Volume 1, Number 1 2011 PRINT ISSN: 2243-9315

Philippine Journal of Child Sexual Abuse

an interdisciplinary publication

Published by
Center for Prevention and Treatment
of Child Sexual Abuse
and
Terre des Hommes - Netherlands

PHILLIPINE JOURNAL OF CHILD SEXUAL ABUSE

AN INTERDISCIPLINARY PUBLICATION

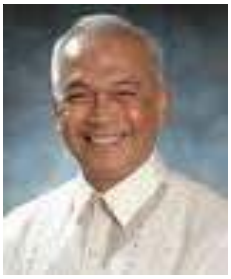
Editorial Board

Dr. Johnny B. Decatoria is a Clinical Psychologist, Educator, Psychotherapist, Clinical Social Worker and a Trauma Specialist. He finished his Liberal Arts degree in Psychology at the University of Negros Occidental-Recoletos in Bacolod City and completed his Master of Arts in Clinical Psychology at Far Eastern University-Manila. In 1994, he earned his Ph.D. in Clinical Social Work and Psychology at La Salle University in U.S.A. under the assistance of the United Nations Development Program (UNDP). He has worked as Consultant for over 10 years with United Nations Agencies, particularly, UNDP/UNICEF and UNHCR. He assisted UNICEF in a number of Caribbean Government Countries as a Clinical Psychologist and Social Services Consultant in providing professional and technical assistance in developing child abuse management programs including CICL, and training social workers, counselors, health personnel, police and prison officers, corrections officers, particularly in the management of cases suc as, victims of violence and trauma in many countries like Saint Lucia, Barbados, Antigua, and Commonwealth of Dominica. At the same time, he had lent his professional expertise with the Penal Reform International based in England and with offices in France and the Caribbean. Dr Decatoria has also worked for the UNHCR in Thailand where he was responsible for implementing psycho-social and mental health services for Vietnamese and Cambodian survivors of violence who were victims of rape and boat piracy attacks. His last two international work assignments are Kosovo and West Africa where he had served as Social Services Technical Adviser and Trainer, providing technical assistance to United Nations and international agencies in developing mental health programs and services to individuals and families who were victims of war. Dr. Decatoria is a Diplomate and Board Certified Expert in Traumatic Stress, awarded by the American Academy of Experts in Traumatic Stress in New York. Eight years ago, he founded the first ever Psychotrauma Clinic in the country, the University of Santo Tomas Graduate School Psychotrauma Clinic in Manila, a community service program of the UST Graduate School, where he served as Consultant and Director. He taught at the UST Graduate School a number of Counseling and psychology courses. At the same time, he served as consultant to a number of government agencies such as, the Department of Social Welfare and Development, Bureau of Corrections, and Department of Justice.

Dr. Emma Porio was Professor and Chair (1997-2002) of the Department of Sociology and Anthropology at the Ateneo de Manila University (ADMU). She directed the Global Urban Research Initiative for Southeast Asia (1994-1998), chaired the Technical Panel for Sociology and Anthropology in the Commission on Higher Education (CHED) of the Philippines(1997-2007) and of the Governing Council of the Philippine Social Science Council (2004-2006) and president of the Philippine Sociological Society (1999-2002). Currently, she is a member of the Executive Committee of the Europe-based, International Sociological Association (ISA), Board of Directors of the Global Development Network (Washington, DC), and international advisor of the panel on climate change of the American Sociological Association. From 1994-1998 she served as regional coordinator for the Global Urban Research Initiative (GURI) in Southeast Asia. Under her leadership (1996-2002), the Department of Sociology of the Ateneo de Manila University become a CHED Center of Excellence. She sits as research advisor to several NGOs or civil society organizations (CSOs) specializing in urban/ local governance, housing, children, poverty, and gender such as the Huairou Commission (New York), International Housing Cooperative Board (Washington, D.C.) and the Forum of Researchers for Human Settlements (Rome). She obtained her PhD (Sociology) from the University of Hawaii and the East-West Center (USA) and has been a recipient of several international research fellowships, the most recent being the Ash Institute Fellowship for Local Governance (Harvard University). For the past 15 years, Dr. Porio has done extensive research on children, women, poverty, development, and governance. She has served as consultant to the World Bank, United States Agency for International Development (USAID), Asian Development Bank, Ford Foundation, and UN agencies like the UNICEF, UNDP, UNFPA, ILO, and WHO. She has written several books including Partnership with the Poor, Pathways to Decentralization, Children in Drugs in the Philippines, Children in Drugs in Southeast Asia, and Urban Governance and Poverty Alleviation in Southeast Asia.

Dr. Lois Engelbrecht has all three degrees in social work. She was born and grew up in India and worked primarily in Asian countries, especially in the Philippines. She has written a variety of materials that are aimed at direct social work and community workers in the area of prevention and treatment of child sexual abuse. Her particular expertise is project development, and has been a part of developing new programs in Malaysia, China, Vietnam, Saudi Arabia, and India. She is a founder of the Center for the Prevention and Treatment of Child Sexual Abuse in Quezon City. Her work has been translated into Hindi, Tamil, Bahasa Malay, Tagalog, Arabic, Chinese, and Vietnamese.

Reynaldo J. Lesaca Jr,, M.D is a privately practicing psychiatrist of 35 years. He recently retlred from government after 17 years of service with the National Kidney and Transplant Institute in Quezon City. He is the only transplant psychiatrist in the country with extensive experience in organ donation and transplantation. He also does consultation-liaison work in the hospital. He was founding president of the Center for the Prevention and Treatment of Chitd Sexual Abuse in 1995 and served as such for ten years. ln 2010 he was appointed as Emeritus President of the Center by the Board of Trustees. Dr. Lesaca offered his clinical services to child and adolescent clients who are victims of child sexual abuse. His influence was essential in getting Personal Safety Lessons incorporated in the curricula of public elementary and high schools with the Department of Education. Dr. Lesaca is also a staunch medical activist.



Dr. Jose Andres Sotto returned to the Philippines in January 2003, after more than 25 years abroad, to accept a call to join the Faculty of Asian Theological Seminary (ATS) and to serve as Consultant to the Department of Social Welfare and Development (DSWD). At ATS, he spearheaded the construction of the Counseling Center and served as Head of the Counseling Department. Dr. Sotto developed, and supervised, the Comprehensive Continuing Education for DSWD Psychologists, a three-year-intensive training program that featured a (live-in) four-week-grounding in theory and practice, as well as two years of one-on-one mentoring in the field. As a suicidologist and community activist, Dr. Sotto founded the South Essex Adolescent Crisis Services in Ontario, Canada, in response to the rising incidence of suicide attempts among teens in the area. This intervention program was the first of its kind in Southwestern Ontario, employing advanced case management approaches. He also served as a consultant to the Children's Aid Societies of Ontario and the Detroit Youth Home, Michigan, USA, on cross-cultural issues in child abuse prevention and treatment, juvenile justice, and adoption. Dr. Sotto's direct involvement in these programs led him to broader engagement in advanced case management, suicide prevention, trauma counseling, forensic social work, and psychological debriefing of disaster victims/workers around the world. In 1991, Dr. Sotto was appointed Director of the International Facilitating Committee of the United Nations Conference on Environment and Development *(Earth Summit)* held in Rio de Janeiro, Brazil. After his term, he joined the Immigration and Refugee Board of Canada as a refugee law judge, and continued his work as community-

based pastoral counselor and therapist. Dr. Sotto earned his Ph.D. in Counseling and Special Education (minor in Social Work) from Wayne State University, Detroit, Michigan; his Master of Education from the University of Windsor, Canada; his Bachelor of Education from Wesleyan University-Philippines*;* and his *Certificate in Youth Ministry* from Princeton Theological Seminary, New Jersey. Dr. Sotto was the recipient of the *Governor General Medal of Honor for Community Development* on the occasion of Canada's 125th Anniversary. He has also been named *Most Outstanding Filipino-Canadian Leader* on seven different occasions. Dr. Sotto's current field of study is on male victims of sexual abuse.

PHILLIPINE JOURNAL OF
CHILD SEXUAL ABUSE

AN INTERDISCIPLINARY PUBLICATION

Volume 1
Number 1
2011

ABSTRACT.

The aim of this quasi-experimental study was to determine the effects of clay therapy as treatment modality and to examine the role of resilience on the trauma symptoms, as measured by Trauma Symptom Checklist for Children (Briere, 1996) of 24 sexually abused girls, ages 11 to 17 years old, from three rehabilitation centers in Negros Occidental.

A nine-session, five-week module on clay therapy, with a trauma-focused cognitive behavioral approach, and resilience, as measured by the Resiliency Scales for Children and Adolescents or RSCA (Prince-Embury, 2007), were the two independent variables. Trauma symptoms consisting of anxiety, depression, anger, post traumatic stress, dissociation and social concerns were the dependent variables.

