

# **SQUARING THE CIRCLE**

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## **Reporting of Child Abuse in Clinical Settings**

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**Master Class in Psychotherapy for the  
Irish Council of Psychotherapy**



# Aims of Seminar

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- To help participants to embrace the importance of understanding the relationship between past and current child abuse issues
- To enable the Development of Procedures for Reporting and Management of Allegations of Child Abuse fit for the Clinical Setting
- To enhance the benefit of combining tertiary treatment with primary prevention



# Duty of Care

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- Avoidance of Harm
- Best possible service to the client (standard of care)
- Continuity of Care
- Responsibility for the Welfare of the Client
- Extended Responsibility to those in contact with the client

# Range of Clinical Settings



- Children or Adults
- In-patient, out-patient, community or primary care
- Statutory, voluntary, private practice
- Code of conduct and ethics of the service provider or professional body



# Definition of Child Abuse

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## As given in the Commission to Inquire into Child Abuse Act, 2000

- 3.3 Definition of Abuse
- **The definition of “abuse” should be sufficiently broad to encompass acts or omissions which include –**
- Physical abuse, meaning the wilful, reckless or negligent infliction on or failure to prevent injury to a child,
- Sexual abuse, meaning the use of a child by another person for the sexual gratification or sexual arousal of that person or another person or other persons,
- Neglect, meaning persistent or severe failure to care for a child which results in serious impairment of health and/or development and/or failure to thrive, and
- Emotional abuse, meaning on the part of a carer, persistent coldness, hostility or rejection towards, or unrealistic expectations or severe over-protection of a child or exposure of a child to the abuse of others, results in severe adverse effects upon behaviour and/or development.

# Child Protection

- From sexual, physical and emotional abuse and from neglect
- Children First  
Health, Welfare and Protection of Children first priority of Irish Health Care System (DoH&C 1999)

“Giving information to others for the protection of a child is not a breach of confidentiality” p.41





## Examples of child sexual abuse include:

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- Exposure of sexual organs or any sexual act intentionally performed in the presence of a child;
- Intentional touching of the body of a child for the purpose of sexual arousal/gratification;
- Oral, vaginal or anal sexual intercourse with a child;
- Sexual exploitation of children – involvement in prostitution, exhibition, modelling or posing, including recording (film, video etc.)
- Showing sexually explicit material to children (often a feature of the “grooming process”)
- Consensual sexual activity involving an adult and an under-age person.

(Children First, 1999)



## Prevalence of CSA in Adult Population

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Estimates vary considerably, e.g.:

- 12% women and 8% men (Baker & Duncan, 1985)
- 38% women report contact abuse, 54% non-contact abuse (Russell, 1986)
- 23% of all women (Jehu, 1988)
- 12-17% women, 5-8% men, contact abuse, non-clinical sample (Gorey & Leslie, 1997)
- Rates for women are 1 ½ to 3 times rate for men (Finkelhor, 1994)
- Majority of CSA cases do not involve incest (i.e. when non-clinical samples are examined), whereas the majority of CSA cases known to professionals (i.e. clinical samples) do involve incest (Finkelhor, 1986).



## Prevalence in Ireland

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SAVI Report (McGee et al., 2002):

- 20 % women reported contact abuse with a further 10% reporting non-contact. Overall 5.6% involved penetrative/oral abuse.
- 16% men reported contact abuse with a further 7% reporting non-contact. Overall 2.7% involved penetrative/oral abuse.
- Community type surveys, such as SAVI, will underestimate the experiences of very vulnerable people, as they do not typically include those residing in institutional settings such as psychiatric hospitals or prisons [Or those who are homeless] (Leigh et al., 2003)



## Impact of Child Sexual Abuse on Adult Mental Health

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- High percentage of affected adults show no clinical symptoms
- History of sexual abuse is reported by 30-70% of female psychiatric patients
- Patients with a history of physical/sexual abuse were more likely to be suicidal, have longer stays in psychiatric hospitals and show the most disturbance in symptoms and behaviour (Read, 1998).
- Two common key features – difficulties with affect regulation and modulation and impulse control.



