SEXUAL ABUSE OF CHILDREN

Implications from the Sexual Trauma Treatment Program of Connecticut

Special Report of
Two Research Utilization Workshops

Community Council
of Greater New York

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The Sexual Trauma Treatment Program
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FOREWORD

Over the years, the Community Council of Greater New York has had as one of its objectives the maximum application of research findings to the development and delivery of human services. Its Research Utilization Program was strengthened in the past year by the funds provided by the New York State Department of Social Services for the development of a specialized program which would give emphasis to the program and policy implications of recent research and demonstration projects related to child abuse and neglect.

One area of special concern has been new findings and insights regarding sexual abuse of children. Because of the increased interest in reaching and serving this group, two of the four Research Utilization Workshops held under the auspices of the Project featured the work of Connecticut's Sexual Trauma Treatment Program, and especially the contribution of Suzanne M. Sgroi, M.D., Project Internist and Chairperson of the Program. Although a total of some 170 persons in New York City and in Syracuse participated in these workshops, we believe there is a need to disseminate the new knowledge under discussion to the broadest possible constituency.

It is for this reason that we are issuing this publication. We hope that all concerned with helping sexually abused children and their families will be able to deepen their understanding of the special needs of this group and enhance their skills in the prevention and treatment of child sexual abuse through a careful and critical reading of this report.

BERNARD M. SHIFFMAN
Executive Director

I. INTRODUCTION

Heightened sensitivity to the nature and extent of the problem of sexual abuse of children has precipitated a demand by professionals from a variety of systems, i.e., child protection, education, mental health, criminal justice, and health, for sound guidance on how to intervene effectively in cases in which incestuous behavior occurs. Unfortunately, few research studies currently exist which can aid practitioners in identifying and treating the problem of intrafamilial sexual abuse.

For this reason, the Child Abuse and Neglect Research Utilization Project of Community Council sponsored two workshops in New York State in 1978, one in Syracuse on August 2, and the other in New York City on December 4, to share the results of an innovative demonstration project, Connecticut's Sexual Trauma Treatment Program (STTP), with professionals involved in the investigation and treatment of intrafamilial sexual abuse. The workshops brought together approximately 170 social workers, nurses, educators, doctors, psychologists, lawyers, police officers, judges and researchers to discuss Connecticut's program, current obstacles which inhibit effective delivery of services to victims of sexual abuse and their families, and ways to develop and improve service approaches.

Suzanne M. Sgroi, M.D., Project Internist and Chairperson of the Program, described the dynamics of the sexual assault of children and STTP's approach to the identification, assessment, investigation, and treatment of sexually abused children and adolescents. Edith Fein, Director of Research, and Karen Bander, Ph.D., Research Associate, Child and Family Services, Inc. of Connecticut, discussed the evaluation component of STTP, and its implications for administrators and clinicians.

Dr. Sgroi's presentation provided the opportunity to hear the perspectives and approach of a knowledgeable, experienced practitioner with sexually abused children and their families. Her presentation also pointed out areas for more rigorous research efforts, e.g., testing and effectiveness of various treatment modalities, and developing methods for preparing and training professionals for intervention in these difficult cases. Edith Fein and Dr. Karen Bander described the Sexual Trauma Treatment Program's "interactive" approach to program evaluation, where program staff and evaluators worked together in designing the focus and format of the evaluation and results were shared with staff on an ongoing basis. In this way, change can be effected in present program structures, producing a "process" rather than an "outcome" evaluation.

We are pleased to issue this report on the papers presented at the workshops. The key implications of the papers for program and evaluation are set forth in Chapter IV.

The sexually abused child has been "nobody's child" for far too long. We hope this publication will stimulate candid discussion of the role and

responsibilities of professionals in dealing with this complex problem and ways in which professionals can work together to build a responsive network of services for victims of intrafamilial sexual abuse and their families.

We would like to express our appreciation to Dr. Suzanne M. Sgroi, Edith Fein and Dr. Karen Bander, for sharing their findings with us, and for contributing their valuable time in planning and implementing the research utilization workshops.

We would also like to extend special thanks to the workshop chairpersons, Irene Arnold, Research Utilization Advisory Committee, Community Council, and Diane Meier-Erne, Executive Director, Alliance, Syracuse; and to the workshop panelists, Ann Bindman, Associate Executive Director, Brooklyn Society for the Prevention of Cruelty to Children, and Clifford Sager, M.D., Director of Family Psychiatry, Jewish Board of Family and Children's Services in New York City, and Frank Harrigan, Director, Children's Protective Services, Onondaga County Department of Social Services, and Louise Maffei, Fairmount Children's Center in Syracuse, for their valuable time and contributions. Special thanks also to James Cameron, Child Protective Services, New York State Department of Social Services, for his generous participation in the workshops and his warm support of the Child Abuse and Neglect Research Utilization Project.

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THE SEXUAL ASSAULT OF CHILDREN:

DYNAMICS OF THE PROBLEM AND ISSUES IN PROGRAM DEVELOPMENT

Suzanne M. Sgroi, M.D.

II. THE SEXUAL ASSAULT OF CHILDREN

The Hartford Sexual Trauma Treatment Program (STTP) is an offshoot of Connecticut's Child Abuse and Neglect Demonstration Center, one of 20 pilot programs funded by the National Center on Child Abuse and Neglect, HEW. It is housed within the Connecticut Department of Children and Youth Services which has statutory authority for receiving complaints of child sexual abuse and for providing protective services to children and their families who are so identified.

The comments I am going to make stem from my various experiences in the Center, in STTP, as an internist, and from my strong interest in community medicine and primary care. I have served as medical supervisor of a walk-in venereal disease clinic that is now jointly run by Mount Sinai Hospital and the Hartford Health Department, and have worked with the Municipal Police Training Council in providing child abuse training to newly hired police officers in Connecticut.

My remarks, then, are from a basic framework of experience with cases of child sexual assault which have presented either to a medical facility or to the police or to a statutory child protection agency. It shouldn't be surprising, then, that my principal concern in any child sexual assault case is that of child protection. Next on the agenda come strengthening the family and, hopefully, helping the child to remain in a safe and constructive family environment.

I think it is very important to mention one's orientation in talking about child sexual abuse. I believe, although it cannot be proved as yet, that there are different populations of child sexual abuse. The population which appears initially in an emergency room may be qualitatively different from the population which first comes to a VD Clinic. These populations may very well differ from those which present initially to the statutory child protection agency or to the police. There may well be still other differences in the populations of child sexual abuse cases which present initially to a child guidance clinic or to a mental health agency or to a mental health practitioner in private practice. I make these presumptions because I think that our experiences, which are very child-protection oriented, are substantially different from those acquired in programs that are more offender-oriented (for example, the Child Sexual Abuse Treatment Program of the Santa Clara County Department of Probation) or more crisis intervention-oriented (for example, the Harborview Sexual Assault Center in Seattle).

I am convinced of one thing. There is no single professional discipline that knows all the answers to this problem. Further, there is no single professional discipline that prepares one to be an "expert" or an "intervenor" or a "therapist" or an "investigator" in child sexual assault. Lastly, there is no single professional discipline that "owns" child sexual assault in that territorial way that we divide up and fight over most of the other problems which interest us. Actually there has been relatively little effort to "divvy-up" child sexual abuse. For the most part it has been nobody's child -- possibly because most people are so perplexed about how to approach the problem or deal with it.

In order to share my own perspective on child sexual assault, I must first share with you my personal conceptual framework of the dynamics and mechanics of this phenomenon. This is based on my own clinical experience as well as on an outline presented by Drs. Ann W. Burgess and Lynda Lytle Holmstrom in a paper entitled "Sexual Trauma of Children and Adolescents: Pressure, Sex and Secrecy."* Some of the framework is also drawn from a paper by Drs. A. Nicholas Groth and Ann W. Burgess entitled "Motivational Intent in the Sexual Assault of Children."*

THE DYNAMICS OF CHILD SEXUAL ASSAULT

First, let's talk about the dynamics of child sexual assault. I believe we are <u>not</u> talking about a capricious, unpredictable, unplanned phenomenon. Instead, I think for the most part the perpetrator is someone who is known to the child and is almost always somecne who has access to the child. The perpetrator must also be someone who has the opportunity to establish a sexual relationship with a child. Opportunity can almost be equated with privacy in these cases. The phenomenon usually takes place with the perpetrator and the child being alone with each other -- rarely when anyone else is around or as part of a group phenomenon.