Participants were randomly assigned to the experimental or control group. The former was given clay therapy, while the latter a placebo activity. For each of the treatment groups, a resilient group and less resilient group were also determined based on the RSCA scores. The study followed a 2x2 fully-crossed factorial design.

It was found that among the six symptoms, sexual concerns were consistently clinically significant and therefore, required more attention in treatment.

T-test results showed that the resilient group was significantly affected by their sexual abuse experience, having higher levels of depression, anger, and dissociation at the start. But they showed

better capacity than the less resilient group to effectively interact and respond more positively to treatment.

A two-way ANOVA revealed no significant interaction between the effects of clay therapy and resilience on trauma symptoms.

T-tests showed that the nine-session, five-week clay therapy intervention was not long enough to produce any significant difference in the participants' trauma symptoms. More time seemed needed for this intervention to show statistically significant effects. However, from their qualitative evaluation of the intervention, clay therapy, obviously, had very positive effects to the participants and showed promise as a powerful and innovative treatment tool for working with sexually abused children.

ABSTRACT.

The traumagenic dynamics framwork of Finkelhor and Browne (1986) was developed based in western experience. This article presents Filipino examples using the framework, validating its use for assessment here. This research is based in randomly chosen 25 case studies of girls who were aged 11 to 18 at the time of intake. Seventeen of the girls were victims of incest that ranged from molestation to rape. Two of the girls were offended by more than one family member. Two of the girls got pregnant by the step-father and gave birth; another girl got pregnant by the father but after she lost the baby she suspected that her father made her drink abortive pills. Eight of the 25 girls were raped by non-family members, five of them were raped by two or more offenders. The duration of abuse ranged from a single incident of sexual assault to nine years of ongoing abuse. Of the 25 cases, the highest of the traumagenic dynamics assessed were stigmatization, followed by betrayal, powerlessness and traumatic sexualization.

Call for Papers

The research on and experience in child sexual abuse in the Philippines is increasing. In order to fill the gap in disseminating the research, the editorial team will make every effort to seek out that research for publication.

Our first several issues will thank its contributors with P1,000.

Refer to the back of this journal for the guidelines for submission. We seek academic as well as practical articles to increase our understanding of the multidisciplinary context of child sexual abuse. Researchers and practitioners in the field of social work, psychology, psychiatry, medicine, law, and education are all invited to contribute to filling in all pieces of the puzzle for effective services in the prevention and treatment of child sexual abuse.

AN EDITORIAL NOTE

The Center for the Prevention and Treatment of Child Sexual Abuse has a history of sharing our work and experience in order to empower individuals and groups to prevent and treat child sexual abuse. We opened our doors for service following a year of collecting research and research-based services on which to build effective services for our children and their families. The challenge we always had was that the research was based in the West. Every step we made was about looking at the research and testing how it would work for our population.

A year after we began our services, we launched our annual Summer Institute with three sessions, one that focused on general awareness, one on prevention and one on treatment services. We shared the research from the West and our practices. We listened to the participants, gaining more insight as we widened our network. Our services and practices have evolved over the years based on evolving insight and research.

This journal has long been a goal of CPTCSA. And now, because of the professional network we've built over the years and funding from Terre des Hommes Netherlands, we are pleased to finally see this goal reach fruition. We have always conducted our own ongoing assessment of our clients, shielding them from the outside. However, with the launch of this journal, CPTCSA has written guidelines for how we can open our work and our clients to outside research while still protecting them physically, emotionally and socially. Our goal is to publish indigenous research to gain respect for our indigenous research-based practices and build insights based in the Philippine psychology and experience from a multidisciplinary perspective.

We thank our brave and committed founding editors. We thank our first authors. And we invite you all in the work to build a safe world for our children.

Zenaida Rosales, RSW
Executive Director, CPTCSA

Philippine Journal of Child Sexual Abuse
Volume 1, Issue 1
ISSN 2243-9315

The Innovative Potential of Clay and Play

(Clay Therapy, Resilience and Trauma Symptoms of Sexually Abused Girls)

Rebecca V. Lanes and **Johnny B. Decatoria**

ABSTRACT.

The aim of this quasi-experimental study was to determine the effects of clay therapy as treatment modality and to examine the role of resilience on the trauma symptoms, as measured by Trauma Symptom Checklist for Children (Briere, 1996) of 24 sexually abused girls, ages 11 to 17 years old, from three rehabilitation centers in Negros Occidental.

A nine-session, five-week module on clay therapy, with a trauma-focused cognitive behavioral approach, and resilience, as measured by the Resiliency Scales for Children and Adolescents or RSCA (Prince-Embury, 2007), were the two independent variables. Trauma symptoms consisting of anxiety, depression, anger, post traumatic stress, dissociation and social concerns were the dependent variables.

Participants were randomly assigned to the experimental or control group. The former was given clay therapy, while the latter a placebo activity. For each of the treatment groups, a resilient group

---

Rebecca V. Lanes *earned her M.S. Psychology, Guidance and Counseling* from the *University of St. La Salle, Bacolod City with guidance from* ***Johnny B. Decatoria****, Ph.D, B.C.E.T.S. (Board Certified Expert in Traumatic Stress, N.Y.) Dr. Decatoria is the Chair of the Graduate Programs in Psychology*, *Recoletos de Bacolod – Graduate School* and the *Founding Consultant of the UST Graduate School Psychotrauma Clinic at University of Santo Tomas, Manila*

and less resilient group were also determined based on the RSCA scores. The study followed a 2x2 fully-crossed factorial design.

It was found that among the six symptoms, sexual concerns were consistently clinically significant and therefore, required more attention in treatment.

T-test results showed that the resilient group was significantly affected by their sexual abuse experience, having higher levels of depression, anger, and dissociation at the start. But they showed better capacity than the less resilient group to effectively interact and respond more positively to treatment.

A two-way ANOVA revealed no significant interaction between the effects of clay therapy and resilience on trauma symptoms.

T-tests showed that the nine-session, five-week clay therapy intervention was not long enough to produce any significant difference in the participants' trauma symptoms. More time seemed needed for this intervention to show statistically significant effects. However, from their qualitative evaluation of the intervention, clay therapy, obviously, had very positive effects to the participants and showed promise as a powerful and innovative treatment tool for working with sexually abused children.

Introduction

Child sexual abuse is devastating and traumatic. It is a serious social issue which affects all sectors of society. It destroys the lives of our young children who, in the words of Atty. Eric Mallonga, legal counsel of Bantay Bata 163, "are not just the future of our society, but are, in fact, the present of our society" (Mallonga, 2008).

Child sexual abuse (CSA) is any contact or interaction between a child below 18 years of age and a more powerful person when the child is being used for the sexual gratification of the more powerful person (Center for the Protection and Treatment of Child Sexual Abuse or CPTCSA, 2004).

In the Philippines, the National Statistical Coordination Board's (NSCB) record on Violence Against Children by Classification of Offenses and Year revealed that out of 32,727 reported cases from 2002 to 2006, more than half (20,389 or 62.3%) were sexual abuse in nature (NSCB, 2006). Of this type of cases, there were 13,008 rape cases (63.8%), 1,345 incestuous rape (6.6%), 1,185 attempted rape (5.8%), 4,646 acts of lasciviousness (22.8%), 127 child prostitution (0.6%), and 78 sexual harassment cases (0.38%). Studies show, however, that all of these figures are merely the tip of

the iceberg, since majority of the cases go unreported. Child sexual abuse is considered, therefore, “a silent epidemic” (Child Protection in the Philippines, 2003).

Due to the assaultive nature of the event and the social stigma attached to it, CSA produces devastating and long-lasting psychological symptoms and difficulties in the victim. Fears, trauma, anxiety, posttraumatic stress disorder (PTSD), nightmares, behavior problems, sexualized behaviors, and poor self-esteem occurred most frequently (Kendall-Tackett et al, 1993). Feelings of depression, shame, anger, guilt and a sense of permanent damage are commonly reported by children who have been sexually abused (Mordeno et al, 2003; Putnam, 2003). Adolescents who have been sexually abused show a high rate of poor impulse control and self-destructive and suicidal behaviors. Posttraumatic stress disorder and dissociative disorders are common in adults who have been sexually abused as children (Kaplan & Sadock, 2007).

In helping child victims heal from the devastating psychological and physical effects of sexual abuse, practitioners use various counseling and psychotherapeutic methods to treat the clinical symptoms**.** In recent years, the use of expressive therapies has gained popularity and attention among practitioners seeking for more innovative, non-traditional, age-appropriate and effective treatment methods for children. Expressive or body-based therapies, include art, music, dance, drama, sound, play and clay therapy (Henley, 2002; Sherwood, 2004; White, 2007; Viceral, 2008; Brillantes, 2009).