## Factors Mitigating the Impact of CSA

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- Duration and frequency of abuse
- Age and sex of abuser
- Age at onset of CSA
- Relationship to abuser – extra/intra familial, level of intimacy and dependency
- Type of sexual activity
- Level of intimidation
- Presence of physical force/violence
- Sense of participation
- Percieved possibility to disclose



## CSA as Trauma

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Child sexual abuse is a developmental trauma that is differentiated from other traumas (e.g. natural disasters, accidents) in a number of ways:

1. It is the result of another individual's premeditated action;
2. In most cases it is committed by someone who is attached to the child (this is always the case with incest);
3. The sexual abuse usually occurs in the context of other abuse (e.g. threats not to tell, force);
4. The act is usually misrepresented to the child;
5. It is usually chronic.



## Briere (1997) Self-Trauma Model

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- Identifies three main self-capacities which arise from normal childhood development and are frequently not formed adequately when child is neglected or abused.
  1. Identity – a secure internal base to organise and contextualise challenging stimuli without excessive disorientation.
  2. Boundary – awareness of the demarcation of self and other. Negotiating interpersonal interactions.
  3. Affect Regulation – comprising of:
    - Affect Modulation – ability to self-soothe, distract etc.
    - Affect Tolerance – ability to tolerate negative affect.



## Presenting Issues

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- Anxiety
- Anger
- Depression
- Self-harm
- Suicidality
- Eating Disorders
- Obsessive/Compulsive Difficulties
- Sexual Problems
- Substance Abuse
- Self-concept, Self-esteem
- Dissociation
- Flashbacks and Nightmares
- Posttraumatic Stress
- Somatization
- Personality Disturbance

(Neuman et al., 1996)



## Presenting Issues continued

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- Evidence of increased risk to further sexual assault/rape (Russell, 1986)
- Some evidence that men are more likely to cope by using avoidant strategies
- Some evidence of high prevalence among men in prison population
- High rates among those seeking help or referred by the courts for – Substance Abuse, Aggressive Behaviour, Antisocial behaviour.



# Triggers for Disclosure

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- Flashbacks
- Death of abuser or parents
- Marriage
- Birth of own child
- Own child reaching age of own abuse
- Physical assault or rape
- Media coverage
- Psychosomatic illness
- Accident
- Fear of abusing
- Urged to tell professional by somebody else
- Sexual difficulties
- Suicide attempt
- Disclosure by other member of family



# Significance of Disclosure of CSA

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Disclosure:

- Mitigates existing crisis point
- Offers new level of intimacy and willingness of cooperation to confidant
- Achieves a break-away from the “natural confidant” (parent)
- Opens new ways of negotiating relationships



## Skills in Managing Disclosure

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- Be kind, sensitive and respectful
- Try not to appear shocked by details you may hear
- Listen if they want to talk, but don't force a discussion
- Resassure them if distressed
- Be cautious in your responses that you are not 'assuming' **anything**
- Normalise physical sensations of panic for your client and yourself
- If client lapses into a flashback gently bring them back into present and ground them by asking them to feel their feet on the ground/keeping their eye on an item in the room.



# Containment at time of Disclosure

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- Be aware of protocol in relation to disclosure of CSA
- Acknowledge importance – create safe space
- Place disclosure into context of your professional context with the client
- Clarify and discuss confidentiality
- Keep intervention at level appropriate to your clinical setting
- Try to ascertain level of risk to client and others
- Inform yourself of other services and initiate referral



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## Reporting and Child Protection Concerns

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### **4.6 Retrospective Disclosures by Adults**

**4.6.1** In recent years there have been increasing numbers of disclosures by adults of abuse which took place during their childhood. These revelations often come to light in the context of adults attending counselling. In these situations it is essential that consideration is given to the current risk to any child who may be in contact with the alleged abuser. If any risk is deemed to exist, the counsellor/health professional should report the allegation to the health board without delay. Investigation of disclosures by adult victims of past abuse frequently uncovers current incidences of abuse and is therefore an effective means of stopping the cycle of abuse.

