused. Although he felt he took an emotional risk in talking to them about adoption, he acted on his own behalf, asserting his right to be part of a family that he had grown to love, and that had loved him and his sister for years.

Andy also made better personal choices about friends. In spite of the fact that his old friends persisted in calling him and coming by his house, he set firm limits on his homework time, often forgoing or delaying social activities until he was done.

Andy told me that he often said to himself, "You've got to do this for you, man. You've got to give yourself a leg up." His new positive self-image motivated his behavior and allowed him to feel optimistic about his future.

Beyond Trauma Processing: Empowerment, Affiliation, Future Orientation

In the last several years I have been interested in, and influenced by, narrative therapy. This approach regards the individual as capable of making change, and provides a focus for learning based on what the individual already knows (from experience) about how to solve a problem. Narrative therapy concerns itself mostly with how the person creates a story about who he or she is (i.e., the person's

sense of self) and what his or her life has been like so far. In particular, narrative therapists believe that when an individual creates a story, he or she may over time become exclusively committed to the story, which then becomes a foundation for the development of attitudes, beliefs, and behaviors. Because of the obvious implications for abused children, who often develop a negative sense of self as a result of prior experiences, or who may have been affected by the powerful lessons of abuse that influence expectations and perceptions, a narrative approach can be very helpful for abused adolescents.

Andy, for example, created a narrative that began with a limited perception of the events that had occurred in his life. As a 4-year-old who had been abandoned by his parents, he told himself (and others) that something intrinsically defective about him had caused his parents to turn away from him. This belief influenced how he interacted with others (not trusting them, not allowing himself to get close, and then emphasizing others' rejection), as well as the kinds of situations he approached or withdrew from (since he felt basically inadequate, he didn't risk failure and withdrew from competition or academic endeavors).

In therapy Andy rescripted his personal narrative, including new information about his parents, their accountability in having children they were not willing or able to care for, and their pattern of bringing children into the world without first creating a safe and nurturing environment. His new narrative was that he had been a "good kid," loving and willing to please, and that his parents had not had the maturity or ability to build responsible lives for themselves. Finally, Andy projected a story about his future and imagined himself as a capable, caring, responsible adult who would create a family different from that of his biological parents. He had grown to see himself as someone with a lot to offer to children and peers. During his senior year in high school, he became a successful peer counselor and began talking about wanting to prepare for a job as a counselor with troubled youths.

A narrative approach seeks to create a balanced self-view, rather than one dominated by one perspective. Durrant and Kowalski (1990), extrapolating from White and Epston's (1990) guiding principles, note their concern with a recent trend in the United States: Some adult survivors of childhood abuse are developing an "abuse-dominated view" of themselves, or building their identities exclusively around their experience of victimization. Certainly it appears that the narrative of victimization, particularly when a modicum of safety has been created, can affect a person's sense of safety, vulnerability, optimism, and/or willingness to engage in specific behaviors and not others.

The narrative approach redirects and expands an individual's focus to information that he or she may have previously overlooked or minimized. For example, if a boy talks about his "drunk father who never had time for me," questioning might focus on times the father was not drunk, times the father did make time for the youngster, or any other information challenging the view that the boy's father was "always" drunk and unavailable. Even if the adolescent cannot come up with alternative information, questions might focus on who else did have time for him, and who else in his life never had a drinking problem.

The narrative approach is particularly helpful with adolescents who believe that they have been vulnerable or helpless in their lives. Helping them recognize how they took care of themselves when they were in danger, or how they tried to stop the abuse, can change these youths' self-view. For example, Anna was 15 years old and had a substance abuse problem. When she was sober, she was plagued with feelings of despair. Often she would say, "Life isn't what it's cracked up to be. Sometimes I wish it would stop now." I frequently responded, "Your life hasn't been easy so far, and I know you want the pain to stop. That's why you drink, it seems, so you don't feel the hurt." "What do I do?" she would plead, and I would say the one thing she didn't want to hear: "You've got to let yourself feel your feelings, and we've got to talk about what did happen to you and why." "I know why," she retorted. "I'm just plain no good."

Working with Anna was a challenge, in that she had developed such a strong belief that she had been hurt because she was unworthy of love. She also felt responsible for being sexually abused by her father, believing that she had "led him on" by being orgasmic dur-

ing the sexual abuse. Many youngsters have difficulty with their bodies' responding with pleasure to the abuse. They believe that if they had physical sensations, this means they were responsible for the fact that the sexual abuse happened. They feel like co-conspirators, and guilt prevails. For Anna, it was important for her to realize that she loved her father and longed for his attention and affection. However, she did not ask for, nor did she have control over, the sexual abuse.