One of the relatively new treatment modalities for CSA victims is clay therapy. Children respond to clay very positively, and practitioners have incorporated it in art and play therapy. In the United States of America, two child therapists have been using Play Doh clay in their therapy work with children (White, 2007; Tratnik, 2007). In Australia, a psychotherapist also used clay in her healing work with clients (Sherwood, 2004). In the Philippines, a team of art therapists and psychologists used terracotta clay in their workshop activity with sexually abused girls in a rehabilitation facility in Manila (Quinto, 2009; Brillantes, 2009). All are in agreement of the effectiveness and power of clay as a medium of expression and healing for traumatized children.

In addition to external interventions, counselors and therapists also recognize the existence of innate qualities within the clients, which help the latter recover from difficult experiences (Bogar

& Hulse-Killacky, 2006; Bonanno, 2004; Caparas, 1998; Banaag, 1997). This quality is called resilience, a complex phenomenon that refers to the ability to rebound from and positively adapt to significant stressors (Dyer & McGuiness, 2004). It is generally defined as the remarkable capacity of individuals to withstand considerable hardships, to bounce back in the face of great adversity, and to go on to live relatively normal lives (Bautista et al, 2000).

Professional helpers consider the internal trait of resilience within the client that would facilitate coping and effective recovery. According to Goldstein (2005), resilience in fact, operates for some young people but not for others. He believes that this quality may actually be the best predictor of positive outcome in adulthood. For him, resilience is a critical component that should be considered, focused upon and enhanced in the treatment process. Given the existence of this innate trait of resiliency, it is deemed useful and interesting, then, to find out how resilience operates within the client during the treatment process.

Recognizing the value of having an evidence-based treatment approach and technique in handling cases of child sexual abuse, this study aimed at gathering data on clay therapy, resilience and trauma symptoms of sexually abused girls. This formed the basis for designing and proposing an intervention program to address the concerns and issues of child sexual abuse in our community.

Problem

The study aimed to determine the effects of clay therapy as a treatment modality on the levels of trauma symptoms of sexually abused girls and to examine the role of resilience on the trauma symptoms of sexually abused girls.

Specifically, it sought to answer the following questions:

1. What is the socio-demographic profile of the participants in this study in terms of age, educational attainment, town or city of origin, nature of sexual abuse (incestuous or non-incestuous rape or acts of lasciviousness), number of and relationship to perpetrator/s, chronicity of abuse, whether or not pregnancy resulted from the sexual abuse, and whether or not there is support or belief by the family members regarding the abuse?
2. What is the level of trauma symptoms of sexually abused girls in the experimental group: a) before the intervention? b) after the intervention?
3. Is there a significant difference between the pre-test and

post-test levels of trauma symptoms of the experimental group?

4. What is the level of trauma symptoms of sexually abused girls in the control group: a) before the placebo activity? b) after the placebo activity?
5. Is there a significant difference between the pre-test and post-test levels of trauma symptoms of the control group?
6. Is there a significant difference between the levels of trauma symptoms of the experimental group and that of the control group: pre- and post-intervention?
7. What is the level of trauma symptoms of the resilient group: pre- and post-intervention?
8. Is there a significant difference between the pre-test and post-test levels of trauma symptoms of the resilient group?
9. What is the level of trauma symptoms of the less resilient group: pre- and post-intervention?
10. Is there a significant difference between the pre-test and post-test levels of trauma symptoms of the less resilient group?
11. Is there a significant difference between the trauma symptoms of the resilient group and those of the less resilient group: pre and post before the intervention?
12. Do clay therapy and resilience have main and interaction effects on the trauma symptoms of the participants?

Conceptual Framework

This study is anchored on two conceptual models for working with children who had traumatic experiences.

The first is a treatment model of cognitive behavioral therapy developed by Lazarus in the early 1970's. The term cognitive behavioral therapy (CBT) is a very general term for a classification of psychotherapies that emphasize the important role of thinking in how we feel and what we do. CBT is based on the idea that our thoughts, assumptions and beliefs cause our feelings and behaviors, not external things like people, situations and events. To feel and act better, even if there is no change in the situation, all we need to do is to change the way we think (Corey, 2001).

Sexually abused children report and exhibit a wide range of emotional and behavioral reactions to the abuse. Their traumatic experience left many of them with negative, irrational and unproductive beliefs and thoughts or cognitions about themselves, others and the world in general. These beliefs and thoughts in turn

cause their dysfunctional feelings and behaviors. Among sexually abused children, six common symptoms of trauma have been found: anxiety, depression, anger, post traumatic stress, dissociation and sexual concerns (Briere & Runtz, 1993; Briere, 1996).

Researchers agree that a trauma-specific therapy is the preferred approach for most sexual abuse treatment as opposed to supportive therapy in which children are not encouraged to discuss their abuse experience. An abuse-specific therapy encourages expression of abuse-related feelings to relieve and prevent problems and symptoms. It clarifies mistaken beliefs about the abuse that could lead to negative thoughts like self-blaming, loss of self-worth and hopelessness (Berliner, 1997; Finkelhor & Berliner, 1995).

Deblinger and Heflin (1996) had found that through a trauma-focused cognitive behavioral therapy (TF-CBT) approach, negative thoughts and beliefs resulting from a traumatic experience such as sexual abuse can be gradually surfaced, identified, expressed, understood, accepted and corrected, then replaced with more positive and realistic ones. These would then produce healthier, more productive feelings and behaviors (Hoch-Espada, Ryan & Deblinger, 2006).

CBT has been used to treat depression, anxiety and other symptoms related to trauma (Reinecke, Dattilio & Freeman, 2003). It has been found to be effective in a group setting for the treatment of youth and child anxiety (Barrett & Sonderegger, 2005).

The second conceptual model used in this study is the theory on resilience, first used by Emmy Werner in the 1970s in her study of poor children in Hawaii who grew up with alcoholic or mentally ill parents but who thrived well and became well adjusted adults (Blum, 1998). Resilient children are expected to adapt successfully even though they have experienced hardships and difficulties in life. They are capable of developing well, being more active and socially responsive.

Clay therapy as a treatment modality is the independent variable in this study. As a therapeutic process, clay therapy is cognitive behavioral therapy (White, 2007). Focusing on the participants' traumatic experience of sexual abuse, it consisted of a series of nine group-work-and-sharing sessions, conducted twice a week over five weeks and facilitated by the researcher. The clay therapy sessions made use of Play Doh, a commercially available colored molding clay as a medium for the participants' clay sculptures to express their thoughts and feelings. Processing of the participants'

thoughts and feelings as expressed in their clay works was the key feature of the treatment process.

Processing in this study means gradually sharing and talking about their sexual abuse experience, the effects and symptoms, and their means of coping. It involved dialoguing with the therapist/facilitator and their group mates regarding their negative thoughts and beliefs which were produced by the traumatic event, and with how they can reframe these negative thoughts and beliefs into more realistic and positive ones. Using clay work with group sharing, participants made, molded, and shaped various clay objects, then shared the symbolic meanings of these objects to their group mates and facilitator. They reflected on the growth process that was happening in them as well as their hopes for healing and recovery. Their interactions and behaviors during the sessions were observed and documented. Their feedback was also deemed important to evaluate the subjective effectiveness of the intervention.

Resilience is a subject variable measured by a standardized test called Resiliency Scales for Children and Adolescents (RSCA). It has three components: sense of mastery, sense of relatedness, and emotional reactivity and two indexes: resource and vulnerability.

Trauma symptoms, as the dependent variable in this study, were measured by a standardized test called Trauma Symptoms Checklist for Children (TSCC), with six clinical scales: anxiety, depression, anger, post traumatic stress, dissociation and sexual concerns.

Methodology

This was a quasi-experimental study using a two independent-samples design, with an experimental (clay therapy treatment) and control (placebo) group. For this investigation, the dependent variables under study were trauma symptoms, specified into anxiety, depression, anger, post traumatic stress, dissociation and sexual concerns, while the two independent variables were clay therapy with a TF-CBT approach and resilience (divided into resilient and less resilient).

The study examined the effects of the two independent variables on the dependent variable by measuring the levels of the six symptoms before and after the treatment period and then comparing the pre-test with the post-test scores of the treatment group versus the control group; the resilient versus the non-resilient group. It also examined how clay therapy interacts with resilience in terms of effecting changes in the dependent variable.

Twenty-four sexually abused girls, ages 11 to 17 years old, from three rehabilitation centers in Negros Occidental participated in the study. They were given the TSCC (Form A), RSCA and a Background Information Form before the actual experiment. Based on their RSCA scores, they were then randomly assigned to either the experimental or control group by fish bowl method.

Clay therapy sessions were given to the experimental group, using the module Clay Therapy for Sexually Abused Children: A Trauma-Focused Cognitive Behavioral Approach. During the sessions, the researcher took notes of the participants' explanation of the meanings for their clay works. At the end of each session, the clay projects were photographed for documentation purposes. At the end of the whole nine-session program, participants were asked to evaluate the clay therapy using the Evaluation of the Clay Therapy Form.