Who, then, is the perpetrator likely to be? Almost always someone in the child's own family -- someone who has access and opportunity within the family circle. Or the perpetrator may be someone given access to the child by the parents or guardian -- again someone within the child's usual daily sphere of activities. Where do we allow little children to be? And with whom? We let them be at home, we let them be in the homes of relatives, we let them be with neighbors, we let them go to sch[illegible] we let them engage in age-appropriate organized group activity such as [illegible]h groups, boy scouts, girl scouts, clubs and so forth. People who are likely to have access to the child are likely to be known to the child in one of these spheres. Thus the dynamics of child sexual assault usually involve a known adult who is in a legitimate power position over a child and who exploits the usual accepted patterns of dominance and authority that our society permits adults to have over children. The exploitation and misuse of accepted power relationships is a highly significant aspect of the dynamics of child sexual assault.

Now how does the perpetrator engage the child? How does the perpetrator get the child to participate in some kind of a sexual relationship? Usually he or she does so by approaching the child in a non-threatening way, depending on the age of the child -- possibly by presenting the activity as a game. There is usually a verbal or non-verbal misrepresentation of moral standards on the part of the adult. In other words the adult conveys to the child "this is ok" and the child accepts this because in our society, children usually look toward adults to provide guidelines for what is right and acceptable behavior. There may be rewards (perhaps you might want to call them bribes) offered for the participation. So the child becomes engaged in sexual activity usually without force, without violence, without injury - frequently, if the perpetrator is adept, without threat and without fear.

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*For complete citation, see Bibliography, p. 39.

THE MECHANICS OF SEXUAL ASSAULT

What are the mechanics of what happens between the perpetrator and the child? Remember that we are talking about non-violent contact. I am now going to present a laundry list of types of behavior that may occur between the two. I am going to start with what I believe may be the most frequent behavior. As I do this, please treat the list as all laundry lists should be treated -- as generalizations.

The behavior will probably begin with exposure. The perpetrator exposes himself, exposes his genitals; the perpetrator persuades the child to expose himself or herself. I talk about male perpetrators almost exclusively because my clinical experience has been limited for the most part to cases with male perpetrators. I suspect that this represents our lack of knowledge of the female perpetrator and our inability to recognize her. So from now on, I will be discussing behavior of male perpetrators exclusively.

The perpetrator then persuades the child to undress partially or completely and to expose his/her genitals. I think we are talking about close to a 50/50 distribution of male and female children. This is contrary to all the statistics, including our own, regarding sex of victims. Again, I think we have a bias against recognizing male children as victims. We aren't looking for them; we aren't interviewing for it. We look at children at risk in a family situation or within a kinship or at a school and we are much more likely to forget about all the little boys and focus on the little girls.

After exposure, what comes next? On the first encounter, perhaps nothing. They may look at each other and call it a day. Or they may progress to autostimulation, to masturbation. The perpetrator masturbates himself; the perpetrator persuades the child to masturbate himself or herself. The activity may stop there; they may never touch each other. Or the activity may progress to fondling. The perpetrator persuades the child to fondle him -- external stroking contact which may begin anywhere on the body but ultimately focuses at the genital or rectal area. Or the perpetrator may fondle the child - gentle stroking contact all over the body but with eventual focus on the buttocks, breasts or genitals of the victim. In Connecticut, this activity is defined as "sexual contact" (as opposed to "sexual intercourse"). Knowing the distinction between sexual contact and sexual intercourse within your own legal jurisdictions is extremely important.*

If there is going to be any penetration of the child's body, the odds are that the area to be penetrated, particularly in a small child, will be the mouth. I think we do not always think of this as readily as we should. The child's mouth is the area of his/her body that is most amenable to penetration.

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*In New York State Penal Law, incest is a felony defined as an act of marrying or engaging in "sexual intercourse with a person whom he knows to be related to him either legitimately or illegitimately as an ancestor, descendent, brother or sister or either the whole or the half blood, uncle, aunt, nephew or niece." Sexual abuse, a misdemeanor, relates to sexual contact such as touching the genitals.

The perpetrator persuades the child to fellate him (contact between the child's mouth and the perpetrator's penis) or the perpetrator may fellate a male child (contact between the perpetrator's mouth and the child's penis) or the perpetrator engages in cunnilingus (contact between the perpetrator's mouth and the vulvo-vaginal area of a female child). The activity may stop here.

If another area of the child's body is to be penetrated, the next most likely area is the child's rectum. The penetration will usually begin with the perpetrator's fingers and then may be followed by full penetration by the perpetrator's penis, depending on the age of the child, the anatomy of the child and the circumstances of the assault. Remember, if you will, that the usual examination of a newborn baby in the delivery room or in the newborn nursery involves having a physician or a skilled examiner checking to see if the rectal opening is patent. This examination is usually done with the gloved little finger. A newborn baby, then, can have his/her rectal opening penetrated digitally by an adult's little finger without causing any trauma. Clearly, an older child's rectal opening can be penetrated by much larger objects including the penis -- again depending on the circumstances of the sexual abuse.

The sexual abuse scenario may also include masturbation by the perpetrator followed by ejaculation against the child's body with or without attempts at forcible penetration. The ejaculation may be against the child's breast area, abdomen or perineum. If the perpetrator ejaculates against the perineum, semen and sperm may enter the vagina through the opening of the hymenal ring without any penetration. Sperm will be found in the victim's vaginal secretions, under these circumstances, <u>if appropriate examination is performed</u>. If an aspirate of vaginal secretions to check for sperm is never performed, I guarantee that no sperm will be found.

Lastly, the behavior may include vaginal penetration of female victims. Again, the anatomy, the age of the child and the child's previous experience will determine how soon vaginal penetration may be attempted. I have done enough examinations for child sexual assault to be convinced that you cannot predetermine what you will find -- you really have to look. We have been told that examination of sexually abused children can possibly be as traumatic as the sexual assault itself. My only response is that medical professionals must have terrific hangups about sexuality if performing an examination seems to re-create the trauma of the assault situation for the child. (Incidentally, the actual sexual abuse experienced by the child, in all likelihood, did <u>not</u> include forcible penetration.)

Further, medical professionals who have such hangups do not do genital examinations routinely and therefore do not know how to appreciate normal findings. I will now proffer my usual plea that these examinations be performed routinely by all primary care physicians who see children -- they should be an integral part of well-child care -- and that the specific examination for child sexual assault include appropriate collection of specimens and recording of findings. (Guidelines for such examinations are included in the Appendix.)

THE SECRECY PHASE

What do all these dynamics and mechanics lead to? A child has been engaged in some kind of sexual behavior which is then followed by an extremely important phase of the activity so far as the child is concerned and so far as the future development of the case is concerned -- the secrecy phase. The perpetrator's primary agenda after the sexual behavior is to get the child to keep their activity a secret. Why? He is probably not stupid. He does not want to get caught. He does not want the child to blow the whistle on their sexual activity. Presumably he would like the activity to continue. And so the child is then usually gently led into a phase in which he/she comes to understand that the special activity between them must be kept secret from others.

The child usually does keep the secret. Why? Rewards have probably been offered. Possibly there may have been threats made -- the less adept the perpetrator, the more likely he is to use threats. If threats were used to enforce the secrecy, they should be carefully assessed for the degree of physical violence proposed, if any. Of course many compelling types of threats for a child will not include physical violence. For example, the perpetrator may threaten the child with anger by a third party ("If you tell Mommy, she'll be awfully mad at us.") Or the threat may involve separation ("If you tell anybody, Mommy may divorce me or I may go to jail.") The personal separation threat may be used, which is highly anxiety-provoking for a child ("If you tell anyone, you will be sent away.") Or the threat may involve self-harm by the perpetrator ("If you tell anybody, I'll kill myself."). Lastly, the threat may involve violence against the child ("If you tell anybody, I'll hurt you or kill you."). In assessing and categorizing these threats, two elements deserve particular attention. First, the degree of physical violence threatened and, second, was any part of the threat ever carried out? A good child protection assessment of any sexual abuse case will include a careful look at all these dynamics inherent in the secrecy phase.

There is still another important reason why the child keeps the secret. The sexual behavior, if introduced early by a known and valued perpetrator who does not hurt the child, tends to be self-reinforcing. In other words, the child keeps the secret because she/he likes it and wants the behavior to continue. We are, after all, talking about pleasant non-violent stimulation -- activity that feels good. Although we behave as if children are born without genitals or at least without the cerebral equipment to appreciate genital stimulation, the fact is that a child's sexuality begins at birth. To ignore that the child may very well find the sexual activity with the perpetrator pleasurable, and that the pleasurable aspects may be a motive for the child to wish to continue the behavior over time, is not only to ignore the obvious but to miss some of the most important dynamics.