**(Children First, 1999)**



## Contraindications for psychotherapy for CSA

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- Lack of basic safety.
- Serious current child protection concerns not addressed.
- Severe current mental health issues.
- Active addiction.
- Client with a history of sexual offending – Outstanding legal issues, Offending behaviour may need to be addressed first.
- Motivation and readiness of client are key to outcome – Little point in 'pushing' someone into counselling.



## Basic Therapeutic Interventions

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- Confirm and validate feelings
- Dispel power of secrecy and the abuser's claim that the client would not be believed
- Confirm symptoms as coping strategies and survival techniques
- Continuously explain and negotiate boundaries
- Address feelings of betrayal and abandonment with the therapeutic relationship
- Recognise the loss of childhood
- Foster new opportunities for enjoyment



## Themes in the Therapeutic Work

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- The 'child within'
- Being believed
- The nature of the abuse
- Responsibility for the abuse
- Family of origin
- Flashbacks and memories
- Regression
- Trust
- Loss
- Getting in touch with feelings
- Anger
- Confrontation
- Forgiveness
- Living in the present: from victim to survivor

(Hall & Lloyd, 1993)



## Other Recurrent Themes

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- Negative self-image
- Disgust with own body
- Anger
- Fear of intimacy
- Mothers
- Sexuality
- Guilt and shame
- Abuser
- Confrontation
- Grieving
- Coping Strategies
- Control and dependency
- Powerlessness

(Sanderson, 1990)



## Some Therapeutic Tasks

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- Provision of a secure base in therapy – developing trust and providing a new model of relationship.
- Facilitating self-exploration – developing a greater sense of identity, challenging negative self-perceptions
- Boundaries – respected and developed
- Developing ability to tolerate and regulate affect
- Identification of traumatic events
- Gradual reexposure to affect associated with a memory of the abuse, while keeping the avoidance responses minimal
- Emotional and cognitive processing



# Vicarious Traumatization

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- The negative effects of caring about and caring for others.
- The negative transformation in the helper that comes about as a result of incomplete empathic engagement with trauma survivors and their trauma material *and* a sense of responsibility to help

(Pearlman, 2005)



## What does VT look like?

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- Each person's experience of vicarious trauma is unique.
- The effects are cumulative, permanent, but modifiable.
- Areas affected include:
  - beliefs and relationships
  - feelings
  - behaviours and symptoms
  - frame of reference
  - decision making



## Working protectively - Perspective

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- Accept the inevitability of vicarious trauma
- Use a theoretical framework
- Understand your role
- Accept your limitations
- Acknowledge personal responsibility
- Identify choices
- Focus on process rather than outcomes
- Seek the positive



## Working protectively - Practice

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- Manage boundaries
- Write up therapy notes
- Focus on resilience in clients
- Meditate between sessions
- Express feelings through writing or art
- Establish professional networks
- Develop informal opportunities to connect
- Monitor work balance and work/life balance
- Take a break – daily, weekly, monthly, annually
- Physical Activity, Fun, Vacation

(Pearlman, 2005)

# How can a child protection protocol help clinical practice?

- Links child protection with the mission, aims and objectives of the organisation
- Explains relationship with investigation, prosecution and rehabilitation
- Clarifies roles and responsibilities
- Sets out procedures





# Related Areas of Concern

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- Protection for vulnerable adults
- Investigation
- Prosecution
- Rehabilitation
- Liability
- Indemnity




# Motivation and Resistance

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- Need to find a balance between clinical needs of the individual patient and the commitment to child protection
- Trust in the therapeutic process
- Prospect of combining tertiary treatment with prevention
- Clinical experience
- Fear to be misunderstood
- Overstepping competence and territory
- Pragmatic of probabilities of therapeutic progress and successful prosecution
- Reality of limited resources
- No definite answers

# ETHICAL PRINCIPLES

(PSI Code of Professional Ethics, Revised  
Version 1998)