The control group had three clay-play sessions only as a placebo activity. They were allowed to do their usual activities in the center for the rest of the treatment period.

In the last step, the TSCC (Form B) was administered to and scored for both experimental and control groups at the end of the treatment period at each center. Scoring of the tests, TSCC Forms A and B, followed with the results used as pre-test and post-treatment data for the dependent variable. Data from the BIF were also collated at this point.

The raw scores from the RSCA and TSCC were obtained and converted to T-scores, based on the conversion tables found in the test manuals. The following statistical procedures were performed:

a.) frequencies and percentages from the BIF data to obtain the demographic profile of the participants to answer Problem 1;

b.) t-score means and standard deviations of each of the trauma symptoms per treatment and resiliency groups to answer Problems 2, 4, 7 and 9;

c.) t-test for paired samples to test for significant differences between the pre-test and post-scores of the treatment and resiliency groups to answer Problems 3, 5, 8 and 10;

d.) independent samples t test for equality of means to test for significant differences between the two treatment group and between the two resiliency groups to answer Problems 6 and 11;

e.) a two-way analysis of variance (ANOVA) to test for main and interaction effects of clay therapy and resilience on each of the six trauma symptoms to answer Problem 12.

Findings

The following is a summary of the major findings:

1. There is no significant difference between the pre-test and post-test levels of trauma symptoms of the experimental group.
2. There is no significant difference between the pre-test and post-test levels of trauma symptoms of the control group.
3. The experimental group had a significantly lower anger level than the control group during the pre-test. The other trauma symptoms of anxiety, depression, posttraumatic stress, dissociation and sexual concerns did not show significant differences between the two groups during the pre-test.
4. There is no significant difference between the post-test trauma symptoms of the experimental and those of the control group.
5. There is no significant difference between the pre-test and post-test trauma symptoms of the resilient group.
6. There is no significant difference between the pre-test and post-test levels of trauma symptoms of the less resilient group except in their anger symptom which showed a significant increase after the intervention period.
7. The resilient group had significantly higher depression, anger and dissociation than the less resilient group during the pre-test.
8. There is no significant difference between the levels of trauma symptoms of the resilient group and the less resilient group after the intervention.
9. Clay therapy and resilience have no main and interaction effects on the trauma symptoms of the participants.
10. The girls who participated in this study were in the late childhood to middle adolescent stage. Over one-half were enrolled in high school, while less than one-half were in the elementary level. All of them were from the province of Negros Occidental, except for one who came from the province of Aklan. Majority were survivors of incest rape, some of non-incest rape and a few of acts of lasciviousness. One survived from both incest and non-incest rapes involving four perpetrators. Almost all of the sexual abuses were

committed by one perpetrator per case. Only a single case involved two perpetrators. All the perpetrators were known to the victims, had wide access to and were trusted by the latter. Fathers ranked first among those who sexually abused the girls, followed by neighbors, uncles, stepfather, brother, half-brother, teacher, and boyfriend. Sexual abuse started as early as six years old up to 16. Three out of four girls were repeatedly abused. Two girls who were sisters got pregnant by their own father. The rest did not. Generally, the girls were believed and supported by their families. Only a few were not.

11. There were no significant differences in the trauma symptoms within and between the experimental and control group both during the pre-test and post-test. This signifies that, statistically, clay therapy showed no significant effect on the trauma symptoms of sexually abused girls. Perhaps, the insufficient duration of the treatment period and the testing effect phenomenon may have contributed to this.
12. Despite the lack of statistically significant effect, clay therapy was evaluated by the participants as having very positive effects and benefits for them. They discovered and appreciated many of the clay qualities. A few pointed out the unpleasantness of re-experiencing the emotional pain of the past as well as of discussing about sex. But as a whole, they considered clay therapy as more advantageous than conventional talk therapy in helping them to identify and communicate their feelings, learn positive values and problem-solving skills, heal their wounds and rebuild themselves. This brings the value of clay-play to clay therapy.
13. The nine-session clay therapy produced slight increases, though statistically insignificant, in anxiety, anger, dissociation and sexual concerns. This was attributed to clay therapy's effectiveness and power to evoke emotional issues that need to be identified and resolved. The temporary discomfort of confronting the pain was considered part of the treatment process towards healing.
14. The placebo activity for the control group, i.e. simple clay play without identification and processing of issues, produced slight improvement, though statistically insignificant, in anxiety, depression, post traumatic stress, dissociation and sexual concerns. Apparently, clay play was an entertaining

activity and can slightly dissipate most of the trauma symptoms but it did not provide opportunity for the working through of buried issues which could possibly surface later.

15. Resilient children initially had significantly higher levels of depression, anger, and dissociation than the less resilient ones. But the former appeared to respond more positively, even if not significantly, to intervention than the latter. Resilience, therefore, may have affected the sexually abused children's capacity to experience the psychological effects of trauma. But it also influenced their ability to cope with the trauma effects by giving the children the capacity to effectively interact and respond more positively to treatment.
16. Among the six trauma symptoms, only sexual concerns consistently showed a clinically significant level for all groups before and after treatment. Anxiety was found to be of moderate degree for the experimental and the resilient groups after treatment. All the other symptoms were not clinically significant both before and after treatment. This means that the symptoms on sexual concerns and anxiety should be given more time to be processed during the treatment sessions.
17. In the post-treatment period, there were no significant differences in the levels of trauma symptoms among the resilient experimental group, less resilient experimental group, resilient control group, and less resilient control group. This means that as a whole, clay therapy and resilience showed no separate or combined significant effect on the trauma symptoms of the participants.
18. Most of the participants felt the support and trust of their families regarding their abuse experience. This was considered an important element in the recovery process of sexually abused children. Intervention programs for non-offending parents were found in the literature to be effective and helpful both for the children and their parents.

Conclusion

The experimental study of clay therapy and resilience on trauma symptoms of sexually abused girls yielded no significant results of a nine-session clay therapy program on the trauma symptoms of the participants. It, however, yielded very positive evaluations from them regarding clay therapy's effectiveness and usefulness for the improvement of their psychological state in their

recovery and self-development. The study found slight evidence of the role of resilience in enabling sexually abused children to respond positively to a trauma-focused cognitive-behavioral treatment utilizing clay. Indeed, it signals a meaningful, powerful and potential modality for traumatized persons, particularly for the sexually abused children.

Beyond the objectives set by the study, the present investigation yielded powerful and meaningful images of the impact of sexual abuse on the victims and what their hopes and strengths were for recovery.

The study showed areas for the improvement of the "Clay Therapy for Sexually Abused Children: A Trauma-Focused Cognitive Behavioral Approach." It points to the need for an intervention program not only for the victims and survivors but also for their non-offending parents.

Recommendations

Based on the findings of this study, the following recommendations are suggested:

1. The treatment program entitled "Clay Therapy for Sexually Abused Children: A Trauma-Focused Cognitive Behavioral Approach" needs to be extended to six or more sessions, totaling at least 15 sessions for the entire program. This should give more time for processing of the clinically and moderately significant issues such as, sexual concerns and anxiety. Of the additional six sessions, two sessions should be devoted for sexual concerns, one for anxiety, and three sessions of plain and fun-focused clay-play towards the end.
2. Follow-up studies with repeated measures at six months and one year could be conducted to track the progress of the clay participants' recovery as well as to determine at which point, if ever, the significant changes in trauma symptoms may have occurred.
3. When replicating this study, sample size should be increased if possible, and participants be limited only to those with single perpetrators to avoid a confounding effect caused by the inclusion of those with multiple perpetrators.
4. The clay therapy program could be used by interested mental health practitioners (e.g. counselors, social workers, child psychologists, child psychiatrists) and educators when working with children who may have difficulties in expressing themselves regarding traumatic experiences. These professional helpers should first undergo training on how to

conduct this program since more trained workers are needed to meet the demands of traumatized children and youth.

5. The intervention program for sexually abused children and their nonoffending parents should focus both on therapeutic and preventive aspects.
6. The current education and awareness programs in schools and communities should give additional focus on the psychological effects of child sexual abuse on the victims. Stronger advocacy on children's rights should be conveyed to the public to prevent and stop the sexual abuse of children.
7. Future researchers might find it interesting to study how clay therapy might impact the trauma symptoms and psychological well- being of traumatized / abused boys.

References

Banaag, C. (1997). *Resiliency: Stories found in the Philippine streets*. Manila: UNICEF.

Barrett, P.M., & Sonderegger, R. (2005). *Anxiety in children* - FRIENDS Program. In A. Freeman, S.H. Felgoise, C.M. Nezu, A.M. Nezu & M.A. Reinecke (Eds.), *Encyclopedia of cognitive behavior therapy*. USA: Springer.

Bautista, V. V., Roldan, A., & Garces-Bascal, M. (2000). *Surviving the odds: finding hope in abused children's life stories*. Quezon City: Save the Children Philippines and UP-CIDS Psychosocial Trauma and Human Rights Program.