Think of child sexual abuse on a continuum over time. In my experience with child sexual abuse cases in the past five years, the incident which initiated the investigation has never been the first incident of sexual abuse experienced by the victim. This has held true for both intra-family cases and extra-family cases whenever an adequate investigation has been done. So think of the children you are working with as being somewhere on a continuum of exposure over time.

THE DISCLOSURE PHASE

Sooner or later we are going to come to another important phase -- the disclosure phase. Somehow the secret gets broken. How the secret gets broken is highly significant, not only from the child protection perspective but also in terms of the intervention plan thereafter. It is extremely important to know if someone told the secret and, if so, who told? If the child himself or herself told the secret, the dynamics will be very different than those which can be expected if someone else told the secret or if the secret was disclosed accidentally.

Why might a child tell the secret? A young child may tell the secret to share it. In other words, this adventure was so much fun, so fulfilling that it simply must be shared with someone. An older child usually tells the secret for very different reasons. Frequently, disclosure by the older child will occur because the child is attempting to escape some type of pressure situation - perhaps pressure unrelated to the sexual abuse. Or the older child who may have been initiated into premature sexual activity by an adult family member much earlier is now reaching adolescence and is more interested in peer and group relationships outside the family circle. This youngster may become interested in dating and staying out late even though an incestuous sexual relationship is continued. Such adolescents may receive increasing pressure to maintain the family fortress and meet all psychosocial needs within the family circle. When this occurs, the child may tell the secret, not because the primary item on the agenda is to stop the sexual abuse activity, but rather in pursuit of some other goal. Those of us who receive complaints of child sexual abuse usually assume that the child complained because he/she is primarily interested in stopping the abuse. Frequently this assumption is incorrect. These children often recant when they see how much family disruption will be caused or they recant because the pressure situation which drove them to make the complaint is altered.

The sexual abuse secret may be disclosed accidentally. Perhaps the perpetrator was not very adept -- someone saw the sexual activity and told about it. Or the perpetrator may accidentally hurt the child and the physical trauma brings the case to light. Or the child may get VD, particularly gonorrhea. Or perhaps a female victim becomes pregnant. Cases characterized by any of these types of accidental disclosure can be expected to present differently than cases which are disclosed by one of the participants. Since none of the key actors in the scenario has chosen to tell, the dynamics in accidental disclosure cases can be expected to be very different.

VALIDATING THE COMPLAINT

In any event, even with competent and thorough evaluations and examinations, we can expect to find corroborating physical evidence in a small proportion of cases. How, then, does one validate a complaint of child sexual abuse? For the most part, validation will depend on investigative interviewing, hinging on the assessment skills and previous experience of the intervenor or interviewers. It requires a skilled and knowledgeable interviewer who is willing to believe. One of the basic hurdles for the interviewer to overcome is a mental attitude which holds that children routinely make allegations of sexual abuse by adults, practically as a rite of passage. This mental attitude

further holds that children either lie about sexual abuse or fantasize its occurrence or both. The skilled and knowledgeable interviewer is not going to be hampered by such a mental attitude. Instead he or she is prepared to accept the credibility of the detailed and explicit descriptions of sexual activity which can often be elicited from the victim using the specialized interviewing skills which are required. I know of no other clinical situation in which the intervenor's payoff for denial of the situation equals or exceeds that of the participants. In other words, we have so much investment in declaring the complaint invalid that we bend over backwards to throw it out -- to turn the case into a "non-case" by not believing that sexual abuse actually occurred.

What other elements are required for successful intervention with child sexual abuse, besides skilled investigative interviewing? Thorough knowledge of the child abuse and sexual assault laws is essential. An ability to engage the sexually abused child and his/her family members is also important. This is just as important in cases involving extra-family perpetrators as in incest cases.

THE ENGAGEMENT PROCESS - THE QUESTION OF INTERVENTION

Let us review the current engagement techniques practiced by members of the helping services. To put it simply, we require people who need help to come to us. This does not work in child sexual abuse -- a fundamentally different engagement process is necessary.

How did we get where we are right now? I find it astonishing that those of us who provide help for troubled people somehow arrived at the conclusion that unless someone recognizes that he has a problem, decides he wants help for a problem, and comes to us for help, we will not try to help him. How did we come to this conclusion? I believe there has been a progression in the practice philosophy of the helping professional that has gone from the early concept of noblesse oblige, to the settlement house approach where the helping person located himself or herself within the disadvantaged community, to the more recent phenomenon of people having to recognize their need for help and come to an agency or practitioner requesting that help.

Where does this progression leave us? I would put it to you that the dynamics of child sexual abuse are such that family participants will rarely come to us asking for help and follow through with the consistence that our current philosophy of helping services demands. The incestuous father is usually a "me-first" person who very frequently has the entire family revolving around him and meeting his needs. This father encourages all family members to erect a "family fortress." The outside world is perceived as hostile and all family members are pressured to limit contacts with peers and outsiders and instead meet all psychosocial needs within the family circle. He is probably quite immature, very rigid and extremely likely to react to disclosure with denial.

What about the mother? She is usually also immature and is frequently a very dependent person. She has failed to protect the children and may have conscious or unconscious knowledge that the sexual abuse has taken place.

Occasionally the mother has "set up" the child for sexual abuse. Mother is frequently absent when the sexual abuse is taking place. She may be very competitive with the target child.

What about the other children in the family? They are frequently aware of the special relationship between the target child and the perpetrator. They may have been victims themselves at one point and, indeed, may have "set up" the sibling who is currently the victim. They are usually very competitive and may be very angered by the family disruption which ensues at the time of disclosure. These siblings may be very unreceptive to and uncooperative with the intervenor who enters the situation and proposes to "handle" the problem by instituting lots of changes.

What about the target child? This person almost always has the expectation that we are going to perform magic. The child may now be regretting the disclosure and wants us to wave a magic wand and somehow change the situation painlessly, without disruption and, hopefully, without telling the parents that the disclosure has been made.

I believe it would be difficult to come up with a roster of involuntary clients that presents a greater challenge to intervention. Unfortunately, we are the inheritors of a 30-50 year time lag in the development and refinement of skills for working with involuntary clients. We have paid little attention to these skills since the 1920's. Most of us have received our own clinical training from a generation of teachers and clinicians who had little expertise in this area and did not practice these skills. I personally believe that the big gap in our child sexual abuse intervention today is that most of us are not prepared to cope conceptually with the involuntary client, much less on a practical level.

Intervention with immature, dependent and hostile clients requires the skills and endurance to break through their denial and resistance. They will not come to us; we have to go to them. We can forget about looking for "motivated" clients to be recipients of our child sexual abuse intervention and therapy. A mandate for intervention and a willingness to work with the involuntary client must be substituted for "client motivation" in these cases. Our clients have to receive this message from us: "No matter what you do, how you act out, how evasive you are, how much you deny and try to make us disbelieve and abandon you -- we won't go away." None of these maneuvers will turn the case into a "non-case" and it is perfectly appropriate to present this philosophy to family members at the outset and predict that the evasive maneuvers will probably surface.

TREATMENT -- POSSIBILITIES FOR SUCCESS

Treatment for child sexual abuse is possible, although I believe that some of these families are "terminal" at the time of referral and that intervention in such cases should focus on assisting and supporting family members through a separation process with treatment goals for individual family members pursued throughout and thereafter. The treatment skills required for child sexual abuse probably are not unique. An analagous clinical situation is that of the

treatment of alcoholism. Studies have shown that successful treatment of alcoholism seems to hinge on the existence of an authoritative incentive for change, with the type of clinical intervention utilized being less critical.

Treatment oriented toward behavior change, then, is possible in some incestuous families. The treatment plan needs to reinforce and encourage constructive behavior patterns and interpersonal relationships among family members while discouraging destructive behavior patterns and relationships. The intervention with these involuntary clients must focus on the sexual abuse behavior and its underlying motivations and implicit rewards. In these multiproblem families, it is tempting to avoid dealing with the impaired sexual relationships while focusing instead on less threatening problems. We have found that the extreme resistance and denial that characterizes these clients makes a focus on the sexual abuse essential in the treatment process. It is, after all, usually our only "handle" and justification for maintaining a relationship with involuntary clients long enough to engage them in a therapeutic relationship. All of us are familiar with incest cases that sometimes are maintained in "therapy" for years without the subject of incest ever arising between therapist and client.