## Respect for the Rights and Dignity of the Person

General Respect  
Privacy and Confidentiality  
Informed Consent and Freedom of  
Consent  
Self-Determination

## Competence

Ethical Awareness  
Limits of Competence  
Limits of Procedures  
Continuing Professional  
Development  
Incapacity for Practice

## Responsibility

General Responsibility  
Promotion of High Standards  
Avoidance of Harm  
Continuity of Care  
Extended Responsibility  
Resolving Dilemmas

## Integrity

Recognition of Professional  
Limitations  
Honesty and Accuracy  
Straightforwardness and Openness  
Conflict of Interests and  
Exploitation  
Actions of Colleagues



# ETHICAL DILEMMA

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## AUTONOMY

- Privacy and Confidentiality
- Informed Consent and Freedom of Consent
- Self-Determination

## DUTY OF CARE

- Extended Responsibility
- Avoidance of Harm
- Continuity of Care



# Clinical Setting in LARAGH

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- Statutory HSE Service
- NCS Ethos
- Community based specialist counselling service
- Strictly for Adults
- Clinical Staff are Counsellor/Psychotherapists (with background in a health care profession)



# Clinical Setting in St. Patrick's Hospital

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- Voluntary Service
- Ethos of patient care
- Transitions between in- and out-patient departments
- Adults and some young persons
- Multidisciplinary teams headed by Consultant Psychiatrists



# Clinical Setting in Private Practice

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- Self-employed – self reliant
- Code of Ethics and Conduct of the ICP
  - Duty of Care
  - Parameters of Contract
- Limited Contact with Referral Agent and/or Support Persons of Client
- Support through network and supervision