Berliner, L. (1997). Trauma-specific therapy for sexually abused children. In D.A. Wolfe, R.J. McMahon, & R. DeV. Peters (Eds.), *Child abuse: New directions in prevention and treatment across the lifespan.* Thousand Oaks, CA: Sage Publications.

Blum, D. (1998, June). Finding strength: How to overcome anything. *Psychology Today*, 31, 32-38, 66-67, 69.

Bogar, C.B., & Hulse-Killacky, D. (2006). Resiliency determinants and resiliency processes among female adult survivors of childhood sexual abuse. *Journal of Counseling & Development*, 84, 318-327.

Bonanno, G.A. (2004). Loss, trauma and human resilience. *American Psychologist*, 59, (1), 20-28.

Briere, J. & Runtz, M., (1993). Child sexual abuse: Long-term sequelae and implications for assessment. *Journal of*

Interpersonal Violence, 8, 312-330.

Briere, J. (1996). *Trauma Symptom Checklist (TSCC) professional manual.* Lutz, FL: Psychological Assessment Resources, Inc.

Brillantes, G. (2009). *An evaluationof visual arts and poetry as therapeutic interventions with abused adolescents*. Doctoral dissertation (unpublished). Quezon City: University of the Philippines.

Caparas, M.V. (1998). The Bahay Tuluyan and its Junior Educator's Program: Strengthening the streetchildren's resilience. *Philippine Social Sciences Review,* Vol. 55(1-4).

Center for the Protection and Treatment of Child Sexual Abuse (2004). *What is Child Sexual Abuse.* Retrieved October 3, 2007 from the World Wide Web: http://www.cptcsa.org/home.php?go=csa&sub=csa_whatis .

Child Protection in the Philippines (2003). *Child Abuse: A Silent Epidemic.* Retrieved October 2, 2007 from the World Wide Web: http://www.childprotection.org.ph/ factsfigures/index.html.

Corey, G. (2001). *Theory and practice of counseling and psychotherapy* (6th ed.). Pacific Grove, CA: Brooks/Cole-Thompson Learning.

Deblinger, E., & Heflin, A.H. (1996). T*reating sexually abused children and their nonoffending parents: A cognitive behavioral approach.* Thousand Oaks, CA: Sage Publications.

Dyer, J.G., & McGuinness, T.M. (1999). Resilience: Analysis of the concept. *Archives of Psychiatric Nursing*, 10, (5), 276-282.

Finkelhor, D. & Berliner L. (1995). Research on the treatment of sexually abused children: A review and recommendations. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, (11), 1408-23.

Goldstein, S. (2005). *Creating a Clinical Psychology of Resilience*. Retrieved March 25, 2008 from the World Wide Web: http://www.samgoldstein.com.

Henley, D. (2002). *Clayworks in art therapy: Plying the sacred circle*. London: Jessica Kingsley *Publishers.*

Hoch-Espada, A., Ryan, E., & Deblinger, E. (2006). Child sexual abuse. In J.E. Fisher & W.T. O'Donohue (Eds.), *Practitioner's guide to evidence-based psychotherapy.* New York: Springer.

Kaplan, H.I., & Sadock, M.D. (2007). *Synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (10th ed.). Maryland: Lippincott Williams & Wilkins.

Kendall-Tackett, P. C., Williams, L. M. & Finkelor, D. (1993). *Impact of Sexual Abuse on Children: A Review of and Synthesis of Recent Empirical Studies.* Retrieved March 2, 2008 from the World Wide Web: http://content.apa.org/journals/bul/ 113/ 1/164.

Mallonga, E. (2008, February 8). Bantay Bata 163 Negros Multi-Sectoral Conference on Prevention of Child Abuse [Lecture Videotaped by ABS-CBN]. Bacolod, Negros Occidental.

Mordeno, I.G., Sibug, N.L., Villanueva, S.M., & Decatoria, J.B. (2003). Trauma Impact Experiences of Sexually Abused Children: Implications for Institution-Based Trauma Counseling and Therapy. *Quarterly Scholarly Journal of the University of Santo Tomas,* 78, 3),335-373.

National Statistical Coordination Board (2006, March 1). 2006 Fact Sheets: *Updates on Women and Men in the Philippines*. Retrieved April 1, 2008 from the World Wide Web: http:// www.nscb.gov.ph/factsheet/pdf06/fs2_06.asp.

Putnam, F.W. (2003). T*en-Year Research Update Review: Child Sexual Abuse*. Retrieved March 2, 2008 from the World Wide Web: http://www.jaacap. com/pt/re/jaacap/ abstract.00004583-200303000-00006.htm.

Quinto, A. (2009). Emailed communication dated April 29, 2009.

Reinecke, M.A., Dattilio, F.M., & Freeman, A. (eds). (2003) *Cognitive therapy with children and adolescents: A casebook for clinical practice* (2nd ed.). New York: Guilford Press.

Sherwood, P. (2004). *The healing art of clay therapy*. Melbourne: ACER Press.

Tratnik, T. (2007). *Why ClayTherapy is Effective in Treating Childhood Trauma*. Retrieved January 26, 2008 from the World Wide Web: http://www.playtherapyclay.com/files/ Why_Clay_Therapy_Is_Effective_In_Treating Childhood_Trauma.pdf .

Viceral, M.A.P. (2008). *Ang sining bilang panlipunang pakikipag-ugnayan: Ang gampanin nito sa paghilom ng mga batang nakaligtas sa pang-aabuso (Art as social engagement: Its role in the healing of children survivors of abuse).* Undergraduate thesis (unpublished). Quezon City: University of the Philippines

White, P.R. (2007). *Clay Therapy: A manual of therapeutic applications of clay with children*. Illinois: Weebstar Press.

Philippine Journal of Child Sexual Abuse
Volume 1, Issue 1
ISSN 2243-9315

Traumagenic dynamics framework with Filipino clients

Regina Rabanillo

ABSTRACT.

The traumagenic dynamics framwork of Finkelhor and Browne (1986) has been developed based in western experience. This article presents Filipino examples using the framework, validating its use for assessment here. This research is based in randomly chosen 25 case studies of girls who were aged 11 to 18 at the time of intake. Seventeen of the girls were victims of incest that ranged from molestation to rape. Two of the girls were offended by more than one family member. Two of the girls got pregnant by the stepfather and gave birth; another girl got pregnant by the father but after she lost the baby she suspected that her father made her drink abortive pills. Eight of the 25 girls were raped by non-family members, five of them were raped by two or more offenders. The duration of abuse ranged from a single incident of sexual assault to nine years of ongoing abuse.

Of the 25 cases, the highest of the traumagenic dynamics assessed were stigmatization, followed by betrayal, powerlessness and traumatic sexualization.

Regine Rabanillo is a Registered Social Worker with her BSW from Philippines Christian University She also has a Professional Diploma in Family Ministries from Center for Family Ministries where she is currently enrolled in the Apprenticeship Program in Pastoral Care. She has been counseling in the field of child sexual abuse for 13 years. She worked with Virlanie Foundation Inc., ABS-CBN Foundation Inc.-Bantay Bata 163 and Center for the Prevention and Treatment of Child Sexual Abuse, where she is the program officer of the treatment unit.

Introduction

Finkelhor and Browne (1986) formulated the traumagenic dynamics of child sexual abuse based in western experience. The framework offers an excellent guideline for assessing cases in preparation for counseling and general case management. The authors state a dynamic on which psychological and behavioral characteristics are built. That is, based on what happened, he or she perceives what happened and act accordingly. Finkelhor and Browne state four traumagenic dynamics: traumatic sexualization, stigmatization, betrayal and powerlessness.

Traumatic sexualization means that the child learned something inappropriate about sex and sexuality. Their sexual development is the point of vulnerability. The dynamics of traumatic sexualization include that the child is rewarded for sexual behavior, is rewarded with attention or love, or that the child is conditioned that sexual activity is negative or a form of punishment. The psychological impact could be increased salience of sexual issues, confusion about sexual identity, confusion about sexual norms, aversion to sexual intimacy, negative association to sexual activities, and arousal sensations, and confusion of sex with love and care-getting or care-giving. Typical behavioral manifestations could be sexual preoccupation and compulsive sexual behaviors, precocious sexual activity, aggressive sexual behaviors, promiscuity, prostitution, avoidance of or phobic reactions to sexual intimacy, sexual dysfunction and inappropriate sexualization of parenting.

Stigmatization refers to the child's feelings based on how others perceive him or her. The point of vulnerability is the parents' and others' reactions to disclosure. The dynamics of stigmatization include that the offender blames and denigrates the victim, the offender and others pressure the child for secrecy, the child infers attitudes of shame about sexual activities, others have shocked reactions to disclosure, others blame the children for what happened, and the victim is stereotyped as damaged goods. The psychological impact could be guilt, shame, a lowered self-esteem, and a sense of differentness from others. Behavioral manifestations include isolation, drug or alcohol abuse, criminal involvement, self-mutilation and suicide.