A combined authoritative and supportive approach has seemed most effective in the child sexual abuse cases we have encountered in the past 18 months. The initial support has to "feel like help" to the client; we usually concentrate on very concrete types of support during the initial crisis period at the time of disclosure and try to fulfill at least one key request of each family member during this period. "Authority" tends to be a dirty word in the lexicon of many helping services professionals. Although initially resistant, many incestuous family members respond well (sometimes with relief) to "being told what to do," especially if the authoritative instruction is firm, consistent, non-punitive, and generally "upbeat" with emphasis on the positive aspects of the situation. Constructive use of authority also involves limit setting for individual family members' relationships with each other as well as with the therapist. Again, since these individuals tend to have few interpersonal boundaries and there is much competitiveness and blurring of roles and responsibilities, authoritative limit setting is often required, especially on behalf of the more passive and less assertive family members.

The authoritative handle, in our experience, must be that of police or court involvement. Lesser incentives have not been effective in maintaining the family in treatment or, indeed, in maintaining access to the target child. Approximately one-half of our cases have had juvenile court involvement; one-third have had criminal justice system involvement. A program policy has been to make at least a blotter report to the police in all cases.

Maintaining access to the child is a critical feature in these cases, and again, requires the authoritative "handle." The child and all "cooperative" individuals are nearly always under enormous pressure from other family members (especially the perpetrator) to recant and move away from a cooperative stance and involvement in treatment. Our insistence in maintaining access to the child and encouragement to family members to form relationships with therapists and peers in group therapy is a critical factor in breaking down the incestuous "family fortress."

Role modeling is an important aspect of treatment for all family members. Opportunities for role modeling abound in both individual and group therapy. The use of multiple therapists or intervenors (later described) and co-therapists in group and couples therapy provides further opportunity to use this technique on many levels.

DEVELOPING A SEXUAL ABUSE TREATMENT PROGRAM

Program development does not necessarily require large quantities of start-up monies. All intervenors must want to be involved in child sexual abuse intervention; this is a sine qua non. Since most child protection agencies, most mental health agencies, most family service agencies and most police departments already handle child sexual abuse cases, it requires only an internal administrative decision to (a) assign these cases to personnel who express willingness and interest in them, and (b) allow such personnel to begin to concentrate their case experience over time by eliminating random case assignments.

The next step in program development is the case review process, both inter-agency and intra-agency. Therapists and intervenors within a single agency should be allowed and encouraged to share their experience in some type of constructive critical review process. At the same time, inter-agency and inter-disciplinary review of child sexual abuse cases should be established within the community.

The minimum number of disciplines to be represented in community inter-agency team review of child sexual abuse cases is three: child protective services, law enforcement and mental health. Medical, legal and non-verbal therapy (e.g., art therapy), participation in team review and consultation are very desirable.

In this day and age, of course, multidisciplinary teams in child abuse intervention are considered so essential that it is practically un-American not to have one in your community. My personal experience is that these teams can be extremely beneficial in establishing liaisons with intervenors, broadening the data base, providing access to skilled consultation for problem cases, sharing responsibility for difficult case management decisions and boosting morale. A word of caution should now be interjected. Teams take time. They usually are developed slowly over time rather than springing up full-blown overnight. Team review can be extremely threatening for any intervenor, especially if he/she lacks experience with this modality. It helps enormously if each team member is a "hands on" intervenor for some child sexual abuse cases in the community. Otherwise, the team members who "get their hands dirty" with actual case intervention tend to be very resentful of comments made by the others. Defensiveness and unwillingness to share cases may often ensue. Ideally, mutual trust and respect and willingness to share responsibility will develop among team members over time. Much time can be saved by focusing on the needs of each case and task assignment based on the skills and responsibilities of each team member rather than spending endless hours of discussion on each individual's "role."

Inservice education is an integral part of child sexual abuse program development. Intervenors and therapists must be allowed time for education and skill building. Inter-agency multidisciplinary team review is also an educational process for all members. However, each agency must critically assess what skills are required for that agency's intervention to be effective. In many instances, the skills can be supplied by a cooperative agency already participating in team review. Since no professional discipline formally prepares one to be a child sexual abuse intervenor, training and skill-building must be done at the field worker level, in particular. The training programs must be self-designed and implemented in most cases.

Some form of evaluation of any child sexual abuse program is essential. Case experience must begin sometime -- unfortunately, it is necessary to make some mistakes in order to learn effective intervention techniques. This trial and error process is justifiable in the current milieu of little intervention and virtually no treatment for child sexual abuse. However, ongoing evaluation must be done if mistakes are to serve as learning tools and not be repeated.

THE SEXUAL TRAUMA TREATMENT PROGRAM

The Intervention Process

The following intervention approach for intra-family child sexual abuse cases has been developed in the Sexual Trauma Treatment Program. The first step upon receiving a complaint of child sexual abuse is to set up an immediate face-to-face interview with the complainant. The effort required to do this (as opposed to proceeding with a telephone interview) will probably be rewarded on several levels. A face-to-face interview gives the intervenor and complainant an opportunity to "size up" each other directly. If the complainant is a professional or community person or a relative or neighbor, he/she can give invaluable assistance to the intervenor. A few complaints will be given less credence based on the intervenor's assessment of the complainant. More often, the intervenor will be able to establish enough of a relationship with the complainant so that he/she will be willing to serve as a bridge between the intervenor and the victim if necessary.

If the complainant is the child's mother, access to the child is virtually ensured. More often, the complainant will be one of the previously mentioned individuals or else the child victim himself or herself. The next step, in any case, is to undertake an interview with the child victim. We bend over backwards to try to do this discreetly and without the parents' knowledge if they are unaware of the complaint. A private interview obtained in this fashion allows the intervenor to assess the child's reaction to the complaint and his/her history in a comparatively low-pressure situation. The contrasting situation, an interview with a child who has been pressured and "prepared" (perhaps threatened) by his/her parent, will probably yield much less accurate information about intra-family child sexual abuse and complicate the assessment and child protection processes.

The validation process usually depends, in large measure, on the assessment of the complainant's and victim's stories by a skilled interviewer. False complaints of child sexual abuse, in our experience, have been very rare.

Depending on the age of the child, his/her living situation, and the circumstances of the sexual abuse, it may be helpful to obtain a medical examination of the child at this time. If one suspects that corroborating medical evidence will be present and/or if a medical statement will be required to obtain temporary custody of the child victim, medical examination should be performed at this early stage. This may, of course, be difficult to arrange without parental consent. However, most states will permit a minor to give his/her own consent for examination for venereal disease and prohibit the medical facility from notifying the parents of such examination. Accordingly, this proviso may also enable a competent medical evaluation for child sexual assault.

Assuming that the perpetrator of intrafamily child sexual abuse is a dominant male figure in the child's home, the next step will be to interview the child's mother. By this time, the intervenor should already have decided if the complaint and the child's allegations are credible. If so, the mother should be approached from this perspective. One of the fastest ways to turn a case into a "non-case" is to approach the child's mother (or father) with this attitude: "I'm here to investigate this incredible allegation but if you good people will only send me the message that it is not true, I will go away and leave you to discipline your dirty-minded and lying child in peace!" How often is this attitude conveyed by police officers, child protective service workers, medical or mental health personnel? Dare we estimate the number of times such a message has been conveyed?

A more appropriate attitude for the intervenor to convey is one of concern for the child and mother coupled with a determination to ensure the child's safety. The mother's response to the message that a skilled intervenor believes that her child is a victim of sexual abuse will greatly influence the child protection assessment and immediate intervention plan. If the mother's response is hostile, punitive, rejecting and denying, the child is unlikely to be safe in the home during the immediate intervention period. If, on the other hand, the mother's response is one of concern for the child, the intervenor can then work through the inevitable denial and disbelief which so often characterize the mother's reaction.

We prefer not to separate the child from the home and other family members if it is at all possible for him/her to remain. On the other hand, the incestuous family power structure will usually be such that after disclosure the victim, mother and all "cooperative" family members will be placed under enormous pressure by the perpetrator to recant the allegation and/or stop "cooperating" with outsiders. It is extremely difficult to establish working relationships with the key family members under such circumstances. We usually try instead to separate the perpetrator temporarily from the rest of the family. If criminal charges have been made, separation of the perpetrator is usually facilitated. Some mothers are strong enough and can be supported enough to insist that the perpetrator leave the family on a voluntary basis. Other mothers are able to leave with the children.

In a few selected cases, we have elected to allow the child to stay in the same home with the perpetrator when the mother appeared to be strong enough to enforce limits and boundaries. The pressure these mothers, victims and other family members face is usually intense. Since significant family

disruption is a fact of life in child sexual abuse cases that have proceeded into a full disclosure phase, the therapeutic challenge is then to make the inevitable disruption a constructive force for breaking down the family fortress, building up passive or downtrodden family members, establishing more appropriate boundaries, and encouraging more positive behavior patterns and interpersonal relationships.