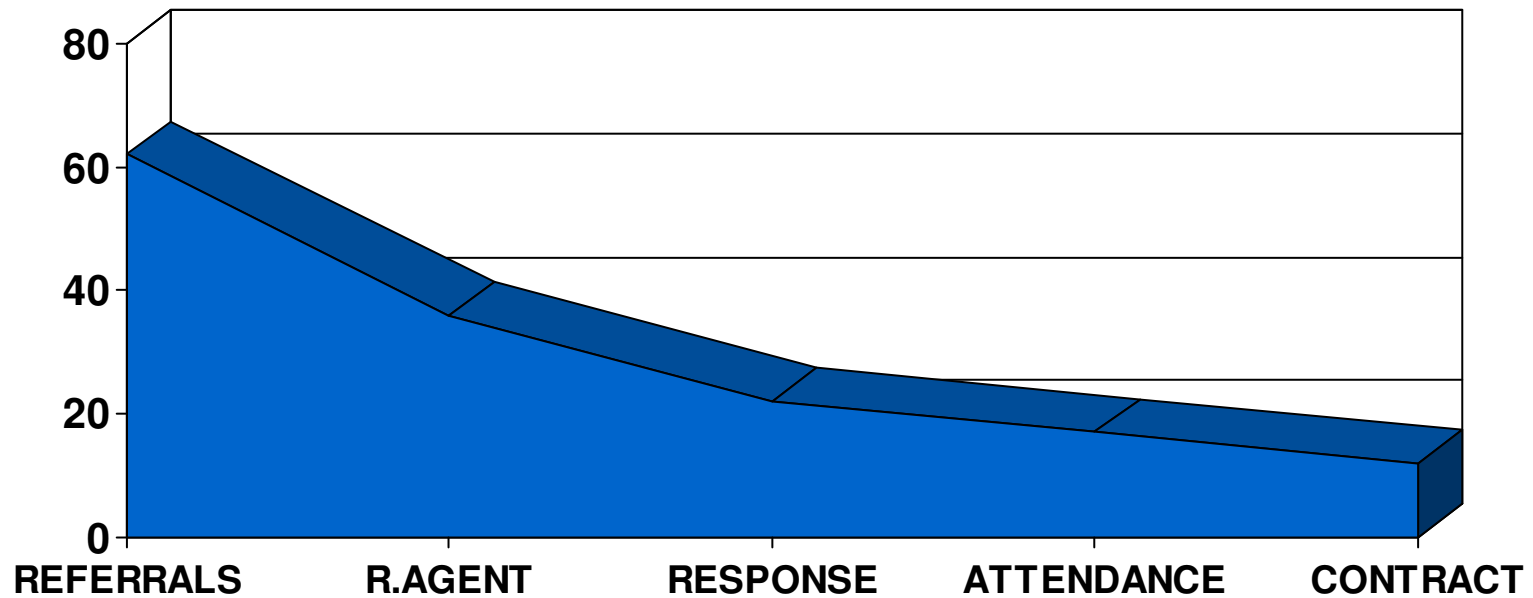


# Guidelines for Good Practice

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- Based on trying to converge ethical codes from different professions
- Identify clearly who is responsible for documenting and/or carrying out any identified action

# CLIENTS' WILLINGNESS TO REPORT LARAGH Clients 1996





# ETHICAL DILEMMA

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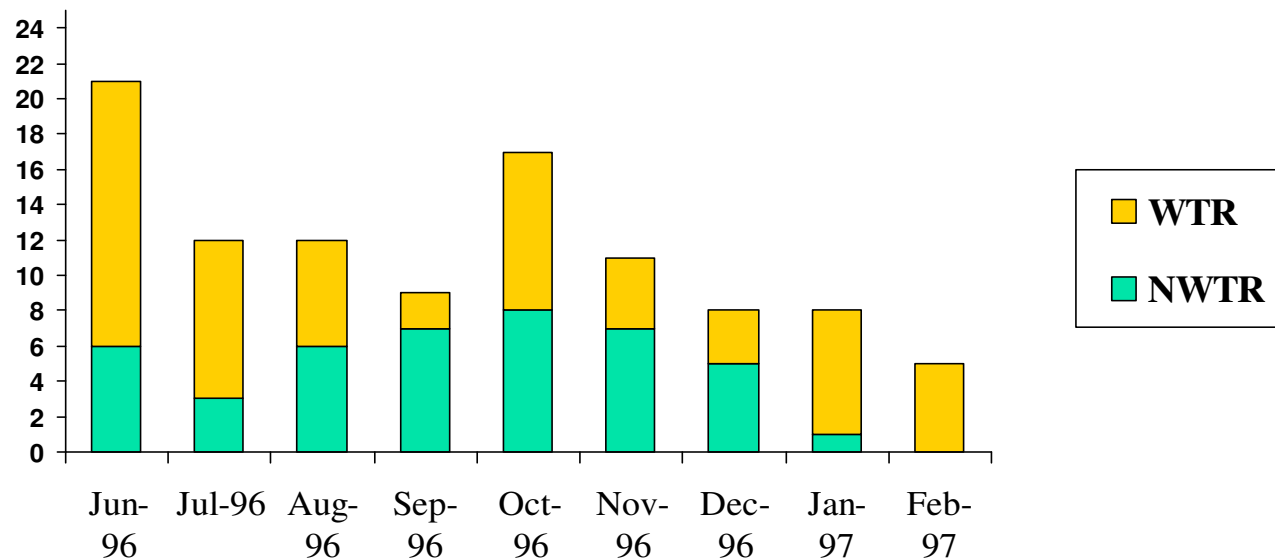
## AUTONOMY

- Privacy and Confidentiality
- Informed Consent and Freedom of Consent
- Self-Determination