As we explored some of Anna's feelings, she stumbled over the fact that she mostly felt bad because she had not said the word "No." When I asked her if she had ever said "No" nonverbally, she remembered that shortly after she was first sexually abused, she had put a safety pin at the top of a zipper on her sleeper pajamas. She seemed excited by the notion that she had said "No" nonverbally, but disappointed by the fact that she had not been successful in stopping the abuse. Finally, when I asked her to think about how she had said "Yes," she sat up and asserted, "I never told him he could do it!" Finally she began to realize that her father did not concern himself with whether or not she said "Yes" or "No." He was sexually abusing her because he could, because he had control, and because she was vulnerable and loving.

Anna still had difficulty reconciling her orgasmic behavior with her lack of responsibility for the abuse; somehow, she viewed this as "proof" that she was just as bad as her "pervert father." I did a very concrete (and symbolic) intervention with Anna—one that I had tried on much younger children before. I brought a red onion into the office, and much to her amazement I cut it. Shortly thereafter, we both cried.

"What's happening?" I asked Anna. "We're bawling," she responded.

"What do you make of that?" I asked her, and she quickly answered, "It's the onion smell."

"Yep," I added. "I'm not sad, you're not sad, and there's nothing to cry about. And yet, when our noses smell the onion, our eyes leak tears. I think there's a lesson to be learned from this."

I put the onion away, asked Anna to think about what had just happened, and went to wash my hands. When I returned she had a smile in her face and a tear in her eye. I sat down and heard words that were music to my ears: "It's like what happened to my body . . . when he touched me in certain places, I got wet, and I got off." She now had a way of understanding that her orgasm was not compliance with sexual abuse, but a way in which her body reacted to sexual stimulation. Anna now had a new narrative about her early experiences.

CONCLUSIONS

The goals of treatment with previously abused adolescents range from addressing generic issues such as identity, self-esteem, autonomy, family conflicts, feelings of isolation, values clarification, sexuality, peer pressure, and specific presenting complaints (substance abuse, depression, suicidality, eating disorders) to addressing issues generally associated with abuse: guilt, shame, sexual identity problems, youth prostitution and running away (Burgess & Hartman, 1995), feelings of betrayal or helplessness, anger, relationship difficulties, and reliance on psychological defenses such as denial or dissociation.

Adolescents are usually referred for therapy because their behavior is a problem or concern to someone else. Although they may not initially be "voluntary clients," my experience is that adolescents eventually come to value the opportunity to be heard and understood, and appreciate having someone they may perceive to be an advocate or ally. Karen (1994) notes: " . . . it would seem important to reach insecurely attached children by adolescence, because that's when it's believed their patterns become more firmly set. Even then they can still be changed; there is still the possibility of psychotherapy, not to mention other vital relationships, and the emotional flux of the adolescent years sometimes opens children up in new ways" (p. 232).

Many abused adolescents do not see how past abuse relates to current problems. Others however, have learned to use past abuse as an explanation for every problem they face. Yet other adolescents

seem to reenact abuse dynamics, exhibiting either identification with aggressors, or experiences of victimization. It is imperative to make careful assessments to determine the most helpful interventions for adolescents with histories of abuse. The overriding goal, however, is to improve the youngster's overall functioning, remove obstacles to ongoing development, and assist with the development of personal power, safety, and mastery.

How these goals are addressed will differ from clinician to clinician, and until we conduct treatment outcome studies to help us determine which specific techniques seem to help the most (or the most quickly), we will need to use good theory coupled with good ethics to inform and shape our treatment interventions. In addition, we must make ongoing efforts to develop treatment plans with measurable goals, incorporate self-report instruments to gauge changes in the client's mood or behavior, and develop standardized methods of accountability including peer review, consultation, and client satisfaction reports. I have long used a practice of having clients evaluate the treatment (both in person and in writing) during termination and I use this feedback as one measure of my contribution to clients' improved functioning.

As noted earlier, the question of whether or not to address past abuse directly in therapy has been a controversial topic among clinicians, and justifiably so. My experience suggests that this question should be answered by the individual client and by the nature of his or her presenting problem. I believe that abuse will generally need to be addressed directly in a structured manner under the conditions described earlier in this chapter. In these cases, adolescents will need a safe environment in which to acknowledge, honor, and process their thoughts and feelings, as well as guidance in altering problem behaviors so that they are functioning in their own best interests.

Therapists will have varied methods of accomplishing these goals, and extraordinary care must be taken to pursue these issues with adolescents who have a strengthened sense of self, an array of internal resources and coping strategies, and feelings of safety. Techniques such as regressive therapies, hypnosis for purposes of accessing

memories, the use of intrusive psychopharmacological measures (e.g., amobarbital), and dream work to resolve abuse issues have not been proven necessary, and have disadvantages that cannot be overlooked. In the next chapter, I discuss techniques for processing trauma that I have found useful.