Betrayal means that the person the child has learned to trust has abused that trust. Their development of trust is the point of vulnerability. The trust can be focused on the offender as well as non-offending adults with whom the child has built trust. Dynamics

of betrayal include that trust and vulnerability have been manipulated, a violation of expectation that others will provide care and protection, and the child's well-being has been disregarded with a lack of support and protection. The psychological impact would include grief, depression, extreme dependence, impaired ability to judge trustworthiness of others, mistrust, anger and hostility. Behavioral manifestations could include clinging, vulnerability to subsequent abuse and exploitation, allowing own children to be victimized, isolation, discomfort in intimate relationships, marital problems, aggressive behavior, and delinquency.

Powerlessness refers to the child's lack of power during or after the event. The point of vulnerability is that the child was tricked or violently forced into the sexual act and/or the child is not believed. The dynamics of powerlessness include that the child's body territory was invaded against her or his will, vulnerability to repeated offenses continues over time, the offender uses force or trickery to involve the child, the child feels unable to protect self and halt the abuse, repeated experiences of fear, and the child is unable to make others believe. The psychological impact would include anxiety, fear, lowered sense of efficacy, perception of self as victim, need to control, and identification with the aggressor. Behavioral manifestations could include nightmares, phobias, somatic complaints, depression, disassociation, running away, school problems, truancy, employment problems, vulnerability to subsequent victimization, aggressive behavior, bullying, delinquency, and becoming an abuser.

Filipino cases

I randomly chose 25 case studies of girls who were aged 11 to 18 at the time of intake. Seventeen of the girls were victims of incest that ranged from molestation to rape. Two of the girls were offended by more than one family member (grandfather and stepfather, father and cousins). Two of the girls got pregnant by the stepfather and gave birth; another girl got pregnant by the father but after she lost the baby she suspected that her father made her drink abortive pills.

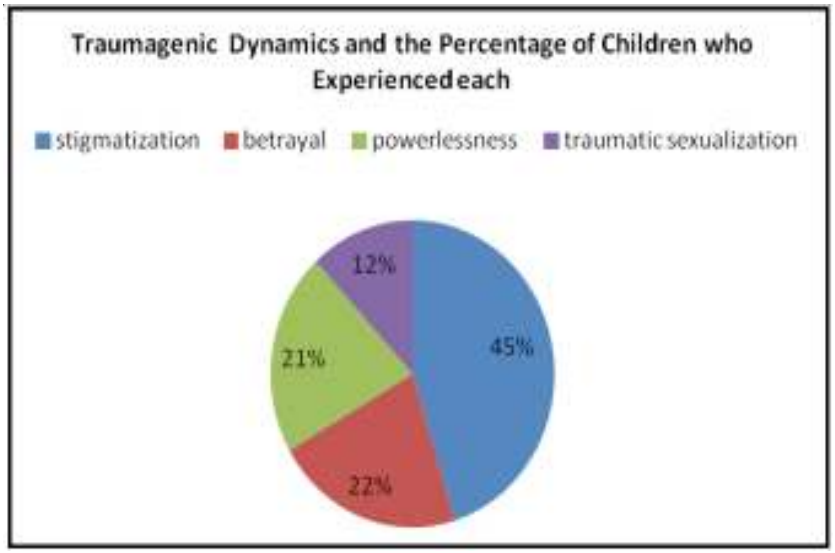
Eight of the 25 girls were raped by non-family members, five of them were raped by two or more offenders.

The duration of abuse ranged from a single incident of sexual assault to nine years of ongoing abuse. Disclosure of the sexual abuse occurred in different ways: nine of the girls immediately disclosed the abuse after the incident, but responses to disclosure also varied. Of the nine who immediately disclosed only one was

given an appropriate response by her parents, who asked for help from the police. The rest of the girls were ignored, advised to stay away from the offender, returned to the offender's custody or asked to recant the disclosure.

Two of the 25 girls did not disclose the abuse but their grandfather accidentally discovered that their stepfather was abusing them.

Figure 1: Traumagenic Dynamics



Stigmatization

Among the four traumagenic dynamics, stigmatization ranked as the most common impact of child sexual abuse among the 25 girls. Nineteen of the girls experienced this dynamic in different ways. In this group of girls, most of them internalized a sense of shame not from what people told them but from internalizing societal norms on virginity. Most of these girls equated sexual experience to being dirty, regardless of how it happened.

The most dominant thought of the girls was that they allowed the abuse to happen and to continue. They claimed responsibility for not telling, especially for not telling immediately. For victims of incest, their thoughts included confusion about their identity, who they were in relation to the children of their abuser, who they were in relation to their mother who is the wife of their abuser, and for children who became pregnant because of the abuse they wondered about the relationship of their child to the other children of the offender, to

themselves and to their mother.

In all of these complicated/tangled relationships, these children had one thought in common, that the abuse was the ugliest experience they had and because of the abuse they looked at their lives as ruined. Some also thought that their identity was equated to being abused; for example, when people talked about them they often said, “Oh, the girl who was raped by her father”. For children who lived in shelters, they felt labelled as the girls who love sex Some clients also thought that people thought of them as prostitutes.

Feelings of shame, sadness, anger, fear, guilt and most of all ambivalence were the most common feelings these children verbalized. They felt ashamed about the experience of sex, ashamed that their father abused them, ashamed that they became pregnant. They were sad because they had to live in shelters, had to stop schooling, and because they could not be as free as the other children who don’t have secrets. Some children felt guilty for keeping the abuse a secret and for some they felt guilty for liking/enjoying the sex. Children were afraid that their friends would no longer like them because they are no longer virgins so assumed that classmates or other children would not want to be friends with them because they were abused. Some children who had a strong attachment with their offenders were ambivalent about their situations. They felt angry towards their offenders but they pitied them because of being in jail. Children felt angry with themselves, angry for not telling immediately and allowing the abuse. They also felt angry towards others for calling them names like prostitutes, abused, flirts and maniacs.

Depending on the intensity of the stigmatization, behaviours varied. Some children, because of an intense sense of shame, became aloof, they isolated themselves. Some, for fear of being found out as abused, refused to go to school, becoming a truant. Some denied the abuse or minimized the experience, sometimes they refused to talk about the experience at all or minimized the experience. Some children, for the sake of acceptance, did whatever friends asked them to do such as, smoking, drinking, cutting classes, drugs and joining gangs. Six of the 19 children who were affected by stigmatization were diagnosed with depression and had to be medicated. Some children, because of ambivalence, visited their offenders in jail.

Case Example

Joan, 17, had been in a shelter for street children for eight years prior to her discharge to a maternal aunt.

She was referred to the shelter after efforts to locate her family remained futile. Originally she was found on the streets of Manila together with other street children. According to Joan she was trying to run after her older sisters who left her in the house of her mother's friend in a nearby province. She said they were badly treated by her mother's friend by giving them too much household chores and beatings whenever they commited a mistake, thus her sisters ran away. She tried to follow her sisters but she didn't know where they went and she ended up staying on the streets in Manila. [Agency A] and [Agency B] took custody of her but referred her to an NGO for long term residential care where she spent eight years.

About a year after she was discharged to a maternal aunt, she was raped by a neighbour. Because the aunt was not supportive of her she was eventually returned to the shelter. Upon her return, she had difficulty relating with other children and the staff. She tended to isolate herself from the group but she was also very aggressive. In one episode of her aggression, she threw stuff outside the window and broke the wind shield of the neighbour's car. She also had difficulty in school. The staff associated all of her behaviour to the sexual assault thus she was referred to counseling.

In the first two sessions, Joan seemed resistant; she would get into the couseling room, curl up in the couch without looking at the counsellor and sometimes cover her face with the throw pillow. She wouldn't talk, wouldn't ask questions, wouldn't write but continued to come to her schedule without being forced by the referring agency. Her answers were often, "I don't know", "nothing" and "I don't remember". Eventually she started to ask questions like, what is the meaning of abuse, what if the child wants it or liked it, what if the child did it for some reason, what if she was not forced.

It was in the fourth session when she talked about feeling so ashamed because she is no longer a virgin and because there were other offenders apart from the one who assaulted her. She said she was about seven when two older men repeatedly had sex with her after they gave her ice candy.