## DUTY OF CARE

- Extended Responsibility
- Avoidance of Harm
- Continuity of Care

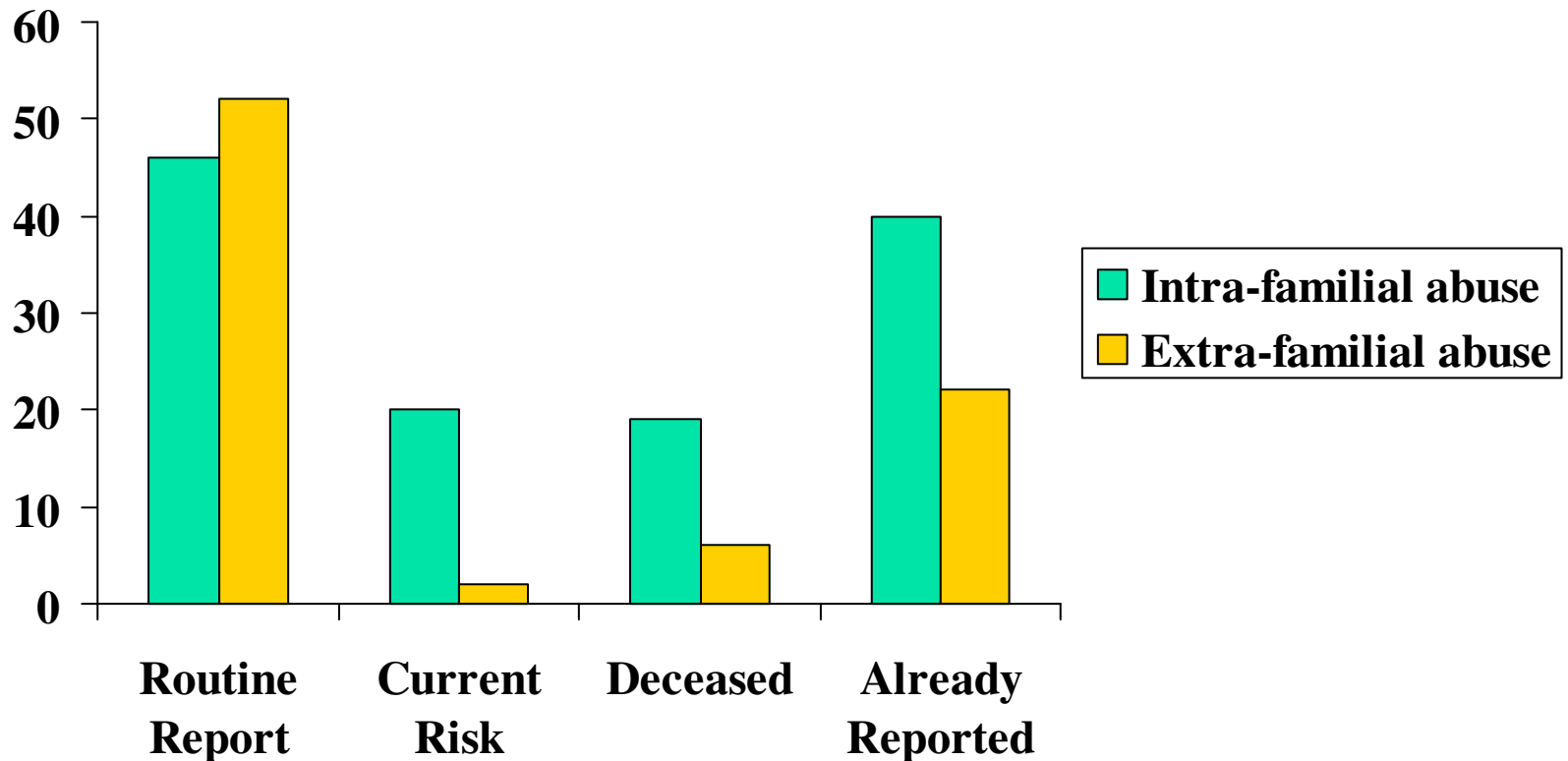
# TELEPHONE CONTACT: CLIENTS' WILLINGNESS TO REPORT



- Within 9 months the service was down to 30% of its original service provision

# PATTERN OF NOTIFICATIONS

## LARAGH Clients 1996/7





# GUIDING PRINCIPLES FOR RESOLVING THE DILEMMA

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- **Ethical Awareness**
- **Integrity**
  - **General Respect for all Concerned Persons**
  - **Honesty and Openness**
- **Improve Standards of Practice**