INTERVENTION MODALITIES

Careful psychosocial assessment of all members of the incestuous family is essential in order to formulate a long term intervention and treatment plan. We have concentrated on developing the following intervention and treatment modalities in the Sexual Trauma Treatment Program.

Individual Therapy

We try to assign a separate intervenor or therapist to each key family member (mother, father, victim). The perpetrators in most of our incest cases have been fathers or father-figures for the children. These individuals have frequently been inaccessible to us -- either because they are being prosecuted and their attorneys advise them to say nothing to the statutory child protection agency or else because they deny responsibility for sexual abuse and refuse to become involved in a remedial program. However, each case under treatment has a minimum of two therapists assigned -- one for the mother and one for the children. We find that use of more than one therapist has several benefits: a broader data base, greater ability to respond to crisis situations, ability to counteract at least in part the mother-child competition factor, opportunity to test out and compare therapists' perceptions with family dynamics, and sharing the burden of coping with the stresses imposed by these multi-problem often highly pathological families.

The quality of the relationship developed with the individual therapist usually determines the extent of "engagement" of that client into a therapeutic program. Engagement is a complex process -- a trust relationship with a therapist, authoritative incentive for involvement, meeting of initial concrete needs and a desire to change the home situation are all probable factors. Other selected intervention and treatment modalities will proceed in conjunction with, rather than as a substitute for individual therapy.

Adolescent Group

We have had a highly successful adolescent group, initiated by one of our social workers who had previous group work experience with disturbed adolescents. The group's stated purpose is to help its members resolve sexual trauma and to work on behavioral goals identified by the adolescent victim herself, her therapist and other group members. Much emphasis is placed on improving the quality of the girls' interpersonal relationships and social skills as well as improving their self image (usually very poor) and increasing self-confidence. Various methodologies are used to achieve these goals, including role playing, role modeling, ventilation and working on individually

contracted behavior change agreements. The group is open-ended, meets weekly and combines social and therapeutic functions. It is co-led by two female therapists who support and "pinch-hit" for each other when necessary. It required more than three months of steady plugging through a long plateau phase by the co-leaders and three adolescent girls before this group acquired more members and became extremely active.

Mother's Group

This group is comprised of mothers of children who have been sexually abused -- nearly all incestuously and by mother's spouse or boyfriend. The purpose of the mother's group is to assist its members to understand the child sexual abuse phenomenon, take responsibility for their failure to protect their children, improve their relationships with their children and work toward establishing a healthier home environment for themselves and their children. This group is also open-ended and co-led by two female therapists. The "plateau phenomenon" with a several month initial lag period with few group members was also experienced with the mother's group. Part of the group's function is to help members overcome denial, focus on the reality of their home situations, improve self image and build not only their self-confidence but also their ability to handle situations for which they had previously been dependent on their spouses or consorts (including discipline of the children, handling a checkbook, household management and so forth).

Art Therapy

We were fortunate to have the services of a highly skilled art therapist, Mrs. Clara Jo Stember, for the first year of the program. She demonstrated very effectively that art therapy can be used as a tool to engage and work with nonverbal individuals, especially children. After her tragic and unexpected death in July 1978, we have been able in part to continue exploring this intervention modality with sexually abused children.

Dyad Therapy

Mother-child dyad theraphy is used in some cases, usually after some progress has been made in individual therapy. The goal is to strengthen and improve the mother-child relationship.

Couples Therapy

In several selected cases, we have worked with husband-wife couples together with a male and female co-therapist. This modality has been used with a definite time framework and with contracted goals set up at the outset. It is basically marriage counseling with a focus on the antecedents and dynamics of the child sexual abuse situation.

Offender Treatment

We made little progress in this area during the first 12 months of the program until Dr. A. Nicholas Groth joined our program as a consultant in August 1978. All the offenders we encountered exhibited a high level of evasiveness, denial and behavioral pathology. We had several initial experiences with incestuous fathers who initially appeared cooperative and then manipulated the program to escape from criminal prosecution. These men then pressured "cooperative" family members to recant their allegations and stop participating in the intervention program. Having successfully maneuvered to escape authority by turning the case into a "non-case," the offenders then declared to family members and the community that we, not they, were the problem. With the family fortress thus successfully re-erected, these incestuous offenders not only foiled intervention but had probably strengthened their own dominant positions vis-a-vis other family members.

I would strongly urge professionals who are starting child sexual abuse treatment programs to try to obtain clinical consultation from individuals with expertise in dealing with sex offenders. The Sexual Trauma Treatment Program now has a strong affiliation with Dr. Groth's sexual offender treatment initiative at Somer's State Prison. We are now assisting Dr. Groth's staff in working with incarcerated incestuous offenders individually and in groups and gaining experience and confidence in this highly specialized program area. Our goal is to form our own offender and/or parent groups with non-incarcerated individuals. Meanwhile, Dr. Groth's consultation and our staff's experience with incarcerated offenders is being applied to the Sexual Trauma Treatment Program's caseload, especially those families who are still intact.

CONCLUSION

To conclude this personal perspective on child sexual abuse and brief description of our program, may I say that I think our experiences in program development are not unique. The essential ingredients for developing a child sexual abuse treatment program are probably available in most urban communities. I would caution against expecting "instant" results. It is very difficult to measure outcomes with these families -- we have seen a bewildering array of changes in some of our cases over a 10-15 month time frame. Start-up time will require at minimum 12-18 months even in communities with well developed helping services. The slow progress of cases within the legal justice system (both juvenile and criminal) is another factor which has great impact on intervention.

Willingness to push into uncharted territory, to join hands with individuals from other disciplines to work toward a common goal, to experience frustration and pain and make mistakes -- all are required. Lastly, a commitment to stick with these cases and programs long enough to learn or re-learn skills in working with involuntary clients is essential. I am deliberately drawing a grim yet realistic picture. The excitement and occasional reward of learning new skills and helping troubled people take even small steps toward a healthier life style cannot be conveyed -- you have to experience them for yourself.

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EVALUATION OF THE SEXUAL TRAUMA TREATMENT PROGRAM: IMPLICATIONS FOR ADMINISTRATORS AND CLINICIANS

Edith Fein and Karen Bander, Ph.D.

III. EVALUATION OF THE SEXUAL TRAUMA TREATMENT PROGRAM

Research and evaluation studies of ongoing treatment programs often pose difficult problems for service providers and researchers alike. Program administrators need to know how effectively and efficiently services are delivered to clients. Ideally the researcher is interested in testing a hypothesis, in setting forth a design, and in establishing control or comparison groups, so that differences in outcomes, if they occur, can be measured and assigned to specific variables. The difficulties of such measurements, however, are myriad.

When Connecticut's Sexual Trauma Treatment Program (STTP) was begun, the evaluators were faced with the question of how to perform a valid evaluation of the program. Ethically, it was not possible to assign families randomly to control and treatment groups. A comparison of findings with the results of other treatment programs was a possibility, but little published data exist. Using attitudinal indicators of client change when behavioral indicators are difficult to obtain was considered unsatisfactory. It was felt, therefore, that the evaluation should focus on providing information that would be helpful in furthering program performance and development. In meeting with the program staff, these questions emerged as most important:

1. What happens to clients?

   - What problems and defenses exist?
   - What plans are formulated to deal with the problems and defenses?
   - What occurs in treatment?

2. What is the model for treatment?

   - What are the roles of consultants, multiple modalities, and team treatment?
   - What are the decision points?
   - Is there a written contract?

3. How is the treatment model implemented on the therapist level and on the system level?

   - How are community resources used by staff in treatment?
   - What is the systemic interplay with other agencies, e.g., mental health, law enforcement?
   - How is the treatment team used?

4. How are outside systems used and affected?

   - What is the role of the treatment team?
   - How are formal and informal working agreements arrived at and do they work?

5. What are the training needs of the present staff? Is assistance needed in:

   - Contract writing?
   - Formulation of treatment plans?
   - The use of groups, consultants, treatment teams or record keeping?

To obtain the data to answer these questions, a new record keeping system was devised. A problem oriented record was developed to monitor presenting and developing problems and resulting treatment plans. Data gathered from the problem oriented record were supplemented with information from staff interviews, from the mandated child abuse and neglect report forms, and from other sources. Results were periodically reported back to staff. This process of exchange, i.e., a formative evaluation, allows program issues to surface as they need attention and program adjustments to occur appropriately. The interactive relationship between the researchers and service providers is an unusual example of effective research utilization.