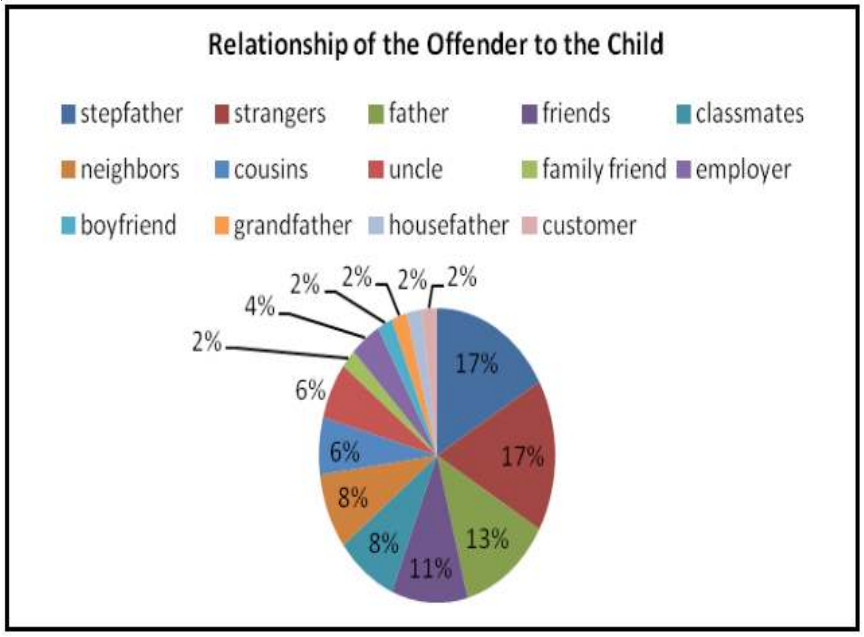
She said she had not talked to anybody about the abuse and refused to admit to anyone that she was sexually abused because of shame and fear that she would not be

accepted. She said she is so ashamed because she did not say no, she allowed it to happen, and she did not stop the offenders. Her constant concern is about confidentiality and fear that other people will look down on her. She said she is sinful and couldn't even pray. She said she refused to comment on any conversation about sexual abuse for fear of being discovered and suffer humiliation. She talked about experiencing palpitation and sweating hands whenever other children talk about sex abuse.

Betrayal

Nine out of the 25 children did not have much concern about stigmatization, primarily because other dynamics were more pronounced in betrayal. Although out of the 25 children, 19 were victims of incest, it is interesting to note that betrayal was not common to this group of children.

Figure 2: Relationship of the Offender to the Child



The dynamics of betrayal came in different forms. Six out of the nine children had parents who were not supportive. They were expecting their mothers to support them. The other three girls who were supported by their mother experienced betrayal from their fathers. For the siblings who were both abused by their paternal uncle, they were expecting support from both parents but only the

mother provided support. The father chose to keep quiet and leave their mother for another woman. The children interpreted this as their father's way of siding with his brother, the offender. One girl who was sexually abused by her father for three years, who got pregnant and tricked into abortion, not only experienced betrayal from her father from whom she expected protection, but also from her paternal aunt who assisted her father in finding an abortionist and eventually evading arrest.

Among the common thoughts of children who were not supported by their mothers were that mothers should support and choose their children instead of their husbands and, "my mother doesn't care about me, and thus it is better if we are not connected because I no longer consider her as my mother". For their fathers they wished them dead, so that they would not have to go through the trial; one client still hoped that her father would support her eventually.

Feelings of anger, fear, pity and ambivalence were also common among these girls. They felt angry and sad that their mother did not believe them, agreed to amicable settlements and for blaming them for the abuse. They also felt angry with their offenders for abusing them. For themselves, they felt so unlucky for having experienced abuse.

Their behaviours included not talking to their mother, running away, running after the father, pleading for support, not talking in court, and not trusting anybody including the counsellor.

Case Example

Julie, 14 was sexually abused by her paternal uncle for about a year. The abuse was accidentally disclosed after a palm reader told her and her sister that they have a very difficult problem. They then disclosed to the palm reader about the sexual abuse. The palm-reader who is also their neighbour reported to a nearby community police that three girls were sexually abused by their uncle.

Police came to the house to investigate the report and the girls were brought to the precinct for investigation. They were asked to identify the suspect. It was on the same date that their parents were made aware of the abuse. Because the last incident of abuse happened almost a month before the investigation, preliminary investigation was required. Before preliminary investigation was finished the suspect was able to run away. Warrant of arrest was released but the accused was nowhere to be found.

Julie felt the support of her mother but thought that her father was half hearted. Paternal relatives were more worried about the uncle than her. They were asking her to forgive the uncle. Some time in the middle of the investigation, the father left allegedly for another woman. But Julie's interpretation was that her father left because he supported his brother and she might have upset him. Because Julie had always been a daddy's girl, she found ways to be connected to her father through the non-offending uncles and aunties. She ran away from her mother and lived with her father and his new partner. She didn't tell her mother about her whereabouts but eventually went back home dejected because allegedly her father could not even defend her from his partner who called her names like, prostitute, and who also physically abused her. Feeling rejected she came home to her mother with the thought that her father may never support her.

Powerlessness

Eight of the nine children who experienced powerlessness dynamics also experienced stigmatization. Common to the nine girls was the thought that they should have done something to halt the abuse but did not or did not do it immediately. These girls also believed that telling about the abuse negatively affected other people's lives. Significant people like their mothers, aunt, siblings, and a friend were big considerations in their decision. They thought about losing the sole breadwinner of the family. They thought about their siblings whom they thought would not be able to go to school should they pursue a legal complaint against their offender. A girl who worked as a nanny thought about the future of her employer's children. Another girl who was abused by the housefather also thought of the future of the children of the housefather which was why she did not consider disclosing the abuse. These girls seemed to see themselves as far less important than the welfare of others. And not important enough for others to believe or do something to help them.

Fear seems to be the most dominant feeling in this dynamic. Children were afraid that the offenders were out to get them after disclosure. They were afraid of the threats such as, that their offenders were set to kill their mothers and siblings. They were afraid to face their offenders in court.

Behavior of these children ranged from passivity to aggression. Seven out of the nine girls said that if they were given

the choice, they would not pursue the legal complaint. They recanted their statement and apologized to the offender. Aggressive behaviours included verbal and physical fights. Others developed destructive behaviours like smoking, drinking and drugs in their effort to forget about what happened and trying to be happy. Some of them had fainting episodes and some had frequent nightmares about being chased.

The duration of abuse averaged three years, the shortest being two months and the longest being seven years.

Case Example

Ana, 14 was sexually abused by her stepfather. The abuse got her pregnant and she gave birth to a baby girl. She had told her mother about the abuse but the mother told her to stay away from the stepfather. Though the mother was not angry with her she was also not angry with the stepfather. The mother was angrier at her eldest daughter, who was adamant at filing charges against the offender.

Ana was convinced by her sister to live with her in their aunt's house and file charges. The stepfather was apprehended and jailed but Ana eventually recanted her statement. She said she felt pity for her mother who is suffering a lot because she has no money, cannot concentrate on her work, and is being harassed by the family of the stepfather. She also thought that her mother deserved some peace of mind and that the latter is correct in saying that although the stepfather was wrong in abusing Ana he should not be suffering in jail because he is already very old. Ana also thought that her daughter deserved to have a father who can provide for her needs. Despite her sisters encouragement Ana left the house of her aunt to live with her mother and together they visited the accused in jail. Ana eventually left her mother's custody and ran away with a new found boyfriend. Her sister could no longer find her.

Traumatic Sexualization

There were five children who experienced traumatic sexualization. In this group of girls the duration of abuse ranged from two to six years. Two were abused by more than one offender, one was abused by three offenders (two strangers and the housefather), and the other was abused by six offenders that included her biological father, three cousins, a boyfriend and one text mate.

These girls believed that people, especially men, would not

take them seriously and they only wanted to have sex with them. One believed that sex is part of relationships and there is nothing wrong with having sex. Two girls also believed that they could not control their sexual urges and sometimes sex was their way to relax and forget about their problems.

The feelings of these girls included apathy, sadness, fear and shame. They felt sad about experiences of being treated in a sexual way. They felt ashamed of their story, they were ashamed especially when they were labelled as sex addicts or sex maniacs. One said she was afraid of men. But in general they were apathetic, especially about what other people thought of them.

Behavior ranged from avoidance of contact with boys to casual unprotected sex.

Case Example

Myrna was in grade 1 when her father first molested her; the molestation eventually progressed to rape. The father sexually abused her for nine years. During those nine years she told her mother about the abuse. With the help of Myrna's maternal grandfather they reported the abuse in the barangay, but to Myrna's perception the barangay settled the problem and she just found herself back to her father's custody.

She was in her father's custody until she was sixteen; the father continued to abuse her sexually and physically. When she was back in her father custody three of her cousins and the husband of her cousin also sexually abused her. The abuses were known to the community who labelled her as prostitute. Upon her return to her father's custody, she was not able to communicate to her mother and other support systems. When she was sixteen she ran away from home and stayed with a friend's house that referred her for counseling.

In counseling she revealed that another man who was her text mate that she met up in the mall took her to a motel and had sex. She said that man promised to send her to school thus she agreed to go with him. Myrna also talked about the times when she felt she could not control her body; it seemed to her that she could not stop herself from having sex. Prior and even after she was placed to a shelter for custody, she had sex with men who appeared nice to her especially when that man had a potential to send her to school. She saw it as her opportunity to have money to support her schooling and her way to a better future.