# ETHICAL AWARENESS AND INTEGRITY

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- **Ethical Awareness**

- Acknowledge Conflict
- Consult with other Professionals
- Recognise Professional Limitations

- **Integrity**

- Straightforwardness and Openness
- Honesty and Accuracy
- Clear Contracts



# IMPLICATIONS FOR CONTEXT AND FRAMEWORK OF THERAPY

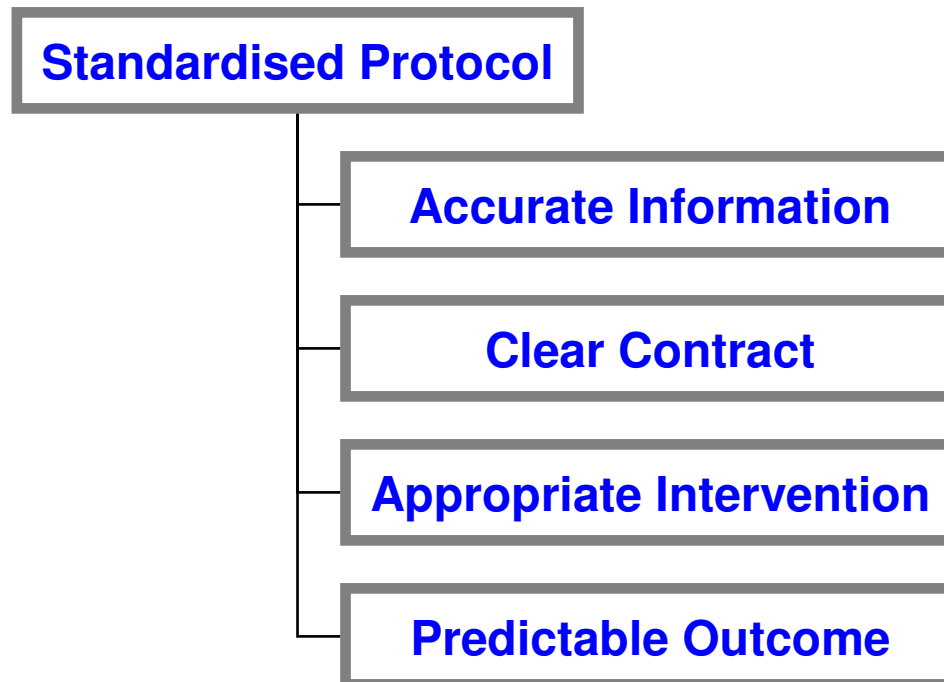
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- Clear Contract
  - limited confidentiality/liability
  - extent of practical support
- Educational Input re Legal Rights and Procedures
  - criminal nature of CSA
  - information and support for reporting and court appearance
- Increase Awareness of Current Risk
  - lack of intervention at client's victimisation
  - realistic assessment of children's situations



# **FUNCTIONS OF A STANDARDISED PROTOCOL**

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# NCS Policy 2000

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- Policy and Procedure Documents
  - Confidentiality, Risk Management and Reporting Procedures
  - Consent Form
  - Notification Form
    - To Child Care Manager
    - To Director of Service



# Confidentiality, Risk Management and Reporting Procedures

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- Support for judicial processes instigated by the client
- Safety measures for clients at risk of harming themselves
- Safety measures for clients posing a risk to others
- Evaluation of current risk situations posed by the alleged perpetrator
- Protection for the therapist
- Clear contract



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

*LARAGH Counselling Service  
Northern Area,  
1, Prospect House  
Prospect Road  
Glasnevin  
Dublin 9*