At this point, the case records of 74 families in the STTP program have been examined. Approximately two-thirds of the cases involved intra-familial sexual abuse. In the other cases, the child was sexually abused by someone outside the immediate family. In examining these cases, preliminary answers to the questions listed above emerged.

CLIENTS

Cases of incest cut across all social and economic classes and generally have a formidable number of needs and problems. In addition to the presenting problem of child sexual abuse, 96 percent of the families experience difficulties in family relationship and impaired communication patterns. Also, a majority of families suffer from additional problems such as major financial, educational, employment and intrapersonal difficulties. In short, these are very needy, multiproblem clients.

TREATMENT MODEL

The proposed model for teatment utilized the different strengths of individual therapy, group therapy, art therapy, marital therapy and family therapy. During their involvement in STTP, families were typically seen in three different treatment modalities. Team treatment was used; approximately 85 percent of the cases were served by two or more therapists. On the average, eight cases were seen four times a month or more; the others had fewer contacts. Temporary separation of the child and the family was necessary in some cases.

Therapists worked as a team with families. This required a high level of coordination among therapists, and meshing of therapeutic styles. The team provided a built-in support system for the therapists in that responsibility for difficult families could be shared.

MULTIDISCIPLINARY TEAM

The multidisciplinary team of the Sexual Trauma Treatment Program, consisting of a lawyer, doctor, art therapist, psychologist, police officer, and program evaluators, was employed to facilitate cooperation with the criminal justice system and other community systems involved in serving the sexually abused child. On an individual case basis, the team assisted program staff in clarifying treatment issues and resolving conflicts in treatment planning. "Good consultation" and effective use of the team was dependent on a non-judgmental atmosphere, the availability of team members, regular attendance and participation of consultants and the establishment of clear goals for the case presentation.

STAFF TRAINING NEEDS

Although workers in the STTP program had prior experience in working with cases of child abuse and neglect, they had little experience with the dynamics of sexual abuse of children. Indeed, even workers with professional training have tremendous emotional difficulties with the problem of child sexual assault.

Training was especially important in diagnosing and assessing sexual abuse. This was provided through ongoing supervision, weekly staff meetings and multidisciplinary team meetings. Workers also expressed a need for training in such areas as family therapy, child development, and the law.

SUMMARY

In summary, Connecticut's Sexual Trauma Treatment Program is testing an innovative method of delivering services to sexually abused children and their families. One of its unique features, an integrated evaluation component, has proved useful to program staff and administrators. The process evaluation offers an opportunity to improve program operation on an ongoing basis and to provide a rational base for future program planning.

For further information on the clinical treatment of incest, contact Norma Totah, Project Director, STTP, 94 Branford Street, Hartford, Connecticut 06105.

For further information on the evaluation of STTP, contact Edith Fein or Karen Bander, Child & Family Services, Inc., 1680 Albany Avenue, Hartford, Connecticut 01605.

SUMMARY OF IMPLICATIONS FOR PROGRAM PLANNING AND EVALUATION

IV. SUMMARY OF IMPLICATIONS FOR PROGRAM PLANNING AND EVALUATION

The experience of the Sexual Trauma Treatment Program and the results of STTP's evaluation have important implications for those planning and implementing programs for sexually abused children and their families. A summary of some of the most significant implications follows.

PROGRAM CONCEPTS

- No single discipline has exclusive jurisdiction over sexual abuse cases nor exclusive knowledge of how to treat cases effectively. Multidisciplinary intervention is critical to effective treatment.

- The mental attitude on the part of the caseworker or others involved with abused children and their families which denies that sexual abuse has occurred must be overcome. Those who work with this group must be educated so that there is a "willingness to believe" that this can happen, and that the child is not lying or fantasizing.

- A "mandate for intervention" is needed in most child sexual abuse cases. This generally requires the use of authority, i.e., the involvement of law enforcement and the courts, in order to maintain access to the child and encourage family members to cooperate in a treatment program. A balance of an authoritative and supportive approach seems to be most effective in these cases.

- Separation of the perpetrator from the family is preferable to removal of the child. In most cases, temporary separation is needed in the initial stages of treatment.

- Since this population has a formidable number and range of problems, in family relationships, impaired communication patterns, and major financial, educational, employment and intrapersonal difficulties, all of these problems must be considered in developing an adequate treatment and service program.

- Sexual abuse of children cuts across all socioeconomic groups. More research is needed to define the specific sub-populations and to determine the most effective treatment modalities for each.

PROGRAM OPERATIONS

- A sexual abuse program can be established without a large monetary investment through the reallocation and reassignment of personnel. However, since the handling of sexually abused children and their families is highly specialized, cases should be assigned only to those workers who express an interest and willingness to work with them. Such personnel should be able to concentrate their caseloads on sexual abuse cases.

- Each case should have a minimum of two therapists assigned to it. Ideally, a different intervenor or therapist should be assigned to each key family member.

- Individual therapy - for the mother, father and victim - is the core of the program, complemented by other modalities such as therapy for mother and child together and for couples, and group therapy for mothers and for adolescents. Art therapy for the child victim is also recommended.

- Professional in-service training should focus on the dynamics of sexual abuse and appropriate assessment and investigative techniques, since validation of the sexual abuse complaint is strongly dependent on the investigative interviewing and assessment skills of the intervenor. It is also important that workers have a thorough knowledge of the state's law concerning child sexual abuse. Training should also stress the development and refinement of skills for working with involuntary clients.

- A multidisciplinary team approach is most effective in working with child sexual abuse cases. The team approach should be used in a critical case review process (both at an intra- and interagency level), and in the treatment process. Team review of child sexual abuse should, at a minimum, include child protective services, law enforcement and mental health representatives. The participation of medical, legal and non-verbal therapy specialists (e.g., art therapy) is desirable.

- Establishment of a sexual abuse treatment program takes time. Twelve to eighteen months may be required even in communities with well-organized services.

- An evaluation component is essential to the assessment of the program's progress. A formative evaluation allows "program issues to surface as they need attention and program adjustments to occur appropriately."

Intervention in cases of child sexual abuse presents unique difficulties for workers. The results of the STTP program do not represent the complete or final answer to the question of how to treat sexual abuse effectively. However, it is hoped that they offer some guidelines that can stimulate communities to initiate new programs or improve existing ones. As Dr. Sgroi points out, successes are limited and "instant" results should not be expected, but with interdisciplinary communication and coordination, progress can be made in helping sexually abused children and their families.

APPENDICES

APPENDIX A

CHILD SEXUAL ASSAULT: SOME GUIDELINES FOR INVESTIGATION AND ASSESSMENT*

A frequent response to child sexual assault is "leave it to the experts." Unfortunately, experts on this topic are relatively few in most communities and usually see victims and their families on a secondary basis via a referral process. The person who has primary contact with the child victim of a sexual assault is most often a police officer, protective service worker, school teacher, guidance counselor or social worker, member of the clergy or health professional who has not had specific training in this area. Nevertheless any front-line person may find himself or herself in the role of the initial investigator of a case of child sexual assault by virtue of being "first on the scene" or the person to whom the victim has appealed for help. On the other side of the coin, any or all of the aforementioned people might be sobered to realize that they are perceived to be "expert" on sexual molestation by the community which they serve. Because of the widespread unfamiliarity and discomfort expressed by many on this topic, the following basis guidelines for investigation and assessment are offered.

I. *GENERAL APPROACH TO PROBLEM*

A. *Keep An Open Mind.* Recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition may exist.

B. *Keep Cool.* Sexual molestation of children is such an emotion-laden topic for most people thatobjectivity requires much effort and self-discipline. Nevertheless it is almost impossible to protect or help the child victim in the absence of a calm and professional approach.

C. *Keep Awake* to the fact that situations of child sexual assault are the most volatile and potentially dangerous of all social problems from the usual perspective of the family and community. Even as <u>you</u> are remaining calm and objective, remember the potential for violent reaction on the part of other participants.

II. *APPROACHES TOWARD INVESTIGATION*

A. *Medical Examination.* This is essential in all cases regardless of the date of the alleged assault. If properly performed this can usually be done with the child's cooperation on an outpatient basis. Hospital admission is rarely required.

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*Prepared by Suzanne M. Sgroi, M.D., for the State of Connecticut Department of Children and Youth Services, Connecticut Child Abuse and Neglect Demonstration Center.