Conclusion

Societal norms on sex and sexuality play a great role on

how children are affected by the experience of child sexual abuse. Messages that children receive from the church, the school, and the media are deeply planted in their thoughts so that when situations/ experiences such as sex abuse occur, the interpretation of the experience comes from stocked knowledge. Children are taught the value of purity as symbolized by the white gown women wear on their wedding day. Children are taught that virginity is the most precious gift a woman can offer her groom. These ideas are the basis of how children make sense of themselves, thus, even if there was no one who told them that they were worthless, a shame and bad, these learned norms have already assigned these labels on them way before anybody was even abused.

Children, like society in general, are forgiving of men's sexual misbehaviours. Mothers forgive their partners and side with them. Children hate their mother for not being supportive more than they hate their fathers and stepfathers for abusing them. Or it can be the other way around, children expect more from their mothers for support and protection, and if their mothers do not support them they become more devastated.

Other factors like poverty also contribute to how children are impacted by the abuse. Survival needs are prioritized over emotional and psychological well being. Children are ready to forgo their sense of safety and protection as long as they and other members of the family are able to eat, go to school, and keep the equilibrium in the family.

Child sexual abuse is not just a single incident of assault but a complicated story that needs comprehensive response. The traumagenic dynamics model gives us a lens to understand how children are impacted by the abuse. A good assessment of the problem makes way for a good prognosis. While there are many tools to choose from in helping sexually abused children, the helping professional can make a lot of difference.

First, the capacity of whoever has contact with the child to empathize allows children to surface thoughts and feelings that are difficult to talk about. Supportive counselling is needed, especially in the early stage of the helping process.

The use of approaches such as cognitive behavioural therapy also helps children correct irrational thoughts about themselves, the abuse, the offender, their mother and significant others. Irrational thoughts such as worthlessness, being dirty, a prostitute and so on that was brought about by stigmatization need to be corrected before

children develop appropriate/healthy coping behaviours to replace destructive behaviour such as drinking, smoking, drug abuse, and truancy.

Gestalt therapy can also help children to look into things that are affecting them now. Like what she can do and cannot do with her mother who would not support her, how this is affecting her now; what are within and beyond her control as a child in relation to her parents.

Finally, child sexual abuse is a social issue that needs to be dealt with in a social context. The person-in-environment theory suggests that a person is affected by what is happening in her or his environment as much as the environment is affected by what is happening to individuals. To facilitate a child's healing from sexual abuse, adjustments in the legal system, the school setting, the church, the barangay and so on can help in fostering healthy environments for children.

References

Finkelhor, D. & Browne, A. (1986). Impact of child sexual abuse: a review of the research. *Psychological Bulletin,* 99, 66-77.

Philippine Journal of Child Sexual Abuse
Volume 1, Issue 1
ISSN 2243-9315

BOOK REVIEW

William Borden (Ed), (2010). Reshaping Theory in Contemporary Social Work: Toward a Critical Pluralism in Clinical Practice. New York, NY: Columbia University Press, 281 pages.

This book provides a collection of writings by authors whose purpose was to review the role of theories in social work today. The chapters are divided into three parts, collectively they "reaffirm(s) the place of theory in social work practice and show(s) how emerging perspectives enlarge ways of seeing, undestanding, and acting over the course of psychosocial intervention" (p. xi). The theories discussed include psychodynamic, behavioral, cognitive, and humanistic perspectives. Mental health and counseling theories tend to be individualistic, which means they focus on making changes within the client often forgetting about the environment around the client that helped shape the client's mental health.

Social work in its generalism embraces eclecticism, yet, as Borden stated, "there is surprisingly little discussion of the ways in which workers integrate different concepts, empirical data, and technical procedures over the course of intervention" (p. 3). Instead, clincians fail to have a deep understanding of the major theories needed to develop integrative approaches that maintain the integrity of those core theories. This book begins the discussion of those theories within the social work person-in-environment framework.

Sharon Berlin writes about certain problematic issues in cognitive therapy that can be mitigated through integration of the client's environment, and at the same time enlarges the social work person-in-environment perspective. Wakefield and Baer discuss overlapping concepts and issues for an integrative approach of psychoanalysis and cognitive therapy. Clark focuses on the individual experience as unique, shaped by biographical and historical frameworks. Kemp works to focus on the environment in the person-

in-environment framework, because that framework tends to be based on psychological theories. Her concept of place instead brings together cultural anthropology, cultural geography, environmental psychology, and phenomenological perspectives. Walsh challenges the focus on individual and family deficit models and "describes the core elements of a family resilience model, focusing on belief systems, organization patterns, and communication processes, that provides a pragmatic framework for clinical and community based intervention and prevention" (p. xv). Finn writes about justice and the role of love and empathy, questioning whether social work today has instead focused more on professionalism. Finn's social justice framework integrates personal meaning, context, power, history and possibility. McCracken and Rzepnicki explain the role of theory in building evidence-based practice. In the final chapter Payne critiques clinical theories and outlines the basis of practice wisdom.

Social work in the Philippines is undergoing revisions as the profession questions its definitions and roles. Of particular concern to this journal's focus is Philippine social work in the child sexual abuse arena. Prevention and treatment of child sexual abuse requires a multidisciplinary response at multi-levels of society, from the individual child and offender to the family, expanding outward to the wider community that includes the national and global levels. The discussion that these chapters can elicit is especially relevant to this work. For example, cognitive theory is perhaps the most common theory used by counselors working with victims and families of child sexual abuse. In my view the most relevant chapter in the book is aptly entitled, *Why Cognitive Theory Needs Social Work* because, as Sharon Berlin stated, the majority of mental health counselors are social workers. She outlined the basis of cognitive theory and its limitation when considering the individual in the environment that, for example in the venue of sexual abuse, labels and blames victims, and condones sexual misbehavior by boys.

Lois J. Engelbrecht, PhD
Center for Prevention and Treatment of Child Sexual Abuse
Quezon City

GUIDELINES FOR SUBMISSION

The Philippines Journal of Child Sexual Abuse provides a multidisciplinary forum on all aspects of child sexual abuse. The Journal will have the two distinct parts of the dialogue on critical pluralism of child sexual abuse in the Philippines: research-based academic manuscripts and evidence-based practical manuscripts. The purpose of the journal is to enhance our understanding of child sexual abuse in the Philippines.

Types of contributions:

1. **Original, theoretical and empirical contributions**: type written in English, double-spaced, margins of at least one inch on all sides; number manuscript pages consecutively throughout the paper; clear of all errors; maximum 8,000 words (excluding references) in 12 Arial font; professional format of your university (such as APA6, http://www2.yk.psu.edu/learncenter/apa-july-09.pdf); accompanied by a statement that it has not been published or sent with hopes to be published elsewhere; permission has been obtained to reproduce copyrighted materials from other sources. All accepted manuscripts and parts within (such as artwork) become the property of the publisher. Submit a cover page with the manuscript, indicating only the article title, and summarized in an abstract of not more than 100 words; avoid abbreviations, diagrams, and reference to the text in the abstract.

2. **Articles on clinical or community practice**: such as case studies, process and program descriptions, outcome studies, original clinical practice ideas for debate and argument; typewritten in English or Tagalog, double-spaced, margins of at least one inch on all sides, numbered manuscript pages consecutively throughout the paper; clear of all errors; maximum 4,000 words (excluding references) in 12 Arial font. The article must have a clear purpose, be evidence-based and practical, state the framework, and conclusion for learning; accompanied by a statement that it has not been published or sent with hopes to be published elsewhere; permission has been obtained to reproduce copyrighted materials from other sources. All accepted manuscripts and parts within (such as artwork) become the property of the publisher. Submit a cover page with the manuscript, indicating only the article title, and summarized in an abstract of not more than 100 words; avoid abbreviations, diagrams, and reference to the text in the abstract.

3. **Brief communication**: shorter articles, commentaries.

4. **Invited reviews**: the editors will commission reviews on specific topics, including book reviews.

295. **Letters to the editor**: letters and responses pertaining to articles published in the Philippines Journal of Child Sexual Abuse or on issues relevant to the field and to the point, should be prepared in the same style as other manuscripts.

6. **Announcements/Notices**: events of national or international multidisciplinary interests are subject to editorial approval and must be submitted at least 6 months before they are to appear.

Review process - All articles will go through a peer-review process by the editors or reviewers chosen by the editorial board using the following criteria:

1. significance of the contribution
2. appropriateness of the literature review
3. clarity of research problem/framework, methodological rigor, quality of analysis and adherence to APA format (academic manuscripts)
4. quality of the possible discussion and interpretation of the results
5. quality of the overall writing

Authors will be given feedback and manuscripts with potential to publish will be returned for reworking or retyping to conform to requirements.

The author will receive a copy of the journal that includes the article.

Submissions should be sent via the internet to Dr. Lois Engelbrecht, ljengelbrecht@hotmail.com