*Ph: (01) 8824100  
Fax: (01) 8824116*

**Report Information**

**Notification Form to Director of Service concerning Previously Reported or Unreported Cases.**

**Client's Name** \_\_\_\_\_

**Referral No:** \_\_\_\_\_

**Brief Description of Abuse.** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Details of Report to Gardai.**

**Garda Station:** \_\_\_\_\_

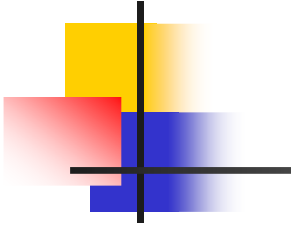
**Date of Report:** \_\_\_\_\_

**Outcome:** \_\_\_\_\_

**Reasons for Unreported Cases:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signed:** \_\_\_\_\_  
Counsellor

**Date:** \_\_\_\_\_



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**NOTIFICATION FORM CONFIDENTIAL**

Notification to the Child Care Manager of adults disclosing childhood sexual abuse

Client's Name \_\_\_\_\_ Client ID \_\_\_\_\_

For further information contact: \_\_\_\_\_ Counsellor

Address: \_\_\_\_\_

\_\_\_\_\_ Telephone \_\_\_\_\_

Brief description of crime, with approx. dates \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previously reported to Gardai? \_\_\_\_\_

Outcome \_\_\_\_\_

Previously reported to Health Board Social Workers? \_\_\_\_\_

Information re current risk: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any specific concerns of client and/or therapist, re interventions by social workers

or Gardai at this time \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

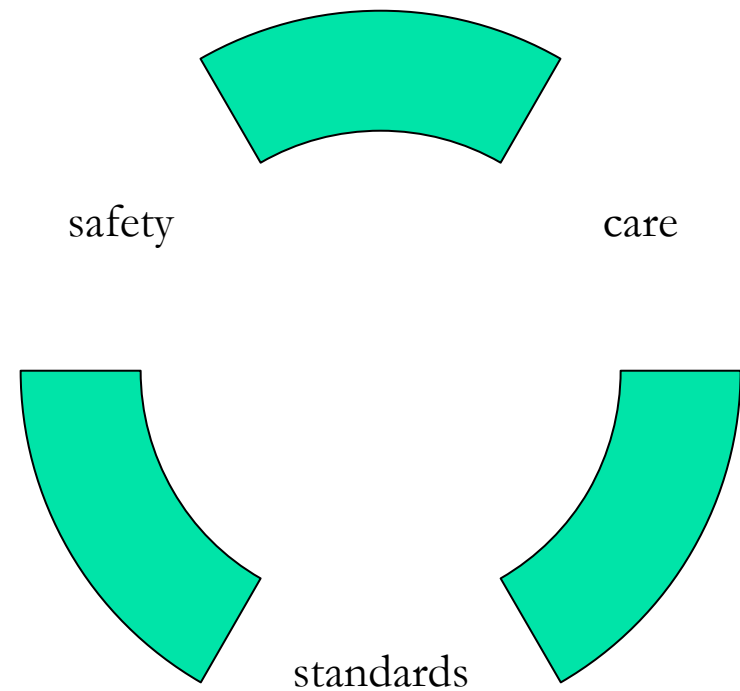
\_\_\_\_\_

Signed \_\_\_\_\_ (Counsellor) Date \_\_\_\_\_

Laragh Counselling Service

Copy to Director of Service 

# Clinical Framework





# INTERAGENCY CO-OPERATION BETWEEN CHILD PROTECTION SERVICES, GARDAI AND MENTAL HEALTH SERVICES

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- Protection for Adult Survivors Making Reports
- Standardised Protocols for Evaluation of and Intervention in Situations of Current Risk
- Mutual Training
- Continuous Evaluation of Service Provision on all levels



# PUBLIC AWARENESS

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- Criminal Nature of CSA
- Prevalence, Profile and Impact of CSA in Adult Population
- Critical Evaluation of Media Coverage
- Treatment Needs
- Resource Implications



# NECESSARY INTERPLAY OF DIFFERENT LEVELS OF INTERVENTION

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Clinical Practice	Clear Contract	Legal Education	Social Interventions
Interagency Co-operation	Protection of Adult Survivors	Standardised Protocol for Current Risk	Mutual Training
Public Awareness	Criminal Nature of CSA	Treatment Needs	Resource Implications