1. The medical examiner should be a physician who is

   a. Knowledgeable about what is required
   b. A credible witness in court (preferably an attending physician or a physician in private practice rather than an intern or even a resident physician)
   c. Unafraid to participate (many physicians are unsure of their own competence in this area and are reluctant to "become involved.")

2. The medical examination should include

   a. A good overall medical history
   b. Identification of all trauma with emphasis on genital, rectal and oral trauma
   c. Careful description of genital anatomy regardless of presence of trauma (e.g., condition of the hymenal ring and size of the vaginal opening in small children)
   d. Tests for presence of sperm and venereal disease. (e.g., blood test for syphilis and cultures for gonorrhea infection of the pharynx, urine, genitals and rectum.)

3. The context should be that of an overall general physical examination. If necessary, be prepared to make the examining physician aware of the need to do a complete physical exam in order to:

   a. Identify other physical signs of child abuse or neglect.
   b. Deemphasize the psychological impact of the genital exam upon the child.

B. *Interviewing for Facts.* This may precede the medical examination or else be initiated as part of the medical exam.

1. Circumstances of the Interview

   a. Try to interview the child alone
   b. Try to obtain the child's version of what happened independent of the parents' or caretakers' or suspected perpetrator's version. Especially try to avoid having the child present during the adult's description of what transpired.

2. Approach to the Child

   a. Try to convey a relaxed, unhurried attitude throughout. If you are anxious, uncomfortable, hurried or ill at ease, the child will quickly pick this up and be affected accordingly.
   b. Establish a relationship with the child prior to discussing the alleged sexual assault. Avoid "zeroing in" on the topic of the assault prior to establishing a relationship.

c. Identify and establish the child's level of understanding of human anatomy. Find out what terminology he or she uses to identify organs and functions. Be prepared to use the child's own terminology if he or she is too young to use appropriate terms. If necessary use diagrams, pictures or dolls to illustrate or act out what may have occurred.
d. Don't dwell too heavily on the identity of the alleged perpetrator. Avoid a "whodunit" approach.
e. Avoid being judgmental about information supplied by the victim. Don't presuppose the experience was bad or painful for the child - it may have been neutral or even pleasurable. Avoid projecting your own feelings or perceptions about the situation onto the victim.
f. Don't presuppose guilt or anger in the child victim - neither may be present. Again, avoid projecting your own reactions upon the child.

C. *Interviewing for Therapeutic Purposes*

1. Child Self-Expression
Encourage the child to talk, bearing in mind that family members may discourage children from verbalizing their reactions. Drawing pictures may also assist a child to express reactions.

2. Child Reassurance
Be prepared to reassure the child about:

a. Possible physical damage to himself or herself
b. Potential consequences to child because of his or her own role in the incident (children are likely to be fearful of punishment).
c. Feelings of shame or guilt - these should be anticipated in all child victims, regardless of the degree of their cooperation with the sexual offender.

3. Parent Reassurance
Be prepared to reassure parents about potential consequences of the assault for the child.

4. Parent Participation
Enlist parents' aid in encouraging the child to express and "work through" reactions to the incident at home.

III. *APPROACH TOWARD CHILD PROTECTION*

A. *Reporting*. Be prepared to report all cases of child sexual assault to the local:

1. Child Protective Services

2. Police (even when the facts of the case do not warrant or permit prosecution, the police should receive reports for statistical purposes)

B. *Avoiding Confrontation.* Avoid confrontation between the child sexual assault victim and the alleged perpetrator whenever the alleged perpetrator is a family member. NEVER confront the alleged perpetrator with the child's own accusation against him or her in an intrafamily situation UNLESS you are certain that the child or alleged perpetrator can and will be removed from the home. To permit or initiate this type of confrontation in the absence of an effective plan to protect the child from retribution by the perpetrator is to expose the child to risk of serious bodily injury or even death.

C. *Offender - Child Relationship.* Don't presuppose that the relationship between the child and perpetrator following the alleged sexual assault incident will be negative if sexual assault actually occurred. On the contrary, a warm affectionate and loving relationship may exist and continue between the child and an incestuous parent. Observable evidence of spontaneous, fearless, and affectionate behavior between the child and alleged perpetrator neither supports nor disproves the allegation of sexual assault and should not be cited or treated as such.

D. *Sex Bias Re Targets.* Because females are traditionally regarded as the most common targets of sexual assault, it is easy to harbor a built-in bias that the only child victims of sexual assault are little girls. Do not overlook the very real possibility that little boys may be targets of sexual assault as well, in both intra-family and extra-family situations. All too often attention is focused on female children in a situation where male children are equally or perhaps at greater risk, depending on the circumstances. Whenever child sexual assault is being investigated, both male and female children should be considered possible targets and interviewed and examined accordingly.

E. *Continuum of Exposure.* In general, the incident of intra-family child sexual assault that comes to community or professional attention is rarely the first incident that has occurred within that family. Be aware that the incest phenomenon usually proves to be a continuum of exposure to sexual contact experienced by the child victim over a long period of time. A continuum of exposure should therefore be pre-supposed by the investigator unless specifically proved otherwise and investigation and examinations proceed accordingly, regardless of how long ago the alleged incident is said to have occurred.

F. *Irresolution.* Every professional who is called upon to assist child victims of sexual assault must learn to live with irresolution of many cases. Frequently the total facts elicited by investigation will neither support nor disprove the allegation. Do not automatically regard all unproved cases as unfounded. Child victims of unproved cases are often more needy of professional support and assistance than are proved victims of child sexual assault.

APPENDIX B

EXAMINATION FOR CHILD SEXUAL ASSAULT*

I. *BASIC PRINCIPLES*

Every child has the right to receive a complete examination by a competent and knowledgeable examiner if sexual assault is suspected.

The child sexual assault examination should include the following components regardless of the child's age:

A. A complete physical examination with special attention to signs of physical abuse or neglect. In children under six years, a developmental examination and skeletal x-ray survey should be strongly considered.

B. Careful inspection and description of genital anatomy with special attention to signs of urethral, genital and/or rectal trauma. In female children, the size of the vaginal opening (introitus), the condition of the hymenal ring and the diameter of the hymenal opening should be documented. An aspirate or smear of the vagina should be done to check for the presence of sperm.

C. Each child should receive special cultures to check for gonorrhea from the following areas: throat (pharynx); urethra (urine); rectum (anus); and vagina. A screening blood test for syphilis should also be done.

D. Preventive treatment for gonorrhea and syphilis (penicillin injection) should be considered. If no preventive treatment is given at the time of the initial examination, then the child should be recultured for gonorrhea (as in C) in 3-4 weeks and re-tested for syphilis (blood test) in three months.

E. A careful interview of the child alone should be done by a sensitive and knowledgeable interviewer for investigative and therapeutic purposes. In contrast, interviews of parents and/or caretaking adults should be done without the child present. Information from these interviews should be recorded by the interviewer.

F. Other children similarly situated to the alleged victim should also be evaluated in cases of sexual assault by a family member.

*Prepared by Suzanne M. Sgroi, M.D.

G. **Findings from A-F should be considered as a whole. Negative or normal findings in any single component area of investigation do not negate the significance of positive or abnormal findings in another area. Absence of proof does not constitute proof of absence.**

II. IMPLEMENTATION

How do you know if the child has received an adequate exam for sexual assault? Ask the following questions.

A. Who examined the child? What is his/her position in the medical facility? If the examination was done by an intern or resident physician, who is the responsible attending physician? Was the attending physician consulted? Did he/she review the findings? Has the case been reported to Protective Services?

B. Was a complete physical examination done? What were the findings? Was there any evidence of trauma or neglect? In children under six years, was a skeletal survey done? A developmental examination? What were the findings?

C. Was a genital/rectal examination done? Was any trauma noted in these areas? In female children, what was the size of the vaginal opening? Of the hymenal opening? Was there a check for the presence of sperm?

D. Were cultures obtained to check for gonorrhea infection of the throat, rectum, urethra, urine, and vagina? What laboratory processed these cultures? What were the results of each? Was a blood test done for syphilis? What was the result? Did the child receive preventive treatment for gonorrhea and syphilis? If not, what plans are made for reevaluation of the child?

E. If tests show that gonorrhea and/or syphilis are present, what arrangements have been made to treat the child and check other family members and children who are similarly situated? Has the case been reported to the Health Department?

F. Was the child interviewed alone? Were the child's emotional style and response to the situation taken into account? Are there any signs that the child requires therapeutic follow-up for emotional trauma, regardless of physical findings?

Remember that the absolute minimum examination to confirm sexual assault consists of genital/rectal inspection; gonorrhea cultures from throat, rectum, urethra, and vagina; a check for the presence of sperm in female children and a blood test for syphillis. If any of these were not done, the child deserves to be re-examined.

Case Name: _____
Case No. _____

APPENDIX C

PROBLEM ORIENTED RECORD*
PROBLEM LIST

Instructions:

The Problem List contains all the problems in the client's life, whether they will be dealt with or not.

Each problem should be numbered sequentially and given the appropriate problem category letter, e.g., 1A, 2A, 3B, 4B, 5C, 6D. Make an entry for each category. If there is no problem in a particular category, use the next number in sequence and the category letter, then write "no problem." Similarly, write "unknown" if the category is as yet unexplored or unknown.

Categories:

A. Child Sexual Relationships (relationships with adults, peers, younger children).

B. Adult Sexual Relationships (relationships between adults, between adults and children).

C. Intra-family Interpersonal Relationships (husband-wife, father-child, mother-child, child-child, etc.).

D. Alcohol or Other Substance Abuse (hard drugs, tranquilizers, etc.).

E. Health Problems (of any family member)

F. Educational/Employment/Financial and Environmental Factors (educational limitations; lack of job; financial; housing; transportation problems; etc.).

G. Criminal Justice System (charges against a family member, court appearances, encounters with police, DCYS, etc.).

H. Feelings About Self (of any family member).

J. Interpersonal/Social Relationships.

K. Other

*The Problem Oriented Record was developed by Child and Family Services, Inc., of Connecticut for use in the Sexual Trauma Treatment Program.

Case Name_____
Case No._____

PROBLEM ORIENTED RECORD
PROBLEM LIST

Date	Wkr	No. Ctgry	Problem	Closing Status (Date)				Activity (Check)		
				Setld	Impr	No Chng	Worse	Wrked On	Tchd	Not Addrsd
11/14	BB	1A	Deborah K. said grandfather sexually molested her.							
11/14	BB	2C	Deborah says grandfather displays pornographic material to her & friends - embarrassing her.							
11/14	NB SB	3C	Deborah & grandfather refuse to tell whereabouts of Deborah's mother.							
11/24	ND	4F	School attendance is spotty - not attending school regularly.							
11/24	ND	5C	Deborah claims grandfather deals in stolen goods.							
11/24	SB	6G	Police have searched grandfather's home for pornographic materials.							
11/24	ND	7C	Child & grandfather disagree about house rules, such as hours, friends, where she goes.							
11/24	ND	8C	Deborah feels rejected and deserted by mother.							

Case Name_____
Case No._____

PROBLEM ORIENTED RECORD
PROBLEM LIST

Date	Wkr	No. Ctgry	Problem	Closing Status (Dates)				Activity (Check)		
				Setld	Impr	No Chng	Worse	Wrked On	Tchd	Not Addrsd
11/24	ND	9C	Deborah has no relationships with father.							
11/24	SB	10A 10A	Grandfather suspects Deborah is sexually active.							
11/24	SB	11B	No problem							
11/24	SB ND	12D	No problem							
11/24	SB ND	13E	No problem							
11/24	SB ND	14H	Unknown							
11/24	ND	15C	Friends call grandfather "Crazy Grandpa John."							
11/24	SB BB	16F	Deborah left grandfather's home & is living with friends.	11/15						
11/24	BB ND	17J	Unknown							

Case Name_____
Case No._____

TREATMENT PLAN

Instructions:

Record a plan for every problem on the problem list, using the problem's identifying number and letter. Be as specific as you can. A problem may have more than one plan. If there is no plan, record "no plan!" If a plan is not carried through, the subsequent plan should state why the original plan was not completed.

The plan sheet should be updated biweekly by dating and initialling in the appropriate column, e.g., initial in "Yes" column if worked on during these two weeks, in "No" if not worked on. If the plan is completed, record date in the completed column. New plans should be recorded and dated.

				Biweekly Update						
				Date		Date		Date		
No. Ctgry	Wkr	Treatment Plan - Include by Whom	IP Date	12/12 Yes	12/12 No	12/26 Yes	12/26 No			Date Cmpld
1A 2C	BB	Assign team Sava-Grandfather, Natalie-Deborah, Marie-Mother.	11/14							11/14
1A 2C	ND	Natalie will see Deb. once a week to explore allegation & subsequent denial of allegation.	11/24	ND			ND			
1A 2C	SB	Sava will see grandfather biweekly to further explore allegation.	11/24	SB		SB				
3C	SB	Sava told grandfather and Deborah to contact mother and inform her of what has happened.	11/24		SB		SB			
4F	SD	Natalie will support school officials in dealing with truancy & encourage Deborah to go to school.	11/24	ND		ND				
5C	ND	No plan	11/24							
6G	SB	No plan	11/24							

Case Name _____
Case No. _____

TREATMENT PLAN

Instructions:

Record a plan for every problem on the problem list, using the problem's identifying number and letter. Be as specific as you can. A problem may have more than one plan. If there is no plan, record "no plan." If a plan is not carried through, the subsequent plan should state why the original plan was not completed.

The plan sheet should be updated biweekly by dating and initialling in the appropriate column, e.g., initial in "Yes" column if worked on during these two weeks, in "No" if not worked on. If the plan is completed, record date in the completed column. New plans should be recorded and dated.

				Biweekly Update						
				Date		Date		Date		
No. Ctgry	Wkr	Treatment Plan - Include by Whom	1P Date	12/12		12/26				Date Cmpld
				Yes	No	Yes	No	Yes	No	
7C	SB	Sava will meet with grandfather to prepare for contingency contract.	11/24	SB						12/09
7C	ND	Natalie will meet with Deborah individually to prepare for contingency contracting.	11/24	ND						12/12
8C	ND	Natalie will explore feelings about mother in individual sessions.	11/24		ND	ND				
9C	ND	No plan	11/24							
10A	ND	Natalie will give sex information & explore use of contraception with Deborah.	11/24		ND		ND			
14H	ND	Natalie will obtain psychological evaluation on Deborah from Klingburg school.	11/24			ND				12/23

APPENDIX D

CHILD SEXUAL ASSAULT - A SELECTED BIBLIOGRAPHY

Articles

Overview and Incidence:

Gagnon, John H., "Female Child Victims of Sex Offenses," Social Problems, 13 (1965), pp. 176-192.

Henderson, D. James, "Incest: A Synthesis of Data," Canadian Psychiatric Association Journal, 17 (1972), pp. 299-313.

Dynamics and Phenomenology:

Broderick, D., "Sexual Behavior Among Pre-Adolescents," Journal of Social Issues, 22 (1966), pp. 6-12.

Burgess, Ann W. and Holmstrom, Lynda Lytle, "Sexual Trauma of Children and Adolescents: Pressure, Sex and Secrecy," Nursing Clinics of North America, 10, No. 3 (September 1975), pp. 551-563.

Groth, A. Nicholas and Burgess, Ann W., "Motivational Intent in the Sexual Assault of Children," Criminal Justice and Behavior, September 1977, pp. 253-264.

Lustig, N., Dresser, J., Spellman, S., Murray, T., "Incest: A Family Group Survival Pattern," Archives of General Psychiatry, 14 (1966), pp. 31-40.

Poznanski, E. and Blos, P., "Incest," Medical Aspects of Human Sexuality, October 1975, p. 46.

Virkunev, M., "Incest Offenses and Alcoholism," Medicine, Science and the Law, 14 (1974), pp. 124-128.

Investigation:

Sgroi, Suzanne M., "Kids with Clap: Gonorrhea as an Indicator of Child Sexual Assault," Victimology: An International Journal, 2, Fall 1977, pp. 251-267,

Stevens, Doris and Berliner, Lucy, "Special Techniques for Child Witnesses" (mimeo) Center for Women's Policy Studies, 2000 P Street, N.W., Suite 508, Washington, D.C. 20036, (1977).

Treatment:

Browning, Diane H. and Boatman, Bonny, "Incest: Children at Risk," American Journal of Psychiatry, 134, (1977), pp. 69-72.

Giarretto, Henry, "Humanistic Treatment of Father - Daughter Incest," Child Abuse and Neglect - The Family and the Community, Editors: R. E. Helfer and C. H. Kempe, Michigan State University, Ballinger Publications, 1977.

Books

Burgess, Ann W., Groth, A. Nicholas, Holmstrom, Lynda Lytle, Sgroi, Suzanne M., Sexual Assault of Children and Adolescents, Lexington Books, Massachusetts, 1978.

De Francis, Vincent, Protecting the Child Victim of Sex Crimes Committed by Adults, American Humane Association, Denver, Colorado, 1969.

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